

The National Policy Guidelines and Service Standards for Reproductive Health Services

Reproductive Health Division
Community Health Department

Ministry of Health

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Preface

The Government of Uganda recognises that its population is the most valuable asset and is an integral component of the development process. The development goals are therefore geared-towards the improvement of the quality of life of its population. The attainment of these goals, however, are being hampered by high fertility, maternal, infant morbidity and mortality rates.

In 1995, the maternal mortality ratio stood at 506:100,000 live births, IMR was 97:1000 live births, the total fertility rate was 6.9 births and the contraceptive prevalence rate was 15%. The major causes of morbidity and mortality are preventable. One of the major strategies for reducing IMR, MMR and fertility is ensuring access to quality integrated RH services. The development of the national policy guidelines and service standards for RH service delivery is therefore geared towards the -attainment of this objective.

The document has been developed by the Ministry of Health, Reproductive Health Division together with the concerted effort of different people and partners interested in the promotion of RH. The MOH is very grateful for their inputs.

It is, therefore, my hope that this document will be utilised by all stakeholders for the improvement of the quality and coverage of reproductive health services.

Thank you,

Professor Francis G. Omaswa Director General of Health Services Ministry of Health

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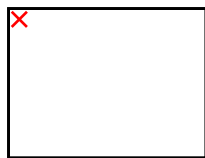
This document was prepared jointly by the MOH, Population Secretariat, representatives of Nurses and Midwives Council, Uganda Medical and Dental Practitioners Council, Commercial Market Strategies Project, Uganda Protestant and Catholic Medical Bureaus, Makerere Medical School, and the Ministry of Gender, Community Development and Labour. The MOH-RH Division, therefore, wishes to acknowledge the contributions of development partners, NGO's, agencies and individuals who made the document a reality.

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We are also very grateful to Dr Khama Rogo for his technical advice, Mrs Janet Nyeko for editorial services, Stella Lamwaka and Rose Makuma for secretarial services.

It is hoped that the integration of quality RH services will now be a reality. For God and my country.



Dr. Florence A.O. Ebanyat

Assistant Commissioner for Health Services (Reproductive Health)

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Acronyms Used

| | |
|------|--------------------------------------|
| ARH | Adolescent Reproductive Health |
| ANC | Ante-natal care |
| BBT | Basal Body Temperature |
| BP | Blood pressure |
| CBC | Community-Based Care |
| CBD | Community-based distribution |
| CBDA | Community-based distribution agent |
| CHW | Community health worker |
| CIN | Cervical intraepithelial neoplasia |
| COC | Combined oral contraceptive |
| CRHW | Community reproductive health worker |
| DDHS | Director of District Health Services |
| DHMT | District health management team |
| DHT | District health team |
| EC | Emergency contraceptives |
| ECP | Emergency contraceptive pill |
| FGM | Female genital mutilation |

| | |
|----------|---|
| FP | Family planning |
| GOP | Gynecological out patients |
| HIS | Health information system |
| HMIS | Health management information system |
| HSD | Health sub district |
| ICPD | International Conference on Population and Development |
| IEC | Information, Education and Communication |
| IMR | Infant Mortality Rate |
| IU | International unit |
| IUD/IUCD | Intra-uterine device/intra uterine contraceptive device |
| IV | Intravenous |
| LAM | Lactational Amenorrhoea Method |
| LC | Local Council |
| LMIS | Logistics Management Information System |
| MOH | Ministry of Health |
| MMR | Maternal Mortality Ratio |
| MTCT | Mother to Child Transmission |
| NGO | Non-Governmental Organization |
| PAC | Post-Abortion Care |
| PDC | Parish Development Committee |
| PID | Pelvic Inflammatory Disease |
| PNC | Post-Natal Care |
| POP | Progesterone Only Pill |
| PWA | People living with AIDS |
| RH | Reproductive Health |
| RHS | Reproductive Health Services |
| SDP | Service Delivery Point |
| STI | Sexually Transmitted Infections |
| TBA | Traditional Birth Attendant |
| TSS | Toxic Shock Syndrome |
| TV | Television |
| UNHRO | Uganda National Health Research Organization |
| UVI | Unaided Visual Inspection |
| VCCT | Voluntary Confidential Counseling and Testing |
| VCT | Voluntary Counseling and Testing |
| VIA | Visual Inspection with Acetic Acid |
| VSC | Voluntary Surgical Contraception |
| VVF/RVF | Vesicle Vaginal Fistula/Recto Vaginal Fistula |
| WHO | World Health Organization |

Chapter 1: Introduction

The mission of the Reproductive Health Division is to attain the highest possible level of health for all the people in Uganda through the development of appropriate RH policies, objectives and strategies.

After adopting the RH concept as recommended by the ICPD conference in 1994, it was noted that the existing service policy catered mainly for family planning and maternal health, while other components of RH received little attention. A decision was, therefore, made to update the policy guidelines to include all components of RH. These are: safe motherhood, family planning, adolescent health, prevention and management of unsafe abortion, RH tract infections including STI/HIV/AIDS, infertility, cancers, obstetric fistulae and gender based violence.

1.1 What the document contains

This document has two sets of guidelines: service policy guidelines and service standards that aim at making explicit the direction of reproductive health within the context of primary health care.

The service policy guidelines spell out the general rules and regulations governing reproductive health services and training, components

of reproductive health services, target and priority groups for services and basic information education and communication (IEC) for the target and priority groups. It also identifies those eligible for services, who will provide what services, and how training, logistics, supervision and evaluation activities will be planned and implemented.

The service standards set out the minimum acceptable level of performance and expectations for each component of reproductive health services, expected functions of service providers, and the various levels of service delivery and basic training content required for the performance of these functions.

In this document, service delivery refers to the combination of technical, organisational and managerial activities. It also refers to the tasks that facilitate service provision and evaluation.

1.2 Purpose of the document

The document is an attempt to address the need for explicit direction and focus, as well as to streamline the training and provision of reproductive health services.

It provides a framework for guiding reform and development of a results oriented national reproductive health program. It also seeks to make reproductive health programmes and services accessible and affordable to the majority of the target groups. It sets priorities for reproductive health development and clarifies the roles of various agencies involved with financing and provision of services and programmes. It is expected that this document will help to provide a coherent and coordinated reproductive health programme.

The policy guidelines and standards presented in the document reflect the current national goals and priorities as stipulated by the Ministry of Health within the framework of the National Health Policy. They also address the gaps and inconsistencies that are currently interfering with the provision of reproductive Health services and training for service improvement. They provide a set of basic expectations and minimum acceptable levels of service provisions and training.

1.3 Who may use it

These guidelines are written for use by -government and non-governmental organisations who participate in reproductive health service delivery. These include programme planners and managers, service managers and supervisors, service providers and trainers at all levels in the pre-service and in-service training programmes.

1.4 How to use it

Programme managers shall use the guidelines to determine national service targets for various components of reproductive health, set service objectives and identify the required resources including categories and numbers to be trained for specific service components. Service managers and providers shall use the guidelines to identify types of services to be provided at each level and how to organize them to meet the established standards. Training programme planners shall use the guidelines to set training targets and priorities, identify required resources and prepare training strategies that respond to service needs and service standards. The guidelines shall be used to monitor and evaluate service availability, accessibility, quality and utilisation.

Chapter 2: Definition of Reproductive Health and Uganda National Policy Concerns

2.1 Definition of Reproductive Health

Reproductive health is a state of complete physical, mental, emotional and social well-being in all matters related to the reproductive system, its functions and processes. It includes sexual health, the enhancement of life and personal relations, counseling and care related to reproduction and sexually transmitted diseases. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when and how often to do so.

2.2 Reproductive Rights

Reproductive rights embrace certain human rights that are already recognized in national laws and international human rights documents. These include:

- the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children;
- the right to information and means to make the decisions as stated above;
- the right to attain the highest standard of sexual and reproductive health;
- the right to make decisions concerning reproduction, free of discrimination, coercion and violence.

These policy guidelines aim at the promotion of these rights in Uganda.

2.3 Components of Reproductive Health and Priorities for Uganda

The 1994 ICPD in Cairo outlined the following components of RH:

- safe motherhood including breast feeding and nutrition, pre-natal care, safe delivery and post-natal care, information, education and counseling on reproductive health and sexuality;
- abortion and post-abortion care;

- family planning;
- information, education and communication (IEC) and counseling for RH services;
- infertility prevention and treatment;
- adolescent reproductive health;
- STI/HIV/AIDS;
- violence against women and female genital mutilation (FGM);
- reproductive health cancer;
- menopause and andropause.

In 1999 the Ministry of Health developed a minimum Reproductive Health Package, being a reflection of the national priorities. This Package includes:

- safe motherhood, including post-abortion care;
- family planning;
- adolescent sexual and reproductive health;
- STIs including HIV/AIDS;
- reproductive organ cancer;
- gender practices that perpetuate poor reproductive health.

2.4 Policy Goals and Objectives

The goal of Uganda's RH policy to improve the sexual and reproductive health of everyone in the country. The objectives are to:

- guide planning, implementation, monitoring and evaluation of quality integrated gender sensitive RH services;
- standardize the delivery of RH services;
- ensure optimum and efficient use of resources for the sustainability of RH services.

2.5 Implementing Reproductive Health Services

The major focus of the RH policy guidelines is to improve and ensure the provision of quality and accessible RH services. The reproductive health care delivery system will operate at the national and district levels, through both the facility and community outreach.

2.5.1 At the national level

The Reproductive Health Division under the Community Health Department will perform the following tasks:

- policy formulation, setting standards and quality assurance;
- resource mobilization for RH programs;
- capacity development and technical support;
- coordination of RH services and stakeholders;
- monitoring and evaluation of overall RH sector performance;
- coordination of reproductive health research;
- strengthening of the linkage between the national, regional and district referral hospitals;
- coordination and ensuring of inter-sectoral linkage with line ministries, NGOs, and the private sector;
- Coordination of IEC interventions.

2.5.2 National and Regional Hospitals:

- offer specialized RHS including emergency obstetric care;
- plan and manage RHS;
- offer promotional, preventive, curative and rehabilitative RHS;
- mobilize resources;
- implement IEC activities
- Implement training
- conduct operations research;
- collect, utilize and disseminate gender desegregated RH data;
- receive and transfer referrals to higher and lower levels;
- supervise lower level health facilities.

2.5.3 Training Institutions:

- Implement training
- conduct operations research;

2.5.4 At the district level:

The following tasks will be performed by the District Health Office:

- planning and management of RHS;
- implementation of RHS;
- monitoring and support-supervision to ensure quality of care;
- resource mobilization;
- coordination of activities of the NGOs, private sector and line ministries;
- providing guidance to district councils and advocating for support for RHS;
- promoting community participation and involvement in RHS delivery;
- ensuring liaison between the center and lower levels;
- gender desegregated health data collection, management, interpretation, dissemination and utilization;
- capacity building for lower levels.
- Coordination and implementation of IEC activities

The district referral hospitals will:

- offer specialized RHS including emergency obstetric care;
- plan and manage RHS;
- offer promotional, preventive, curative and rehabilitative RHS;
- mobilize resources;
- implement IEC activities
- Implement training
- conduct operations research;
- collect, utilize and disseminate gender desegregated RH data;
- receive and transfer referrals to higher and lower levels;
- supervise lower level health facilities.

The Health Center IV will:

- Services the county catchment area
- offer specialized RHS including emergency obstetric care;
- plan and manage RH services;
- implement RH services;
- offer promotional, preventive, curative and rehabilitative RHS;
- mobilize resources;
- Provide IEC
- conduct operations research;
- collect, utilize and disseminate gender desegregated RH data;
- receive and transfer referrals to higher and lower levels;
- supervise lower level health facilities.

The Health Center III will:

- service sub-county catchment area;
- provide preventive, promotional, curative and maternity care;
- supervise community outreach;
- refer clients to Health Center IV or district hospital.

The Community level:

In line with the Health policy, community participation is key to the success and sustainability of the RH program. There are different resource persons at the community level. These include the TBA, CBDA, CRHW, peer providers, herbalists, families and individuals whose role should be to:

- mobilize people for RHS;
- mobilize resources;
- distribute commodities;
- provide and disseminate RH information;
- promote cultural practices that enhance reproductive health while discouraging the negative ones.

2.5.3 Service integration:

In line with the MOH health policy, the integration of RH services into all existing health services will be facilitated through:

- capacity building (training);
- improvement of infrastructure;
- increasing the range of commodities and sustaining availability;
- integrated supervision (monitoring and evaluation).

2.6 Training

Since the adoption of the ICPD recommendations, it has been necessary to orient health care providers to implement the minimum Reproductive Health Care Package while at the same time maintaining quality. In order to offer improve the quality of health care, training will be carried out at all levels. Top priority will be given to preparing providers to handle adolescents and men.

The Reproductive Health Division in collaboration with the Human Resource Division and districts will prioritize institutional capacity building at the district level.

It will also identify reproductive health training needs for service providers and address them through appropriate integrated continuing education. In addition, the Division will give technical guidance and support to the Human Resource Division, professional councils and Ministry of Education and Sports during the development, review and updating of training manuals and curricula for pre service training as the need arises. In order to standardize RH-related training and quality of care, programs implementing reproductive health activities will use only the Ministry of Health- approved curriculum and manuals.

2.7 Infrastructure Improvement

All service delivery points (SDPs) providing RH will be, rehabilitated and, remodeled to enhance patient flow and ensure privacy to patients and clients. An important consideration will be to make them friendly to the adolescents, youth and men.

2.8 Logistics and Supplies

The implementation of the Reproductive Health Package requires the availability of the standard commodities and supplies at all levels, in optimum quality and quantities, at all times.

2.8.1 Procurement

The procurement of RH commodities and supplies into the country will be carried out in accordance with the approved national MOH standards and procedures and within the guidelines laid down by the National Drug Authority. Within the country, it will be carried out in accordance with the stipulated national MOH and local government guidelines.

2.8.2 Storage

The National Medical Store will provide storage facilities and distribute commodities and supplies according to the national guidelines. At the district level, they will be received and stored at the District Medical Store and at the health facility level, they will be received and stored in an approved storeroom and the inventory management will be carried out according to approved guidelines.

2.8.3 Distribution

The distribution of commodities and supplies will be according to district requirements on request and follow a regular schedule as developed by the National Medical Store. From district to lower level facilities, it will be demand driven. In all cases, distribution of commodities and supplies will be according to approved maximum/minimum principles.

2.8.4 Equipment

Procurement, distribution and maintenance of equipment will be according to the MOH national guidelines.

2.9 Monitoring, Evaluation, Supervision and Research

2.9.1 Monitoring and evaluation

The aim of monitoring and evaluation of the reproductive health services is to assess:

- the scope, effects and impact of training health workers and implementation of services;
- the quantity and quality of services provided at various service delivery points
- to ensure adequate/appropriate response to the reproductive health needs of all clients;
- the response levels and trends to the RH services as a factor of the quantity and quality of services.

Regular monitoring will be carried out at every level and results used to influence decision and practice at that level. Standard indicators will be used for monitoring and evaluating the process and impact as laid down by the national supervision requirements.

2.9.2 Supervision

Supervision is an essential component of program evaluation and ensures adherence to guidelines in the provision of services. Support and facilitative supervision at all levels will be carried out in accordance with the national supervision guidelines for health services using standard instruments developed by the MOH and RH division.

2.9.3 Research

Research is a critical tool for evidence-based policy and decision making.

In collaboration with UNHRO and the district directors of health services, RH research agenda will be identified, implemented and utilized to guide RH planning and further policy articulation and changes.

Chapter 3: Family Planning and contraceptive Service Delivery

3.1 Background

Implicit in the ICPD definition of RH is the right of men and women to be informed and have access to safe, effective, affordable and acceptable method of family planning of their choice. Family planning, therefore, offers individuals and couples the ability to anticipate and attain the desired number of children through spacing and timing of their births. This may be through the treatment of involuntary infertility and contraception.

3.2 Policy Goal and Objectives

The goal is to provide information and services that will enable individuals and couples to decide freely and responsibly when, how often and how many children to have. While the objectives are to:

- increase access to quality, affordable, acceptable and sustainable family planning services to everyone who needs contraception;
- promote strong integrated family planning information and services in all health sectors and levels.

3.3 Target and Priority Groups

Everyone in need of contraception is to be targeted. However, the priority groups will be:

- women who have had 1 or more pregnancies;
- post abortion and post-partum clients;
- women who are over 35 years old;
- adolescents;
- women with current or post obstetric, medical and surgical conditions likely to worsen with pregnancy and child birth e. g sickle cell disease, hypertension, diabetes mellitus, psychiatric conditions and cesarean sections etc;
- couples who want to limit or space their families;
- polygamous men;
- women who have had unprotected or unwanted sex;
- individuals or couples infected with HIV.

3.4 Strategies

To achieve the set objectives the following strategies will be strengthened:

- IEC, using all modalities of communication to reach everyone;
- counseling;
- provision of quality family planning services; training;
- Reorganization of service sites to accommodate youth and men.

These will be realized through the:

- expansion of service delivery points;
- improvement of communication through community based and social marketing approaches;
- improvement of the training of service providers to enhance technical skills and change attitudes;
- guaranteeing the availability of family planning commodities and supplies at all levels;
- improvement of family planning logistics management (LMIS/HMIS);
- enhancement of political and community support and participation in family planning activities;
- improvement of record keeping;
- strengthening of the follow-up, supervision and referral systems.

3.5 Eligibility for Family Planning Services

All sexually active males and females in need of contraception are eligible for family planning services provided that:

- they have been educated and counseled on all available family planning methods and choices;
- attention has been paid to their current medical, obstetric contra-indications and personal preferences.

3.6 Consent for family planning services

No verbal or written consent is required from parent, guardian or spouse before a client can be given family planning services.

3.7 Family Planning Service Standards

Family planning service standards describe:

- modalities of providing IEC;
- service delivery outlets;
- basic family planning services to be provided;
- basic family planning methods to be provided at each service delivery point;
- provider cadres, adequately trained in accordance with the policy guidelines to give different types of family planning services;
- job functions of the family planning providers.

3.7.1 Information Education and Communication:

IEC aims at increasing everyone's awareness of contraception so as to increase the utilization of the FP services. The following settings and channels will be used for the dissemination of FP information:

Settings

- service delivery points where a health provider comes into contact with a potential or actual client;
- social mobilization for any health services;
- youth clubs and schools through family life education activities;
- women and men organized clubs/groups;
- work places.

Channels

- bill boards;
- home visits;
- public addresses;
- electronic and print media;
- local council meetings;
- group discussions;

The basic FP messages should include:

- health and non-health benefits of family planning;
- socio-economic and demographic benefits of FP;
- dangers of grand multiparity;
- benefits of pre-conception care and counseling;

- benefits of post abortion care and counseling;
- dangers of pregnancy in persons with medical conditions and disorders;
- risks of conception and pregnancy in persons with HIV infection and AIDS;
- types of FP methods available for females and males and where to obtain them;
- prevention of STD and HIV/AIDS.

Both health and non-health personnel will be actively involved with IEC activities after they have been well trained or oriented in respective subjects, counseling and communication for FP services.

3.7.2 Service delivery outlets

In line with the health policy of the MOH, services will continue to be provided through government, non-governmental and private sector facilities, units and outlets. The following being the recognized outlets of FP service provision:

- clinic or facility based outlets such as hospitals, health centers and dispensaries;
- outreach services including mobile clinics;
- community-based outlets e.g. community-based distribution (CBD), drug shops and dispensing machines;
- social marketing;
- private sector facility such as clinics, maternity and nursing homes, pharmacies and drug retail shops.

| Service Provision by Cadre of staff | | | | | | | |
|-------------------------------------|------------------|-------------------------|--------------------|-------|---------|------------------|--------|
| | Social Marketing | Community Health Worker | Nursing Assistants | Nurse | Midwife | Clinical Officer | Doctor |
| | X | X | X | X | X | X | X |
| | X | X | X | | | | |
| talks | X | X | X | X | X | X | X |
| ages | X | X | | X | X | X | X |
| messages | | | | X | X | X | X |
| intraconatives | X | X | X | X | X | X | X |
| / Pill | X | X | X | X | X | X | X |
| | X | X | X | X | X | X | X |
| | | | | X | X | X | X |
| | | | | X | X | X | X |
| ce | | | | | X | | x |
| | X | X | X | X | X | X | X |
| | X | X | X | X | X | X | X |
| | | | | | X | | x |
| tion | | | | | | | X |
| | | | | | | | X |
| | | | | | X | X | x |
| ception | X | X | X | X | X | X | x |
| er cadres | | | | X | X | x | x |

Note: Natural FP methods officially known for their effectiveness will be encouraged at every level by all service providers.

All personnel involved in the provision of FP services must be adequately trained and equipped to provide quality service. The training in the FP and RH will be based on the curriculum approved by the MOH. The training of FP service providers will be conducted at two levels: **pre-service** at recognized institutions and **in-service** by recognized institutions and NGOs and by trainers certified by the MOH.

- **IUCD insertion will only be inserted by midwives who have been trained and certified by the MOH.**

3.7.3 Basic family planning services to be provided

These will consist of counseling and screening for contraceptive use.

Counseling:

In order to promote informed choice, all clients seeking contraceptives will be given adequate information about all methods available in the country and counseled on each. This is important for the initiation and continuation of FP practice. Counseling of new clients will be done individually and in a dignified manner. The discussion between the service provider and client must be private, confidential and should never include incentives or coercion for the adoption of any method.

Initial counseling will include the following:

- a discussion of a client's reproductive goals, previous knowledge and/or experience with any method;
 - clarification of misconceptions or rumors the client may have about each type of method;
 - showing the FP methods available;
 - information on how each method prevents pregnancy;
 - how effective the method is and what conditions make it effective;
 - method failure;
 - common side effects;
 - the follow-up regarding each method;
 - where the method can be obtained;
 - importance of physical and pelvic examination;
 - counseling on STI/HIV and AIDS;
 - information about breast and cervical cancer.

Subsequent counseling will aim at promoting and encouraging continued use of a method and should include:

- a review of the client's satisfaction or problem with the method;
- a review of the client's understanding of user instructions;
- dispelling rumors and/or misconceptions, if any;
- if indicated, a review of change of the client's reproductive goal necessitating the need for a long-term or permanent method;
- counseling on STI and HIV/AIDS;
- possible method failure;
- prevention of breast and cervical cancer.

Counseling is also important:

- where a contraceptive method has failed;
- there is permanent method regret;
- in cases of rape or defilement;
- where there is need for referral for appropriate care.

The Counselling process (the GATHER process)

The six possible steps in counseling are easy to remember as **GATHER**

Greet and prepare the client

- Establish rapport
- Assure confidentiality

Explain that the counseling session may take a long time and ensure that the client has time

Ask client about self

- Use positive statements e.g. encouragers, thank you
- Reasons for visit
- Awareness about problems
- Identified problems effect on self and family
- Help Client to decide on priority problems

Tell about /provide complete, accurate and clear information in relation to: The issues

Tell about/provide complete, accurate and clear information in relation to the issues

Help Client

- To explore all possible solutions
- Choose the most suitable service
- make a voluntary decision on what she/he would like to address

Explain

- Steps to implement the solutions

Return visit scheduled for/refer

- Resupply
- Follow-up
- Further Counselling

Screening:

After a thorough counseling a client should then be ready to choose a contraceptive method. The next step is to screen for contraceptive use.

- Clients opting for **hormonal** method should have relevant health, social history taken and physical assessment carried out on the first or subsequent visits. **Where indicated, a complete physical check-up is essential to rule out contra-indication to method use.** Where it is not possible or necessary to perform routine physical assessment, the client should be screened by a qualified staff or FP trained nurse aide/assistant using a standard checklist to initiate or re-supply oral contraceptive or Depo provera.
- After the screening, important findings will be communicated to the client including any issues she/he may want clarification on. The client will then be provided with the appropriate or preferred method.

Routine physical or pelvic examination is no obligatory for initiating or re-supply of OCs or Depo provera. However, an examination could be valuable for reproductive health and may help to rule out contra-indications to method and/or establishing the presence or absence of infections or cancer.

Where selected physical assessment or laboratory tests are indicated and is not possible to carry them out at a particular clinic, clients should be referred to a health unit capable of providing the assessment test.

- Clients opting for **IUD** should have their health, social and relevant physical/pelvic assessment carried out in accordance with the stipulated IUD procedure.
- In case of **community based distribution services**, the CBD agent should obtain the client's health and social history during the initial encounter using the standard checklist. The agent will then initiate or provide the appropriate OC or barrier method if no problems are identified.
- In **social marketing outlets**, the screening will depend on the level of the service, the competence of the provider and resources available.

3.8 Types of Family Planning Methods to be Made Available

In order to increase the method mix and promote informed choice, all methods, both temporary and permanent, will be provided and made available in the country. The following methods are available in Uganda: hormonal, intra-uterine device, barrier, permanent, and fertility awareness based. Some of the methods require authorization for use by a qualified health worker as shown in Table 1 (**prescriptive methods**) while others can be offered by trained non-skilled personnel such as community Reproductive Health workers (CRHWs) and social marketing agents (**non-prescriptive methods**).

3.8.1 Prescriptive methods

These include the following hormonal contraceptives:

- oral contraceptive, both combined (COP), Progesterone only pills (POP), Levonorgestrel Progesterone only emergency contraceptive pills;
- Injectables e.g. Depo provera and Noristerat
- Implants e.g. Norplant;

Or intra-uterine contraceptives:

- Copper T 380 A
- Multiload;

Or permanent contraceptives:

- tubal ligation;
- vasectomy.

Re-supply of pills may be carried out by non-skilled and social marketing, agents without revisiting a qualified health worker,

3.8.2 Non-prescriptive methods

Include:

- natural family planning methods (fertility awareness);
- barrier methods e.g. condoms (both female and male), spermicidal foam and jelly, foaming tablets, and diaphragm;
- lactational amenorrhea (breast feeding).

Family planning clients have the right to be referred to another SDP if their preferred method of choice is not available at the health unit of call or the provider lacks the skills needed to provide such services safely. During the referral, appropriate counselling and alternative temporary contraceptive should be provided to prevent unwanted pregnancy.

Most family planning methods do not protect against STI/HIV. If there is a risk of STI/HIV the correct and consistent use of condoms is recommended either alone or with another contraceptive. Male/Female latex condoms are proven to protect against STI/HIV

3.9 Eligibility for Family Planning Methods

This spells out persons who are eligible for particular family planning methods.

3.9.1 Combined oral contraceptives (COC)

Who can use COC?

- sexually active adolescents;
- women with anemia;
- women with dysmenorrhoea;
- women with irregular cycles;
- women with history of ectopic pregnancies;
- diabetics lasting less than 20 years or without evidence of hypertension;
- patients with endometrial, ovarian or cervical cancer; but the basic problem must be treated
- women with BP less than 160/100 mmHg;
- women with trophoblastic disease.

Who should not use COC?

The following contra-indicate administration of COC:

- pregnancy;
- complications or side effects that a service provider is not capable of handling;
- breast feeding mothers less than 8 weeks post partum;
- unexplained vaginal bleeding;
- women due for major surgery within four weeks;
- current deep vein thrombosis;
- vascular disease;
- Heavy smokers(>20 sticks a day)
- migraine;
- current breast cancer undiagnosed;
- liver disease e.g. hepatitis, cancer, cirrhosis;
- history of ischaemic heart disease;
- stroke;
- major surgery with prolonged immobilization;
- jaundice;
- hypertension greater than 160/100 mmHg;
- women judged to be forgetful or mentally retarded;
- active hepatitis.

To date there is no concrete evidence that oral contraceptives have any effect on the transmission of HIV or the course of AIDS once a person is infected.

When can the client start taking the pill?

The client can start taking the pill:

- anytime provided pregnancy has been ruled out;
- during the first seven days of the menstrual cycle;
- three weeks following delivery, if not breast feeding;
- six months post partum if breast feeding;
- immediately following abortion.

3.9.2 Progesterone only pill (POP)

Who can use POP?

- breast feeding mothers;
- post abortion clients;
- women in whom oestrogens are contra-indicated;
- women with BP more than 180/110 mmHg;
- women with sickle cell disease;
- diabetics **without** evidence of hypertension or history of a heart attack;
- women who have isolated history of pregnancy-induced hypertension;
- smokers;
- those due for major surgery;
- those with thrombo-embolic disease;
- those with congenital heart disease;

Who should not use POP?

- pregnant mothers;
- women deemed forgetful or mentally retarded;
- women with breast cancer;
- women undertaking treatment for epilepsy with phenytoin or TB with Rifampicin.

When a woman is not breast feeding and can use combined oral contraceptive pills, she should consider using them rather than progesterone oral pills because the former are more effective.-

When can the client begin to use POP?

- any time provided pregnancy has been ruled out;
- the first 7 days of the menstrual cycle;
- immediate post-partum period if not breast feeding;

Initial- 150 mgs, administered deep intramuscularly.

Subsequent visits- 3 months after each injection is the optimal interval

Interval between one injection and the next-dose of Depo provera clients who return after 12 weeks and before 14 weeks will also be given their usual

Noristerat

Initial -200 mgs, administered intramuscularly

Subsequent dose(s) – 8 weeks

Interval between one injection and the next - clients who return any time between 9 and 12 weeks shall be given the usual dose of Noristerat without having to be tested for pregnancy exclusion.

3.9.4 Norplant implants

Who can use Norplant implants?

- women who desire a long term hormonal reversible method of contraception that does not require daily action;

- women with desired family size who do not want tubal ligation;
- women with history of ectopic pregnancy;
- women who cannot remember to take the pill every day (e.g. some adolescents).

Who should not use Norplant implants?

As for POP.

3.9.5 Intra-uterine contraceptive devices (IUD) Who can use IUD?

- women of reproductive age who prefer a non-hormonal long term method of contraception that does not require daily action;
- women living far away from FP service delivery points;
- breast feeding mothers;
- women at low risk of STIs;
- women who can not remember taking the pill every day;
- women who can not use or do not want the hormonal methods .

Who cannot use IUD?

- pregnant women;
- women with unexplained vaginal bleeding;
- those with PID within the last 3 months;
- women with trophoblastic disease or pelvic tuberculosis;
- women with genital cancer including endometrial cancer;
- those with polygamous or multiple sexual partners.
- women with conditions that impair their response to infection, for example,
- those who are HIV-positive, have AIDS or diabetes mellitus.
- women with pueperal sepsis;
- women immediately after a septic abortion;
- women with known uterine cavity abnormality.

Timing of insertion of IUDs:

- any time provided pregnancy is ruled out;
- the first 7 days of the menstrual cycle;
- immediately following delivery;
- any time beyond 6 weeks after delivery;
- immediately or within 7 days of an uncomplicated abortion;
- 3 months after a cesarean section.

Check-up routine for users of IUDs:

- at 6 weeks following insertion;
- at 6 months;
- annually and whenever the need arises.

For procedures on insertion and check-up see the Procedure Manual

3.9.6 Barrier Methods

Barrier methods must be used consistently and correctly if they are to be effective.

Condoms (male and female)

Who can use condoms?

Condoms can be used by any man and woman but more so:

- men wishing to participate more actively in family planning;
- couples who need contraception immediately and are not yet protected;
- couples who need a temporary method while waiting for another method;

- couples needing a backup method;
- individuals in a relationship in which either partner has more than one sexual partner;
- women at risk of STIs;
- couples who have sexual intercourse infrequently;
- couples where one or both partners are HIV positive.

Barrier methods, if used correctly, have been shown to provide a high degree of protection against exposure to STI/HIV/AIDS. However, this protection is full proof

Who should not use condoms?

- Those allergic to rubber.

Spermicides and diaphragms

Who can use them?

- women in whom hormonal contraceptives are contra-indicated or who do not opt for them;
- breast feeding mothers who need contraception and have no other protection;
- couples needing a temporary method while awaiting another method;
- couples needing a backup method;
- couples who have intercourse infrequently.

Who should not use the spermicides and diaphragms?

- women who are unable or do not want to touch their own cervix/vagina;
- women with uterine prolapse;
- women allergic to material from which diaphragm or spermicide is made;
- women with a history of Toxic Shock Syndrome (TSS);
- women with vaginal stenosis (only for diaphragm).

3.9.7 Voluntary surgical contraception

Because these are permanent methods, special counseling procedures must be followed to ensure that the client completely understands them to minimize chances of regret. Clients less than 30 years or with less than 3 children particularly require special counseling.

Tubal ligation

Who can have tubal ligation?

In general most women who want sterilization can have a safe and effective procedure in a routine setting, provided they have been counseled and give informed consent

The following are a priority:

- women/couples who are certain that they have achieved their desired family size;
- women of reproductive age who want a highly effective permanent protection against pregnancy;
- post-partum women (within 7 days), if decision has been made before delivery;
- post abortion clients if decision has been made before abortion;
- women whose lives or those of families are deemed to be at risk if pregnancy occurs.
- Women with irregular or heavy vaginal bleeding or painful menstruation.

Who should not have tubal ligation?

- women who are pregnant;
- women with PID current or within the last 3 months;
- women with prolonged rupture of membranes more than 24 hours before delivery (Delay early post-partum tubal ligation).
- women with genital tract cancer (this is a contra-indication);
- women with acute systemic infection;
- women with severe anemia (Hb less than 7 g/100 mis);

- women after 7 to 42 days post-partum;
- women with uterine rupture or perforation;
- women with post-partum or post abortion sepsis.

Timing of the procedure

- any time during the menstrual cycle provided pregnancy is ruled out;
- (day 6 - 13 of the cycle is optimal);
- 2 days after or 6 weeks post-partum;
- immediately or within 7 days following an uncomplicated abortion.

Vasectomy

Who can have vasectomy?

- men who understand and voluntarily consent to the procedure;
- men who want a highly effective permanent contraceptive method;
- men whose wives have age, parity or health problems that pose a serious health risk to their lives if they became pregnant.
- There is no medical condition that would absolutely restrict a person from sterilization. However, the procedure should be delayed in those with:
- local skin infection;
- acute urethritis or genital ulcerative disease;
- systemic diseases.

Who should not have vasectomy?

- men who do not fully understand or are not willing to consent to the operation;
- men or couples who are not sure they have completed their families.

Clients with the following conditions will require a provider with extensive experience:

- inguinal hernia;
- scar tissue;
- previous scrotal surgery;
- intra-scrotal mass;
- undescended testes;
- AIDS related illness.

3.9.8 Behavioral methods

Breast feeding - lactational amenorrhoea method (LAM)

The effect of breast feeding on reducing fertility is well known. However, the protection is insufficient. A method based on breast feeding is called the lactational amenorrhoea method. The principle of LAM is that a woman who continues to fully or nearly fully breast feed her infant and who remains amenorrhoeic during the first 6 months post-partum period is protected from pregnancy during this time at a rate of over 18%.

Who can use LAM?

- women who are fully or nearly fully breast feeding as characterized by:
 - breast feeding whenever the baby desires (every 4 hours);
 - night time feeding at least every 6 hours;
 - not substituting other feeds for breast milk.
- women who have not had a return of menses.
- women with less than 6 months post-partum.

Who can not use LAM?

Certain conditions or obstacles which affect breast feeding may also affect duration of amenorrhoea making the risk of pregnancy higher. These include:

- baby not suckling frequently (at intervals exceeding 4 hours during the day and 6 hours at night);
- the mother offering supplementary feeds to the baby;
- baby older than 6 months;
- when the mother is ill and cannot produce adequate milk supply and has to supplement;
- psychiatric illness where the mother rejects the baby;
- a mother who is not breast feeding.

An HIV-positive mother should be counseled about all infant feeding methods and the risks involved, so as to make an informed choice and be supported in her choice.

Fertility awareness methods

A couple or a woman avoids sexual intercourse during the fertile phase of the menstrual cycle (when pregnancy is most likely to occur) to prevent pregnancy, or has intercourse during the fertile period in order to conceive. The fertile and safe periods of the menstrual cycle can be determined by one of the following methods:

- calendar (rhythm);
- basal body temperature (BBT);
- cervical mucus;
- symptom-thermal.

A couple or woman wanting use one of these methods needs special training from a trained counselor.

Who can use fertility awareness for contraception?

Any woman or couple who:

- are willing and motivated to observe, record and interpret fertility signs daily;
- finds other contraceptive methods unacceptable for various reasons
- women with religious reasons for not using other methods;
- women unable to use other methods;
- a couple willing to abstain from sexual intercourse for more than one week in each cycle.

Who can not use fertility awareness for contraception?

There are no medical conditions which become worse because of use of fertility awareness-based method. However, there are some conditions that make their use complicated. If these conditions exist, the method can either be delayed or a special counseling from a provider is required to ensure the correct use.

3.9.9 Emergency contraception (EC)

Emergency Contraceptive method is used immediately after unprotected sexual intercourse to avoid pregnancy. However, it should not be used as a routine contraceptive method.

Intra Uterine Contraceptive Device (IUCD) can be inserted and used as an emergency contraception, and continue as a regular method.

Pills should be started within 72 hours of unprotected intercourse. Dosage of pills for emergency contraception:

Combined oral pills (Lo-Feminal, Microgynon or Pilpian) - low dose.

- Take 4 pills in two doses 12 hours apart.

Progesterone only pills (Ovrette)

- Take 20 pills in two doses 12 hours apart.

Who can use ECP?

- Any woman who has had unprotected sexual intercourse.
- Women who have been raped.
- Any woman whose contraceptive method fails for example a slipped or burst condom; or a dislodged IUD or diaphragm.

- Any woman who has missed to swallow her pills for 3 days

Follow up?

- ECP should not be used as regular contraceptive method.
- Women should be counseled for regular contraceptive methods.

3.10 Record Keeping System

Health workers and auxiliaries providing FP services, both within government and non-governmental organizations, will use the **national standard formats** for record keeping and reporting to ensure the availability of core FP information. The formats have adequate space to record essential information on each FP service area as outlined in the Service Standards. Data from these records will be used to feed the national Health Information System (HIS) for continuous monitoring and improvement of service delivery. Each level of FP service delivery site should analyze, interpret and compile data collected and use it for improving the quality of its services. It should also submit it as per reporting procedures and requirements.

3.11 Equipment and Supplies

Basic equipment and supplies for FP/RH service provision will be provided according to the health unit level and its functions or service provided.

3.12 Supervision of Family Planning Services

In accordance with supervision guidelines, supervision of FP delivery shall be carried out as an integral part of the routine reproductive health services supervision system at all levels. It will be the responsibility of the central, district, HSD and health unit in-charges. It will be done using developed standardized supervision indicators as agreed on by MOH, NGOs and other partners.

Chapter 4 : Safe Motherhood: Maternal and Newborn Health Care

4.1 Policy Goal and Objectives

The goal of the Safe Motherhood Program is to ensure that no woman or newborn dies or incurs injuries due to pregnancy and/or childbirth. This can be made possible by providing timely, appropriate and comprehensive quality care during preconception, pregnancy, childbirth and puerperium to women, men, adolescents and newborn babies.

Ante-natal and post-natal services will be provided on a daily basis at all levels of the reproductive health service delivery. While delivery of maternity services will be provided 24 hours everyday in units licensed and equipped to provide them.

The objectives are to:

- provide guidance to health care providers in the delivery of quality maternal and newborn care services at all levels;
- enhance quality of safe motherhood services thereby reducing maternal and
- newborn morbidity and mortality in the country;
- integrate maternal and newborn care services in the national health system.
- Provide adequate and accurate information education and counseling services.

4.2 Components of Maternal and New born Health Services

The following comprise the maternal and newborn health services:

- preconception care;
- ante-natal care;
- post abortion care;
- intra-partum care;
- emergency obstetric care;
- care of newborn;
- post-natal care.

4.3 Target and Priority Groups

The target for all maternal services are all women of childbearing age, newborns, male partners, care givers and family members. While the priority groups are:

- pregnant women and their partners;
- women in labor;
- post-natal and breast feeding mothers;
- adolescents;

- women who are HIV-positive or suffering from AIDS and are pregnant;
- women with disabilities;
- women who are aborting;
- where pregnancy is a result of sexual abuse;
- newborn babies who are:
 - sick;
 - have low birth weights;
 - have congenital abnormalities;
 - born to HIV-positive mothers and
 - babies whose mothers die during childbirth.

4.4 Preconception Care

This is health care information and services given to an individual or couple before biologically fathering or mothering a child. The **objective** is to promote safe and responsible sexual behavior and parenthood during the preconception period.

The **services** will include:

- immunization with tetanus toxoid;
- family planning;
- iron and folic acid supplementation;
- screening and management of anemia;
- screening and management of STI /HIV/AIDS;
- voluntary counseling and testing for HIV.

The **information** provided will include:

- proper nutrition practices;
- good hygiene practices;
- responsible motherhood and fatherhood;
- contraception and family planning;
- STI/HIV/AIDS prevention;
- malaria prevention;
- sex education;
- life skills;
- indications for tetanus toxoid.

4.5 Ante-natal Care

Ante-natal service is health care given to a mother and partner during pregnancy.

The **objectives** are to:

- promote and maintain physical, mental and social health of the mother and the unborn baby;
- detect and treat pre-existing condition or complication arising during pregnancy, whether medical, surgical or obstetric;
- prepare the mother for safe childbirth and successful breast feeding;
- achieve delivery of a full term healthy baby or babies with minimal morbidity to mother;
- help the mother to experience normal puerperium and in conjunction with the partner, take good care of the child physically, psychologically and socially.

4.5.1 Basic services to be offered during ante-natal

- Information, Education and communication on risk factors and warning signs and symptoms during pregnancy.
- checking for and management of anemia and worms;
- provision of iron and folic acid supplement;
- screening for pre-eclampsia (BP , protein in urine and oedema);
- urine testing for sugar and protein;

- Examination of the mother to evaluate the-pregnancy (fetal growth and maternal well being);
- early detection and referral or management of high risk pregnancies;
- immunization against tetanus;
- syphilis screening;
- voluntary counseling and confidential testing for HIV;
- presumptive anti-malarial treatment with sulphadoxine/pyrimethamine.

4.5.2 Information given during ante-natal should include:

- proper nutrition and hygiene;
- malaria prevention;
- breast feeding and child welfare;
- prevention of STI/HIV/AIDS;
- warning signs of pregnancy complications;
- preparation for delivery;
- post-natal care and family planning;
- HIV testing and counseling;
- dangers of self medication and use of traditional medicines during labor.

4.5.3 Minimum frequency and timing of ante-natal care visits

A minimum of 4 visits should be made as follows:

- | | | |
|--------------|---|--|
| first visit | - | early in first trimester after two missed periods; |
| second visit | - | at 28 weeks; |
| third visit | - | between 32-36 weeks; |
| fourth visit | - | after 36 weeks. |

4.6 Labor and Delivery Care

Labor is the onset of regular, rhythmic, painful uterine contractions increasing in frequency, duration and strength leading to progressive dilation of the cervix and descent of presenting part, resulting in complete expulsion of the baby, placenta and membranes. The main **objective** for care is to ensure a safe delivery for the mother and baby.

Services offered during labor will include:

- monitoring the labor using a partograph;
- identification and management of abnormal occurrence;
- involvement of the father and other relatives according to the mother's wishes;
- ensuring the comfort of the mother and re-hydration;
- cord preservation and prolapse
- ensuring a clean and safe delivery of the baby, placenta and membranes.

4.7 Care of the Newborn

This is health care given to a baby immediately after birth up to the first 24 hours.

Its **objectives** are to;

- ensure the well being of the newborn in the first 24 hours of life;
- identify, manage, and/or refer problems in the newborn child;
- screen for congenital abnormalities and refer.

Services should include:

- clearing the airway and ensuring normal breathing;
- weighing the baby;
- applying tetracycline ointment to the eyes;
- applying cord ligature to ensure there is no bleeding;
- initiating breast feeding within the first 30 minutes except where the mother

- chooses not to breast feed;
- keeping the mother with the baby "bedding in
- providing training and support for the mother and father to use breast milk
- alternatives when breast feeding is not possible;
- conducting a full physical examination of the baby and ruling out congenital abnormality;
- providing necessary referral;
- giving BCG and Polio O and Vitamin A supplement.

The following **information** to the mother on care of the newborn

- continue to breast feed;
- continue to keep the baby warm;
- observe for general condition (color, breathing and abnormal movements) and other warning signs.

4.8 Immediate Puerperium Care

This is the care given to the mother during the first 24 hours after childbirth.

Services offered will include:

- monitoring general maternal condition;
- ensuring the bladder is empty;
- ensuring the uterus is well contracted and no excessive bleeding;
- monitoring the blood pressure, pulse and temperature;
- relieving pain;
- keeping the mother comfortable and warm;
- giving Vitamin A 200,000 IU international unit.

The following **information** should given:

- importance of continued on demand breast feeding;
- maintaining proper hygiene;
- proper nutrition;
- when to resume sex after childbirth;
- danger and warning signs of mother and child;
- infection prevention;
- immunization and growth monitoring for the baby;
- importance and benefits of attending post-natal clinic;
- information on contraceptives;
- proper care of the baby.

As much as possible, the partner should be encouraged to participate in the session

4.9 Emergency Obstetric Care

This is an urgent medical care given to a woman for problems related to pregnancy, labor, delivery and puerperium.

The **objectives** are to:

- manage obstetric complications and conditions likely to cause morbidity or injury to the mother and/or baby;
- improve the readiness of the facility to manage obstetric complications;
- improve skills and attitudes of service providers.

4.9.1 Common obstetric emergencies

- During pregnancy:
 - ectopic pregnancy;

- ante-partum hemorrhage;
- severe pre-eclampsia and eclampsia;
- cord prolapse;
- severe malaria or fever;
- severe anemia;
- premature rupture of membrane.
- During labor:
 - hemorrhage;
 - pre-eclampsia and eclampsia;
 - obstructed labor;
 - prolapsed cord;
 - fetal distress;
 - ruptured uterus;
 - malpresentation.
- During delivery:
 - hemorrhage;
 - delayed second stage;
 - fetal distress;
 - maternal exhaustion;
 - uterine rupture; I
 - impacted shoulders;
 - amniotic fluid embolism;
 - retained placenta;
 - perineal tears and cervical laceration.
- During puerperium:
 - post-partum hemorrhage;
 - puerperal sepsis;
 - hypoglycemia/dehydration
 - severe anemia.
 - Inversion of the uterus, shock and collapse

4.9.2 Emergency obstetric services

This will depend on the cause and nature of the emergency presenting and may include any of the following:

- anticipate and refer from previous history;
- resuscitate and/or refer as necessary;
- IV fluids;
- blood transfusion;
- surgical interventions as necessary;
- antibiotics as required.

4.9.3 Information on emergency obstetric care This should include:

- how to recognize or detect risk factors in pregnancy;
- family planning to avoid high risk pregnancy;
- Early ANC booking;
- decision making on where to deliver;
- preventive e.g. nutrition, prevention of anemia;
- long term implications of the way the obstetric emergency was managed.

4.10 Post-natal Care

This is a health care given to a mother and baby after childbirth up to six weeks. The objectives are to:

- maintain physical and psychological well being of the mother and baby;
- detect or screen for complications of mother and baby, congenital abnormality of the baby and manage or refer;
- provide health education on nutrition, family planning, breast feeding, immunization, hygiene, STD/HIV/AIDS prevention and when to resume sexual intercourse.

The basic services are:

- full examination of the mother and the state of involution of the uterus;
- provision of FP methods after counseling and ensuring informed consent;
- examination and screening for cervical and breast cancer;
- general health education.

The basic information, preferably given to couples, at post-natal care should include:

- exclusive breast feeding for up to 6 months;
- proper nutrition for the mother;
- proper hygiene for the mother and baby;
- When it is safe to resume sexual intercourse
- family planning including LAM;
- STI/HIV/AIDS prevention;
- malaria prevention for family and new baby;
- immunization and growth monitoring;
- Vitamin A supplementation;
- general care of the baby;
- screening for cervical and breast cancer.

4.11 Referral

All mothers and newborn babies presenting with problems or issues which the service provider can not handle at her/his work site should be referred to the next higher level without delay, according to the guidelines on referral:

- a referral note should be completed and given to the mother;
- all relevant documents, ANC card, partograph or post-natal card, should be included with the referral note;
- in case of obstetric emergency, the mother should be accompanied by a qualified health worker and transport provided where possible;
- the partner and relatives should be informed and encouraged to accompany the patient;
- the partner and relatives should be informed of what may be needed at the referral point;
- referral unit should be informed by radio or telephone, where possible;
- a feedback from the referral to referring unit should be ensured.

4.12 Community Outreach Reproductive Health activities

The following basic services for reproductive health are to be provided during community outreach education on:

- proper nutrition and benefits of exclusive breast feeding;
- proper hygiene;
- STI/HIV/AIDS prevention including voluntary counseling and testing;
- benefits of ANC and PNC delivery under skilled personnel; -
- family planning;
- birth planning and preparedness;
- danger of self medication for pregnant mothers;
- danger signs and risk factors during pregnancy, labor and after child birth;
- dangers of unsafe abortion;
- importance of timely self-referral;

- prevention of anemia;
- prevention and management of malaria in pregnancy.
- immunization of pregnant mothers, adolescents and children;
- routine iron and folic acid supplementation for all pregnant women;
- de-worming of pregnant women as appropriate;
- provision of contraceptives including female and male condoms;
- syndromic management of STIs and other reproductive tract infections;
- malarial prevention, treatment and prophylaxis;
- registration of vital events at community level e.g. "near miss" and "death" audits (through PDCs).

During community mobilization, newly delivered mothers, disabled pregnant mothers, breast feeding mothers, men and adolescents should be targeted.

For the above services, special efforts to reach adolescents during community outreaches should be made

4.13 Post Abortion Care (PAC)

This is health care given to a woman who has had an abortion from any cause. The care, to be provided on a 24-hour basis, is to be an integral part of RH services. The services are to be provided in all hospitals and health centers where there are doctors, midwives and clinical officers trained in PAC and where the minimum hygienic standards are met. Other nurses and nursing assistants should provide counseling services. These facilities should observe the patients' rights.

The **objectives** of PAC are to:

- manage and/or refer abortion complications;
- create public awareness of the dangers of unsafe abortion and educate clients on complications and where to obtain help or treatment;
- prevent repeat unwanted pregnancies through the provision of family planning counseling services;
- provision of FP counseling and methods
- promote community involvement in the prevention of unprotected sex and unsafe abortion, especially among adolescents;
- modify providers and community's negative attitudes towards abortion.

4.13.1 Basic components of PAC

- emergency management of abortion complications including resuscitation, evacuation of a uterus for incomplete abortion (including the use of a manual vacuum aspiration if gestation is 12 weeks and below);
- appropriate referral;
- post abortion counseling including self care, post treatment expectations, post abortion family planning and services. This will include information on emergency contraception.
- linking of PAC clients to other existing RHS including STI/HIV treatment and counseling, infertility and screening for gynecological cancer, among others.
- PAC services will be an essential part of life saving skills training.

4.13.2 Target and priority groups for PAC

The target will be all women who have had abortions and abortion complications and their partners. The following will be the priority for PAC services:

- adolescents;
- women with repeated abortions;
- women with badly needed pregnancies.

4.13.3 PAC IEC activities and messages Activities will emphasize:

- prevention of abortion;
- early reporting and danger signs of abortion;
- proper management;
- breaking the cycle of abortions through using proper contraception.

Basic messages:

- awareness of the dangers of unsafe abortion;
- early recognition and reporting of abortion and abortion-related complications;
- common causes of abortions and their prevention;
- where to seek assistance;
- different elements of PAC;
- self care and expectations;
- post abortion FP and counseling;
- availability of other RH services.

Target groups:

- community
 - male partners;
 - adolescents;
 - health workers;
 - traditional healers.
- providers
 - managers;
 - administrators;
 - implementers.

4.13.4 Consent for PAC services

Written or appropriate consent should be obtained from the patient or legal guardian for:

- evacuation for incomplete abortion;
- examination under general anesthesia;
- any surgical interventions.

For a patient whose physical condition does not enable her to give a written consent, the procedure should be performed to save life.

CHARTS REMOVED – SEE ORIGINAL

Chapter 5: The Management of Obstetric Fistula

5.1 Definition and Background

Obstetric fistula, which is either vesicle-vaginal (VVF) or rectal-vaginal (RVF) is a condition in which a direct opening is created between the vagina and either the bladder or the rectum leading to uncontrolled passage of urine or faeces through the vagina. This is usually a result of prolonged obstructed labor when the foetal head gets jammed in the pelvis and presses on the surrounding tissue. The result is necrosis of the tissues separating the vagina and bladder or rectum, which creates an opening and thus the passage of urine or faeces. The victims become outcasts in society due to the resulting smell.

Although quite common, it continues to be a silent morbidity among Ugandan women. In spite of its physical and psychological trauma, it arouses little interest and no data on its prevalence is available. There are very few hospitals and specialists who offer services for the victims.

5.2 Policy Goal and Objectives

The goal is to support individuals, couples or families with problems of VVF/RVF so that they can be rehabilitated into society. While the objectives are:

- to integrate the management of VVF/RVF into existing RH services;
- to improve access to the management and rehabilitation of clients with VVF/RVF;
- to eliminate /reduce the factors that cause VVF/RVF formation by ensuring information dissemination and good obstetric care.

5.3 Strategies

- Services:
 - training of service providers in counseling and referral of VVF/RVF clients;

- pre and in-service training of service providers in pre and post -operative procedures for VVF/RVF;
- integration of the management of VVF/RVF into existing RH services at general and referral hospitals;
- development and printing of training curriculum, service guidelines and manuals for prevention and management of VVF;
- upgrading HMIS format to capture data on VVF/RVF.
- IEC
 - the development and printing of IEC materials on VVF/RVF.
- Advocating for the removal of gender bias and isolation of the victims.

5.4 Target and Priority Groups

The target will be:

- health workers;
- all adolescents male and female for information and services;
- women and men of reproductive age;
- communities and community health workers to dispel bias.

While the following will be the priority groups:

- adolescent girls;
- women with VVF/RVF problems;
- families of victims with VVF/RVF.

5.5 Components of VVF/RVF Management

5.5.1 Prevention

- IEC on:
 - importance of good nutrition for children and especially the girl child for proper pelvic development;
 - delay first pregnancy up to 20 years;
 - early attendance for ANC for guidance and proper pelvic assessment;
 - dangers of using traditional herbs in pregnancy and labor.

5.5.2 Services

- Prompt referral of complicated cases/obstructed labor.
- Encourage delivery under skilled attendance and health facility.
- Proper assessment and monitoring of labor using the partograph.
- Prompt surgical intervention for prolonged and obstructed labor.

5.6 Service Standards for VVF/RVF

This will include raising the community awareness about VVF/RVF services.

5.6.1 Settings

- all service delivery points;
- schools and institutions;
- electronic and print media;
- public gatherings;
- local council, religious and sensitization meetings.

5.6.2 VVF/RVF IEC counseling content

- definition of VVF/RVF;
- basic anatomy of the female reproductive health system;
- risk factors for VVF/RVF and its causes;
- availability of management services and referral centers;
- community support for victims and their families
- advocacy for delay in age of marriage and childbearing.

Table 7: VVF/RVF Service Availability**Type of service**

| Type of Service | Facility | | | | |
|-----------------|--------------------|---------|-------------|------------------|-------------------|
| | Community outreach | HCI-III | HC IV (HSD) | General hospital | Referral hospital |
| History-taking | X | X | X | X | X |
| Examination | | | | X | X |
| IEC/counseling | X | X | X | X | X |
| Referral | X | X | X | X | |
| Investigation | | X | X | X | X |
| Prevention | X | X | X | X | X |

5.7 Integration of VVF/RVF Services into RH Services

VVF/RVF services shall be integrated within the existing RH services at all levels of health care depending on the provider competence and availability of facilities.

Emphasis on prevention will be promoted**Chapter 6: The Management of Adolescent Reproductive Health****6.1 Background**

Adolescence is a period of transition from childhood to adulthood. It is characterized by physical, psychological and biological changes. The WHO defines adolescence period as ranging from 10-19 years. For purposes of programming, we shall target 10-24 years as stipulated in the National Adolescent Health Policy.

All adolescents are eligible for the health services. The services will be provided in a friendly environment and manner that meet their needs.

6.2 Policy Goal and Objectives

The goal of the adolescent health service is to address this age group's sexual and reproductive health issues such as early and unprotected sex, unwanted pregnancy, substance and drug abuse, unsafe abortion and sexually transmitted infections, including HIV/AIDS. Some of the underlying causes of the above problems include:

- limited access to information and education, particularly on sex, sexuality and life skills;
- experimentation and risk-taking behavior;
- lack of income generating activities;
- harmful traditional practices;
- low contraceptive utilization;
- poverty;
- low utilization of available health services;
- reliance on peer for information and advice on RH.

The objectives are to:

- provide adolescents with appropriate, acceptable and affordable quality information and sexual reproductive health services;
- increase availability and accessibility of accurate information to adolescents.

6.3 Components of Adolescent Reproductive Health

These will include both services and information.

- Services:
 - family planning including emergency contraception;
 - information;
 - maternal health care such as ANC, maternal and post-natal care;
 - STI/HIV/AIDS including VCT;

- post abortion care;
- support and counseling for unwanted pregnancy;
- support for the prevention and protection of harmful traditional practices e.g. female genital mutilation;
- care of babies born to adolescents;
- support services to adolescent mothers (single);
- screening for pregnancy, cervix and breast cancer.
- Information will be provided to cover the following:
 - sex, sexuality and life skills;
 - drug and substance abuse;
 - supportive organizations;
 - rights of adolescents, especially the girl child;
 - proper nutrition and hygiene;
 - sources of adolescent-friendly health services.

6.4 Target and Priority Groups for Service Delivery

Males and females aged between 10-24 are the target.

While the priority groups, in both rural and urban areas, will include:

- adolescent girls;
- adolescents in employment likely to expose them to sexual and substance abuse and unprotected sex;
- adolescents with mental/physical disabilities;
- adolescents living with HIV/AIDS;
- adolescents with violent behavior;
- adolescents under conviction or incarceration;
- orphaned adolescents;
- adolescents with substance abuse problems;
- adolescents with abortion complications;
- displaced adolescents e.g. refugees and street children;
- pregnant and lactating adolescents;
- physically abused adolescents;
- adolescents in poverty situation;
- adolescents in civil strife.

6.5 Service Delivery Points

These will include:

- institutions such as schools, religious and community centers;
- youth/adolescent clubs;
- LC/youth council meeting places;
- health units;
- community outreach.

The services will be available on a daily basis and timed to suit the adolescents.

6.6 Information, Education and Communication for Adolescent Health

The messages will include:

- adolescent sexuality;
- contraception, including emergency contraception;
- unwanted pregnancies;
- unsafe abortions;
- early marriages;
- gender based domestic, sexual abuse and violence such as rape, defilement and incest;
- care during pregnancy;
- care of infants;

- prevention of STI/HIV/AIDS;
- voluntary counseling and testing for HIV;
- harmful traditional practices e.g. FGM and early marriage;
- risky sexual behavior;
- substance abuse;
- proper nutrition and personal hygiene;
- how to avoid accidents;
- special RH needs for adolescents with disabilities;
- socio-economic consequences of adolescent ill health;
- life skills.

The messages should be clear, accurate, gender and culturally sensitive, and observe the rights of adolescents . They will be carried and relayed through a variety of media and formats e.g. print (posters, charts, booklets, brochures, leaflets), radio, video and TV.

6.6.1 Target for IEC messages of ARH

The messages will be targeted at the following:

- adolescents;
- parents/guardians;
- service providers including Community Based Distributors and Community Health Workers;
- school teachers;
- sectoral extension workers;
- community leaders at all levels;
- NGOs and development partners;
- religious bodies and leaders;
- high risk male groups e.g. boda-boda, taxi, and truck drivers;
- "sugar mummies and daddies".

6.6.2 Personnel to carry out IEC activities

Anybody who is adequately trained will be actively involved. It is, however, intended that the following will be at the forefront:

- peer educators;
- all trained/oriented service providers;
- all oriented teachers, community development officers/assistants;
- community RH workers;
- LC/youth/women councilors;
- all extension workers;
- village RH committee members;
- national, district and sub-county RH, social/health service committee members, and Parish Development Committees.

6.6.3 Modes of IEC dissemination

IEC messages will be provided and/or disseminated through a variety of settings and fora.

- The district health team will develop and implement district specific activity plans.
- In order to mobilize the community, the district team will sensitize key district-based stakeholders on important messages on adolescent health.
- All available media, including the traditional means, will be utilized to disseminate key messages.
- NGOs, training institutions, schools, and youth organizations will be used to disseminate key messages on adolescent health. Messages and materials will be placed in areas frequented by adolescents.
- Operational staff will be involved in the dissemination of the messages to primary and secondary target audiences at various fora.

6.7 Counseling

Will focus on:

- psycho-social problems;
- ARH;
- family planning;
- promotion of parent-child communication;
- relationships;
- life skills.

Appropriate referrals should be made for the following problems:

- complications of abortions;
- mental health;
- high risk pregnancies;
- sexual abuse or defilement;
- substance abuse;
- FGM-related complications;
- obstetric emergencies;
- STI/HIV/AIDS.

A register of organizations offering specialized services should be available at all sites providing adolescent friendly services.

Chapter 7: Integrating STI/HIV/AIDS into Reproductive Health Services

7.1 Background

The operational definition of integration is the combination of services that prevent or manage STI/HIV/AIDS with those for maternal and child health and family planning, into a single, coordinated and synergetic program. At the moment, the integration of STI/HIV/AIDS into the reproductive health service is weak because of the following factors:

- lack of trained staff;
- under staffing in most health units;
- lack of clear guidelines on integration;
- lack of office space for counseling and laboratory services;
- restriction on drug prescription by certain health cadres;
- lack of awareness on the part of the clients;
- stigmatization and gender issues associated with STI/HIV/AIDS;
- Self-treatment, especially among men.

Other areas of concern are:

- limited behavioral change towards safer sexual practices;
- low level of condom use;
- lack of clear guidelines on breast feeding for babies born to HIV-positive mothers;
- unclear policies for the protection of the rights of people living with AIDS (PWAs);
- lack of effective interventions targeting vulnerable groups;
- the high cost of anti-retroviral drugs.

7.2 Policy Objectives

These are to **integrate** the management of STI/HIV/AIDS into all reproductive health services and to **strengthen** existing strategies to reduce mother-to child transmission of HIV.

7.3 Strategies

- IEC and advocacy:
 - development, production and dissemination of relevant IEC materials;

- advocacy for change in the attitude and practices of service providers and managers;
- sustaining education on STI/HIV/AIDS.
- Service delivery:
 - integration of STI/HIV/AIDS activities into RH services including voluntary confidential counseling and testing (VCCT);
 - intensification of infection prevention measures;
 - strengthening interventions for the reduction of MTCT of HIV; - syphilis screening and treatment.
- Training:

All RH service providers will be equipped with adequate knowledge and skills for the management of STI/HIV/AIDS.

7.4 Target and Priority Groups

Everyone attending RH services will be targeted. While the priority groups will be:

- for IEC and advocacy
 - the general population;
 - program managers of RH and health workers.
- for the prevention and control of the spread of STI/HIV/AIDS
 - clients attending RH services;
 - adolescents;
 - commercial sex workers;
 - homosexuals;
 - program managers and RH health workers.

7.5 Specific Services

The following services will be provided:

- health education on the prevention of STI/HIV/AIDS;
- laboratory diagnosis according to the level of a health facility;
- syndromic management of STI/HIV;
- counseling and partner notification of STI/HIV/AIDS;
- provision of anti-retroviral drugs to prevent MTCT and HIV/AIDS;
- syphilis screening and treatment;
- routine application of tetracycline eye ointment for newborn.

Chapter 8: The Management of Infertility

8.1 Background

Infertility is the failure to conceive or father a baby after one year of unprotected sexual intercourse. Primary infertility applies to those who have never conceived or fathered a baby. While secondary infertility designates those who have conceived or impregnated a woman sometime in the past. Infertility remains a significant RH problem in Uganda.

8.2 Policy Goal and Objectives

The goal is to support individuals and couples with problems of infertility to attain their full fertility intentions. While the objectives are to:

- integrate the management of infertility into existing RH services;
- improve access to the management of infertility.

8.3 Strategies

The strategies are to provide services and advocate for the removal of gender bias in the handling of infertility.

The services will include:

- training service providers in counseling and referral of infertile couples;
- pre and in-service training of health providers in infertility management and prevention;
- integrating infertility management services into existing RH services at
- general and referral hospitals;

- developing and printing of a training curriculum for infertility;
- developing service guidelines for the management and prevention of infertility;
- upgrading HMIS format (tools) to capture data on infertility;
- developing, printing and distributing IEC materials on infertility.
- advocating for the removal of gender bias in the handling of infertility.

8.4 Target and Priority Groups

- The following people will be **targeted** generally:
 - adolescents;
 - men and women in the community;
 - the community in general, to dispel biases.
- **Priority** for infertility services:
 - men with sexual dysfunction;
 - men and women with proven infertility as per definition;
 - women with recurrent pregnancy wastage.
- The following people will be **eligible** for the services:
 - all women in the reproductive age group who have failed to conceive;
 - women with recurrent pregnancy wastage;
 - men who have failed to father a child;
 - couples who have failed to have a baby as per definition.

8.5 Components of Infertility Management

The components of infertility management are prevention, treatment and adoption.

8.5.1 Prevention

- Services:
 - provision of condoms to encourage protected sex;
 - early diagnosis of STIs;
 - appropriate treatment of STI which will entail:
 - detailed history-taking;
 - physical examination;
 - offering appropriate investigations;
 - STI treatment where necessary;
 - appropriate surgery or medical treatment;
 - proper management of post abortion complications.
- Information:
 - long-term complications of STI and unsafe abortions;
 - danger of inappropriate treatment of STI and post abortion complications;
 - risk factor of infertility for men of e.g. mumps infection.

8.6 Service Standards

Raising community awareness for infertility services includes the settings, IEC information, service availability and integrating it into RH services.

- Settings:
 - all service delivery points;
 - electronic and print media;
 - public gathering e.g. LC, church, and sensitization meetings.
- IEC/counseling content of information:
 - definition of infertility;
 - basic anatomy of the male and female reproductive systems;
 - risk factors for infertility;

- causes of infertility (male and female);
- availability of management service/referral;
- prevention of infertility;
- community support for those affected;
- advocacy for couple investigations.

- Service availability see Table 7

For Reproductive Health Services

Table 7: Service Availability for Infertility

| Type of service | Community | Outreach | HC 11-III | HSD (HC IV) | General hospital | Referral hospital |
|--------------------|-----------|----------|-----------|-------------|------------------|-------------------|
| History-taking | X | X | X | X | X | X |
| Examination | | | | X | X | X |
| IEC/counseling | X | X | X | X | X | X |
| Referral | | X | X | X | X | X |
| Investigation | | | | X | X | X |
| Prevention | X | X | X | X | X | X |
| Management | | | | | | X |

Integration of infertility services into RH services will be done within the existing RH services at various levels of health care depending on provider competence and availability of facilities.

Chapter 9: The Prevention and Management of Reproductive Tract Cancer

9.1 Background

According to the national cancer registry record, cervical cancer is the leading cause of female malignancy (40%), closely followed by breast cancer (23%). Prostate cancer remains the commonest malignancy in males in Uganda (Wabinga 1998). The burden of these diseases have been overshadowed by the acute specific illnesses mainly caused by infectious elements. There is, therefore, no specific program targeting them because they are taken as part of routine health care. Concern is also being raised about the emergence of cervical and breast cancer among females aged less than 30 years old.

9.2 Policy Goal and Objectives

The policy goal is to enhance the integration of services for the screening and management of reproductive cancers for both male and females (MOH-RH Five Year Strategic Plan 1999-2004). While the objectives are to:

- strengthen delivery of services for reproductive health cancer;
- raise awareness about risk factors, warning signs, symptoms and complications;
- integrate the services for screening and management of reproductive health cancer into existing RH services.

9.3 Strategies

All clients will be given adequate information about cancer and the services available. The training of health workers in RH tract cancer will be both at the pre and in-service levels using curricula approved and trainers recognized by the Ministries of Health and Education.

The information to be provided will include IEC, advocacy and services available.

- IEC/advocacy:
 - raising awareness in the community about RH cancer;
 - the diagnostic or therapeutic procedures to be carried out, their safety and /or side effects;
 - assurance of confidentiality with regard to the findings;
 - the benefits of screening and their effects on one's reproductive goals;
 - the need for follow-up visits and/or referral. - advocacy for community support for those affected by the disease.
- Services for the prevention and/or management of RH cancer will be provided at every level of health care. The type of service will depend on the facility, cadre of health workers, technical competence and availability of resources.

These will include:

- capacity building;
- the provision of services e.g. screening and management;
- the creation of a database within the existing HMIS system.

9.4 Target and Priority Groups

Everyone aged 15 years and above is to be targeted. However, different groups will be targeted for different cancer:

- Cervical cancer:
 - women*
 - who are sexually active;
 - Under treatment for STI;
 - with multiple sexual partners;
 - with polygamous husbands;
 - who bore children with different husbands;
 - who had first sexual intercourse before 18 years;
 - with abnormal vaginal bleeding;
 - attending post-natal, gynecological out patient and STI clinics.
- Breast cancer:
 - women*
 - with a family history of breast cancer;
 - who had first pregnancy after 35 years;
 - who had menopause before 40 years;
 - who did not breast feed;
 - who are nulliparous.
- Prostate cancer:
 - men*
 - over 50 years;
 - in polygamous marriages.

9.5 Exclusion Criteria

Exceptions will include:

- women outside the 15 and 75 years age bracket for cervical cancer;
- a woman in her periods;
- women who have had a total hysterectomy for any reason;
- women who have had bilateral mastectomies;
- men who have undergone prostatectomy or bilateral orchidectomy.

9.6 Service Delivery Standards

As an integral part of RH services, everyone aged 15-75 years and/or sexually active will receive information, education and counseling on risks, danger and complications of cervical, breast, prostate and testicle cancer. The IEC will be geared at raising awareness, promoting health seeking behavior, clarifying public concerns related to the diseases, raising public belief in the confidentiality of the procedure and dispelling misconceptions. The messages will be directed at the target and priority groups identified in **94**.

9.6.1 Settings for IEC dissemination

All channels of communication will be used to relay messages which are approved by the technical committee on RH at the national and district levels.

The following fora will be used for disseminating information on RH cancer:

- health education talks;
- service delivery points for GOP, post-natal, immunization, FP and STI.
- workshops and seminars;
- women and men's group meetings;
- public gathering;
- youth, women and men's clubs;
- local council meetings.

The main modes of disseminating information will include:

- health education talks;
- public gathering;

- electronic and print media;;
- posters, brochures and leaflets.

9.6.2 Eligibility to offer information on RH cancer

- Health workers and/or those trained in the content of RH cancer, counseling and communication.
- In the community, local resource people will create awareness and mobilize men and women for services available at the health unit.

9.6.3 Basic IEC messages on RH cancer

- Prevention topics:
 - the importance of periodic screening;
 - risk factors;
 - warning symptoms and signs;
 - monthly breast examination for women aged 20 and above;
 - biannual rectal examination for men aged 50 and over;
 - the benefits of prolonged breast feeding;
 - dispelling misconceptions and rumors on causes and symptoms.
- Management:
 - availability of cancer screening services at health units offering RH services as part of the integration.

These will include:

- self breast examination;
- pap smears;
- unaided visual examination;
- testicular examination;
 - the available modes of treatment, their indication/contra-indications, effectiveness and side effects;
 - referrals for management in case of suspicion or presence of cancer.
- Community support and palliative care for patients involve raising everyone's awareness on the:
 - prevention of cervical and breast cancer;
 - risk factors, symptoms;
 - availability of services;
 - supporting patients with RH cancer.

9.6.4 Screening for RH cancer will involve:

- physical examination of the breasts;
- physical examination of the testicles;
- rectal examination for enlarged prostates,
- vaginal unaided visual inspection (UVI)/speculum and digital examination of the cervix;
- visual inspection of the cervix with acetic acid (VIA);
- pap smear;
- cytology;
- mammography;
- ultra sonography for enlarged prostates;
- cervical punch biopsy;
- cervical cone biopsy;
- breast biopsy.

9.6.5 Management

- staging for cervical cancer;
- prostate biopsy;
- testicular biopsy;

- surgical treatment for cancer;
- radiotherapy for cervical and breast cancer;
- chemotherapy for breast, prostate and testicular cancer;
- palliative/terminal care for incurable disease.

A scheme of the sites and cadres of health workers to perform various tasks for screening and management of RH cancer are shown in Tables 9 and 10.

7.6.6 Equipment and supplies

The equipment and supplies for the screening and management of RH cancer will be distributed with the basic RH equipment. The type will depend on level of the health facility, service expected and technical competence of providers.

Table 8: Type of Service by Level

| Type of service | Facility | | | | | | |
|---|-----------|----------|---------|---------------|-----|------------------|-------------------|
| | Community | Outreach | HCI-III | Health center | HSD | General hospital | Referral hospital |
| IEC/counseling | X | X | X | X | X | X | X |
| Breast examination | X | X | X | X | X | X | X |
| Mammography | | | | | X | X | X |
| Breast lump biopsy | | | | | X | X | X |
| UVI | X | X | X | X | X | X | X |
| VIA | | X | X | X | X | X | X |
| Pap smear | | X | X | X | X | X | X |
| Ultrasound | | | | | X | X | X |
| Cervical biopsy | | | | | X | X | X |
| Staging of cervical | | | | | | | X |
| Histopathology | | | | | | | X |
| Surgical treatment | | | | | | | X |
| Radiotherapy | | | | | | | X |
| Prostate biopsy | | | | | | | X |
| Chemotherapy for breast and prostate cancer | | | | | | | X |
| Rectal examination | | X | X | X | X | X | X |
| Palliative/terminal | X | | | | | | X |

Table 9: Service Provision by Health Workers' Category

| Type of Service | Cadre | | | | | | | |
|---|-------|--------------|----------|------------------|-----------------|---------------|------------------|---------------|
| | CRH W | Nursing aide | Mid-wife | Clinical officer | Medical officer | Gyne/ Surgeon | Phy/ Radio/ Cyto | Social worker |
| Referral | X | X | X | X | X | X | X | X |
| IEC/counseling | X | X | X | X | X | X | X | X |
| Breast examination/teaching self breast examination | | X | X | X | X | X | X | |
| Mammography | | | | | X | X | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Breast lump biopsy | | | | | X | X | | |
| UVI | | X | X | X | X | X | X | |
| VIA | | X | X | X | X | X | X | |
| Pap smear | | | X | X | X | X | | |
| Ultrasound | | | | | X | X | | |
| Cervical biopsy | | | | | X | X | | |
| Staging of cervical | | | | | | X | | |
| Histopathology | | | | | | X | | |
| Surgical treatment | | | | | X | | | |
| Radiotherapy | | | | | | | X | |
| Prostate biopsy | | | | | X | X | | |
| Chemotherapy for breast and prostate cancer | | | | | | | X | |
| Rectal examination | | | | X | X | X | X | |
| Palliative/terminal | X | X | X | X | X | X | X | X |

Table 10: Type of Service by Target Group

| Type of service | Target group | Unsuitable for |
|--------------------|--|--|
| IEC/Counseling | <ul style="list-style-type: none"> clients attending clinics for RH and out patients' services; clients met by CRHWs adolescents; | |
| Breast examination | <ul style="list-style-type: none"> women above 15 years; women attending clinics for RH services; women with family history of breast cancer; women whose first conception was after 35 years; women who had menopause before 40 years; women who did not breast feed; nulliparous | |
| Rectal examination | <ul style="list-style-type: none"> men above 50 years | |
| UVI | <ul style="list-style-type: none"> women with abnormal vaginal bleeding; women with abnormal vaginal discharge; when acetic acid is not available; | <ul style="list-style-type: none"> women in their monthly period; during puerperium; |
| VIA | <ul style="list-style-type: none"> women who have had sexual intercourse; during follow-up visits of those being treated for STIs; women with multiple sexual partners; women with polygamous husbands; women who bore children with different men; females who had sexual intercourse before the age of 18 years; women with abnormal vaginal bleeding; smokers; women attending post-natal, gynecological out patients, FP and STI clinics; | <ul style="list-style-type: none"> women in their monthly period; during puerperium; |

| | | |
|-------------|--|--|
| Pap smear | <ul style="list-style-type: none"> clients with suspicious lesions following UVI or VIA; women first seen in a hospital for other RH services but are of the high risk category; | |
| Ultrasound | <ul style="list-style-type: none"> men with urinary retention; men with enlarged prostates on rectal examination; | |
| Mammography | <ul style="list-style-type: none"> women aged more than 23 years | |

| Type of service | Target group | Unsuitable for |
|---|--|---|
| Cervical biopsy | <ul style="list-style-type: none"> clients with macroscopically suspicious lesions; | |
| Breast lump biopsy | <ul style="list-style-type: none"> women with breast lumps; | |
| Prostate biopsy | <ul style="list-style-type: none"> men undergoing excision biopsy of the prostate | |
| Staging for cervical | <ul style="list-style-type: none"> histologically proven cervical cancer; referral from peripheral units with overt cervical cancer, | |
| Cone biopsy | <ul style="list-style-type: none"> clients with CIN II or III or CIS who still want children; | <ul style="list-style-type: none"> pregnant women; |
| Surgical treatment | <ul style="list-style-type: none"> cervical cancer <ul style="list-style-type: none"> those with CIN or CIS who do not have the desire for more children; those with proven stage I or II disease; those where radiotherapy is contra-indicated; patients with concurrent pelvic pathology warranting surgery, operable breast cancer; operable prostate cancer; | |
| Radiotherapy | <ul style="list-style-type: none"> all stages of invasive cervical cancer; following radical or palliative surgery for the disease; patients where surgery is contra-indicated; | <ul style="list-style-type: none"> immuno-suppressed patients bowel/bladder involvement |
| Chemotherapy for breast and prostate cancer | <ul style="list-style-type: none"> as a complimentary therapy following surgery | |
| Palliative/terminal | <ul style="list-style-type: none"> those with operative cancer; those who fail to improve with surgical, radiotherapy and chemotherapy | |

9.7. Referral of Clients

Service providers will follow the above tree in referring clients they cannot handle including follow-up of those undergoing any form of treatment. Referral notes will be given to the patients at each level of health care including when sending the client to a lower level. The DDHS together with the DHMT shall formulate catchment areas for the health sub-districts and their respective health units. Sensitisation on the health sub-district concept and functioning will also be the role of the DDHS and extended DHT.

Service providers will follow the above tree in referring clients they cannot handle and follow-up those undergoing any form of treatment. Referral notes will be given to the patients at each level of health care, including when sending a client to a lower level.

The DDHS together with the DHMT will formulate catchment areas for health sub-district and their respective health units. Sensitization on the health sub-district concept and functioning will also be the-role of the DDHS and extended DHMT.

Chapter 10: The Management of Menopause and Andropause

10.1 Definition

Menopause is the last menstrual flow which marks the end of a woman's normal reproductive period as a result of the cessation of her ovarian function.

10.2 Policy Objectives

- To create awareness and respond to concerns about symptoms and signs of menopause/andropause.
- To provide an appropriate management of clients with bothersome enopause/ andropause symptoms;
- To integrate counseling services for menopause/andropause into the existing health delivery service.

10.3 Target and Priority Groups

All women over 40 and men over 50 years will be targeted. While the priority will be:

- women with menopause symptoms and their spouses;
- men with andropausal symptoms;
- women and men whose ovarian or testicular function has been or is to be terminated on medical grounds through surgery, radiotherapy or chemotherapy.

10.4 Service Standards

Information on menopause/andropause will be channeled through:

- health education talks;
- service delivery points for GOP, ante-natal, post-natal, immunization, FP and
- STI;
- LC meetings;
- women's group meetings;
- electronic and print media;
- public gathering;
- RH workshops and seminars.

10.5 IEC on Menopause/Andropause

Basic messages will include:

- physiology of the menopause/andropause;
- how to cope with the signs and symptoms;
- availability of services at health units;
- diseases associated with it;
- dispelling misconceptions;
- available treatment;
- the importance of follow-up visits following treatment.

10.6 Service Delivery Points

The following facility types will be the service delivery points for cancer information, care, treatment and management:

- hospitals;
- health sub-districts;
- health centers;
- general clinics;
- special clinics;
- maternity centers;
- community outreaches.

10.6.1 Services

Services which will be offered on a daily basis will include:

- counseling on:
 - symptoms suggestive of menopause/andropause;
 - the gradual adaptation of the human body to the changes;
 - the availability of hormonal replacement therapy, indications and contra- indications and side effects;
 - sexual activity after menopause;
- hormonal replacement therapy.

Chapter 11: Combating Gender-based Violence

11.1 Background and Definition

Violence against women and children is still rampant in Uganda. According to the UN definition, gender-based violence is any act that results in physical, sexual or psychological harm or suffering to women and children. These include threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life. The violence can be either physical or psychological or both and have a bearing on the sexual and reproductive health status of women and children.

Gender-based violence commonly manifests itself in the form of:

- domestic violence such as wife battering, oppression and intimidation;
- sexual abuse e.g. rape, defilement and incest;
- sexual harassment and intimidation at work;
- harmful cultural practices like female genital mutilation and widow inheritance;
- early marriage;
- coercion or arbitrary deprivation of liberty;
- belief in large families;
- dowry related violence;
- forced prostitution;
- violence perpetrated or condoned by the state.

There are gaps and challenges in the existing health services. These include:

- lack of reporting to the health services;
- inadequate knowledge among health service providers;
- inadequate capacity of health facilities to manage gender-based violence;
- poor linkage between health facilities, the community and other agencies
- involved in the prevention and management of gender-based violence.

11.2 Policy Objectives and Strategies

These are to orient the health system to respond to the prevention and management of gender-based violence. The strategies include:

- data collection to accurately define the problem;
- improving knowledge, attitudes and skills of health workers;
- equipping health facilities for case management;
- integration of services that respond to gender-based violence into the RH programs;
- community mobilization for the prevention and early referral of the victims.

11.3 Target and Priority Groups

The following will be targeted:

- women and children;
- parents;
- health workers and managers;
- community leaders;
- the general population;
- other stakeholders involved in the prevention program;
- mass media practitioners.

While the priority group will be:

- all children;
- adolescents;
- displaced persons including refugees;
- disabled persons;
- prisoners;
- people in institutions.

11.4 Service Standards

- The pre and in-service RH curricula will include topics and practices on how to treat gender-based violence;
- Health facilities should be equipped with information, examination and laboratory facilities for the detection and management of gender-based violence;
- Referral mechanism will be established to create linkages between the health system, community, law enforcement and legal system.
- Guidelines will be made available for health service providers for the provision of the following:
 - counseling;
 - records and referral procedure;
 - management procedure (diagnosis and treatment);
 - integration of these services for the RH managers.
- Messages responsive to gender-based violence should be integrated in the RH IEC and advocacy activities.
- HMIS to include data on gender-based violence.

11.5 Monitoring

Indicators that capture gender-based violence will be developed and integrated into the supervision and monitoring tools of the Ministry of Health.