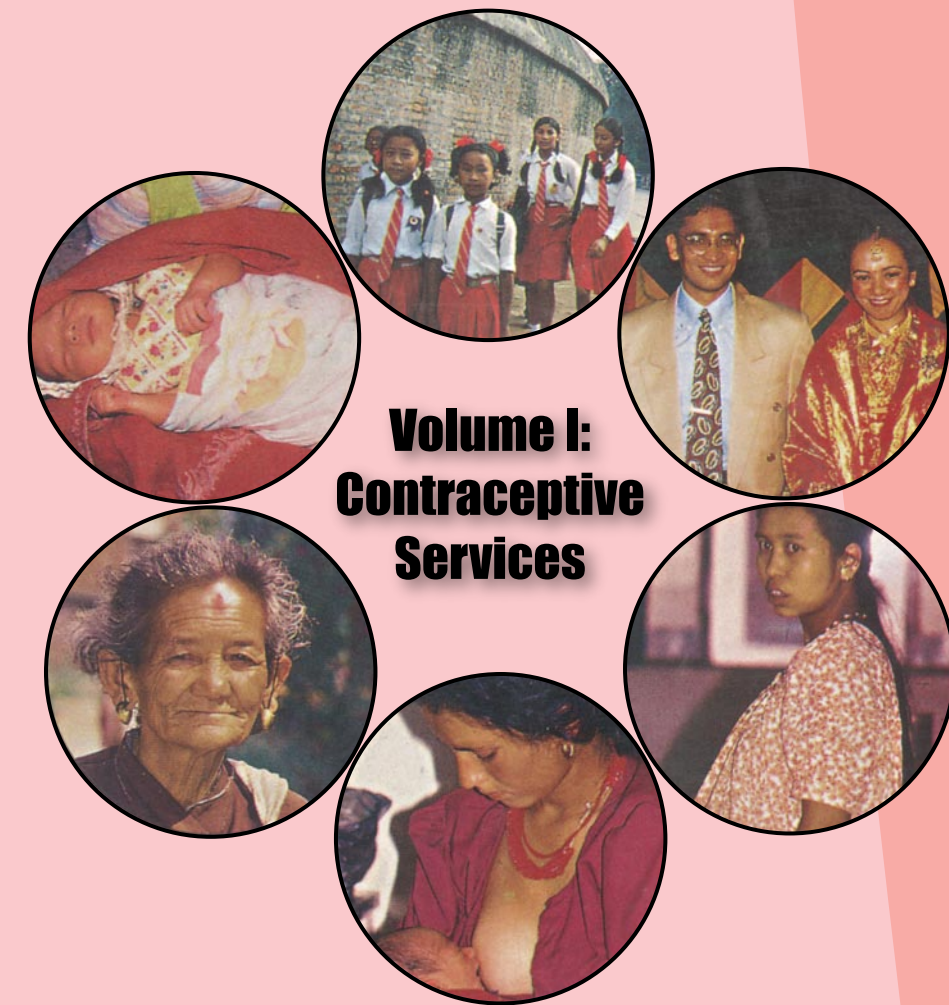


NATIONAL MEDICAL STANDARD FOR REPRODUCTIVE HEALTH

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Volume I



Government of Nepal
Ministry of Health and Population
Family Health Division
February 2010



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NATIONAL MEDICAL STANDARD FOR REPRODUCTIVE HEALTH

**Volume I: : CONTRACEPTIVE SERVICES
Fourth Edition**

**Government of Nepal
Ministry of Health and Population
FAMILY HEALTH DIVISION
February 2010**



Government of Nepal
Ministry of Health & Population

DEPARTMENT OF HEALTH SERVICES



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ACKNOWLEDGEMENTS

The *National Medical Standard for Contraceptive Services* was first published in 1991. In order to keep up with technical advances and changes in contraceptive technology and policy, it was reviewed and published in 1995 and in 2001 as the *National Medical Standard for Reproductive Health (NMS-RH) Volume I: Contraceptive Services*. Once again, we are pleased to bring forth the fourth edition of *NMS-RH Volume I: Contraceptive Services*. The latest updates in contraceptive and other reproductive health technology and the changes in the government's policy regarding family planning program and methods have been incorporated into this edition. Similarly, we have also tried to include the suggestions and comments provided by service providers, managers and policy makers.

This new edition of *NMS-RH Volume I* has been made possible due to the efforts of many people and organizations. It is my privilege to acknowledge the following persons for their valuable contributions:

First of all, a Technical Advisory Group (TAG) was formed to initiate the review process. This group comprised of the following members: Dr. Bal Krishna Suvedi, Mr. Bhogendra Raj Dotel and Dr. Shilu Aryal, Family Health Division (FHD); Mr. Sita Ram Devkota, United States Agency for International Development (USAID); Dr. Jeevan Bhattarai, Chetrapati Family Welfare Centre (CFWC); Mr. Dirgha Raj Shrestha and Dr. Rajendra Bhadra, Nepal Family Health Program II; representatives from Management Division and United Nations Population Fund (UNFPA). I want to express my sincere thanks to the members of this technical advisory group.

I would like to thank all the participants of the first and the second workshop who have contributed in reviewing and rewriting of various chapters in this edition.

Many valuable suggestions were also received from representatives of DDA, USAID/Nepal, NFHP II, FPAN, PSI/Nepal, MSI/Nepal, AED/NMARC, MEH Consultant and ADRA/Nepal. I am also thankful to numerous people including service providers, supervisors and managers working at various Governmental and Non- Governmental organisations for their valuable suggestion and feedbacks during the revision process.

I would like to thank USAID/Nepal and NFHP II for the financial assistance to publish this edition of the *National Medical Standard*. Similarly, appreciation is due to Dr. Pradeep Pyakhurel for his co-ordination work and all the staff of Nepal Fertility Care Centre (NFCC) for their technical support in bringing out this edition.



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This document would not have come to publication without the technical expertise, hard work and commitment of the editorial team who had the responsibility of seeing this document through to completion: Dr. Jeevan Bhattarai, CFWC; Mr. Dirgha Raj Shrestha, and Dr. Shilu Adhikari NFHPIL.

I believe that the contents provided in this publication, which is based on international reference materials and programmatic experiences of Nepal, will be pivotal to all health professional and program managers seeking to expand and improve the quality of family planning care through different delivery points in Nepal.

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FOREWORD

It gives me immense pleasure to know about the publication of the fourth edition of *National Medical Standard for Reproductive Health (NMS-RH) Volume I: Contraceptive Services*. This edition has incorporated the latest technical and policy updates and we expect this to serve as a guide for managers and supervisors to improve the quality of family planning services. This manual provides accurate and up-to date information that will also help family planning providers to update their knowledge as well as offer family planning services effectively and safely.

I would like to thank all the experts; USAID and other organisations, most notably Nepal Family Health Program II for their contribution in bringing out this edition of National Medical Standard for Reproductive Health Volume I: Contraceptive Services.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
AHW	Auxiliary Health Worker
ANM	Auxiliary Nurse Midwife
ARV	Antiretroviral
BP	Blood Pressure
CFWC	Chhetrapati Family Welfare Center
CMA	Community Medical Assistant
CPR	Contraceptive Prevalence Rate
CYP	Couple Years Protection
COC	Combined Oral Contraceptive
COFP	Comprehensive Family Planning
DHO	District Health Office
DMPA	Depo Medroxy Progesterone Acetate
DPHO	District Public Health Office
DVT	Deep Vein Thrombosis
EE	Ethinyl Estradiol
FCHV	Female Community Health Volunteer
FHD	Family Health Division
FHI	Family Health International
FPA	Family Planning Assistant
FPAN	Family Planning Association of Nepal
HA	Health Assistant
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HLD	High Level Disinfectant
HIV	Human Immuno Deficiency Virus
GoN	Government of Nepal
HMIS	Health Management Information System
IPPF	International Planned Parenthood Federation
IUCD	Intrauterine Contraceptive Device
IV	Intravenous
JSI	John Snow Incorporated
LAM	Lactational Amenorrhoea Method
LMP	Last Menstrual Period
MCHW	Maternal Child Health Worker
MO	Medical Officer
MOHP	Ministry of Health and Population
NFCC	Nepal Fertility Care Center
NFP	Natural Family Planning
NGO	Non Governmental Organization
NHTC	National Health Training Centre

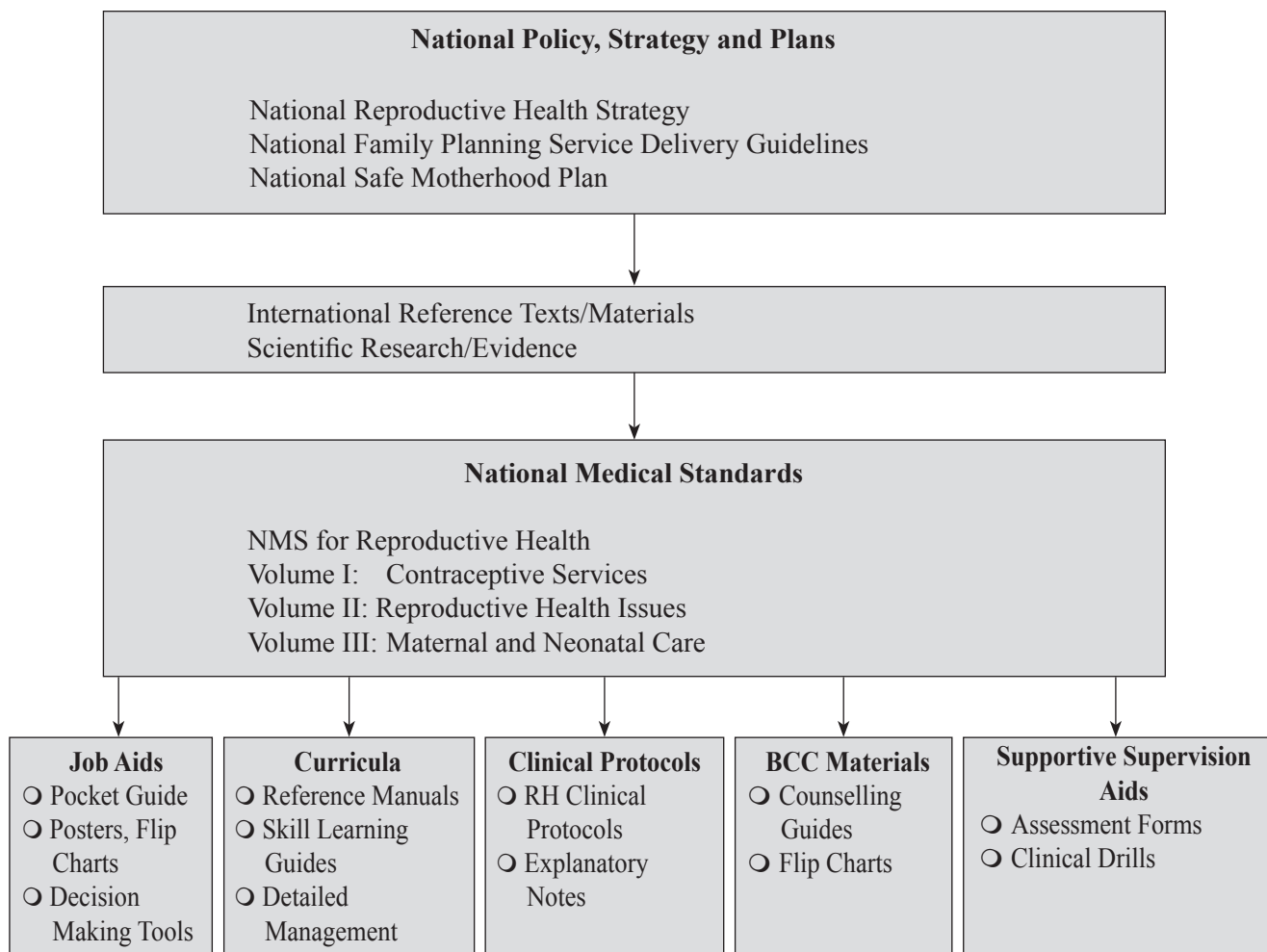
NMS-RH	National Medical Standard for Reproductive Health
NSV	No-Scalpel Vasectomy
PID	Pelvic Inflammatory Disease
OC	Oral Contraceptive
PIC	Progestin Injectable Contraceptive
POC	Progestin Only Contraceptive
POP	Progestin Only Pills
QOCMC	Quality of Care Management Centre
RH	Reproductive Health
SBE	Subacute Bacterial Endocarditis
SN	Staff Nurse
STIs	Sexually Transmitted Infections
TBAs	Traditional Birth Attendants
TUTH	Tribhuban University Teaching Hospital
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VHW	Village Health Worker
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

INTRODUCTION

The *National Medical Standard for Reproductive Health* is designed to provide policymakers, district health officers, hospital directors, clinical supervisors and service providers with accessible, clinically oriented information to guide the provision of reproductive health services in Nepal. This *Volume I* contains standards for contraceptive services. *Volume II* includes the remaining reproductive health issues and *Volume III* includes maternal and neonatal care as outlined in the ICPD.

The *National Medical Standard for Reproductive Health* reflects the national health policy as outlined in the *National Reproductive Health Strategy*, and relies on international reference materials and scientific evidence. The standards serve as a country-specific reference document for essential clinical materials and tools that support patient care and service provision.

National-Level RH Materials



The information in the *NMS-RH Volume I* states the medical criteria for use of contraceptive methods, and sets a national standard for the provision of these services. The document is divided into three sections to aid the reader when accessing information. Chapters in Section I address the national standards for counselling, client assessment, infection prevention, and medical supervision and monitoring, and family planning complication management systems for provision of family planning services in Nepal. In Section II, national standards for specific contraceptive methods available in Nepal are presented by

chapter, each organized to include basics, pre requisites, counselling and informed consent, indications/precautions, client assessment, method provision, client instructions/follow-up, side effects, and requirements for facilities and providers. Section III of these standards takes into account clients with special needs, such as a woman with a specific medical problem (e.g., women with post abortion complications, STI), or a woman in a particular age group. The Appendices includes specific forms, lists of essential instruments and facility criteria required in Nepal and Medical Eligibility Criteria for Contraceptive Use.

When possible, the *NMS* refers readers and clinicians to specific GoN clinical guidelines and protocols (such as the *Reproductive Health Clinical Protocols*, the *National STD Case Management Guidelines* and the NHTC method-specific training materials) that provide more information to guide practicing clinicians.

The information in the *NMS* is based on the latest material available and expert advice from Nepali reproductive health experts. Important reference documents for this volume include: *Family Planning: A Global Handbook for Providers developed through worldwide collaboration* and *Medical Eligibility Criteria for Contraceptive Use (WHO)*.

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CHAPTER ONE



COUNSELLING, INFORMED CHOICE AND CLIENT RIGHT

CHAPTER ONE

COUNSELLING, INFORMED CHOICE AND CLIENT RIGHT

1.1 INFORMED CHOICE AND COUNSELLING

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

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

Strategies to support informed choice

Following are the staff behaviours that promote informed choice:

- Provide information on a variety of methods
- Offer in a private, comfortable setting that fosters trust
- Focus on client's needs
- Adhere to client's rights and social equality
- Exhibit respect and mutual understanding

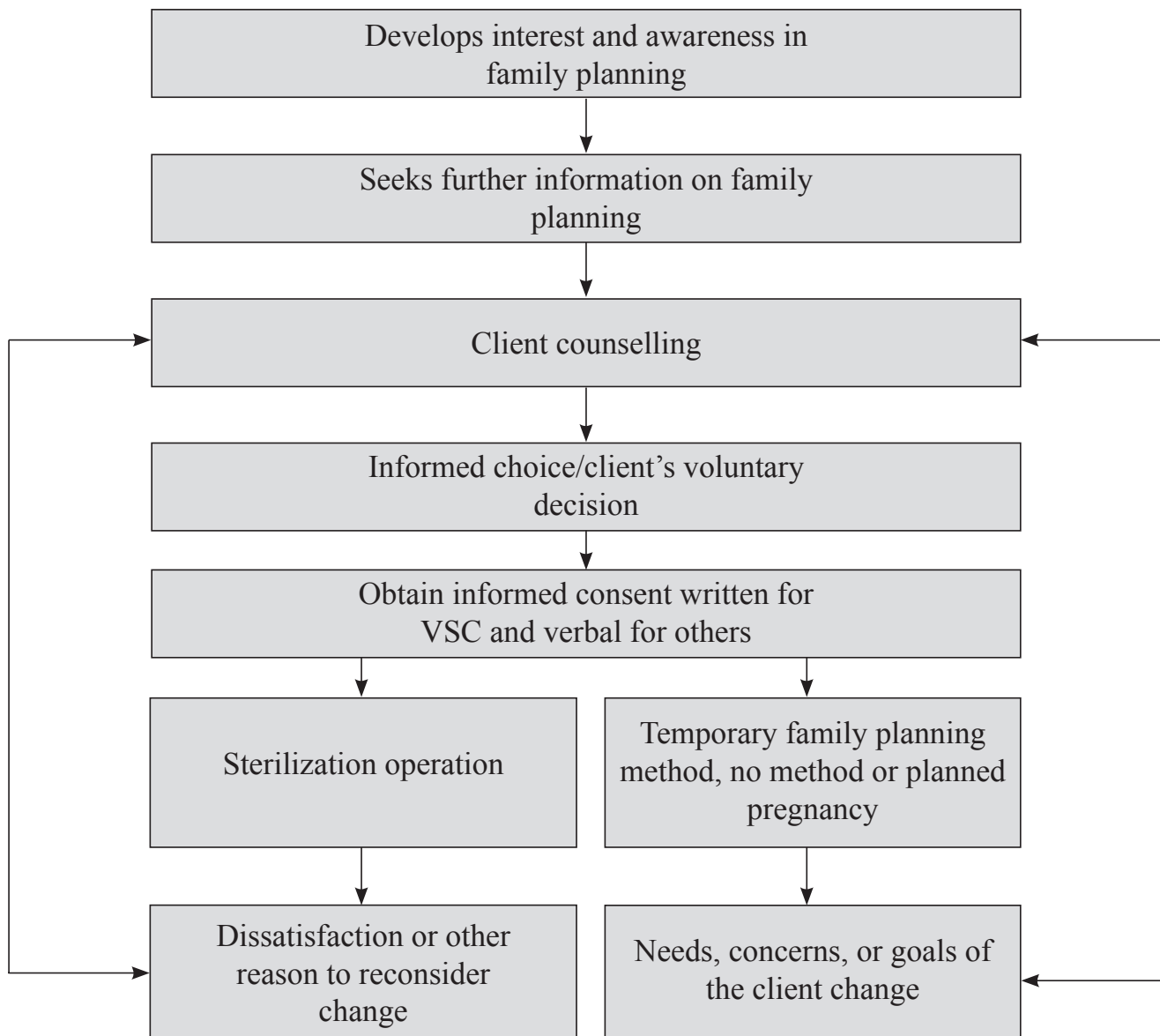
Principles of family planning counselling

Effective family planning counselling is based on the following principles:

- **Client's Needs:** Individuals have their own norms, values, beliefs, culture and attitudes—all of which influence decisions. Counselling is conducted in a respectful way using a communication process that seeks to understand the client's needs and personal circumstances.
- **Voluntary Choice:** Decisions are based on complete and accurate information and must be made **free of pressure, intimidation, enticements, coercion or incentives**. Making a voluntary choice correlates with client compliance and satisfaction with the contraceptive method.
- **Empowerment:** Enables client to understand and exercise individual rights. Counselling should be conducted in a non-judgemental, unbiased manner, without discrimination, based on economic, ethnic, linguistic, educational, gender, age or marital differences.
- **Confidentiality:** The content of a counselling session with a client must never be discussed by the counsellor or staff with outside staff or visitors, without the client's consent. The counselling session should be conducted in a private space where outsiders cannot overhear/view the interactions.

- **Consent:** Verbal acknowledgement of client understanding about the method choice is required before providing the family planning method. With all voluntary surgical contraception (VSC) procedures, **a written, signed consent is required and mandatory.**

1.2 COUNSELLING AND INFORMED CHOICE ALGORITHM



1.3 INFORMED CONSENT

Informed consent is the client’s voluntary decision to undergo a family planning procedure, in full possession and understanding of the relevant facts. Informed consents are taken verbally for temporary methods, and additional written consent is required for permanent methods. The consent form is a legal authorization for the procedure to be performed.

The consent form (see Appendix D I) becomes a legal document when signed/marked by the client. **A consent is valid and binding only if the client was fully informed and knowledgeable about the content of the consent before signing.**

- If a client is unable to read the consent, staff must read or explain in detail the contents of the document in a language understood by the client, and in the presence of a witness (preferably of the same sex as the client). The witness must also sign the consent to verify the client understands the content, and also verifies the client's mark/thumbprint.
- Since VSC procedures are permanent, in the case of a married couple, it is **advisable, but not required**, to obtain a jointly signed consent and if possible to include the client and spouse in the counselling session.
- The person executing the consent must also sign the document.
- The physician is responsible for ensuring that the informed consent is obtained. Thus the physician's role is to oversee informed consent is obtained with proper client understanding by the family planning staff and the client has signed the informed consent form with full understanding.

Spousal consent for VSC is advisable, BUT NOT REQUIRED.

Below are the seven elements of VSC services that the client must fully understand to obtain an informed consent:

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

Special Considerations—Mobile and Seasonal VSC Sites

In mobile and seasonal VSC sites, clients frequently arrive at the site already having made a decision for the VSC procedure. At these sites, where there are large numbers of clients and time constraints, family planning information can be given to clients together in small groups. After completion of the group session the provider/registrar meets with each client privately to verify that the client's decision is based on accurate and complete understanding of the seven points in the informed consent form. If the client has insufficient knowledge and understanding, then the counsellor/screening nurse must conduct a thorough and private counselling session.

The counselling process

Family planning staff must be properly informed about available contraceptive methods and be able to assist potential users to make an informed choice. Information should be given to aid a client's choice, not to persuade, press or induce a person to use a particular method. Counselling service should be provided taking into account the general and reproductive rights of the client. Staff dealing with family planning clients must be trained in counselling techniques and have the appropriate materials and job aids to conduct the counselling session.

<p>Reproductive Rights, ICPD, 1994 The rights of individuals or couples: To decide freely and responsibly the number, spacing and timing of their children. To have the information needed to do that. To attain the highest standard of sexual and reproductive health. To make decisions concerning reproduction free of discrimination, coercion and violence.</p>	<p>Client's rights: Information Access to services Informed choice Safety to services Privacy and confidentiality Dignity, comfort and expression of opinion Continuity of care</p>
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Family planning counselling is to be provided wherever family planning methods are available. The counselling session may be an individual session (client and service provider) or a couple counselling session, (client with partner and service provider). As per the client's request and desire, a close friend or family member may be present in the counselling session. Staff who have completed a certified counselling training or are certified in providing family planning contraceptive services may conduct counselling sessions.

For further information on the counselling process, refer to *The Comprehensive Family Planning (COFP)/Counselling Reference Manual*, published by National Health Training Centre (NHTC), 1999.

Client-provider interactions

<p>Principles of Good Client Provider Interaction</p> <ul style="list-style-type: none"> ● Treat each client with respect ● Tailor the interaction to the individual client's needs, circumstances, and concerns ● Interact, encourage the clients active participation ● Avoid information overload ● Provide the client's preferred method for FP or address the client's primary concern (for other SRH issues). ● Use and provide audio-visual aids
--

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

- Treat client with respect, exhibiting friendly, calm behaviour and an unrushed manner.
- Treat all clients as equals, without preferential treatment by age, gender, religion, values, caste, languages, economic status or marital status.
- Speak in a language understood by the client or arrange for a translator to help communication.
- Assure confidentiality concerning the client's information.
- Describe how the client can be helpful during the procedure and what to expect before, during and after the procedure.
- Provide the client an opportunity to ask questions and address concerns.
- Assure that client's modesty is maintained.
- Address doubts, fears or misconceptions held by the client.
- Minimize the client's pain and address the client's anxiety.

When staff members take time to treat clients in a gentle, considerate manner, giving them full information, the counselling process will go smoothly for the staff and clients alike. Brief information on clients is essential before proceeding counselling service like: name of the client, age, sex, marital status, history of abortion, number of previous live birth and surviving child, age of the child and breast feeding, economic status, education, social status (culture) etc.

Need based (Situation-specific) counselling

Situation-specific counselling saves time and makes counselling effective and focused. Clients are of different types like: new or old, satisfied or unsatisfied, decided or undecided. These clients need to be counselled based on needs and situation. For new clients with preference of contraceptive the counselling should focus on client's choice. For new client with limited knowledge of contraceptives, provide information on all available contraceptives as per the need of the clients. For unsatisfied client, first of all find out the cause of his or her non satisfaction and then provide the counselling service. For satisfied client, try to assess whether or not the client is using the method as appropriate and do not try to overload with unnecessary information.

Besides these other clients like, VSC clients, postpartum clients, post abortion care clients, male clients, adolescents, newly married couples, clients nearing menopause and clients with HIV/AIDS should be counselled with following attention:

VSC clients

Since permanent methods are irreversible, require bodily exposure and are surgical in nature, the following must be addressed:

- In-depth counselling and written informed consent are required.
- Assume that all clients have fears and anxiety and address these concerns in a clear and helpful manner. **Female VSC clients in particular have high levels of fear and anxiety around the procedure.**
- Fully explain each part of the process including screening, pre-operative medications, gowning, operation theatres, post-operative pain, side effects, warning signs, recovery at home and follow-up.
- Maintain the client's dignity and modesty during each stage of the procedure—in counselling, screening, urinating, clipping, changing, waiting, wearing gowns, in operation theatre during procedure and re-dressing.

Postpartum clients

- The service provider must ascertain that the client is not limited by physical or emotional factors (sedation, labour, severe pain, trauma) that would compromise the client's ability to make a clear decision
- The effectiveness of the Lactational Amenorrhoea Method (LAM), return of fertility before menses and family planning methods that do not adversely affect breastfeeding is to be explained.

Postabortion care client

- Acceptance of contraception must not be a prerequisite for postabortion care services or treatment of complications.

- Family planning counselling can occur at anytime, before or after the procedure or treatment.
- The service provider must ascertain that the client is not limited by physical or emotional factors (sedation, severe pain and trauma) that would compromise the client's ability to make a clear decision. In this case, the client and/or partner should be given condoms, instructions for use, and referral and follow-up information.
- Counselling should include information on the rapid return of fertility (after 2 weeks) and potential for pregnancy before menses resume.
- If pregnancy was due to contraceptive failure, counselling must include effectiveness of methods.

Male clients

- As with female clients, male counselling should include information on reproduction, sexuality and contraception, and use of flipcharts and anatomic models. Misconceptions about methods should be clarified.
- Condoms should be demonstrated using anatomic model, not just verbally explained or handed out. Instructions for condom use should be readily made available in clinics.
- Couple counselling should be encouraged.

Adolescents

- Non-judgemental, unbiased counselling is essential to establish rapport, comfort and trust.
- Confidentiality must be assured and protected.
- Complete information should be available in sexual and reproductive health, with an emphasis on adolescent issues: self-esteem, physical appearance, negotiating unwanted sexual advances and pressure from peers or partners, and handling relationships.
- Make condoms and instructions about use of condoms available to the adolescent in a private setting, free of embarrassment.
- Assess the fertility intention.
- Encourage adolescent client who are sexually active to adopt a FP method of their choice in order to prevent pregnancy.
- Reinforce the health benefits of delaying pregnancy for both mother and child.
- Explain that there are a variety of FP methods that can be used to prevent pregnancy.

Young couple

- Explain the well planned family size and discuss on the healthy timing for pregnancy and risk of pregnancy at an early age.
- Young married adolescent need time to physically mature so they are prepared for pregnancy and child birth.
- Delaying the first child until a young woman is at least 20 years increases the chance of having a healthy pregnancy and a healthy child.
- Young married adolescent must understand the risk of early pregnancies to health.

Women nearing menopause

- Women over 35 years of age who are mothers should be encouraged to stop smoking if they continue to use COCs.
- If the woman desires to limit her family, she should be informed about the long term methods or permanent method.
- She should be properly informed about the signs and symptoms of menopause and also about the effects of family planning methods on menopause.
- Most women after 35 years may have other reproductive health problems so they need to be advised to do regular check ups of their reproductive organs.

People living with HIV/AIDS

- Assess the fertility intentions and desired family size of a PLHA.
- Remind her that pregnancy places a heavy burden on her body and over all health so she should be careful to limit her pregnancies and space them adequately so she has time to recover between pregnancies. Further, women with HIV/AIDS are at a greater risk of having preterm births, stillbirths, and low birth weight babies.
- Inform her that PMTCT programs can dramatically decrease the risk of a mother passing on HIV to her baby during pregnancy and delivery.
- Explain the client about a healthy sexual life by preventing pregnancy, preventing injection and having a healthy baby.
- PLHA also have FP contraceptive needs so they can use almost any FP methods including LAM.
- Ensure that the PLHA know how to prevent STIs: and use of condom for dual protection.
- PLHA should be strongly encouraged and helped for partner testing and counselling.
- PLHA should be encouraged to use condoms and emergency contraception if needed.

CHAPTER TWO

2

CLIENT ASSESSMENT

CHAPTER TWO

CLIENT ASSESSMENT

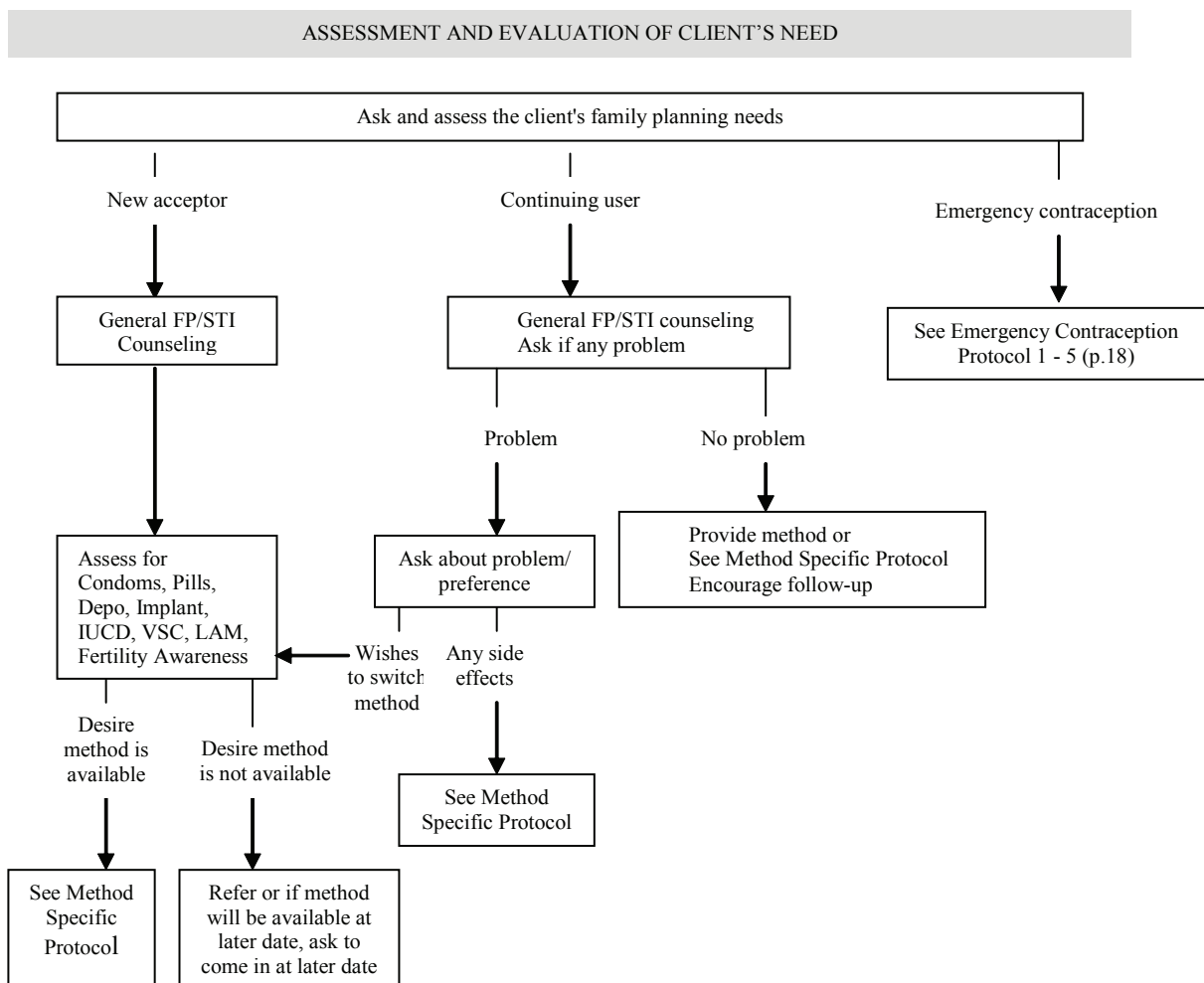
2.1 BASICS

The objectives of client assessment prior to providing a contraceptive method are to determine the following:

- That the client is not pregnant;
- That the client is eligible for the chosen method; and
- Whether the client has any medical problems (e.g., diabetes or high blood pressure) that may require more frequent follow-up or management.

For most clients, this can be accomplished by asking a few key questions. To enable clients to obtain the best contraceptive method of their choice, client assessment should be limited **only** to those procedures that are essential and mandatory for all clients in **all** settings. (Refer to **Table 2-1, and 2-2 Client Screening Checklist**, to assess clients considering reversible methods). Clients need can be further assessed by Decision Making Tools developed by WHO and adapted in Nepalese context.

2.2 CLINICAL ASSESSMENT



2.3 INDICATIONS AND PRECAUTIONS FOR PARTICULAR METHODS

In this *National Medical Standard*, **contraindications** are listed for any condition or disease that makes the use of a contraceptive strongly inadvisable or unsafe for a client. **Precautions** are listed for conditions that require extra attention and closer follow-up.

In Nepal the risk of dying from pregnancy related complication is much greater than the risk of dying from complication or side effect of family planning method. Therefore precaution should not be over emphasised.

In Nepal the high maternal mortality and morbidity rate associated pregnancies that are too close, too many and unwanted must always be considered. Therefore, precautions should not be over emphasized.

WHO classification system, Refer to Appendix H

2.3.1 Client Screening Checklist for Reversible Methods

If all responses in the list below are negative (No) and pregnancy is not suspected, the client may go directly for method-specific counselling and provision of or referral for the contraceptive. Any positive response (Yes), however, means that the client should be further evaluated before making a final decision.

Note: Clients do not always have exact information about the conditions listed below. As a consequence, healthcare workers must know how to assess the accuracy of the information. If necessary, they may need to restate the question(s) in several different ways. They need to take into account any social, cultural or religious factors that might influence how the woman (or her spouse) responds.

Table 2-1: Client Screening Checklist for Hormonal Methods

History	Yes	No
Possibly pregnant		
Breastfeeding and less than 6 weeks postpartum ¹		
Non breastfeeding and more than 3 weeks postpartum ¹		
Unexplained vaginal bleeding		
Diabetes ³		
Abnormal yellow skin or eyes (jaundice)		
Smoker over age 35 ²		
Severe headaches		
Severe pain in calves or thighs with swollen legs (oedema) or history of deep vein thrombosis (DVT) ²		
Blood pressure above 160 / 100 mmHg (for COC 140/90 mmHg)		
Diagnosis or history of breast cancer		
Taking rifampicin or anti-epilepsy (seizure) medications or griseofulvin ²		
History of stroke or cardiovascular accidents		

- 1 Combined oral contraceptives (COCs) are the method of last choice anytime for breastfeeding women, especially in the first 6 weeks.
- 2 DVT : Does not apply to Depo-Provera and Implant

- 3 With vascular disease or DM for > 20 years, category to be assessed according to severity for combined oral contraceptives (COCs) and DMPA

Table 2-2: Client Screening Checklist for Intrauterine Contraceptive Device (IUCD)

IUCDs	Yes	No
Possibly pregnant		
Client (or partner) has other sex partners		
History of sexually transmitted diseases (STIs) within 3 months		
HIV positive		
History of pelvic infection (PID) within 3 months		
Unexplained vaginal bleeding		
After 48 hours to 4 weeks postpartum		
Post septic abortion or puerperal sepsis		
Current genital CA and pelvic tuberculosis		

2.3.2 How to be Reasonably Sure That the Client is NOT Pregnant

All female clients should be screened for pregnancy before provision of any family planning method. If a woman who is unknowingly pregnant is given a family planning method, it is likely that people in her family and community will believe that the method she used is not effective, and false rumours will spread about that method.

You can be reasonably sure the client is not pregnant after using the following pregnancy checklist:

Figure 2-1: Pregnancy Checklist

Ask the client questions 1–6. As soon as the client answers "yes" to any question, stop and follow the instructions below.

NO			YES
	①	Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and had no monthly bleeding since then?	
	②	Have you abstained from sexual intercourse since your last monthly bleeding or delivery?	
	③	Have you had a baby in the last 4 weeks?	
	④	Did your last monthly bleeding start within the past 7 days (or within the past 12 days if the client is planning to use an IUCD)?	
	⑤	Have you had a miscarriage or abortion in the last 7 days (or within the past 12 days if the client is planning to use an IUCD)?	
	⑥	Have you been using a reliable contraceptive method consistently and correctly?	

<p>↑</p> <div style="border: 1px solid black; padding: 10px; width: 80%; margin: auto;"> <p>If the client answered "no" to all questions, pregnancy cannot be ruled out. The client should wait for her next monthly bleeding or use a pregnancy test.</p> </div>	<p>↑</p> <div style="border: 1px solid black; padding: 10px; width: 80%; margin: auto;"> <p>If the client answered "yes" to at least one of the questions, and she has no signs or symptoms of pregnancy, you can give her the method she has chosen.</p> </div>
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Physical exam is seldom necessary, except to rule out pregnancy of greater than 6–8 weeks gestation (measured from the last menstrual period).

Pregnancy testing is unnecessary except in cases where:

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

In these situations, a sensitive urine pregnancy test (i.e., detects less than 50 mIU/ml of HCG) may be helpful, if readily available and affordable. If pregnancy testing is not available, counsel the client to use a temporary non-clinical contraceptive method or abstain from intercourse until her menses occurs or pregnancy is confirmed.

2.4 CLIENT ASSESSMENT REQUIREMENTS

The following table indicates the client assessment requirements for each type of family planning method:

Table 2-3: Client Assessment Requirements for Family Planning Methods

Procedure	LAM/ Breast feeding	Male and female condoms	Hormonal Methods (COCs/ Depo- Provera®/ Implant®)		Sterilization Female/Male
Screen for Pregnancy	No	No	Yes	Yes	Yes
STIs Screening (High Risk)	No	No	No	Yes	Yes
Medical and Reproductive History	Yes	No	Yes	Yes	Yes
Physical Exam					
Female					
Blood Pressure	No	No	Yes	No	Yes
Breast Examination*	No	No	No	No	No
Abdominal	No	No	No	Yes	Yes
Pelvic Exam (Bimanual and speculum)	No	No	No	Yes	Yes
Male					
Exam (groin and genitals)	N/A	No	N/A	N/A	Yes
Laboratory Test (Female only)					
Haemoglobin	No	No	No	No	Yes ¹
Protein and Sugar in Urine	No	No	No	No	Yes

* When facilities and trained staff are available then breast exam may be done before initiating hormonal methods

¹ In Nepal the risk of dying from a pregnancy-related complication is much greater than the risk of dying from complication of the minilap procedure. A large number of Nepalese women suffer from anaemia and to refuse them minilap services solely on the criteria of borderline anaemia could defeat the very purpose of providing them quality reproductive health services. A physician's decision to conduct minilap on a severely anaemic client (Hb < 7 gm/dl or Hct < 20) should be based on her risk of pregnancy-related complication and her access to services, versus the risk of operating on an anaemic client.

CHAPTER THREE

3

INFECTION PREVENTION

CHAPTER THREE

INFECTION PREVENTION

3.1 BASICS

Infection prevention procedures are simple, effective, and inexpensive. Infectious organisms of the concern in Family Planning clinic include bacteria (such as staphylococcus), viruses (particularly HIV and Hepatitis B), fungi, and parasites. In the clinic, infectious organism can be found in blood, body fluids or tissue. The organisms can be passed through mucous membranes or broken skin, such as cuts and scratches, and by needle sticks with used needles and other puncture wounds. The aim of the infection prevention is to minimize the transmission of infections to clients and service providers, including clinic helpers who handle contaminated instruments and wastes.

Risk of HIV infection in the clinic

Health care providers may be exposed to HIV through needle pricks, contact with mucous membranes, or broken skin, but the risk of infection is low:

- The average risk of HIV infection after a needle pricks exposure to HIV-infected blood is 3 infections per 1,000 needle pricks.
- The risk after exposure of the eye, nose, or mouth to HIV-infected blood is estimated to be about 1 infection per 1,000 exposures.

Following universal precautions is the best way that providers can avoid workplace exposure to HIV and other fluid-borne infections

3.2 PROTECTIVE BARRIERS

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

- Hand washing
- Putting on gloves and surgical attire
- Using antiseptic solutions
- Processing equipment, instrument and other items
- Managing clinical waste

3.2.1 Hand washing

Hand washing may be the single most important procedure in preventing infection. To encourage hand washing, program managers should make every effort to provide a continuous supply of fresh water, either from the tap or a bucket, and soap. The hand washing may be simple hand washing for non surgical procedures and surgical hand scrubbing for surgical procedures.

When to wash hands:

- After arriving at work and before leaving
- Before and after food

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

Items required for hand washing

- Soap
- Soap box with hole
- Clean running water
- Jug
- Basin to collect water
- Personal towel—clean and dry
- Betadine for surgical scrub

Alternate to hand washing in difficult situation

When it is difficult to wash hands frequently, (as in disaster situation) use an alcohol handrub. The solution can be prepared by adding 2 ml of glycerin, propylene glycol or sorbitol to 100 ml of 60% – 90% rectified spirit. Use 3–5 ml of this solution for each application and continue rubbing the solution over the hands for about 2 minutes, using a total of 6–10 ml per scrub.

Technique of hand washing

For non-surgical procedure (e.g., examination of a client, pelvic examination insertion/removal of IUCD):

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

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

- Remove all items of jewellery, including wristwatch.
- Wash hands with betadine hand scrub for 3 to 5 minutes.
- Scrub hands, beginning at the fingertips; wash between all fingers and move towards the elbow.
- Repeat for the second hand.
- Rinse each arm separately, fingertips first, holding hands above the level of the elbows to prevent water from running down from the elbow to the hands.
- Dry hands with a sterile towel.
- After hand washing has been completed, hold hands above the level of the waist. Repeat hand washing if hands touch any unsterile object before gloves are put on. However, if this happens while putting on gloves, just change gloves.

It is the best practice for providers to wash their hands between each client contact. However, in high volume settings (high volume is defined as five or more clients waiting for family planning procedures), this may be difficult to practice. In such situations the following are the minimum standards:

Minimum hand washing requirement for VSC and other family planning services:

Routine Setting	High Volume Setting	
	Minilap, Vasectomy, Implants and IUCD	Injectables
After every case	After every 5 cases or hourly	After every 10 cases or hourly

Note: Gloves **must** be changed between cases no matter which of the above procedures is followed.

3.2.2 Putting on gloves and surgical attires

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

Indication

Types of gloves	Indications
Sterile gloves	While performing surgical procedure such as minilap, vasectomy, insertion and removal of implants and IUCD etc.
High-level disinfected gloves (single use or reusable)	When sterile gloves are not available for surgical procedure.
Utility gloves	<ul style="list-style-type: none"> • While making 0.5% chlorine solution, • While handling used instruments, cleaning blood or body fluids and handling waste.

Using other surgical attire and use of cell phones

Other surgical attire such as caps, masks, apron, boots, eyeglasses, gloves and gowns help reduce the risk of post-procedure infections in clients. In addition, as use of cell phones has increased incidence of operation theatre infections, use of cell phones in operation should be avoided as far as possible.

Surgical attire required for family planning procedures

Family Planning Procedure	Gloves	Cap/Mask	Gowns
IUCD	Yes	No	No
Implants	Yes	No	No
NSV	Yes	Yes	No
Minilap	Yes	Yes	Yes
Laprosopy	Yes	Yes	Yes

3.2.3 Using antiseptic solutions

Antisepsis involves cleaning of the client's skin or mucous membrane with an antiseptic substance to remove or eliminate as many micro organisms as possible, prior to any invasive procedure. Care should be taken not to irritate or damage skin or mucous membrane.

Indications to use antiseptics

- Surgical hand scrub
- Skin, cervical and vaginal preparation before a clinical procedure
- Hand washing in high-risk situations, such as before invasive procedures (e.g., insertions of central venous catheters or tubes) or before contact with clients at high risk of infections (e.g., newborns or immuno suppressed clients)

Notes on preparing skin and shaving hair at operative site: While preparing skin for surgical procedure, do not shave hair at the operative site. Shaving increases the risk of infection as the tiny nicks in the skin provide an ideal setting for micro organisms to grow and multiply. If the hair must be cut, trim the hair close to the skin surface immediately before surgery.

Selection of antiseptics

The following antiseptic solutions are approved for use:

- Iodophors, various concentrations 0.5% to 10% (e.g., Betadine)
- Alcohols (60 to 90%), ethyl, isopropyl, "Rectified spirits"
- Chlorhexidine gluconate 4% (e.g. Hibitane, Hibiscrub) Centrimide and chlorohexidine gluconate (CHG), various concentrations (e.g., Savlon)
- Iodines (2 to 3%), tincture and aqueous (e.g., Lugol's) (not for use on mucous membranes such as vagina)

Remember: antiseptics do not have the same killing power as the chemicals used for HLD. Therefore, antiseptic solutions should never be used to:

- Disinfect inanimate objects, such as instruments and reusable gloves
- Clean surfaces, such as floors or countertops

Instruments and items such as pickups (lifters, cheatle forceps), scissors, scalpel blades, catgut, umbilical tie thread and suture needles should never be left soaking in an antiseptic solution like spirit water and savlon; they should always be stored dry. Micro organisms can live and multiply in antiseptic solutions and contaminate the instruments and other items, leading to infections.

Storage and dispensing of antiseptics

Contamination of every antiseptic has been documented. Micro organisms contaminating antiseptic solutions include gram-negative bacilli and endospores and, rarely, staphylococcus. These antiseptics with organisms can cause subsequent infection when used for hand washing or on a client's skin or mucous membrane.

To prevent contamination of antiseptic solutions

- **Pour the antiseptic**, unless supplied commercially in small quantities, into small, clean, reusable containers and label it for daily use. This prevents evaporation and contamination, which could occur if the large container is opened too often. Do not store gauze or cotton wool in aqueous antiseptics as this promotes contamination. Prepare and use fresh spirit swabs everyday.

- **Establish a routine schedule** (e.g., each week) for preparing new solutions and cleaning reusable containers. (Solutions are at increased risk of becoming contaminated after one week's storage of being prepared.)
- Wash the reusable container thoroughly with soap and water, boil and dry before refilling. Label it with the date each time it is washed, dried and refilled.
- **Store** antiseptics in a cool, dark, clean room and well ventilated area. Never store chemicals in direct sunlight or in excessive heat (e.g., upper shelves in a tin-roofed building).
- When using antiseptic solutions, always pour the solution out of the container. Touching the rim or contents of the container with gauze, a cotton swab or hand contaminates the entire bottle of antiseptic.

3.2.4 Processing of equipment and other items

The purpose of processing of instrument is to reduce the spread of micro organisms by equipment, instrument and other items while reusing these materials for providing services. It is not only for clients/patients but also for service providers and clinic support staff.

Steps in processing equipment and other items

1. Decontamination
2. Cleaning (includes holding in detergent water, drying and wrapping)
3. HLD or sterilization
4. Storage

3.2.4.1 Decontamination

Decontamination is important for pre-treating instruments and objects that may have come in contact with body fluids, to make them safer to handle by personnel who clean them. Proper decontamination will inactivate Human Immunodeficiency Virus (HIV) and hepatitis B virus (HBV), hepatitis C virus (HCV) and hepatitis D, making instruments safer for staff to handle. Using 0.5% chlorine solution (virex) is an inexpensive and effective way to do decontamination.

Items required

- Mask
- Plastic bucket of 10 liter capacity
- Utility gloves
- Chlorine powder
- Plastic jug of 1 liter capacity to measure water
- Clean water

Preparation of 0.5% chlorine solution

Chlorine solution can be made from liquid household bleach (sodium hypochlorite) or from other chlorine compounds available in powder (calcium hypochlorite or chlorinated lime) or tablet form (sodium dichloroisocyanate).

Process of decontamination

- Keep fresh plastic buckets containing 0.5% chlorine solution near the procedure site.
- Immediately after each procedure, place the used items in 0.5% chlorine solution for 10 minutes. Do not wait too long before starting decontamination, to prevent organic materials from drying and becoming hard to remove.

- After 10 minutes, rinse with water and remove gross organic material before cleaning. Soaking instruments for excessive periods of time in the chlorine solution damages them.
- Decontaminate large surfaces (e.g., pelvic examination tabletop) by wiping them with 0.5% chlorine solution.
- Then after 10 minute wiping them with clean water.

Precautions

- Use only plastic clean containers for chlorine solution. Chlorine damages metal containers.
- Use utility gloves while working with chlorine solution.
- Submerge all the instruments in 0.5% chlorine solution so that the chlorine solution level is above the instruments. Open jointed items such as clamps and scissors.
- To prevent damage to the instruments do not keep them in chlorine solution for more than 10 minutes.
- Chlorine solutions should be replaced daily or more often if necessary, because they lose potency rapidly over time or after exposure to light.
- Rinse the instruments with cold water immediately after decontamination.
- Store the chlorine powder where there is good ventilation. Do not keep it in a general storage area where there are other metal instruments and equipment.

3.2.4.2 Cleaning

Cleaning is a crucial step in instrument processing. Cleaning greatly reduces the number of organisms and endospores on instruments and other equipment. The steps in cleaning includes holding items under detergent water, drying of items and wrapping of items once cleaned

Items required

- Soap or detergent
- Clean water
- Brush (fine bristled), such as a toothbrush
- Utility gloves and other protective attire

Process

- Use of soap is important for effective cleaning because water alone will not remove protein, oils and grease. The use of hand (bar) or powdered soap is discouraged because the fatty acids in bar soap react with the minerals in hard water leaving a residue or scum (insoluble calcium salt), which is difficult to remove. Using liquid soap, if available, is preferable because it mixes more easily with water than bar or powdered soaps. In other foreign matter in solution so that they can be removed more easily by the cleaning process. Do not use abrasives (e.g., Vim or Comet) because they may damage instruments.
- Be sure to remove all materials caught in the small spaces (e.g., between the teeth of clamps or hemostat) and around the joints.
- Rinse thoroughly with water, as soap may interfere with chemical disinfection or sterilization.
- Dry by air or with a clean towel. (Water from wet instruments will dilute chemicals used for sterilization or disinfection.) Drying is not necessary for instruments which are to be boiled.

3.2.4.3 High-Level Disinfection

High-level disinfection is effective in destroying all micro organisms but does not always kill endospores. High-level disinfection is appropriate for items that do not come into contact with the bloodstream or tissues under the skin. Also, when sterilization is not possible, high-level disinfection is the only acceptable alternative for processing instruments and other items for reuse.

HLD can be achieved by two techniques:

- **Boiling and**
- **Chemical disinfection.**

Boiling

Items required

- Clean pot with a lid
- Water
- Fuel source: Either electric stove or Kerosene stove

Process

- Decontaminate, clean and rinse items thoroughly. Completely immerse items in water. Open jointed instrument such as clamps and scissors. Disassemble items composed of more than one part. Make sure that any bowls and containers to be disinfected are full of water.
- Cover and bring water to a rolling boil. Boil items for 20 minutes. Begin timing after water reaches a rolling boil. Do not add or remove any item once timing begins.
- Lower heat to keep water at a rolling boil because too vigorous boiling wastes fuel evaporates the water and may damage equipment.
- After 20 minutes, remove items from water using high-level disinfected forceps/pickups.
- Allow items to air dry. Use immediately or store in a high-level disinfected container for up to 1 week.
- Use the same water throughout the day, adding only enough to keep the surfaces at least 2 cm above the equipment to be disinfected. Frequent draining and replacement of water increases the risk of mineral deposit.

3.2.4.4 Chemical disinfection

Items required

- Disinfectant solution such as a 2% glutaraldehyde (i.e., Cidex)
- Plastic bucket or clean container for soaking
- Boiled and cooled water for rinsing

Process

- Decontaminate, clean and rinse items thoroughly.
- Completely immerse items in a high-level disinfectant solution so that the solution touches all surfaces. Open jointed instrument such as clamps and scissors. Disassemble items composed of more than one part. Make sure that any bowls and containers to be disinfected are full of chemical solution.

- Soak for 20 minutes. Do not add or remove any items once timing has begun. Remove, using disinfected forceps or gloves.
- Thoroughly rinse items with boiled water.
- Allow to air dry. Use immediately or store in a high-level disinfected container for up to 1 week.

Precautions

- The vapors of glutaraldehyde are toxic and irritating to the skin, eyes and respiratory tract. Always wear gloves and use it in a well-ventilated area.
- Chemical disinfection of needles and syringes should be avoided because they are difficult to rinse effectively, and chemical residues may interfere with the action of medications being injected.

3.2.4.5 Sterilization

Sterilization kills all micro organisms including endospores and should be used for all objects entering body cavities or the vascular system. Sterilization can be achieved by using steam (autoclaving), dry heat (oven) or soaking in a chemical sterilant.

Steam sterilization

High-pressure saturated steam is generally the method of choice for sterilizing instrument and other items used in family planning and other healthcare facilities.

Items required

- Autoclave
- Wrapping material (paper or double-layered cotton)
- Fuel source: electricity or kerosene stove
- Water

Process

- Decontaminate clean, rinse and air dry items thoroughly.
- Wrap items with desired wrapping materials.
- Arrange items/packs in autoclave to allow free circulation of steam.
- Sterilize wrapped items for 30 minutes, unwrapped items for 20 minutes at 121°C (250°F) and 106 kPa pressure (915 lbs./in). If using a mixed load, sterilize for 30 minutes. Start timing when required temperature and pressure have been reached.
- When time is complete, turn off heater and release the pressure valve. Wait until pressure gauge reads zero (approximately 20 to 30 minutes) to prevent steam from escaping abruptly when opening the door and hurting the person performing the procedure.
- Wrapped items can be stored for up to 7 days. Unwrapped items should be used immediately or stored in a covered sterile container for up to 7 days.

Chemical sterilization

Chemical sterilization may be used for items which are sensitive to heat such as endoscopes.

Items required

- Chemical sterilant: 2% glutaraldehyde (i.e., Cidex)
- Clean container with cover
- Sterile water for rinsing

Process

- Decontaminate, clean, rinse and dry items thoroughly.
- Completely immerse items in chemical sterilant solution. Open jointed instrument such as clamps and scissors. Disassemble items composed of more than one part. Make sure that any bowls and containers to be disinfected are full of chemical solution.
- Allow to soak for 10 hours in 2% glutaraldehyde solution. Do not add or remove any items once timing has begun.
- Remove items with sterile forceps/pickups, rinse well with sterile water and allow to air dry.
- Store in a covered sterile container for up to 7 days.

Storage of sterile or disinfected equipment

Proper storage of high-level disinfected and sterilized equipment is just as important as the high-level disinfection or sterilization process itself.

Sterilized/disinfected equipment should be stored in enclosed shelves or in covered containers to protect it from moisture, dust and debris. The storage area should be easily accessible, but away from circulation of contaminated material and individuals not related to the preparation or handling of equipment and materials. It should also be separated from the area where contaminated material is cleaned and prepared for sterilization or disinfection.

Remember

- Store the packs when they reach room temperature.
- Do not place warm packages in plastic dust covers. Moisture will be trapped and remain there until opened.
- If the pack is dropped, torn or gets wet, consider it contaminated.
- Mark packs and containers used for storing sterile or disinfected items with expiration date and list of items.
- Store packs and containers (drums) containing sterile items off the floor.
- Items should be stored in an enclosed cabinet.
- Re-process objects which have not been used within 1 week.

3.3 WASTE DISPOSAL

Wastes from family planning and health care facilities may be non-contaminated or contaminated.

The purposes of proper disposal of clinic wastes are to:

- Prevent the spread of infection to clinic personnel who handle the waste, and to the local community.
- Protect those who handle wastes from accidental injury.
- Provide an aesthetically pleasing atmosphere.
- Prevent infestation of vermin and other disease carriers.

Do not pile contaminated waste behind the clinic. This practice puts staff and members of the community at risk for injury and infection.

Proper management of waste items minimizes the spread of infection and harm to clinic personnel and to the local community. Proper management includes sorting, transportation and disposal.

Sorting

Separate containers should be used for disposing of general and medical waste. The person who generates it should put waste in the appropriate containers.

Within the health facility wastes are to be sorted and segregated as follows:

- **Sharps:** disposed in puncture proof container
- **Burnable contaminated and non-contaminated wastes:** collected in covered plastic or metal buckets
- **Human tissues:** collected in leak-proof container

Transportation of waste

Waste containers in operating theatres, procedure rooms, indoor rooms, toilets and sluice rooms should be emptied when they become three quarters full (at least once daily). Transport contaminated waste in covered, leak-proof waste containers to the disposal site. Persons handling wastes should wear heavy gloves.

Disposal of waste

Whenever possible, medical waste should be disposed of on the premises; this allows staffs who understand the risks involved to supervise the disposal process.

Burning is preferable method to burying medical waste, because the high temperature destroys micro organisms and reduces the amount of waste. Burning in an incinerator or oil drum is recommended.

If medical waste cannot be burned, onsite burial is the next best option. However, burial is feasible only when there is sufficient space to dig a pit the size needed to accommodate the amount of medical waste generated at the facility. Choose a site that is at least 50 meters away from any water source to avoid contaminating the water source. A fence or wall to limit access to it and to prevent scavenging for waste should surround the pit.

Remember

- Use utility gloves
- Use non-corrosive washable containers (plastic or galvanized metal) with covers for contaminated wastes.
- Place waste containers at convenient places for users (carrying waste from place to place increases the risk of infection for handlers).
- Equipment which is used to hold and transport wastes must not be used for any other purpose in the clinic or health care facility.
- Wash all waste containers with a disinfectant cleaning solution (e.g., 0.5% chlorine solution) and rinse with water. (Clean contaminated waste containers each time they are emptied, and non-contaminated ones when visibly soiled.)
- When possible, use separate containers for combustible and non-combustible wastes. (This prevents workers from having to handle and separate wastes by hand later.)
- Wash hands after handling wastes.

3.4 MAINTENANCE OF OPERATION THEATRE

The following points should be considered to maintain the operating theatre as a standard facility for providing services.

- In static clinics, the operating theatre and the IUCD insertion area should have a tile or concrete floor that can be easily and thoroughly cleaned.
- The operating theatre should be enclosed, free of dust, fly-proof, has adequate lighting, and be well isolated from the part of the clinic that is open to the public.
The operating theatre should be locked when not in use.
- The operating theatre should not store unnecessary drugs, equipments and supplies. Ideally, the operating theatre should be air-conditioned, but if a fan must be used, it should be a pedestal fan (stand fan).
- Windows should be 1.8 m (6 ft.) above the floor, or high enough to prevent cross-ventilation in the operative field, and should be screened against flies and mosquitoes.
- If there is a problem with insects, the room should be fumigated with insecticides at least once a week, on non-working days.
- After each case, the operating table, floor around the table (if blood or body secretion spilled), instrument stands and other potentially contaminated areas such as light handles and counter tops should be wiped down with a 0.5% chlorine solution. This procedure should be carried out at the end of the day with a cleaning solution that contains both a disinfectant (chlorine) and a detergent (soap). On the morning of each day that the operating theatre is to be in use, the floor should be cleaned with a damp mop (water only) and counters/table tops wiped with a damp rag (water only).
- The operating theatre should be thoroughly cleaned at least once a week.

3.5 EQUIPMENT PROCESSING AREA

- The equipment processing area should be designed in such a way so that there is no chance of cross contamination. Different steps of equipment processing activities should be done in separate area as follow:
- **Receiving and Clean-up Area:** All soiled items are received and washed, rinsed and dried in this area. They should already be decontaminated before they arrive here. Items should be decontaminated immediately after use, in the area where they were used.
- **Clean Work Area:** Cleaned items are wrapped when appropriate and high-level disinfected or sterilized in this area.
- **Sterile Storage Area:** All processed items should be stored in this area, which is not located next to the receiving area. Sterile items should be stored in a closed cabinet so that they don't become easily contaminated by general activity in the room, and should be kept dry.

Management of injuries from needles and other sharps

In case of injury with a used needle or other sharp or if blood/body fluids are splashed into the mouth, eyes or onto broken skin, carry out the following procedure:

Needle pricks, cuts, or scratches (that penetrate the skin)

- Wash thoroughly with soap and water.
- Cover with a waterproof sterile dressing.
- If doubtful repeat blood test after 3 month

Splashes to mouth or eyes

Rinse thoroughly with plenty of running water.

Most experts agree that the larger the volume of blood involved in the exposure, the greater the risk of infection. Therefore first aid must begin as soon as possible after the exposure and aim to flush away as much inoculation as possible.

For All Exposures That Penetrate Skin

If you are sure that the patient is positive for blood-borne infections, you can reduce the risk of transmission by using post-exposure prophylaxis measures. To receive such preventive measures, please consult with the DHO/DPHO, or infectious disease specialist familiar with post exposure prophylaxis.

CHAPTER FOUR

4

MEDICAL SUPERVISION, MONITORING AND LOGISTICS

CHAPTER FOUR

MEDICAL SUPERVISION, MONITORING AND LOGISTICS

4.1 BASICS

Supervision is an ongoing support process and system performed by supervisors or trained persons in their assigned territory and health facilities to service providers to improve their performance and increase the quality of health services. Supervision system has mainly the following objectives:

- To improve performance of service providers and quality of services of health facilities and
- To fulfil RH needs and increase level of client satisfaction

Supervisors from central level e.g. Family Health Division conduct supervision to DHO/DPHO level. Similarly, at the district level, DHO/DPHO and other supervisory staff including the Family Planning Officers/Assistants and Health Post In-charge conduct supervision in their defined health facilities and outreach clinics.

Supervision should be done to improve performance of service providers and quality of health facilities. It should focus mainly on counselling, informed choice/consent, infection prevention, emergency preparedness, client assessment, skills and attitude of providers, logistic and supplies, timeliness completeness and accuracy of medical records and reports. In addition, it focuses on overall maintenance of building, equipment, and cleanliness. Supervision team may also assist in identifying interested and committed service providers for in service training courses offered through the NHTC.

The supervision team as well as the clinic staff should use the standard checklist to supervise service providers and service provided by health facilities. Checklist should be based on standard and guidelines provided by the FHD, MoHP for providing quality family planning services at the health facilities.

4.2. STEPS OF SUPERVISION PROCESS

Supervisor should follow following steps while conducting supervision. These steps will help supervisors to conduct supervision more effectively.

4.2.1. Planning for supervision

Supervisor should do proper planning. During planning following activities should be done;

- Prepare field schedule and share with concerned persons
- Review previous reports, checklists, data etc
- Manage supplies/logistic, if they have demanded in previous supervision visit
- Inform the in charge of office or health facility about visit. Some time, supervisors can visit without informing to staff

4.2.2. Implement Supervision

Supervisors should follow following steps during supervision at facility:

- Inform about objectives and activities
- Request them to ask questions/concerns during visiting time
- Observe all parts of health facility
- Observe service technique, recording/reporting, store room, infection prevention practices, etc
- Conduct meeting together with all staff and share main findings.
- Develop action plan to improve services.

4.2.3. Follow up

After supervision, supervisors should do following activities for follow up:

- Prepare report
- Share findings with concerned persons either through reports or meeting
- Send logistics/supplies or take actions to solve problems, if you have committed during supervision
- Thanks staff for their support through mail, letter, telephone etc.

4.3 SELF-ASSESSMENT AND SITE CERTIFICATION

4.3.1 Methods of Self-Assessment

All personnel including Doctors/Medical Officers (MOs), DHOs, DPHOs, SNs, HAs, AHWs, ANMs, maternal and child health workers (MCHWs), VHWs and support staff should continuously assess their own activities and behaviour. The technical practices of all staff should be in adherence to the *National Medical Standard*. Should any staff be in doubt as to the quality of services provided, he/she should refer to this *National Medical Standard* for guidance or if possible get help from Family Health Division to clarify their doubts.

4.3.2 Site Certification

Checklists based on the *National Medical Standard* have been developed for certifying service sites. Rather than visiting every centre, FHD will provide these checklists to concerned DHO/DPHO. This will allow the DHO/DPHO to select the criteria for certification, and to maintain the facility at all times to the level of the *National Medical Standard*. The site certification forms will be filled out before starting the service and at least once a year. After that site certification copies should be forwarded to the Regional Health Directorate Office and the FHD. In addition, spot supervisory visits will be made as feasible. The following types of certification forms are recommended:

- Services for VSC (See Appendix D III VSC site criteria).
- Implant and IUCD Site Certification (See Appendix B II and C II).
- Private clinics and nongovernmental organizations (NGOs) will use the same criteria for a site certification as the government facilities.

4.4 DIRECT OBSERVATIONS/MONITORING

4.4.1 Methods of Direct Observation

Some aspects of quality of care can only be monitored by observing the activities and behaviours of staff. Methods of direct observation include routine daily supervision by local staff, routine supervisory visits to health posts by district and regional supervisors, and random site visit by supervisors from FHD or team or individual assigned by FHD. The primary purpose of this site visit is to provide support and guidance to the clinic to achieve and maintain standard quality services. The supervisor will write a report about the findings, support and recommendations given during the site visit, and provide it to the FHD.

4.4.2 Certification of Providers (VSC, Implants, IUCD)

NHTC will issue certificates to providers of clinical family planning methods after the successful completion of a basic skills course in family planning under the supervision of clinical trainers certified by NHTC.

NHTC will certify a provider who was trained prior to the establishment of NHTC, if two trainers attest in writing that he/she has demonstrated competence during observation.

The certificates for each method will be printed and signed by NHTC and provided to each competent trainee. If a trainee is trained in more than one method (e.g., vasectomy and implants), a certificate is provided for each method.

Trainees who are not fully competent, and whose training cannot be extended further at the time, will be given only a certificate of course attendance, but not of competency.

Clinical family planning services can only be provided by trained health personnel. If there is a need for new service providers, the DHO or DPHO will make a request to the FHD in writing for the training of their staff in specific family planning methods. FHD will recommend those candidates to NHTC for training. All the participants should fulfil the basic selection criteria for the specific training as outlined by NHTC.

4.5 RECORD KEEPING AND REPORTING

4.5.1 Client Medical Records

Each family planning acceptors has a Medical Record Card for recording medical information. Screening operative and post-operative findings are recorded on the medical records cards. It is the responsibility of the provider to ensure that these forms are completed. There are three types of forms, depending on the method. These forms are shown in Appendix-A IV, E I and F I.

In case of procedures requiring signed consent, the signed consent will be kept as part of the medical record.

4.5.2 Management Information System

The health management information system (HMIS) helps collect data from all over the country and feeds them to the central data bank. The HMIS has several types of records and reports. The records are collected from the record registers maintained at each service site. The **Monthly Report Forms** gives vital information as to the number of new acceptors, repeat client visits, method change, etc. These data are collected by the DHO and forwarded to the central and regional offices. These data help to identify trends in program growth, staff workloads, Contraceptive Prevalence Rate (CPR) and Couple Years Protection (CYP). These reports and inferences are used as management tools for making decisions about which method needs extra program emphasis or which area should receive further service strengthening. All service sites should maintain their clinical records correctly and update them regularly to assist the National Family Planning program.

4.5.3 Logistic Records

From Central Stores, contraceptive supplies are sent to district stores. Buffer stocks are kept at Regional Warehouses for distribution to districts when needed. It is the duty of the DHO/DPHO to ensure distribution within the district to all service sites, including hospitals, the Primary Health Care Centre, health posts and NGOs who submit their data to the DHO.

In order to rationalize the distribution system, logistic forms have been developed for use at central, regional, district and service site levels. These forms report use of supplies and serve as order forms for replenishment of supplies at quarterly intervals. Emergency re supply can be made at any time.

4.5.4 Special Reports for Deaths and Complications

Every death that may have been associated with clinical contraception will be investigated by a doctor who is not a staff of the facility where the death occurred. FHD can lead a committee of family planning experts to do further investigation of such deaths, if required. For deaths there is a special form for the investigation. This form is shown in Appendix G III.

4.5.5 Special Research and Investigation

In-depth research studies and investigations enable programs to give special and thorough attention to carefully selected issues. The FHD may wish to examine important issues or problems in depth (e.g., a study of client satisfaction, or reasons for dropouts of methods, or value of post-operative antibiotics). Such studies may be costly, may require independent contractors and the topics need to be carefully selected for the benefit of the program.

4.5.6 Resources for Medical Reporting and Supervision

A monitoring and supervision system requires both human and material resources. Resources need to be available at central, regional and district levels for this activity. The cost of monitoring and supervision is part of the total cost of the service program. These costs should be included as an integral part of the program budget at regional and district levels.

CHAPTER FIVE

5

FAMILY PLANNING COMPLICATION MANAGEMENT SYSTEM

CHAPTER FIVE

FAMILY PLANNING COMPLICATION MANAGEMENT SYSTEM

5.1 BASICS

A complication is an unexpected unwanted occurrence that is directly related to a procedure or method and requires management beyond what is considered normal. A complication may be immediate (occurring during or soon after completion of a procedure, example: uterine perforation) or delayed (example: wound infection, method failure— pregnancy).

5.2 HOW WILL IT HELP THE SERVICE PROVIDERS AND HEALTH SYSTEM

It helps the service providers and the health system by:

- Ensuring the efficient management of family planning related complications
- Supporting service providers and DHOs/DPHOs in management of complications
- Maintaining accurate documentation
- Serving as the basis for reimbursement of complication funds
- Improving family planning service delivery system and training curriculum, and reduce number of complications

5.3 REFERENCE MANUALS AND GUIDELINES

Reference manuals on clinical guidelines for management of immediate and delayed complications are found in method-specific training manuals and other reference books published by the Government of Nepal (GoN) MoHP:

- *Managing Emergencies in Family Planning Services in Nepal*
- *No-Scalpel Vasectomy Reference Manual*
- *Minilaparotomy Reference Manual*
- *Intrauterine Contraceptive Device Reference Manual*
- *Implants Reference Manual*
- *COFP/Counselling Reference Manual*
- *Reproductive Health Clinical Protocols for Medical Officers*

5.4 PREVENTION AND MANAGEMENT OF COMPLICATIONS

- To reduce the numbers of complications, the physician/nurse in charge should regularly orient other staff to infection prevention practices, aseptic technique and review operating theatre management. Emergency preparedness should be reviewed and medications and equipment checked regularly to ensure that they are in functional condition.

- All health care facilities (GoN, family planning private clinics, and NGO clinics) are to treat, stabilize and, if required, assist with referral/transfer.
- Staff will initiate clinical interventions immediately to the extent to which they are trained. If complication is beyond the scope of their expertise, staff will stabilize the client and coordinate transfer.
- Transfer to the facility that can appropriately and skillfully treat the complication, not necessarily to the closest higher facility.
- The client will be stabilized before transfer: Intravenous (IV) hydration, oxygen, control of bleeding, and whatever is vital and essential.
- A brief written summary of findings/interventions is to accompany the client.
- The DHO/DPHO will be notified of the complication, and will oversee and coordinate the management. FHD will assist as needed.
- DHO/FHD will support service providers who are involved in an emergency and will make every effort to help coordinate care and to assure service provider safety.

5.4.1 Complication Types and Complication Reporting System

Types	Example	Reporting System
(I) Minor Acutenes	<ul style="list-style-type: none"> ● wound separation ● minor wound infection ● minor complaints (headache, backache, fatigue) 	Minor Complication Report Form (Appendix G-II) filed quarterly by DHO and sent to FHD.
(II) Moderate Acuteness	<ul style="list-style-type: none"> ● haematoma responding to conservative management ● minor drug reaction ● haemorrhage responding to conservative management 	DHO is to be notified. Surgical Complication Report Form (Appendix G-I) completed by DHO, filed in DPHO and sent to FHD.
(III) Major and/or Life Threatening : It needs surgical intervention or hospitalization	<ul style="list-style-type: none"> ● Scrotal haematoma and/ or abscess which needs drainage ● bowel, bladder, fallopian tube, or testis injury ● vaso- cutaneous fistula ● Uterine perforation following IUCD ● sepsis, systemic infection peritonitis or tetanus ● severe haemorrhage ● large haematoma requiring I&D or blood transfusion ● gas/air embolism ● convulsions ● aspiration of vomitus ● allergic or anaphylactic reactions ● drug overdose/over-sedation ● respiratory/cardiac depression or arrest 	Immediately contact DHO. DHO to assist with management and consult with FHD as needed. Surgical Complication Report Form (Appendix G-I) filled out by DHO filed in DPHO and sent to FHD.

Types	Example	Reporting System
(IV) Chronic and Other Conditions	<ul style="list-style-type: none"> • Sterilization method failure • HBV, HCV, HIV • Impacted IUCD • Surgical removal of Implant • Inability to complete procedure • Incorrect procedure (example: occlusion of ligamentum rotundum) • Chronic pain • Psychosomatic illness, regret following death of children • Spermatocele, fistula 	<p>Notify DHO; Surgical Complication Report Form (Appendix G-I) completed by DHO and sent to FHD.</p> <p>FHD will assist DHO with arrangement of consultation and/or referral as needed.</p>
(V) Death following or during procedure	<ul style="list-style-type: none"> • Any complication that is directly related to the family planning procedure or method and results in death 	<p>Immediate notification to DHO who will contact FHD Director. File Death Investigation Form (Appendix G-III).</p>

5.4.2 Confidentiality

The content of a complication form is confidential. It is only discussed with persons directly involved in the management of the case and the DHO/FHD staff and FHD advisors.

5.4.3 Filing Minor Complications

Minor complications (Acuteness I) are to be collected at the health care facilities providing the service.

- District Family Planning Officer /Assistant (FPO/A)/DPHO staff will collect the information concerning complications from the district health facilities in a quarterly basis.
- The Minor Complication Report Form is filled in duplicate: one form remains at the health facility and other form is sent to DHO.
- A summary of the findings from these forms will be sent from DHO to FHD.
- See Appendix G-II for a sample of the Minor Complication Report Form.

5.4.4 Filing Complication Form for Moderate and Major Complications, Chronic and Other Conditions

- The Surgical Complication Report Form is filled out by the DHO with the assistance of the service provider overseeing the case.
- The form is available in the DPHO and in the NMS and is filled out in duplicate: one copy is filed at the DPHO; the other copy forwarded to FHD along with accompanying paperwork:
 - Client summary sheet
 - Consent form (if applicable)
 - Prescriptions for medications
 - X-ray/test findings and fees
 - Procedures and lab tests
 - Receipts for treatment, supplies, medications

- Forms are to be submitted as soon as possible, without delay (i.e., immediately after resolution of the complication). These forms are not to be collected at the DPHO and sent only at the end of the fiscal year, as this creates difficulties with data collection and reimbursements.
- See Appendix G-I for a sample of the Surgical Complication Report Form.

5.4.5 Filing of Death Investigation Form (Type V)

- The DHO is to notify the FHD Director by phone about the client's death.
- The form is to be filled out by the DHO and sent to FHD with accompanying documentation.
- FHD will assist the DHO in coordinating an investigation if this is determined by the FHD Director.
- A sample of the Death Investigation form is in Appendix G-III.

5.4.6 Budgetary System

- Each district receives funds to cover the expenses for treatment of minor family planning complications. Costs related to management of minor complications are paid through the district budgets.
- For major complications budget provision is made at DoHS. DHO/DPHO should complete the necessary process while providing treatment for complicated clients. They should submit all necessary documents to FHD as mentioned in 5.4.4.

CHAPTER SIX



NON-CLINICAL METHODS

CHAPTER SIX

NON-CLINICAL METHODS

MALE CONDOMS

6.1 BASICS

Most male condoms are made of thin latex rubber and some are made of animal tissue (lamb caecum) or of polyurethane. However, this section describes male latex condoms.

6.1.1 Male Condoms Available in Nepal

Male condoms are widely available in Nepal. There are male condoms with different brand names and have to be purchased from retail stores.

6.1.2 Effectiveness

Contraceptive effectiveness depends upon the way it is used. The effectiveness is different for consistent and correct user; and common user. For consistent and correct user, in the first year of use it is 2 pregnancies per 100 women and for common user it is 15 pregnancies per 100 women.

Protection against HIV

- When used consistently and correctly, male condom use prevents 80% to 95% of HIV transmission that would have occurred without condoms.
- Male condoms reduce the risk of becoming infected with many STIs (HIV, gonorrhoea, chlamydia, herpes, human papilloma virus) when used consistently and correctly.

6.1.3 Return of Fertility

When the user stops using male condoms, fertility returns instantly.

6.2 PREREQUISITES

6.2.1 Facilities

It is not necessary to have a special facility for distribution of male condoms, but it is important to have a place to do counselling and demonstration of use.

6.2.2 Supplies

Male condoms are freely available at all levels of health facilities of Nepal including community based distribution. Some brands of male condoms have to be purchased from retail stores. Female condoms are only available in private pharmacies.

6.2.3 Category of Provider/ Training

Providers do not need specific training on male condom for its distribution. Condoms are available for people as needed without consulting with health service provider. Male condoms are also distributed free of charge by FCHVs, TBAs, and many NGO community health workers.

6.2.4 Record Keeping and Reporting

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

6.3 SERVICE DELIVERY

Key points for providers and clients

- Male condoms help protect against sexually transmitted infections, including HIV. Condoms are the only contraceptive method that can protect against both pregnancy and sexually transmitted infection
- Require correct use with every act of sex for greatest effectiveness
- Require both male and female partner's cooperation. Talking about condom use before sex can improve the chances that one will be used
- May dull the sensation of sex for some men. Discussion between partners sometimes can help overcome the objection

6.3.1 Counselling and Informed Choice (For more detail, refer to Chapter One: Counselling and Informed Choice):

- Male condom clients should receive appropriate counselling for selecting and using the method, whenever possible and convenient for them. Counselling helps to ensure informed choice, proper condom use, and set environment for couple counselling. However, counselling should not be a prerequisite for providing condoms.
- As with female clients, male counselling should include information on reproduction, sexuality and contraception, and should involve the use of using flipcharts and anatomic models. Misconceptions about methods should be clarified.
- Male condoms should be demonstrated using an anatomic model, not just verbally explained or handed out. Instructions for condom use should be made easily available in clinics.
- Couple counselling is to be encouraged.

6.3.2 Eligibility

All man can safely use male condoms except those with severe allergic reaction to latex rubber. (For more detailed information refer to Appendix H: Medical Eligibility Criteria for Contraceptive Use).

Indication:

Male Condom is particularly appropriate for the following clients:

- A male partner who wishes to take responsibility for contraception

- A client who needs or desires protection against STIs, including HIV transmission
- A client who is worried about side effects of other methods.
- A client who needs a temporary, alternative or backup to another method (e.g., for the back up following vasectomy, if a women forgets to take her COCs for 3 or more days)

Precautions

Allergy to latex rubber in either man or woman

6.3.3 Client Instructions and Follow-up

Instructions should be given to anyone coming to clinic for condoms for the first time. Demonstrate condom application as possible preferably on the penis model.

6.3.4 Procedure of Condom Use

- Use a new condom for each act of sex. Check condom package for expiry date, any damage or tear. Open it carefully.
- Before any physical contact, compress the tip of the condom between the finger and thumb, place the condom on the tip of the erect penis with the rolled side out. Make sure there is no air in the tip of the condom.
- Unroll the condom all the way to the base of the erect penis.
- Immediately after ejaculation, hold the rim of the condom in place and withdraw the penis while it is still erect.
- Take out the condom from the penis and check the condom whether it is intact or not before throwing it away. If the condom tears or comes off in the vagina, use emergency contraception (refer to Chapter 18: Emergency Contraception).
- Dispose the used condom safely.

Refer to the *COFP/Counseling Reference Manual* for details of condom use.

What condom user should not do

Some practices can increase the risk that the condom will break and should be avoided

- Do not unroll the condom first and then try to put it on the penis
- Do not use lubricants with an oil base because they damage latex
- Do not use a condom if the colour is uneven or changed
- Do not use a condom that feels brittle, dried out or very sticky
- Do not reuse condoms
- Do not have dry sex
- Also, do not use the same condom when between different penetrative sex acts, such as from anal to vaginal sex. This can transfer bacteria that can cause infection.

6.4 MANAGING PROBLEMS ASSOCIATED WITH MALE CONDOM USE

Problems with condoms affect client satisfaction and use of the method. They deserve the provider's attention. If the client reports any problems, listen to the client concerns and give

advice. Offer to help the client choose another method unless condoms are needed for protection from STIs, including HIV.

Table 6-1: Problems Associated with Male Condom Use and Their Management

Problems	Solution/Management
Condom breaks, slips off the penis, or is not used (<2%)	<ul style="list-style-type: none"> • ECPs can help prevent pregnancy in such cases. • Little can be done to reduce the risk of STIs If a client reports breaks or slips: • Ask clients to show how they are opening the condom package and putting the condom on, using a model or other item. Correct any errors. • Ask if any lubricants are being used. The wrong lubricant or too little lubricant can increase breakage. Too much lubricant can cause the condom to slip off. • Ask when the man withdraws his penis. Waiting too long to withdraw, when the erection begins to subside, can increase the chance of slips.
Difficulty putting on condom	<ul style="list-style-type: none"> • Ask clients to show how they put the condom on, using a model or other item. Correct any errors.
Difficulty persuading partner to use condoms or not able to use a condom every time	<ul style="list-style-type: none"> • Discuss ways to talk about condoms with partner and also dual protection rationales. • Consider combining condoms with another effective contraceptive method for better pregnancy protection. • If the client or partner is at risk for STIs, encourage continued condom use.
Mild irritation in or around the vagina or penis or mild allergic reaction to condom (itching, redness, rash and/or swelling of genitals, groin or thighs during or after condom use)	<ul style="list-style-type: none"> • Suggest trying another brand of condoms. • Suggest putting lubricant or water on the condom to reduce rubbing that may cause irritation. • If symptoms persist, assess or refer for possible vaginal infection or STI as appropriate.
Female partner is using miconazole or econazole (for treatment of vaginal infection)	<ul style="list-style-type: none"> • A woman should not rely on latex condoms during vaginal use of miconazole or econazole. They can damage latex. (Oral treatment will not harm condoms.) • She should use female condoms or plastic male condoms, another contraceptive method, or abstain from sex until treatment is completed.
Severe allergic reactions to condom (hives or rash over much of body, dizziness, difficulty breathing, or loss of consciousness during or after condom use)	<ul style="list-style-type: none"> • Tell the client to stop using latex condoms. • Refer for care, if necessary. Severe allergic reaction to latex could lead to life-threatening anaphylactic shock. Help the client choose another method. • If the client or partner cannot avoid risk of STIs, suggest the use of plastic female or male condoms, if available.

FEMALE CONDOMS

6.5 BASICS

Female condom is a sheath, or lining, that fit loosely inside a woman's vagina, made of thin, transparent, soft plastic film. It has flexible rings at both ends. One ring at the closed end helps to insert the condom. The ring at the open end holds part of the condom outside the vagina. It lubricates with a silicone-based lubricant on the inside and outside. It works by forming a barrier that keeps sperm out of the vagina, preventing pregnancy. Also keep infections in semen, on the penis, or in the vagina from infecting the other partner.

6.5.1 Female condoms available in Nepal

Female condoms are available with different brand names include Femidom, V-Amour in the private clinics, pharmacies in Nepal.

6.5.2 Effectiveness

Contraceptive effectiveness depends upon the way it is used. The effectiveness is different for consistent and correct user; and common user. For consistent and correct user, in the first year of use it is 5 pregnancies per 100 women and for common user it is 21 pregnancies per 100 women.

Protection against HIV and other STIs:

- Female condoms reduce the risk of infection with STIs, including HIV, when used correctly with every act of sex.

6.5.3 Return of Fertility

When the user stops using female condoms, fertility returns instantly.

6.6 PREREQUISITES

6.6.1 Facilities

It is not necessary to have a special facility for distribution of female condoms, but it is important to have a place to do counselling and demonstration of use.

6.6.2 Supplies

Female condoms are only available in private pharmacies.

6.6.3 Category of Provider/ Training

Providers do not need specific training on female condom for its distribution.

6.7 SERVICE DELIVERY

Key points for providers and clients

- Female condoms help protect against sexually transmitted infections, including HIV. Condoms are the only contraceptive method that can protect against both pregnancy and sexually transmitted infections.
- Require correct use with every act of sex for greatest effectiveness.
- A woman can initiate female condom use, but the method requires her partner's cooperation.
- May require some practice. Inserting and removing the female condom from the vagina becomes easier with experience.

6.7.1 Counselling and Informed Choice (For more detail, refer to Chapter One: Counselling and Informed Choice)

- Female condom clients should receive appropriate counselling for selecting and using the method, whenever possible and convenient for them. Counselling helps to ensure informed choice, proper condom use, and set environment for couple counselling. However, counselling should not be a prerequisite for providing condoms.
- Counselling should include information on reproduction, sexuality and contraception, and should involve the use of using flipcharts and anatomic models. Misconceptions about methods should be clarified.
- Female condoms should be demonstrated using an anatomic model, not just verbally explained or handed out. Instructions for condom use should be made easily available in clinics.

6.7.2 Eligibility of Female Condom

- All female can safely use female condoms except those with severe allergic reaction to latex rubber. (For more detailed information refer to Appendix H: Medical Eligibility Criteria for Contraceptive Use).

Indication: Particularly appropriate for the following clients:

- A female partner who chooses condom as her method of choice for family planning.
- A client who needs or desires protection against STIs, including HIV transmission.
- A client who is worried about side effects of other methods.
- A client who needs a temporary alternative or backup to another method (e.g., for the back up following a woman forgets to take her COCs for 2 or more 3 days).

6.7.3 Client Instructions and Follow-up

Instructions should be given to anyone coming to the clinic for condoms for the first time. Demonstrate condom application as possible, preferably on the model.

6.7.4 Procedure of Female Condom Use

IMPORTANT: Whenever possible, show the client how to insert the female condom. Use a model or picture, if available, or your hands to demonstrate. You can create an opening similar to a vagina with one hand and show how to insert the female condom with the other hand.

1. Use a new female condom for each act of sex

- Check the condom package. Do not use if torn or damaged. Avoid using a condom past the expiration date—do so only if newer condoms are not available.
- If possible, wash your hands with mild soap and clean water before inserting the condom.

2. Before any physical contact, insert the condom into the vagina

- Can be inserted up to 8 hours before sex. For the most protection, insert the condom before the penis comes in contact with the vagina.
- Choose a position that is comfortable for insertion—squat, raise one leg, sit, or lie down.
- Rub the sides of the female condom together to spread the lubricant evenly.
- Grasp the ring at the closed end, and squeeze it so it becomes long and narrow.
- With the other hand, separate the outer lips (labia) and locate the opening of the vagina.
- Gently push the inner ring into the vagina as far up as it will go. Insert a finger into the condom to push it into place. About 2 to 3 centimeters of the condom and the outer ring remain outside the vagina.

3. Ensure that the penis enters the condom and stays inside the condom

- The man or woman should carefully guide the tip of his penis inside the condom—not between the condom and the wall of the vagina. If his penis goes outside the condom, withdraw and try again.
- If the condom is accidentally pulled out of the vagina or pushed into it during sex, put the condom back in place.

4. After the man withdraws his penis, hold the outer ring of the condom, twist to seal in fluids, and gently pull it out of the vagina

- The female condom does not need to be removed immediately after sex.
- Remove the condom before standing up, to avoid spilling semen.
- If the couple has sex again, they should use a new condom.
- Reuse of female condoms is not recommended.

5. Dispose of the used condom safely

- Wrap the condom in its package and put it in the rubbish or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing.

Supporting the User**Ensure client understands correct use**

- Ask the client to explain the 5 basic steps of using the female condom while handling one.
- If a model is available, the client can practice inserting the condom in the model and then taking it out.

Ask the client how many condoms she thinks she will need until she can return

- Give plenty of condoms and, if available, lubricant.
- Tell the client where she can buy female condoms, if needed.

Explain why using a condom with every act of sex is important

- Just one unprotected act of sex can lead to pregnancy or STI—or both.

- If a condom is not used for one act of sex, try to use one the next time. A mistake once or twice does not mean that it is pointless to use condoms in the future.

Explain about emergency contraception (EC)

- Explain EC use in case of errors in condom use—including not using a condom—to help prevent pregnancy.

Discuss ways to talk about using condoms

- Discuss skills and techniques for negotiating condom use with partners.

6.8 MANAGING PROBLEMS ASSOCIATED WITH FEMALE CONDOM USE

Problems with condoms affect clients' satisfaction and use of the method. They deserve the provider's attention. If the client reports any problems, listen to the client's concerns and give advice. Offer to help the client choose another method unless condoms are needed for protection from STIs, including HIV.

Table 6-2: Problems Associated with Female Condom Use and Their Management

Problems	Solutions/Management
Difficulty inserting the female condom	<ul style="list-style-type: none"> • Ask the client how she inserts a female condom. If a model is available, ask her to demonstrate and let her practice with the model. If not, ask her to demonstrate using her hands. Correct any errors.
Inner ring uncomfortable or painful	<ul style="list-style-type: none"> • Suggest that she reinsert or reposition the condom so that the inner ring is tucked back behind the pubic bone and out of the way.
Condom squeaks or makes noise during sex	<ul style="list-style-type: none"> • Suggest adding more lubricant to the inside of the condom or onto the penis.
Condom slips, is not used, or is used incorrectly	<ul style="list-style-type: none"> • ECPs can help prevent pregnancy (see chapter on Emergency Contraception). • Little can be done to reduce the risk of STIs if a condom breaks, slips, or is not used. If the client has signs or symptoms of STIs after having unprotected sex, assess or refer. • If a client reports slips, she may be inserting the female condom incorrectly. Ask her to show how she is inserting the condom, using a model or demonstrating with her hands. Correct any errors.
Difficulty persuading partner to use condoms or not able to use a condom every time	<ul style="list-style-type: none"> • Discuss ways to talk with her partner about the importance of condom use for protection from pregnancy and STIs.

Mild irritation in or around the vagina or penis (itching, redness, or rash)	<ul style="list-style-type: none"> • Usually goes away on its own without treatment. • Suggest adding lubricant to the inside of the condom or onto the penis to reduce rubbing that may cause irritation. • If symptoms persist, assess and treat for possible vaginal infection or STI, as appropriate. • If there is no infection, help the client choose another method unless the client is at risk for STIs, including HIV. • For clients at risk of STIs, including HIV, suggest using male condoms. If using male condoms is not possible, urge continued use of female condoms despite discomfort.
Suspected pregnancy	<ul style="list-style-type: none"> • Assess for pregnancy. • A woman can safely use female condoms during pregnancy for continued STI protection.

NATURAL FAMILY PLANNING METHOD

6.9 BASICS

A couple voluntarily avoids sexual intercourse during the fertile phase of the woman's cycle (time when the woman can become pregnant) or has intercourse during the fertile phase to achieve pregnancy.

Techniques used to determine high-risk pregnancy days include:

The cervical mucus method monitors the quality and quantity of cervical mucus at the vaginal opening.

- Fertile mucous occurs approximately mid-cycle and is abundant, thin, slippery and elastic, like an egg white.
- Infertile mucous is thick, sticky and scant and is found at the beginning and end of the cycle.
- Abstinence is practiced when fertile mucus is present.

The basal body temperature method monitors the resting body temperature each day.

- Just at or immediately after ovulation (mid-cycle), there is 0.3–0.5° rise in body temperature.
- Abstinence is practiced from the beginning of the cycle until 3 days after the rise in body temperature.

The sympto-thermal method combines observation of cervical mucus and monitoring of the basal body temperature in order to more accurately pinpoint the fertile period.

The calendar method uses a mathematical formula to calculate the fertile period. The woman first must observe the length of at least six menstrual cycles and then applies the formula to these observations.

6.9.1 Effectiveness

Contraceptive effectiveness depends upon the way it is used. The effectiveness is different for consistent and correct user; and common user. For consistent and correct user, in the first year of use it varies from 3-5 pregnancies per 100 women and for common user it is 25 pregnancies per 100 women.

6.10 SERVICE DELIVERY

6.10.1 Eligibility

Indications

Natural family planning may be an appropriate method for:

- Highly motivated couples willing to undergo extensive abstinence as well as observing, recording and interpreting fertility signs
- Women who have a regular menstrual cycle
- Couples who wish to avoid pregnancy without using mechanical or pharmacological contraceptives
- Couples for whom other more effective methods are contraindicated or cannot be used
- Couples with religious/cultural prescription against other methods
- Couples who can tolerate a high failure rate
- Not appropriate for adolescents until cycle is regular

COITUS INTERRUPTUS (WITHDRAWAL)

6.11 BASICS

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

6.11.1 Effectiveness

Contraceptive effectiveness depends upon the way it is used. The effectiveness is different for consistent and correct user; and common user. For consistent and correct user, in the first year of use it is 4 pregnancies per 100 women and for common user it is 27 pregnancies per 100 women.

6.12 SERVICE DELIVERY

6.12.1 Eligibility

Indications

- Couples who can communicate well during intercourse
- Disciplined men who can ignore urge to continue with intercourse
- Couples with cultural/religious prescriptions against other methods
- Couples who can tolerate high failure rate
- Adolescents: not recommended due to low compliance

6.12.2 Client Instructions and Follow-up

- Practice withdrawal using back-up method until both partners master withdrawal.
- Use emergency contraception if ejaculation occurs prior to withdrawal.

Remember

- Coitus interruptus does not eliminate the risk of STIs: the pre-ejaculate can contain HIV-infected cells, and lesions or ulcers on the genitals can transmit infections.
- Although popularly considered an effective method, coitus interruptus provides efficacy similar to that of barrier methods of contraception

CHAPTER SEVEN

7

COMBINED ORAL CONTRACEPTIVE PILLS (COCs)

CHAPTER SEVEN

COMBINED ORAL CONTRACEPTIVE PILLS (COCs)

7.1 BASICS

7.1.1 COCs Available in Nepal

In Nepal, the most common COCs are combined low dose pills in 28-day packages. LO-FEMINAL, available at all GoN facilities, contains norgestrel (progestin) 0.3 mg and ethinyl estradiol (estrogen) 0.03mg in each pill. The last 7 brown pills contain 75mg ferrous fumarate (iron). “Nilocon” and “Sunaulo Gulaf” are available throughout the country in medical shops.

7.1.2 Effectiveness

Contraceptive effectiveness depends upon the way it is used. The effectiveness is different for consistent and correct user; and common user. For consistent and correct user, in the first year of use it is 0.3 pregnancies per 100 women and for common user it is 8 pregnancies per 100 women.

7.1.3 Return of Fertility

When the woman stops taking the pill, her fertility will return to normal relatively quickly, although it may not be immediate. Uses of the pill do not alter a woman’s capacity for normal fertile cycles. If a woman does not resume normal cycles after stopping the pill, a specific cause other than pill use should be sought.

7.2 PREREQUISITES

7.2.1 Facilities

Minimum facilities for providing oral contraceptive services are:

- A place to register and counsel and
- Examine the client

7.2.2 Supplies

- First supply 3-month packet
- Re-supply 3- to 6-month packet

7.2.3 Category of Provider/Training

The COC pills can be provided by any health worker who has been trained to explain pill use and manage minor side effects, and explain alternative methods of contraception. Beyond the health post, pills may be provided for the first time by the VHW, the MCHW and re-supplied by the FCHV.

7.2.4 Record Keeping and Reporting

The provider should fill the following forms before and after providing COCs:

- Master Register (HMIS No. 1) Appendix A I
- Family Planning Card (HMIS No. 12) Appendix A IV
- Family Planning Register (HMIS No. 13) Appendix A V

The provider should ensure that the medical record forms are completed, regularly maintained and reported to the DHO/DPHO.

7.3 SERVICE DELIVERY

7.3.1 Counselling and Informed Choice (For more detailed information refer to Chapter One: Counselling and Informed Choice.)

All COC clients must receive appropriate counselling for selecting and using the methods. Encourage clients to ask all their questions so that any uncertainties and misunderstandings can be cleared up.

7.3.2 Eligibility

Indications

COCs should be provided to any woman who requests them after receiving appropriate counselling and reaching an informed decision, and who does not have any contraindications to their use. (For more detailed information refer to Appendix H: Medical Eligibility Criteria for Contraceptive Use)

COCs may be particularly appropriate for those who:

- Want a highly effective method of contraception
- Are motivated and willing to use a method which requires action daily, and will be able to obtain supplies on a continuous basis
- Have or do not have child, married or not married and after abortion
- May benefit from one or more of the ancillary protective health effects of COC use; this include women who have:
 - Anaemia from heavy menstrual bleeding
 - A history of ectopic pregnancy
 - Painful menstrual periods, ovulation pain
 - Recurrent benign ovarian cysts
 - A history of, or are at risk of, acute pelvic inflammatory disease (PID)
 - Family history of ovarian cancer
 - Symptoms of endometriosis.

Combined Oral Contraceptives for Women with HIV

- Women who are infected with HIV, have AIDS, or are on antiretroviral (ARV) therapy can safely use COCs.
- Urge these women to use condoms along with COCs. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs. Condoms also provide extra contraceptive protection for women on ARV therapy. Some ARV medications may reduce the effectiveness of COCs

ALERT: The following conditions where there are no restriction for COC Use

- **Age:** Adolescents may safely use COCs, and the risk of COC use does not increase with age (more than 35) if there are none of the following risk factors:
 - Smoking
 - Diabetes
 - A mother, father, sister or brother who had a heart attack or stroke before age 50 years.
 - Family history of increased lipids (hyperlipidaemia)
- **Headaches (Non-migraine “tension” headaches):** Women with non-migraine headache are not at increased health risk from COCs.
- **Diabetes:** Although glucose (carbohydrate) tolerance may change slightly, both insulin-dependent and noninsulin dependent diabetics can use COCs unless they have or develop vascular disease or have diabetes for more than 20 years.
- **Genital tract cancer (cervical, endometrial or ovarian):** Infact, COC use reduces the risk of developing uterine (endometrial) cancer.
- **Pregnancy-related benign jaundice (cholestasis):** Although a history of pregnancy-related benign jaundice (cholestasis) may predict an increased risk of developing COC-related cholestasis, there is no known risk for using COCs in clients with this history.

Precautions

- **Has a suspected pregnancy by history, symptoms, or signs:** Although there is no reported harm to the woman or foetus from the small amount of estrogen and progestin in low-dose COCs, no health risk is considered acceptable. It is unwise for a woman to take any drugs in early pregnancy.
- **Six weeks to 6 months postpartum (while breastfeeding):** Use by breastfeeding mother (6 weeks to 6 months postpartum) slightly diminishes the quantity of breast milk. These mothers should not use COCs unless other more appropriate methods (e.g., IUCD or progestin-only method) are not available or acceptable.
- **Taking anti-seizure drugs for epilepsy (seizure disorder) or rifampicin for tuberculosis:** Use of drugs for epilepsy (except valproic acid) and rifampicin for tuberculosis causes the liver to metabolize estrogens and progestins very quickly and therefore COCs may be less effective. Overall, COCs do not appear to alter seizure activity, and can be provided with caution.
- **Major surgery contradictions and prolonged immobilization:** If she is having major surgery, or her leg is in a cast, or for other reasons she will be unable to move about for several weeks, she should;
 - Stop taking COCs and use a backup method during this period
 - Restart COCs 2 weeks after she can move about again.
- **Breastfeeding:** COCs should not be initiated before 6 weeks postpartum.

- **Active liver disease (Jaundice):** COCs are not recommended for clients until they have fully recovered from acute liver disease (i.e., until either 3 months after becoming asymptomatic or normal liver function returns). They should not be used unless more appropriate methods are not available or acceptable.
- **Breast cancer** (current or past with no current evidence of disease): For women with a history of breast cancer, COCs are not recommended, unless other more appropriate methods are not available or acceptable.
- **Smoking** over 15 cigarettes a day and **over age 35:** Client should use another contraceptive method (e.g., IUCD or progestin-only method). Women 35 years or older who smoke (especially heavy smokers) are at increased risk of heart attack, stroke and other clotting problems if they use COCs.
- **Headaches** (recurrent vascular migraine with focal neurologic symptoms): Client should be advised to use another non-estrogen method.
- **High blood pressure** (hypertension, severe with or without vascular problems): If BP more than 140/90mmHg (moderate hypertension) they should not use COCs.
- Current or past history of **venous thromboembolic disorders** (blood clots in the legs, lungs or eyes): Women who currently have blood clots or have a history of blood clots may be at increased risk of further clotting problems if they take COCs. These women should not take COCs if other methods are available.

7.3.3 Clinical Assessment

In Nepal, COCs are available without medical supervision because their health benefits far exceed their health risk. However, women who obtain their pills where screening is possible will benefit from a screening history and exam to rule out certain precautions such as:

- Known or suspected pregnancy
- Taking certain medications (rifampin for tuberculosis and medications for seizure disorders (epilepsy))
- Thromboembolic disorders (blood clots in the legs, lungs or eyes)
- Heavy smoker (if over 35)
- BP >140/90mmHg, or history of hypertension if BP not taken
- Active jaundice

If none of these conditions are present, COCs may be given. If any of these conditions are suspected, the health care provider must carefully consider the risks and benefits of COC use for this particular client. Refer also to Table 2-1 Client Screening Checklist for Hormonal Methods on page 2–2, and Contraindications and Precautions for COCs.

7.3.4 Clinical Procedure

When to Start?

- If pills are begun within 5 days of the start of menses, no backup method is needed.
- If pills are begun after 5 days of the menstrual cycle, a backup method must be used for next 7 days to ensure protection from pregnancy. It should be certain that the woman is not pregnant (See Figure 2-1: Pregnancy Checklist).
- **Postpartum** (For the earliest time to start refer to chapter 13)
 - a) Fully or nearly fully breast feeding mothers: Pills should be started 6 months after child birth
 - b) Partially breast feeding or non-breastfeeding mothers: After 3 weeks postpartum. (Within 3-4 weeks no back up method is needed and after 4 weeks back up method is needed)

- Within 5 days following **spontaneous or induced first trimester abortion**; if, however, pills are begun after the fifth day, a backup method must be used for 7 days to ensure protection from pregnancy.
- Switching: A woman using injectables when switch to COCs we can begin it from the day of repeat injection time (immediate switch from the same day).

7.3.5 Client Instructions

Instructions for taking COCs

- Take one pill each day, preferably at the same time of day.
- Start with the pill in the top left hand corner of the packet and continue taking the next pill one each day following the arrow until all the white pills are gone (for 21 days) and then start the brown pills taking one pill each day for 7 days until all are gone.
- When the client begins to take the COCs, she may have some bleeding between menstrual periods. The light bleeding is not her menstrual period, is not dangerous and will likely go away after the first 3 months. She should continue taking the pill each day.
- The client may have some nausea or dizziness or headache because her body is adjusting to the pill. These discomforts usually disappear after one or two packs of pills. She should try taking the pill at bedtime or with the evening meal. If discomfort persists, she should come back to the clinic.
- When the 28-day pack is empty, the client should start taking pills from a new packet the next day. During the 7 days on the brown pills, she will have some withdrawal bleeding. Even if she is still bleeding after finishing them she should start the new packet the next day.
- Clients should not stop and start pills when their partner is away for a short period of time. COCs are not effective if not taken consistently.
- The client should use condoms in addition to COCs if she thinks there is any chance that she or her partner are at risk for exposure to STIs, including HIV.
- Acute vomiting and/or diarrhoea interfere with the effectiveness of COCs. If these symptoms persist for more than 24 hours, recommend the use of additional contraceptive protection until the client has been without the symptoms for 7 days.

Instructions for missed pills

- If she forgets to take one or two pills, she should take the pill as soon as she remembers, even if it means taking two pills on one day and continue taking pills, one each day.
- If she forgets to take 3 or more pills in the first or second week, take a pill as soon as she remember, continue taking pills, one each day, use a back up method for the next 7 days and if she have had sex in the past 5 days, can consider ECPs.
- If she forgets to take 3 or more pills in the third week
 - take a pill as soon as she remembers,
 - continue taking pills, one each day
 - finish all hormonal pills and start a new pack the next day.
 - use a back up method for the next 7 days.
 - if she had sex in the past 5 days can consider ECPs.

Follow-up care

Advise the client to visit a clinic or to contact community based services 3 months after starting

COCs for a routine follow-up. In addition, encourage the client to visit the clinic or contact the community workers anytime, if necessary.

Assess the following:

- Assess the client’s satisfaction with the method.
- Determine if the client has had any problems or side effects and, if so, record them in the clinical records.
- If any serious problem or side effect is detected, refer the client to a clinical facility.
- At the clinical facility, update the medical history; measure blood pressure and weight, and perform any examination indicated by the history.
- Provide appropriate counselling and/or treatment as required.

7.3.6 Side Effects and Management

Review the common COC side effects with the client, as well as what to do if certain problems occur.

Table 7-1: Management of Side Effects and Health Problems

Side Effect	Assessment	Management
Amenorrhoea (absence of vaginal bleeding or spotting)	Ask how she has been taking her pills. Has she missed any pills in the cycle? Has she stopped taking pills? Rule out pregnancy by history, symptoms and physical exam (speculum or bimanual) or a pregnancy test (if indicated and available).	If intrauterine pregnancy is confirmed, stop COCs and assure her that the small dose of estrogen and progestin in the COCs to which she was exposed will have no harmful effect on the foetus. If she is not pregnant, no treatment is required except counselling and reassurance. Explain that if her period was irregular before beginning COCs, it will usually be irregular when COCs are stopped. Advise client to return to clinic if amenorrhoea continues to be a concern. If client is not taking COCs correctly, review instructions for use. If the client is taking COCs correctly, reassure her. Explain that absent menses most likely is due to lack of build-up of uterine lining; there is no menstrual blood present.
Spotting or Bleeding (common during the first three months after starting the pills). See also Reproductive Health Clinical Protocols for Bleeding and Spotting on Hormonal Methods.	Has client recently begun COCs? Ask if she has missed one or more pills, or if she takes pills at a different time every day. As appropriate: Exclude gynaecological problems (e.g., uterine tumours, pregnancy, abortion, PID). If client taking rifampicin or epilepsy medication?	If yes, reassure. Advise that spotting and bleeding are common during the first 3 months of COCs use and decrease markedly in most women by the fourth month of use. Review and or refer in 3 months if problem persists. If yes, give instructions about what to do for missed pills and the importance of taking the pill at the same time every day. If she continues to miss pills, she may need to switch to another method to minimize risk of pregnancy. If gynaecological problems are present, refer to a doctor if possible, or manage according to clinical practice. Counsel client to switch to another method until she discontinues rifampicin or epilepsy medication.

Side Effect	Assessment	Management
High Blood Pressure	<p>Allow 15 minutes rest, then repeat BP reading.</p> <p>Recheck BP on three visits, 1 week apart:</p> <p>Assess BP; if over 140/90 mm Hg on two more visits one week apart, stop COCs.</p>	<p>If blood pressure increases in a client who usually has normal blood pressure and is using COCs, follow closely. If any warnings (severe headaches, chest pain, blurred vision) occur on two occasions or blood pressure > 140/90, COCs should be discontinued.</p> <p>If COCs are discontinued, help client make an informed choice of a non-hormonal method. Tell her that high BP due to COCs usually goes away within 1 to 3 months. Take BP every month, for 3 months, to be sure it returns to normal. If it does not, refer for further evaluation.</p>
Nausea/ Dizziness/ Nervousness (usually improves during first 3 months)	<p>Find out if pills are taken in morning or on an empty stomach.</p> <p>As appropriate: Exclude pregnancy.</p> <p>Rule out other causes of nausea (gall bladder disease, hepatitis).</p>	<p>Take with evening meal or before bedtime.</p> <p>If pregnant, manage as above (see Amenorrhoea).</p> <p>Evaluate for disease (gall bladder disease, hepatitis, gastroenteritis). Counsel that it will probably decrease with time, or switch to a lower estrogen or a progestin-only method if problem is intolerable.</p>
Severe Vomiting	<p>Rule out other causes of vomiting.</p>	<p>If vomiting within 2 hours after taking the pill repeat the pill and manage vomiting with Clopropramide 1 tab 8 hourly for 3 days or SOS</p>

Table 7-2: Other Problems (May or May Not Be Method-Related)

Problem	Assessment	Management
Acne	<p>Ask how and how often she cleans her face.</p> <p>Ask if she is currently under great stress.</p>	<p>Acne can initially worsen with COC use, but commonly improves with long-term use. Recommend cleaning face frequently with cold water and twice a day with an astringent, like lemon, and advise to avoid heavy creams. Counsel as appropriate. If condition is not tolerable, consider another method.</p>
Breast Fullness or Tenderness (usually improves within 3 months of starting the COCs)	<p>Determine whether client is pregnant by history and physical exam.</p> <p>Determine whether the woman has breast lumps or nipple discharge suspicious for cancer. If she is breastfeeding and breasts are tender, examine for breast infection.</p> <p>Ask whether client notices this only at a certain time of the month.</p>	<p>If pregnant, treat as above for Amenorrhoea.</p> <p>If physical exam shows lump or discharge suspicious for cancer, refer to appropriate source for diagnosis. If malignancy is discovered, help client make an informed choice of another method.</p> <p>If breasts are not infected, recommend appropriate clothing for support.</p> <p>If breast infection present, use warm compression, advise to continue breastfeeding and give antibiotics as appropriate.</p> <p>Switch to a lower estrogen pill if not already on lowest estrogen COCs. Advise client to avoid caffeine, chocolate, etc. If the lowest dose pill is unacceptable, and symptomatic management not helpful, help client to make an informed choice of another method.</p>

Problem	Assessment	Management
Cholasma (“mask of pregnancy”)	<p>Look for skin diseases. Determine whether she is pregnant. Ask about other causes, e.g., use of skin lightening creams containing mercury, recent pregnancy or sunburn.</p> <p>If no other cause is found, ask if the client sees this as a serious problem.</p>	<p>Treat or refer as appropriate.</p> <p>Counsel on stopping use of such creams and avoiding sunlight. Advise use of a sun hat. If recently pregnant, advise to wait 3 months and look for improvement.</p> <p>If “yes,” counsel the client to choose another method.</p>
Headaches	<p>Are the headaches severe, frequent or associated with nausea?</p> <p>Has she had loss of speech, numbness, weakness or tingling, or visual changes associated with the headaches?</p> <p>Have the headaches become worse since she began pills?</p> <p>Has she ever had high blood pressure?</p>	<p>If not severe, frequent or associated with nausea, reassure.</p> <p>If “yes,” discontinue COCs; help client to make an informed choice of another method. Refer for evaluation</p> <p>If worse on COCs, switch to another contraceptive method if no other contraindications. If no worse or better, explore cause of headaches. COCs can be continued unless high blood pressure or neurologic symptom or signs develop, or headaches worsen on COCs.</p> <p>Regardless of history, check the blood pressure. If elevated, see High Blood Pressure above.</p>
Significant Unwanted Weight Gain or Weight Loss	<p>Inquire about eating habits which might promote weight gain or weight loss.</p> <p>If the client denies poor eating habits, but complains of increased appetite or weight gain without apparent cause, ask if the weight gain is unacceptable.</p> <p>Rule out weight gain due to pregnancy.</p>	<p>Instruct the client in proper nutrition and exercise.</p> <p>Explain to the client that all hormonal contraceptives might have a slight effect on weight, but the dose of hormones in COCs is very low and should have only a modest effect.</p> <p>If the client is pregnant, refer her according to her pregnancy. Stop COCs.</p>
Mood Change or Depression	<p>Discuss changes in mood</p>	<p>If client thinks her depression has worsened while using COCs, help her make an informed choice of another method. If COCs have not caused depression to worsen, the pills can be continued.</p>

Note: There are also progestin-only pills (POPs) containing 0.075 mg of norgestrel only. They are useful for women who can’t tolerate estrogen and they are useful during breastfeeding after 6 weeks postpartum.

CHAPTER EIGHT

8

INJECTABLE CONTRACEPTIVES (DEPO-PROVERA[®]/DMPA)

CHAPTER EIGHT

INJECTABLE CONTRACEPTIVES (DEPO-PROVERA[®]/DMPA)

8.1 BASICS

8.1.1 Injectables Available in Nepal

Currently depot-medroxy progesterone acetate (DMPA) known as Depo-Provera[®] is the injectable contraceptive available in Nepal. Depo-Provera is also available as “Sangini” in the private sector in Nepal.

8.1.2 Effectiveness

Contraceptive effectiveness depends upon the way it is used. The effectiveness is different for consistent and correct user; and common user. For consistent and correct user, in the first year of use it is 0.3 pregnancies per 100 women and for common user it is 3 pregnancies per 1000 women.

8.1.3 Return of Fertility

When a client stops taking Depo-Provera she may become pregnant after 10-12 months after the last injection. The duration a woman has used depo makes no difference on how quick her fertility returns.

8.2 PREREQUISITES

8.2.1 Infection Prevention

Infection prevention guidelines must be strictly applied while following safe injection procedures (For more detail on infection prevention practices, see Chapter Three: Infection Prevention.)

8.2.2 Facilities

The minimum facilities for an injectable contraceptive service are:

- A place to register the clients
- A private area for counselling and injection
- A place for disposal of used syringes, needles and other waste

8.2.3 Equipment and Supplies

For injection, essential supplies needed are disposable sterile syringes and needles, cotton, spirit and a puncture-proof container for disposal of used needles and syringes.

8.2.4 Category of Provider/Training

Providers should be health staff trained in the use of Depo-Provera. Such training should be based on the GoN/ NHTC /COFP/Counselling Training Curriculum. Health staff may include physicians, nurses, paramedics and other trained health personnel (e.g., VHWs and MCHWs).

8.2.5 Record Keeping and Reporting

The provider should fill the following forms before and after providing Depo Provera:

- Master Register (HMIS No. 1) Appendix A I

- Family Planning Card (HMIS No. 12) Appendix A IV
- Family Planning Register (HMIS No. 13) Appendix A V

The provider should ensure that the medical record forms are completed, regularly maintained and reported to the DHO/DPHO

8.3 SERVICE DELIVERY

8.3.1 Counselling and informed choice (For more detailed information refer to Chapter One: Counselling and Informed Choice.)

All clients must receive appropriate counselling for selecting and using the method. Encourage clients to ask all their questions so that any uncertainties and misunderstandings can be cleared up. For selecting the method, counsel about:

- Advantages and disadvantages.
- The possibility of change in menstrual bleeding patterns, including amenorrhoea and menstrual irregularity.
- Alternative family planning methods, including information on effectiveness risks and benefits, side effects and cost, as appropriate.
- Timing of injection
- Return of fertility.

8.3.2 Eligibility

Indications

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

Depo-Provera may be particularly appropriate for those who:

- Have or do not have children.
- Are not married.
- Are of any age, including adolescents and women over 35 years old.
- Have just had an abortion or miscarriage.
- Smoke cigarettes, regardless of woman's age or number of cigarettes smoked.
- Are breastfeeding (starting as soon as 6 weeks after childbirth).
- Are infected with HIV, whether or not on antiretroviral therapy.
- Nearly all women can use Depo safely and effectively, including women who.
- Prefer a method that does not require taking contraceptive action every day or before having intercourse or want long-term birth spacing or have the number of children they want but do not want or cannot have a permanent method (voluntary sterilization) at this time.
- Cannot use contraceptives that contain estrogen, or have developed estrogen-related complications after taking COCs.
- Want a hormonal method but cannot use COCs because they are heavy smokers (over 15 cigarettes a day), and are over 35 or have high blood pressure.

Depo Provera for Women with HIV

- When who are infected with HIV, have AIDS, or are on antiretroviral (ARV) therapy can safely use depo provera.
- Urge these women to use condoms along with depo. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.

Precautions

- **Suspected pregnancy** by history, symptoms or signs: If the possibility of pregnancy cannot be excluded by examination, Depo-Provera injection should be delayed until the next menstrual period. In the interim, the client should use condoms.
- Active liver disease (jaundice) or benign or malignant liver tumours: Depo-Provera is not recommended for clients until they have fully recovered from liver disease. It should not be used unless more appropriate methods are not available or acceptable.
- Unexplained Vaginal Bleeding
- Breast cancer (current or past with no current disease). For women with breast cancer, Depo-provera is not recommended.
- **Diabetes Mellitus:** Diabetes for >20 years duration may increase the risk of thrombosis.
- High BP: If > 160/100 do not provide Depo-provera.
- **Headache (severe, recurrent vascular or migraine):** Women with a history of severe vascular or migraine headaches should be carefully followed to be sure their headaches do not worsen with use of Depo-Provera.
- **Depression:** Women with a history of depression should be followed when using Depo-Provera. Help the client choose another method if depression worsens or recurs to a serious degree.
- Current Deep Vein Thrombosis (DVT).
Heart attack (Myocardial Infarction)

8.3.3 Clinical Assessment

Pregnancy can be excluded in most clients by history alone (refer to Chapter Two: Client Assessment). If pregnancy cannot be excluded, Depo-Provera should not be started. Where facilities and trained staff are available, breast and pelvic exam should be provided for new Depo-Provera clients.

During the screening and physical exam, the following conditions should be looked for:

- Known or suspected pregnancy
- Unexplained vaginal bleeding
- Breast lumps and possible breast cancer
- Migraine/ headache
- Diabetes
- Jaundice
- Hypertension
- Deep vein thrombosis
- Heart attack (Myocardial infarction)

If none of these are found, Depo-Provera may be given. If any of these conditions are found or suspected, the health provider must carefully consider the risks and benefits of Depo-Provera use for this particular client. Refer also to Table 2–1, the Client Screening Checklist for Hormonal Methods and Contraindications and Precautions for Depo-Provera.

Timing of Injection

- **Injectable contraceptive should be given:**
 - Within the first 7 days of the menstrual cycle.

- Any time during the menstrual cycle if it is reasonably sure the woman is not pregnant. (For detailed information, refer to Chapter Two: Client Assessment.) Provide 7 days of backup method if injected after the first 7 days of the menstrual cycle.

Postpartum (For earliest time to start refer to chapter 13)

- Fully or nearly fully breastfeeding mothers: If the woman is using the LAM, the depo should be given when her menses returns or at 6 months post partum which ever comes first
- Partially breastfeeding: 6 weeks after child birth
- Non breast feeding mothers: Immediately
- Immediately after complete spontaneous or induced abortion if started within 7 days: no backup method is needed. If started after 7 days back up for 7 days is needed.

8.3.4 Clinical Procedure

Technique of injection

- Check expiry date of Depo-Provera vial and syringe to be used
- The vial containing Depo-Provera should be carefully and gently shaken till fluid becomes smooth and homogenous before aspirating the material into the syringe. The exact amount of medication should be carefully drawn into the syringe (Depo-Provera 150 mg)
- Careful aseptic technique should be used (sterile syringes, needles). Otherwise a serious problem could be caused (e.g., an abscess or hepatitis)
- Aspirate before injection to ensure that the needle is not in a vessel
- Deep intramuscular injection in the gluteal or deltoid muscles should be carried out, preferably with the client in a sitting or prone position. The injection site should not be massaged
- Dispose the syringes and needles safely

Possible Emergency and Management

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

8.3.5 Client Instructions and Follow-up

Assure every client that she is welcome to come back anytime for any problems or questions.

Subsequent injections

Instruct the client to return for another injection every 3 months (13 weeks). Give an exact appointment date for her to return. Let the client know that it is important that she return on the date given; if she cannot return on that date it is preferable to return before that date rather than after, although the next injection can be given from 2 weeks before that date until 2 weeks after that date.

Note: If the client returns after 15 weeks from her last injection, do not give a Depo-Provera injection unless she is currently menstruating and is within the first 7 days of her cycle, or if it is reasonably sure she is not pregnant. If the Depo-Provera injection is to be delayed, give condoms or another back-up method and instruct her to return when she next menstruates.

8.3.6 Side Effects and Management

Table 8-1: Side Effects and Their Management for the Use of Depo-Provera

Side Effect	Assessment	Management
<p>Amenorrhoea (absence of vaginal bleeding or spotting)</p>	<p>Rule out pregnancy by checking symptoms; perform a pelvic exam (speculum and bimanual) and a pregnancy test (if indicated and available).</p>	<p>Periods of amenorrhoea are common with Depo-Provera users (40%). However, amenorrhoea for 6 weeks or more after a pattern of regular menses may signal pregnancy and should be evaluated.</p> <p>If intrauterine pregnancy is confirmed, counsel client and refer for appropriate care. Discontinue injections and assure her that the small dose of hormone (Medroxyprogesterone) will have no harmful effect on the foetus.</p> <p>If negative pregnancy test, but enlarged uterus, counsel client to return in 2 to 4 weeks for repeat pelvic exam and pregnancy test.</p> <p>If ectopic pregnancy is suspected, refer for complete evaluation.</p>
<p>Bleeding/Spotting (prolonged spotting or moderate bleeding)</p> <p>Prolonged spotting: >8 days</p> <p>Moderate bleeding: same as normal menses</p> <p>See <i>Clinical Protocol</i> 1-9 regarding Bleeding on Hormonal Contraceptives (Heavy or prolonged bleeding)</p>	<p>Perform a pelvic exam (speculum and bimanual) to be sure bleeding is not due to other cause (e.g., genital tract lesion such as vaginitis, cervicitis, cervical polyps or uterine fibroids).</p> <p>If pregnancy (intrauterine or ectopic) or incomplete abortion is suspected, examine and perform pregnancy test if indicated and available.</p>	<p>If abnormality of the genital tract is found, treat the problem if possible or refer for treatment. Do not discontinue Depo-Provera. Advise client to return for additional counselling after management of problem.</p> <p>Reassure her that light intermenstrual bleeding or spotting occurs in a large percentage of women using Depo-Provera (15–20%) during the first few months of use. It is not serious and usually does not require treatment.</p> <p>If haemoglobin less than 9 g/dl, hematocrit less than 27 or conjunctival pallor significant, give iron or iron folate (1 tablet daily for 1 to 3 months) and nutritional counselling. If anaemia persists, or client requests, discontinue Depo-Provera and help client choose another method.</p> <p>If not satisfied after counselling and reassurance, but wants to continue using Depo-Provera, give:</p> <ul style="list-style-type: none"> • A cycle of COCs or • Ibuprofen (800 mg three times daily for 5 days) or • Mefenamic acid 500mg 2 times daily after meal for 5 days. <p>If pregnancy is confirmed, see Amenorrhoea section in this table.</p>
<p>Weigh Gain or Loss (change in appetite)</p>	<p>Compare pre-injection weight (if known) and current weight.</p> <p>Rule out pregnancy as appropriate:</p> <p>Check that the client is eating and exercising properly</p>	<p>Counsel client that weight changes may occur. 1-2 kg/year</p> <p>Review diet if weight change is excessive. If weight gain is unacceptable, help client choose another method.</p>

Table 8-2: Other Problems (May or may not be method-related)

Problem	Assessment	Management
Breast Tenderness (mastalgia)	Rule out pregnancy. Check breasts for: <ul style="list-style-type: none"> • Lumps or cysts • Discharge or galactorrhea (leakage of milk-like fluid) 	Refer for evaluation if abnormality present. If no abnormality, reassure. Do not discontinue injections unless client requests it.
Jaundice	Acute jaundice occurring after Depo-Provera injection is not method related. Rule out: <ul style="list-style-type: none"> • Active liver disease (hepatitis) • Gall bladder • Benign or malignant tumours 	Progesterone has little effect on liver function and does not increase the risk of gall bladder disease or liver tumours. If she has hepatitis and does not want to stop using Depo-Provera, it is unlikely to worsen liver disease and is safer than pregnancy.
Nausea/dizziness or Nervousness	Rule out pregnancy by checking symptoms; perform a pelvic exam (speculum and bimanual) and pregnancy test (if indicated and available).	If pregnant, refer as above for Amenorrhoea . If not pregnant, reassure that this is not a serious problem(s) and usually disappears with time.
Excess hair growth (hirsutism), acne/dermatitis or hair loss	Review history, pre- and post-injection of Depo-Provera.	Pre-existing conditions such as increased facial or body hair might be worsened. Changes usually are not excessive, may improve over time, and do not require discontinuation of Depo-Provera unless client requests it after counselling.
Lower Abdominal/ Pelvic Pain (with or without symptoms of pregnancy)	Take careful history, perform abdominal and pelvic (speculum and bimanual) examination. Check vital signs: <ul style="list-style-type: none"> • Pulse • Blood Pressure • Temperature Examine to rule out: <ul style="list-style-type: none"> • Ectopic pregnancy • PID • Appendicitis • Ovarian cysts Do lab tests for Hb/Hct and pregnancy test if indicated and available.	Refer immediately if the client has any of the following: <ul style="list-style-type: none"> • Lower abdominal tenderness • Elevated resting pulse (more than 100 BPM) • Decreased blood pressure (less than 90/60) • Elevated oral temperature (38.3° C) • Suspected/confirmed pregnancy and acute anaemia (e.g., less than 9 g/ dl Hb or less than 27% Hct)

CHAPTER NINE

9

SUBDERMAL IMPLANTS

CHAPTER NINE

SUBDERMAL IMPLANTS

9.1 BASICS

There are different types of implant. Jadelle and Sinoplant are two rod implants and Implanon is a single rod implant. This chapter describes about Jadelle. Though Norplant services are discontinued, there will still be some cases who will come for Norplant removal services.

9.1.1 Implants Available/Approved for Nepal

Contraceptive subdermal implants Jadelle is available in Nepal and consist of two rods. Each rod is 2.5 mm in diameter and 43 mm in length and contains 75 mg of levonorgestrel. It protects from pregnancy for up to 5 years.

9.1.2 Effectiveness

Jadelle implants are one of the most effective reversible methods. In the first year of use it is 0.05 pregnancies per 100 women user. Implants start to loose effectiveness sooner for heavier women. Therefore women weighing 80 kg or more should have their implant removed after 4 years

9.1.3 Return of Fertility

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

9.2 PREREQUISITES

9.2.1 Infection prevention

Because the insertion and removal of Jadelle implants are minor surgical procedures, aseptic technique, including good surgical technique, must be followed to prevent infections at the incision site. For more detailed information, refer to Chapter Three: Infection Prevention.

9.2.2 Facilities

The minimum facilities for implants insertion / removal service are:

- A place to register the clients.
- A private area for consultation and counselling.
- A clean private room with good light source for insertion and removal.
- A hand washing facility.

- An autoclaving area
- A place for disposal of wastes

9.2.3 Equipment and Supplies

Refer to Appendix B I.

9.2.4 Category of Provider/Training

Providers should be health staffs who have been trained in the use of Jadelle implants. This training should be based on the GoN/NHTC training curriculum. The health staff may include physician, HA, SN, public health nurse, AHW, and ANM.

9.2.5 Record Keeping and Reporting

The provider should fill the following forms before and after providing Jadelle:

- Master Register (HMIS No. 1) Appendix A I
- Family Planning Card (HMIS No. 12) Appendix A IV
- Family Planning Register (HMIS No. 13) Appendix A V

The provider should ensure that the medical record forms are completed, regularly maintained and reported to the DHO/DPHO monthly.

9.3 SERVICE DELIVERY

9.3.1 Counselling and Informed Choice

Jadelle implants clients must receive appropriate counselling for selecting and using the method. Encourage and give client an opportunity to ask all of their questions so that any uncertainties and misunderstandings can be cleared up.

Clearly discuss the following points for selecting the method:

- Alternate family planning methods
- The physical characteristic of the implants, how and where (which part of the body and how will it feel under the skin)
- Benefits and side effects of Jadelle implants
- Instruction for removal of Jadelle implants

After the client has chosen the implants as her method, make sure that she understands the following:

- Possible changes in her menstrual bleeding pattern
- Benefits, side effects and complications
- Importance of removal or replacement after 5 years

9.3.2 Eligibility

Indications

Jadelle implants should be provided to any woman (married or unmarried or with or without children) who selects them after appropriate counselling and who does not have any contraindication to its use.

Jadelle implants are particularly appropriate for those who:

- Prefer a method that does not require taking contraceptive action every day or before having intercourse.
- Want long-term birth spacing or have the number of children they want but do not want or cannot have a permanent method (voluntary sterilization).
- Are breastfeeding (after 6 weeks postpartum) and need a contraceptive.
- Prefer not to use contraceptives that contain estrogen, or have developed estrogen-related complications while taking combined oral contraceptives (COCs).

Implants For Women with HIV

- Women who are infected with HIV, have AIDS, or are on antiretroviral (ARV) therapy can safely use implants.
- Urge these women to use condoms along with implants. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.

Precautions

- Has **suspected pregnancy** by history, symptoms or signs: If the possibility of pregnancy **cannot** be excluded by examination, insertion of Jadelle implants should be delayed until the next menstrual period. In the interim, the client should use condoms.
- **Unexplained vaginal bleeding:** Could be due to pregnancy or caused by a serious problem. Until the cause of the bleeding is determined and any serious problem treated, the client should not use implant (Pregnancy, DUB and bleeding disorders are contraindication for its use).
- **Active liver disease:** Implants are not recommended unless other more appropriate methods are not available or acceptable.
- **Taking drugs for epilepsy (phenytoin and barbiturates) and tuberculosis (rifampicin):** Clients taking drugs for these disorders should be carefully counselled about the potential reduction in the effectiveness of Jadelle implants.
- **Breast cancer:** For women with a history of breast cancer, Jadelle implants are not recommended unless other more appropriate methods are not available or acceptable. There is no evidence that low-dose progestin cause breast cancer; however, breast cancer is a hormonally sensitive tumour. Implants can be used safely by women with benign breast disease or a family history of breast cancer.

Other Conditions Requiring More Frequent Follow-up

- **Diabetes Mellitus:** Diabetics should be followed up to be sure the disease is controlled and to rule out infection at the implant site.

- **High blood pressure 160/100:** Women with BP 160/100 or more can use Jadelle implants but should be followed to be sure their hypertension is controlled.
- **Headache:** Women with a history of severe vascular or migraine headaches should be carefully followed to be sure their headaches do not worsen.
- **Depression:** Women with a history of depression should be followed to see whether depression worsens or recurs.

Followings conditions are not a restriction for Jadelle Implants:

- Smoking (any age)
- Pre-eclampsia (history)
- Surgery (with or without prolonged bed rest)
- Gall bladder disease (symptomatic or asymptomatic)
- Vascular heart disease (uncomplicated and complicated)

9.3.3 Clinical Assessment

Pregnancy can be excluded in most clients by history alone (refer to Chapter Two: Client Assessment). If pregnancy cannot be excluded, Jadelle implants should not be inserted. Where facilities and trained staff are available, breast and pelvic exams should be provided for new Jadelle implants clients.

During the screening and physical exam, the following conditions should be looked for:

- Pregnancy known or suspected (the only absolute contraindication to Jadelle implants use)
- Unexplained vaginal bleeding
- Active liver disease (jaundice)
- Breast lumps and possible breast cancer
- Migraines
- Diabetes
- Hypertension
- Current medications, especially anti-convulsants and rifampin
- Depression

If none of these are found, Jadelle implants may be given. If any of these conditions are found or suspected, the health provider must carefully consider the risks and benefits of Jadelle implants use for this particular client. Refer to Table 2-1 and Section 9.3.2.

9.3.4 Clinical Procedure

Timing of insertion

- Within the first 7 days of the menstrual cycle.
- Any time during the menstrual cycle if known that the woman is not pregnant (for detail information, refer to Chapter 2: Client Assessment) Provide 7 days of a backup method if inserted after the first 7 days of the menstrual cycle.
Postpartum (For earliest time to start refer to chapter 13)

- Fully or Nearly fully breastfeeding mothers: If the woman is using the LAM, the rods should be inserted when her menses returns, or at 6 months postpartum, whichever comes first.
- Partially breast feeding mothers: 6 Weeks after child birth.
- Non-breastfeeding mothers: Immediately.
- Immediately after complete spontaneous or induced abortion.

9.3.5 Client Instructions and Follow-up

Wound care

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

- Keep the area dry and clean for at least 48 hours. The incision could become infected if the area gets wet while bathing or washing clothes.
- There may be bruising, swelling or tenderness at the insertion site for a few days. This is normal.
- Routine work can be done immediately, but do not put unusual pressure on the area for a few days.
- Leave the gauze pressure bandage in place for 3 to 5 days to avoid having people touch the area while it is still tender and the adhesive bandage for 5-7 days.
- If signs of infection occur, such as fever, inflammation (**redness with heat**) **at the site, or if there is persistent pain for several days**, return immediately to the clinic.

9.3.6 Implants removal

Clients should be provided implants removal services. Though Norplant is discontinued, still clients will come for Norplant removal services. Number of rods to be removed should be kept in mind.

9.4 SIDE EFFECTS AND MANAGEMENT

Table 9-1: Side effects and Management of Jadelle Implants

Side Effect	Assessment	Management
Amenorrhoea (absence of vaginal bleeding or spotting)	Rule out pregnancy by checking symptoms, perform a pelvic exam (speculum and bimanual) and a pregnancy test (if indicated and available).	<p>If not pregnant counseling and reassurance.</p> <p>If intrauterine pregnancy is confirmed, counsel and refer for appropriate care. Remove the implant and assure her that the small dose of hormone (levonorgestrel) to which she was exposed will have no harmful effect on the foetus.</p> <p>If pregnancy is ruled out, but enlarged uterus, counsel client to return in 2 to 4 weeks for repeat pelvic exam and pregnancy test.</p> <p>If ectopic pregnancy is suspected, refer for complete evaluation.</p>

Side Effect	Assessment	Management
<p>Bleeding Spotting and Irregular bleeding (bleeding as like normal menses but at unexpected times and bothers the client)</p> <p>Heavy bleeding (twice as much as usual or longer than 8 days)</p> <p>See Clinical Protocol 1-9 regarding Bleeding on Hormonal Contraceptives</p>	<p>As appropriate: Perform a pelvic exam (speculum and bimanual) to be sure bleeding is not due to other cause (e.g., genital tract lesion such as vaginitis, cervicitis, cervical polyps or uterine fibroids).</p> <p>If pregnancy (intrauterine or ectopic) or incomplete abortion is suspected, examine and perform pregnancy test if indicated and available.</p>	<p>If abnormality of the genital tract is found, treat the problem if possible or refer for treatment. Do not discontinue implants. Advise client to return for additional counselling after management of problem.</p> <p>Reassure her that light intermenstrual bleeding or spotting occurs in a large percentage of women using implants during the first few months of use. It is not serious and usually does not require treatment. Most women can expect their bleeding pattern to become more regular after 6–12 months.</p> <p>If haemoglobin less than 9 g/dl, hematocrit less than 27 or conjunctival pallor significant, give iron or iron folate (1 tablet daily for 1 to 3 months) and nutritional counselling. If anaemia persists, or client requests, discontinue implants and help client choose another method.</p> <p>If not satisfied after counselling and reassurance, but wants to continue using implants, give:</p> <ul style="list-style-type: none"> • A cycle of COCs or • Ibuprofen (800 mg 3 times daily for 5 days) or • Mefenamic acid 500mg x 3 x 5 days (after meal) <p>If pregnancy is confirmed, see Amenorrhoea section above.</p>
Rods Expulsion	Check for partial or complete expulsion of rods.	Remove partially expelled rod(s). If an area of insertion is not infected (no pain, heat and redness) replace with new rods. If area of insertion is infected, see “Infection” below.
Infection	Check area of insertion for infection (pain, heat and redness), pus or abscess.	<p>If infection (not abscess):</p> <ul style="list-style-type: none"> • Do not remove rods, and instruct client not to attempt to remove the rods. • Cleanse with (soap and water or antiseptic). • Give appropriate oral antibiotic for 7 days. • Ask client to return after 1 week. If no improvement, remove rods and insert a new set in the other arm or help client choose another method. Continue to treat infection with 7 additional days of antibiotics.
Headache (especially with blurred vision)	<p>Ask if there has been a change in pattern or severity of headaches since beginning implants.</p> <p>Perform Physical examination and check BP.</p> <p>Examine as appropriate:</p> <ul style="list-style-type: none"> • Eyes (fundoscopic) • Neurologic system 	<p>If headaches are mild, treat with paracetamol and reassure.</p> <p>Reevaluate after 1 month if mild headaches persist.</p> <p>If blurred vision or vision difficulties are present, refer and/or remove implants.</p> <p>If headaches are severe and/or recurrent or blood pressure is elevated since starting implants, refer and/or remove implants.</p>

Side Effect	Assessment	Management
Breast Tenderness (mastalgia)	<p>Rule out pregnancy. Check breasts for:</p> <ul style="list-style-type: none"> • Lumps or cysts • Discharge or • Galactorrhea (leakage of milk-like fluid) 	<p>Refer for evaluation if abnormality present.</p> <p>If no abnormality, reassure and recommend appropriate clothing and suggest paracetamol.</p> <p>Do not remove implants unless client requests it.</p>
Excess Hair Growth (hirsutism), acne/dermatitis or hair loss	<p>Review history, pre- and post-insertion of implants.</p>	<p>Pre-existing conditions such as increased facial or body hair might be worsened. Changes usually are not excessive, may improve over time, and do not require discontinuation of implants unless client requests it after counselling.</p>
Weight Gain or Loss (change in appetite)	<p>Compare pre-insertion weight (if known) and current weight.</p> <p>Rule out pregnancy.</p>	<p>Counsel client that normal fluctuations (increase or decrease of 1-2 kg) may occur. Review diet if weight change is excessive. If weight gain is unacceptable, help client choose another method.</p>
Depression, mood changes and changes in the sex drive	<p>Ask about these changes and give support as appropriate. For serious problem refer.</p>	<p>If depression has worsened, help her choose another method</p>
Lower Abdominal/ Pelvic Pain (with or without symptoms of pregnancy)	<p>Take history, perform abdominal and pelvic (speculum and bimanual) examination.</p> <p>Check vital signs: Pulse, BP, Temperature</p> <p>Examine to rule out:</p> <ul style="list-style-type: none"> • Ectopic pregnancy • PID • Appendicitis • Ovarian cysts <p>Do laboratory test for Hb/ Hct and pregnancy test</p>	<p>Refer immediately if the client has any of the following:</p> <ul style="list-style-type: none"> • Lower abdominal tenderness • Elevated resting pulse (more than 100 BPM) • Decreased blood pressure (less than 90/60) • Elevated oral temperature (38.3 degree C) • Suspected/confirmed pregnancy and acute anaemia (e.g., less than 9 g/ dl Hb or less than 27% Hct)

CHAPTER TEN

10

INTRAUTERINE CONTRACEPTIVE DEVICES (IUCD)

CHAPTER TEN

INTRAUTERINE CONTRACEPTIVE DEVICES (IUCD)

10.1 BASICS

10.1.1 IUCD Available in Nepal

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

10.1.2 Effectiveness

The Cu T 380A is the most cost-effective reversible contraceptive on the market today. Contraceptive effectiveness depends upon the way it is used. The effectiveness is different for consistent and correct user; and common user. For consistent and correct user, in the first year of use it is 0.6 pregnancies per 100 women and for common user it is 0.8 pregnancies per 100 women.

After insertion, the effective contraceptive action lasts at least 12 years. Note that an IUCD inserted into a client just before the shelf life of the packaging expires is still effective for up to 12 years.

10.1.3 Return of Fertility

Fertility returns immediately after the removal of IUCD.

10.2 PREREQUISITES

10.2.1 Infection prevention

Infection prevention must be strictly followed for safe insertion and removal procedures and no touch technique should be strictly followed.

The no-touch technique involves:

- Loading the IUCD into the inserter while the IUCD is still in the sterile package, to avoid touching the IUCD directly.
- Cleaning the cervix thoroughly with antiseptic before IUCD insertion.
- Being careful not to touch the vaginal wall or speculum blades with the uterine sound or loaded IUCD inserter.
- Passing both the uterine sound and the loaded IUCD inserter only once each through the cervical canal.

Preventing Infection at IUCD Insertion

Proper insertion technique can help prevent many problems, such as infection, expulsion, and perforation.

- Follow proper infection-prevention procedures.
 - Use high-level disinfected or sterile instruments.
 - Use a new, presterilized IUCD that is packaged with its inserter.
- The "no-touch" insertion technique is the best. This includes not letting the loaded IUCD or uterine sound touch any unsterile surfaces (for example, hands, speculum, vagina, table top).

10.2.2 Facilities

The minimum facility for insertion and removal of IUCD are:

- A place to register the client
- A private area for consultation and counselling.
- A clean, good light source and curtained or separate area for pelvic examination, insertions and removals.
- Hand washing facility.
- A place for sterilizing equipment
- Toilets
- A recovery area with a bed/couch
- Waste disposal area

10.2.3 Equipment and Supplies

Refer to Appendix C I.

10.2.4 Category of Provider/Training

Providers should be health staffs who have been trained in the use of IUCD insertion and removal. Such training should be based on the GoN/ NHTC Training Curriculum. Health staff may include physician, integrated physician, SN and ANM. The Female Health Assistant and AHW or Community Medical Assistant can provide service after training.

10.2.5 Record Keeping and Reporting

The provider should fill the following forms before and after inserting IUCD:

Master Register (HMIS No. 1) Appendix A I

- Family Planning Card (HMIS No. 12) Appendix A IV
- Family Planning Register (HMIS No. 13) Appendix A V

The provider should ensure that the medical record forms are completed, regularly maintained and reported to the DHO/DPHO.

10.3 SERVICE DELIVERY

10.3.1 Counselling and Informed Choice

All IUCD clients must receive appropriate counselling for selecting and using the method. Review the woman's history to determine the possibility of existing contraindications to the method, such as the risk of STIs, and take this into account when providing counselling. Encourage clients to ask all of their questions so that any uncertainties and misunderstandings can be cleared up.

Before selecting the method discuss the following points:

- Advantages and disadvantages of IUCD
- Alternative family planning methods
- The type of IUCD inserted (a sample should be shown) and the proper time for replacement
- Importance of regular follow-up

10.3.2 Eligibility

Indications

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

IUCD may be particularly appropriate for those who:

- Prefer a method that provides highly effective, long-term contraception, but do not want a permanent method (voluntary sterilization)
- Prefer a method that does not require taking contraceptive action daily or before sexual intercourse.
- Have or do not have children
- Are breastfeeding and needs a contraceptive
- Prefer not to use a hormonal contraceptive method such as combined oral contraceptive pills, or is a heavy smoker (more than **15** cigarettes per day) who is over **35** years of age or has high blood pressure
- Have successfully used an IUCD in the past
- Are at low risk of contracting a STIs (i.e., are in a mutually faithful sexual relationships)
- Are postabortion clients who do not have evidence of infection.

Intrauterine Devices for Women with HIV

Women who are at risk of HIV or are infected with HIV can safely have the IUCD inserted. Women who have AIDS, are on antiretroviral (ARV) therapy, and are clinically well can safely have the IUCD inserted.

Women who have AIDS but who are no ARV therapies or who are not clinically well should not have IUCD inserted.

If a woman develops AIDS while she has an IUCD in place, it does not need to be removed.

IUCD users with AIDS should be monitored for pelvic inflammatory disease.

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

Precautions

- Has **suspected pregnancy** by history, symptoms or signs: If the possibility of pregnancy **cannot** be excluded by history, examination or pregnancy testing, insertion of an IUCD should be delayed until the client's next menstrual period. In the interim, help the client to choose another contraceptive method, such as condoms.
- PID or STI currently or within the last 3 months.
- Is at high risk for **STIs**: A woman who has more than one sexual partner or whose partner has more than one sexual partner should be counselled that she is at risk for STIs and that the IUCD will not protect her from STI. If she elects to use an IUCD, she (or her partner) should also use condoms.
- **Unexplained vaginal bleeding**: Ideally, the cause of any persistent, unexplained vaginal bleeding or spotting (e.g., between periods or after intercourse) should be determined and, if possible, treated before an IUCD is inserted. Until the cause of the bleeding is determined and any serious problems treated, the client can use another reliable method.

ALERT: Other Problems Requiring Action for The Use of IUCD Vaginal infection

(candidiasis or bacterial vaginosis without cervicitis): Treat and resolve infection before inserting an IUCD. Give another temporary method until the infection is cleared up.

Severe anaemia (i.e., haemoglobin less than 7 gm/dl or hematocrit less than 20%): Choose the IUCD only if it is the best overall method for that client. If after counselling, the Copper T 380A IUCD is still the client's chosen method, she should be treated with iron or iron/folate for anaemia.

Cervical stenosis: Counsel the client about this problem. If indicated, refer client to a centre where cervical dilation with local anaesthesia is available if client chooses IUCD.

Have painful menstrual periods: Counsel client about this to be certain she understands potential problems with having an IUCD. IUCD should not be the first choice.

10.3.3 Clinical Assessment

The purpose of the health assessment is to determine the client's suitability for the use of the method. It is also an opportunity to offer other available sexual and reproductive health services as appropriate.

- **Medical/social history**: include gynaecological and obstetric history; present illness, including diabetes, anaemia or immunodepression; and history of STIs, including HIV, PID and risk factors to STI such as multiple sexual partners.
- **Physical examination**: speculum visualization of cervix and bimanual pelvic examination must always be included and any other examination as indicated by the medical history.
- **Laboratory tests**: these are not routinely required for the use of an IUCD except when indicated by medical history and physical examination.

10.3.4 Clinical Procedure

Timing of insertion of the IUCD

Interval insertion

- Within 12 days after the start of her monthly bleeding.
- If it is more than 12 days of monthly bleeding, she can have the IUCD inserted at any time. If it is known that the woman is not pregnant (for detailed information refer to Chapter 2: Client Assessment). There is no need of back up method with IUCD.
- **Postpartum (for earliest timing of insertion refer to chapter 13)**
- **Fully or nearly fully breastfeeding mothers:** Within 48 hours of delivery or after involution of the uterus is complete (4 weeks) even after the C/S
- **Partially breast feeding or non-breastfeeding mothers:** Within 48 hours of delivery or after involution of the uterus is complete (4 weeks) even after the C/S
- **After spontaneous or medically induced first-trimester abortion:** An IUCD may be safely inserted immediately at this time except in women with pelvic infection.
- **IUCD insertion after second trimester abortion** or miscarriage requires specific training. If not trained, delay insertion until at least 4 weeks after miscarriage or abortion

Note: Immediate and early postpartum insertion and immediate postabortion insertion should be performed only by specially trained health personnel.

Removal of IUCD

If there is difficulty with removal, including breaking of the string, excessive pain, or a question of perforation or embedding of the IUCD, referral to a physician in a fully equipped facility should be undertaken. The indication for removal may be medical or personal:

- **Medical**
 - Pregnancy (only if threads visible)
 - Excessive bleeding
 - Severe anaemia (haemoglobin less than 8 gm/dl or hematocrit less than 20%)
 - Unacceptable lower abdominal pain associated with menstrual cramping
 - Signs of pelvic inflammatory disease
 - Known or suspected uterine or cervical neoplasia
 - Partial expulsion
 - Menopause
- **Personal**
 - Desire for pregnancy
 - Change of method
 - No need for protection against pregnancy

10.3.5 Management of Possible Problems during Insertion and Removal

Table 10-1: Management of Problems during Insertion or Removal of IUCD

Problem	Assessment	Management
Fainting (syncope); slow heart rate (bradycardia) or vasovagal episode during IUCD insertion or removal	<p>Is woman extremely anxious?</p> <p>Does she have a small uterus or cervical stenosis?</p> <p>(These characteristics increase risk for fainting and/or vasovagal reaction.)</p>	<p>Every step of IUCD insertion and removal should be done slowly and very gently, with an explanation of each step to the client.</p> <p>If available, aspirin, acetaminophen or ibuprofen may reduce pain associated with IUCD insertion or removal. Provide 30 minutes prior to procedure and for 24 hours afterwards.</p> <p>Maintain a calm, relaxed, unhurried atmosphere and a gently reassuring approach to the client.</p> <p>At the earliest sign of fainting, stop the insertion. Resume the procedure once the episode has passed and client desires.</p>
IUCD Sterile Package Damaged	Inspect package before use. Be alert for break in seal or plastic cover.	Discard and use another IUCD from a sterile package.
Suspected Uterine Perforation (during uterine sounding or IUCD insertion)	Client complains of sudden significant pain during procedure.	<p>Stop the procedure (and remove IUCD if inserted). Observe for signs of intra-abdominal bleeding (e.g., falling BP, rising pulse, severe abdominal pain, tenderness, guarding and rigidity). If intra-abdominal bleeding is suspected, stabilize (IVs) and refer (if necessary) for further evaluation and possible surgery.</p> <p>If intra-abdominal bleeding not suspected, keep for observation and take BP and pulse every 15 minutes for 90 minutes.</p> <p>If negative after 2 hours, discharge with instructions for warning signs, which require immediate return to clinic. Return after 1 week for check up.</p> <p>Provide backup contraceptive method and help client make an informed choice of another method.</p>

10.3.6 Client Instructions and Follow-up:

Instruct clients on following points:

- To visit the clinic after one month even if there is no problem and if any problem visit the clinic right then
- Expulsion of IUCD is uncommon
- Since most expulsions occur during menstruation, the IUCD user should check menstrual cloths, pads or tampons, as well as the toilet or latrine, during menstrual periods. If the device is expelled accidentally, she should return to where she received her IUCD for possible insertion of another IUCD. She should use another contraceptive method until her IUCD is replaced. It is not necessary to check the string after every menstruation as recommended earlier but the client need to be careful on missing string

Missing strings (suggesting possible pregnancy, uterine perforation, or expulsion)

- **Ask the client:**

- Whether and when she saw the IUCD come out
- When she last felt the strings
- When she had her last monthly bleeding
- If she has any symptoms of pregnancy
- If she has used a backup method since she noticed the strings were missing

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

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

Changes in the client's menstrual periods

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

Special concern for return visits

A woman should get medical help as soon as possible if she has any of the following problems:

- P= Period late (pregnancy), abnormal spotting or bleeding.
- A= Abdominal pain, pain with intercourse, severe cramping.
- I= Infection exposure (such as gonorrhea), abnormal discharge.
- N= Not feeling well, fever, chills, especially if accompanied by lower abdominal pain.
- S= String missing, shorter or longer, or the plastic tip of the IUCD.

Also, if either the women or her husband begins having sexual relations with other partners without using condoms, this increases her risk of getting a sexually transmitted disease because IUCDs do not protect against them. STIs increase the risk of pelvic inflammatory disease, which lead to infertility or ectopic pregnancy.

10.3.7 Side Effects and Management

Table 10-2: Management of Side Effects for the Use of IUCD

Side Effect	Assessment	Management
<p>Amenorrhoea (absence of vaginal bleeding or spotting)</p>	<p>Ask client When she had her LMP When she last felt the IUCD strings If she has symptoms of pregnancy</p> <p>Rule out pregnancy (intrauterine or ectopic) by checking symptoms, and performing a pelvic exam (speculum and bimanual) and a pregnancy test (if indicated and available).</p>	<p>If the client is over 48, amenorrhoea could be due to menopause.</p> <p>If pregnancy is ruled out, no treatment is required except counselling and reassurance. Explain that blood does not build up in the uterus. Advise the client to return to the IUCD provider for further evaluation if amenorrhoea remains a concern.</p> <p>If pregnancy is less than 13 weeks (by LMP and/or exam) and strings are visible, explain that the IUCD should be removed to minimize risk of pelvic infection. If client agrees, remove IUCD. Advise her to return to the clinic if she has excessive bleeding, cramping, foul discharge or fever.</p> <p>If client is pregnant and wishes to continue pregnancy but does not want IUCD removed, advise on increased risk of miscarriage (spontaneous abortion) and infection and that pregnancy should be followed closely.</p> <p>Do not attempt to remove IUCD if:</p> <ul style="list-style-type: none"> • Strings are not visible or • Pregnancy is greater than 13 weeks (by LMP and/or exam)
<p>Irregular bleeding with or without symptoms of pregnancy</p>	<p>Perform abdominal and pelvic (speculum and bimanual) examination to check for infection, pelvic pain or tenderness, palpable adnexal mass or enlarged uterus (consistent with pregnancy).</p>	<p>Ectopic pregnancy must be suspected in clients with irregular bleeding and/or abdominal pain (see Amenorrhoea and Heavy Bleeding in this section). Refer to appropriate facility for complete evaluation.</p>

Side Effect	Assessment	Management
<p>Bleeding (heavy/prolonged) Amount: more than normal period Duration: more than 8 days</p>	<p>Perform pelvic examination (speculum and bimanual) to be sure that client does not have: Intrauterine or ectopic pregnancy Incomplete abortion Vaginal, cervical or pelvic infection</p> <p>Ask how much and how long she has been bleeding. Check for signs of marked anaemia: Pale conjunctivae or nail beds Rapid pulse more than 100/min.</p>	<p>If client has had IUCD less than 3 months: If exam is normal, reassure and give iron tablets (1 tablet daily for 1–3 months). Ask client to return in 3 months for another check. Use locally approved drugs, such as ibuprofen, during bleeding episodes, if available, to decrease bleeding (400 mg 3 times daily for 5day) or Indomethacin 25 mg 2 times a daily for 5 days after meal or Tranexamic acid 1500mg 3 times daily for 3 days, then 1000 mg 2 times daily for 2 days.</p> <p>If bimanual examination shows enlarge or irregular uterus due to fibroids, tell client of the problem and refer for evaluation. Remove the IUCD if bleeding worsens and client is anaemic or requests removal, and help client select another method.</p> <p>If client has had IUCD more than 3 months: If examination is normal and bleeding intervals short (less than 3 days) determine if bleeding is a problem. If not, leave the IUCD in place. If the client is bothered, remove the IUCD and counsel for another method.</p>

Side Effect	Assessment	Management
Missing Strings	<p>Ask the client whether she knows if the IUCD has come out/been expelled.</p> <p>If client does not know if IUCD was expelled, ask her: When she had her LMP When she last felt the strings</p> <p>If she has any symptoms of pregnancy</p> <p>If she used a backup method (e.g., condom) from the time she noticed the missing strings</p> <p>Rule out pregnancy by symptoms, physical examination or pregnancy test, if necessary and available.</p> <p>If she returns while menstruating and strings are not visible, rule out lost IUCD or perforation.</p> <p>If she returns with delayed (more than 4 weeks) menses, check for pregnancy.</p>	<p>If client knows the IUCD fell out, check for pregnancy. If not pregnant, insert new IUCD, or provide back-up method and insert new IUCD during her next period.</p> <p>If exam reveals ectopic pregnancy (lower abdominal pain, spotting, cramping), refer to appropriate facility for complete evaluation.</p> <p>If exam reveals pregnancy, and strings are visible, see management under Amenorrhoea.</p> <p>If exam reveals pregnancy and strings are not visible, see management under Amenorrhoea.</p> <p>If strings are not found by carefully probing the cervical canal, client should use a non-hormonal contraceptive method and return with menses or in 4 weeks if her period does not start. Strings may come down with menses. If strings are seen, reassure client that strings are present and help her feel them.</p>
Expulsion or partial expulsion	Rule out pregnancy	If partially expelled remove it completely and come after the period.
Partner Complains About Strings	Check to be sure that IUCD is in place (i.e., not partially expelled)	Counsel client that one option is to cut strings even with the cervical os, and inform her that she will no longer be able to feel strings. Record in chart that strings have been cut to the level even with cervix for future removal.

Side Effect	Assessment	Management
<p>Pelvic Infection</p> <p>Cramping accompanied by abdominal tenderness, fever, flu-like symptoms, headache, chills, nausea or vomiting, painful intercourse, palpable pelvic mass</p>	<p>Perform abdominal and pelvic (speculum and bimanual) examination and STI testing if available.</p>	<p>If abdominal and pelvic examinations confirm uterine and/or adnexal tenderness, and/or microscopic testing supports diagnosis of PID, remove the IUCD and treat with antibiotics.</p> <p>If diagnosis equivocal, treat with antibiotics without removing IUCD. Observe carefully for results of antibiotic treatment.</p> <p>If urethritis or cervicitis (purulent discharge or inflamed red cervix), check gram stain of cervical discharge.</p>
<p>Vaginal Discharge</p>	<p>Check client’s history for STIs and examine for vaginitis or purulent cervicitis or inflamed red cervix.</p> <p>Examine saline and KOH wet mounts of vaginal discharge for trichomonas, monilia (candida) and bacterial vaginosis.</p>	<p>Obtaining accurate history will facilitate diagnosis and treatment.</p> <p>If saline or KOH wet mounts are positive, treat approximately for specific organism. If simple vaginitis, it does not require removal.</p> <p>If positive for GNIDs, treat for gonorrhoea. If negative for GNIDs and purulent cervicitis or inflamed red cervix, treat for Chlamydia. Obtain GC culture if available. Remove IUCD if gonorrhoea or chlamydia is confirmed or strongly suspected.</p>

CHAPTER ELEVEN

11

MINILAP

CHAPTER ELEVEN

MINILAP

11.1 BASICS

11.1.1 Voluntary Sterilization Procedures

- Voluntary Surgical Contraception
 - For women
 - Minilap
 - Laparoscopy
 - For men
 - Non Scalpel Vasectomy (NSV)

11.1.2 Effectiveness

Minilap is 99.5% effective, with a surgical complication rate of less than 2%. Failure usually is due to one of the following:

- Spontaneous recanalization of fallopian tube
- Incomplete procedure
- Incorrect surgical technique

11.1.3 Permanency

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

11.2 PREREQUISITES

Guiding principles for Minilap services:

- The operating physician and staff must be trained and skilled in: the approved surgical techniques; the guidelines for conscious sedation and local anaesthesia; the management of emergencies; and standards of infection prevention practices.
- All instruments and equipment, including emergency equipment and supplies, must be in optimum working order before the start of the surgical procedure.
- Clients must be carefully counselled and screened; meet medical eligibility criteria and written informed consent must be obtained.

- Individual providers are not to exceed the following recommended number of procedures per day: 5 procedures per hour per surgeon not exceeding 50 cases per day per surgeon.

11.2.1 Infection Prevention

Because Minilap is surgical procedure, aseptic technique including good surgical technique must be followed to prevent infection at the incision site. For more detailed information, refer to Chapter Three: Infection Prevention and Operation Theatre Technique and Management reference manuals.

11.2.2 Facility

- The facility should have sufficient size with enough rooms to accommodate Minilap services.
- Proper set-up to maintain infection prevention practices includes an excellent instrument/equipment sterilization system, client flow system that maintains privacy, hygiene and asepsis, and proper lighting and privacy.

See Appendix D III VSC Site Criteria for detailed facility requirements.

11.2.3 Equipment and Supplies

See Appendix E II Expendable supply estimates for Minilap

11.2.4 Category of Provider/Training

Minilap

Operation theatre staff (physician and scrub nurse) is to be certified in procedure by NHTC, GoN. Additional staff needed with skills and training to perform their job responsibilities are:

No.	Position	Function
1	Trained Physician/Surgeon	Oversee pre-operative client assessment and perform surgery
1	Staff Nurse	Client screening, ensure understanding and documentation of informed choice/informed consent, and postoperative care
1	Staff Nurse	OT Management
2	ANM	Assist in OT
1	Clinic Helper	Sterilization activities
1	Community Medical Assistant (CMA)/VHW	Registration and counselling
1	Peon	Assist in cleaning instruments
1	Sweeper	Cleaning facilities
1	Driver	For transport purpose
1	FCHW	For social mobilization

11.2.5 Record Keeping and Reporting

The provider should fill the following forms before and after providing VSC:

- Master Register (HMIS No. 1) Appendix A I
- Contact Card (HMIS No. 2) Appendix A IV
- Face Sheet (HMIS No. 12) Appendix E I
- Sterilization Register (HMIS No. 14) Appendix A VI

The provider should ensure that the medical record forms are completed, regularly maintained and reported to the DHO/DPHO.

11.3 SERVICE DELIVERY

11.3.1 Counselling and Informed Choice (For more detailed information refer to Chapter One.)

Counselling is of particular importance in programs providing Minilap services, because the method is surgical and permanent. Minilap involves consequences, risks and concerns that need to be discussed with each client.

- Discuss other temporary and permanent family planning methods that are available.
- The client must be counselled in a language that s/he understands. Privacy must be maintained during counselling.
- Ensure that client has decided to use the method without any coercion and incentives.
- The following information should be understood by clients:
 - Side effects for the method selected.
 - Advantages/disadvantages of the method selected.
 - Each step of the process including screening, pre-operative medications, gowning, operating theatre, postoperative pain, side effect, warning signs, recovery at home and follow-up.

The counsellor should discuss each client's feelings about ending fertility and assess the client's psychological readiness for the procedure and its consequences. Client doubts, fears or misconceptions should be identified and addressed.

Informed consent is the client's voluntary decision to undergo a sterilization procedure, in full possession and understanding of the relevant facts. In Nepal, the client's signature on an informed consent form (See Appendix D I) is the legal authorization for the procedure to be performed. Therefore service providers should ensure that client has signed the informed consent form with full understanding.

11.3.2 Eligibility

11.3.2.1 Indications

- The client seeks permanent method and wants no more children.

- The client should be above the age of 22 years and below the age of 49 years. **However, with adequate counselling there is no age restriction.**
- There should be at least 2 living children. **However, with adequate counselling there is no parity restriction.**
- Do not need to have husbands/ guardians permission
- The client or partner has a medical condition that would lead to a high-risk pregnancy or serious health problems.

11.3.2.2 Precautions for Minilap

The situations and conditions below require careful consideration and counselling before proceeding with provision of a permanent method.

Female Sterilization for Women with HIV

- Women who are infected with HIV, have AIDS, or are on antiretroviral (ARV) therapy can safely undergo female sterilization. Special arrangements are needed to perform female sterilization on a woman with AIDS.
- Urge these women to use condoms in addition to female sterilization. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.
- No one should be coerced or pressured into having female sterilization, and that includes women with HIV.

Situational issues

If Minilap is inappropriate for the reasons below, the counselor should further assess concerns and, if appropriate, help the client choose another method.

- Desires another child
- Shows excessive interest in reversal
- Has religious beliefs that would be violated
- Disagrees with/does not want to sign informed consent
- Is under pressure from another person
- Has marital problems
- Is single without children
- Has no children

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

General medical issues:

- Acute systemic infection
- Depression: help client choose another method and refer for treatment of depression
- STI
- Uncontrolled diabetes

Female Specific medical issues

- Current pregnancy
- 7–42 days postpartum
- Postpartum after a pregnancy with severe pre-eclampsia or eclampsia
- Serious postpartum or postabortion complications (such as infection, hemorrhage, or trauma) except uterine rupture or perforation
- A large collection of blood in the uterus
- Unexplained vaginal bleeding that suggests an underlying medical condition
- Pelvic inflammatory disease
- Purulent cervicitis, chlamydia, or gonorrhoea
- Pelvic cancers (treatment may make her sterile in any case)
- Malignant trophoblast disease

Documenting denial of Minilap sterilization

When a client is judged unsuitable for Minilap, the client record should specify the reason(s) and should describe what action was taken. These records are to be kept at the service site.

11.3.3 Client Assessment

The recommended information to include in a preoperative medical evaluation of a client is:

Demographic information

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

Medical history

- History of chronic/acute conditions: active tuberculosis, heart disease, hypertension, anaemia, diabetes, bleeding disorders, convulsions, psychiatric conditions, pelvic or abdominal surgery, pelvic inflammatory disease, vaginal discharge, urinary tract infections
- Recent injuries or infections
- History of pregnancies, miscarriages, abortions, deliveries and any complications
- Date of LMP and description of menses
- Breastfeeding
- Family planning method use, side effects, reason for discontinuation
- Allergies to medication
- Epilepsy

Physical examination

The physical examination should include the following:

- Weight/Height
- Temperature
- Blood pressure
- Pulse
- Auscultation of heart and lungs
- Abdominal examination
- Pelvic exam—speculum and bimanual,
- Pregnancy test if LMP and pelvic exam is suggestive of pregnancy
- Evaluation of the client's nutritional status
- Examination of the local operative area
- Other examinations as indicated by the medical history

Laboratory investigations

- Exam for haemoglobin, urinalysis for sugar and protein should be performed on all Minilap clients. Haemoglobin 7 gm/dl and above (or Hb 20% and above) is acceptable.
- Chest x-ray, pregnancy test should be conducted if indicated.
- For postpartum Minilap procedure, haemoglobin is required if there is bleeding after delivery.

Conditions to be reviewed by physician

When on exam/history the women have abnormal finding(s), it must be reported to the physician, and the physician will examine the client and determine whether the procedure can be pursued. Below are conditions to be reviewed by the physician:

For all clients:

- A systemic or localized infection
- Heart disease
- Irregular pulse
- Respiratory problems
- Hypertension (should be controlled before surgery)
- Mass in the pelvic area
- Diabetes (should be controlled before surgery)
- Bleeding disorders

For postpartum client:

- Puerperal fever

- Prolonged rupture of membranes
- Hypertensive states, including pre-eclampsia and eclampsia
- Antepartum or postpartum haemorrhage
- Major trauma to the genital tract
- History of postpartum psychosis

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

- Pelvic or abdominal adhesions due to previous surgery
- Obesity
- Abdominal wall or umbilical hernia (for immediate postpartum and laparoscopic procedures)
- Severe organ disease of heart, lung, kidney, liver
- Coagulation disorders
- Known pelvic TB

11.4 CLINICAL PROCEDURE

Timing of procedure

- Interval Minilap may be performed: During menstruation, or within 5 days of LMP or any time in the menstrual cycle if client is known to be not pregnant. (See Chapter 2: Client Assessment for pregnancy screening.)
- Postpartum Minilap may be performed within 7 days, or 6 weeks after delivery.

11.5 PREOPERATIVE MEDICATION AND ANESTHESIA

Premedication serves to reduce fear and anxiety. It can provide analgesia, prevent postoperative nausea and vomiting, and induce amnesia. The goals of anaesthesia are to minimize psychological and emotional distress and trauma in the client and free her from pain and discomfort.

Local anaesthesia with sedation (so-called “modified local”) is safer than either general or conductive (spinal/epidural) anaesthesia, especially when these procedures are being performed in an outpatient setting. Use of general anaesthesia is not routinely recommended for VSC procedures.

Conscious sedation with local anaesthesia

When performing minilap the operating physician should give conscious sedation with local anaesthesia and choose either Option 1 or Option 2, **not both**.

MINILAP
Conscious Sedation with Local Anaesthesia: Option 1
Diazepam 5 mg orally for client <35 kg weight or Diazepam 10 mg orally for client \geq 35 kg by weight Give 45 minutes before the operation
Pethidine 25 mg IV with Phenergen 12.5 mg IV with Atropine 0.6 mg IV To be administered together intravenously in operating theatre just before procedure with monitoring of vital signs every 5 minutes.
Xylocaine 1% 10–20 ml. Local infiltration to the skin and wait 1–2 minutes after infiltration to begin procedure.
Conscious Sedation with Local Anaesthesia: Option 2
Diazepam 5 mg orally for client <35 kg weight or Diazepam 10 mg orally for client \geq 35 kg by weight Give 45 minutes before the operation.
Pentazocine 30 mg IV with Atropine 0.6 mg IV (optional) To be administered together intravenously in OT just before procedure with monitoring of vital signs every 5 minutes
Xylocaine 1% 10–20 ml. Local infiltration to the skin and wait 1–2 minutes after infiltration to begin procedure.

The use of IV diazepam for premedication is not recommended.

Monitoring client during procedure for clients administered conscious sedation

Monitoring and recording of vital signs must take place before, during and after the operation until the client has fully recovered.

Preoperative: Blood pressure, pulse and respiration should be monitored and recorded before and after the preoperative dose of sedative is given. This provides the baseline data for the client.

Intraoperative: To assess the status of analgesia, a staff member should converse with the client continuously. During surgery, the medical team should monitor and record blood pressure, pulse and respiration at least every 5 minutes.

Postoperative: Blood pressure, pulse and respiration must be monitored and recorded at least every 15 minutes until stable (they have returned to preoperative levels). Under no circumstances should the client be left alone. The client must be observed constantly during the postoperative period. Once the client is stable, vital signs should be monitored once every hour until she is fully awake.

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

- Excessive somnolence

- Breathing rate of less than 10 per minute
- Hyperventilation
- Systolic blood pressure less than 90 mm Hg
- Rapid (over 100) or weak pulse
- Pallor or cyanosis

For further information about preoperative monitoring, refer to the *Operating Theatre Technique and Management* reference manual.

11.6 MANAGEMENT OF COMPLICATIONS

Anaesthesia complications

Major complications may occur with general and local anaesthesia for Minilap. Serious complications i.e. less than 2% are likely to occur as a result of overdose or improper administration of anaesthesia. Inadequate monitoring is often a factor when a complication has become serious before it is recognized. Refer to the *Management of Emergencies in Family Planning Services in Nepal* reference manual.

Surgical emergencies

The surgical team should manage surgical emergencies at the operative site in accordance with the techniques outlined in the *Management of Emergencies in Family Planning Services in Nepal* reference manual.

Table 11-1: Management of Complications During Minilap

Complications	Assessment	Management
Wound Infection	Confirm presence of infection or abscess.	If skin infection is present, treat with Amoxicillin/ Cloxacillin 500 mg 8 hourly for 5 days. If abscess is present, drain and treat as indicated.
Postoperative Fever	Determine source of infection.	Treat infection based on findings.
Bladder, intestinal injuries (rare)	Determine presence of hematuria, other signs of internal injury.	Manage as outlined in the <i>Management of Emergencies in Family Planning Services in Nepal</i> reference manual.
Haematoma (subcutaneous)	Determine presence of infection or abscess.	Apply warm, moist packs to site. Observe—usually will resolve over time but may require drainage if extensive.
Shock or acute (very rare) distress	Check for increased respiration and pulse, decreased blood pressure, evidence of hemodynamic instability.	Manage as outlined in the <i>Management of Emergencies in Family Planning Services in Nepal</i> reference manual.
Pain at incision site	Determine presence of infection or abscess.	Treat based on findings.
Superficial Bleeding (skin edges or subcutaneously)	Determine presence of infection or abscess	Treat based on findings.

Complications	Assessment	Management
Intraoperative Haemorrhage (injury to mesosalpinx)	Determine presence of injury to mesosalpinx	Manage as outlined in the <i>Management of Emergencies in Family Planning Services</i> reference manual.

11.6.1 Preoperative, Postoperative and Discharge Care and Client Information

Preoperative client information

At community level

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

- Receiving counselling about family planning procedures and specifics about Minilap
- Bathing, wearing clean and loose clothes
- Fasting for 8 hours before surgery and taking no medications for 24 hours prior to surgery unless prescribed by a physician
- Being accompanied to Minilap site and home after the procedure

At Minilap Site

Counsellor and Minilap staff to inform the client of the following:

- The steps of the operation, including information on sedation/anaesthesia, screening, lab tests, what to expect in operating theatre, expectations about pain/discomfort, emptying bladder before surgery
- Removal of jewellery, nail polish, hairpins, eye glasses and dentures before surgery

Post-operative client information

- Medications and dosages
- Discharge information—resumption of activities, wound care and warning signs (signs of infection, bleeding pain), referral site for complications
- Timing of follow-up visit
- Printed postoperative information to be given on discharge

Post-operative danger signs

- Fever (greater than 100.4°F/38°C)
- Dizziness with fainting
- Abdominal pain that is persistent or increasing
- Bleeding or fluid coming from the incision

Postoperative care

Minilap staff should monitor the client's vital signs every 15 minutes after surgery until she is stable. Discharge may occur after 2 hours post-procedure when the client's vital signs are stable, she has eaten, has passed urine, is able to dress herself and is ambulatory.

Required client discharge instructions are outlined in Appendix E III. For additional information on postoperative care, refer to the *Minilap Under Local Anaesthesia for Nepal* reference manual.

Postoperative medications

- Analgesics tablets for 3 days
- **Antibiotics are not recommended for routine use with Minilap.** Antibiotics should only be given if there is bowel injury, documented infection or severe breach in infection prevention practices/aseptic technique.

Post-procedure follow-up

The follow-up visit is to take place within 7 days of surgery. The client should return to the site where the procedure was conducted or to a referral site as instructed by the discharge staff.

MOBILE MINILAP SERVICES

11.7 BASICS

Mobile services available in Nepal

High quality voluntary surgical contraception services should be available and accessible to all people, regardless of where they live. Because mobile services are usually delivered far from comprehensive emergency facilities, quality standards in these settings should be maintained as they are in permanent facilities.

Types

- A trained surgical team from outside the district travels to district health care facilities that do not offer voluntary surgical contraception to their clients. The team brings with it any equipment and supplies that are unavailable at the local sites.
- A trained surgical team travels from the district centre to areas that do not have voluntary surgical contraceptive services and performs surgery in temporary medical settings, such as schools and community centres. While the team brings with it almost all necessary equipment and supplies it also uses tables, lamps and other items available at the local sites.

11.8 PREREQUISITES

11.8.1 Personnel

Mobile teams must be staffed by trained, skilled and experienced personnel. Because a mobile team often does not have ready access to the backup emergency facilities available in most urban areas, the team's personnel must be skilled at recognizing problems promptly and managing them immediately.

Sometimes mobile teams go into the field sporadically, perhaps only a few weeks or months out of a year. If this is the case, members of the surgical team may need practice or retraining between their trips, especially if they do not routinely perform voluntary surgical contraception year round. Surgical skills diminish if they are not used.

Cases should not exceed 50 Minilap procedures per day per surgeon.

11.8.2 Equipment and Supplies

Mobile teams must go into the field with all the supplies and equipment needed to manage surgical emergencies. In addition, they should have formal relationships with established medical facilities in the areas where they work. In this way, clients who need continued medical treatment after emergencies will have a way to receive it. The local backup facilities must have the supplies, equipment and trained staff required to handle complications following voluntary surgical contraception (See Appendix D II) for emergency drugs and equipment). For more information, refer to the *Management of Emergencies in Family Planning Services in Nepal* reference manual.

11.9 STANDARD OF SERVICES

All Minilap standards outlined in this chapter apply to both mobile and static service sites.

CHAPTER TWELVE

12

NO SCALPEL VASECTOMY

CHAPTER TWELVE

NO SCALPEL VASECTOMY

12.1 BASICS

12.1.1 Voluntary Sterilization Procedure

For men

- No Scalpel Vasectomy (NSV)

12.1.2 Effectiveness

Pregnancy rates are 2 to 3 per 100 women over the first year after their partners have had a vasectomy.

NSV is an effective procedure with a surgical complication rate of less than 2%. Failure usually is due to one of the following:

- Spontaneous recanalization of vas deferens
- Inability to complete procedure
- Incorrect surgical technique

12.1.3 Permanency

NSV is considered permanent (irreversible). It is possible in some cases to reverse the procedure that is rejoining the vas deferens. But in Nepal, the microsurgical services required to reverse NSV procedure are rare. Even when such services are available, the client may not be a proper surgical candidate or a reversal attempt may not be successful. Therefore, couples considering NSV should be certain that they do not wish to have any more children.

12.2 PREREQUISITES

Guiding principles for NSV services:

- The operating physician and staff must be trained and skilled in: the approved surgical techniques; the guidelines for conscious sedation and local anaesthesia; the management of emergencies; and standards of infection prevention practices.
- All instruments and equipment, including emergency equipment and supplies, must be in optimum working order before the start of the surgical procedure.
- Clients must be carefully counselled and screened; meet medical eligibility criteria and written informed consent must be obtained.
- Individual providers are not to exceed the following recommended number of procedures per day: 5 procedures per hour per surgeon, not exceeding 50 procedures per surgeon per day.

12.2.1 Infection Prevention

Because NSV is surgical procedure, aseptic technique including good surgical technique must be followed to prevent infection at the puncture site. For more detailed information, refer to Chapter Three: Infection Prevention. In addition refer to Operation Theatre Technique and Management reference manuals.

12.2.2 Facility

- The facility should have sufficient size with enough rooms to accommodate NSV services.
- Proper set-up to maintain infection prevention practices includes an excellent instrument/equipment sterilization system, client flow system that maintains privacy, hygiene and asepsis, and proper lighting and privacy.

See Appendix D III NSV Site Criteria for detailed facility requirements.

12.2.3 Equipment and Supplies

See Appendix F II Facilities and equipment for Vasectomy

12.2.4 Category of Provider/Training

NSV

The provider should be health staff trained in NSV. Such training should be based on the NHTC, GoN training curriculum.

The minimum number of staff required to safely conduct a no scalpel vasectomy operation is as follows:

No.	Position	Function
1	Trained Doctor	Oversee preoperative assessment and perform surgery
1	HA/Sr. AHW/Staff Nurse	Perform preoperative assessment, ensure understanding and documentation of informed choice/informed consent and assist the surgeon in OT and prepare OT
1	Clinic Helper	Work in the OT/sterilization, instrument cleaning and packing
1	CMA/ANM/VHW	Registration, counselling and postoperative cares.
1	Driver	Assist in transportation services.
1	Peon	Assist in preoperative preparation and other tasks.
1	FCHV	Assist in advocacy and social mobilization

12.2.5 Record Keeping and Reporting

The provider should fill the following forms before and after providing NSV:

- Master Register (HMIS No. 1) Appendix A I
- Family Planning Card (HMIS No. 12) Appendix A IV

- Sterilization Register (HMIS No. 14) Appendix A VI
- Medical Record Card -Appendix F I

The provider should ensure that the medical record forms are completed, regularly maintained and reported to the DHO/DPHO.

12.3 SERVICE DELIVERY

12.3.1 Counselling and Informed Choice (For more detailed information refer to Chapter One.)

Counselling is of particular importance in providing NSV services, because the method is surgical and permanent. NSV involve consequences, risks and concerns that need to be discussed with each client.

- Discuss other temporary and permanent family planning methods that are available.
- The client must be counselled in a language that s/he understands. Privacy must be maintained during counselling.
- Ensure that client has decided to use the method without any coercion and incentives.
- The following information should be understood by clients:
 - Side effects for the method selected.
 - Advantages/disadvantages of the method selected.
 - Each step of the process including screening, pre-operative medications, gowning, operating theatre, postoperative pain, side effect, warning signs, recovery at home and follow-up.

The counsellor should discuss each client's feelings about ending fertility and assess the client's psychological readiness for the procedure and its consequences. Client doubts, fears or misconceptions should be identified and addressed.

Informed consent is the client's voluntary decision to undergo a sterilization procedure, in full possession and understanding of the relevant facts. In Nepal, the client's signature on an informed consent form (See Appendix D I) is the legal authorization for the procedure to be performed. Therefore service providers should ensure that client has signed the informed consent form with full understanding.

12.3.2 Eligibility

12.3.2.1 Indications for NSV

- The client seeks permanent method and wants no more children.
- The client should be above the age of 22 years. **However, with adequate counselling there is no age restriction. Even though it is so if client is a minor then seek suggestion from FHD.**
- There should be at least 2 living children. **However, with adequate counselling there is no parity restriction.**
- Do not need to have spousal permission

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

12.3.2.2 Precautions for NSV

The situations and conditions below require careful consideration and counselling before proceeding with provision of a permanent method.

Vasectomy for Men with HIV

- Men who are infected with HIV, have AIDS, or are on antiretroviral (ARV) therapy can safely have a vasectomy. Special arrangements are needed to perform vasectomy on a man with AIDS.
- Vasectomy does not prevent transmission of HIV.
- Urge these men to use condoms in addition to vasectomy. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.
- No one should be coerced or pressured into getting a vasectomy, and that includes men with HIV.

Situational issues

If NSV is inappropriate for the reasons below, the counsellor should further assess concerns and, if appropriate, help the client choose another method.

- Desires another child
- Shows excessive interest in reversal
- Has religious beliefs that would be violated
- Disagrees with/does not want to sign informed consent
- Is under pressure from another person
- Has marital problems
- Is single without children
- Has no children

General medical issues

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

- Acute systemic infection
- Depression: help client choose another method and refer for treatment of depression
- STI
- Uncontrolled diabetes

Medical issues

- Local skin or scrotal infections
- Large varicocele

- Filariasis
- Intrasrotal mass
- Inguinal hernia
- Crypto-orchidism
- Large hydrocele (As VAS deference could not be palpated)

Documenting denial of NSV

When a client is judged unsuitable for NSV, the client record should specify the reason(s) and should describe what action was taken. These records are to be kept at the service site.

12.4 CLIENT ASSESSMENT

Preoperative Assessment

The recommended information to include in a preoperative medical evaluation of a male client is:

Demographic information

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

Medical history

The medical history should record any of the following:

- Respiratory problems (e.g., asthma)
- Heart disease
- Diabetes
- Bleeding disorders
- Convulsions
- Psychiatric conditions
- Scrotal or inguinal surgery
- Genitourinary infections
- Sexual impairment and scrotal abnormalities
- Allergies to medications
- Addictions
- History of recent trauma
- Current medications

Physical examination

The physical examination should include the following:

- Blood pressure
- Pulse

- Examination of the local operative area
- Other examinations as indicated by the medical history

The physical examination is part of the medical screening, not part of the surgical procedure. The examination should be done before the client has received anaesthesia for surgery.

Laboratory examination

Routine laboratory tests are not necessary.

Conditions to be reviewed by physician

The following localized conditions can make the operation difficult or increase risks:

- Large varicocele
- Large Hydrocele
- Inguinal hernia
- Filariasis (elephantiasis)
- Scar tissue
- Crypto orchidism
- Previous scrotal surgery
- Intrascrotal mass

Certain systemic disorders require special precautions and possible hospitalisation for the procedure, including the following:

- Severe anaemia (Hb less than 7 g/dl, or Hct less than 20%)
- Bleeding disorders
- Diabetes (should be controlled before surgery)
- Heart disease

In cases where there is increased risk, the physician and the client must weigh the risks of the procedure against its benefits.

Clinical procedure

12.4.1 Timing of Procedure

Male clients with no contraindications should be offered surgery.

12.4.2 Preoperative Medication and Anaesthesia

Premedication for NSV clients should be discouraged. However, if the client appears to need sedation, he may be given diazepam 5–10 mg orally 45–60 minutes before the operation. NSV should be performed using local anaesthesia with 1% Xylocain (without epinephrine).

12.4.3 No-Scalpel Techniques

The NSV technique uses two specially designed but simple instruments to puncture the scrotum to access the vas. The instruments are:

NSV ringed forceps (3.0 to 4.0 mm diameter ring)

NSV dissecting forceps

After isolating the vas through the skin with the ringed forceps, the dissecting forceps is used to puncture the scrotal skin (as opposed to an incision) to access and deliver the vas. The NSV technique does not require skin suture.

For detailed information refer to the *No-Scalpel Vasectomy* reference manual.

Vas occlusion methods

In Nepal the preferred method is to divide the vas, remove a small segment and ligate at both ends with 2 0 silk sutures. (ligation +excision+ fascial interposition). Cautery may be impractical in many service centers. However, thermal cautery with fascial interposition gives the best success rate, with about 0.5% failure rate.

Refer to the *No-Scalpel Vasectomy* reference manual.

Monitoring client during procedure

The client may be monitored by observing his general condition and state of consciousness during and after surgery.

12.5 MANAGEMENT OF COMPLICATIONS

Anaesthesia complications

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

Surgical complaints

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

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

Surgical emergencies

The surgical team should manage surgical emergencies in accordance with the techniques outlined in the *Management of Emergencies in Family Planning Services in Nepal* reference manual.

Table 12-1: Management of Complications of NSV

Complication	Assessment	Management
Superficial Bleeding (skin edges or subcutaneously)	Apply secure pressure over wound. Then check if bleeding persists.	Postoperatively Place secure pressure dressing on wound. If bleeding persists, reopen wound under local anaesthesia, identify the bleeders and ligate them with sterile suture.
Vasovagal Reaction	Check vital signs.	Reassure client. Elevate client's lower extremities. Provide additional local anaesthesia if needed.
Wound Infection	Confirm presence of infection or abscess.	If skin infection is present, treat with amoxillin, cotrimoxazole or erythromycin. If abscess is present, drain and treat as indicated.
Postoperative Fever	Determine source of infection.	Treat infection based on findings.
Haematoma	Confirm presence of blood collection.	Apply warm, moist packs to site. Observe; if extensive may require drainage. If infected, treat as indicated.
Unusually severe pain at puncture site	Determine presence of infection or abscess.	Treatment based on findings (e.g., moist heat, analgesics).
Vaso-cutaneous Sinus (Discharging Scrotal Sinus)	Confirm the presence of discharging sinus and any concomitant infection.	If infection—treat before referring for release operation. Antibiotics should be given.
Sperm Granuloma	Confirm presence of nodule. Determine if infection is present.	Asymptomatic: no treatment. Pain: analgesic if persistent pain. Evacuate cyst, cut and seal ¼" towards the testis.
Chronic Pain	History of reaction of unilateral or bilateral scrotal pain.	Non-steroidal analgesic.

Complication	Assessment	Management
Pregnancy of the Partner	Determine if pregnant and age of gestation. Determine period elapsed since the procedure. Assess for azospermia by semen analysis.	Refer for appropriate care. If more than 3 months since NSV and semen analysis is positive for sperm, discuss repeat vasectomy for man, if necessary, or possibly tubal ligation for partner.
Vasectomy Failure	Repeat to confirm positive semen analysis.	Explain how failure happened. Refer to repeat procedure.

12.6 PREOPERATIVE, POSTOPERATIVE AND DISCHARGE CARE AND CLIENT INFORMATION

Pre-operative client information

- **At community level:**
Community health staff to inform the clients to prepare for surgery by:
 - Receiving counselling about family planning procedures and specifics about NSV
 - Bathing, wearing clean clothes
 - Refraining from alcohol use on day of procedure
- **At NSV Procedure Site:**
Health staff and counsellor should explain in detail the following before the client undergoes the procedure:
 - the steps of the operation, including information on local anaesthesia and screening
 - what to expect in operating theatre
 - expectations about pain/discomfort

Post-operative client information

Required client discharge instructions are outlined in Appendix F III.

The following points must be explained to all clients:

- **Post-NSV Contraception:** Some form of contraception, either male or female, is required for 3 months. Semen examination should be performed and azospermia established before use of temporary methods of contraception is stopped. Health care worker should provide the client with condoms for 3 months, and explain how to use them.
- **General Discharge information:** Resumption of activities, wound care and warning signs (signs of infection, bleeding, pain), medications and dosages, referral site for complications, timing of follow-up visit, printed post-operative information should be given on discharge.

Postoperative danger signs

- Fever (greater than 38°C or 100.4°F)
- Dizziness with fainting
- Persistent or increasing scrotal pain and/or swelling
- Bleeding or fluid coming from the puncture site

Post-operative care

Clients may be discharged after 30 minutes if stable without abnormal findings. If sedation has been used, client must be ambulatory, alert and oriented with normal vital signs. Before the client is discharged, a trained staff member should repeat and verify client understanding of discharge instructions.

MOBILE NSV SERVICES

12.7 BASICS

Mobile services available

High quality voluntary surgical contraception services should be available and accessible to all people, regardless of where they live. Because mobile services are usually delivered far from comprehensive emergency facilities, quality standards in these settings should be maintained as they are in permanent facilities.

Types

- A trained surgical team from outside the district travels to district health care facilities that do not offer voluntary surgical contraception to their clients. The team brings with it any equipment and supplies that are unavailable at the local sites.
- A trained surgical team travels from the district centre to areas that do not have voluntary surgical contraceptive services and performs surgery in temporary medical settings, such as schools and community centres. While the team brings with it almost all necessary equipment and supplies it also uses tables, lamps and other items available at the local sites.

12.8 PREREQUISITES

12.8.1 Personnel

Mobile teams must be staffed by trained, skilled and experienced personnel. Because a mobile team often does not have ready access to the backup emergency facilities available in most urban areas, the team's personnel must be skilled at recognizing problems promptly and managing them immediately.

Sometimes mobile teams go into the field sporadically, perhaps only a few weeks or months out of a year. If this is the case, members of the surgical team may need practice or retraining between their trips, especially if they do not routinely perform voluntary surgical contraception year round. Surgical skills diminish if they are not used.

12.8.2 Equipment and Supplies

Mobile teams must go into the field with all the supplies and equipment needed to manage surgical emergencies. In addition, they should have formal relationships with established medical facilities in the areas where they work. In this way, clients who need continued medical treatment after emergencies will have a way to receive it. The local backup facilities must have the supplies, equipment and trained staff required to handle complications following NSV for emergency drugs and equipment (See Appendix D II). For more information, refer to the *Management of Emergencies in Family Planning Services in Nepal* reference manual.

STANDARD OF SERVICES

All NSV standards outlined in this chapter apply to both mobile and static service sites.

**CHAPTER
THIRTEEN**

13

**POSTPARTUM
CONTRACEPTION AND
LACTATIONAL
AMENORRHOEA
METHOD (LAM)**

CHAPTER THIRTEEN

POSTPARTUM CONTRACEPTION AND LACTATIONAL AMENORRHOEA METHOD (LAM)

POSTPARTUM CONTRACEPTION

13.1 BASICS

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

- The client should be given instructions on how to use the method, or when to return to initiate the method.
- When appropriate, the client should be given the selected method prior to leaving the facility, rather than referring the client to an outpatient department or other clinic to obtain services.
- Providers who perform outreach services to women who have had home births should carry with them a supply of family planning methods in order to provide these methods to women who choose them.
- Facilities offering postpartum tubal ligation or post placental/immediate postpartum IUCD insertion require special training and equipment for these services.

13.2 COUNSELING POSTPARTUM WOMEN

Contraceptive counselling and service provision should be part of:

- Immediate postpartum care for hospital-based birthing services
- Initial and follow-up visits to postpartum women during outreach services
- Routine postpartum services offered to women in the first 6 weeks following childbirth
- Extended postpartum

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

Refer to the *National Medical Standard Volume III* for additional information on the care of postpartum women.

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

- Encourage full breastfeeding.
- Do not recommend that clients discontinue breastfeeding to begin use of a contraceptive method.

- Counsel clients to choose a contraceptive method that does not adversely affect breastfeeding or the health of the infant.

Refer to Chapter 1: Counselling and Informed Choice for the general principles of counselling, informed choice and client provider interaction.

13.3 RETURN OF FERTILITY

The timing of return of fertility for **non-breastfeeding** is usually around 6 weeks postpartum and for **breastfeeding** mothers, it is longer than that as suckling inhibits ovulation. The return of fertility, however, is not predictable (conception can occur before the woman has signs or symptoms of the first menses).

13.4 CONTRACEPTION FOR BREASTFEEDING WOMEN

Breastfeeding women need contraceptive methods before or at the time fertility return during lactation, depending on personal and social circumstances. Contraceptives provided for breastfeeding mothers must not affect lactation and health and must be effective and safe.

Breastfeeding women do not need additional contraception for at least 6 weeks postpartum, and for up to 6 months if they are using the LAM. **Figure 12-1** shows the recommended time of starting contraception for breastfeeding women. Breastfeeding women deciding to use contraception other than LAM should be counselled about the potential effects of some contraceptives on breastfeeding. COCs are considered to be the method of last choice for breastfeeding women before 6 months postpartum because they can decrease breast milk production.

Figure 13-1: Earliest Time That a Woman Can Start a Family Planning Method After Childbirth

Family Planning Method	Fully or Nearly Fully Breastfeeding	Partially Breastfeeding or Not Breastfeeding
Lactational Amenorrhea Method	Immediately	(Not applicable)
Vasectomy	Immediately or during partner's pregnancy [‡]	
Male or female condoms	Immediately	
Copper-bearing IUD	Within 48 hours, otherwise wait 4 weeks	
Female sterilization	Within 7 days, otherwise wait 6 weeks	
Fertility awareness methods	Start when normal secretions have returned (for symptoms-based methods) or she has had 3 regular menstrual cycles (for calendar-based methods). This will be later for breastfeeding women than for women who are not breastfeeding.	
Progestin-only injectables	6 weeks after childbirth [§]	Immediately if not breastfeeding [§] 6 weeks after childbirth if partially breastfeeding [§]
Implants		
Combined oral contraceptives	6 weeks after childbirth [§]	21 days after childbirth if [§]

[‡] If a man has a vasectomy during the first 6 months of his partner's pregnancy, it will be effective by the time she delivers her baby.

[§] Earlier use is not usually recommended unless other, more appropriate methods are not available or not acceptable.

THE LACTATIONAL AMENORRHOEA METHOD (LAM)

13.5 BASICS

Breastfeeding has been internationally recognized as an effective, temporary contraceptive. The use of LAM enables both mother and infant to take full advantage of the numerous other benefits of breastfeeding, including longer birth intervals and the healthiest source of nutrition for infants. Women who choose LAM for contraception should be seen again 5 months postpartum to help them choose another method if desired.

13.5.1 Effectiveness

LAM provides more than 98% effectiveness for women who satisfy these three major conditions:

- are fully or nearly fully breastfeeding
- have not had return of menses
- are less than 6 months postpartum

13.5.2 Return of Fertility

When the baby sucks on the mother's nipples it causes a surge in prolactin in the mother's blood, which inhibits ovulation. Ovulation remains disrupted or suppressed, as long as the frequency, duration and intensity of suckling are high. Ovulation in a lactating woman often naturally resumes around 6 months postpartum.

13.6 SERVICE DELIVERY

13.6.1 Counselling

The LAM can be easily understood by the mother if the time is taken to explain it in a language she understands, and her concerns and questions are addressed. The desired outcome is a woman who:

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

Counselling should include the following:

- Begin immediately to obtain the benefit of colostrums
- Feed on demand, at least every 4 hours in day, every 6 hours at night
- Fully breastfeed for 6 months (baby's diet is more than 90% breast milk)
- Encourage nutritional diet for mother
- Continue to breastfeed as long as possible (2 years or more)

- Initiate an alternative contraception method before 6 months postpartum in women desiring continued contraception

When to stop using LAM as the sole contraceptive method:

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

Discuss complementary family planning methods for lactating mother:

- Refer to **Figure 13-2** in this chapter for description of other methods for lactating women.
- Offer client a back-up method before she no longer meets the LAM criteria, so she can be fully protected before she is at risk for pregnancy.
- Counsel the client that lubricated condoms can help with vaginal dryness associated with breastfeeding. The client will then be protected until she can visit the family planning clinic for help in choosing a different method if desired.

13.6.2 Eligibility

Indications

For mothers who wish to use LAM as a contraceptive, a central consideration must be that breastfeeding needs to be done “fully or nearly fully.” This means that the principal source of nutrition for an infant comes from breast milk:

- intervals between feedings should not exceed 4 hours during the day and 6 hours during the night,
- feedings is on demand more than 6 times per 24 hours, and
- supplementation should not exceed 10% of all feeding episodes.

If a mother cannot fully or nearly fully breastfeed, then another method of contraception must be used. A physical exam or laboratory investigation is not necessary.

The Lactational Amenorrhea Method for Women with HIV

- Women who are infected with HIV or who have AIDS can use LAM. Breastfeeding will not make their condition worse. There is a chance, however, that mothers with HIV will transmit HIV to their infants through breastfeeding. As breastfeeding is generally practiced, 10 to 20 of every 100 infants breastfed by mothers with HIV will become infected with HIV through breast milk in addition to those already infected during pregnancy and delivery. HIV transmission through breast milk is more likely among mothers with advanced disease or who are newly infected.
- Women taking antiretroviral (ARV) medications can use LAM. In fact, ARV therapy during the first weeks of breastfeeding may reduce the risk of HIV transmission through breast milk.
- Replacement feeding poses no risk of HIV transmission. If—and only if—replacement feeding is acceptable, feasible, affordable, sustainable, and safe, it is recommended for the first 6 months after childbirth. If available replacement feeding cannot meet these 5 criteria, exclusive breastfeeding for the first 6 months is the safest way to feed the baby, and it is compatible with LAM. (For guidance on infant feeding for women with HIV)
- One strategy for making breastfeeding safer is expressing breast milk and heat-treating it. For women relying on LAM, expressing milk may be slightly less effective at preventing pregnancy than breastfeeding.
- Urge women with HIV to use condoms along with LAM. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.

13.6.3 Contraindications

Table 13-1: Contraindications for the use of LAM

Condition	Precaution	Rationale
Has resumed her menses.	Counsel about need for another method.	Menses indicates resumption of ovulation and the likelihood of pregnancy occurring if another contraceptive method not used. Of the three LAM criteria, the return of menses is the most important indication of fertility return.
Baby suckles infrequently, (less than six to ten times a day on both breasts) or her baby sleeps through the night.	Counsel about need for another method.	Decreased breastfeeding frequently allows the pituitary ovarian axis to recover from lactational suppression and ovulation resumes.
Has added regular supplemental foods or liquids to her baby's diet. NOTE: "Supplemental" does not include tiny amounts of ritual or medicinal liquids or food; "supplemental" refers to liquid or food, which substitutes for a breastfeed.	Counsel about need for another method.	Decreased breastfeeding frequently allows the pituitary ovarian axis to recover from lactational suppression and ovulation resumes.
Baby is 6 months old or older.	Counsel about need for another method.	After 6 months, the likelihood that breastfeeding alone will effectively prevent pregnancy is reduced. This is true because breastfeeding frequently is decreased due to regular supplementation of the baby's diet. (See above.)

13.6.4 Risk of Exposure to STIs, Including HIV/HBV

Clients should use condoms with or without spermicides in addition to breastfeeding if there is any chance that she or her partner is at risk for STIs, including HIV/HBV. A client should be encouraged to seek treatment should she ever feel that she or her partner is infected with a STI. Refer to Chapter Fourteen: Contraception and STI.

If mother is HIV-positive, there is a chance that HIV will be passed to the infant during birth or during the year following. Although HIV can be transmitted to the infant through breast milk, it is important that in resource poor settings the risks and benefits of breastfeeding be taken into consideration. The UNAIDS recommendation on breastfeeding by HIV sero-positive women in resource-poor setting is that women be encouraged to make an informed decision about infant feeding (i.e., consideration of the risks and benefits be individualized for each woman).

13.7 CONTRACEPTION FOR NON-BREASTFEEDING WOMEN

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

- Barriers, spermicides, and withdrawal with the resumption of sexual intercourse following delivery
- Hormonals, IUCDs or VSC—BEFORE the resumption of sexual intercourse following the delivery.

Due to pregnancy-induced risks of possible blood clotting problems (elevated coagulation factors) present until 3 weeks postpartum, COCs **should not** be started before that time. On the other hand, POCs can be started immediately postpartum because they do not increase the risk of blood clotting problems. **Figure 12-2** shows the recommended time of starting contraception for non-breastfeeding women.

Table 13-2: Contraceptive Method Information for the Postpartum Period

Method	Timing	Characteristics	Remarks
Lactational Amenorrhoea Method (LAM)	Should begin breastfeeding immediately (within one hour) after delivery. Highly effective for up to 6 months if fully breastfeeding and amenorrheic.	Considerable health benefits for both mother and infant. Gives time to choose and prepare for other contraceptive methods.	For greatest effectiveness, must be fully breastfeeding.

Method	Timing	Characteristics	Remarks
<p>COCs</p> <p>(Also see chapter on Combined Oral Contraceptives)</p>	<p>If breastfeeding, COCs: Should not be used during the 6–8 weeks postpartum. Should be avoided from 6 weeks to 6 months postpartum unless other more appropriate methods are not available or acceptable.</p> <p>If not breastfeeding, COCs can be started after 3 weeks postpartum.</p>	<p>During the first 6–8 weeks postpartum, COCs decrease the amount of breast milk. (This effect may continue for up to 6 months).</p> <p>During the 3 weeks postpartum, the estrogen in COCs slightly increases the risk of blood clotting problems.</p> <p>If client has resumed menses and sexual activity, start COCs only if reasonably sure she is not pregnant.</p>	<p>COCs should be the last choice for breastfeeding women less than 6 months postpartum.</p> <p>COCs may be given for women who were pre-eclamptic or had hypertension during pregnancy as long as BP is in normal range when starting COCs.</p> <p>There is no increased risk of blood clotting beyond the 3rd week postpartum.</p>
<p>POCs (implants, PICs and POPs)</p> <p>(Also see chapter on Subdermal Jadelle Implants and Depo-Provera)</p>	<p>Before 6 weeks postpartum, POCs are not the method of first choice.</p> <p>If using LAM, POCs may be delayed until 6 months postpartum.</p> <p>If not breastfeeding, can be started immediately.</p> <p>If not breastfeeding and more than 6 weeks postpartum or already menstruating, start POCs only if pregnancy can be ruled out.</p>	<p>During the first 6 weeks postpartum, progestin.</p> <p>No effect on quantity of breast milk.</p>	<p>Irregular bleeding may occur with POC use, even in lactating women.</p>
<p>IUCDs (Copper T 380A)</p> <p>(Also see chapter on IUCDs)</p>	<p>May be inserted immediately post placental pregnancy, after caesarean section or postpartum (within 48 hours of delivery).</p>	<p>No effect on quantity of breast milk.</p> <p>Fewer post insertion side effects (bleeding, pain) when IUCD inserted in breastfeeding women.</p>	<p>Requires trained provider for insertion.</p> <p>Client should be counselled and screened during prenatal period for post placental pregnancy insertion.</p> <p>First year IUCD removal rates are lower among breastfeeding women.</p> <p>Spontaneous expulsion rate higher (6–10%) than for interval insertion (lowest rates if inserted high in fundus within 10 minutes after placenta delivered).</p>

Method	Timing	Characteristics	Remarks
<p>Condoms and Spermicides (foam, cream, tablets)</p> <p>(Also see chapter on Barrier Methods and Withdrawal)</p>	<p>May be used any time postpartum.</p>	<p>No effect on quantity of breast milk.</p> <p>Useful as interim method if initiation of another chosen method must be postponed.</p>	
<p>Natural Family Planning</p> <p>(Also see chapter on LAM and Postpartum Contraception)</p>	<p>Not recommended until resumption of 3 regular menses. Client may begin charting at 3 weeks postpartum but should continue to use LAM.</p>	<p>No effect on quantity of breast milk or health of infant.</p> <p>Requires a high degree of couple motivation.</p>	<p>Cervical mucus difficult to “read” until menses have resumed and are regular (ovulatory).</p> <p>Basal body temperature fluctuates at night during breastfeeding. Thus, measuring “early morning” basal body temperature elevation after ovulation may not be reliable.</p>
<p>Withdrawal (Coitus Interruptus) or Abstinence</p> <p>(Also see chapter on Barrier Methods and Withdrawal)</p>	<p>May be used any time postpartum.</p>	<p>No effect on quantity of breast milk.</p> <p>Abstinence only is 100% effective. Withdrawal is less effective.</p>	<p>Withdrawal or long periods of postpartum abstinence not always practiced.</p> <p>Acceptable in cultures in which postpartum abstinence is traditional.</p> <p>Backup method needed if couple decides to resume intercourse.</p>
<p>Minilap</p> <p>(See Minilap)</p>	<p>May be performed immediately postpartum or within 48 hours, or else should be delayed until 6 weeks postpartum.</p>	<p>No effect on quantity of breast milk.</p> <p>Postpartum minilaparotomy is easiest to perform within first 48 hours of delivery.</p>	<p>Counselling and informed consent should take place prior to labour and delivery (during prenatal period).</p>
<p>Vasectomy</p> <p>(See NSV)</p>	<p>Can be performed anytime.</p>	<p>Not immediately effective.</p>	<p>Vasectomy performed at this time leads to less disruption of intercourse for the couple.</p> <p>Partner’s contact with health care system may be a good time for man to use services.</p>

Table 13-3: Postpartum Contraception for Non-Breastfeeding Women

Method	Timing
IUCD	<ul style="list-style-type: none"> • Immediately postpartum by trained provider • Intra-operative following C-section • 4 weeks after child birth
Condom, Spermicides	<ul style="list-style-type: none"> • As soon as sexual intercourse has resumed
Progestin Injectable (Depo-Provera)	<ul style="list-style-type: none"> • Immediately after delivery • Any time in the in the first 6 weeks after childbirth • Any time after 6 weeks postpartum and it is reasonably certain that the client is not pregnant
Subdermal Implants (Jadelle)	<ul style="list-style-type: none"> • Immediately after delivery • Any time in the first 6 weeks after childbirth • Any time after 6 weeks postpartum and it is reasonably certain that the client is not pregnant
Female Sterilization	<ul style="list-style-type: none"> • Immediately postpartum within 48 hours after childbirth • 6 weeks after child birth
Male Sterilization	<ul style="list-style-type: none"> • Anytime after childbirth
Combined Oral Contraceptive Pills	<ul style="list-style-type: none"> • Start 3 weeks after childbirth

Table 13-4: Postpartum Contraception for Breastfeeding Women

Method	Timing
LAM	<ul style="list-style-type: none"> • Begin breastfeeding immediately after delivery • Highly effective for up to 6 months if fully breastfeeding and amenorrheic
Condoms	<ul style="list-style-type: none"> • When sexual activity is resumed
IUCD	<ul style="list-style-type: none"> • Immediately postpartum by trained provider • Intra-operative following C-section • 4 weeks after childbirth
Female Sterilization	<ul style="list-style-type: none"> • Immediately postpartum within 48 hours after childbirth • 6 weeks after delivery
Male Sterilization	<ul style="list-style-type: none"> • Anytime after childbirth
Progestin Injections	<ul style="list-style-type: none"> • 6 weeks after childbirth
Jadelle Implants	<ul style="list-style-type: none"> • 6 weeks after childbirth
Combined Oral Contraceptive Pills	<ul style="list-style-type: none"> • 6 months after childbirth

**CHAPTER
FOURTEEN**

14

**POST ABORTION CARE
COUNSELLING AND
CONTRACEPTION**

CHAPTER FOURTEEN

POST ABORTION CARE COUNSELLING AND CONTRACEPTION

14.1 BASICS

Linking post abortion care with family planning services increases access to family planning. This linkage will help in preventing future unwanted pregnancies and yet another episode of abortion care services.

14.2 LINKING POSTABORTION CARE TO FAMILY PLANNING

Provision of comprehensive abortion care is one of the few occasions when a woman and her partner come in contact with the health care system. Therefore, it represents an important opportunity for providing contraceptive counselling information and services.

Postabortion family planning should include the following components:

- Counselling about contraceptive needs in terms of the client's reproductive goals
- Choices among various methods
- Assurance of contraceptive supply
- Access to follow-up care
- Information about the need for protection against STIs

Postabortion family planning should also be based on an individual assessment of each woman's situation:

- Her personal characteristics,
- Clinical condition, and
- The service delivery capabilities in the community where she lives.

Even if clients cannot receive comprehensive postabortion care at a given facility, or if assessment suggests complete abortion and therefore uterine evacuation is not necessary, counselling and family planning should be offered.

14.3 COUNSELLING FOR POSTABORTION FAMILY PLANNING SERVICES

Family planning counselling for women during postabortion care requires special considerations. Women experiencing loss of a pregnancy are in a special situation. This situation may be a planned one or unplanned one. If this situation is a planned one then additional counselling is to be provided to prevent future unwanted pregnancy. Clients need to be discouraged on taking abortion services as a substitute to family planning services. As in any situation, the needs and interests of the client must be respected.

Following needs to be considered while counselling abortion clients:

- Clients should be encouraged to understand the meaning of unwanted pregnancy and ways and means to avoid unwanted pregnancy thereby unwanted abortion care services

- Clients should be counselled on abortion services and the message of abortion services is not a substitute to family planning services should be clearly transferred
- Acceptance of contraception must not be a prerequisite for postabortion care services or treatment of complications.
- Family planning counselling can occur at anytime, before or after the procedure or treatment.
- The service provider must ascertain that the client is not limited by physical or emotional factors (sedation, severe pain and trauma) that would compromise the client's ability to make a clear decision. In this case, the client and/or partner should be given condoms, instructions for use, and referral and follow-up information.
- Counselling should include information on the rapid return of fertility (after 2 weeks) and potential for pregnancy before menses resume.
- If pregnancy was due to contraceptive failure, counselling must include effectiveness of methods.

14.4 WHEN TO START POSTABORTION FAMILY PLANNING

Postabortion family planning services need to be initiated immediately because ovulation may occur as early as 11 days after abortion and usually occurs before the first menstrual bleeding. All women receiving postabortion care need counselling and information to ensure they understand:

- That they can become pregnant again before the next menses;
- That there are safe, effective contraceptive methods to prevent pregnancy temporarily or permanently; and
- Where and how they can obtain family planning services and appropriate methods.

14.5 POSTABORTION CONTRACEPTIVE METHODS

All modern methods of contraception are appropriate for use after abortion as long as the service provider:

- Screens the woman for the standard precautions for use of a particular method, and
- Gives adequate counselling.

It is recommended that women should not have intercourse until postabortal bleeding stops. Recommendations for contraceptive use following abortion are similar to those for interval use (i.e., women who have not been pregnant within the last 4 to 6 weeks and are not breastfeeding).

Table 14-1: Postabortion Use of Various Contraceptive Methods

Method	Timing After Abortion	Characteristics	Remarks
COCs and Progestin Only Contraceptives (POCs) (implants, progestin injectable contraceptives (PICs) and POPs)	Start COC or POC use immediately, preferably on the day of treatment.	Can be started immediately even if infection is present. Highly effective. Immediately effective. Minimize blood loss (i.e., improve anaemia), especially COCs.	Provide client with adequate supply of pills for 3 months and refer appropriately for ongoing care.
IUCDs	IUCDs can be inserted immediately if high-risk condition and presence of infection can be ruled out. Be sure there is no uterine infection. If infection suspected, delay insertion until the infection has been resolved for 3 months.		The woman should be counselled before the treatment. If she selects an IUCD and the conditions are favourable, it can be inserted immediately after the manual vacuum aspiration (MVA) treatment. If adequate counselling and informed decision-making cannot be guaranteed, delay insertion and provide a temporary interim method. Following second trimester abortion, the uterine cavity is larger and the risk of perforation during insertion is greater.
Barriers (condoms) and Spermicides (foam, cream, suppositories, tablets)	Start use as soon as intercourse is resumed.	Good interim method if initiation of another more effective method must be postponed.	
NFPM	NFPM is not recommended for immediate postabortion use.		The first ovulation after an abortion will be difficult to predict and the method is unreliable until a regular menstrual pattern has resumed.
Minilap	Technically, minilap can be performed immediately after treatment of abortion complications unless infection or severe blood loss is present. Do not perform until infection is fully resolved (3 months) or injury healed.	Minilap after a first trimester abortion is similar to an interval procedure; after a second trimester abortion it is similar to a postpartum procedure.	Adequate counselling and informed decision-making and consent must precede minilap; this often is not possible at the time of emergency care.
Vasectomy	May be performed at any time. Timing is not related to abortion.	Not immediately effective; therefore an interim contraceptive method must be used.	Adequate counselling and informed decision-making and consent must precede voluntary sterilisation procedures (vasectomy); this often is not possible at the time of emergency care.

Table 14-2: Guidelines for Contraceptive Use by Clinical Condition Following Abortion

Clinical Conditions	Precaution	Recommendation
<p>Confirmed or Presumptive Diagnosis of Infection</p> <p>Signs and symptoms of sepsis/ infection</p> <p>Signs of unsafe or unclean induced abortion</p> <p>Unable to rule out infection</p>	<p>IUCDs: Do not insert until risk of infection ruled out or infection fully resolved (approximately 3 months).</p> <p>Female voluntary surgical sterilisation: Do not perform procedure until risk of infection ruled out or infection fully resolved (approximately 3 months).</p>	<p>COCs: can begin use immediately.</p> <p>POCs: can begin use immediately.</p> <p>Barriers and Spermicides: can be used when sexual activity is resumed.</p> <p>Male Partner Sterilization: at any time if desired.</p>
<p>Injury to Genital Tract</p> <p>Uterine perforation (with or without bowel injury)</p> <p>Serious vaginal or cervical injury, including chemical burns</p>	<p>IUCDs: Do not insert until serious injury healed.</p> <p>Spermicides: Do not use until vaginal or cervical injury healed.</p> <p>Female voluntary surgical sterilisation: Do not perform procedure until serious injury healed.</p>	<p>COCs: can begin use immediately.</p> <p>POCs: can begin use immediately.</p> <p>Condoms: can be used when sexual activity is resumed.</p> <p>Male Partner Sterilization: at any time if desired.</p>
<p>Severe Bleeding (haemorrhage) and Related Severe Anaemia (Hb less than 7g/dl or Hct less than 20%)</p>	<p>Female voluntary surgical sterilisation: Do not perform procedure until the cause of haemorrhage or anaemia resolves.</p>	<p>COCs: can begin use immediately (beneficial when haemoglobin is low).</p> <p>Barriers and Spermicides: can be used when sexual activity is resumed.</p> <p>Male Partner Sterilization: at any time if desired</p> <p>Implants: Delay insertion until acute anaemia improves.</p> <p>PICs: Delay injection until acute anaemia improves.</p> <p>POPs: Use with caution until acute anaemia improves.</p> <p>IUCDs: (inert or copper-bearing): Delay insertion until acute anaemia improves.</p>

**CHAPTER
FIFTEEN**

15

**CONTRACEPTION AND
STI, HIV/AIDS**

CHAPTER FIFTEEN

CONTRACEPTION AND STI, HIV/AIDS

15.1 BASICS

It is important to provide STI screening for family planning clients. Sexually transmitted disease and family planning services overlap substantially. STIs are frequently encountered in family planning clients, especially in certain high-risk groups (e.g., clients who have more than one sexual partner). Furthermore, some contraceptive methods have a range of characteristics—from protecting against STI transmission to increasing the risk of complications from STI infection. The main linkages between contraception and STI services are:

- Prevention
- Client screening
- Counselling
- Treatment

More about HIV and AIDS

- HIV is the virus that causes acquired immune deficiency syndrome (AIDS). HIV slowly damages that body's immune system, reducing its ability to fight other diseases.
- People can live with HIV for many years without any signs or symptoms of infection. Eventually, they develop AIDS- the condition when the body's immune system breaks down and is unable to fight certain infections, known as opportunistic infections.
- There is no cure for HIV infection or AIDS, but antiretroviral (ARV) therapy can slow how the disease progresses, improve the health of those with AIDS, and prolong life. ARVs also can reduce mother –to- child transmission at the time of delivery. Opportunistic infections can be treated.
- Family planning service providers can help with prevention and treatment efforts for HIV/AIDS, by:
 - Counselling about ways to reduce risk of infection
 - Refer clients for HIV counseling and testing and for HIV care and treatment if the clinic does not offer such services.

15.2 SERVICE DELIVERY

15.2.1 Clinical Assessment

Prevention

- high-risk sexual behaviours
- the protective benefits or disadvantages of specific contraceptive methods
- condom use for protection against transmission of STIs including HIV

15.2.2 Client screening

The risk of STIs including HIV in all clients should be assessed. Effective screening depends on the identification of the presence signs or symptoms of STI and risk assessment. Costly laboratory/microscopy tests are not required. In order to assess STI risk and effectively screen clients, the service provider should:

- be knowledgeable about high-risk sexual practices
- be aware of the signs and symptoms of STIs
- be aware of which STIs are particularly common in the client population
- carefully evaluate clients in whom STIs are suspected, based on their medical history or physical examination findings

Sexual behavior that can increase exposure to STIs includes:

- Sex with a partner who has STI symptoms
- A sex partner who has recently been diagnosed with or treated for an STI
- Sex with more than one partner- the more partners, the more risk
- Sex with a partner who has sex with others and does not always use condoms

Where many people in the community are infected with STIs, sex without a condom may be risky with almost any new partner.

15.2.3 STI screening history should include

- Do you have a vaginal/penile sores or discharge?
- In the past year, have you had a genital tract problem such as a vaginal/penile discharge, ulcers or skin lesions in your genital area?
- Has your sex partner been treated for a genital tract problem, such as discharge from the vagina/penis or swollen groin glands, in the last 3 months? Which?
- Do you know if your sex partner has other sex partners?
- Are you or your partner in a profession that puts you at high risk (e.g., commercial sex worker, MSM, driver, military, migrants)?
- Have you had more than one sex partner in the last 3 months?
- Do you think that you might have a STI?

15.2.4 Counselling issues

Clients identified with high-risk sexual behaviours should receive counselling on the risks and benefits of particular contraceptive methods. Two types of contraceptive may be required: a highly effective form of contraceptive to prevent pregnancy, and condoms to prevent STIs. Therefore, it is important to offer condoms to all clients, regardless of which contraceptive method they choose.

15.2.5 Consequences of STIs

- Increased risk of HBV and HIV transmission
- Ectopic pregnancy (7–10 times increased risk in women with history of PID)

- Increased risk of cervical cancer Human Papilloma Virus (HPV)
- Chronic abdominal pain (18% of females with a history of PID)
- Infertility:
 - 20–40% of males with untreated Chlamydia and gonorrhoea
 - 55–85% of females with untreated PID (8–20% of females with untreated gonorrhoea develop PID)

In addition, infants can be infected at birth with blinding eye infections and pneumonia, suffer central nervous system damage or die as a result of STIs.

15.3 CLINICAL PROCEDURE

In primary health care facilities, diagnosis usually rests solely on clinical findings (signs/symptoms) or risk assessment. In secondary health care facilities, where pelvic examinations can be done and a microscope and simple laboratory testing are available, greater accuracy in managing the most common STIs is often possible. For further information on the clinical findings, diagnosis and treatment of STIs, refer to GoN National STI Case Management Guidelines.

If a client or partner has any clinical findings of STIs, both the client and partner should be treated. Many methods of contraception are appropriate in this setting, should the client be currently using or have an interest in using family planning services.

Table 15-1: Counselling Outline and Clinical Recommendations

Method	Remarks Regarding STIs
COCs (Also see chapter on Combined Oral Contraceptives Pills)	<ul style="list-style-type: none"> ● No protection against STIs (e.g., HBV, HIV). ● If high risk behaviour or previous STI detected in screening history, concurrent use of condoms is recommended. ● Some protective effects against PID.
POCs (implants and Depo) (Also see chapters on Depo- Provera and Implants)	<ul style="list-style-type: none"> ● No protection against STIs (e.g., HBV, HIV). ● If high-risk behaviour or previous STI detected in screening history, concurrent use of condoms is recommended. POCs offer some protective effects against PID.
IUCDs (Also see chapter on IUCDs)	<ul style="list-style-type: none"> ● No protection against STIs (e.g., HBV, HIV/AIDS). ● Should not be used by women at risk for or with clinical findings of STIs. If such a client insists on using an IUCD, concurrent use of condoms is required. ● Should not be used by women with current, recent (less than 3 months) or recurrent PID. ● If a clinical finding of a simple vaginal infection is present (candidiasis or bacterial vaginosis), treat and recheck before IUCD is inserted.
Condoms (male and female) (Also see chapter on Non-Clinical Methods)	<ul style="list-style-type: none"> ● Protect against STIs (e.g., HBV, HIV) ● To be fully effective, condoms must be worn at all times during genital contact, and with every act of intercourse.

Method	Remarks Regarding STIs
Minilap and NSV (Also see chapter on Minilap and NSV)	<ul style="list-style-type: none"> No protection against STIs (e.g., HBV, HIV/AIDS). If high-risk behaviour or previous STI detected in screening history, concurrent use of condoms is recommended.

Table 15-2: Special Family Planning Considerations for Clients with STIs, HIV, AIDS, or on Antiretroviral Therapy

Method	Has STIs	Has HIV or AIDS	On Antiretroviral (ARV) Therapy
Intrauterine device (copper-bearing or hormonal IUCDs)	Do not insert an IUCD in a woman who is at very high individual risk for gonorrhea and chlamydia, or who currently has gonorrhea, chlamydia, purulent cervicitis, or PID. (A current IUCD user who becomes infected with gonorrhea or chlamydia or develops PID can safely continue using an IUCD during and after treatment.)	A woman with HIV can have an IUCD. A woman with AIDS should not have an IUCD inserted unless she is clinically well on ARV therapy. (A woman who develops AIDS while using an IUCD can safely continue IUCD.)	Do not insert an IUCD if client is not clinically well.
Female sterilization	If client has gonorrhea, chlamydia, purulent cervicitis, or PID, delay sterilization until the condition is treated and cured.	Women who are infected with HIV, have AIDS, or are on ARV therapy can safely undergo minilap. Special arrangements are needed to perform minilap on a woman with AIDS. Delay the procedure if she is currently ill with AIDS-related illness.	
Vasectomy	If client has scrotal skin infection, active STI, swollen, tender tip of penis, sperm ducts, or testicles, delay sterilization until the condition is and cured.	Men who are infected with HIV, have AIDS, or are on antiretroviral therapy can safely undergo vasectomy. Special arrangements are needed to perform vasectomy on a man with AIDS. Delay the procedure if he is currently ill with AIDS-related illness.	
Hormonal methods (combined oral contraceptives, progestin-only pills, progestin-only injectables, monthly injectables, patch, ring, implants)	Can safely use any hormonal method.	Can safely use any hormonal method unless she is on ARV therapy that includes a ritonavir-boosted protease inhibitor. See column to right. →	If her ARV therapy includes a ritonavir-boosted protease inhibitor, she generally should not use combined oral contraceptives, progestin-only pills, monthly injectables, the patch, or the ring. This type of ARV may make these methods less effective. She can use progestin-only injectables or implants. Women whose ARV therapy does not include a ritonavir-boosted protease inhibitor can use any hormonal method.

**CHAPTER
SIXTEEN**

16

**CONTRACEPTION
FOR WOMEN NEAR
MENOPAUSE**

CHAPTER SIXTEEN

CONTRACEPTION FOR WOMEN NEAR MENOPAUSE

16.1 BASICS

Women over the age of 35 years are in need of safe and effective contraception because pregnancy can carry increased health hazards (morbidity and mortality) for mothers and their babies. Fertility declines in women over 35 years, resulting in less attention paid by these women to contraceptive protection. Pregnancies, however, are possible and therefore contraception should be provided.

There are specific problems related to pregnancy in this age group:

- Maternal mortality among women in their forties is about five times greater than that of women in their twenties
- Perinatal mortality doubles as maternal age doubles
- Chromosomal abnormalities, particularly Down's syndrome, increases
- Spontaneous abortion rates increase

The possibilities of these problems make the importance of reliable contraception for this age group very clear.

In the past, because of a higher dose of estrogen in early COCs (more than 50 Pg EE), women over 35 were considered to be at increased risk for serious complications (heart attack, stroke and blood clotting problems). Recent data, however, based on women using the newer low-dose COCs (30-35 pg EE), show that these women now can safely use hormonal methods, until they are menopausal and beyond, if they have no additional risk factors.

Although some women may be concerned about the risk of breast cancer if they continue to use hormonal methods after age 35, current data show no overall association between breast cancer and increasing duration of COC use. Women, over 35 years who smoke, however, should be encouraged to stop smoking regardless of whether they are using COCs or not.

In summary, women near menopause can continue to use contraceptive methods, including low dose COCs. By itself, age does not restrict women from using any contraceptive method.

Any woman who has reached menopause and has no bleeding for 12 months in a row is considered not ovulating and do not need any contraceptive method.

In the following table factors relevant to the use of specific contraceptives by women near menopause are discussed.

Table 16-1: Considerations for Women near menopause

Method	Remarks
COCs	<ul style="list-style-type: none"> • COCs should not be used by women over 35 years of age who are heavy smokers (>15 cigarettes per day). These women should be encouraged to stop smoking. • Use of method not usually recommended unless other more appropriate methods are not available or not acceptable • Low-dose COCs may be a source of estrogen replacement during perimenopause providing both the needed contraception and relief from uncomfortable symptoms of menopause.
POCs (implants,PICs and POPS)	<ul style="list-style-type: none"> • POCs can be used safely by women over 35 years of age and in the perimenopausal years (40-50s) even if they are heavy smokers. • Implants are highly recommended for women over 35 who want long- term contraception, especially if client has had trouble using another method or does not want voluntary sterilization.
IUCDs	<ul style="list-style-type: none"> • May be used safely by women if not at risk for STIs (e.g., HBV, HIV/AIDS). • May be the preferred method for women because newer IUCDs (copper- and progestin-releasing): <ul style="list-style-type: none"> • are highly effective, • require no follow-up care unless there are problems, and • are long-term methods (Copper T 380A effective at least 12 years). • Progestin containing IUCDs reduce menstrual flow; heavy menses are a frequent complaint in this age group. • Expulsion rates fall as women grow older, and are lowest in women over 40 years of age • Insertion may be more difficult due to tightening of the cervical canal
Condoms	<ul style="list-style-type: none"> • Only method that protects against other STIs (e.g., HBV, HIV/AIDS) • Best used by women who can predict acts of intercourse and who are highly motivated to avoid pregnancy
Minilap	<ul style="list-style-type: none"> • Appropriate for clients/couples who are certain about desire for permanent contraception
Emergency Contraceptive pills	<ul style="list-style-type: none"> • Can be used by women of any age, including those who cannot use hormonal methods on a continuing basis

**CHAPTER
SEVENTEEN**

17

**CONTRACEPTION
FOR ADOLESCENTS**

CHAPTER SEVENTEEN

CONTRACEPTION FOR ADOLESCENTS

17.1 BASICS

In the Program of Action (POA) adopted at International Conference on Population and Development (ICPD) held in Cairo in 1994, the international community acknowledged for the first time that adolescent sexual and reproductive health involves a specific set of needs, which are distinct from adult needs. In Nepal, the Ministry of Health developed the National Adolescent Health and Development Strategy (2000) to address adolescent reproductive health and development issues and provide standard information and services.

Nepal uses the World Health Organization definition of adolescence as the **period between 10-19 years of age**. Adolescence is a period of transition from childhood to adulthood and this is not only period of growth, exploration and opportunities, but also a time of risk taking, experimentation, and vulnerability. While adolescence generally is a healthy period of life, adolescents are often not well informed about how to protect their sexual and reproductive health, thus are at potential risk for unwanted pregnancies, unsafe abortion, STIs, and HIV. They are less informed, less experienced, less comfortable, and have fewer resources to access reproductive health services including family planning than adults. Adolescents need special attention, guidance and support to address their specific concerns, problems and needs and to assist them in developing responsible behavior and a healthy life style.

17.2 ELEMENTS OF CARE

Adolescent Reproductive Health Care services should be friendly, affordable, accessible, confidential and non-judgmental in order to appeal to adolescents and improve utilization of health care services.

The following are important components of Adolescent Reproductive Health Care:

- Counseling and education about sexual and reproductive health
- Prevention and management (counseling, education, referral or provision of services) of STIs (including HIV/HBV)
- Counseling and education, with referral or provision of services for pregnancy prevention, family planning, pregnancy management
- Linkages and referrals to other reproductive health care and other facilities

This chapter deals with Contraception/Family Planning services. For other component of adolescent health service **Please refer** to *National Medical Standard Vol II, Chapter Five, Adolescent Health Services*.

17.3 PRE-REQUISITES

17.3.1 Adolescent Friendly Services

The services should have characteristics of Adolescent Friendly Services in terms of program, provider and health facility.

Programmatic Characteristics:

Following are key Programme characteristics;

- Adolescents involvement in program design (adolescent input should be solicited about what services should be offered and how including perceptions of welcome, privacy and confidentiality)
- Both married and unmarried boys and girls are welcomed and served
- Parental involvement encouraged but not required
- Affordable fees
- Adequate supply of commodities
- Short waiting times
- Educational material available on-site
- Linkages with schools, youth clubs, and other institutions
- Alternative ways to access information, counseling, and services

Provider Characteristics:

Adolescent services involve counseling and a variety of services, some of which may not be offered on site. All facilities should have staff to provide basic counseling, basic examination and assessment, and know where to refer for services not available on site.

- Counseling: Many appropriate staff (eg. FCHV, MCHW, VHW, ANM, AHW, HA, MBBS or higher) trained on adolescent issues and provide non-judgmental counseling.
 - Demonstrate respect for young people
 - Maintain privacy and confidentiality
 - Allow adequate time for client and provider interaction
- For contraceptive services: The type of care needed will determine what cadre (as above) is appropriate.

Facilities: Health Facility Characteristics:

The minimum facility for providing Adolescent Reproductive Health Services should include:

- A place to register the client and adequate waiting area
- Sufficient Privacy:
 - A private/curtained area for consultation and counseling
 - A private/curtained procedure area equipped for clinical procedures
- Convenient Hours
- Convenient Location
- Adequate Space
- Comfortable surroundings

17.3.2 Equipment and Supplies of Adolescent Friendly Services

There is no unique equipment or supplies needed to provide adolescent friendly services, however availability of adolescent specific educational materials is required.

17.3.3 Record Keeping and Reporting

Information on adolescent visits should be registered and reported to the FHD according to the regular format and schedule. Attempts should be made to maintain the confidentiality of these records as appropriate.

17.4 SERVICE DELIVERY

17.4.1 Counseling and Informed Choice

Counseling should be flexible and responsive to individual needs. Counseling adolescent clients may require a different approach than the regular FP counseling. The client's partner or other immediate family member should be included in a counseling session only with the consent of the client. For general FP counseling, **pleaser refer** *Chapter One: Counseling and Informed Choice*.

Counselor may need special training in dealing with the particular needs and concerns of adolescents and should:

- create a safe environment in which adolescents can express their needs
- build rapport with adolescents through use of language they are familiar with
- ensure confidentiality, including agreeing not to discuss decisions with parents (guardians), as appropriate
- be open and nonjudgemental in response to their questions and expressions about their sexuality

(For detail please refer to NMS Vol II)

Counselling for adolescents should include discussion of the:

- Benefits of certain contraceptive methods (condoms) in protecting against STIs (including HBV and HIV/AIDS) as well as preventing pregnancy.
- Safety of contraception is not affecting long-term fertility.
- Appropriate sex education that enables adolescents to develop the knowledge and confidence to make decisions related to their sexual behaviour, including the decision not to engage in sexual intercourse until they are ready to do so.
- Sexuality and reproductive health with emphasis on adolescent issues: self-esteem, appearance, negotiating unwanted sexual advances, pressure from peers or partners.

17.4.2 Clinical Assessment:

For successful management of the problems of adolescents, service providers should obtain detail information. For most of the adolescent client, the clinical history taking and examination particularly reproductive health related is a new experience thus is hesitant to allow examination. Therefore following things should be considered while examining an adolescent:

- Presence of a attendant/chaperon
- Be gentle
- Informed consent (explain why and what you are going to do)
- Watch very carefully the comfort level of the client
- Avoid unnecessary examination or clinical procedure (eg. pelvic examination for adolescents requesting COCs) which may discourage them from using the method.

17.4.3 Counseling on Pregnancy Prevention/ Family Planning

During counseling it is important to discuss about safer sex, including abstinence, non-penetrative sex and all relevant FP methods including condoms and emergency contraception (EC). Most of the available contraceptive methods are safe and effective for adolescents to use (see below Table 17.1).

In our society, marriage of adolescents is still widespread. These married adolescents face many of the same issues as unmarried adolescents. In addition they are usually under pressure from their families and society to bear children soon after marriage. It is important to emphasize pregnancy prevention and following discussion point would be useful.;

- High risk of contracting STIs (including HBV and HIV/AIDS) through unprotected sexual intercourse
- Unwanted pregnancy resulting in unsafe abortion
- Early childbearing (less than 19 years of age) resulting in high risk of complications for both mother and child due to the mother's physical immaturity with respect to labour and birth
- Especially for females, early childbearing leading to reduced opportunities for further education and employment that in turn affects their social and cultural development

17.5 EMERGENCY CONTRACEPTION FOR ADOLESCENTS

Emergency contraception has an important place in family planning services for adolescents because young people may have difficulties in obtaining contraceptive supplies and are often likely to have unplanned and unprotected sexual intercourse. Emergency contraception can be used as a back-up in case of condom breakage or improper use of the withdrawal method. It is important to publicize the availability of emergency contraception together with thorough counselling.

- All emergency contraception methods are effective and safe for use in adolescence.
- IUCDs are less desirable except for parous adolescents with low risk of STIs.

For more detailed information refer to Chapter 18: **Emergency Contraception.**

17.6 CONTRACEPTIVE METHODS

Under this section only factors relevant to their use by adolescents are provided. Detailed information for each method is given in the relevant chapters on that method.

Various methods of contraception are suitable for adolescents. Adolescent women are often less tolerant to side effects than older women. With counseling, however, they will know what to expect and may be less likely to stop using their methods. Effective contraception for adolescents, whether they are married or unmarried, is especially important because of more serious consequences of unwanted pregnancies. An important consideration is better protection against possible pregnancy. It should be remembered that adolescents may require two forms of contraceptions: a highly effective form of contraception to prevent pregnancy and condoms to prevent STIs/HIV.

Table-17-1: Counselling Outline and Clinical Recommendations for Contraceptive methods

Method	Remarks Regarding Adolescents
COCS (Also see chapter on Combined Oral Contraceptive Pills)	<ul style="list-style-type: none"> • May be safely used once an adolescent has started menstruating. • Requires strong client motivation. Forgetfulness and irregular use increase method failure. • Conditions requiring precautions are rare in adolescents. • No protection against STIs (e.g., HBV, HIV/AIDS); therefore adolescents may need to use condoms as well. • WHO MEC - Category 1
Progestin only Pills (POPs)	<ul style="list-style-type: none"> • May be safely used once an adolescent has started menstruating. • No protection against STIs (e.g., HBV, HIV/AIDS); therefore adolescents may need to use condoms as well. • WHO MEC - Category 1
Implants (Also see chapter on Implants)	<ul style="list-style-type: none"> • Recommended for adolescents who want intermediate or long term effective contraception, especially if they had trouble with compliance while using another method. • Should be well counselled about the possibilities of weight gain, irregular bleeding/spotting which can be bothersome to adolescents. • No protection against STIs (e.g., HBV, HIV/AIDS), therefore adolescents may need to use condoms as well. • Implants are visible beneath the skin. • Lack of need for supplies makes this method attractive to adolescents. • WHO MEC - Category 1
DMPA (Also see chapter on DMPA)	<ul style="list-style-type: none"> • Highly recommended for adolescents who require intermediate-duration effective contraception, especially if they had trouble with compliance while using another method. • Should be well counselled about the possibilities of weight gain, irregular bleeding/spotting which can be bothersome to adolescents. • Lack of need for supplies and non-visibility make this method attractive to adolescents. • Some studies suggest that use of Depo-Provera in adolescents (below 18) within 2 years of menarche may pose a risk of osteoporosis. • No protection against STIs (e.g., HBV, HIV/AIDS); therefore adolescents may need to use condoms as well. <p>WHO MEC - Category 2 (below 18 yr) and Category 1 (18 and above)</p>
IUCDs (Cu-T) (Also see chapter on IUCDs)	<ul style="list-style-type: none"> • Can be an adequate option for parous adolescents who require long-term protection against pregnancy. • IUCDs are more likely to come out among women who have not given birth because their uterus is small. <p>WHO MEC - Category 2 (below 20 yr) and Category 2 (20 or above)</p>
Condoms (both male and female) (Also see chapter on Condoms)	<ul style="list-style-type: none"> • Protects against STIs (e.g., HBV, HIV/AIDS). • Very effective only if used properly. • Counselling on the availability of emergency contraception should be given in case of condom breakage. • Should be made widely available for adolescents. • Provides immediate protection. • Not clinic dependent. • Requires planning and couple motivation with each act of intercourse. Not always at hand during unplanned intercourse.

<p>Withdrawal (Coitus Interruptus)</p>	<ul style="list-style-type: none"> • Withdrawal may be the only method available to many adolescents. They should be fully informed about the technique. • Withdrawal method requires the man to know when he is about to ejaculate so he can withdraw in time. This may be difficult for some young men. • Withdrawal offers no protection against STIs (e.g., HBV, HIV/AIDS).
<p>Fertility Awareness Method</p>	<ul style="list-style-type: none"> • Until adolescent women has regular menstrual cycle, this methods should be used with caution. • Need a backup method or ECPs on hand in case abstinence fails.
<p>Voluntary Surgical Contraception (Also see chapter on NSV and Minilap)</p>	<ul style="list-style-type: none"> • Sterilization is permanent method so not appropriate for adolescents in most circumstances. • Proper in-depth counseling must be done. Provide with great caution. Young people and people with few or no children are among the those most likely to regret sterilization • For female sterilization: WHO MEC - Category C (caution)

Note: WHO MEC- WHO Medical Eligibility Criteria—see appendix H

**CHAPTER
EIGHTEEN**

18

**EMERGENCY
CONTRACEPTION**

CHAPTER EIGHTEEN

EMERGENCY CONTRACEPTION

18.1 BASICS

Emergency contraception is contraception provided to women to prevent unwanted pregnancy following an unprotected sexual intercourse.

In unprotected intercourse, and method failure (e.g., condom breakage), highly effective emergency methods are available to prevent unwanted pregnancy. Health care providers should regularly inform clients about emergency contraception. Family Planning programs should make emergency contraception available and accessible by:

- providing emergency contraception services every day
- having numerous providers who are familiar with its use
- allowing packaging of oral contraceptives for use as emergency contraception (However, separate packaging for emergency contraception is available in Nepal)
- allowing providers who do not typically initiate oral contraceptive pills (i.e., MCHWs or VHWs) to provide the method and counsel clients to seek regular contraceptive services

18.1.1 Emergency Contraception Available/Approved in Nepal

Women who may need this service (including those using barrier methods) should be aware of it and know where they can easily obtain it. Ready access is important because of the short time period after unprotected intercourse during which emergency contraception is likely to be effective. Health professionals to whom these women may turn should either be able to give the treatment themselves or refer the women as a matter of urgency to a suitable health care facility. Insertion of an IUCD with its necessary examination is more intrusive than the use of oral pills and may be unacceptable to some women, especially if they have only recently started sexual intercourse or are the victims of rape.

There are three main methods available in Nepal that can be used as emergency contraceptives. Some of these are available from health network of MoHP and some other is available through social marketing system. E-Con and Postinor are available through social marketing system. They are:

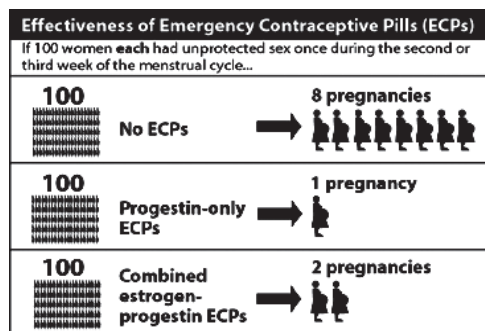
- Combined oral contraceptive pills (COCs)
- Intrauterine Contraceptive Devices (IUCDs)
- Progestin-only pills (POPs)

While all contraceptives are appropriate **before** intercourse, several methods also can be used within a short time **after** unprotected intercourse. Often called “morning after pills,” it is more appropriate to call them **secondary or emergency contraceptives**. These names remove the idea that the user must wait until the morning after unprotected intercourse to start Emergency Contraception.

Emergency Contraception Pills should not be used as a regular method of contraception. A woman who uses emergency contraceptive pills regularly is more likely to have an unintended pregnancy than a woman who uses another contraceptive regularly.

18.1.2 Effectiveness

- If 100 women each had sex once during the second or third week of the menstrual cycle without using contraception, 8 would likely become pregnant.
- If all 100 women used progestin-only ECPs, one would likely become pregnant.
- If all 100 women used estrogen and progestin ECPs, 2 would likely become pregnant.



Emergency Contraceptive Pills can be taken up to 5 days after unprotected sex. However sooner it is taken, the better.

18.1.3 Return of Fertility after taking ECPs

No delay. Taking ECPs prevents pregnancy only from acts of sex that took place in the 5 days before. They will not protect a woman from pregnancy from acts of sex after she takes ECPs—not even on the next day. To stay protected from pregnancy, women must begin to use another contraceptive method at once.

18.2 SERVICE DELIVERY

18.2.1 Eligibility

Indications

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

- When no contraceptive method has been used
- In case of contraceptive accident or misuse, for example:
 - condom breakage, slippage or misuse
 - failed coitus interruptus
 - miscalculation of the periodic abstinence method
 - IUCD expulsion
 - unprotected intercourse prior to the effective time of vasectomy
- When the woman has been a victim of sexual assault

If a woman is breastfeeding but not using LAM (refer to Chapter Thirteen: Postpartum Contraception and LAM) and thinks she might be at risk of pregnancy, emergency contraception may be used.

Correcting Misunderstanding

Emergency contraceptive pills:

- Do not cause abortion
- Do not cause birth defects if pregnancy occurs
- Are not dangerous to a women's health
- Do not promote sexual risk taking
- Do not make women infertile

Precautions**Risk of already being pregnant**

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

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

If pregnancy is suspected, **before** providing emergency contraception, counsel the client regarding her options and the theoretical risk of potential problems if she is already pregnant. In general, a one-time use of oral contraceptives as emergency contraception would have no impact on an early, unrecognised pregnancy.

Risk to clients with vascular problems

Women who are at increased risk of vascular problems (current or past blood clotting problems, heart attack or stroke) should be advised of a slight additional risk of a serious complication if they use COCs or estrogen-only pills. COCs taken for a short duration (2 days) in a physically active client, however, are highly unlikely to cause a serious problem even in women with these risks. In addition, pregnancy causes a much greater risk to these women. Therefore, do not withhold treatment if the client requests it.

Contraindication

There are no known contraindications to the use of hormonal emergency contraception. The dose of hormones used in emergency contraception is small and the pills are given for a short time, so the contraindications associated with continuous use of combined hormonal contraception do not apply.

IUCD as emergency contraceptives

- If it is possible to remove the IUCD at the next menses, some contraindications that apply to continuous use of IUCDs do not apply.

- In case of pelvic infection or a condition that poses a risk of introducing infection (e.g., in a woman with purulent cervicitis) the use of an IUCD should be avoided.
- The possibility that the woman may already be pregnant should be excluded, since insertion of an IUCD increases the risk of abortion.

18.3 CLINICAL PROCEDURE

Emergency contraception is prescribed as two oral doses, taken 12 hours apart, of combined estrogen and progestin (COCs) initiated within 120 hours of sexual act or progestin alone (POPs) initiated within 120 hours of unintended exposure. Women may experience nausea, especially with the combined pill method, and an anti-emetic may be prescribed. Adequate absorption occurs in the first hour after ingestion, but if vomiting occurs before this interval the dose should be repeated with an anti-emetic.

IUCD insertion within 5 days of sexual act is highly effective for prevention of pregnancy. Note that many circumstances leading to a need for emergency contraception are not compatible with safe use of the IUCD (e.g., possible risk of infection). Clients who receive an IUCD for emergency contraception should be followed up carefully to ensure that they remain good candidates for IUCD use.

18.4 SIDE EFFECTS

Some users report the following:

Changes in bleeding patterns including:

- Slight irregular bleeding for 1–2 days after taking ECPs
- Monthly bleeding that starts earlier or later than expected

In the week after taking ECPs:

- Nausea
- Abdominal pain
- Fatigue
- Headaches
- Breast tenderness
- Dizziness
- Vomiting

18.5 CLIENTS INSTRUCTIONS AND FOLLOW – UP

Clients who are provided emergency contraception should be counselled to expect a menses within 3–4 weeks. If they have not had a menses they should return to the clinic and a sensitive test for pregnancy should be performed. If positive, they should receive counselling and referral for antenatal care.

Table 18-1: Emergency Contraception

Methods	Timing	Remarks	Client Instructions
COCs	Should be taken within 120 hours of unprotected intercourse and repeated after 12 hours.	<ul style="list-style-type: none"> • 2% become pregnant Side effects: <ul style="list-style-type: none"> • Nausea • Vomiting • Breast tenderness, headache, dizziness • Irregular uterine bleeding: Some women may experience spotting. If menstrual period is delayed, the possibility of pregnancy should be excluded. • If pregnancy is not prevented, counsel client for antenatal care. 	COCs (low-dose) contains norgestrel (progestin) 0.3 mg and ethinyl estradiol (estrogen) 0.03mg in each pill Take 4 tablets as soon as possible, upto 120 hours after an unprotected sex ↓ 12 hours later ↓ Take 4 more tablets Total = 8 tablets
Progestin-Only Pills (POPs)	Should be taken within 120 hours of unprotected intercourse and repeated after 12 hours	<ul style="list-style-type: none"> • Less than 3% become pregnant • Same side effects as with COCs but significantly less severe and nausea, vomiting is minimal • If pregnancy is not prevented, counsel client for antenatal care (ANC) 	POPs (0.75 mg levonorgestrel, e.g., Postinor®) Take 1 tablet as soon as possible within 120 hours after unprotected sex ↓ 12 hours later ↓ Take 1 more tablet (Total dose = 1.5 mg of levonorgestrel) OR POPs (0.075 mg norgestrel, e.g., Ovrette®) Take 20 tablets within 120 hours ↓ 12 hours later ↓ Take 20 more tablets (Total dose = 3.0 mg of norgestrel)

Methods	Timing	Remarks	Client Instructions
IUCD	Should be inserted within 5 days of unprotected intercourse	<ul style="list-style-type: none"> • Less than 1% become pregnant • Few side effects • Provides long-term contraception as well • Failure increases with longer interval between unprotected intercourse and insertion • Insertion requires a minor procedure that must be performed by a trained service provider • Should not be inserted in women at risk for STIs (e.g., HBV, HIV/AIDS) • May not be advisable for young nulliparous clients 	<ul style="list-style-type: none"> • Counsel client about post-insertion spotting. Help her understand how to distinguish this from a menstrual period.

Note: Mestranol 50 µg is available as part of a COC pill in some areas of Nepal. This estrogen is two thirds as potent as ethinyl estradiol and therefore should be regarded as a low-dose oral contraceptive pill equivalent to the 30–33 µg ethinyl estradiol pills.

**CHAPTER
NINETEEN**

19

**INCREASING ACCESS
OF IUCD AND IMPLANT
SERVICES THROUGH
SATELLITE CLINICS**

CHAPTER NINETEEN

INCREASING ACCESS OF IUCD AND IMPLANT SERVICES THROUGH SATELLITE CLINICS

19.1 INTRODUCTION

Family Health Division has planned to expand FP services to reach all population including those unreached till now. The long term, temporary methods like IUCD and Implants are currently available from most district FPMCH clinics and selected PHCs. However provision of regular long term family planning services at peripheral level still remains a challenge. To address this situation, FHD plans to increase the access of these services through satellite clinics. In these clinics it is imperative to ensure that the clients receive adequate counseling before and after insertion of Implant or IUCD. It is also equally important that the services for removal of these methods be available at the same site if the client requests for removal due to various reasons.

19.2 OBJECTIVE

The objective of satellite clinic is to reach the clients who want IUCD or Implants services but do not have the access to it. This clinic would also provide an opportunity for the clients to fulfill their FP needs.

19.3 STEPS IN ORGANIZING SATELLITE CLINICS

- **Selection of site:**
 - The site should be a government health facility like PHC, HP or SHP.
 - Site selection should be based on need assessment i.e.
 - Where there is high demand of such services but no access to it.
 - Which marginalized community reside
 - Date of the service should be fixed after interaction and discussion with community stake holders and FCHVs.
- Prior to starting the satellite clinic, a visit to the site should be made to ensure the following:
 - **Infection Prevention:** Ensure that the site will have infection prevention provisions like hand washing facility, protection from dust and smoke, adequate lighting system etc.
 - **Confidentiality:** Site should have separate areas for counseling, examination & service provision to maintain client's confidentiality.
 - **Furniture and Instrument:** Site should have adequate furniture, equipments and instruments to provide quality services.
 - **Staff:** Site should have appropriate technical and administrative staffs.
- Prior to starting the services all the staffs in that site should receive orientation on the objective of satellite clinic, requirement of adequate instruments, equipments & furniture for provision of quality service, importance of proper counseling, eligibility criteria for selection of appropriate clients as well as other technicalities of service provision.

- Information should reach the prospective clients timely: Prospective clients should get information on date, time and availability of services before hand. These information can be disseminated through FCHV, community health workers, from health facility and BCC activities as well.
- Preparing a list of the prospective clients beforehand: If possible it is desirable to make a list of prospective clients before the actual service starts. This list will help in making necessary preparations in the most efficient way to ensure that there is adequate equipments, human resources etc for provision of quality services.
- In between the timing of satellite clinics there should be a service provider in that site who can adequately address client's problems and queries.
- Satellite clinics for IUCD and Implant should be organized regularly throughout the year (For example: once in every two week or monthly).

19.4 RECORDING AND REPORTING:

The services provided from these satellite clinics should be recorded in face sheets and service register in the health facility and these records should be inevitably incorporated during reporting.

APPENDIX- A (I)

Government of Nepal
Ministry of Health and Population, Department of Health Services

MASTER REGISTER

HMIS -1

Date

SN	Registration No		First Name	Family Name	Ethnic code*	Age		Address		Types of Service	Fee Structure	Remarks
	New	Old				Female	Male	VDC/Mun	Ward			

* Note: See at the back of register for ethnic code

APPENDIX- A (II)

Government of Nepal
Ministry of Health and Population, Department of Health Services

MULTI PURPOSE CONTACT CARD

HMIS -2

District-----

Name of the Institution-----

1. Master Register No:
2. Name of the Client -----
3. Age: -----
4. Sex: ----
5. Address (VDC/Mun): ----- Ward #------ Tole -----
6. Types of services and registration no.-----

6.1 Family Planning Service:	Pills	<input type="text"/>	Depo	<input type="text"/>	Male VSC	<input type="text"/>
	IUCD	<input type="text"/>	Implant	<input type="text"/>	Female VSC	<input type="text"/>

6.2 Diseases: Tuberculosis Leprosy

Date of T.T.inj given

6.3	1	2	3	4	5
-----	---	---	---	---	---

6.5 Other: -----

7. Diagnosis, treatment/ advice

Date	History/ Diagnosis	Treatment/Advice	Follow up Date	Signature

Note: Please bring this card when you return to the clinic.

Date	History/ Diagnosis	Treatment/Advice	Follow up Date	Signature

APPENDIX- A (III)

Government of Nepal
Ministry of Health and Population, Department of Health Services

FAMILY PLANNING CARD (FACE SHEET)

HMIS -12

Reg No:

Date:

Name of the service center:

District:

Address of client: District:VDC/Municipality: Ward No.

Detail	Name, Surname	Age	Education	Occupation
Wife				
Husband				

Birth details

Children	Total Live Birth	Age of the living Children			Remarks
No. of Daughter					
No. of Sons					

FP Contraceptives used before (✓): Condom Pills Depo-Provera

IUCD Implant Others..... None

Reason for discontinuation:

Wanted Children Physical Problem Not needed

Other (Specify)

Last menstrual period (LMP)

चिकित्सा सम्बन्धी विवरण (हार्मोनल साधन लिने सेवाग्राहीका लागि)

- | | |
|---|-------------------|
| १. कमलपित्त रोग लागेको | छ/छैन |
| २. खुट्टा सुनिने र छिटो छिटो सास चल्ने रोग | छ/छैन |
| ३. बेस्करी टाउको दुख्ने | हुन्छ/हुँदैन |
| ४. गर्भावस्थामा खुट्टा सुनिने र दुख्ने रोग लागेको | थियो/थिएन |
| ५. चिनी रोग भएको | छ/छैन |
| ६. स्तनमा गाँठा गुठी | छ/छैन |
| ७. रजस्वला महिना महिनामा | हुन्छ/हुँदैन |
| ८. दुई रजस्वला बीच रक्तश्राव | हुन्छ/हुँदैन |
| ९. रजस्वला अवधिमा रक्तश्रावको परिमाण | थोरै/धेरै/सामान्य |

चिकित्सा सम्बन्धी विवरण (आइ.यु.सि.डी. का लागि)

१. तल्लो पेट दुख्ने समस्या	छ/छैन
२. गन्हाउने पानी बग्ने समस्या	छ/छैन
३. तीन महिना यता पाठेघर सम्बन्धी संक्रमणको उपचार गरेको	हुन्छ/हुँदैन

Preferred Contraceptives

- Pills Depo-Provera Implant IUCD Minilap
 Vasectomy ECP

If ECP used, please fill up these details

1. Date of unprotected intercourse: -----
2. How was the intercourse unprotected?

- Contraceptive not used
- Rape
- Condom slippage/breakage
- Mistake in calculating safe period
- Forgotten to take pills for 3 continuous days
- Delay in taking Depo-Provera Injection
- Failure of withdrawal technique
- Other reasons, Specify -----

Follow up, Supervision, Treatment and Advice

Date	Complaints/ Diagnosis	Treatment/Advice	Follow up Date

Recorded By:

Name: -----

Designation: -----

Signature: -----

Service Provided By:

Name : -----

Designation: -----

Signature: -----

Government of Nepal
Ministry of Health and Population, Department of Health Services

APPENDIX- A (VII)

TRANSFER/REFERRAL SLIP

HMIS-8

(Please provide service to the client mentioned below and it is necessary to give this information to the referring service site)

1. Name of the referral site: ----- Date: -----
2. Name, Surname of the client: -----
3. Age : ----- Sex: -----
4. Address: District----- Mun/VDC ----- Ward No. ----- Village/Tole -----
5. Contraceptive using at present -----
6. Follow up date: -----
7. Reason for referral: -----
8. Description of Service: -----
9. Medicines used : -----
 1. Mention if other investigations are needed: -----
10. Others: -----

Name of the person who referred: -----

Designation: -----

Signature: -----

(Description of service provided and follow-up information)

Mr/ Ms -----

Name of Client ----- Age ----- Sex -----

Address District----- Mun/VDC ----- Ward No. ----- Village/Tole -----

Date of follow-up visit: -----

Description of information to be given to the referring site: services:-----

Name of person who provided information: -----

Designation: ----- Signature ----- Date: -----

Name and Address of the service site who provided the information: -----

Note: This form is to be used when clients are transferred or referred
--

Government of Nepal
Ministry of Health and Population, Department of Health Services

APPENDIX- A (VIII)

DEFAULTER FOLLOW-UP SLIP

HMIS-26

(Please submit the report after follow-up for the under mentioned client to encourage him/her to have regular service.)

1. Name, surname: ----- Age: ----- Sex: -----
2. Address: VDC/ Mun: ----- Ward No.----- Village/ Tole: -----
3. Head of household (Name, surname): -----
4. Service received: -----
5. Date of return visit: -----

Person who asked for follow-up of defaulter

Name: -----

Designation: -----

Date: -----

(To be filled by the person who conducted follow-up of defaulter)

Date of contact: -----

Reason for being defaulter: -----

Remarks -----

Person who conducted follow-up

Name -----

Designation-----

Signature: -----

Date: -----

Note: Please fill up this form if clients fail to return on the given time , for any contraceptive method.

APPENDIX- B (I)

IMPLANT INSERTION AND REMOVAL EQUIPMENT AND SUPPLIES

Non-Expendable Equipment		
Name of equipment/Supplies	Unit	Quantity per set
Scalpel handle	Piece	1
Syringe, disposable 5 ml	Piece	1
Needle 22 Gauge x 2"	Piece	1
Mosquito forceps, curved 5"	Piece	2
Dissecting forceps (Non-toothed)	Piece	1
Forceps, circle, curved 5.5"	Piece	1
Implant trochars with canula	Piece	1
Sponge holding forceps	Piece	1
Small metal bowl	Piece	2
Scalpel blade size 11	Piece	1
Cheatle forceps with jar	Piece	1
Expendable supplies for 100 cases		
Instruments Wrapping cloth 18" sq	Piece	2 for each Jadelle set
Arm drapes with central hole (Eye-towel) 12" sq	Piece	1 for each Jadelle set
Small hand towel	Piece	1 for each Jadelle set
Butterfly or plain band-aid	Piece	100
Sterile Gloves size 6 ½ with bag disposable	Pair	50
Sterile Gloves size 7 with bag	Pair	50
Gauze 4" X 4"	Pack	600
Roller bandage 3"	Roll	25
Jadelle Implants	Set	100
Local anaesthetic 1% Xylocaine 30 ml	Vial	15
Bar soap	Piece	5
Betadine antiseptic solution 500 ml	Bottle	2

APPENDIX B (II)

IMPLANT SITE CERTIFICATION FORM

1. Staff:

At least one trained/and certified Jadelle provider (paramedic, nurse or doctors)

1) Name: Post:..... Year trained:

2) Name:..... Post:..... Year trained:.....

2. Facility:

- a) A clean private room isolated from public traffic
- b) Provision of a good light source
- c) Access to water source
- d) Maintenance of adequate IP standards
 - a. Handwashing facility
 - b. Decontamination
 - c. HLD or sterilization
 - d. Manpower to process instrument

3. Equipment and supplies (See Appendix B I)

CERTIFIED BY:

POSITION:

DATE:

APPENDIX C (I)

IUCD EQUIPMENT AND SUPPLIES

Non-Expendable Equipment		
Name of equipment/Supplies	Unit	Quantity per set
Vaginal speculum, medium	Piece	1
Sponge holding forceps	Piece	1
Small metal bowl (Galley pot)	Piece	1
Cervical tenaculum/Volsellum	Piece	1
Uterine sound	Piece	1
Scissors, Long Handled	Piece	1
Instrument pan and cover	Piece	1
Torch/Flashlight, two cell	Piece	1
Long curved artery forceps	Piece	1
Cheatle forceps	Piece	1
Cheatle jar	Piece	1
Kidney Tray (Big size)	Piece	1
Eligator Forcep (for removal)	Piece	1
Small size curator (for removal)	Piece	1
Expendable Supplies for 100 cases		
Copper- T 380 A	Piece	100
Bar soap	Piece	5
Torch with batteries, size D	Piece	1
Surgical gloves, size 6	Pair	50
Surgical gloves, size 7	Pair	50
Surgical cotton 400 gms	Roll	2
Betadine solution 500 ml	Bottle	2
Instrument wrapping cloth 18" sq	Piece	2 per IUCD set
Small hand towel (inside set)	Piece	1 per IUCD set

APPENDIX C (II)

IUCD SITE CERTIFICATION FORM

1. Staff:

At least one trained/ and certified IUCD provider (paramedic, nurse or doctors)

1) Name: Post:..... Year trained:

2) Name:..... Post:..... Year trained:.....

2. Facility:

- a) A clean private room isolated from public traffic
- b) Provision of a good light source
- c) Access to water source
- d) Maintenance of adequate IP standards
 - a. Handwashing facility
 - b. Decontamination
 - c. HLD or sterilization
 - d. Manpower to process instrument

3. Equipment and supplies (See Appendix C I)

CERTIFIED BY:

POSITON:

DATE:

APPENDIX D (I)

VSC INFORMED CONSENT FORM

I, _____, the undersigned, (client's name) request that a sterilization via _____ be performed on me. (specify the procedure)

I make this request of my own free will, without having been forced or given any special inducement. I understand the following:

1. There are temporary methods of contraception available to me and my partner.
2. The procedure to be performed on me is a surgical procedure, the details of which have been explained to me.
3. This surgical procedure involves risks, discomfort and complication in addition to benefits, both of which have been explained to me.
4. If the procedure is successful, I will be unable to have any more children.
5. The procedure is less than 100% effective.
6. The effect of the procedure is permanent.
7. I can decide against the procedure at any time before the operation is performed (and no medical, health, or other benefits or services will be withheld from me as a result).

Signature or mark of client

Date

Signature of attending physician/
counselor or delegated assistant

Date

If the client cannot read, a witness of the client's choosing, of the same sex, and speaking the same language must sign the following declaration:

I, the undersigned, attest to the fact that the client has affixed his/her thumbprint or mark in my presence.

Signature or mark of witness/guardian

Date

APPENDIX D (II)

EMERGENCY DRUGS AND EQUIPMENT REQUIRED FOR VSC

Drugs:

SN	Contents	No. in Kit
1	Epinephrine (Adrenaline) 1:1000/ml vial	2
2	Dexamethasone (Decadron) 4 mg/ml in 2 ml vial	4
3	Naloxone (Lethidrone) 0.4 mg in 1 ml vial	1
4	Promethazine (Phenergan) 50 mg in 2 ml vial	2
5	Atropine 0.6 mg/cc in 1 ml vial	2
6	Diazepam (Calmpose) 5 mg/ml in 2 ml vial	2
7	Pethidine Chloride (Pethidine) 50 mg/ml in 2cc vial	2
8	Pheniramine (Avil) 25 mg/ml in 2ml vial	2
9	Pheniramine (Avil) 25 mg tablets	10 tablets
10	Lignocaine (Xylocaine) 1% or 2% 20ml vial	1
11	Pentazocine (Fortwin) 30 mg	10 tablets
12	Bottles Ringer's Lactate solution, 540 ml	2

Equipment:

13	Ambu Bag and Mask	1
14	Oxygen cylinder, regulator, flow meter and key	1
15	Oral airway	1
16	Nasal airway	1
17	3.0 Chromic gut suture with needle	2
18	Syringes and needles	5
29	Oxygen tubing and mask	1
20	IV Infusion sets	2
21	16 or 18 gauge IV cannulas	2

All staff should be familiar with the location and proper use of the emergency equipment and drugs.

APPENDIX D (III)

VSC SITE CRITERIA

1. Sterilization System: A functioning autoclave with two drums by trained staff in of proper use of autoclave. Adequate space to clean sort and pack instruments and supplies. Place to wash and dry instruments/linen with adequate water supply.
2. Facility:
 - OT: Electricity and lights available with functioning generator backup, adequate space for OT team to perform work, able to isolate room from rest of facility.
 - Scrub area: Running water or temporary water tank situated adjacent to OT area should be present.
 - Waiting, Registration, Screening, lab and recovery room: All must have adequate lighting, privacy and size to comfortably manage clients and as workplace for staff. Private area for counseling and client screening.
 - Staff housing: In or near facility adequate and comfortable housing for VSC staff to sleep, relax and eat
 - Storage area: Room to store supplies
 - Toilet: Clean separate area with water supply
 - Waste disposal area: Area to dispose waste properly.
 - Compound: Parking area for VSC vehicle that is available for emergency transport of client and returning clients to residences
 - Equipment, Instruments and Supplies: All equipment and supplies required for VSC services to be available and functional. Unusable or broken items must be repaired or replaced before services commence (see Appendix E (II) and F (II) for list of equipment and supplies)
 - Emergency Equipment/Supplies: All emergency equipment and supplies [see Appendix D (II)] should be available
3. Medications: All medications required for pre-surgery, intra-surgery must be available with adequate supplies

All emergency medications must be available and in adequate supply
4. Staff: Facility site manager must be identified all staff must be available and properly trained per standard

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APPENDIX E (I)
MINILAP/LAPAROSCOPY

1. Name of Facility: _____ 2. District: _____ Reg. No. _____

Name of client: _____

I. MENSTRUAL HISTORY

Date of last menstrual period

Duration of flows (in days)

Intermenstrual bleeding Scanty Moderate Heavy

Discharge Normal Abnormal

II. MEDICAL HISTORY

	Yes	No
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal mass	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Postcoital bleeding	<input type="checkbox"/>	<input type="checkbox"/>

Others (Specify) _____

III. PHYSICAL EXAMINATION

Pulse:	Resp:	BP:	Weight:	Temp:
	Normal	Abnormal	Normal	Abnormal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Uterus size:	Normal Bulky
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Uterus Position:	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	Mobility:	Yes No
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	Uterine cervix:	Unhealthy Healthy
			Adenexa:	Normal Abnormal

IV. LABORATORY

Hemoglobin:	gm	%	Signature of operating Physician.....
Urine:	Glucose	Yes	No
	Protein	Yes	No

Others _____

Signature of Lab. Tech Date

V. PRE OPERATIVE

Hours since last food or drink.....

Diazepam given.... mg ... minutes prior to surgery (P.O.)

VI. SURGICAL NOTE

.....

Surgeon..... Assistant.....

Swab and instrument counted by.....

VII. TOTAL MEDICATION

Before surgery During operation

Given by Given by.....

After operation

Given by

VIII. MONITORING RECORDS

Premedication: BP Pulse

Prior to analgesia:

At the end of surgery:

Recovery Room:

At time of discharge:

Additional Notes:

Wound bleeding: Yes No

Vomiting: Yes No

Bleeding PV: Yes No

APPENDIX E (II)

EXPENDABLE SUPPLY ESTIMATES FOR LAPAROSCOPY AND MINILAP

(1,000 CASES)

MINILAP		
Description	Unit	Total Quantity Needed
1. Roller Bandage, 3"	Roll	200
2. Cotton, 400 gm	Roll	20
3. Gauze Cloth, 18 x 1 m	Than	30
4. Adhesive Tape 4"x 5 m	Roll	50
5. Glove # 6.5	Pair	1,333
6. Glove # 7	Pair	333
7. Glove Powder, 1 lb	Packet	30
8. 5 cc Disposable Syringe	Each	1,000
9. 10 cc Disposable Syringe	Piece	1500
10. Surgical Blade # 10	Each	1,000
11. Cu. Cut. Needle # 10/ 11	Pack (1x6)	35
12. Round Body Needle # 10/11	Set	35
13. Catgut Plain # 1/0	Each	500
14. Catgut Chromic 1/0	Each	500
15. Xylocaine Inj. 1% 30 ml	Vial	700
16. Liq. Betadine, 500 ml	Bottle	50
17. Virex	Pack	50
18. Rectified Spirit 450 ml	Bottle	10
19. Calmpose 5 mg Tablet	Each	2,000
20. Amoxicillin 250 mg Cap.	Each	12,00
21. Multivitamin Tablet	Each	14,000
22. Tab Iron	Each	14,000
23. Tab. Ibuprofen 400 mg	Each	10,000
24. Inj. Pethidine 50 mg	Ampule	750
25. Inj. Phenargan 50 mg.	Ampule	500
Or		
26. Inj. Fortwin (Pentazocine)	Ampule	1000
27. Inj. Atropine 0.6 mg	Ampule	1000

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APPENDIX E (III)

**POSTOPERATIVE INSTRUCTIONS FOR THE FEMALE VSC CLIENT
(WRITTEN AND ORAL)**

1. Rest for 5 to 7 days. Resume normal activities as you gradually become more comfortable.
2. Avoid intercourse for 1 week and stop if it is uncomfortable.
3. Avoid strenuous lifting for one week to allow the incisions to heal.
4. Return to the clinic or contact the clinic or doctor promptly if you develop post-operative danger signs.
5. Take 1 or 2 analgesic tablets at 4 to 6 hour intervals if you need them for pain. (Do not use aspirin since it may promote bleeding).
6. You may bathe 48 hours after surgery, but avoid putting tension on the incision and do not rub or irritate the incision for 1 week. Dry the incision site after bathing.
7. Stitches will dissolve and do not require removal. (**Note:** this instruction must be modified if non absorbable sutures, such as silk, are used).
8. Return to the clinic 1 week after the procedure to make sure that the healing process is normal.
9. If you think you are pregnant at any time in the future, return to the clinic immediately. Pregnancy after female surgical contraception is rare. But if pregnancy does occur, there is an increased chance that it will be outside the uterus (womb). This is a dangerous condition and must be treated by a doctor. (**Note:** give name of doctor, clinic address, telephone number etc).

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APPENDIX F (I)

VASECTOMY

1. Name of facility _____ 2. District _____ Reg. No. _____
 Name of client: _____

I. MEDICAL HISTORY

	Yes	No
Previous Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Problem	<input type="checkbox"/>	<input type="checkbox"/>

Others (Specify) _____

III. OPERATIVE NOTE

Skin Preparation: Betadine Yes No
 Local Anesthesia: Xylocaine 1%C.C.
 Fascial interposition: Yes No
 Suture of vas: Silk, chromic catgut, cotton thread
 Fulguration: Yes No
 Surgical notes:

II. PHYSICAL EXAMINATION

	Normal			Abnormal	
Scrotum	<input type="checkbox"/>	<input type="checkbox"/>	Hydrocele	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Vericocele	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Skin (Scrotal area)	<input type="checkbox"/>	<input type="checkbox"/>	Undescended Testes	<input type="checkbox"/>	<input type="checkbox"/>
			Previous Scrotal Surgery	<input type="checkbox"/>	<input type="checkbox"/>
			Scrotal Mass	<input type="checkbox"/>	<input type="checkbox"/>

Others (Specify) _____

Pain during procedure: None/Mild/Moderate/Severe
 Intraoperative complications: Yes No
 If yes, Explain with treatment given.....
 Assistant Signed (Surgeon)
 Date: Date

IV. DISCHARGE NOTE

Wound OK: Yes No
 If no (specify)
 Follow - up appointment given: Yes No
 Discharge instruction given: Yes No
 20 Condoms given: Yes No
 Signed Date

APPENDIX F (II)

FACILITIES AND EQUIPMENT FOR VASECTOMY

Instrument Packs:

Depending on the anticipated number of clients at the operating facility, 10-20 instrument packs will be available. Each pack will contain the following items:

Instruments (No Scalpel Vasectomy)

Description	Unit	Quantity per set
1. Iodine Cup, 4 oz 1.5" high	Piece	1
2. Addison Forceps, 5"	Piece	1
3. Forceps, Artery, Straight, 5 1/2"	Piece	1
4. Forceps, Artery, Curved	Piece	1
5. Ringed Forceps, 4.0 mm ring	Piece	1
6. Ringed Forceps, 3.5 mm ring	Piece	1
7. Hemopoint/Dissecting Forceps for NSV	Piece	1
8. Iris Scissors, curved	Piece	1
9. Sponge Holding Forceps	Piece	1

Expendable Supplies		
Description	Unit	Total Quantity Needed for 1000
OTHER ITEMS¹¹		
1. Gauze cloth 18 mts X 1 mt	Than	15
2. Cotton 400 gm	Roll	5
3. Gloves, sizes 6, 6.5, 7 and 7.5	Pairs	600
4. Glove powder 1 lb	Packet	20
5. Liq. Betadine 500 ml	Bottle	30
6. Tab. Cetamol 500 mg	Each	6000
7. Rectified Spirit 450 ml.	Bottle	10
8. Adhesive Tape 4" X 5"	Roll	10
9. Vit. B Complex Tablet	Each	14000
10. Xylocaine Inj. 1% 30 ml	Vail	180
11. Amoxycilling 250 mg. Cap	Each	1200
12. Virex	Pack	50
13. Disposable Syringe 5 ml with 1.5", gauge 23-24 needle	Each	1000
14. Black Silk or Cotton thread	Roll	5

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APPENDIX F (III)

POSTOPERATIVE INSTRUCTIONS FOR THE MALE VSC CLIENT
(WRITTEN AND ORAL)

1. Following the surgery, return home and rest for about 2 days wearing a scrotal support. You may be able to resume your normal activities after 2 or 3 days.
2. Avoid strenuous physical exercise for 1 week. Strenuous exercise means hard physical exertion or lifting or straining that could bring pressure to the groin or scrotum.
3. Do not shower or bathe for the first 2 days after vasectomy.
4. The stitches will dissolve and do not have to be removed. (**Note:** this instruction must be modified if non-absorbable skin sutures, such as silk, are used or if there are no skin sutures) with NSV no stitches are applied.
5. You may resume sexual intercourse after 2 or 3 days if you feel that it would be comfortable; but remember, you are not sterile immediately. For many men, sperm will not be cleared from the tubes until after 20 ejaculations. Until then, use condoms or another method of birth control to prevent pregnancy. The best way of finding out if you are sterile is to do a semen study after 20 ejaculations.
6. If you have pain or discomfort, simple analgesics taken at intervals of 4 to 6 hours usually give adequate relief. (**Note:** Name and doses should be specified).
7. It is important for you to know what is normal and what is abnormal following your surgery. There will probably be some pain and swelling in the scrotal region; the scrotum may be somewhat discolored. This is normal and should not worry you. Occasionally, blood from a tiny blood vessel may escape into the scrotum at the time of surgery, and bleeding may continue. Notify the doctor or the health worker if you have any of the danger signals or if you notice any other unusual body changes.

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APPENDIX G (I)

SURGICAL COMPLICATION REPORT FORM

(This form should be filled by the physician who treated the complication and needs to submit to Family Health Division through the District Health Office/District Public Health Office or other concerning agency.)

Date: _____

1. Demographic Description of Clients:

Client's name: _____ Age: _____ Sex: M / F
Address: _____ VDC/Municipality, _____ Ward, _____ District
Number of live births (For female client only) _____
Total number of pregnancies (For female client only) _____

2. Type of procedure/method:

Minilaparotomy **Laparoscopy** **Vasectomy**

Other procedure (specify) _____
Other method (specify) _____
Date of procedure/method _____
Location of procedure/method _____
Name of service site where complication occurred _____
Date of onset of complication (day/month/year) ____/____/____

3. Type of complication(s):

A. Complication related to anesthesia:
 Respiratory arrest/depression Cardiac arrest Convulsions
 Allergic reaction Other (specify) _____

B. Unintended injury:
 Injury to bladder Injury to testicle
 Injury to fallopian tube Injury to cervix
 Injury to bowel Uterine perforation
 Other (specify) _____

C. Bleeding:
 Hemorrhage Hematoma

D. Infection:
 Injection site abscess Wound infection Pelvic/Abdominal infection
 Scrotal Other (specify) _____

E. Pregnancy: _____

F. Other complication (specify) _____

4. Treatment:

Duration of treatment _____

Briefly describe management of the complication:

5. **Outcome:**

6. **Describe any change in practice, training, or procedure made to prevent a recurrence of this type of complication:**

7. **Name of physician offering treatment:** _____

Signature: _____

Name of institution: _____

8. **Costs:**

<u>Description:</u>	<u>Amount</u>
Physician's Fees	_____
Medicine	_____
Transportation	_____
Food	_____
Hospital bed charges	_____
Other	_____
Total	_____

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APPENDIX G (II)

MINOR COMPLICATION REPORTING FORM

Name of Health Institution: _____ **District:** _____

Name of service provider who treated the complication: _____

Name of client: _____

Address of client: District: _____ Mun/VDC: _____

Type of FP methods used: _____

Place of FP method received: _____

Type of complications:

_____ Wound infection _____ Vaginal bleeding _____ Hematoma _____ Fever

_____ Wound separation _____ Weakness/anemia _____ Pregnancy (failure)

Others (describe): _____

Cost (If any): _____

Name of In-charge: _____ Signature: _____

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APPENDIX G (III)

FAMILY PLANNING DEATH INVESTIGATION FORM

Investigator(s) Name and Title:

1. Demographic Description of Client:

Client's name: _____ Age: _____ Sex: M / F
Address: _____ VDC/Municipality, _____
Ward, _____ District _____
Number of live births (For female client only) _____
Total number of pregnancies (For female client only) _____

2. Type of procedure/method:

Minilaparotomy Laparoscopy Vasectomy
 Other FP method (specify) _____

Date of procedure/method _____
Location of procedure/method _____
Date of Death _____
Location of death _____
Probable Cause of Death _____

3. Names of staff assisting with procedure/method

Name	Title	Address

4. Names of staff treating client at time of death

Name	Title	Address

5. Findings from site visit where procedure took place (infection prevention practices, condition of equipment and supplies, emergency preparedness, aseptic technique, condition of facility, etc.)

6. Findings from site visit where death occurred (if different location)

7. Results of the Postmortem:

8. Results of examination/tests of any supplies, medications or equipment that may have contributed to the death

List of people interviewed (surgeon, OT staff, paramedic staff, family members, client's friends, field staff)

Name	Title	Address

9. Attach a written narrative of the findings from the interviews conducted.

10. Attach copies of all medical records related to the procedure and the death (pre-op, intra-op, post-op, consent form, lab findings, readmission, referral hospital, second surgery, etc.)

11. Attach a written summary of the findings from a review of the records.

13. Conclusions from Investigation:

14. Describe any change in practice, training, or procedure to prevent a recurrence:

15. Follow-up Recommended:

Form completed by (name and title): _____

Signature: _____

Name of institution: _____

Costs:

Description:	Amount
Physician's Fees	_____
Medicine	_____
Transportation	_____
Food	_____
Hospital bed charges	_____
Other	_____
Total	_____

APPENDIX H

Medical Eligibility Criteria for Contraceptive Use

The table on the following pages summarizes the World Health Organization Medical Eligibility Criteria for using contraceptive methods. These criteria are the basis for the Medical Eligibility Criteria checklists in Chapters 1 through 19.

Categories for Temporary Methods

Category	With Clinical Judgment	With Limited Clinical Judgment
1	Use method in any circumstances	Yes (Use the method)
2	Generally use method	
3	Use of method not usually recommended unless other more appropriate methods are not available or not acceptable	No (Do not use the method)
4	Method not to be used	

Note: In the table beginning with Personal Characteristics and Reproductive History, category 3 and 4 conditions are shaded to indicate that the method should not be provided where clinical judgment is limited.

See conditions relating to vasectomy, male and female condoms, spermicides, diaphragms, cervical caps, and lactational amenorrhea method. See conditions relating to fertility awareness methods.

Categories for Female Sterilization

Accept (A)	There is no medical reason to deny the method to a person with this condition or in this circumstance.
Caution (C)	The method is normally provided in a routine setting, but with extra preparation and precautions.
Delay (D)	Use of the method should be delayed until the condition is evaluated and/or corrected. Alternative, temporary methods of contraception should be provided.
Special (S)	The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anesthesia, and other backup medical support. The capacity to decide on the most appropriate procedure and anesthesia support also is needed. Alternative, temporary methods of contraception should be provided if referral is required or there is otherwise any delay.

- = Use the method
- = Do not use the method
- I = Initiation of the method
- C = Continuation of the method
- = Use the method
- NA = Not applicable

Combined Oral Contraceptives	Monthly Injections	Combined patch and vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device	Levonorgestrel intrauterine device	Female sterilization*
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Condition

PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY										
Pregnant	NA	NA	NA	NA	NA	NA	NA	4	4	D
Age	Menarche to < 40 years			Menarche to < 18 years				Menarche to < 20 years		Young age
	1	1	1	1	2	1	—	2	2	C
	≥ 40 years			18 to 45 years				≥ 20 years		
	2	2	2	1	1	1	—	1	1	
				> 45						
Parity				1	2	1	—			
Nulliparous (has not given birth)	1	1	1	1	1	1	—	2	2	A
Parous (has given birth)	1	1	1	1	1	1	—	1	1	A
Breastfeeding										
< 6 weeks postpartum	4	4	4	3 ^a	3 ^a	3 ^a	1	b	b	*
≥ 6 weeks to < 6 months postpartum (primarily breastfeeding)	3	3	3	1	1	1	1	b	b	A
≥ 6 months postpartum	2	2	2	1	1	1	1	b	b	A
Postpartum (not breastfeeding)										
< 21 days	3	3	3	1	1	1	—	b	b	*
≥ 21 days	1	1	1	1	1	1	—	b	b	
Postabortion										
First trimester	1	1	1	1	1	1	—	1	1	*
Second trimester	1	1	1	1	1	1	—	2	2	
Immediate post-septic abortion	1	1	1	1	1	1	—	4	4	
Past ectopic pregnancy	1	1	1	2	1	1	1	1	1	A
History of pelvic surgery	1	1	1	1	1	1	—	1	1	C*
Smoking										
Age < 35 years	2	2	2	1	1	1	—	1	1	A
Age ≥ 35 years										
< 15 cigarettes/day	3	2	3	1	1	1	—	1	1	A
≥ 15 cigarettes/day	4	3	4	1	1	1	—	1	1	A

- * See additional conditions relating to emergency contraceptive pills and female sterilization.
- a In settings where pregnancy morbidity and mortality risks are high and this method is one of few widely available contraceptives, it may be made accessible to breastfeeding women immediately postpartum.
- b Postpartum IUD use: For the copper-bearing IUD, insertion at <48 hours is category 1. For the LNG-IUD, insertion at <48 hours is category 3 for breastfeeding women and category 1 for women not breastfeeding. For all women and both IUD types, insertion from 48 hours to <4 weeks is category 3; ≥4 weeks, category 1; and puerperal sepsis, category 4.

	Co m b i n e d O r a l C o n t r a c e p t i v e s	M o n t h l y I n j e c t a b l e s	C o m b i n e d p a t c h a n d c o m b i n e d v a g i n a l r i n g	P r o g e s t i n - o n l y p i l l s	P r o g e s t i n - o n l y i n j e c t a b l e s	I m p l a n t s	E m e r g e n c y c o n t r a c e p t i v e p i l l s*	C o p p e r b e a r i n g i n t r a u t e r i n e d e v i c e	L e v o n o r g e s t r e l i n t r a u t e r i n e d e v i c e	F e m a l e s t e r i l i z a t i o n *
= Use the method										
= Do not use the method										
I = Initiation of the method										
C = Continuation of the method										
= Use the method										
NA = Not applicable										
Condition										
Obesity										
>30 kg/m2 body mass index	2	2	2	1	1**	1	—	1	1	C
Blood pressure measurement unavailable	NA ^C	NA ^C	NA ^C	NA ^C	NA ^C	NA ^C	—	NA	NA	NA
CARDIOVASCULAR DISEASE										
Multiple risk factors for arterial cardiovascular disease (older age, smoking, diabetes, and hypertension)	3/4 ^d	3/4 ^d	3/4 ^d	2	3	2	—	1	2	S
Hypertension^e										
History of hypertension, where blood pressure CANNOT be evaluated (including hypertension in pregnancy)	3	3	3	2 ^c	2 ^c	2 ^c	—	1	2	NA
Adequately controlled hypertension, where blood pressure CAN be evaluated	3	3	3	1	2	1	—	1	1	C
Elevated blood pressure (properly measured)										
Systolic 140–159 or diastolic 90–99	3	3	3	1	2	1	—	1	1	C ^f
Systolic ≥ 160 or diastolic ≥ 100 ^g	4	4	4	2	3	2	—	1	2	S ^f
Vascular disease	4	4	4	2	3	2	—	1	2	S
History of high blood pressure during pregnancy (where current blood pressure is measurable and normal)	2	2	2	1	1	1	—	1	1	A
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)										
History of DVT/PE	4	4	4	2	2	2	*	1	2	A
Acute DVT/PE	4	4	4	3	3	3	*	1	3	D
Family history of DVT/PE (first-degree relatives)	2	2	2	1	1	1	*	1	1	A
DVT/PE and on anticoagulant therapy	4	4	4	2	2	2	*	1	2	S

** From menarche to age <18 years, ≥30 kg/m2 body mass index is category 2 for DMPA, category 1 for NET-EN.

c In settings where pregnancy morbidity and mortality risks are high and this method is one of few widely available contraceptives, women should not be denied access simply because their blood pressure cannot be measured.

d Then multiple major risk factors exist, any of which alone would substantially increase the risk of cardiovascular disease, use of the method may increase her risk to an unacceptable level. However, a simple addition of categories for multiple risk factors is not intended. For example, a combination of factors assigned a category 2 may not necessarily warrant a higher category.

e Assuming no other risk factors for cardiovascular disease exist. A single reading of blood pressure is not sufficient to classify a woman as hypertensive.

f Elevated blood pressure should be controlled before the procedure and monitored during the procedure.

g This condition may make pregnancy an unacceptable health risk. Women should be advised that because of relatively higher pregnancy rates, as commonly used, spermicides, withdrawal, fertility awareness methods, cervical caps, diaphragms, or female or male condoms may not be the most appropriate choice.

	Combined Oral Contraceptives	Monthly Injectable	Combined and vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device	Levonorgestrel intrauterine device	Female sterilization*			
= Use the method													
= Do not use the method													
I = Initiation of the method													
C = Continuation of the method													
= Use the method													
NA = Not applicable													
Condition													
Major surgery													
With prolonged immobilization	4	4	4	2	2	2	—	1	2	D			
Without prolonged immobilization	2	2	2	1	1	1	—	1	1	A			
Minor surgery without prolonged immobilization	1	1	1	1	1	1	—	1	1	A			
Known thrombogenic mutations (e.g., Factor V Leiden, Prothrombin mutation; Protein S, Protein C, and Antithrombin deficiencies) ^g	4	4	4	2	2	2	*	1	2	A			
Superficial venous thrombosis													
Varicose veins	1	1	1	1	1	1	—	1	1	A			
Superficial thrombophlebitis	2	2	2	1	1	1	—	1	1	A			
Ischemic heart disease ^g				I C		I C			I C				
Current	4	4	4	2	3	3	2	3	*	1	2	3	D
History of													C
Stroke (history of cerebrovascular accident) ^g	4	4	4	2	3	3	2	3	*	1	2		C
Known hyperlipidemias	2/3 ^h	2/3 ^h	2/3 ^h	2	2	2	—	1	2	A			
Valvular heart disease													
Uncomplicated	2	2	2	1	1	1	—	1	1	C ⁱ			
Complicated ^{g†}	4	4	4	1	1	1	—	2 ⁱ	2 ⁱ	S*			
SYSTEMIC LUPUS ERYTHEMATOSIS					I C			I C					
Positive (or unknown) antiphospholipid antibodies	4	4	4	3	3	3	3	—	1	1	3	S	
Severe thrombocytopenia	2	2	2	2	3	2	2	—	3	2	2	S	
Immunosuppressive treatment	2	2	2	2	2	2	2	2	2	1	2	S	
None of the above	2	2	2	2	2	2	2	—	1	1	2	C	
NEUROLOGICAL CONDITIONS													
Headaches^j	I C	I C	I C	I C	I C	I C	I C			I C			
Nonmigrainous (mild or severe)	1	2	1	2	1	2	1	1	1	1	1	1	A
Migraine													
Without aura	I C	I C	I C	I C	I C	I C	I C				I C		
Age < 35	2	3	2	3	2	3	1	2	2	2	2	2	A
Age ≥ 35	3	4	3	4	3	4	1	2	2	2	2	2	A
With aura, at any age	4	4	4	4	4	4	2	3	2	3	2	3	A
Epilepsy	1 ^k	1 ^k	1 ^k	1 ^k	1 ^k	1 ^k	1 ^k	—	1	1			C

^h Assess according to the type and severity of hyperlipidemia and the presence of other cardiovascular risk factors.

ⁱ Prophylactic antibiotics are advised before providing the method.

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

^k If taking anticonvulsants, refer to section on [drug interactions](#).

[†] Pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis

	Co m b i n e d O r a l C o n t r a c e p t i v e s	M o n t h l y I n j e c t a b l e s	C o m b i n e d p a t c h a n d c o m b i n e d v a g i n a l r i n g	P r o g e s t i n - o n l y i n j e c t a b l e s	P r o g e s t i n - o n l y i n j e c t a b l e s	I m p l a n t s	E m e r g e n c y c o n t r a c e p t i v e p i l l s *	C o p p e r - b e a r i n g i n t r a u t e r i n e d e v i c e	L e v o n o r g e s t r e l i n t r a u t e r i n e d e v i c e	F e m a l e s t e r i l i z a t i o n *
= Use the method										
= Do not use the method										
I = Initiation of the method										
C = Continuation of the method										
= Use the method										
NA = Not applicable										
Condition										
DEPRESSIVE DISORDERS										
Depressive disorders	1 ¹	1 ¹	1 ¹	1 ¹	1 ¹	1 ¹	—	1	1 ¹	C
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS										
Vaginal bleeding patterns									I C	
Irregular pattern without heavy bleeding	1	1	1	2	2	2	—	1	1	A
Heavy or prolonged bleeding (including regular and irregular patterns)	1	1	1	2	2	2	—	2	1	A
Unexplained vaginal bleeding (suspicious for serious condition), before evaluation	2	2	2	2	3	3	—	I C I C 4 2 4 2		D
Endometriosis	1	1	1	1	1	1	—	2	1	S
Benign ovarian tumors (including cysts)	1	1	1	1	1	1	—	1	1	A
Severe dysmenorrhea	1	1	1	1	1	1	—	2	1	A
Trophoblast disease										
β-hCG regression	1	1	1	1	1	1	—	3	3	A
β-hCG elevation ^g	1	1	1	1	1	1	—	4	4	D
Cervical ectropion	1	1	1	1	1	1	—	1	1	A
Cervical intraepithelial neoplasia (CIN)	2	2	2	1	2	2	—	1	2	A
Cervical cancer (awaiting treatment)	2	2	2	1	2	2	—	I C I C 4 2 4 2		D
Breast disease										
Undiagnosed mass	2	2	2	2	2	2	—	1	2	A
Benign breast disease	1	1	1	1	1	1	—	1	1	A
Family history of cancer	1	1	1	1	1	1	—	1	1	A
Breast cancer										
Current ^g	4	4	4	4	4	4	—	1	4	C
Past, no evidence of disease for at least 5 years	3	3	3	3	3	3	—	1	3	A
Endometrial cancer^g	1	1	1	1	1	1	—	I C I C 4 2 4 2		D
Ovarian cancer^g	1	1	1	1	1	1	—	3	2	D
Uterine fibroids										
Without distortion of the uterine cavity	1	1	1	1	1	1	—	1	1	C
With distortion of the uterine cavity	1	1	1	1	1	1	—	4	4	C

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

	Com bi ned Or al Co n tra ce p ti ve s	Mo n t h ly I n j e c t a b l e s	Co m b i n e d p a t c h a n d c o m b i n e d v a g i n a l r i n g	Pr o g e s t i n o n l y p i l l s	Pr o g e s t i n o n l y i n j e c t a b l e s	I m p l a n t s	E m e r g e n c y c o n t r a c e p t i v e p i l l s *	Cop p e r - b e a r i n g i n t r a u t e r i n e d e v i c e	Le v o n o r g e s t r e l i n t r a u t e r i n e d e v i c e	F e m a l e s t e r i l i z a t i o n *		
= Use the method												
= Do not use the method												
I = Initiation of the method												
C = Continuation of the method												
= Use the method												
NA = Not applicable												
Condition												
Anatomical abnormalities												
Distorted uterine cavity	—	—	—	—	—	—	—	4	4	—		
Other abnormalities not distorting the uterine cavity or interfering with IUD insertion (including cervical stenosis or lacerations)	—	—	—	—	—	—	—	2	2	—		
Pelvic inflammatory disease (PID)												
Past PID (assuming no current risk factors for STIs)								I	C	I	C	
With subsequent pregnancy	1	1	1	1	1	1	—	1	1	1	1	A
Without subsequent pregnancy	1	1	1	1	1	1	—	2	2	2	2	C
Current PID	1	1	1	1	1	1	—	4	2 ^m	4	2 ^m	D
Sexually transmitted infections (STIs)^g								I	C	I	C	
Current purulent cervicitis, chlamydia, or gonorrhea	1	1	1	1	1	1	—	4	2	4	2	D
Other STIs (excluding HIV and hepatitis)	1	1	1	1	1	1	—	2	2	2	2	A
Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	1	1	1	1	1	1	—	2	2	2	2	A
Increased risk of STIs	1	1	1	1	1	1	—	2/3 ⁿ	2	2/3 ⁿ	2	A
HIV/AIDS^g												
								I	C	I	C	
High risk of HIV	1	1	1	1	1	1	—	2	2	2	2	A
HIV-infected	1	1	1	1	1	1	—	2	2	2	2	A
AIDS	1	1	1	1	1	1	—	3	2	3	2	S ^o
Treated with NRTIs	1	1	1	1	1	1	—	2/3 ^p	2	2/3 ^p	2	—
Treated with NNRTIs	2	2	2	2	DMPA 1 NET- EN 2	2	—	2/3 ^p	2	2/3 ^p	2	—
Treated with ritonavir-boosted protease inhibitors	3	3	3	3	DMPA 1 NET- EN 2	2	—	2/3 ^p	2	2/3 ^p	2	—

Note: NRTIs = nucleoside reverse transcriptase inhibitors; NNRTIs = non-nucleoside reverse transcriptase inhibitors
^m Treat PID using appropriate antibiotics. There is usually no need to remove the IUD if the client wishes to continue use.
ⁿ The condition is category 3 if a woman has a very high individual likelihood of exposure to gonorrhea or chlamydia.
^o Presence of an AIDS-related illness may require a delay in the procedure.
^p AIDS is category 2 for insertion for those clinically well on antiretroviral therapy; otherwise, category 3 for insertion.

	Com bi ne d Or al Co n t r a c e p t i v e s	M o n t h l y I n j e c t a b l e s	Co m b i n e d p a t c h a n d c o m b i n e d v a g i n a l r i n g	Pr o g e s t i n - o n l y p i l l s	Pr o g e s t i n - o n l y i n j e c t a b l e s	I m p l a n t s	E m e r g e n c y c o n t r a c e p t i v e p i l l s*	Co p p e r - b e a r i n g i n t r a u t e r i n e d e v i c e	Le v o n o r g e s t r e l i n t r a u t e r i n e d e v i c e	Fem a l e s t e r i z a t i o n*	
<input type="checkbox"/>	= Use the method										
<input type="checkbox"/>	= Do not use the method										
I	= Initiation of the method										
C	= Continuation of the method										
<input type="checkbox"/>	= Use the method										
NA	= Not applicable										
Condition											
OTHER INFECTIONS											
Schistosomiasis											
Uncomplicated	1	1	1	1	1	1	—	1	1	A	
Fibrosis of liver (if severe, see cirrhosis, next page) ^g	1	1	1	1	1	1	—	1	1	C	
Tuberculosis ^g											
Non-pelvic	1	1	1	1	1	1	—	I	C	I	C
Known pelvic	1	1	1	1	1	1	—	4	3	4	3
Malaria	1	1	1	1	1	1	—	1	1	A	
ENDOCRINE CONDITIONS											
Diabetes											
History of gestational diabetes	1	1	1	1	1	1	—	1	1	A ^q	
Non-vascular diabetes											
Non-insulin dependent	2	2	2	2	2	2	—	1	2	C ^{i,q}	
Insulin dependent ^g	2	2	2	2	2	2	—	1	2	C ^{i,q}	
With kidney, eye, or nerve damage ^g	3/4 ^r	3/4 ^r	3/4 ^r	2	3	2	—	1	2	S	
Other vascular disease or diabetes of >20 years' duration ^g	3/4 ^r	3/4 ^r	3/4 ^r	2	3	2	—	1	2	S	
Thyroid disorders											
Simple goiter	1	1	1	1	1	1	—	1	1	A	
Hyperthyroid	1	1	1	1	1	1	—	1	1	S	
Hypothyroid	1	1	1	1	1	1	—	1	1	C	
GASTROINTESTINAL CONDITIONS											
Gall bladder disease											
Symptomatic											
Treated by cholecystectomy	2	2	2	2	2	2	—	1	2	A	
Medically treated	3	2	3	2	2	2	—	1	2	A	
Current	3	2	3	2	2	2	—	1	2	D	
Asymptomatic	2	2	2	2	2	2	—	1	2	A	
History of cholestasis											
Pregnancy-related											
Past combined oral contraceptives-related	3	2	3	2	2	2	—	1	2	A	
Viral hepatitis											
Acute or flare	I	C	I	C	I	C					
Carrier	3/4 ^r	2	3	1	1	1	1	1	1	2	
Chronic	1	1	1	1	1	1	—	1	1	A	

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

^r Assess according to severity of condition.

^s In women with symptomatic viral hepatitis, withhold these methods until liver function returns to normal or 3 months after she becomes asymptomatic, whichever is earlier.

	Combined Oral Contraceptives	Monthly Injections	Combined and combined vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device	Levonorgestrel intrauterine device	Female sterilization*
= Use the method										
= Do not use the method										
I = Initiation of the method										
C = Continuation of the method										
= Use the method										
NA = Not applicable										
Condition										
Cirrhosis										
Mild (compensated)	1	1	1	1	1	1	—	1	1	A
Severe (decompensated) ^g	4	3	4	3	3	3	—	1	3	S
Liver tumors										
Focal nodular hyperplasia	2	2	2	2	2	2	—	1	2	A
Hepatocellular adenoma	4/2	3	4	3	3	3	—		3	C ^t
Malignant (hepatoma) ^g	4	3/4	4	3	3	3	—	1	3	C ^t
ANEMIAS										
Thalassemia	1	1	1	1	1	1	—	2	1	C
Sickle cell disease ^g	2	2	2	1	1	1	—	2	1	C
Iron-deficiency anemia	1	1	1	1	1	1	—	2	1	D/C ^u
DRUG INTERACTIONS (for antiretroviral drugs, see HIV/AIDS)										
Anticonvulsant therapy										
Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	3 ^l	2	3 ^l	3 ^l	DMPA 1 NET-EN 2	2 _l	—	1	1	—
Lamotrigine	3 ^{††}	3 ^{††}	3 ^{††}	1	1	1	—	1	1	—
Antimicrobial therapy										
Other antibiotics	1	1	1	1	1	1	—	1	1	—
Antifungals and antiparasitics	1	1	1	1	1	1	—	1	1	—
Rifampicin or rifabutin therapy	3 _l	2	3 _l	3 _l	DMPA 1 NET-EN 2	2	—	1	1	—

^l Liver function should be evaluated.

^u For hemoglobin < 7 g/dl, delay. For hemoglobin ≥ 7 to < 10 g/dl, caution.

^{††} Combined hormonal contraceptives may reduce the effectiveness of lamotrigine.

Additional conditions relating to emergency contraceptive pills:

Category 1: Repeated use; rape.

Category 2: History of severe cardiovascular complications (ischemic heart disease, cerebrovascular attack, or other thromboembolic conditions, and angina pectoralis).

Additional conditions relating to female sterilization:

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

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

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

Conditions relating to vasectomy:

No special considerations: High risk of HIV, HIV-infected, sickle cell disease.

Caution: Young age; depressive disorders; diabetes; previous scrotal injury; large varicocele or hydrocele; cryptorchidism (may require referral); lupus with positive (or unknown) antiphospholipid antibodies; lupus and on immunosuppressive treatment.

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

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

Conditions relating to male and female condoms, spermicides, diaphragms, cervical caps, and the lactational amenorrhea method:

All other conditions listed on the previous pages that do not appear here are a category 1 or NA for male and female condoms, spermicides, diaphragms, and cervical caps and not listed in the Medical Eligibility Criteria for the Lactational Amenorrhea Method.

<input type="checkbox"/>	= Use the method					
<input type="checkbox"/>	= Do not use the method					
<input type="checkbox"/>	= Condition not listed; does not affect eligibility for method					
NA	= Not applicable					
Condition		Male and female condoms	Spermicides	Diaphragms	Cervical caps	Lactational amenorrhea method**
REPRODUCTIVE HISTORY						
Parity						
Nulliparous (has not given birth)		1	1	1	1	—
Parous (has given birth)		1	1	2	2	—
< 6 weeks postpartum		1	1	NA ^v	NA ^v	—
CARDIOVASCULAR DISEASE						

Complicated valvular heart disease (pulmonary hypertension, risk of atrial fibrillation, history of subacute bacterial endocarditis) ^g	1	1	2	2	—
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS					
Cervical intraepithelial neoplasia	1	1	1	4	—
Cervical cancer	1	2	1	4	—
Anatomical abnormalities	1	1	NA ^w	NA ^x	—
HIV/AIDS^g					
High risk of HIV	1	4	4	4	—
HIV-infected	1	3	3	3	C ^y
AIDS	1	3	3	3	C ^y
OTHERS					
History of toxic shock syndrome	1	1	3	3	—
Urinary tract infection	1	1	2	2	—
Allergy to latex ^z	3	1	3	3	—

^v Wait to fit/use until uterine involution is complete.

^w Diaphragm cannot be used in certain cases of uterine prolapse.

^x Cap use is not appropriate for a client with severely distorted cervical anatomy.

^y Women with HIV or AIDS should avoid breastfeeding if replacement feeding is affordable, feasible, acceptable, sustainable, and safe. Otherwise, exclusive breastfeeding is recommended during the first 6 months of a baby's life and should then be discontinued over a period of 2 days to 3 weeks.

^z Does not apply to plastic condoms, diaphragms, and cervical caps.

**Additional conditions relating to lactational amenorrhea method:

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

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

Conditions relating to fertility awareness methods:

<input type="checkbox"/> A = Accept <input type="checkbox"/> C = Caution <input type="checkbox"/> D = Delay Condition	Symptoms-based methods	Calendar-based methods
Age: post menarche or perimenopause	C	C
Breastfeeding < 6 weeks postpartum	D	D ^{aa}
Breastfeeding ≥ 6 weeks postpartum	C	D ^{bb}
Postpartum, not breastfeeding	D ^{cc}	D ^{aa}
Postabortion	C	D ^{dd}
Irregular vaginal bleeding	D	D
Vaginal discharge	D	A
Taking drugs that affect cycle regularity, hormones, and/or fertility signs	D/C ^{ee}	D/C ^{ee}
Diseases that elevate body temperature		
Acute	D	A
Chronic	C	A

^{aa} Delay until she has had 3 regular menstrual cycles.

^{bb} Use caution after monthly bleeding or normal secretions return (usually at least 6 weeks after childbirth).

^{cc} Delay until monthly bleeding or normal secretions return (usually < 4 weeks postpartum).

^{dd} Delay until she has had one regular menstrual cycle.

^{ee} Delay until the drug's effect has been determined, then use caution.

APPENDIX I

CONTRACEPTIVE EFFECTIVENESS

Rates of Unintended Pregnancies per 100 Women

Key

0–0.9	1–9	10–25	26–32
Very effective	Effective	Moderately effective	Less effective

Family planning method	First-Year Pregnancy Rates (Trussella)		12-month Pregnancy Rates (Cleland & Alib)
	Consistent and correct use	As commonly used	As commonly used
Implants	0.05	0.05	
Vasectomy	0.1	0.15	
Levonorgestrel IUD	0.2	0.2	
Female sterilization	0.5	0.5	
Copper-bearing IUD	0.6	0.8	2
LAM (for 6 months)	0.9 _c	2 _c	
Monthly injectables	0.05	3	
Progestin-only injectables	0.3	3	2
Combined oral contraceptives	0.3	8	7
Progestin-only oral pills	0.3	8	
Combined patch	0.3	8	
Combined vaginal ring	0.3	8	
Male condoms	2	15	10
Ovulation method	3		
TwoDay Method	4		

Standard Days Method	5		
Diaphragms with spermicide	6	16	
Female condoms	5	21	
Other fertility awareness methods		25	24
Withdrawal	4	27	21
Spermicides	18	29	
Cervical caps	26 ^d , 9 ^e	32 ^d , 16 ^e	
No method	85	85	85

^a Rates largely from the United States. Source: Trussell J. Contraceptive efficacy. In: Hatcher R et al., editors. Contraceptive technology. 19th revised ed. 2007 (in press). Rates for monthly injectables and cervical cap are from Trussell J. Contraceptive failure in the United States. Contraception. 2004;70(2): 89—96.

^b Rates from developing countries. Source: Cleland J and Ali MM. Reproductive consequences of contraceptive failure in 19 developing countries. Obstetrics and Gynecology. 2004;104(2): 314—320.

^c Rate for consistent and correct use of LAM is a weighted average from 4 clinical studies cited in Trussell (2007). Rate for LAM as commonly used is from Kennedy KI et al., Consensus statement: Lactational amenorrhea method for family planning. International Journal of Gynecology and Obstetrics. 1996;54(1): 55—57.

^d Pregnancy rate for women who have given birth

^e Pregnancy rate for women who have never given birth

APPENDIX J

Government of Nepal Ministry of Health and Population, Department of Health Services

Finance slip

Name of center:

District:

Total no. of Family:

Date:

Preferred F.P. Contraceptives:

Name of Doctor:

Vasectomy, Minilap

Signature:

Laproscopy, IUCD

Assistant's Signature:

Client's Name, Surname:

Address:

Signature:

Approved by:

(Only for Doctors)

(Office incharge)

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