NATIONAL STANDARDS
FOR
REPRODUCTIVE HEALTH SERVICES

FAMILY PLANNING FOR BIRTH SPACING

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Reproductive Health Task Force
Department of Women and Reproductive Health
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TRANSITIONAL ISLAMIC GOVERNMENT OF AFGHANISTAN

FOREWORD

NATIONAL FAMILY PLANNING SERVICE GUIDELINES FOR BIRTH SPACING

The National Family Planning Service Guidelines for Birth Spacing is based on the Mission, Vision, Values and Principles of the Ministry of Health and the National Health Policy of the Government of Afghanistan. The Policy states that the Ministry of Health will ensure that women and men have access to family planning (FP) information and services and incorporate and integrate the FP services into the national health care system.

Purpose of Guidelines

The purpose of this document is to provide national FP service guidelines for birth spacing.

Objectives

The objectives of this document are to:

1. Provide a basic reference document for FP providers at all levels of health services
2. Provide guidance for the following key categories:
   - Policy makers
   - Health managers
   - Service providers
3. Develop training materials for all health providers
4. Develop appropriate material for use in the community

The Guidelines contribute to meeting the first objective of the FP strategy, "improved access to and quality of family planning services," as enunciated in the National Reproductive Health Strategy. While implementing the guidelines, efforts should be made to promote advocacy and behavior change communication activities. These activities are critical for increasing utilization of FP services.

It is hoped that the document will be adapted for various levels of health care. The first priority is to adapt it for the Basic Health Services.

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INTRODUCTION

THE NATIONAL HEALTH POLICY

The Ministry of Health of the Government of Afghanistan is committed to attaining the goals of "Health for All" built on the following principle: "the enjoyment of the highest standard of health is a fundamental right for every human being." Based on the principles of (Primary Health Care, the national health sector will be organized and streamlined to deliver the Basic Package of Health Services (BPHS) to the entire population, with given to the rural areas and the most vulnerable groups. The BPHS will be delivered through health facilities backed up with appropriate and accessible referrals for emergencies. Family planning (FP) counseling, information, and service are some of the components of the BPHS.

Reproductive health is one of the "Health Sector Priorities to Save and Improve Lives." The principle policy guidelines in priority areas under Reproductive Health clearly articulates that "the Ministry of Public Health will ensure that women and men have access to FP information and services and incorporate and integrate the FP services into the national health care system." The mechanisms for achieving the above, as listed in the policy guidelines are:

- Access to safe, effective, affordable, and acceptable methods of FP of their choice will be improved.
- Couples will be provided with good quality, client-oriented information and services, a wider range of birth spacing methods, and confidential counseling that is responsive to and respectful of client's needs.
- The service providers will be trained in technically accurate and culturally appropriate counseling techniques.
- The support of community and religious leaders will be sought.
- An information, education, and communication campaign emphasizing child spacing, safe motherhood, and women's health will be carried out.

NATIONAL REPRODUCTIVE HEALTH STRATEGY

The National Reproductive Health Strategy is built on the Mission, Vision, Values, and Principles of the Ministry of Health and the National Health Policy. The two strategic components of the strategy are FP and safe motherhood. The safe motherhood strategy includes birth spacing as an important element of services. The FP strategy focuses on three objectives:

1. Improving access to and quality of FP services;
2. Strengthening information, education, and behavior change communication for FP birth spacing; and
3. Creating an enabling environment for utilization of FP services.

The strategic approaches for achieving the above objectives are as follows:

- Delivery of package of FP services at different levels with special focus on increasing coverage of FP services as part of the BPHS. The other approaches include use of community-based distribution of contraceptives, social marketing of contraceptives, development of a contraceptive logistics management system, development of national service delivery protocols, capacity building, and training.

- Development of behavior change communication plan and materials, identification of communication channels and audience, information, education and communication for male involvement, family life and life skills education in schools and cooperation with other ministries for implementing the behavior change communication activities.
- Involvement of community, civil society organizations, and community and religious leaders for promoting birth spacing.

The Family Planning Service Guidelines contribute to achieving the first objective of the FP strategy by describing the standards for quality of care.

SECTION 1: FAMILY PLANNING FOR BIRTH SPACING IN AFGHANISTAN

CHAPTER 1: FAMILY PLANNING AND ITS ROLE IN NATIONAL DEVELOPMENT GOALS

OBJECTIVE

The objective of this chapter is to provide information to health workers for use during counseling clients for FP.

FERTILITY STATUS AND CONTRACEPTIVE USE IN AFGHANISTAN

Basic Demographic Information[1]

- The population of Afghanistan is estimated to be 22 million.
- The sex ratio (number of females to 1000 males) is 1.05:1.
- The total fertility rate (average number of children born to a woman) is 6.9.
- The crude birth rate is 51.3 per 1000 population.
- The infant mortality rate is 152 per 1000 live births.
- The maternal mortality ratio is 1600 per 100,000 live births.[2]

Family Planning Indicators

- The contraceptive prevalence rate ranges from 2% to 12%[3] in the eastern region.
- The use of oral contraceptives is 10% and injectable contraceptives is 2%. The use of all other methods is negligible.[3]
- The unmet need of contraception is not known.

High Fertility and Its Impact on Mothers and Children

The reasons for high fertility are early pregnancies (among adolescents), closely spaced births, and too many pregnancies. The impacts of these are given below.

Problems Related to Early Childbearing (among adolescents less than 18 years)

- Because the adolescent is still growing, pregnancy affects the growth of both the girl and the fetus because of competing demands for nutrients between the adolescent and the fetus.
- A young girl who starts her family early may become pregnant more often, thus increasing her risk of morbidity and mortality due to high parity.
- Some life-threatening problems of pregnancy are more common among young girls who are pregnant.
- Pregnancy worsens existing anemia, which is already common, in many young girls:
  - An anemic mother may give birth to an anemic child.
  - An anemic mother is more at risk from bleeding during childbirth.
  - Babies born to very anemic mothers may be low birth weight and are at high risk of illness and death.

[1] UNFPA: Humanitarian Crisis in Afghanistan: Fact Sheet on Reproductive Health Indicators
[2] UNICEF, CDC: Maternal Mortality Survey in Afghanistan.
[3] UNICEF, GTZ: Multiple Indicator Cluster Curvey-2 East Afghnistan.2002

- A young girl:
  - is at high risk of developing complications, injury to the genital tract (e.g., obstetric fistula), and death during childbirth.
  - may be emotionally immature to take care of children.
  - is at risk of contracting sexually transmitted infections (STIs) at an early age due to early exposure to sexual activity.

Problems Related to Pregnancies at Close Intervals

- The risk of dying among newborns and infants, born at close birth intervals, is high. Other children under 5 are also at increased risk of dying.
- The chances of giving birth to low birth weight babies are high when pregnancies are closely spaced. Low birth weight babies are at high risk of frequent illness or death.
- Anemia is common among mothers with closely spaced pregnancies, as the body does not get adequate time to replenish the nutrients lost during pregnancy and childbirth. An anemic mother gets tired easily and is at risk of frequent illness, which usually affects the health of her children.

Problems Related to Too Many Pregnancies

- The risk of maternal death during labor and childbirth, due to bleeding and prolonged labor, is increased.
- The risk of abnormal presentation of the baby, leading to prolonged labor, is increased. Prolonged labor increases the risk of death and disability of the baby.
- The mother becomes severely anemic due to blood loss during multiple pregnancies. Severe anemia increases the risk of bleeding and heart failure during childbirth.
- Frequent exposure to infections during childbirth increases the risk of reproductive tract infections.
- Babies born to high parity mothers are at risk of being low birth weight. Such babies are at high risk of frequent illness or death.
- The prevalence of malnutrition among children under five, in families with too many children, is high.

Adolescent pregnancy, closely spaced pregnancies, and too many pregnancies are leading causes of maternal and child death.

Family Planning and Its Benefits

How Family Planning Saves the Lives of Mothers and Children

Family planning:

- Improves survival of mothers and children by helping women to have children at the right age at the right interval, and by limiting the number of pregnancies;
- Decreases the risk of death of children by ensuring the survival of their mothers. The increased risk of death of children of mothers who die is well documented.

Family planning saves lives by reducing the risk of death related to "the four toos": too young, too old, too many, and too close together.

How FP Improves the Health of Mothers and Children

Family planning helps to:

- Delay the first pregnancy until 18 years of age, thus:
  - helping young girls attain their full growth potential; and
  - reducing the risk of injury and infection of reproductive organs, which are not yet fully developed.
- Space pregnancies adequately, thus:
  - providing the mother enough time to replenish the nutrients lost during pregnancy and childbirth, reducing the risk of anemia and infections;
  - allowing more time for the mother to take care of the youngest baby; and
  - reducing the risk of death among children.
- Limit the number of pregnancies, thus:
  - reducing the risk of maternal death;
  - preventing severe anemia in mothers; and
  - improving the chances of survival of infants and children under five by reducing the risk of low birth weight and malnutrition.

In addition, the use of certain barrier methods of contraception (e.g., condoms) protects from STIs including HIV/AIDS.

Family Planning and Women's Empowerment

Family planning is a basic human right of a woman that has been violated in many communities across the country. Every woman has the right to make a choice about her reproduction.

- Family planning helps a woman to plan her family, which may be the first decision she has taken about her own life. This decision gives her self-confidence and encourages her to make other decisions in her life.
- Planning her family increases a woman's opportunities for employment outside the home, which in turn widens her access to information. Repeated pregnancies and childbirth limit employment opportunities.
- Planning her family provides opportunities for continued learning and education, which contributes to empowerment.
- The ability to make decisions and the increased capacity to earn through employment will gradually empower a woman.
- Family planning helps a woman to improve her role as care taker of the family. With fewer pregnancies, the woman will have more time to devote to the needs of her family and society.

Family Planning Methods and Their Health Benefits

Some contraceptive methods provide many non-contraceptive benefits:

- Combined oral contraceptives:
  - protect women from ovarian and uterine cancers and ovarian cysts
  - protect women from benign diseases of the breast
  - reduce the risk of ectopic pregnancy in women with a past history of the condition
  - reduce pelvic inflammatory diseases
- Condoms prevent transmission of STIs including HIV/AIDS

Family planning, by saving lives of women and children, contributes to achieving the development goals of reducing child mortality, improving maternal health, and promoting empowerment of women. It also contributes to the goal of combating HIV/AIDS. By reducing population growth (by preventing unwanted births), it also contributes to eradicating extreme poverty and hunger through increased opportunities for education and employment and ensures environmental sustainability.

CHAPTER 2: OVERVIEW OF FAMILY PLANNING METHODS

OBJECTIVE

To provide information to health workers for use during counseling clients for FP.

OVERVIEW OF FAMILY PLANNING METHODS

There are two types of FP methods:

- Traditional methods:
  - Fertility awareness based methods (cervical mucus method, basal body temperature method, sympto-thermal method, and calendar method)
  - Coitus interruptus (withdrawal)
- Modern methods:
  - For spacing births: condoms, oral and injectable contraceptives, and intrauterine devices (methods currently available in Afghanistan)
  - For limiting births: tubal ligation and no-scalpel vasectomy

A brief description of modern methods, how they work, their effectiveness in preventing pregnancy, and their advantages and disadvantage are given in the table at the end of the chapter.

MENSTRUAL CYCLE AND ITS RELATION TO CONTRACEPTIVE METHODS

The menstrual cycle prepares the woman's body for a possible pregnancy. This event occurs every month during the woman's reproductive years. The average menstrual cycle lasts 28 days (range from 25 to 32 days). The length of the menstrual cycle is counted from the first day of menstrual bleeding until the day before the first day of the next menstrual period.

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

The menstrual cycle consists of three phases:

1. Menstrual bleeding phase (usually days 1 to 5),
2. Estrogen phase (usually days 6 to 14), and
3. Progesterone phase (usually days 15 to 28).

The way in which different contraceptive methods interrelate with changes in the menstrual cycle is described below.

Method	How contraceptive methods interrelate with the menstrual cycle
Fertility awareness-based method	The prediction of the fertile period is dependent on the length of the menstrual cycle (8th day after onset of menstruation to the 19th day).
Oral contraceptives	Oral contraceptives must be started within the 1st to 5th day of the menstrual cycle (1st day preferred) in order to be fully effective as a contraceptive in the first cycle.
Injectables	The preferred time of initiation of the injection is within seven days after onset of menstruation (rationale as described above).
IUD	The preferred time of insertion is within the first 12 days after the onset of menstruation. During this period, the cervical os is open and this allows easy insertion of the IUD.
Tubal ligation	The preferred time for the procedure is within five days after the onset of menstruation (rationale as described above under hormonal contraceptives).

Method	What it is and how it works	Effectiveness in preventing pregnancy	Advantages	Disadvantages
Condom	A sheath made of latex, which when put on the erect penis during sexual intercourse and taken off carefully after intercourse prevents the ejaculate from spilling inside the woman and thus prevents pregnancy and STIs including HIV/AIDS. A fresh condom is to be used with each act of intercourse.	97% effective with correct and consistent use	• Easy to use • Protects against STIs including HIV/AIDS	• Interferes with sexual activity • Failure rate is high if not used correctly and consistently
Combined oral contraceptives	Tablets containing female sex hormones similar to the ones naturally present in the body, which are taken daily. Prevents pregnancy by suppressing the release of ovum and thickening the cervical mucus, preventing sperm from entering the uterus.	99.7% effective with correct and consistent use	• Very effective • Not related to sexual activity • Improves menstrual problems • Protects from cancers of the uterus and ovary and benign breast disease	• Minor side effects such as nausea, vomiting, breast tenderness, headaches and weight gain in the first 3 months of use • Complications in women above 35 years who smoke heavily • Does not protect against STIs including HIV/AIDS • Cannot be used by breastfeeding women in the first 6 months after childbirth

Method	What it is and how it works	Effectiveness in preventing pregnancy	Advantages	Disadvantages
Injectable contraceptives	Injections containing a female sex hormone similar to the one in the body, to be given every three months. Prevents pregnancy by suppressing the release of ovum and thickening the cervical mucus	99.7% effective when injections are taken regularly	• Very effective • Effective within 24 hours of receiving the injection • Prevents pregnancy for 3 months • Unobtrusive • Not related to sexual activity • Can be used by breastfeeding	• Provider dependent • No menses (common problem) • Prolonged spotting/bleeding • Does not protect from STIs including HIV/AIDS
Intrauterine device (IUD)	A T-shaped device with copper wires on the arms and vertical stem that when inserted into the uterus prevents pregnancy by interfering with the movement of the sperm and preventing implantation of the embryo	99.2% effective	• Very effective long-term contraceptive • Cost effective • Can be used by breastfeeding women	• Dependent on provider • Side effects such as cramps and increased bleeding during menstruation • Serious complications such as perforation, a rare condition if the procedure is done correctly • Does not protect from STIs including HIV/AIDS

Method	What it is and how it works	Effectiveness in preventing pregnancy	Advantages	Disadvantages
Tubal ligation and no-scalpel vasectomy	In women, through a small cut in the lower part of the abdomen, the tube that transports ovum from the ovary to the uterus is cut so that the ovum cannot reach the uterus. In men, through a small hole over the scrotum, the tube that carries the sperms is cut so that sperm don't reach the ovum during intercourse.	99% effective	• Very effective • Usually safe	• Permanent • Even with re-connecting the tubes (re-canalization) by highly skilled doctors, the chances of conception are negligible

SECTION 2: ELEMENTS OF QUALITY SERVICE PROVISION

CHAPTER 3: COUNSELING

OBJECTIVE

The objectives of this chapter is to provide guidance for health workers to help clients achieve their reproductive health goals (timing and number of births) and meet their reproductive health needs by using FP methods based on informed choice.

WHAT IS COUNSELING?

Counseling is a face-to-face two-way exchange of information that helps to clarify doubts, resolve problems, and make voluntary and well considered decisions (informed choice). Counseling is not telling someone what to do, nor is it imposing one's values on the person who is being counseled.

Counseling for Family Planning

Counseling is one of the critical elements of quality FP services. Family planning counseling helps clients to:

- initiate use of appropriate contraceptive method
- use the contraceptive method more effectively
- continue with the current contraceptive method
- switch to another acceptable method to avoid pregnancy
- prevent STIs, including HIV/AIDS, and seek early treatment for STIs:

Wherever possible the spouse should also be counseled, and confidentiality and privacy should be ensured at all counseling sessions.

Confidentiality and privacy should be maintained during counseling.

Steps in Effective Family Planning Counseling

The steps in effective FP counseling, known by the acronym "GATHER," are as follows:

1. **G**reet the client. This first step is essential for building a rapport and making the client feel comfortable.
2. **A**sk relevant questions to identify the client's needs: personal, social, family, medical, reproductive health including reproductive tract infections (RTIs)/STIs, FP goals, and past/current use of FP methods.
   - Be supportive and non-judgmental.
3. **T**ell the client (provide information) about:
   - Benefits of FP in the context of Afghanistan, focusing on specific benefits for the woman, her children, and her family.
   - Various contraceptive methods, their mechanisms of action, benefits and disadvantages, and timing for initiation of the method (use information in Chapter 2).
4. **H**elp the client choose a method and assess whether the method chosen is appropriate (see Chapter 4). If the chosen method is not appropriate, explain the reason and help choose another method.

5. **E**xplain the use of the method (see Chapters 5 to 9) and provide the contraceptive. If the method is not available in the facility, provide information and assistance to get the appropriate method.
6. Discuss when to **R**eturn for supplies/follow up and what to do in case of problems.

Method-Specific Counseling

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

- Counsel every time a client visits: during the first visit and each subsequent visit.
- Ensure that privacy and confidentiality are maintained at all times.
- Establish rapport with the client.
- Ask the client what s/he knows about the specific method, whether s/he has heard any rumors about the method, and if s/he has any past experience with the method (in case of clients who have used the method). (Refer to Appendix 6 for common rumors).
- Provide information as relevant, and clarify doubts. If the client is new, provide the information given below (**show the contraceptive chosen while providing information**):
  - Mechanism of action
  - Effectiveness
- Advantages, disadvantages
- When to start using the contraceptive (in relation to menstrual period)
- Instructions on use (where relevant) emphasizing the importance of following instructions and what to do incase the instructions are not followed
- If the client is still convinced about the decision to use the method, assess the client for medical eligibility as detailed in Chapter 4 and in Chapters 5 to 9 on specific contraceptive methods.
- Record history and findings in the client record.
- If found eligible for using the method as described in Chapter 4 and in Chapters 5 to 9, demonstrate the use of the contraceptive or describe the procedure as described in specific sections in Chapters 5 to 9.
- Ask the client to repeat instructions (where relevant).
- Tell the client about:
- likely problems/side effects in the first three months and what to do in such situations;
- situations when condom use is advised (risk of pregnancy due to non-compliance, conditions that affect the effectiveness of the method or exposure to STIs);
- if condom use is advised, how to use the condoms (ask to repeat the instructions on the use of condoms);
- storing the contraceptive (where relevant); and
- follow up.
- Provide the method/perform the procedure:
- Record the supply of the contraceptive or the procedure
- Provide a packet of condoms for use in case of situations listed above.

Counseling a Client Who Is Being Referred

It is important to counsel a client who is being referred for problems or for a method chosen that is not available at the facility. If the client is accompanied by a husband/relative, explain the reason for referral.

- Explain why the client is being referred, where is the referral site, and what is the likely procedures at the referral site.
- Give a referral letter with all the details of history and findings and the reason for referral (and/or send the client card). Request feedback from the referral site.
- Instruct the client to report back after returning from the referral site.
- If the client is reluctant for the referral, counsel for other methods of FP.
- Give a packet of condoms in case there is delay in referral. Make sure the client knows how to use the condoms.
- Record the referral.

Follow up all clients who have been referred (request their to return to the clinic or to contact a health care worker).

Counseling During Follow Up

Every time a client comes for follow up, it is important to counsel the client to ensure continuation of the method.

- Ask the client whether she and her spouse are satisfied with the method.
- Ask about problems and reassure as required.
- Ask about any history of pelvic pain or discharge from the vagina or any history suggestive of STIs in the spouse.
- Assess the client (history and examination) to confirm/rule out problems reported or to identify any new conditions that are contraindications for use of the method. Record findings.
- Manage problems as discussed in Chapters 5 to 9.
- If the client has developed conditions that are contraindications for the method, counsel for other contraceptive methods.
- If the client is continuing with the method, ask to repeat the instructions and what to do if problems arise.
- Provide supplies (where relevant) and record the same.

Counseling a Client Who Wants to Change or Stop Using a Method

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

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

Counseling When Gender Concerns Override the Need for Family Planning

Preference for males is common in Afghan society. The desire for boys results in many pregnancies leading to poor maternal and newborn health and even death. In such situations, reproductive rights of women are not respected. Although in such situations, the steps in counseling are not different (as in 4.2), counseling in such situations requires additional emphasis on the following steps:

- Establishing a rapport with the women- respecting, gaining their trust and confidence.
- Identifying the client's needs by actively listening and trying to understand the client's feelings without offending the client or getting the client defensive
- Find out whether the problem is due to family pressure or societal pressure
- Being supportive and non-judgmental
- While providing information, emphasize the following:
- non-health benefits of FP such as opportunity to provide quality care to the family and to earn some income
- who is responsible for the sex of the child
- the value of girls and making them economically independent through education
- Encourage the client to discuss these issues with the spouse (if not present at the counseling session)
- Give time for the client to make a decision about using any FP method.
- Maintaining confidentiality and privacy is critical

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

CHAPTER 4: CLIENT ASSESSMENT

OBJECTIVE

The objective of this chapter is to provide guidance to health workers to ensure that the clients are eligible for the use of the chosen method, to minimize complications and to ensure continuity with the method.

CLIENT ASSESSMENT

History

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

- Personal history: Age of the client - to help decide on the most suitable method of contraception
- Social history: social habits such as smoking- to determine eligibility for use of oral contraceptives.
- Reproductive health history:
  - Number of children ever born, number living and their sex, age of last child, desire for more children - to help decide a method that is most appropriate
  - If last child is less than 6 months of age- history of breastfeeding, frequency, any supplementary feeding -to determine eligibility for use of combined oral contraceptives and lactational amenorrhea method
  - Menstrual history: date of last menstrual period – for initiating use of all contraceptives, regularity and bleeding in between periods- to determine eligibility for use of oral contraceptives, injectable contraceptive and Intrauterine Devices (IUD)
- Medical history:
  - History of heart disease, stroke, hypertension, diabetes, jaundice, cancer of the breast and genital tract, convulsions and mental illness - to determine eligibility for use of oral contraceptives and injectables
  - History of taking treatment for tuberculosis and convulsions and antibiotics as some of the medicines affect the effectiveness of the oral contraceptives.
  - Any surgery: history of major surgery and prolonged immobilization is important as the risk of deep vein thrombosis is high among such people- to determine eligibility for use of oral contraceptives and injectable contraceptives.
- Family history (e.g., diabetes, hypertension, heart disease and cancers of the breast and genital tract, as these tend to run in families) to determine eligibility for use of oral contraceptives and injectables
- Contraceptive history: history of contraceptive use and past experience with the method as this information is important while advising a particular contraceptive
- History of STIs and sexual history: history of discharge from genitalia and history of husband having multiple sexual partners (more than one wife/partner) to determine eligibility for use of IUDs and to provide treatment for the client and spouse.

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

Physical Examination

- General and systematic examination (e.g., pallor, jaundice, pulse, blood pressure) to determine the eligibility for use of contraceptives such as oral contraceptives,

injectables and IUDs.
- Abdominal examination to rule out liver disease and pelvic inflammatory disease to determine the eligibility for use of oral contraceptives and injectables.
- Pelvic examination to determine eligibility for use of IUDs.

Laboratory Examination

- Hemoglobin where possible
- Urine examination for protein and sugar where possible

Record

Record findings on the client card.

Ruling out Pregnancy

Ruling out pregnancy is important for determining the eligibility for most of the contraceptives. Pregnancy can be ruled out as follows:

- If no symptoms and signs of pregnancy such as missed periods, early morning nausea, vomiting, breast tenderness and
- Client gives the following in history:
- Has been using a contraceptive correctly and consistently
- Within first 7 days of menstruation
- No intercourse since last menses
- Time of last delivery/abortion:
    - within 4 weeks post-partum and not breastfeeding
    - more than 4 weeks but less than 6 months and exclusively breastfeeding and no periods
    - within first 7 days of abortion

Note: Pelvic examination and pregnancy tests are only advised if it is difficult to rule out pregnancy by history and in cases where it is more than 6 weeks since missing the last period.

Eligibility Criteria

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

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

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

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

The eligibility criteria for each method are discussed in Chapters 5 to 9.

Contraindications and Precautions

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

Contraindications

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

Precautions

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

Remember: It is important to remember that in Afghanistan many mothers die due to complications of pregnancy and childbirth. Women should be helped to plan their families using the contraceptives of their choice. If eligible, all efforts should be made to provide the contraceptive and the precautions listed with each specific method should not be considered a contraindication for using the method.

SECTION 3: CLINICAL GUIDELINES FOR THE PROVISION OF SPECIFIC METHODS OF CONTRACEPTION

The objective of chapters 4 to 9 in this section is to provide guidance to health workers to provide quality services for the methods chosen by clients and to ensure sustained use of contraceptives by managing problems if any.

CHAPTER 5: CONDOMS

A condom is a sheath made of thin latex (synthetic rubber) that is put on a man's erect penis before intercourse.

METHOD CHARACTERISTICS

Mechanism of Action

Condoms prevent pregnancy by creating a barrier, which prevents the sperms from entering the vagina and thereby preventing fertilization of the ovum.

Effectiveness

If used correctly and consistently, condoms are 97% effective in preventing pregnancy. However, the effectiveness is only 86% as commonly used.

Advantages

- Fairly effective if used correctly and consistently
- Easy to use
- Easily available
- Male participation in contraception (by agreeing to use the condom)
- No method related health risk
- Can be used with other contraceptives where risk of STI / HIV is present
- Readily reversible birth control method for men
- Health benefits:
  - Protection against STIs/HIV and the consequences of these conditions
  - Helps protect against cervical cancer as it prevents STIs (some STIs are known to cause cervical cancers)

Condoms provide “dual protection” as they prevent pregnancy as well as STIs including HIV/AIDS.

Disadvantages

Limitations

- Can interfere with sexual pleasure
- May decrease sensitivity for some men
- Small risk of slipping, tearing and spillage of semen if not used properly
- High level of motivation required to use a condom consistently and correctly
- Difficulty in disposing used condoms
- Quality of the condom can deteriorate if not stored properly

Side effects

- Allergy to latex, experienced by both men and women, is rare.

METHOD-SPECIFIC COUNSELING

Counsel as detailed in Chapter 3. Specific points to be noted while counseling for condoms include:

- Rumors about the method (see Appendix 6)
- Fears about breakage of condoms
- Ensure that the client has understood the correct use of condoms

Eligibility

Indications

Condoms are appropriate for most couples because it rarely causes any side effects. They are also appropriate for couples:

- Where the husband wants to actively participate in FP
- Where the wife has conditions that are considered precautions for other methods of contraception
- Who need a back-up method such as in the case of forgetting the oral contraceptive pill
- Waiting for surgical contraception or IUD insertion
- Where the wife is the first 6 months of lactation and wants to use a contraceptive
- At risk of exposure to STIs /HIV.

Precautions

- Allergy to latex

INSTRUCTING ON THE USE OF CONDOMS

- While instructing a client, show the condom. Demonstrate on an anatomical model/illustrations (if possible).
- Show the client how to check the expiry date on the packet.
- Instruct on the following:
  - Do not use the condom if it is discolored or brittle
  - Do not test the condoms for holes as it is already electronically tested
  - Do not lubricate the condom as it is already lubricated
- Ask the client to repeat the instructions.
- Provide a month's supply of condoms (approximately 15 pieces) and ask them to return for follow up or collecting supplies.
- Record the supply of contraceptives.

Correct and consistent condom use prevents pregnancy and protects from STIs including HIV. Therefore it is very important that the health worker ensures that the client has understood the correct use of condoms.

Client Instructions

- When should you use a condom:
  - Use a condom **every time** with **every act of intercourse**.

- Be sure you have a condom before you need it.

- How to use the condom correctly:
  - Put the condom on the penis when it is erect and before the penis is in contact with the spouse's genitals.
  - Remove the condom carefully from the packet taking care not to tear it.
  - Do not unroll the condom before it is put on the penis.
  - Place the condom on the erect penis ensuring that the rolled rim remains on the outside of the condom.
  - **Squeeze the tip of the condom** to ensure that half an inch air free space is left to collect the ejaculate. In case of condoms with readymade tip, squeeze the tip first to expel air. Care should be taken not to tear the condom with fingernails.
  - Continue to squeeze the tip while unrolling it all the way to the base of the penis.
  - Cover the penis fully for preventing slipping of condoms as well as preventing contact with ulcers (if present) on the penis or in the vagina.
  - After the intercourse, hold the rim of the penis before coming out of the vagina to prevent slippage of the condom and spilling of contents in the vagina.
  - Pull the penis out before it goes limp so that the condom does not slip and gets left in the vagina which will result in the ejaculate spilling and causing a pregnancy or transmitting STIs / HIV.
  - Slide the condom slowing without spilling the contents **only after** the penis is pulled out of the spouse and is not in contact with the spouse.
  - Tie a knot so that the contents do not spill and dispose it off carefully either burying or burning.
  - Use a new condom if the condom has not been properly put or there is a breakage.
- If the condom slips or breaks:
  - Immediately wash the genitalia with soap and water to minimize risk of pregnancy and STIs/HIV.
  - Contact a health worker for emergency contraception.
- Storage of condoms
  - Make sure the supplies are adequate.
  - Store condoms in a cool and dry place and not exposed to sunlight as heat and sunlight cause breakage of condoms.
- Ask the client to demonstrate proper use of condoms.
- Instructions for return visit
  - Return to the provider if your spouse or you are not satisfied with the method.
  - In case of allergy, return to the provider for advice.
  - Return after one month or earlier for supplies. Provide information on other sources of supplies (if any).

Management of Side Effects

Always counsel clients who have side effects and other complications as described in Chapter 3. If the client wants to stop the use of condom, counsel for other methods of FP.

Table 5.1 Management of Side Effects of the Condom

Side effect or problem	Assessment	Management
Condom broken before or after use	Check for holes	Before use: advise to use a new condom. After use: advise to wash the genitalia with soap and water immediately. Provide emergency contraception as discussed in Appendix 3.
Local irritation to penis or vagina	Rule out allergy	If allergic to latex, counsel for another method.
Diminished sexual pleasure		Counsel for another method.

CHAPTER 6. COMBINED ORAL CONTRACEPTIVES

Combined oral contraceptives (COCs) commonly called "the Pill," are hormonal contraceptives. The pill contains low doses of two synthetic hormones called estrogen and progestin, very similar to the hormones naturally occurring in the body. A packet of oral contraceptives has 28 tablets with first 21 tablets containing the hormones and the last 7 tablets containing iron.

METHOD CHARACTERISTICS

Mechanism of Action

The pill provides effective protection against pregnancy mainly by:

- Suppressing release of ovum from the ovary
- Thickening cervical mucus making it difficult for the sperms to enter the uterus
- Altering the endometrium, making it unsuitable for pregnancy

Note: Continuous taking of the pill for 7 days is critical for suppressing the ovulation. Each tablet's effect lasts only for 48 hours.

Effectiveness

COCs are very effective when taken correctly and consistently (99.7% effective).

Return to Fertility

Fertility returns quickly (may not be immediate) after the woman stops taking the pills.

Advantages

COCs are very effective when taken correctly and consistently. They are:

- Safe for most women
- Easy to use
- Reversible (can stop the pill on her own whenever desired by the client with no loss of fertility)
- Non-invasive
- Unrelated to sexual activity

Health benefits of COCs include:

- Menstrual cycle;
  - Regularizes menstrual cycle to 28 day cycle
  - Reduces menstrual cramps
  - Decreases menstrual blood loss and duration, thus reduces anemia
- Reduces incidence of pelvic inflammatory disease (PID) as the thick cervical mucus prevent microorganisms from entering the uterus
- Protection from ectopic pregnancy, in women who gives history of the problem, as no ovum is released
- Protection from cancers of ovary and uterus and ovarian cysts
- Protects from benign breast tumors
- Useful in the treatment of abnormal uterine bleeding

- Reduces pimples on the face (acne)

Disadvantages

Limitations

- Has to be taken every day and depends on the motivation of the user
- Does not protect against STIs/ HIV
- Not appropriate for mothers who are breastfeeding infants less than 6 months old as it may decrease the quantity of milk
- Effectiveness of the pill may be decreased in women who are on treatment for tuberculosis (rifampicin), convulsions (phenytoin, carbamazepine, barbiturates, primidone) and on certain antibiotics (griseofulvin).

Side Effects

- Minor side effects listed below are most common during the first 3 months of use and these usually disappear with continued use:
  - Amenorrhea
  - Bleeding in between periods or spotting
  - Nausea
  - Headache
  - High blood pressure
  - Weight gain
  - Breast tenderness
- Serious side effects such as heart attack or stroke are rare with low-dose pill.
- High risk for women who smoke and above 35 years
- Women who smoke, irrespective of whether they use the pill, are at increased risk for heart attack or stroke.

Minor side effects are most common in the first three months of use of the pill. These disappear with continued use of the pill.

Remember: The risk of dying due to complications of pregnancy and delivery is much higher than the risk of dying from complications of the pill in properly screened low risk patients.

METHOD-SPECIFIC COUNSELING

Counsel as detailed in Chapter 3. Specific points to be noted while counseling for pill:

- Rumors about the method (see Appendix 6)
- Timing of starting the pill
- Fears about the side effects. Emphasize that the unlikely complications in women who are eligible for use of the pill are negligible compared to the risk of dying from complications of pregnancy and childbirth.
- Ensuring that the client has understood the correct use of the pill

Eligibility

Indications

COCs are appropriate for:

- Women in the reproductive age group, who desire a highly effective contraceptive and who meet the eligibility criteria
- Use immediately after abortions
- Women with menstrual problems such as heavy cramps, heavy bleeding or has irregular cycles as the pill decreases such problems
- Women with anemia as menstrual bleeding is decreased
- Women with previous history of ectopic pregnancy
- Women with family history of cancer of the ovary of uterus or cysts of the ovary as the pill provides protection

Contraindications

The pill should not be prescribed in the following conditions/situations:

- Pregnancy
- History of thrombo-embolic disorders in the present or past: stroke / deep vein thrombosis as the pill adds to the existing pre-disposition to clotting
- History of heart disease such as ischemic heart disease, angina, cardiac failure, valvular heart disease and others as the pill adds to the pre-disposition to clotting
- High blood pressure 160+/100+ as the pill causes slight increase in the blood pressure
- Severe headache or migraine with focal neurological symptoms as it may be an indication of increased risk of stroke, a condition where the use of the pill is contraindicated
- Major surgery with prolonged immobilization as the risk of deep vein thrombosis is increased, a condition where the use of the pill is contra-indicated
- Long standing diabetes or diabetes with vascular complications such as retinopathy, nephropathy or neuropathy as they are more at risk of cardiovascular disease and clotting and the pill adds to the complications
- Is above 35 years old and is a heavy smoker (15 cigarettes a day) as the pill adds to the existing risk of cardiovascular disease and clotting as a result of smoking
- Has cancer of the breast, history suggestive of cancer or undiagnosed lump in the breast as the pill may contribute to the progress of the condition
- Has severe or active liver disease, gall bladder disease or history of jaundice in the previous 6 months or recurrent jaundice during pregnancy, as the pill is metabolized in the liver
- Breastfeeding less than 6 months postpartum because of the increased risk of thrombosis in the mother (first 3 weeks), the risk of newborn being exposed to the hormones through breast milk (first six 6 weeks) and a decrease in quantity of breast milk

Precautions

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

- Age over 40 years as the risk of heart disease increases with age and the pill may add to the risk

- on treatment for tuberculosis (rifampicin), convulsions (phenytoin, carbamazepine, barbiturates, primidone) and on certain antibiotics (griseofulvin) for more than a week as these medicines reduce the effectiveness of the pill.

Special circumstances when COC should be withheld include:

- Planned surgery: COC should e discontinued at least four weeks in advance of the surgery because of its effect on increasing coagulation of blood.
- Girls who have not reached menarche

CLIENT ASSESSMENT

It is advisable to have the clients assessed although this is not an absolute requirement as many programs distribute the pill without any client assessment. The following table provides a history checklist to determine the eligibility of the client.

Table 6.1 History Taking Checklist for Use of Oral Contraceptive Pills

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

Instructions for Health Care Workers in Health Post

- If any of the above is present, refer to a doctor/midwife for further assessment. **Age above 35years is significant only if associated with smoking.**
- It is not possible to identify all the above conditions by history taking alone. Therefore, it is advisable to refer the client to a doctor/midwife (if possible) within the first 3 months of starting the pill. The referral is for a complete physical examination including a pelvic examination and is recommended as a good preventive practice.

- Record information on the client card.
- Follow up is important especially in the first 3 months to ensure the continuation of the method.

Instructions for Health Care Workers in Facilities

Health workers posted in health facilities should do a physical examination as follows:

- Check for pallor, jaundice, and varicose veins
- Check blood pressure
- Whenever possible, it would be advisable, but not mandatory, to offer pelvic examination as a good preventative practice. It should not, however, be a barrier to providing the method.
- Record information on the client card.
- Follow up is important especially in the first 3 months to ensure the continuation of the method.

GUIDELINES FOR INSTRUCTING ON USE OF COCS

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

Client Instructions

- The pills are a safe and effective method of contraception if it is taken correctly and regularly. There are 28 tablets in the packet and the first 21 are white and the last 7 are colored.
- When to start taking the pill
  - Start the first pill from the packet on any day between the **first to the fifth day of menstrual cycle** (ideally). However, if your menstrual flow is very little (just spotting), then it is better to start the pill on the fifth day when you are sure that you are menstruating.
  - Start any day, if reasonably sure of not being pregnant, but must abstain from sex or use another contraceptive for next 7 days (after starting the pill).
  - Start within 5 days of abortion (if relevant)
- How to take the pill correctly
  - Swallow one pill every day. It is preferable to take it at bedtime. This will help you to remember it everyday and also prevent any possible discomfort.

- Follow the arrow to know which pill should be taken next.
- Do not miss the pill even on a single day, even if you do not have sexual relations.
- Continue taking the pill even if you are menstruating. Menstruation usually starts while taking the colored pills.
- When you finish one packet, start the next packet the next day starting with the pill where START is marked.
- You may have some spotting or bleeding between the periods in the beginning. This is not menstrual bleeding and do not stop the pill. This usually stops after 2-3 months.
- You may have some nausea, dizziness or headache while taking the pill. These usually disappear after the first two or 3 months. If you take the pill at bedtime, you may not feel these symptoms.
- Do not stop the pill without consulting a health worker. If you do stop the pill, do not stop mid menstrual cycle as it will cause withdrawal bleeding.

- What to do if you miss taking the pill
  - Emphasize that each day of missing 'the pill' increases the risk of pregnancy.
  - If one pill is missed, take it as soon as you remember it.
  - The next pill should be taken at the same time as usual (two pills may have to be taken on one day).
  - If the pill is missed for two days or more:
    - Take the pills as soon as possible.
    - Take the next pill at the same time as usual.
    - As the birth control effect of a single pill lasts only for 48 hours, avoid sex or use condoms for 7 days till the pill has been taken for 7 continuous days (for the pill to be effective).
    - Discard the missed pills.
- In case of vomiting within 2 hours of taking the pill (as the first one may have been vomited out), take another pill.
- Use condoms :
  - If the pill is missed for two or more days
  - If the packet of pills is finished and you have no new packet
  - If at risk of exposure to STIs/HIV
  - In case of diarrhea or vomiting for 2 more days when the chances of absorption of the pill are decreased and the risk of pregnancy is increased.
- Inform the doctor/nurse during every medical consultation on the use of the pill to avoid the doctor prescribing medicines that affect the effectiveness of the pill.
- Contact the health worker for advice if started on treatment for tuberculosis, convulsions or on long term treatment for infections as these drugs reduce the effectiveness of the pill.
- Keep the pill in a cool, dry place, out of reach of children.
- When to come for follow up
  - Return to the clinic/provider within 3 months of starting the pill. Bring the used packets (even the empty ones).
  - Return to the clinic/provider before the scheduled date if you:
    - are not satisfied with the method:
    - develop jaundice
    - pregnancy is suspected
    - develop risk of STI/HIV
    - develop lumps in the breast
    - have inter-menstrual or post-coital bleeding
  - Contact the doctor **immediately** if any of the following as they are life threatening conditions:

- Severe abdominal pain
- Severe chest pain, cough, breathlessness
- Severe headache, dizziness, weakness, numbness
- Eye problems, speech problem
- Severe pain in calf or thigh.

WARNING SIGNS

The following acronym will help to remember the warning signs:

A – Abdominal pain
C – Chest pain
H – Headache
E – Eye problem
S – Severe leg pain

Management of Side Effects and Other Complications

Always counsel clients who have side effects and other complications as described in Chapter 3. If the client wants to stop the pill, counsel for other methods of FP. Always counsel clients who are being referred as in Chapter 3.

Table 6.2 Management of Side Effects of Oral Contraceptive Pill Use

Side effect/problem	Assessment	Management
Amenorrhea	• Find out whether the pill is being taken correctly and consistently • Ask for history of diarrhea and vomiting • Rule out pregnancy by checking symptoms or physical examination and /or pregnancy test (depending on the level of provider)	• If pregnant, assure the client that the pill (already taken) will not harm the baby and advise for antenatal care • If not pregnant: - If the pill is being taken regularly, counsel and continue with the pill - If the pill is **not** being taken correctly, repeat instructions • Refer to specialist if amenorrhea, continues
Spotting or bleeding	• Find out whether the pill is being taken correctly and consistently • Ask for history of diarrhea and vomiting • Rule out pregnancy (as above)	• If pregnant, advise as above • If not pregnant: - the pill is being taken regularly, counsel and continue with the pill - the pill is not being taken correctly, repeat instructions • Refer to specialist if spotting continues • Advisable to refer to specialist for ruling out other problems that cause bleeding

Side effect/problem	Assessment	Management
Nausea	• Find out whether the pill is being taken correctly and consistently and the time of the day it is taken • Rule out pregnancy (as above).	• If pregnant, advise as above • If not pregnant: - If the pill is being correctly, counsel - If the pill is not being taken correctly, repeat instructions on taking the pill (take at night, not to take on empty stomach) • Refer to specialist if nausea continues to rule out other causes.
High blood pressure	• Find out whether rise in blood pressure is after starting the pill • Check blood pressure (where possible) two times in a week	• Refer such cases to specialist. • Repeat warning signs (severe headache, blurred vision, chest pain) • If the blood pressure is raised, refer
Headache	• Rule out high blood pressure (where possible) • Find out the severity of the headache, any blurring, giddiness	• If no rise in BP, reassure • If headache continues, refer to specialist
Weight gain	• Check if the weight gain is after the pill • Assess food intake • If no reason found, rule out pregnancy by checking symptoms	• If pregnant, advise as above • If not pregnant, counsel
Breast fullness or tenderness	• Find out whether the pill is being taken correctly and consistently • Rule out pregnancy as above. • Rule out breast lumps, ulcer and infection of the breast (if breastfeeding)	• If pregnant, advise as above • If not pregnant and no breast lumps, counsel • Refer to specialist in case of breast lumps or ulcer.

Use of COCs for Emergency Contraception

COCs can be used for emergency contraception in case of unprotected sexual intercourse due to no use of contraceptives, contraceptive accident or misuse (condom rupture, incorrect use or slippage, failed traditional contraceptive methods, IUD expulsion) and sexual assault (see details in Appendix 3).

CHAPTER 7: INJECTABLE CONTRACEPTIVES

Injectable Contraceptives commonly called 'injectable' are hormonal contraceptives. The injection contains one of the synthetic hormones called progestin, which is very similar to the hormones that naturally occur in the body. The injectable contraceptive discussed in this chapter is Depo medroxyprogesterone acetate (DMPA).

METHOD CHARACTERISTICS

Mechanism of Action

The injectable provides effective protection against pregnancy mainly by:

- Suppressing ovulation
- Thickening cervical mucus making it difficult for the sperm to enter the uterus
- Making the endometrium thin, which is not suitable for pregnancy

Effectiveness

Very effective when the injections are taken regularly (the effectiveness is 99.7%).

Return to Fertility

It may take about 7 months from the first missed injection or 10 months from the last injection.

Advantages

- One of the most effective methods when taken regularly.
- Rapidly effective (within 24 hours of taking the injection)
- Prevents pregnancy for 3 months
- Unobtrusive and easy to use (women may take the decision to use DMPA on her own without spouse/family members knowing about it)
- Few method related risks compared to the pill
- Does not interfere with breastfeeding
- Does not interfere with sexual intercourse
- Reversible (can stop whenever desired by the client)
- Health benefits:
  - Menstrual cycle
  - Reduces menstrual cramps
  - Decreases menstrual blood loss and duration, thus reduces anemia
  - Reduces incidence of PID as compared to non-users as the thick cervical secretions prevent microorganisms from entering the uterus
  - Protection from ectopic pregnancy in women who gives a history of the problem, as no ovum is released
  - Protection from endometrial cancer

Disadvantages

Limitations

- Need to contact a health worker every 3 months

- Does not protect against STIs/HIV

Side effects

- Amenorrhea
- Prolonged bleeding (for more days than normal) in the first month of use
- Irregular bleeding or spotting
- Delayed return of fertility
- Weight gain (less common)
- Headaches or dizziness (less common)
- Breast tenderness/discomfort (less common)

METHOD-SPECIFIC COUNSELING

Counsel as detailed in Chapter 3. Specific points to be noted while counseling for injectable are:

- Rumors about the method (see Appendix 6)
- Timing of injection
- Make sure the woman understands about the side effects such as amenorrhea, bleeding/spotting and delayed return of fertility
- Ensuring client has understood the importance of regular injections.

Eligibility

Indications

Injectable contraceptives are appropriate for:

- Women in the reproductive age group, who desire a highly effective contraceptive, who meet the eligibility criteria
- Any woman who wants a long-term birth spacing method or has completed her family, but not ready for a permanent method.
- Women who are not eligible for use of estrogen containing contraceptives
- Breastfeeding women who are less than 6 months post-partum
- Women who want a temporary, immediately effective method while the spouse is awaiting for sterilization

Contraindications

As in the case of the pill, the contraindications are due to the effect of the hormones, however it is much less compared to the pill.

The injectable should not be prescribed in the following conditions/ situations:

- Pregnancy
- History of thrombo-embolic disorders in the present or past: stroke / deep vein thrombosis
- History of heart disease such as ischemic heart disease, angina, cardiac failure, valvular heart disease and others
- High blood pressure 160/100
- Severe headache or migraine with focal neurological symptoms
- Long standing diabetes or diabetes with vascular complications

- Unexplained vaginal bleeding
- Has cancer of the breast
- Has disease of the liver or jaundice in the previous 6 months
- Breastfeeding women who are less than **6 weeks** postpartum because of the risk of newborn being exposed to the hormones through breast milk
- Women with depression as the hormones may worsen the depression

Precaution

- Nulliparous women (due to return of delayed fertility)

CLIENT ASSESSMENT

Look specifically for the history listed in the following table. Use the checklist to determine the eligibility of the client.

Table 7.1 History Taking Checklist for Use of Injectable Contraceptives

Checklist for History Taking Ask the client the following:	
1. Date of last menstrual period Suspected pregnancy?	Yes No
2. Date of last child birth and if less than 6 months, whether breastfeeding	Yes No
3. History of stroke or deep vein thrombosis	Yes No
4. History of heart disease	Yes No
5. History of high blood pressure	Yes No
6. History of frequent severe headaches	Yes No
7. History of cancer of the breast	Yes No
8. History of jaundice now or in the last 6 months or history of liver disease or tumors	Yes No
9. History of diabetes and years with the disease	Yes No
10. History of depression	Yes No

Instructions for Health Care Workers in Health Post

- If any of the above is present, refer to a doctor/midwife for further assessment.
- It is not possible to identify all the above conditions by history taking alone. Therefore, it is advisable to refer the client to a doctor/midwife (if possible) within the first 3 months of starting the pill. The referral is for a complete physical examination including a pelvic examination and is recommended as a good preventive practice.
- Record the information in the client card.

Instructions for Health Care Workers in Facilities

- Health workers posted in health facilities should do a physical examination as follows:
- Check for pallor, jaundice, varicose veins
- Check blood pressure
- Whenever possible, it would be advisable, but not mandatory, to offer breast examination as a good preventative practice. It should not, however, be a barrier to providing the method.
- Whenever possible, it would be advisable, but not mandatory, to offer pelvic examination as a good preventative practice. It should not, however, be a barrier to providing the method.
- Record the information in the client card.

GUIDELINES FOR USE OF INJECTABLE CONTRACEPTIVES

Health Care Worker Instructions

- The injectable comes in single vials.
- If using disposable (one time use) syringes and needles, dispose them as recommended in Chapter 11 on infection prevention. If using reusable syringes and needles, follow infection prevention guidelines recommended in Chapter 11. Infection prevention is a critical element of quality FP services.
- Explain the timing of the first injection.
- Explain that the first day of menstruation is the day when bleeding/spotting starts
- Explain that the client may suffer from prolonged bleeding, irregular bleeding or spotting or no periods and this is not dangerous as it is an effect of the injection. Emphasize that the problems usually disappear after the first few months.
- Tell the client what to do in case the injection is missed.
- Provide information on what to do in case of warning signs.
- Ask the client to repeat the instructions.
- Ask the client to return after 3 months for the next dose or earlier if problems develop.
- Provide a packet of condoms in case of missed injections. Demonstrate how to use the condom if the client does not know how to use the same.
- Follow up of clients in the first 3 months is very important. Follow up is important to remind the client about the next injection.

Client Instructions

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

- When to start with the first dose of the injection
  - The first injection is to be taken within 7 days of menstrual cycle
  - Any day, if reasonably sure of not being pregnant, but must abstain from sex or use another contraceptive for the next 7 days
  - At 6 weeks post-partum
  - Within 7 days after abortion
- When to take the next dose of the injection:
  - 3 months after the last injection
- What to do if you miss taking the injection:
  - If missed more than two weeks of the expected date of injection, take the injection, but **abstain from sex or use another contraceptive for next 7 days**.
  - If one menstrual period is missed, it is probably not pregnancy as it is usual to miss

periods or have less bleeding.

- You may experience prolonged bleeding or spotting. This is not dangerous but is an effect of the injection.
- Giving injection (see Appendix 8: Steps for giving DMPA injection)

Post-Injection Counseling

- Repeats the advice about when to return.
- Repeats the side effects and advises to return anytime to the provider.

Management of Side Effects and Other Complications

Always counsel clients who have side effects and other complications as described in Chapter 3. If the client wants to stop the injectable, counsel for other methods of FP. Always counsel clients who are being referred as in Chapter 3.

Table 7.2 Management of Side Effects of Injectable Contraceptive Use

Side effect/problem	Assessment	Management
Amenorrhea	• Find out whether taking injections regularly • Rule out pregnancy by checking symptoms or physical examination and /or pregnancy test (depending on the level of provider) •	• If pregnant, assure the client that the injectable (already taken) will not harm the baby and advise for antenatal care • If not pregnant, if the injectable is being taken regularly, counsel to continue • Refer to specialist if amenorrhea, continues **for more than 6 weeks**.
Spotting or bleeding	• Find out whether the injectable is being taken regularly • Rule out pregnancy (as above).	• If pregnant, advise as above • If not pregnant, if the injectable is being taken regularly, counsel to continue. • Refer to specialist if spotting continues • Advisable to refer for ruling out other causes
Weight gain	• Check if the weight gain is while on the injectable • Assess food intake • If no reason found, rule out pregnancy (as above)	• If pregnant, advise as above • If not pregnant, counsel
Nausea	• Find out whether the injectable is being taken regularly • Rule out pregnancy (as above)	• If pregnant, advise as above • If not pregnant, if the injectable is being correctly, counsel • Refer to specialist if nausea continues to rule out other causes.

Side effect/problem	Assessment	Management
Breast fullness /tenderness	• Find out whether the injection is being taken regularly • Rule out pregnancy (as above) • Rule out breast lumps /ulcer and infection of the breast (if breastfeeding)	• If pregnant, advise as above • If not pregnant and no breast lumps, counsel • Refer to specialist in case of breast lumps or ulcer.

CHAPTER 8: INTRAUTERINE DEVICES

Intrauterine devices are to be provided only by trained providers (community midwives, nurses, midwives and doctors) in facilities that have the adequate equipment for inserting the device.

The intrauterine device (IUD) discussed in this chapter is Copper T 380A. Copper T 380 A is shaped like a T and has copper on the stem and the arms. A thread is attached to the lower end of the vertical stem. The Copper T is inserted in the uterus with an applicator through the opening of the cervical canal.

METHOD CHARACTERISTICS

Mechanism of Action

The major mechanism through which the copper T prevents pregnancy is by:

- Preventing sperms from reaching the ovum by immobilizing them
- Preventing implantation of the embryo is another mechanism.

Effectiveness

Copper T 380 A is one of the most cost effective spacing methods with an effectiveness of 99.2%.

Return to Fertility

Once the Copper T is removed, fertility returns immediately.

Advantages

Copper T 380 A is a safe and reliable method of contraception and it offers several advantages as listed below.

- Highly effective
- Immediately effective after insertion
- Effective for 10 years
- Does not interfere with sexual intercourse
- No continued effort to use the method regularly
- One time insertion procedure and does not require supplies regularly
- Cost effective as no expenses for supplies
- Does not affect breastfeeding
- Does not interact with any medicines the client may be taking
- Can be removed when required by qualified staff as desired by the client
- Return of fertility immediately after removal

Disadvantages

Limitations

- Requires a skilled provider to insert the device and remove it
- Does not protect against STIs /HIV
- Can not be used by women who suffer from RTIs/ STIs or by women whose spouses have STI

- Client needs to check thread after every menstrual period

Side Effects

- Common side effects:
  - In the first week: mild cramps, bleeding or spotting
  - In the first 3 months: longer and heavier periods, increased cramps during periods, bleeding or spotting between periods and expulsion of Copper T (partial or complete)
- Less common side effects and complications:
  - Continuation of side effects beyond 3 months
  - Anemia
  - Perforation of uterus
  - Lost Copper T thread
  - Infections of the genital tract due to poor infection control
  - Risk of ectopic pregnancy (does not prevent ectopic pregnancy).

METHOD-SPECIFIC COUNSELING

Counsel as detailed in Chapter 3. Specific points to be noted while counseling for Copper T:

- Show the Copper T and make the client feel it
- Rumors about the method (see Appendix 6)
- Timing of insertion of Copper T
- Likely problems and complications
- The importance of checking the thread
- Warning signs
- Use of condoms if at risk of STI or HIV/AIDS

Eligibility

Indications

The IUD is appropriate for:

- Any woman in the reproductive age group, who has borne a child and who wants to space or prevent pregnancy
- Women who are breastfeeding
- Women who are unable to or unwilling to consistently use another effective contraceptive method including women who have contraindications for using a hormonal contraceptive
- Are at low risk of contracting STIs

Contraindications

The copper T **should not** be inserted in the following conditions/ situations:

- Pregnancy
- Excessive menstrual bleeding or irregular bleeding in between periods or after intercourse that are signs of malignancy of the genital tract or other uterine pathology - Copper T may increase the bleeding and increase risk of infection or perforation in such situations

- Active genital tract infection or infection in the recent past: Vaginitis, cervicitis, PID, puerperal/post-abortal sepsis, STIs of self/spouse and at risk of STI/HIV as the infection may spread while inserting the Copper T leading to subsequent infertility or the existing inflammation may be aggravated.
- Uterine pathology such as known cases of pelvic tuberculosis as Copper T may cause bleeding and secondary infection.
- Known cases of uterine cavity abnormality (congenital or due to uterine fibroids) as it will be difficult to insert the Copper T and the chances of expulsion/peroration are high.

Precautions

- Nulliparous women
- Post-abortal (within first 2 weeks)

CLIENT ASSESSMENT

Health care workers in health posts should refer the clients for assessment to the relevant institutions with a referral note.

History

Table 8.1 History Taking Checklist for Use of Intrauterine Device

Checklist for history taking Ask the client the following:	
1. Date of last menstrual period Suspected pregnancy	 Yes No
2. Date of last child birth/abortion Any history of infection (post-partum/post-abortal)	Date Yes No
3. History of discharge from the vagina now or in the recent past	Yes No
4. History of severe lower abdominal pain	Yes No
5. History of STIs	Yes No
6. History of pelvic tuberculosis	Yes No
7. History of cancer of the uterus /cervix or other uterine pathology	Yes No

Physical Examination

Trained health workers who have adequate facilities for inserting IUDs should do the following:

- Check for pallor
- Check for lower abdominal tenderness or masses to rule out PID
- Pelvic examination:
- Inspection of external genitalia: to rule out redness, patches, ulcer, growth, warts,

swelling and discharge, suggestive of RTI/STI
- Inspection of the vagina and cervix to rule out ulcer, abnormal discharge, cysts, polyp, growth and bleeding sites suggestive of RTI/STI or malignancy.
- Bimanual examination to rule out malignancy, to identify the position of the uterus (anteverted or retroverted), to rule out pregnancy, cancer of the cervix or other pathology of the uterine cavity and PID,

Laboratory Examination

- Hemoglobin (if possible) to enable treatment of anemic mothers)

Record

Record information on the client card.

INSTRUCTIONS FOR INSERTION OF COPPER T 380 A

Provider Instructions

- Explain to the client where to go for the Copper T insertion (in case of referrals).
- Explain the timing of procedure:
  - Within 12 days of menstruation
  - At 6 weeks post-partum
  - After 2 weeks of abortion
  - Any other time provided the client is sure she is not pregnant
- Show the Copper T to the client and explain once again that the Copper T will be inserted using the white plastic rod. Make the client feel the nylon thread.
- Explain that during the insertion, the client may feel pain.
- Explain that the Copper T is immediately effective after insertion.
- Explain the likely problems after insertion (see below under post-insertion counseling) and that the Copper T can be removed anytime time if there are major problems and if so desired by the client.
- Explain the importance of checking the thread to see whether the Copper T is in place and explain how to check the thread (see below under post-insertion counseling).
- Emphasize to contact the health worker immediately in case of warning signs (see below under post-insertion counseling)
- Record the insertion of Copper T.
- It is advisable to follow up the clients who are using Copper T to reassure them and to find out if they are having any problems.

Insertion of Copper T

See Appendix 9: Steps for insertion of Copper T 380 A.

Post-Insertion Counseling

Counsel the client after insertion. Provide the following information (in case of referrals, it is advisable to provide the information before being referred).

- The Copper T is immediately effective after insertion.
- There may be slight bleeding or spotting for a week. If the bleeding is profuse or prolonged, contact the health workers.

- It is normal to have slight cramping in the first 48 hours. Take some pain killer if needed. The cramping should not last longer than 48 hours. If it becomes severe, contact the health workers.
- Check for the string of the Copper T to be sure that the Copper T is still inside the uterus as instructed below. (Use the cut end of the string to make the client feel the texture of the string):
  - First wash hands to reduce chances of introducing infection.
  - Sit in a squatting position and reach into the vagina as far as back as possible and feel for the strings. **Do not pull the thread as it might dislodge the Copper T.**
  - Wash hands again.
- Check for the string after each menstrual period
  - Check menstrual cloth for Copper T as sometimes it is expelled with menstrual blood.
- There may be spotting or increased bleeding during menstrual period for the first 2-3 months, but the periods become normal thereafter. If the problem continues, contact health worker. The Copper T can be removed if so desired.
- Report immediately to health workers if any of the following happens (warning signs):
  - Missed periods, abnormal bleeding or spotting
  - Abdominal pain, pain with intercourse
  - Exposure to STIs, abnormal discharge per vagina
- String of Copper T missing, getting longer or shorter or Copper T felt inside the vagina or has been expelled.
- Return after a month or after the first periods for follow up.

WARNING SIGNS

P – Periods late, spotting, bleeding
A- Abdominal pain, pain with intercourse, severe cramps
I – Infection: discharge, exposure to STIs
N – Not feeling well, fever, chills along with lower abdominal pain
S – String missing, shorter or longer

Management of Side Effects and Other Complications

Always counsel clients who have side effects and other complications as described in Chapter 3. If the client wants to remove the Copper T, counsel for other methods of FP. Always counsel clients who are being referred as in Chapter 3.

Table 8.2 Management of Side Effects of Intrauterine Device Use

Side Effect/Problem	Assessment	Management

Side Effect/Problem	Assessment	Management
Spotting or bleeding	• Find out whether the client is having spotting or bleeding • Ask whether associated with lower abdominal pain and if so the severity of the pain • Perform pelvic examination to rule out infection, intrauterine pregnancy or ectopic pregnancy.	• If intrauterine pregnancy, evidence of ectopic pregnancy, vaginal, cervical or pelvic infection or any pathology (fibroid), refer to a specialist. • If less than 3 months and no evidence of pregnancy or pathology, counsel to continue using Copper T and ask the client to return if situation worsens. - Refer to specialist if the problem continues beyond 3 months • If more than 3 months after insertion, refer to specialist even if no evidence of pathology
Lower abdominal pain	• Find out whether the cramps are mild or severe • Do a pelvic examination to rule out infection or displacement of Copper T. •	• If mild pain, give paracetamol and instruct to contact if no relief or pain worsens • If severe pain, refer to a specialist.
Vaginal discharge	• Pelvic examination. Rule out pelvic tenderness.	• Refer to a specialist
Amenorrhea	• Ask about last menstrual period, • Ask whether she felt the strings after the periods • Ask for symptoms of pregnancy • Do a pelvic examination to find out whether the Copper T is in situ and rule out pregnancy	• If no evidence of pregnancy and Copper T is in situ, counsel for continuation of the method • If pregnant or Copper T is missing, refer to a specialist
Missing Copper T strings	• Ask when the client last felt for the string and whether there is any evidence that the Copper T expelled • Do a pelvic examination to confirm whether the Copper T is expelled and to rule out pregnancy	• If the Copper T is expelled and there is no evidence of pregnancy or infection, counsel for re-insertion. • If strings visible, no evidence of pregnancy, gently remove the Copper T. • If strings visible and there is evidence of pregnancy, refer to a specialist.

Removal of Copper T

Indications for Removal and/or Re-Insertion

- After five years of insertion. This should be done preferably during post-menstrual

period. Can be re-inserted at the same time if the client desires**. Use a new Copper T for re-insertion.**

- Wants another child
- Client desires removal
- Severe bleeding
- Severe abdominal pain
- Pelvic infection not responding to treatment
- Pregnancy
- Menopause (Cessation of periods for one year)
- Evidence of Copper T displacement.

In case of re-insertion, make sure that the client is not pregnant.

See Appendix 9: Steps for removal of Copper T 380 A.

CHAPTER 9: TRADITIONAL METHODS OF FAMILY PLANNING

FERTILITY AWARENESS-BASED METHOD

Fertility awareness-based methods are based on practice of voluntarily avoiding sexual intercourse during the fertile period of a woman's cycle to avoid pregnancy.

- Communication and understanding between spouses is critical for effective use of these methods.
- Sexual behavior of couples will have to be modified for effective use of the method

The method discussed in this chapter is **Standard Days Method**.

Method Characteristics

Mechanism of Action

Prevents pregnancy by avoiding sexual intercourse during fertile periods when ovum is released.

Effectiveness

The effectiveness (in preventing pregnancy) is 91-98% when the method is used correctly and consistently.

Advantages

- No exposure to side effects from pharmacological or mechanical methods of contraception
- Not provider dependent
- Does not affect breastfeeding
- No side effects

Disadvantages

- Dependent on a person's control of self to avoid sexual intercourse during fertile period
- High failure rate
- Does not protect from STI/HIV

Method-Specific Counseling

- Counseling is critical for couples who want to practice fertility awareness method.
- Ensure the spouse is present.
- Ensure the client/couple understands the fertile period.
- Provide condoms as back up method and demonstrate the use of condoms.

Eligibility

The following are eligible to use the method:

- Couples who can abstain from sexual intercourse during fertile periods
- Women with **regular** menstrual cycles
- Women who want to practice contraception using non-mechanical or chemical methods
- Women who have contraindications for other methods

- For religious or cultural reasons
- Delay the use of the method
- In the following conditions, it is difficult to assess the fertile period as the woman is not having periods or has irregular periods
  - Breast feeding women who are less than 6 months post-partum
  - Post abortion (delay till after next period)
  - Irregular periods

Instructing on the Use of Fertility Awareness-Based Methods (Standard Days Method)

Provider Instructions

- Find out the menstrual cycle pattern of the client and advise on the period of fertility based on the menstrual cycle pattern.
- Ensure that the client understands the period of fertility.
- Use colored illustrations (if possible) to explain the menstrual cycle and fertile period.
- Provide condoms as back up method and demonstrate the use of condoms. Ensure that the client has understood the use of condoms.

Client Instructions

- Count the 8th day of menstrual cycle (counting the first day of onset of bleeding/spotting as day 1).
- Avoid sexual intercourse from the 8th to the 19th day. This is the time when the ovum is released and the risk of pregnancy is high.
- If sex cannot be avoided, use a condom.
- From the 20th day it is safe to have sex.

COITUS INTERRUPTUS (WITHDRAWAL METHOD)

Coitus interruptus is a traditional method of FP in which the man completely withdraws his penis from the woman's vagina before he ejaculates.

- Communication and understanding between the couple are critical for effective use of the method
- Sexual behavior of couples will have to be modified for effective use of the method.

Method Characteristics

Mechanism of Action

Prevents pregnancy by preventing the deposition of sperms in the vagina.

Effectiveness

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

Advantages

- No exposure to side effects from pharmacological or mechanical methods of contraception
- Not provider dependent
- Does not affect breastfeeding
- No side effects

Disadvantages

- Dependent on the man's self control to withdraw the penis in time before full ejaculation takes place
- High failure rate
- Does not protect from STI/HIV

Method-Specific Counseling

- Counseling is critical for couples who want to practice fertility awareness method.
- Ensure the spouse is present.
- Ensure the client/couple understands the importance of full withdrawal.
- Explain to the client/couple the fertile period to enable them to avoid sex during that period.
- Provide condoms as back up method and demonstrate the use of condoms. Ensure that the client has understood the use of condoms.

Eligibility

- The following are eligible to use the method:
- Couples have control over their sexual act and can withdraw fully before ejaculation
- Women who want to practice contraception using non-mechanical or chemical methods
- Women who have contra-indications for other methods
- For religious or cultural reasons

Advice in Situations Where the Method is Not Used Correctly

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

CHAPTER 10: REFERRALS

OBJECTIVE

Referral service is one of the critical elements of the continuum of quality FP services. The objective of this chapter is to help health workers provide continuum of FP care in situations beyond their level of competence.

OBJECTIVES OF REFERRALS

- To help clients to sustain the use of contraceptives by minimizing physical and psychological risks to them through early provision of specialist care in case of complication.
- To provide access to a wider choice of FP methods by referring clients to a facility where the method of choice of the client can be provided

PREREQUISITES TO EFFECTIVE REFERRAL

- A formal referral linkage between health posts/ basic health centers with a higher facility should be in place. These facilities may be in the government or non-governmental sector.
- Orientation of the staff of the referral facility on procedures related to referred cases including feedback to the worker/facility that has referred the cases.

COUNSELING OF CLIENTS BEING REFERRED

Counseling of clients being referred **along with spouse/relative** is important for **facilitating the utilization** of the referral facility. This is important, as in the current situation of Afghanistan most referral facilities are not easily accessible for many communities, especially women. Chapter 3 provides the steps in counseling clients who are being referred. In addition to the steps listed in Chapter 3, the counseling should focus on the following:

- Being extra-sensitive to the fears of the clients in case of side effects/complications
- Allaying the fears of the client. This is critical for providing motivation for the clients to follow the referral advice and for ensuring that the clients continue using FP
- Assuring that continued care will be provided.

REFERRAL SLIP

- All clients referred should be provided with a referral slip that includes relevant information of the client, the method in use (in case of referrals for side effects/complications) and the reason for referral (see Appendix 7).
- A request for feedback should be included in the referral slip.
- Where the workers are illiterate, the use of a written slip may be difficult. In such situations, other ways of communicating (pictorial cards) should be explored.
- The referral center should ensure that a feedback is provided to the health worker who has referred the case.

The referral slip is a very useful tool for improving quality of FP services as described below:

- Helps to monitor complications of methods and design strategies for minimizing complications based on in-depth analysis of such cases.
- Helps to identify training needs of health workers (based on analysis of common

complications referred).

FOLLOW UP

All cases referred must be followed up through home visits or requesting the clients to report to the health post or basic health center. Follow up is one of the elements of quality of care and is critical in FP services. Follow up helps to:

- nurture the trust of the client
- ensure that the client is following instructions
- monitor any new problems

CHAPTER 11: INFECTION PREVENTION

This chapter only deals with infection prevention procedures as relevant for provision of birth spacing methods in health posts and health facilities. For more information, refer to the document on infection prevention.

OBJECTIVE

The objective of this chapter is to provide guidance to health workers to practice infection prevention in their facilities while providing FP services and other services.

INTRODUCTION

Microorganisms that cause infections live everywhere in the environment, in human beings, animals, plants, soil, air and water. Human beings normally carry them on their skin and in the throat, intestines and genital tract. All microorganisms become dangerous when the right circumstances are present. Microorganisms include bacteria, virus, fungi and parasites. Infections can be spread in health facilities from client to client, client to provider or provider to client due to lack of infection prevention practices and/or through contaminated equipment and instruments.

WHAT IS INFECTION PREVENTION

Infection prevention is the interruption (breaking) of the disease transmission cycle from the infected person to another person. The aim of infection prevention in FP clinics is to:

- To minimize infections in clients due to FP procedures and
- To prevent the transmission of HIV and Hepatitis virus between clients and health workers including helpers who clean the facility and dispose of waste.

PROTECTIVE BARRIERS

Infection prevention is achieved by placing a barrier between the human beings and microorganisms. These barriers are called protective barriers that prevent transmission of infection from client to client, client to provider or provider to client.

The protective barriers are physical (wearing gloves), mechanical (hand washing), and chemical (antiseptics and disinfectants). The protective barriers include:

- Hand washing
- Wearing gloves, masks, caps, gowns
- Using antiseptic solutions
- Processing of equipment and other items
- Managing clinical waste

Hand Washing

Hand washing is the single most important procedure in preventing infection. The vigorous rubbing together of all surfaces of hands with soap mechanically removes and often inactivates most of the organisms. One of the pre-requisites for ensuring the practice of hand washing is

continuous supply of water either from a tap or a bucket and soap.

Hand washing is the single most important procedure in infection prevention.

Types of hand washing

- Simple hand wash (15-30 seconds) (before and after examining patients, giving injections, pelvic examination and insertion and removal of IUDs)
- Surgical hand wash (3-5 minutes) (for surgical procedures)

When to do hand washing

- Before and after examining a client
- Before wearing sterile gloves and after removing them
- After handling contaminated instruments
- After accidentally touching blood or other body fluids

How to do simple hand washing

- Simple hand washing is done by scrubbing the hand vigorously with plain soap about 15-30 seconds
- Air dry by shaking off excess water. If a clean towel is available, use the clean towel
- Collect the used water in a container and discard it.
- It is advisable to avoid using standing water in basins and other containers as microorganisms grow and multiply in moisture.
- Make sure where the soap is kept there is adequate drainage of water
- Use running water from a tap. If no tap available, use a bucket with a tap or a bucket with a mug so that the water is not contaminated.

Wearing Gloves

- All health workers should wear gloves prior to contact with blood and body fluids, both while providing services to a client (example: during pelvic examination and insertion / removal of IUD), while handling infected equipment and materials).
- Gloves should be changed between each client to avoid cross contamination.

The type of gloves used while providing FP services include:

- single use/ re-usable gloves (high-level disinfected or sterile) for surgical procedures, insertion/removal of IUD and pelvic examination
- utility gloves (household gloves) for handling used instruments, cleaning blood and body fluids and handling wastes

Re-usable gloves need to be washed and high-level disinfected or sterilized according to need (See Appendix 10 for details of processing of gloves). Care should be taken not to contaminate gloves while wearing them.

Do not wear gloves that are torn, cracked or peeling.

Antisepsis

Antisepsis is the prevention of infection by killing or inhibiting microorganisms on skin and mucus membranes (for example, cervical and vaginal) by using a chemical agent (antiseptic). Microorganisms present on the skin and hands of the provider can cause infection after DMPA injections. Washing hands and applying antiseptic solution at the injection site, before giving the injection, prevent the infection in such cases.

When to Use Antiseptic Solutions

Use antiseptic solutions to:

- clean the skin before giving injections
- clean the skin, cervix and vagina before inserting IUD

Antiseptic solutions should **never** be used for:

- high-level disinfection
- disinfecting instruments and re-usable gloves
- cleaning surfaces such as floors or counter tops.

Antiseptic Solutions

Antiseptic solutions recommended for use are:

- Iodophores (various concentrations; Povidione iodine, e.g., Betadine, if available, is highly recommended.
- Alcohols (60-90% concentration)
- Chlorhexidine gluconate (various concentrations, e.g., Savlon)
- Iodines (2-3%): tincture and aqueous **(not to be used on skin that is allergic or on mucus membranes)**

Storage and Dispensing of Antiseptics

Microorganisms grow and multiply in antiseptic solutions and can cause infection if not stored and dispensed properly. The steps listed below will be useful in preventing contamination.

- If supplied in large quantities, pour small quantities into a small, clean, boiled and dried container for daily use. Ensure that the sides of the bottle do not touch the container.
- Establish a routine of changing the antiseptic solution every week (mark the date of changing on the container).
- Store in a cool, dark area (never in places where there is direct sunlight or excessive heat).
- Do not leave instruments in antiseptic solutions.
- Do not store cotton or gauze in antiseptic solution as it promotes contamination.
- Change antiseptic solutions weekly.
- Clean, boil and dry containers before use.
- Label the containers with date of changing.

Processing Equipment and Other Items

Processing of equipments that are re-used prevents spread of infections, through these items, to clients as well as to providers. The four steps in processing are:

1. Decontamination:

2. Cleaning
3. High-Level disinfection or sterilization
4. Storage

Decontamination

This is the first step in treating instruments and objects that have come in contact with blood and body fluids to make them safer for handling by personnel before cleaning them. Proper decontamination inactivates the HIV and hepatitis viruses.

- Soaking soiled instruments and objects in 0.5% chlorine solution for 10 minutes effectively decontaminates them (see Appendix 10 for preparation of 0.5% chlorine solution and steps for decontamination).
- Decontaminate surfaces using 0.5% chlorine solution. Decontaminate surfaces daily and more often as required.

Change chlorine solution daily.

Cleaning

Cleaning is a crucial step that helps reduce the number of organisms and endospores (such as tetanus) on the instruments and other objects.

- A thorough cleaning using a soft brush and detergent followed by rinsing helps to physically remove tissues and blood (see Appendix 10 for steps). Organic matter such as blood and tissues trap microorganisms that make it difficult to kill them during high-level disinfection or sterilization. They also inactivate some of the disinfectants making them less effective.
- Soapy solution should be made using a detergent (not soap) in lukewarm water. Do not use powders or cakes that are used for scrubbing.

High-Level Disinfection

- High-level disinfection is effective in destroying microorganisms (including the HIV and hepatitis viruses). The process does not kill endospores. This is the only acceptable alternative when sterilization is not possible.
- High-level disinfection is appropriate for items that do not come in touch with blood stream or tissues under the skin (such as instruments and gloves used for pelvic examination, IUD insertion)
- The pre-requisite for high-level disinfection is that all instruments and objects that have to be high-level disinfected must be first decontaminated with chlorine solution, cleaned and air-dried.
- Types of high-level disinfection

- Boiling: moist heat at 80°C kills microorganisms in 20 minutes (higher altitude requires more time) (see Appendix 10 for steps).
- Chemical disinfection: chemical agents such as 2% glutaraldehyde (Cidex), 0.1% chlorine, and formaldehyde, provide high-level disinfection. The most commonly recommended is 2% glutaraldehyde as it is less toxic and irritating and does not corrode metal (see Appendix 10 for steps). Chemical disinfection is not recommended for needles and syringes, as it is difficult to rinse them effectively.

Sterilization

- Sterilization is effective in killing microorganisms and endospores.
- Appropriate for all objects entering the blood vessel.
- The pre-requisite for sterilization is that all instruments and objects that have to be sterilized must be first decontaminated with chlorine solution, cleaned and air-dried.
- Types of sterilization:
  - Steam: high pressure saturated steam (at 121° and 106 kPa pressure (15 lb/inch^2 for 20 to 30 minutes depending on the contents) (see Appendix 10 for steps)
  - Chemical sterilization: submerging the instruments and objects in 2% glutaraldehyde for 10 hours (see Appendix 10 for steps).

Table 11.1 Processing instruments and other items for various family planning procedures

Instruments/Object	Decontaminate	Clean	Sterilize or high-level disinfection
DMPA syringes and needles	Soak in 0.5% chlorine for 10 minutes before cleaning	Wear gloves and clean with soap and water until clean. Rinse and air-dry	• Sterilize • Boil for 20 minutes (if sterilization not possible)
Rubber gloves for pelvic examination and IUD insertion	Soak in 0.5% chlorine for 10 minutes before cleaning	Wear gloves and clean with soap and water until clean. Rinse and air-dry	• Boil for 20 minutes or • Soak for 20 to 30 minutes in 2% glutaraldehyde, then rinse with boiled water
Metal instruments for IUD insertion/ removal and pelvic examination	Soak in 0.5% chlorine for 10 minutes before cleaning	Wear gloves and clean with soap and water until clean. Rinse and air-dry	• Sterilize • (preferred, not mandatory) • Boil for at least 20 minutes or soak for 20 to 30 minutes in 2% glutaraldehyde, then rinse with boiled water
Metal containers for storing instruments	Soak in 0.5% chlorine for 10 minutes before cleaning	Wear gloves and clean with soap and water until clean. Rinse.	• Boil for 20 minutes once a week • Autoclave or soak interior surface for 20-30 minutes in any disinfectant and rinse
Pelvic examination table top	Wearing gloves, wipe the top with 0.5% chlorine solution		

Adapted from INTRAH: Infection Prevention in FP/MCH Clinics. Appendix 11. Revised September 1996.

Storage of Sterile and Disinfected Items

Proper storage is as critical as sterilizing or high-level disinfection:

- Sterile items should be stored in closed containers, properly labeled, away from contaminated areas.
- The sterile items should be handled properly so that they do not get contaminated.
- Sterile containers should not be left on the floor and should be stored in enclosed cabinets to protect from dust and other contaminants.

The stored sterile items should be re-processed after a week.

See Appendix 10 for steps in storing the equipment.

Waste Disposal

Proper disposal of wastes is important for preventing transmission of infection to the handlers of wastes as well as to the community.

Proper waste disposal protects:

- those who handle from accidental injury
- prevent infestation of insects and rodents that carry disease

Proper management of wastes includes the following steps:

1. Sorting the wastes as follows:
   - Sharps to be collected in puncture-proof containers (see Appendix 10 under disposal of syringes and needles).
   - Burnable contaminated and non-contaminated wastes should be collected in covered buckets.
   - Human tissues and fluids collected in leak-proof containers.
   - Glass collected in separate containers.
   - Place containers at convenient places so that the wastes need not be carried from one place to the other, which increases the risk of infection.
2. Transportation of waste as follows:
   - Persons handling wastes should wear heavy-duty gloves to avoid injuries by accidental pricking.
   - The waste containers should be emptied when three quarters full or at least once daily.
   - Transport in closed, leak proof containers to the disposal site.
3. Disposal of waste should be done as follows:
   - Contaminated waste should be incinerated (most preferred method), burned or buried. Ensure that the pit for burial is deep so that animals cannot dig it out and is at least 50 meters away from water source.
4. Wash all the waste containers especially the ones with contaminated waste with 0.5% chlorine and rinse with water.

CHAPTER 12: CONTRACEPTIVE LOGISTICS (SUPPLIES AND STORAGE)

This chapter only deals with the health post and health facility management of contraceptive logistics. For more information, please refer to the document on contraceptive logistics management system.

OBJECTIVE

The objective of this chapter is to orient the health workers about the importance of ensuring regular supplies and about storing them properly.

ENSURING REGULAR SUPPLIES

- Afghanistan has a high level of unmet needs of FP. Shortage of supplies is one of the major reasons.
- Regular monitoring of supplies is also an important element of service provision.
- The stock registers help to monitor the supply level of various contraceptives. It is important to update the stock registers regularly and to tally the items distributed with the records of the FP register.

ORDERING ADEQUATE SUPPLIES

- The need for supplies is estimated based on the records of monthly consumption which in turn is based on either three months or six months distribution (supply) frequency.
- Add an extra 10% to the previous month's supply if demand (consumption) is seen to be increasing. For example, if 100 pieces of condoms have been distributed per month in the previous three-month period, then the requirement for the next three-month period will be 300. If distribution is more than 300 in the last period, then the requirement will be 300 + 10%.
- Fresh supplies must be ordered according to the existing cycle of ordering taking into account the time lag between indenting (ordering) and receiving of supplies.
- Some factors/conditions which may affect the time lag are seasonality, access, supply levels at the district/central stores
- Supplies are usually ordered on a form called indent and issue voucher. On one side of the form, the ordering agency records requests and on the other side form of the form, the supplying facility records the supplies. This is done in triplicate (one to be retained by the requesting facility, one by the supplying agency and one to be sent with supplies).

Ensuring Proper Storage of Supplies

- Special attention must be taken to see that the commodities have not reached/exceeded their expiry date.
- Any commodity that has on month or less shelf life should not be distributed to the health post.
- Supplies must be stored in cool (temperature 20 to 30° C) and dry place, away from direct sunlight.
- Whenever possible, windows that have screens should be opened and fans should be turned on between 10 AM and 4 PM.

- Packets of condoms or pills that have their covers torn or discolored or contents seem sticky or oily or brittle should not be accepted or supplied.
- Injections of DMPA should not be discolored or no powder should be sticking to the vials.
- Supplies must be stored in such a way that those with an early expiry date would be used first (first expiry, first out).

Discoloration of Copper T in a packet that is not damaged or open, should not be thrown away as it is not clinically significant.

CHAPTER 13: SUPERVISION AND MONITORING

OBJECTIVE

The objective of this chapter is to enable the supervisors of health workers to promote continuous quality improvement of FP services.

FAMILY PLANNING RECORDS AND REPORTS

Family planning records and reports are important tools for supervision and monitoring. The Health Management Information System (HMIS) is being developed in Afghanistan. Two commonly used FP records are described in this chapter. The other records as relevant should be added once the HMIS is fully developed.

Client Card

The client card records the socio-demographic and health history, physical examination findings and current method of use. The follow up section of the card records the history and physical examination findings at the time of the visit (see Appendix 7 for a sample client card).

- The client card provides information on past and current use of a FP method and method switch (if any).
- It is an important tool for monitoring the quality of services as it provides information on whether the client has been screened for eligibility to use the method.
- It is useful for follow up of clients.
- When the client cards are organized in a systematic way, it helps to track defaulters.

Family Planning Register

This register records relevant information of all the couples eligible for FP in a defined geographical area. The information is usually collected through a survey and updated periodically. The register includes information on the parity of the client, FP method used and the date of last visit (in case of condoms, combined oral contraceptives and injectables). The register:

- Provides information on the contraceptive prevalence in a specified geographical area
- Useful tool for tracking clients, especially defaulters
- Provides information on supplies of contraceptives.

Referral records

Records of clients referred are obtained from the referral records. These records are described in Appendix 7.

Supplies records

Records of contraceptive supplies are described in Chapter 12.

Reports

Family planning reports provide information on the progress of the various indicators that have been identified by the Ministry of Health. The reports should include complications with use of methods. The reports are important tools for monitoring.

SUPERVISION

Supervision is a **continuous, interactive process** that enhances the capability of the health system to:

- meet the FP objectives of the district/province health system and thus contribute to achieving the FP objectives of the National Reproductive Health Strategy
- maintain the quality of care
- keep the staff trained and motivated
- monitor the supplies
- meet client needs.

Supportive supervision helps to achieve the above as described below:

- Emphasizes helping health workers to:
  - Understand the objectives of FP services,
  - Identify gaps in meeting the objectives, and
  - Reach the objectives
- Facilitates two-way communication between the supervisor and the provider who is being supervised leading to improved performance and outputs and to improved client satisfaction.
- Helps to provide feedback to higher level authorities about successes and constraints in order to facilitate assistance as required.
- Ensures involvement of all levels of staff promoting ownership that leads to sustainability.

Roles of Supervisor

Some suggested roles of supervisors are to:

- Help health workers to do self-assessment of their own performance using national standards and guidelines and to provide assistance in meeting the needs for information and training.
- Assess sites where IUD insertions are done and facilitate meeting the gaps.
- Certify providers of IUD insertion through direct observations and client assessments.

Prerequisites to Effective Supervision

- Training of supervisors to be a catalyst for quality improvement, joint problem solving and facilitative styles of communication, as well as in technical skills (as required)
- Development of a supervisory plan that includes the following:
  - Who is to be supervised and the frequency of supervision
  - What will be reviewed: records, skills of providers, attitudes of providers, client assessment, clinic visits (maintenance of building and equipment, cleanliness, privacy, confidentiality, infection prevention measures, emergency preparedness, adequacy of equipment and supplies)
  - What should be achieved before the next visit (decided jointly with the provider who is being supervised)

MONITORING

Monitoring is a continuous process that helps to gauge progress towards achieving the objectives of the program. Monitoring may be qualitative as well as quantitative. Qualitative monitoring is an integral part of supportive supervision.

Tools for quantitative monitoring are the FP records and reports including reports of complications with use of contraceptives.

- Health workers should be trained to monitor their own progress towards achieving the objectives of the program.
- Managers at the district, province and national level should provide regular feedback on findings of the monitoring review.

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APPENDICES

APPENDIX 1: POSTPARTUM CONTRACEPTION

OBJECTIVE

The objective of this appendix is to enable the health worker to provide the correct advice on use of contraceptives to postpartum women.

INTRODUCTION

Many postpartum women want no more children or would like to delay pregnancy for at least 2 years. Unfortunately, too few women leave obstetrical delivery services having received counseling about FP or contraceptive methods. All postpartum women should be provided with FP options. The International Planned Parenthood Federation (IPPF) recommends the following guidelines for counseling postpartum women:

- Encourage full breastfeeding for all postpartum women.
- Do not discontinue breastfeeding to begin use of a contraceptive method.
- Contraceptive methods used by breastfeeding women should not adversely affect breastfeeding or the health of the infant.

POSTPARTUM INFERTILITY

Following delivery every woman experiences a period of infertility. In **nonbreastfeeding** women it may be less than 6 weeks (on average, the first ovulation occurs 45 days postpartum). For **breastfeeding** mothers, the period of infertility is longer because frequent suckling blocks ovulation. The return of fertility, however, is not predictable (conception can occur before the woman has any signs or symptoms of the first menses).

LACTATIONAL AMENORRHEA METHOD (LAM)

It has long been recognized that breastfeeding could be an effective, temporary contraceptive if a woman could reliably know when she is no longer protected. LAM provides the means to do this. It provides effective contraception for a breastfeeding mother if she is fully or nearly fully breastfeeding, her menses have **not** returned (lactational amenorrhea), and she is less than 6 months postpartum. If these criteria are met, then LAM will provide more than 98% protection from pregnancy during the first 6 months following delivery. When any one of these criteria changes, however, another contraceptive method—one that does not interfere with breastfeeding—should be started if the woman does not want to become pregnant. In addition, use of LAM enables both mother and infant to take full advantage of the numerous other benefits of breastfeeding.

WHEN TO START CONTRACEPTION

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

- Spermicides
- Condoms (lubricated condoms may help overcome vaginal dryness)

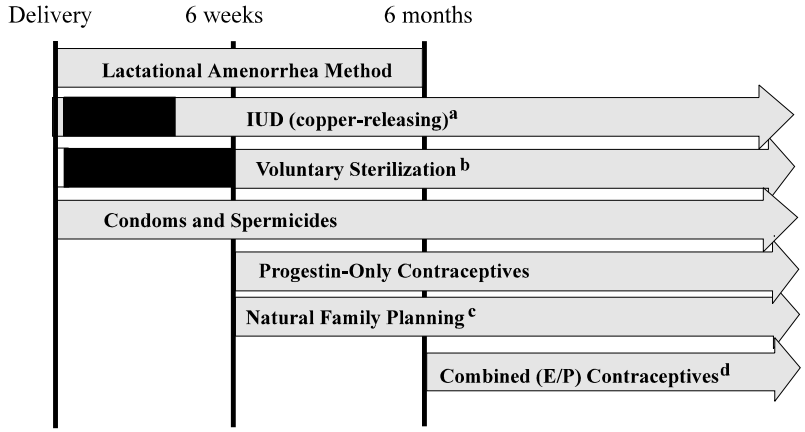
- Withdrawal (both condoms and withdrawal prevent seminal fluid from being deposited in the vagina)

A diaphragm cannot be used until after 6 weeks postpartum because it cannot be properly fitted. Attempting to do so earlier than this may cause discomfort, especially in women who have had an episiotomy.

Breastfeeding Women

Women who are breastfeeding do not need contraception for at least 6 weeks postpartum—up to 6 months if they are using LAM. **Figure 1** shows the recommended time of starting contraception for breastfeeding women. If a breastfeeding woman decides to use contraception other than LAM, she should be counseled about the potential effect of some contraceptives on breastfeeding and the health of the infant. For example, COCs and CICs are considered to be the methods of last choice for any women who is breastfeeding. All COCs, even low-dose pills (30–35 µg EE) decrease breastmilk production, and there is theoretical concern that they may affect the normal growth of a baby during the first 6 to 8 weeks postpartum.[4] Waiting at least 8 to 12 weeks postpartum before starting COCs or CICs has the added advantage of permitting breastfeeding to be better established.

Figure 1. Recommended Time to Start for Breastfeeding Women



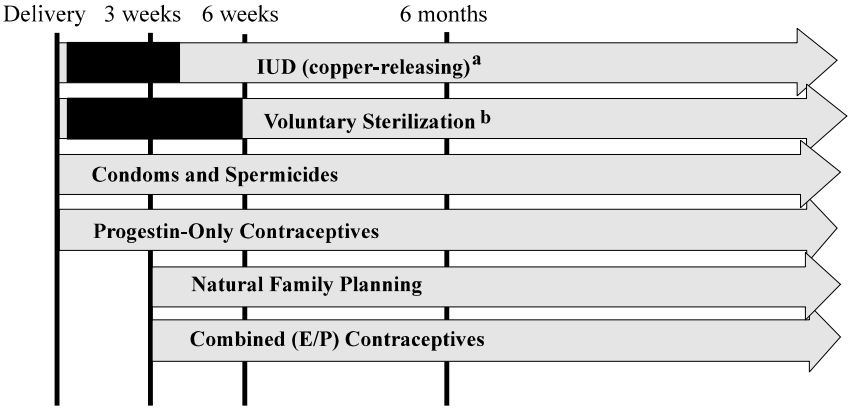
Nonbreastfeeding Women

Although most nonbreastfeeding 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. If a couple wishes to avoid all risk of pregnancy, however, contraception should be started at the time of (barriers, spermicides, withdrawal) or before (hormonals, IUDs or VS) the first sexual intercourse. Because the pregnancy-induced risk of blood clotting problems (elevated coagulation factors) is still present until 2 to 3 weeks postpartum, COCs and CICs should not be started before that time. By contrast, POCs can be started immediately postpartum because they do not increase the risk of blood clotting problems. Other differences in the recommended time for starting contraception in nonbreastfeeding women are depicted in **Figure 2**.

4 These restrictions do not apply to women who are only doing token (i.e., minimal) breastfeeding.

The following pages provide additional information about the use of contraceptive methods by postpartum women.

Figure 2. Recommended Time to Start for Nonbreastfeeding Women



[a] If delivery is in a hospital or other health care facility, immediate postplacental or postpartum (< 48 hours) IUD insertion is appropriate under certain circumstances (i.e., with adequate counseling and a specially trained service provider).

[b] Vasectomy can be performed at any time.

[c] Fertility awareness-based methods (FAB) may be harder for breastfeeding women to use because reduced ovarian function makes fertility signs (e.g., mucus change, basal body temperature) more difficult to interpret. As a result, FAB can require prolonged periods of abstinence during breastfeeding.

[d] During the first 6 months postpartum, COCs and CICs may affect the quantity of breastmilk and the healthy growth of the infant. If a mother is breastfeeding but not using LAM, she may start COCs or CICs as soon as 6 weeks postpartum if other methods are not available or acceptable. (WHO class 3)

Adapted from (both figures): Family Health International 1994.

Table 1. Postpartum contraceptive methods for breastfeeding and non-breastfeeding mothers			
METHOD	**TIMING AFTER CHILDBIRTH**	**RELATED METHOD CHARACTERISTICS**	**REMARKS**
Lactational Amenorrhea Method (LAM)	Should begin breastfeeding immediately after delivery. Highly effective for up to 6 months if fully breastfeeding and no menstrual bleeding (amenorrheic).	Considerable health benefits for both mother and infant. Gives time to choose and arrange for surgical or other contraceptive methods.	98% effective up to 6 months if all criteria for LAM are in place For greatest effectiveness, must be fully breastfeeding. Effectiveness declines as weaning takes place or breastfeeding is supplemented.
COCs and POPs	If breastfeeding, COCs: • should not be used during the first 6–8 weeks postpartum. (WHO class 4) • should be avoided from 6 weeks to 6 months postpartum unless other more appropriate methods are not available or acceptable. (WHO class 3) If breastfeeding, POPs can be started after 3 weeks. If using LAM, delay for 6 months. Start COCs when weaning begins. (WHO class 2) If **not** breastfeeding, COCs can be started after 3 weeks postpartum.	During the first 6–8 weeks postpartum, COCs **decrease** the amount of breastmilk and may affect the healthy growth of the infant. (This effect may continue for up to 6 months.) During the first 3 weeks postpartum, the estrogen in COCs slightly increases the risk of blood clotting problems. If client has resumed menses and sexual activity, start COCs only if reasonably sure she is not pregnant.	COCs should be the last choice for breastfeeding clients. 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. There is no increased risk of blood clotting beyond the 3rd week postpartum.
Injectables (DMPA)	Before 6 weeks postpartum, breastfeeding women should avoid using Injectables unless other more appropriate methods are not available or acceptable. (WHO class 3) If using LAM, Injectables may be delayed until 6 months postpartum. (WHO class 1) If **not** breastfeeding, can be started immediately. If **not** breastfeeding and more than 6 weeks postpartum or already menstruating, start injectables only if reasonably sure the woman is not pregnant. (WHO class 1)	During the first 6 weeks postpartum, progestin may affect the healthy growth of the infant. No effect on quantity or quality of breastmilk or health of infant.	Irregular bleeding may occur with injectables use, even in lactating women.

Table 1. Postpartum contraceptive methods for breastfeeding and non-breastfeeding mothers			
METHOD	**TIMING AFTER CHILDBIRTH**	**RELATED METHOD CHARACTERISTICS**	**REMARKS**
IUDs (copper-releasing)5	May be inserted immediately postplacental, after caesarean section or postpartum (within 48 hours of delivery). (WHO class 1) If not inserted postplacentally or within 48 hours postpartum, insertion should be delayed until 4–6 weeks postpartum. (WHO class 3) If breastfeeding and menses have resumed, insert only if reasonably sure the client is not pregnant.	No effect on quantity or quality of breastmilk or health of infant. Fewer postinsertion side effects (bleeding, pain) when IUD inserted in breastfeeding women.	Require provider trained in postplacental or postpartum insertion. Clients should be screened and counseled during prenatal period for postplacental insertion. First year IUD removal rates are lower among breastfeeding women. Spontaneous expulsion rate higher (6–10%) than for interval insertion (lowest rates if inserted high in fundus within 10 minutes after placenta delivered). After 4–6 weeks postpartum, the provider does not have to be trained in postpartum IUD insertion (technique same as for interval client).
Condoms	May be used any time postpartum.	No effect on quantity or quality of breastmilk or health of infant. Useful as interim methods if initiation of another chosen method must be postponed.	Lubricated condoms and spermicides help overcome vaginal dryness during intercourse (common problem in breastfeeding women).
Fertility Awareness Based Methods	Not recommended until resumption of regular menses. Client may begin charting at 6 weeks postpartum but should continue to use LAM.	No effect on quantity or quality of breastmilk or health of infant.	Cervical mucus difficult to "read" until menses have resumed and are regular (ovulatory). Basal body temperature fluctuates when mother awakens at night to breastfeed. Thus, measuring "early morning" basal body temperature elevation after ovulation may not be reliable.
Withdrawal (Coitus	May be used any time.	No effect on quantity or quality of	Some couples find withdrawal or long

5 Progestin-releasing IUDs should not be inserted until after 6 weeks postpartum. (WHO class 3)

Table 1. Postpartum contraceptive methods for breastfeeding and non-breastfeeding mothers			
METHOD	**TIMING AFTER CHILDBIRTH**	**RELATED METHOD CHARACTERISTICS**	**REMARKS**
Interruptus) or **Abstinence**		breastmilk or health of infant. 100% effective (abstinence).	periods of postpartum abstinence difficult. Yet, it is acceptable in cultures in which postpartum abstinence abstinence is traditional. Counsel the couple about the need for a backup method if they decide to resume intercourse.
Tubal Occlusion	May be performed immediately postpartum or within 48 hours. If not performed within 48 hours, should be delayed until 6 weeks postpartum. **Ideal timing**: After recovery from delivery and once the health of the infant is more certain.	No effect on quantity or quality of breastmilk or health of infant. Postpartum minilaparotomy is easiest to perform within first 48 hours of delivery because the position of the uterus makes the fallopian tubes easier to find and see.	Perform using local anesthesia/ sedation. This minimizes risk to the mother and possible prolonged separation of mother and child due to anesthetic complications. Ideally, counseling and informed consent should take place prior to labor and delivery (during prenatal period).
Vasectomy	Can be performed anytime after delivery. **Ideal timing**: Once the health of the infant is more certain.	Not immediately effective. An interim method should be provided for 3 months (or at least 20 ejaculations) if the couple is sexually active.	In cultures in which postpartum abstinence is traditional, vasectomy performed at this time leads to less disruption of intercourse for the couple. Partner's contact with health care system may be a good time for man to use services.

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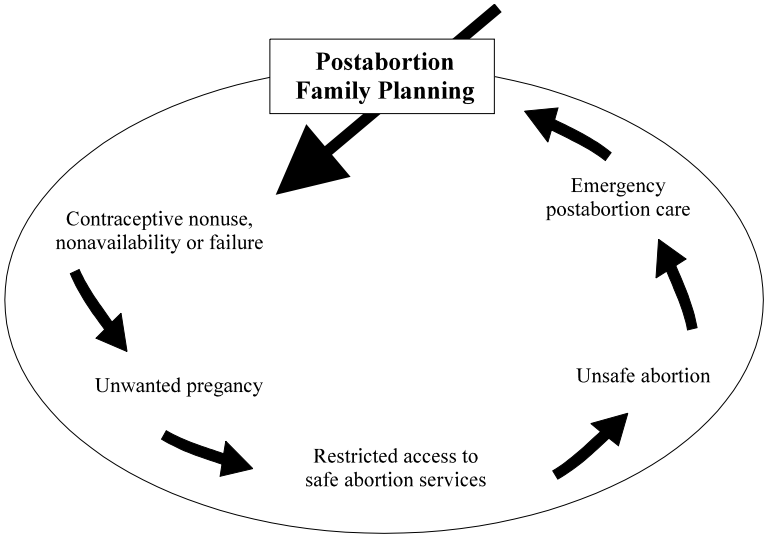
APPENDIX 2: POSTABORTION CONTRACEPTION

Throughout the developing world, many women are trapped in a dangerous cycle of repeat unwanted pregnancy and unsafe, often illegal abortion. Although the importance of linking postabortion care and FP services seems obvious, these two types of care rarely are offered together. Typically, emergency treatment services for postabortion complications do not include provision of or referral to FP counseling and method delivery. As a consequence, women are denied access to the means of preventing future unwanted pregnancies as well as being exposed to the risk of additional unsafe abortions, both of which contribute to the poor overall health status of women in many countries. **Figure 3** shows the way in which postabortion FP can break the cycle of unsafe abortion.

Figure 3. Breaking the Cycle of Unsafe Abortion



***Source*: IPAS 1993.**

LINKING POSTABORTION CARE TO FAMILY PLANNING

Provision of emergency postabortion care may be one of the few occasions when a woman and her partner come into contact with the health care system. Therefore, it represents an important opportunity for providing contraceptive information and services.

Postabortion FP should include the following components:

- Counseling about contraceptive needs in terms of the client's reproductive goals
- Information and counseling about all available methods, their characteristics, effectiveness and side effects
- Choices among methods (e.g., short- and long-term, hormonal and nonhormonal)
- Assurance of contraceptive resupply
- Access to followup care
- Information about the need for protection against sexually transmitted diseases (STDs)

Postabortion FP 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.

WHEN TO START

Postabortion FP services need to be initiated immediately because ovulation may occur as early as 11 days following treatment of incomplete abortion and usually occurs before the first menstrual bleeding. At a minimum, all women receiving postabortion care need counseling and information to ensure they understand:

- they can become pregnant again before the next menses,
- there are safe contraceptive methods to prevent or delay pregnancy, and
- where and how they can obtain FP services and methods.

WHICH CONTRACEPTIVE METHODS CAN BE USED

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

- screens the woman for the standard precautions for use of a particular method, and
- gives adequate counseling.

It is recommended that women not have intercourse until postabortal bleeding stops.

Recommendations for contraceptive use following first trimester abortion (up to 14 weeks from LMP) 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). Recommendations for contraceptive use following second trimester spontaneous or incomplete abortion are more similar to those for the postpartum period.

The following pages (adapted from *Postabortion Care: A Reference Manual for Improving Quality of Care*) outline the factors relevant to the postabortal use of various contraceptive methods.

Table 2. Contraceptive methods for the postabortion client			
METHOD	**TIMING AFTER ABORTION**	**RELATED METHOD CHARACTERISTICS**	**REMARKS**
Oral Contraceptives (COCs and POPs) and Injectable Contraceptives	Start COCs, POPs or Injectable (DMPA) use immediately, preferably on the day of treatment. (WHO class 1)	Can be started immediately even if infection is present. Highly effective. Immediately effective. Minimize blood loss (i.e., improve anemia), especially COCs.	If adequate counseling and informed decision-making cannot be guaranteed, delay first injection (DMPA) and provide a temporary interim method.
IUDs	First Trimester: IUDs can be inserted immediately if risk or presence of infection can be ruled out. (WHO class 1) Delay insertion until serious injury is healed, hemorrhage is controlled and acute anemia improves. (WHO class 4)		If adequate counseling and informed decision-making cannot be guaranteed, delay insertion and provide a temporary interim method. Access to a provider skilled in insertion and removal is necessary.
	Second Trimester: Delay for 4 to 6 weeks unless equipment and expertise (trained provider) are available for immediate postabortal insertion. (WHO class 2) Be sure there is no uterine infection. If infection suspected, delay insertion until the infection has been resolved for 3 months. (WHO class 4)		Following second trimester abortion, the uterine cavity is larger and the risk of perforation during insertion is greater.
Condoms	Start use as soon as intercourse is resumed.	Good interim methods if initiation of another method must be postponed.	
Fertility Awareness-Based Methods (FAB)	FAB is not recommended for immediate postabortion use.		The first ovulation after an abortion will be difficult to predict and the method is unreliable until after a regular menstrual pattern has resumed.

Table 2. Contraceptive methods for the postabortion client			
METHOD	**TIMING AFTER ABORTION**	**RELATED METHOD CHARACTERISTICS**	**REMARKS**
Tubal Ligation	Technically, tubal occlusion (minilaparotomy) 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.	Minilaparotomy after a first trimester incomplete abortion is similar to an interval procedure; after a second trimester incomplete abortion it is similar to a postpartum procedure.	Adequate counseling and informed decision-making and consent must precede voluntary sterilization procedures (tubal occlusion); 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 counseling and informed decision-making and consent must precede voluntary sterilization procedures (vasectomy); this often is not possible at the time of emergency care.

GUIDELINES FOR CONTRACEPTIVE USE BY CLINICAL CONDITION

CLINICAL CONDITION	PRECAUTION	RECOMMENDATION
Confirmed or Presumptive Diagnosis of Infection · **Signs and symptoms of sepsis/infection** · **Signs of unsafe or unclean induced abortion** · **Unable to rule out infection**	IUDs: Do not insert until risk of infection ruled out or infection fully resolved (approximately 3 months). Female voluntary sterilization: Do not perform procedure until risk of infection ruled out or infection fully resolved (approximately 3 months).	COCs: can begin use immediately. DMPA: can begin use immediately. Condoms: can be used when sexual activity is resumed.
Injury to Genital Tract · **Uterine perforation (with or without bowel injury)** · **Serious vaginal or cervical injury, including chemical burns**	IUDs: Do not insert until serious injury healed. Female voluntary sterilization: Do not perform procedure until serious injury healed.	COCs: can begin use immediately. DMPA: can begin use immediately. Condoms: can be used when sexual activity is resumed.
Severe Bleeding (hemorrhage) and Related Severe Anemia (Hb < 7 g/dl or Hct < 20)	DMPA: Delay injection until acute anemia improves. IUDs (inert or copper-bearing): Delay insertion until acute anemia improves. Female voluntary sterilization: Do not perform procedure until the cause of hemorrhage or anemia resolved.	COCs: can begin use immediately (beneficial when hemoglobin is low). IUDs (progestin-releasing): can be used with severe anemia (decreases menstrual blood loss). Condoms: can be used when sexual activity is resumed.

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APPENDIX 3: EMERGENCY CONTRACEPTION

When sexual intercourse occurs without contraceptive protection, unplanned and undesired pregnancy can result. Fortunately, because there are highly effective methods to prevent such pregnancies, clients need not be turned away to anxiously await their menstrual period. Unfortunately, few clients are aware of the availability and safety of such methods. To correct this, health care providers should routinely educate clients about emergency contraception. In addition, FP programs may want to consider providing emergency contraceptives as a preventive measure.

While most contraceptives are appropriate before intercourse, several methods also can be used within a short time after unprotected intercourse. Often called "morning after pills," they are better named secondary or emergency contraceptives. These names remove the idea that the user must wait until the morning after unprotected intercourse to start treatment or that she will be too late if she cannot obtain the pills or an IUD until the afternoon or night after intercourse.

Currently there are two types of emergency contraceptives: mechanical and chemical. The only mechanical method is the IUD. When inserted up to 5 days after unprotected intercourse, copper-releasing IUDs can prevent a pregnancy from becoming established. In terms of chemical methods, fifteen regimens using oral contraceptives are said to exist, but only four have been adequately studied and are recommended for widespread use. In some countries increased demand for emergency contraception has led to special packaging of oral contraceptives (COCs and POPs) for this use.

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 fact that the method is not effective if she is already pregnant.

BREASTFEEDING WOMEN

If a woman is fully breastfeeding, amenorrheic and fewer than 6 months postpartum (using LAM), she should not need emergency contraception. If she is breastfeeding but not using LAM and thinks she might be at risk of becoming pregnant, emergency contraception may be used. The effect on lactation and risk to the infant are minimal.

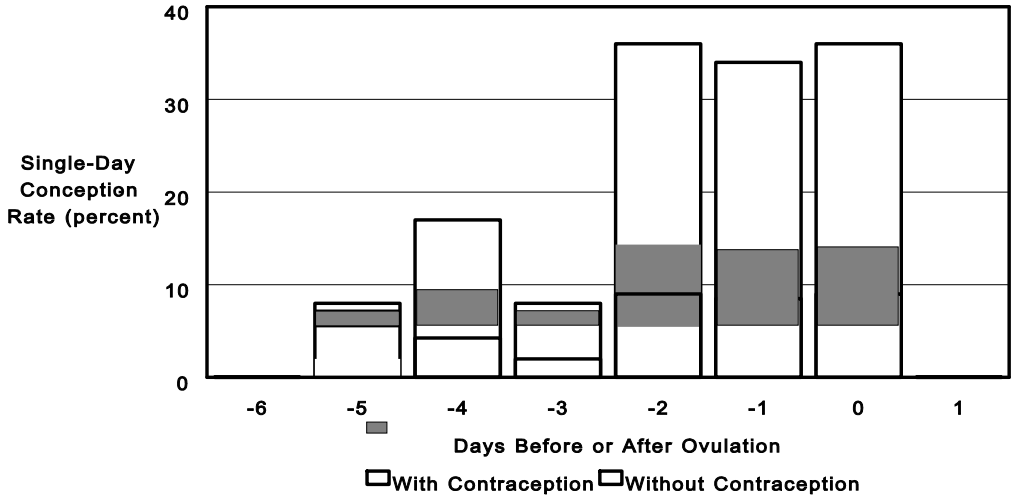
RISK TO CLIENTS WITH VASCULAR PROBLEMS

Women who are at increased risk of vascular problems (current or past blood clotting problems, heart attack or stroke) should be advised of a very slight additional risk of a serious complication if they use the high-dose (50 µg) estrogen regimens (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; therefore, do not withhold treatment if client requests it.

RISK OF BECOMING PREGNANT

The risk of becoming pregnant depends on the day of the woman's cycle in relation to ovulation. Calculating the exact risk is best done using data in which only a single act of intercourse potentially could have led to conception. On the basis of 129 such cycles, Wilcox et al (1995) observed that the risk of pregnancy increased from 8% at 5 days before ovulation to 36% on the day of ovulation (see white bars in **Figure 4**). These new data indicate that the fertile period lasts only about 6 days, is clustered around a 2 to 3 day interval (days -2 to 0) and ends on the day of ovulation (i.e., cycle days 9 to 14 of a 28 day cycle). The decrease in fertility immediately following ovulation (day 0) suggests a short survival time for ova (less than 24 hours) as well as a rapid change in the cervical mucus that may prevent entry of new sperm.

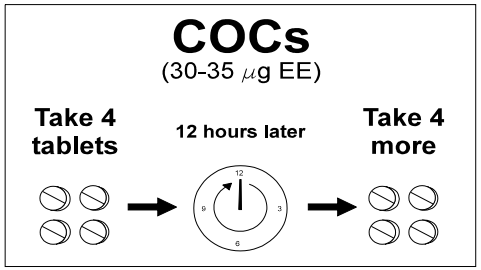
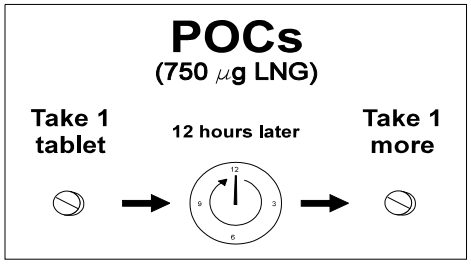
Figure 4. Probability of Conception by Cycle Day



***Adapted from*: Wilcox et al 1995.**

Use of emergency contraception during the fertile period reduces the risk of pregnancy by at least 75%. For example, as shown in the figure (gray bars) a 36% risk would be reduced to about 9%. Overall, however, only 1–3% of women emergency contraception become during that cycle. In practice, because the fertile period for a given cycle can only be estimated, it is often difficult to assess accurately a woman's risk of becoming pregnant. Fortunately, because all emergency contraceptives are quite safe, their use is appropriate any time in the cycle when a woman is concerned she might be pregnant.

Table 3. Contraceptive methods for use as emergency contraception

METHOD	TIMING IN RELATION TO UNPROTECTED INTERCOURSE	REMARKS	CLIENT INSTRUCTIONS
COCs (Morning After Pills)	Should be taken within 72 hours of unprotected intercourse.	Effective (2% become pregnant). Side effects: · Nausea (> 1 day) · Vomiting (see last page of this chapter for management) · Breast tenderness If pregnancy not prevented, counsel client regarding options.	Take four tablets of a low-dose COC (30–35 µg EE) orally within 72 hours of unprotected intercourse. Take four more tablets in 12 hours. (Total = 8 tablets)6 OR Take two tablets of a high-dose COC (50 µg EE) orally within 72 hours of unprotected intercourse. Take two more tablets in 12 hours. (Total = 4 tablets) If no menses within 3 weeks, consult clinic or service provider to check for possible pregnancy.
			
Progestin-Only Pills (POPs)	Should be taken within 48 hours of unprotected intercourse.	Effective (< 3% become pregnant). Same side effects as with COCs but less severe. If pregnancy not prevented, counsel client regarding options. These regimens have not yet been as widely studied as those using COCs.	Take 750 µg of levonorgestrel (20 tablets of the progestin-only pill) orally within 48 hours of unprotected intercourse. Take 20 more tablets in 12 hours. (Total is 40 tablets) If no menses within 3 weeks, consult clinic or service provider to check for possible pregnancy.
			

[1] **If COCs not available, high-dose estrogen can be substituted. The recommended dose of each medication (2.5 mg EE, 10 mg conjugated estrogens or 5 mg esterone) must be taken twice daily (e.g., 5 mg EE) for 5 consecutive days.**

Table 3. Contraceptive methods for use as emergency contraception			
METHOD	**TIMING IN RELATION TO UNPROTECTED INTERCOURSE**	**REMARKS**	**CLIENT INSTRUCTIONS**
IUDs	Should be inserted within 5 days of unprotected intercourse.	Very effective (< 1% become pregnant). Few side effects. Failure increases with longer interval between unprotected intercourse and insertion. Insertion requires a minor procedure that must be performed by a trained service provider. Provides long-term contraception as well. Should not be inserted in women at risk for GTIs and other STDs (e.g., HBV, HIV/AIDS). May not be advisable for nulliparous clients.	If no menses within 3 weeks, consult clinic or service provider to check for possible pregnancy. If pregnancy not prevented, counsel client regarding options.

MANAGEMENT OF NAUSEA AND VOMITING

Because of the high total dose of estrogen in COCs, nausea is a common side effect. This is less of a problem with the POPs. If accompanied by vomiting within the first 2 hours, the effectiveness of COCs when used for emergency contraception may be decreased.

- To minimize nausea and vomiting, advise clients to take each dose with food. If appropriate, taking the first dose at bedtime may reduce nausea and vomiting.
- While there is some decrease in nausea and vomiting if anti-emetics are taken prophylactically, routine use is not recommended. They are of no help if given after vomiting has started.
- If vomiting occurs within 2 hours of taking the first or second dose:
  - the client may repeat the dose, or
  - consider administering the dose vaginally.
- An extra treatment (e.g., 8 COC tablets containing 30-35 µg EE each) may be given to clients for use as backup.

CLIENT INFORMATION FOR COCs

- There is no reported harm to the woman or a developing embryo (if pregnant during the previous cycle) from the small amount of estrogen and progestin in COCs taken for 2 days. It is, however, unwise for a woman to take any drugs in early pregnancy unless absolutely necessary.
- If a client is pregnant at the time she takes COCs, their use will not cause an abortion.
- COCs taken for a short duration (2 days) are highly unlikely to cause a serious problem even in women at risk for vascular problems (current or past blood clotting problems, heart attack or stroke).
- About 8% of women using COCs for emergency contraception will have spotting during the treatment cycle. About 50% will get their menses at the expected time and most others will start menses earlier than expected.
- Emergency contraception should not be used on a regular basis (from month to month) because it is much less effective than other methods.
- Tell client how and when to start her chosen contraceptive method.

WHEN TO RETURN

A client should return to the clinic if she has:

- no menses within 3 weeks (check for normal or ectopic pregnancy)
- any concerns

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APPENDIX 4: CONTRACEPTION FOR PEOPLE UNDER 18

Sexually active young women and men are in need of safe and effective contraception. Studies show that large numbers of married women are still in their adolescent years and are sexually active. In addition, many young women and men do not use effective contraceptive methods, and those who do are likely to use them infrequently or incorrectly. This often leads to early childbearing that is associated with poor health in both young mothers and their infants.

In addition to the social and cultural reasons that may prevent young people from seeking contraception, there are also misperceptions in the clinical arena that place inappropriate restrictions on the use of various contraceptive methods by young people. Providers, managers and policy makers should have accurate clinical information when making decisions about the use of contraception by people under the age of 18. For example, once a woman has begun her periods, hormonal contraception (e.g., DMPA or COCs) will not impact her ability to have regular menstrual cycles.

All young women and men need access to FP, and services for them should avoid unnecessary clinical procedures that may embarrass young people and discourage them from using FP services (e.g., pelvic examinations for young women requesting COCs). Furthermore, because adolescents may be less reliable in how they use a method, it is important that they have access to emergency contraceptive services (see Appendix 3).

In the following pages, only factors relevant to the use of specific contraceptive methods by young men and women are provided.

Table 4. Counseling outline for method selection for people under age 18	
COUNSELING OUTLINE	
METHOD	**REMARKS**
Oral Contraceptives (COCs and POPs)	Conditions requiring precautions are rare in young women Forgetfulness increases failure (common among young women) Although there has been concern about the use of COCs by young adolescents (theoretical effect on growth), they may be safely used once a young woman has started menstruating.
Progestin Only Injectable Contraceptives (DMPA)	Side effects such as irregular bleeding/spotting, acne and weight gain may be particularly bothersome to young women. Thorough counseling is required. Lack of need for supplies and non-visibility make these methods attractive to young women. Highly recommended for young women who require intermediate-duration contraception. Some studies show that use of DMPA in young women within 2 years of menarche may pose an additional long-term risk of osteoporosis.
IUDs	Not the most ideal method before first child. Thorough counseling is essential.
Condoms	Provide immediate protection but require planning (coitus-related). Should be easily available as young women are likely to have unplanned intercourse. Only method that protects against GTIs and other STDs (e.g., HBV, HIV/AIDS).
Voluntary Sterilization (tubal occlusion and vasectomy)	Not appropriate for adolescents in most circumstances.
Withdrawal (Coitus Interruptus) and **Abstinence**	May be appropriate for married adolescents. Thorough counseling is essential.
Emergency Contraception	Should be available as young women are likely to have unplanned, unprotected intercourse. All methods effective and safe for use in teenagers. IUDs are less desirable.

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APPENDIX 5: FAMILY PLANNING AND REPRODUCTIVE TRACT INFECTIONS

OBJECTIVE OF THE CHAPTER

To provide guidance to the health workers in screening FP clients for RTIs/STIs.

RTIs AND STIs

Since the concept of reproductive tract infections (RTIs) and sexually transmitted infections (STIs) was first described, the spectrum of diseases included in this category has expanded greatly. Some, but not all RTIs are sexually transmitted. STIs are transmitted through vaginal, anal and oral sexual intercourse with an infected man or woman. Gonorrhea, syphilis, Chlamydia, chancroid, trichomoniasis and HIV are some of the common STIs.
Some of the important facts about RTIs and STIs are the following:

- People suffering from RTIs and STIs are at an increased risk of becoming infected with HIV.
- STIs present with signs and symptoms that may be mild or severe.
- The most common symptoms and signs of RTIs and STIs are vaginal discharge, urethral discharge, genital ulcers, burning on urination and lower abdominal pain.
- Many STIs particularly those in women show some symptoms that disappear without treatment. But the microorganisms causing the disease are still inside the body and the following can happen:
  - Infect another person
  - The microorganisms move into the blood and go to other parts of the body such as heart and brain and cause problems
- The severe consequences of some of the STIs include increased risk of ectopic pregnancy, still births and congenital anomalies in the fetus during pregnancy, blindness and pneumonia in the new born and infertility, hepatitis, cancer of the cervix and dementia.

Currently, more than twenty microorganisms are known to be transmissible through sexual intercourse. The complications arising from STIs, from pelvic inflammatory disease (PID) in particular, present enormous public health problems. In addition, transmission of hepatitis B and HIV is facilitated by ulcerative genital conditions, and possibly by vaginitis and cervicitis.

To address these public health problems and help the greatest number of clients, practical and economical STI diagnosis and treatment programs are required. Because sexually transmitted disease (STD) and FP services overlap substantially, it is important to provide STD screening for FP clients. STDs frequently are encountered in FP clients, especially in certain high-risk groups (e.g., clients who have more than one sexual partner).

How FP Services Contribute to Prevention and Management of STIs

Family planning services include some elements of care that strengthen STI prevention and management and promote integration of FP and STI services as listed below.
Counseling for FP includes history of sexual practices that will help to:

- Identify clients at risk of STI/HIV
- Provide advice about prevention using condoms and
- Refer to the appropriate facility for further counseling and treatment.

Client assessment includes screening for STIs and is an element of quality FP services (see under screening for STIs). All FP clients must be screened (by checking history) for STIs and risk of STIs. This is important for advising appropriate methods or "dual protection" using condoms.

Prevention of STIs

Contraceptives such as condoms prevent transmission of STIs and HIV. Health workers should help the clients with suspected history of STIs/ at risk of STIs, do the following:

- In the case of clients not currently using any contraceptives, help to choose a method such as condom that will provide "dual protection" (protection from pregnancy as well as STI)
- In case of clients currently using a contraceptive, but develops STI or at risk of STI and would like to continue the use of the same contraceptive,, advise use of condoms.
- Referral of clients to appropriate facilities for treatment.

CLIENT SCREENING

Because a thorough examination (including microbiologic and serologic studies) of all FP clients usually is not possible, at a minimum, the risk of STDs in all clients should be assessed. Effective screening does not require the use of complicated protocols or costly laboratory tests. To do this, health care providers should:

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

Questions a STD screening history should include:

- Do you have a vaginal discharge?
- In the past year, have you had a genital tract problem such as a vaginal discharge, ulcers or skin lesions in your genital area?
- Has your sex partner been treated for a genital tract problem, such as discharge (drip) from the 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, driver, military)?
- Have you had more than one sex partner in the last 2 months?
- Do you think that you might have a STD?

WHAT ARE GTIs?

- GTIs are genital tract infections caused by a small number of microorganisms (bacteria, viruses and fungi) which usually are sexually transmitted.
- Most STDs are GTIs, although some STDs such as hepatitis B and AIDS (which are primarily but not exclusively sexually transmitted) are also systemic diseases.
- Most GTIs (e.g., gonorrhea, syphilis) can be treated. All can be prevented; and if not prevented, early diagnosis and treatment can decrease the possibility of serious complications such as infertility in both women and men.

GTIs Are a Significant Problem

GTIs are almost as common as malaria: > 250 million new cases each year. The consequences of untreated GTIs are devastating; they include:

- Ectopic pregnancy (7–10 times increased risk in women with history of PID)
- Increased risk of cervical cancer
- Chronic abdominal pain (18% of females with a history of PID)
- Infertility:
  - 20–40% of males with untreated Chlamydia and gonorrhea
  - 55–85% of females with untreated PID (8–20% of females with untreated gonorrhea develop PID)
- Increased risk of HBV and HIV/AIDS transmission

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 GTIs and STDs.

In view of the enormous health problems caused by sexually transmitted GTIs, coupled with the limited resources available in many countries, reducing the incidence of GTIs is unrealistic. A more realistic aim is to reduce the number of GTI complications, such as PID and male and female infertility, and to reduce the transmission of HBV and HIV/AIDS.

FAMILY PLANNING IN RELATIONS TO STDs

The clinical features of specific GTIs are summarized in this section. To assist the clinician in determining the relationship between the GTI and FP this table has been created.

Table 5. Considerations regarding contraception and genital tract infections			
GTI	**CLINICAL FINDINGS (signs/symptoms)**	**DIAGNOSIS**	**FAMILY PLANNING CONSIDERATIONS**
Vaginal/Urethral Discharge			
Bacterial vaginosis	Vaginal discharge with fishy odor, grayish in color Not necessarily sexually transmitted	> 20% "clue cells" (vaginal epithelial cells covered with bacteria) on saline wet mount (or Gram stain); elevated vaginal pH (> 5) and positive "whiff" test for fishy smell	Should delay IUD insertion until infection is completely cleared. Condoms do not offer additional protection or benefit as this is not a sexually acquired infection.
Yeast (candidiasis)	Women · Curd-like vaginal discharge, whitish in color · Moderate to intense vaginal or vulvar itching (pruritus) Men · Itchy penile irritation (balanitis) Frequently not sexually transmitted	Presumptive diagnosis by symptoms; confirmed by microscopic examination of saline or KOH wet mount preparation	Should delay IUD insertion until infection is completely cleared. Condoms do not offer additional protection or benefit as this is not a sexually acquired infection.
Vaginal/Urethral Discharge (*continued*)			
Trichomoniasis	May produce few symptoms in either sex Women · Often will have a frothy (bubbly), foul-smelling, greenish vaginal discharge · Intense pruritus (itching) Men may have a urethral discharge.	In both sexes, diagnosis is made easily by observing microscopically the whipping motion (flagellating) of the parasite on saline wet mount.	Condoms should be used until both partners are treated and the treatment is complete.

Table 5. Considerations regarding contraception and genital tract infections			
GTI	**CLINICAL FINDINGS (signs/symptoms)**	**DIAGNOSIS**	**FAMILY PLANNING CONSIDERATIONS**
Gonorrhea ("clap" or "drip")	Women · Purulent (containing mucopus) vaginal discharge · Pain (or burning) on passing urine (dysuria) · Inflamed (red and tender) urethra 70% of women are asymptomatic in initial stages. If left untreated, can result in: · infection of the pelvic organs (PID), · infertility due to tubal blockage, or · increased risk of ectopic pregnancy (tubal scarring). Men · Pain (or burning) on passing urine (dysuria) · Purulent (containing mucopus) urethral discharge (drip) If left untreated, can result in: · infection of the epididymis (coiled tube leading from the testis to the spermatic cord), · urethral abscess or narrowing (stricture), or · infertility (blockage of the epididymis).	Women 40–60% positive Gram-negative intracellular diplococci (GNIDs) on Gram stain of cervical smear Men Up to 98% positive GNIDs microscopically on Gram stain of urethral smear	Condoms should be used until both partners are treated and the treatment is complete. IUD insertion should be delayed for three months following treatment of symptomatic gonorrhea infection.

Table 5. Considerations regarding contraception and genital tract infections			
GTI	**CLINICAL FINDINGS (signs/symptoms)**	**DIAGNOSIS**	**FAMILY PLANNING CONSIDERATIONS**
Chlamydia	Women Produces few symptoms, even with upper genital tract infection ("silent PID"); on examination, purulent vaginal or cervical discharge, frequently a "beefy" red cervix which is friable (bleeds easily) Men Most frequent cause (50%) of nongonococcal urethritis (NGU)	Presumptive diagnosis based on mucopus and/or friable (easily bleeding) cervix and negative GNIDs Definitive diagnosis by serologic tests or culture	Condoms should be used until both partners are treated and the treatment is complete. IUD insertion should be delayed for three months following treatment of symptomatic gonorrhea infection.
Genital Ulcers and Buboes			
Chancroid (soft chancre)	Painful, "dirty" ulcers located anywhere on the external genitalia In 25–60% of cases, an enlarged lymph node (bubo) develops in the groin. Most common cause of genital ulcers in many parts of the world	Presumptive diagnosis often rests on clinical features (syphilitic chancres usually are not painful) and a negative darkfield (microscopic) examination or serology (RPR or VDRL). Confirmation sometimes can be made if the causative bacteria are seen (Gram-negative coccobacilli in chains—the so-called "school of fish").	Condoms should be used until both partners are treated and the treatment is complete.

Table 5. Considerations regarding contraception and genital tract infections			
GTI	**CLINICAL FINDINGS (signs/symptoms)**	**DIAGNOSIS**	**FAMILY PLANNING CONSIDERATIONS**
Syphilis	Occurs in 2 forms—early (primary and secondary) and late. Early syphilis · Initially, painless ulcer (chancre): in women on the external genitalia (labia), in men on the penis; and enlarged rubbery lymph nodes · Later (several months): non-itchy body rash Both types of lesions disappear spontaneously. Late syphilis develops in about 25% of untreated cases and is often fatal due to involvement of the heart, great vessels and brain.	Definitive diagnosis made by darkfield microscopy of secretions from a primary or secondary lesion or serology (RPR or VDRL) in equivocal cases or when there are no signs or symptoms (latent stage).	Condoms should be used until both partners are treated and the treatment is complete.
Lympho-granuloma venereum (LGV)	· Small, usually painless papules (like pimples) on the penis or vulva, followed by · buboes in the groin which ultimately break down forming many fistulae (draining openings) If untreated, the lymphatic system may become blocked, producing elephantiasis (swelling of the genitals or extremities).	Clinical findings may not be helpful. Microscopic diagnosis rests on seeing inclusion bodies in white cells (PMNs) of bubo aspirate.	Condoms should be used until both partners are treated and the treatment is complete. IUD insertion should be delayed for three months following treatment of symptomatic gonorrhea infection.
Granuloma inguinale (Donovanosis)	An uncommon cause of ulcerative GTIs Typically, the infected person develops lumps under the skin which break down to form “beefy” red, painless ulcers.	Diagnosis rests on identifying “Donovan bodies” inside the cell in Giemsa-stained smear from the groin or perineal buboes.	Condoms should be used until both partners are treated and the treatment is complete.

Table 5. Considerations regarding contraception and genital tract infections			
GTI	**CLINICAL FINDINGS (signs/symptoms)**	**DIAGNOSIS**	**FAMILY PLANNING CONSIDERATIONS**
Genital herpes	Multiple, painful, shallow ulcers which clear in 2 to 4 weeks (first attack) and may be accompanied by watery vaginal discharge in women; recurrent (multiple bouts) more than 50% of the time	Presumptive diagnosis by signs and symptoms and, often, by exclusion	Condoms should be used or intercourse should be avoided while either of the partners has an active lesion or prodromal symptoms (which suggest that a lesion is about to appear).
Genital warts (condyloma acuminata)	Single or multiple soft, painless, "cauliflower" growths which appear around the anus, vulvo-vaginal area, penis, urethra and perineum	Presumptive diagnosis by signs and symptoms. Exclude syphilis by darkfield examination or serology.	Condoms may be protective against transmission.
Lower Abdominal Pain			
Pelvic inflammatory disease (PID)	Acute: lower abdominal tenderness, cervical motion tenderness (CMT) on pelvic examination and one or more of the following: · purulent (containing mucopus) vaginal/cervical discharge, · temperature > 38°C, · GNIDs on cervical smear, or · presence of a pelvic mass.	GNIDs on cervical smear	Condoms should be used until both partners are treated and the treatment is complete. IUD insertion should be delayed for three months following treatment of symptomatic gonorrhea infection.
Acute Scrotal Pain and/or Swollen Scrotum			
Epididymitis/ Orchitis (sexually acquired)	Acute: Severe pain in one or both testes, sudden swelling of the testes	May include urethral discharge (or past history)	Condoms should be used until both partners are treated and the treatment is complete.

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APPENDIX 6: RUMORS AND FACTS ABOUT CONTRACEPTION

Condoms

Rumor	Fact
1. Condoms may remain in the vagina and move up in the body.	1. If condoms are used properly, it is unlikely that it will slip off. Condoms cannot migrate up into the body.
2. Condoms decrease sexual pleasure.	2. Condoms may increase the period of erection and prevents premature ejaculation. Condoms provide protection against pregnancy and STIs and HIV, which makes sexual intercourse free of worries.
3. The rubber in the condom causes pain in the vagina during sexual intercourse.	3. Latex does not cause any pain. However, there may be pain if there is allergic reaction to latex (rare). Pain also may be felt due to dryness of the vagina and use of non-lubricated condoms.
4. Condoms are meant to be used with prostitutes only.	4. Condoms are used by many married couples as a form of contraception.

Combined Oral Contraceptive Pill

Rumor	Fact
1. The pill causes cancer.	1.Women on COCs are less likely to develop cancers of the ovary and endometrial lining. It also decreases benign breast diseases, uterine fibroids and ovarian cysts.
2. The pill causes deformed babies and multiple deformities.	2.The number of babies born deformed or the number of multiple births among women who use COCs are no different from those who do not use them.
3.hen a woman stops taking the pill, she will have trouble getting pregnant.	3.After stopping the pill, the ovaries function as before taking the pill and women get pregnant soon after stopping the pill. However, in some women, there may be a delay of 2-3 months in becoming pregnant. Experts feel that these women may have experienced trouble in getting pregnant even if they were not on the pill.

Injectable (DMPA)

Rumor	Fact

1. The injectable causes weakness in woman and she is less able to work.	1. Experience from the world shows that the injectable does not cause weakness. In fact it strengthens the woman by decreasing the anemia through decreased blood loss.
2. Injectable causes heavy bleeding.	2. Heavy bleeding is unlikely. Injectable may cause frequent and irregular light bleeding, which subsides in few months. The woman may have no menstrual periods at all.
3. Injectable cause loss of appetite and weight.	3. It causes gain in weight more often than loss of appetite and weight.
4. Women on injectable may need to stop it for few days to regain fertility.	4.Experience from around the world has shown that a woman can continue with the method continuously as long as she wishes and does not affect her fertility.
5. Since the injectable stops menstruation, unclean blood builds up in the body.	5. Injectable does not cause any build up of blood in the body. In fact, it decreases menstrual bleeding.

IUD

Rumor	Fact
1. The IUD causes discomfort to the man during intercourse.	1. The strings if left long does cause discomfort to the man during intercourse. The strings can be trimmed. If the IUD is felt, it may be because it is being expelled and needs a check-up at the clinic.
2. The IUD can travel up from the uterus to the brain.	2. Rarely, perforation of the uterus takes place and in such situations, it remains inside the abdominal cavity.

APPENDIX 7: RECORDS

FAMILY PLANNING CARD OF THE INTEGRATED FAMILY CARD

Family Planning

Initial Evaluation

Medical History	Heart disease (yes or no)		Contraceptive and Reproductive History	Last menstrual period (LMP)	
	Stroke (yes or no)			Previous method (specify, if any)	
	Hypertension (yes or no)			Abnormal vaginal bleeding (yes or no)	
	Diabetes (yes or no)			Time since last pregnancy (months/years)	
	Jaundice (yes or no)			Breastfeeding (yes or no)	
	Breast cancer (yes or no)			Current or recent vaginal discharge (yes or no)	
	Genital tract cancer (yes or no)			History of ectopic pregnancy (yes or no)	
	Thromboembolism (yes or no)			Able to obtain method resupply (yes or no)	
	Migraine headache (yes or no)		Physical Examination	Blood pressure (mmHg)	
	Tuberculosis (yes or no)			Pulse (per minute)	
	Other (specify, if any)			Skin (normal or other)	
	Tobacco use(yes or no. If yes, specify how many per day?)			Abdomen *(as needed)* (normal or other)	
	Medications for tuberclosis (yes or no)			Pelvic exam *(as needed)* (normal/other)	
	Medications for convulsions (yes or no)			IUD in place (yes or no)	
General Assessment				Other (specify)	
			Laboratory Test *(as needed)*	Pregnancy test (positive or negative)	
				Hemoglobin (gr/dl)	
				Other (specify)	

Method specific counseling and provision	Contraceptive method provided *(mark an "x" for the method given)*			If yes, specify	
	IUD	Type	Insertion Date	Removal Date	Remarks
	Oral pills	Name	Quantity given	Remarks	
	DMPA injection	Injection site	Date	Remarks	
	Other (if yes, specify)				

Return Visits and Evaluations

Date	Interval History	New medical findings	LMP	Method	Instructions and remarks
				Same New	
				Same New	
				Same New	
				Same New	

All follow up visits: Assess client's satisfaction and understanding of method. Reinforce method specific counseling. Schedule follow up visit

REFERRAL SLIP

Date of referral___

Name of the referral site_____

Name of the client_____

Age____ Sex____ Address_____

Significant findings: History, Physical examination

_____

Reason for referral_____

Services provided till date_____

Name of the person who referred_____

Designation_____

Name of the health center_____

_____

Feedback

Description of services provided_____

Advice given_____

Special instructions to the health center staff_____

Date of follow up_____

Name of the person who sent the note_____

Designation_____

Date_____

APPENDIX 8: GIVING DMPA INJECTION

PREPARATION

- Gather necessary equipment
- Check the expiry date of the injection vial
- Position the client properly

PREPARING INJECTION

- Shake thoroughly, but gently to avoid creating bubbles
- Remove the plastic or metal cover from the vial
- Open the sterile pack containing the syringe and needle
- Attach the needle to syringe by holding the base of the needle and barrel of the syringe
- Turn the vial upside down and draw the injection into the syringe. Use the same needle you would use for the injection.
- Hold the filled syringe vertically and tap gently to force any air bubbles to the top.
- Push the plunger to expel the air from the syringe

PREPARING INJECTION SITE

- Wash hands with soap and water
- Clean the injection site with methylated spirit (alcohol) wiping with a circular motion moving outward from the center of the injection site
- Allow the skin to dry before giving the injection

GIVING THE INJECTION

- Give deep intra-muscular injection in the arm (deltoid) or buttock. Ensure that the **injection is given deep** as otherwise the injection will not be absorbed rapidly and will not be effective immediately.
- Pull back the plunger before injecting the DMPA to check for appropriate placement of needle (to make sure not in blood vessel)
- If no blood seen, inject slowly and remove the needle

POST-INJECTION TASKS

- Apply pressure to the injection site with cotton, but do not rub
- Discard the assembled needle and syringe in a puncture proof container with out recapping or breaking/bending the needle
- Wash hand thoroughly with soap and water

APPENDIX 9: STEPS FOR INSERTION AND REMOVAL OF COPPER T 380A IUD

INSERTION OF IUD

> The IUD must be inserted only in a health facility.

Equipment and Supplies Required for Copper T Insertion

- Sim's/Cusco's speculum
- Anterior vaginal wall retractor
- Allis forceps/vulsellum (small toothed)
- Sponge holding forceps
- Uterine Sound
- Scissors
- Toothed forceps
- Gloves
- Sterilized cotton swabs
- Bowl for antiseptic solution
- Kidney tray for keeping used instruments
- Cheatles forceps
- Antiseptic solution (any recommended in Chapter 11). Ensure that the above are freshly prepared. If povidone iodine (Betadine) solution is available, it is preferable to use it.
- Proper light source/ torch
- Copper T in a pre-sterilized packet

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

Sterilization of Instruments and Gloves

- Copper T is available in a pre-sterilized pack.
- Instruments and gloves:
- Ensure that all the instruments and gloves for Copper T insertion are high-level disinfected (see Chapter 11).

Preparation

- Ensure that the equipment and supplies needed for Cu-T insertion have been prepared using high-level disinfection.
- Ensure that the client is prepared as follows:
    - Explain the various procedures to the client and continue to explain before each step.
    - Ask the client to empty her bladder and lie down on the table on her back with knees flexed.
    - Protect the client's privacy.
    - Wash and scrub hands. Wear sterile gloves taking care that the outer side of

gloves does not get contaminated.

Insertion of Copper T

Every client must be assessed for eligibility for use of Copper T through history and physical and pelvic examination as discussed in Chapter 8.

Pelvic Examination

Conduct the following examinations:

- Examination of external genitalia for evidence of STDs
- Speculum examination for evidence of vaginal and cervical infection
- Bimanual examination for determining the uterine position and for ruling out PID

If the client is eligible for use of Copper T, then proceed as follows:

Uterine Sounding

The procedure is essential to determine the length of the uterus for ensuring that the Copper T is placed against the fundus of the uterus. Sounding also helps to determine the direction of the uterine cavity and to find out any obstruction in the cervical canal.

- Wash gloved hand in antiseptic solution or change gloves.
- Explain the procedure to the client.
- Insert the sterile speculum as described earlier under speculum examination. (Use the anterior wall retractor with Sim's speculum).
- After inserting the speculum, clean the cervix with antiseptic solution (Povidone Iodine (Betadine preferred) starting with the cervical canal, wiping away mucus and applying antiseptic solution. Throw the gauze away and start wiping the cervical os with a fresh swab and prepare the whole cervix.
- Grasp the anterior lip of the cervix with a Vulsellum/Allis forceps (tell the client that she may feel slight discomfort). Apply gentle traction of the cervix with the Vulsellum/Allis forceps downward and outward to correct the position of the uterus and maintain the same traction continuously. This will help in introduction of the uterine sound and Copper T.
- Hold the sound between the finger and thumb. If the uterus is anteverted, the curve of the sound should be upwards. If the uterus is retroverted, the curve of the sound should be backwards.
- Introduce the uterine sound into the uterus gently till a slight resistance is felt which indicates that the tip of the uterine sound has reached the fundus of the uterus. **Care should be taken to introduce the sound according to the position of the uterus and direction of the uterine cavity** (as detected during the bimanual pelvic examination). While introducing the sound, care should be taken not to contaminate the sound by touching the vaginal wall or speculum.
    - **If there is difficulty in inserting the sound or it causes pain, do not push. Refer the client to a specialist.**
    - **If the client shows symptoms of fainting, stop the procedure.**
- Determine the length of the uterus by placing your finger against the sound at the level

of the cervical os.. It varies between 6 to 9 centimeters.

- Do not attempt to insert the Copper T into a uterus less than 6 centimeters in depth.
- Do not insert the Copper T if the uterus sounds 9 centimeters or more as the sound may have perforated or the uterus is enlarged due to tumor or pregnancy.
- In case of perforation, manage as recommended below.

The IUD should not be introduced into a uterus that is less than 6 centimeters and more than 9 centimeters in length. If there is difficulty in introducing the sound in the cervical canal or it causes pain, stop the procedure. Refer to a specialist.

No-Touch Technique of Loading the Copper T

Copper T is provided in a pre-sterilized package. To minimize the chances of contamination, do not remove the contents of the package before beginning the insertion procedure.

If any of the contents of the package become contaminated prior to insertion, discard the package and Copper T.

- Make sure that:
  - the vertical stem of the Copper T is fully inside the insertion tube and
  - the insertion tube's farthest end is close to the 'open' sign on the packet.
- Place the packet flat on a clean, flat surface with the transparent side up.
- Partially open the package where it is marked 'open' till half way to the blue flange on the inserter tube.
- Pick up the package with the open end up so that the contents do not fall out. Ensure that the opened flaps are folded out to avoid contamination of the Copper T.
- With the free hand, remove the plunger (white rod), taking care not to touch the plunger on any unsterile surface or object
- Insert the plunger into the insertion tube till it touches the bottom of the vertical stem of the Copper T.
- Release the flaps and put the packet flat on the clean surface with the transparent side up.
- Through the clear plastic cover, place the thumb and index finger over the ends of the horizontal arms of the T and hold the T in place.
- With the free hand, slide the identification card behind the T to the top sealed end of the packet.
- Continuing to hold the horizontal arms with the thumb and index finger, with the free hand, push the inserter tube against the horizontal arm which will bend the arm towards the stem of the Copper T.
- Continue bending the arm with the finger and thumb till the arms are by the side of the inserter tube.
- Pull the inserter tube down to below the tip of the arms.
- Elevate the package, push and rotate the inserter tube so that the arms are trapped inside the tube next to the stem. Take care that the tips of the transverse arms are not

more than 6 mm within the tube. **The arms of the Copper T should not be kept bent for more than five minutes as it may cause the arms to remain bent. It is important to load the Copper T only just before inserting in the uterus.**

- Adjust the movable blue flange on the inserter tube according to the length of the uterus (as measured by the uterine sound) so that the Copper T within the tube will just reach the upper end of the uterine cavity. Align the flange and the folded arms of the T in a horizontal position.
- Peel the plastic cover of the package and lift the loaded Copper T horizontally taking care not to drop the plunger and place it on a sterile surface. Be careful not to push the plunger towards the T.

Insertion of Copper T

- Wash gloved hand in antiseptic solution or change gloves if possible
- For inserting the Copper T, grasp the Allis forceps/Vulsellum (which is still in place on the cervix after sounding) and pull firmly downward and outward to bring the uterine cavity in line with the cervical canal.
- The loaded Copper T with the plunger is than gently introduced through the cervical canal upwards till the blue flange comes in contact with the cervix and resistance of the uterine fundus is felt. **Be sure that the flange is in the horizontal plane.**
- Hold the vulsellum and the plunger steady with one hand and with the other hand withdraw the tube downwards till it reaches the thumb grip of the plunger. This will release the arms of the Copper T in the uterine cavity at the fundus. **This is the withdrawal technique to minimize perforation.**
- Once the arms have been released, gently push the inserter tube until a slight resistance is felt. This will ensure that the arms of the Copper T are as high as possible in the uterus.
- Remove the plunger by holding the inserter tube firmly. The plunger should be removed before the inserter tube is pulled out, otherwise the threads may be caught between the tube and plunger resulting in downward displacement of Copper T or expulsion of Copper T from uterine cavity.
- Withdraw the inserter tube gently and slowly from the cervical canal. One should be able to see the strings protruding through the cervical os.
- Cut the strings so that they protrude only 2-3 centimeters into the vagina. Do not throw the cut ends of the string as it can be used to make the client feel the texture of the thread.
- Remove the Allis forceps/Vulsellum and see if there is excessive bleeding from the Allis forceps/Vulsellum site. This can be controlled by pressing on the bleeding point with a sterile cotton swab, using a clean sponge holding forceps. Remove the speculum. Put all the instruments for decontamination and sterilization.
- The client should be kept lying on the table for 5-10 minutes after insertion, since occasionally a vaso-vagal attack may occur on getting down from the table immediately after the insertion. Help the client to sit up slowly and get down from the table.
- Wash the gloved hands. Remove the gloves and put for decontamination and high-level disinfection as described in Appendix 10. Wash hands.
- Give post-insertion counseling as described in Chapter 8.

Care of Instruments and Gloves After the Insertion of Copper T

- Process the instruments and gloves as recommended in Chapter 11.
- Dispose of waste such as cotton into a covered waste container.

Perforation While Inserting
Perforation is suspected if:

- while sounding the uterus:
  - there is feeling of giving way
  - sound measures more than 9 centimeters
- there is a rapid pulse
- the woman has severe abdominal cramps

Perforation occurs most frequently during insertion.
While inserting the Copper T, perforation can occur if the steps for insertion are not followed closely or the selection of the client is not appropriate. The risk of perforation is high if the uterus is retroverted or if the size of the uterus is less than 6 centimeters.

- If perforation is suspected:
  - stop the procedure
  - check the pulse and blood pressure
- If the pulse is rapid, the blood pressure is low or the pain is severe around the uterus, hospitalize. Start IV fluids and refer the client to a specialist.
- If the pulse and blood pressure are normal, make the client lie down and check the pulse and blood pressure every 15 minutes for an hour.
- **If the client is stable**, make her sit up and walk around and observe for another hour. **If stable**, send home with instructions to avoid intercourse for a week. Counsel for another method of FP.

REMOVAL OF COPPER T

Always counsel the client as described in Chapter 3.

Equipments and Supplies

- All the equipments and supplies as used for insertion
- Artery forceps

Steps for Removal of Copper T

- Explain the procedure to the client.
- Ask the client to empty the bladder.
- Position the client as for Copper T insertion.
- Wear sterile gloves.
- Swab the vulva and vagina with fresh antiseptic solution.
- Put the sterile speculum into the vagina, locate the thread; grasp the thread close to the cervix with sponge holding forceps /artery forceps and pull it out by steady gentle traction.
- **If the removal requires more than a gentle traction, refer to a specialist.**
- Show the Copper T to the client and discard it.
- If the thread is not seen, refer the client to a specialist.
- Treat if any evidence of infection.
- Record removal of the Copper T.

APPENDIX 10: PROCESSING OF EQUIPMENT AND OTHER ITEMS

PROCESSING INSTRUMENTS AND OTHER ITEMS

Steps for Decontamination

- Health workers must wear utility gloves while decontaminating instruments or surfaces.
- Soak all instruments and other objects (fully) in 05% chlorine solution **immediately** after use.
- Do not delay as it will be difficult to remove the contaminants. Dried material traps microorganisms.
- Do not soak for more than 10 minutes as chlorine may damage the instruments.
- After 10 minutes, rinse with water and remove visible pieces of tissue or blood.

Preparation of Chlorine Solution

- Dissolve a tablespoon (5 g) of bleaching powder in one liter of water.
- Use a plastic bucket for preparation of chlorine to avoid corrosion.
- Prepare fresh chlorine solution every day.

Steps for Cleaning

- Wearing utility gloves, hold the items under soapy water (warm if available) and vigorously scrub to remove the tissue or blood.
- Rinse thoroughly with water to remove the traces of soap.
- Dry by air or with a clean towel (drying is important, otherwise the water from the instruments will dilute the disinfectant during high-level disinfection.

Steps for Boiling

- Decontaminate and clean the instruments and other objects as recommended above
- Use a clean vessel with a cover for the procedure.
- Put the decontaminated instruments fully immersed in water in the covered pan and bring the water to boil (rolling boil) (bubbling)
- **Boil the instruments for 20 minutes from the time the water started to bubble. In high altitudes (above 5500 feet), the boiling time has to be increased to 30 minutes.**
- After boiling, instruments should be removed from the container using a high-level disinfected Cheatle's forceps to prevent contamination
- Place them in a container with a cover that has been sterilized or high level disinfected and allow them to air dry. The container should be placed in a clean area.
- Store up to one week.

Important Points to Remember for Boiling:

- Change water daily before boiling
- Always boil for 20 minutes in a clean pot with a lid
- Start timing after the water begins to boil
- Items must be completely covered with water during boiling
- Do not add anything to the pot after boiling begins
- Air dry before use or storage

Steps for Chemical Disinfection

- Decontaminate, clean and air dry the instruments and other objects.
- Do the disinfection in a well-ventilated area as vapors of glutaraldehyde are toxic and irritating. **Always wear utility gloves**.
- Submerge the decontaminated and cleaned instruments and objects in 2% activated glutaraldehyde (Cidex) for 20 minutes in a high-level disinfected covered container. Do not remove or add any objects once the disinfection has started.
- Remove the items with high-level disinfected Cheatle's forceps and rinse with sterile water/ boiled cool water
- Air-dry on a high-level disinfected tray before storing.
- Store up to one week.

Steps for Steam Sterilization

- Decontaminate, clean and air-dry the instruments and other objects.
- Wrap items in gauze or paper.
- Arrange the items in the autoclave in such a way that there is good circulation of steam.
- Sterilize wrapped items for 20-30 minutes at 121° and 106 kPa pressure.
- When the time is complete, turn off heater and release the pressure valve. Wait until pressure gauge reads zero (takes 20-30 minutes).
- Wrapped items can be stored up to one week. Unwrapped items must be stored in a sterile covered container and can be stored for a week.

Steps for Chemical Sterilization

- Decontaminate, clean and air-dry the instruments and other objects.
- Completely immerse in 2% activated glutaraldehyde (Cidex) for 10 hours in a high-level disinfected covered container. Do not remove or add any other objects once the disinfection has started.
- Remove the items with high –level disinfected Cheatle's forceps and rinse with sterile water/boiled cool water.
- Air-dry on a high-level disinfected tray before storing.
- Store up to one week.

Steps for Storing Sterile Items

- Wait for the items to reach room temperature before storing them.
- Store the items in closed containers, properly labeled and away from contaminated area.
- Mark each of the containers with date of high-level disinfection/sterilization.
- Reprocess the items after a week.
- Take care:
  - not to drop the items as dropped items are considered unsterile
  - while handling the items taking care not to contaminate them
  - not to leave sterile containers on the floor.

Processing Needles and Syringes

Decontamination

All used needles and syringes must be decontaminated

- Do not detach the needle from the syringe
- Fill syringe with 0.5% chlorine solution by drawing up through the needle

- Expel disinfectant solution through needle
- Fully immerse the syringe and needle in the 0.5%Chlorine solution for 10 minutes

Cleaning

- Disassemble and clean with soapy water. (Be sure to clean hub area.) Insert stylet or needle wire through hub of needle to ensure that the needle is not blocked.
- Reassemble and rinse syringe and needle in water by filling and expelling water at least three times (fill and expel through needle).
- Detach needle from syringe and make sure hub area is clean.
- Examine needle and syringe for bent needle tips or other damage, syringe seal condition (rubber ring), needle hub fit to syringe, readable syringe markers, etc. Dispose of damaged needles and syringes in a special impervious container for sharp objects
- After cleaning as described above, sterilize or high-level disinfection by boiling.

When available and affordable, single-use (disposable) syringes and needles are recommended for all client care and surgical procedures.

PROCESSING GLOVES

Decontamination

- Fully immerse the gloves the 0.5%Chlorine solution for 10 minutes

Cleaning

- Clean the gloves with soapy water. Rinse clean till no particles of soap is left as soap can interfere with disinfection.
- After cleaning as described above, proceed with high-level disinfection of sterilization..

DISPOSAL OF SINGLE USE NEEDLES AND SYRINGES

- After use, dispose of used needles and syringes in special puncture proof containers for sharp objects to avoid accidental injury and possible infection of workers during refuse removal.
  - Puncture-resistant containers can be made of easily available objects such as a heavy cardboard box, a tin can with lid, or a heavy plastic bottle.
  - Place the container close to the area where it will be used so that workers do not have to carry sharp items any distance before disposal.
- Avoid accidental needle sticks; do not bend or break needles prior to disposal.
- **Needles should not be recapped** routinely, but if necessary, a **one-handed recap** method should be used:
  - First, place cap on a hard, flat surface, then remove hand
  - Next, with one hand, hold syringe and use needle to "scoop-up" cap
  - Finally, when cap covers needle completely, use other hand to secure cap on needle.
- When the "sharps" container is 3/4 full, tightly close the container.
- Dispose of container when 3/4 full by burying.
- Wash hands after handling sharps containers and decontaminate and wash gloves.