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Standards of Care for Health Centers

Volume III

Reproductive Health

Reproductive Health

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Introduction

Health for all is an achievable goal for the citizens of the Hashemite Kingdom of Jordan where primary care focuses on providing high quality preventive, promotive, and curative care in a cost-effective manner. The Jordanian Ministry of Health and USAID-funded Primary Health Care Initiatives Project (PHCI) have formed a partnership to reach this goal.

The Standards of Care for Health Centers described here represent a milestone in the road towards better health. They are tangible evidence of the considerable thought and effort that has been devoted to promoting quality of care by the Ministry of Health.

The purpose of the "Standards" is to ensure that health center staff members have the basic and essential guidance required for safe, effective, and humane service delivery. The Standards are contained in five volumes, each addressing a distinct aspect of health center services. A sixth volume of performance checklists is included with the Standards to facilitate self-assessment and performance review. As a set, the Standards are intended to serve as a convenient reference, a guide for service delivery, and a tool to support performance improvement. When following the guidelines set forth in the Standards, members of health center staff are assured that services meet the accepted standard of care required by their communities. The volumes and contents are described below.

Volume 1: Health Center Management

The Management Standards are organized in four sections. The first section contains job descriptions for staff providing direct and supportive care at health centers. The descriptions are meant to serve as a job aid for those who hold the positions and their supervisors rather than a model for staffing. The second section conveys the expected values and norms for health center services through a description of patient and provider rights and responsibilities. The third section contains the MOH guidance for managing health center accounting procedures and records. The fourth section contains instructions for procurement of drugs, contraceptives, vaccines, and supplies for laboratory and dental services.

Volume 2: Case Management

The five clinical problems addressed in the Case Management guidelines are: diabetes mellitus type II, hypertension, acute respiratory infection, asthma, and diarrhea. These conditions represent a significant percentage of the common medical problems encountered at health centers. Detailed guidance for diagnosis and management of each clinical problem is given, including recommendations for drug management, health education, referral, and follow-up care. Algorithms accompanying each clinical problem inform critical diagnostic or management decision-making. Together, these tools provide reference options for both quick and comprehensive review. Performance checklists complete the package for facilitating self-assessment and peer review.

Volume 3: Reproductive Health

This volume contains guidance for the reproductive health care services typically performed by doctors, nurses, and midwives at primary health centers. Antenatal care focuses on initial assessment and continuing support for pregnant women. The postnatal care section guides follow-up care for new mothers and their infants. Family planning includes guidance for counseling and information on the full range of contraceptive methods available in Jordan. A brief section on HIV/AIDS provides general information, basic education, and prevention messages for the community. All procedures described in the volume are accompanied by performance checklists, which reinforce and highlight the essential skills required for high quality reproductive health services.

Volume 4: Preventive Services

This volume addresses two different but complementary aspects of prevention, which are of great importance to the communities served by health centers. The first section covers prevention of childhood diseases through immunization; the second addresses the prevention of infection transmission within the health facility and among clients, staff, and the communities they serve. Immunization guidelines describe management of the cold chain and vaccines, immunization procedures and schedules, roles of staff, recordkeeping, and supervision. Infection prevention includes guidelines for maintaining protective barriers through handwashing, use of gloves and antiseptics, and procedures for decontamination, cleaning, sterilization, and waste disposal. Performance checklists are provided for all important procedures as a guide for self-assessment and performance review.

Volume 5: Nursing Care

Nursing procedures influence the care of most patients who visit the clinic by supplying the medical information that forms the basis for higher-level medical decisions about care and follow-up. This volume gives special attention to the procedures that are commonly called nursing care, but which are frequently performed by other members of the health center team. Guidance for home visits, child growth and development, immunizations, general care, and first aid is presented. As in the other volumes, performance checklists are included.

Volume 6: Performance Checklists

The performance checklists presented in each of the five volumes have been compiled in this final volume. These compiled checklists are a convenient tool and job aid for refreshing knowledge, guiding self-assessment, and standardizing performance assessment at the health centers.

List of Acronyms

AIDS: *Acquired Immunodeficiency Syndrome*

BCG: *Bacilli-Calmette-Guerin vaccine*

BMI: *Body Mass Index*

BP: *Blood Pressure*

BSE: *Breast Self-Examination*

C&S: *Culture & Sensitivity*

CBC: *Complete Blood Count*

CMM: *Cervical Mucus Method*

COCs: *Combined Oral Contraceptives*

DBP: *Diastolic Blood Pressure*

EC: *Emergency Contraception*

ECP: *Emergency Contraceptive Pills*

EDD: *Expected Date of Delivery*

EE: *Ethinyl Estradiol*

EFM; *Electronic Fetal Monitoring*

FAM: *Fertility Awareness Method*

FP: *Family Planning*

GATHER *"Greet-Ask/Assess-Tell-Help-Explain-Return"*

GDM: *Gestational Diabetes Mellitus*

GTT: *Glucose Tolerance Test*

HLD: *High-level Disinfection*

HIV: *Human Immunodeficiency Virus*

HVS: *High Vaginal Swab*

List of Acronyms continued

IUD: *Intrauterine Device*

IUGR: *Intrauterine Growth Retardation*

LAM: *Lactational Amenorrhea Method*

LMP: *Last Menstrual Period*

MOH: *Ministry of Health*

PCV: *Packed Cell Volume*

PHC: *Primary Health Care*

PID: *Pelvic Inflammatory Disease*

POPs: *Progestin-only Pills*

SBP: *Systolic Blood Pressure*

SFH: *Symphysis Fundal Height*

STI: *Sexually Transmitted Infection*

U/S: *Ultrasound*

UTI: *Urinary Tract Infection*

VSC: *Voluntary Surgical Contraception*

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Antenatal Care

Introduction

Pregnancy is a very important event from both social and medical points of view. Therefore, pregnant women should receive special care and attention from the community and from health care providers. Since effective communication builds trust and fosters confidence, providers should talk with women and their husbands in a manner that encourages communication about potential symptoms of complications or high-risk pregnancies. Keep in mind that pregnant women who develop complications may have difficulty explaining their problems.

Antenatal care includes the provision of counseling and health care, the identification of high-risk clients and appropriate fetal surveillance. The objective of antenatal care is to assure that every pregnancy culminates in the delivery of a healthy baby without impairing the health of the mother. It is essential for the provider who assumes responsibility for the antenatal care to be very familiar with the normal physiological changes as well as the pathological changes that may develop during pregnancy.

Rights of the Pregnant Woman

Health care providers should be aware of the client's rights when offering antenatal care services. The pregnant woman has the right to:

- Information about her health
- Discuss her concerns, thoughts, and worries
- Know in advance about any planned procedure to be performed
- Privacy
- Express her views about the services she receives

Antenatal care should address both the psychosocial and the medical needs of the client, within the context of the health care service delivery system and the culture in which she lives. Periodic antenatal care check-ups provide the opportunity to increase a woman's confidence in her provider and receive counseling related to her pregnancy. In addition, antenatal care makes it feasible to identify and manage maternal complications or risk factors.

Objectives

The major objectives of antenatal care are to:

1. Promote, protect, and maintain health status of the mother and fetus.

2. Determine the gestational age of the fetus and monitor fetal growth and development.

3. Identify the client at risk for complication and minimize that risk wherever possible.

4. Anticipate and prevent problems before they occur to the pregnant woman or fetus and decrease occurrence of problems when possible.

5. Educate clients concerning ways to remain healthy during pregnancy, prepare for labor and delivery, including birth plan, and how to care for a newborn infant.

Schedule of Antenatal Care Visits

The early initiation of antenatal care is important for screen and preventing maternal complications. Early antenatal care also allows for the development of interpersonal relationships between health care providers and clients so that each pregnant woman's particular needs and wants are known and expressed in a plan for delivery.

Normally, the schedule of antenatal visits should be as follows:

Up to 28 weeks	—	Once every 4 weeks
28-36 weeks	—	Every 2 weeks
After 36 weeks	—	Weekly

Note: *The WHO Technical Working Group[1] (1994) recommended a minimum of four antenatal visits for a woman with a normal pregnancy to set a basic, essential standard for quality. In Jordan, the practice is for five antenatal visits, scheduled at specific times during the pregnancy to provide*

essential antenatal services. Additional visits may be necessary depending on the woman's condition and needs.

For antenatal care to be effective, it should be:

EARLY: beginning as early as possible in the first trimester

PERIODIC: according to the follow-up visit schedule and with a frequency that depends on client needs and level of risk

ACCESSIBLE: to reach the target population

Table 1. Timing and Content for the Minimum Number of Antenatal Care Visits

Timing		**Content**
First Visit	Before end of 3rd month (12 weeks)	· Screen & treat anaemia · Screen & treat an reproductive tract infections · Screen for risk factors & medical conditions · Initiate prophylaxis where required (*e.g.*, iron supplementation for anaemia)
Second Visit	6th or 7th month (24-28 weeks)	· Assist mother to develop a birth plan · Begin discussion about family planning options · Review risk factors
Third Visit	8th month (32 weeks)	· Screen for pre-eclampsia, multiple gestation, anaemia · Further develop the individualized birth plan and prepare for labor and delivery · Counsel about family planning options

Fourth Visit	In 9th month (36 weeks)	· Continue screening for risk factors: pre-eclampsia, multiple gestation, anaemia · Identify fetal lie/presentation · Continue review to prepare for labor and delivery · Refer to where client has decided to give birth · Counsel about importance of postpartum care and family planning
Fifth Visit	38 weeks	· Review signs of labor and when to go to hospital · Review process of labor & delivery · Counsel about importance of post-partum care

Initial Evaluation

History

An obstetric history should be taken by a trained midwife or trained physician. The data requested should be accurate, complete and include the following.

- Client profile (registration): name, age, address, highest level of education achieved, occupation, duration of marriage, consanguinity, special habits like smoking, and emergency contact.
- Husband's profile: highest level of education achieved, occupation.
- Risk factors: age of mother, number of children, and space between children.
- LMP and Estimated Date of Delivery (EDD). If the pregnant woman does not know when her last menstrual period was, recommend using ultrasound to determine the EDD.

Note: *EDD (Expected date of delivery) is calculated by Naegele's Rule: add seven days, subtract three months from the first day of the LMP, or use the Birth Wheel.*

- Menstrual regularity, lactation, use of contraception in the past, gravidity, parity, abortions, pre-term deliveries, still births
- Mode, place, and date of previous deliveries.
- Client's desire for pregnancy; social history and support; history of medical problems; any other complaints or problems.
- Outcomes and complications of previous pregnancies (*e.g.*, full term normal healthy baby, stillborn, cesarean section, bleeding/spotting during pregnancy), postpartum hemorrhage; multiple gestation; eclampsia, sepsis, or other complications; operative delivery; neonatal death; small infant (premature or intra-uterine growth retarded);
- Current pregnancy: symptoms of pregnancy; time of initial quickening during current pregnancy (Normal: 16-18 weeks for multiparas; 18-20 weeks for primiparas);
- Any symptoms or complaints during current pregnancy.
- Medications taken during pregnancy.
- Smoking or non-smoking (cigarettes or other forms).
- Fetal movement.
- Perform risk assessment at initial visit, and reassessed throughout pregnancy. Use Coopland Risk Assessment table (see "*Attachment 1: Antenatal Risk Assessment Form*").
- Family history: Diabetes mellitus, hypertension, multiple pregnancy, congenital abnormality, thalassaemia.
- Surgical history: previous operations, abortion, caesarian sections.

Physical Examination

Perform the physical examination according to the following guidelines:

- In a private area to ensure and protect the client's privacy, dignity, and health.
- In a comfortable manner.
- In a systematic way, informing the client of results.

Confirm diagnosis of pregnancy:

- By missed menstruation in otherwise normal cycles.
- Typical changes in breasts and evidence of pregnancy on pelvic exam.
- Pregnancy test: Urine ß-HCG most accurate on first morning specimen, and within 7-10 days after missed menstrual period.

Height and Weight

Height measurement can indicate the need for risk assessment. A woman with a height of 145 cm or shorter should be referred.

- Weight should be measured at each visit by a trained staff member.
- Measure height and weight at first visit in order to determine the body mass index (BMI) using the BMI calculator/wheel. Continue to determine and document BMI at successive visits. The Normal range for BMI is 18.5-24.9

$$\text{BMI} = \frac{\text{Weight (kg)}}{\text{Height (m)}}$$

- Use an adult scale to weigh the client:
  - *Adjust balance at zero on a flat level.*
  - *Weigh client in light clothing without shoes.*
  - *Record weight in kilograms (kg).*
- Document any sudden weight gain and underline in red.
- Total weight gain during the entire pregnancy should be determined according to the client's B MI at the initial visit.
- Average total weight gain during pregnancy is 9-12 kg.

Note	*There has not been any documented evidence that weight gain is a significant risk factor.*

Blood Pressure

- Should be taken for *every client at each visit.*
- Allow client five minutes to rest.
- Check sphygmomanometer and stethoscope for proper operation.
- Measure blood pressure using the following protocol:
    - *Patient is in sitting or supine position and BP is measured at the level of client's heart.*
    - *Cuff of suitable size; stethoscope placed 2.5 cm above the antecubital fossa of arm.*
    - *Note appearance of first sound (korotoff) as systolic blood pressure (SBP).*
    - *Note disappearance of sound as diastolic blood pressure (DBP).*
    - *Record results and underline in red if deviated from normal. Range of normal: 80/60-140/90. If BP is higher than 140/90 and does not come down after rest, refer for medical management.*

HEENT (Head, Eyes, Ears, Nose and Throat)

- Inspect (look at): face for puffiness; conjunctiva for paleness and lips for cyanosis, tongue for color; mouth for cavities.
- Palpate (feel) thyroid for enlargement.

Breast

- Inspect the breasts for symmetry, condition of nipples (flat, inverted).

Chest

- Auscultate (listen to) heart and lung sounds.

Extremities

- Inspect fingernails for color, hand for swelling (ability to remove rings), feet and legs for swelling (an impression or dent when pressed by your fingers).

- Check reflexes, tap knee with reflex hammer. If woman's leg jerks VERY briskly and quickly, refer in the presence of high blood pressure.

Back

- Tap the back over the kidney for signs of tenderness. If pain, check for other signs of urinary tract infection.

Abdominal Examination

- Inspect: shape and symmetry of the abdomen; signs/scars of previous operations; and for fetal movement.

Obstetrical Examination

- Palpation: assess growth by fundal height measurement starting at 16 weeks. Measure symphysis fundal height (SFH) in centimeters; determine approximate gestational age in weeks when the bladder is empty starting from upper edge of pubic bone up to the upper limit of the fundus; any discrepancy between date and SFH should be marked in red (see "Attachment 2: Fundal Height Measurement").
- Starting at 16-20 weeks, use a fetoscope to measure fetal heart sound (auscultating) listening for rate and regularity. Doppler can pick-up fetal heart tones easier and earlier but first detection with a fetoscope helps in dating pregnancy; fetal heart can first be heard with a fetoscope between 18 and 20 weeks. Abnormality in fetal heart rate should be underlined in red and referred. Expected fetal heart rate is 120-160 beats per minute
- Use the technique described in "*Attachment 3: Lie & Presentation*" for abdominal palpation in each visit after 28 weeks.
- Manage and document any abnormality.

Pelvic Examination when specific vaginal or pelvic complaints exist

Note	*Pelvic examination is not routinely required at the initial evaluation. See "Attachment 4: Pelvic Examination" for steps of the pelvic examination:*

Step 1: External genital inspection

Step 2: Internal speculum inspection

Step 3: External genital palpation

Step 4: Internal bimanual palpation

Step 5: Rectovaginal palpation

Ultrasound (U/S)

If not routinely available, women at risk should be referred.

- Ultrasound scan for determination of fetal size or abnormalities when indicated. Note that ultrasound scanning is not routinely recommended for normal, uncomplicated pregnancies without any of the following indications (see also Attachment 5):
  - *Assessment of bleeding or pain in early pregnancy.*
  - *Differential diagnosis of troublesome vomiting.*
  - *Estimation of gestational age if otherwise uncertain.*
  - *In mothers who have large or small newborns (for gestational age) in past pregnancies.*
  - *Monitor fetal growth in high-risk pregnancies.*
  - *Assessing placental site, or identifying the source of antenatal bleeding or hemorrhage.*
  - *Examination of the fetus when the risk of congenital anomaly is high.*
  - *Determination of fetal presentation if unclear from the abdominal examination.*

Electronic Fetal Monitoring

- Electronic Fetal Monitoring (EFM) should be done when indicated (*e.g.*, postdate).

Note: *In the case of postdates or reduced fetal movement, refer the client to the hospital for management including EFM.*

Laboratory Tests

- Urine for albumin, glucose, and acetone at each visit
- Urine analysis: first visit, second and third trimesters
- Blood group and RH factor at first visit (see Attachment 6 for Rh incompatibility and indications for Rh type testing)
- Hb and PCV at first visit, second trimester, and in last month:
  Hb value of <10.5 mg underlined in red and refer for treatment
  PCV: value of <32% underlined in red. Alternatively, a CBC can be ordered to more fully assess anemia
- VDRL (if indicated by history); if positive, Dark Field Examination is recommended
- Rubella antibody titre (recommended)
- Hepatitis B screening (recommended)
- Vaginal smear if necessary for abnormal discharge
- Blood sugar*: 18 weeks
- Gestational Diabetes Mellitus (GDM) screening: if no risk factors screen at 28 weeks gestation; if any symptoms described in "*Attachment 7: GDM Screening*" are present, then screen in first trimester or at first visit, at 28 weeks, and 34-36 weeks.

* Random blood sugar for all clients at initial visit and not later than 18 weeks; screen for gestational diabetes for a woman with a high risk for GDM by determining if blood sugar level is over (135mg-140mg). A three-hour GTT should be performed and referred according to standards.

Health Education Topics

Client Health Education Messages

General Guidelines

- Divide information over the course of antenatal visits giving information when it would be most relevant.
- Information needs to be repeated or assessed throughout the course of the pregnancy.
- Build on information previously given.
- Avoid giving too much information at one time.
- If you may see the woman only once, choose the most important information to give her.

Specific Client Health Education Messages

1. Birth planning 2. Common complaints and symptoms of pregnancy 3. Nutritional advice 4. Immunizations during pregnancy 5. Bathing and personal hygiene 6. Clothing 7. Relaxation and sleep 8. Danger signs during pregnancy 9. Travel 10. Drug education and classification of drugs 11. Work during pregnancy 12. Sexual relationships	13. Care of teeth and gums 14. Breast care 15. Breastfeeding (lactation) counseling 16. Bowel habits 17. Birth spacing counseling 18. Exercise 19. Fetal movement 20. Health hazards to pregnant women and infants: smoking and alcohol 21. Childbirth education 22. Warning signs of preterm labor 23. Physiology of labor 24. Postnatal care 25. Psychosocial problems

1. Birth Planning

Counsel the client and her family to think ahead and make plans for when the client will need to come to the facility to give birth. Waiting until the last minute will only add additional stress to a very exciting period. Guide clients in discussion to consider the following and take appropriate actions:

- How far from where you live is the facility where you will give birth?
- How will you get there? Who will go with you?
- If you have to leave home during the night, who will care for the children?

If you have to use public transportation:

- How much will it cost (transportation costs)? How can you save the amount?
- Will the transportation be available at night? How will you get in contact with transportation?

Help the client make realistic plans and link her to resources in her area.

2. Common Complaints & Symptoms of Pregnancy

Many discomforts are expected in pregnancy, which are related to cardiovascular changes, hormonal effects, uterine growth, and the change in body posture.

After investigation to rule out a serious pathologic condition, treatment may be directed to symptomatic relief.

Table 2. Common Complaints of Pregnancy.

Complaint	What to Tell the Client	Provider Management
Constipation	· Increase your water intake (8 glasses); eat high-fiber foods, and take daily exercise. · Use mild laxatives as a last resort.	· Counsel the client on diet. · Prescribe psyllium hydrophilic mucilloid (Metamucil), Lactulose (Duphalac) · Suggest mild laxatives only if the other measures have failed.

Headache	· Take mild pain relievers; *e.g.*, paracetamol. Avoid aspirin. · Inform provider if pain becomes severe.	· Determine that the headache is not a ***Danger Sign*** (see below). · Offer paracetamol (Panadol, Revanin) 300 mg every 3-4 hours. · For severe headache or migraine, offer codeine or other related narcotic might be used. ***Remember***: headache can be associated with hypertension.
Complaint	**What to Tell the Client**	**Provider Management**
Backache	· Avoid excessive bending, lifting, or walking without a rest period. · Rock pelvic periodically during the day for relief. · Wear supportive, low-heeled shoes. · If severe, wear a maternity girdle for additional support. · Heat or ice to back for relief, whichever is more comforting.	· Counsel regarding comfort measures. ***Remember***: the symptoms of UTI and onset of labor include backache.
Nausea and vomiting	· Eat small, meals frequently. Keep crackers at bedside and eat before getting out of bed. Eat fruit or drink fruit juice before going to sleep. · Avoid oily, spicy foods. · Get out of bed slowly. · Symptoms should not extend beyond the first three months; if severe and persistent, see your health care provider.	· Counsel about comfort measures. · Provide Vitamin B6, 50 mg, twice daily. · If symptoms are severe, refer for possible hospitalization and intravenous fluids. Medications for management may include: - Meclozine, promethazine (Phenergan) - Diphenhydramine (Benadryl) - Other antihistamines · Birth defects have not been associated with the use of these drugs.
Varicosities	· Elevate legs periodically during the day. · Wear support hose (elevate legs before putting on hose for maximum support).	· Prescribe support hose, as necessary. · Refer if varicosities are severe and painful.
Complaint	**What to Tell the Client**	**Provider Management**

Vaginal discharge	· Cleanse genitalia daily. Wear cotton underwear. · Use light sanitary pads if discharge is heavy. · Avoid vaginal douching. · If discharge develops with itching, irritation or foul odor, see the provider as soon as possible for treatment.	· If not infection, counsel for genital hygiene. · With symptoms of infection, treat according to guidelines or refer for treatment.
Leg cramps	· During cramping, straighten leg slowly with the heel pointing and the toes upward or push the heel of the foot against the footboard of the bed or floor, if standing. · Exercise daily to enhance circulation. · Elevate legs periodically throughout the day. · Take calcium tablets daily. Eat calcium rich foods such as dairy and dark green leafy vegetables.	· Prescribe Calcium carbonate or calcium lactate tablets

3. Nutritional Advice

Eat foods from each of the six major food groups:

1) *Fat (sparingly)*
2) *Milk, yogurt, cheese*
3) *Vegetables*
4) *Meat*
5) *Fruit*
6) *Bread, cereals, and other carbohydrates*

Drink plenty of liquids (especially water—8 to 10 large glasses, or 2 liters), increase fiber, and increase calcium and iron intake. For women whose BMI is normal before pregnancy, maintain a normal weight gain according to BMI. This is usually achieved by a well-balanced diet containing 60-80 gm protein, 2400 or more calories, low sugar and fats, high fiber, milk and other dairy products; higher weight gain may be required. Excessive weight gain or high pre-existing maternal weight is associated with increased risk factor for the infant in terms of birth trauma and delivery by Caesarean section.

Table 3. BMI Assessment and Recommended Weight Gain.

BMI	Assessment of Weight	Recommend Weight Gain
Less than 18.5	Underweight	12.5-18 Kg
18.5-24.0	Normal weight	11.5-16 Kg
24.0 and above	Overweight	7.0 - 11.5 Kg

Prescribing prenatal vitamins in most cases may not be necessary where diets supply adequate calories, protein, and minerals for appropriate weight gain. However, there are two exceptions:

Folic Acid Supplementation pre-conceptually and throughout the early part of pregnancy has shown to decrease the incidence of fetal neural tube defects. Thirty to sixty (30-60) mg/d calcium up to 1.5 mg/d in later months of pregnancy and during lactation.

Iron Supplementation after 12 weeks is recommended. Also, increased iron requirements in the latter part of pregnancy are difficult to meet in the routine diet. To enhance the absorption of iron, instruct mothers to take iron when eating meat or vitamin-rich foods (fruits and vegetables). Avoid tea, coffee, and milk at the same time when taking iron; it interferes with the body's absorption of iron. Iron can also be taken between meals with orange juice.

4. Immunizations during pregnancy for previously non-immunized women: adjust for immunized women.

Tetanus toxoid should be administered during pregnancy, especially if exposure to pathogens is likely.

Table 4. Tetanus Toxoid Immunization Schedule.

Dose	Schedule
TT1	At first contact, or as early as possible during pregnancy
TT2	Four weeks after TT1
TT3	Six to 12 months after TT2, or during subsequent pregnancy
TT4	One to three years after TT3, or during subsequent pregnancy
TT5	One to five years after TT4, or during subsequent pregnancy

- *Live virus vaccine* should be avoided during pregnancy because of possible damaging effects on the fetus.
- *Hepatitis B vaccine* series may be given in pregnancy to women at risk of exposure.
- *Immune globulin* is recommended for pregnant women exposed to measles, Hepatitis A, Hepatitis B, tetanus, chickenpox, or rabies.

5. Bathing and Personal Hygiene

- There is no objection to bathing during pregnancy; it is encouraged.
- Advise taking extra precautions not to slip or fall when bathing or showering near the end of the pregnancy.
- Tub baths at the end of pregnancy may be not advisable, as the heavy uterus usually upsets the balance of the pregnant woman and increases the likelihood of tripping and falling in the bathtub. Advise using a shower or pouring water over the body.
- Advise washing breasts daily with a soft cloth and wearing a supportive bra. Avoid massaging nipples during washing.
- Advise cleansing external genital daily, wiping from front to back, especially if vaginal discharge is present. Change underwear frequently, and if possible, use cotton underwear.

6. Clothing

- The clothing worn during pregnancy should be practical and non-constricting.
- Well fitting supporting brassieres indicated.
- Contracting garters should be avoided.
- Low-heeled shoes are recommended.

7. Relaxation and Sleep

Instruct the pregnant woman to continue all ordinary activities with one or two hours bed rest during the day. Adequate sleep may be difficult to achieve as sleeping patterns change. Therefore, it becomes more important to ensure rest breaks during the day.

8. Danger Signs During Pregnancy

Teach the pregnant woman and her family to report any of the following conditions immediately:

- Vaginal bleeding
- Sudden gush of fluid or leaking of fluid from vagina
- Severe headache not relieved by Paracetamol
- Dizziness and blurring of vision
- Sustained vomiting
- Swelling (hands, face, etc.)
- Loss of fetal movements
- Convulsions
- Premature onset of contractions (before 37 weeks)
- Severe or unusual abdominal pain
- Chills or fever

9. Travel

- Travel is not harmful for a healthy pregnant woman. Avoid long periods of sitting, and take a walk every two hours to promote circulation.
- Travel in pressurized aircraft presents no unusual risks.

10. Drug Education and Drug Classification

The following are guidelines for the clinician who prescribes medication during pregnancy or lactation:

- Try to avoid any medication during the first trimester.
- Use single, non-combination, short-acting agents.
- Choose topical (if available) over-the-counter medications.
- Use the lowest effective dosage of the safest known medication.
- Instruct breastfeeding mothers to use a single dose or short acting medication so they can feed again, past the peak blood level to minimize the risk to infants.

- Encourage breastfeeding mothers to watch and see whether the infant seems to have any problems related to any medication the mother may be taking.

Table 5. Drug Classification Scale (to be used with Attachment 8):

Category	Description
A	No fetal risks (multivitamins). Proven Safe during pregnancy.
B	Fetal risks not demonstrated in animals but there are no human studies.
C	No adequate studies, fetal risks unknown.
D	Some evidence of fetal risks.

11. Work During Pregnancy

Most women can safely work until term without complications. A flexible approach must be taken. Pregnant women who work should take breaks every two hours and walk around frequently to support circulation.

Pregnant women my have less tolerance to heat, humidity, environmental pollutants, prolonged standing, and heavy lifting.

Pregnant women who should probably *not* work include:

- Those with history of two premature deliveries.
- Incompetent cervix and fetal loss, secondary to uterine abnormalities.
- Cardiac disease greater than Class II (tires after minimal activity).
- Hemoglobinopathies.
- Diabetes; greater risk with retinopathy or renal involvement.
- Third trimester bleeding.
- Premature rupture of the membranes
- Multiple gestations after 28 weeks.

12. Sexual Relationships

There are no restrictions of sexual relations for pregnant women without complications. Whatever is comfortable and pleasurable may continue unless or until a pregnancy complication occurs (*e.g.*, vaginal bleeding, preterm labor, known placenta previa). Support the woman to avoid sexual contact if she or her partner has symptoms of STI; ask her to see the provider immediately. Encourage couples to use condoms where the risk of STI exists. Instruct the mother to avoid sexual intercourse if the waters break or labor begins.

13. Care of Teeth and Gums

- Encourage the importance of daily care and brushing of the teeth after meals.
- Encourage the daily drinking of milk and eating dark, leafy vegetables to prevent loss of calcium and loss of teeth.
- Pregnancy does not prevent dental care; it is required during pregnancy to prevent serious infections.
- Encourage dental visits when needed.

14. Breast Care

- Avoid nipple stimulation (touching, rubbing) and massage since these can provoke contractions.

15. Breastfeeding (lactation) Counseling

Counsel the client on infant feeding during the third trimester, using client materials and videos covering the advantages and behaviors of successful breastfeeding and care of the breasts. Review breastfeeding preparation messages at the 36th week of gestation. Breastfeeding is vital for child survival, maternal health, and birth spacing. Introduce or reinforce LAM criteria and optimal breastfeeding practices.

LAM Criteria

A woman can use LAM if she answers "No" to ALL of these questions:

- Is your baby 6 months old or older?
- Has your menstrual period returned? (Bleeding in the first 8 weeks postnatally does not count.)
- Is your baby taking other foods or drink or allowing long periods of time (4 or more hours) without breastfeeding, either day or night?

If the woman answers "Yes" to **any one** of these questions, she **cannot** rely on LAM for prevention of pregnancy, but she can continue to breastfeed her baby while using a method of contraception that will not interfere with lactation.

16. Bowel Habits

During pregnancy, bowel changes may occur due to sluggishness of the intestinal tract caused by the effect of progesterone and pressure from the growing uterus. The following changes may be observed:

- Constipation (common), due to generalized relaxation of smooth muscle and compression of lower bowel by the uterus. It is characterized by discomfort caused by passage of hard fecal material.
- Bleeding and painful small tears may develop in the swollen and vascular rectal mucous.
- Development of hemorrhoids.

Tell the client that, to avoid these problems, she should:

- Increase water intake (eight glasses per day); drink prune juice; take warm water or hot fluids upon waking.
- Pay close attention to bowel habits; go to the toilet when you feel the urge. Take sufficient quantities of fluid, vegetables, and fruits with their skins, to increase dietary fiber.
- Engage in reasonable amount of daily exercise (*e.g.*, brisk walking).
- Take stool softener prescribed by provider with plenty of water.

17. Birth Spacing Counseling

Introduce client to family planning and its purposes during the second trimester, using health education talks, pamphlets and posters, and videos. During the third trimester, counsel the client regarding all available methods. This will be particularly important for women wanting immediate postnatal IUD insertion or immediate postnatal voluntary surgical contraception. Counseling should continue after delivery until the mother is discharged and provide her chosen method, if appropriate.

Emphasize to the client that the recommended interval for spacing of children is a minimum interval of at least two years.

- Birth spacing is vital for maternal health and child survival. Benefits of birth spacing are:
    - *Gives the mother time to renew nutrient stores.*
    - *Reduces the risk of death and illness of the mother and infant.*
    - *Promotes the health of the entire family by ensuring a healthy mother.*
    - *Saves lives.*

18. Exercise

Continue to be active but avoid fatigue. The trained athlete can continue rigorous training during pregnancy but should avoid raising her core temperature or becoming dehydrated. Exercise should be varied during the third trimester to avoid too much stress on knee and ankle joints. Walking can be accepted to the needs of most women. Exercise should include women's posture, muscular relaxation, and breathing exercise.

19. Fetal Movements

Fetal activity is usually of cyclic frequency or pattern and may vary throughout pregnancy. Lack of fetal movement or marked decrease in frequency may be warning signal of fetal distress; inform provider immediately.

20. Health Hazards to Pregnant Women and Infants: Smoking and Alcohol

Smoking should be discontinued during pregnancy. It is important to counsel patients about this and record their compliance. The potentially harmful effects of cigarette smoking during pregnancy include low birth weight, premature labor, miscarriage, stillbirth, (cot) death, birth defects, and increased respiratory problems in neonates. More than 10 cigarettes a day can have a pronounced effect on birth weight. Many

women do not realize the severity of the risk. Patient education is important, with counseling or referral to appropriate community groups.

Alcohol use should be discontinued in pregnancy. Chronic alcoholism has been shown to cause fetal mal-development that is commonly referred to as fetal alcohol syndrome. The more alcohol the mother drinks, the more the fetus is at risk of damage. Encourage mother to avoid social drinking.

Avoid	*Exposure to X-rays and contact with persons with infectious diseases (e.g., German measles, chicken pox).*

21. Childbirth Education

During the second half of pregnancy, provide information about preparation for labor and birth, the proper place and who will attend the delivery, preparation of baby's and mother's clothes, care of newborn, breastfeeding, care of other family member, in order to:

- Help the mother and family take a decision about the appropriate place of delivery.
- Promote hospital delivery and delivery by trained health professional (doctor and midwife).
- Promote breastfeeding.
- Explain these processes to the mother and her family:
  - *Process of labor.*
  - *Process of birth.*
  - *Labor relaxation techniques.*
  - *Comfort and support measures by those staying with the woman.*

- *Postnatal care/infant care. See "Client Health Education Messages" (see #18 below) below for additional details concerning physiology.*

See also "*Attachment 9: Preparing the Pregnant Woman for Labor & Delivery*."

22. Warning Signs of Preterm Labor

Infant outcomes are improved when preterm labor is diagnosed and treatment is started early. Teach the mother signs of preterm labor. These signs include:

- A feeling that the baby is "balling up" which lasts more than 30 seconds and occurs more than four times per hour.
- Contractions or intermittent pains or sensations between nipples and knees, lasting more than 30 seconds, and recurring four or more times per hour.
- Menstrual-like sensations, occurring intermittently.
- Change in vaginal discharge, including bleeding.
- Indigestion or diarrhea.

23. Physiology of Labor

During the second half of pregnancy, teach the woman, her partner, and her family, through discussions with health care staff, lectures, pamphlets, and videos, about the normal physiology of labor, stages, preparation, anatomy of birth canal, signs of labor progression, breathing, and nature of pain in order to:

- Reduce the need for analgesia and anesthesia during labor.
- Ensure cooperation of client with the attending staff during delivery.
- Minimize fetal distress.
- Reduction of some maternal complications (*e.g.*, exhaustion) during delivery.
- Minimize instrumental and operative interference.
- Ensure smooth and shorter progression of labor.

See also "*Attachment 9: Preparing the Pregnant Woman for Labor & Delivery*."

24. Postnatal Care

Instruct pregnant women when to return after delivery for postpartum visits. The first visit should be within the first week after delivery, and the second visit should be two to six weeks after delivery or sooner, if necessary. Explain to the woman that if the following occur anytime during the postnatal period, she should return to the health center or hospital immediately:

- Heavy bleeding.
- Fever or chills.
- Abdominal pain or foul-smelling lochia (vaginal discharge).
- Pain and/or tenderness, heat in the calf of the leg(s).
- Feeling depressed or not happy.

Explain the importance of postpartum care:

- Monitors the mother's full recovery from the effect of pregnancy and delivery.
- Helps detect complications early for their effective management.
- Facilitates family planning counseling and provision of method(s).

25. Psychosocial Problems

The pregnant woman may have worries and fears about labor, or may doubt her ability to care for the baby or for her other children. Health providers need to be sympathetic, reduce anxiety, and provide problem solving with counseling and/or education for the woman.

Follow-up Visits

It is the responsibility of the provider to share the schedule of visits with the client. The standard schedule of visits is as follows:

Up to 28 weeks	—	every month
28-36 weeks	—	very two weeks
After 36 weeks	—	every week

- Frequency of visits: In normal pregnancy, minimum of 5 visits
- High-risk patients should be seen more frequently; every 2 weeks till 28 weeks then weekly till delivery with the physician.
- During each visit:

History

Talk with the client about the following:

- Family and community support
- Any complaints or problems
- Follow-up on advice, health education messages, care, or referral provided at previous visits.

Physical Examination

Include the following during follow-up visits:

- General appearance: weight, blood pressure, clinical signs of anemia
- Fundal height in second and third trimester
- Fetal well-being, using fetal movements or fetal heart sounds in the second and third trimester - (not less than 10 movements in 12 hours)
- Signs of physical abuse.
- Lie and presentation in the third trimester
- Physical examination for assessment of complaints.
- Inquire if any problems since last visit (vaginal discharge, bleeding, edema, etc.)

Laboratory Investigations

- Urine for sugar, protein and acetone.

Referral: Sending a Client for Additional Services

A referral form should be completed in full and signed.

Referral Criteria

- High-risk women: use "*Antenatal Risk Assessment Form*" (*Attachment 1*) to determine risk. Refer to a specialist if score is 3 or more (high or severe risk).
- For U/S *if indicated.*
- Last trimester before delivery: in a normal pregnancy, the pregnant woman should be advised to see the specialist (obstetrician/gynecologist) at the 38th week.
- Special conditions as required by the physician
- Complete client management: document the course and recommended follow-up. Inform the provider who made the referral.

Completion of Client Records

For the Provider Accepting a Referral

A trained midwife or provider should complete and sign client records.

- Keep client records complete with all relevant information.
- Document findings and management at each visit.

Attachment 1

Antenatal Risk Assessment Form (Coopland)

Client Name:_____ File Number:_____

Age:_____

Gravida:_____ Para:_____

Abortions:_____

LMP: _____ EDD:_____ EDD by Ultrasound

_____

A. Reproductive History	**Risk Score**	**B. Medical or Surgical History**	**Risk Score**	**C. Present Pregnancy**	**Risk Score**
Age	1	Previous gynecologic	1	Bleeding	

<16 or >35 years		surgery		> 20 weeks < 20 weeks	1 3
1st visit > 20 weeks	1	Chronic renal disease	1	Anemia < 11%	1
Parity 0 >5	 1 2	Diabetes Class B or Greater	3	Postmaturity	1
Abortion > 2	1	Gestational diabetes (Class A)	1	Premature rupture of membrane (ROM) or Polyhydramnious	2
History of infertility	1	Epilepsy	1	IUGR	3
Antepartum or postpartum bleeding	1	Psychiatric problem	1	Multiple pregnancy	3
Infant > 4 Kg	1	Other significant medical disorders (*e.g.* cardiac disease). Score 1-3 according to severity.		Abnormal fetal position (breech or malpresentation)	3
Infant < 2 Kg	1			Rh isoimmunization	3
Toxemia or hypertension	2			Preeclampsia or hypertension	2
Previous C/S	2				
Abnormal or difficult labor	2				
Column Total					

Total Score* = Total of three columns (A + B + C)

Low Risk: 0 – 2 High Risk: 3 – 6 Severe Risk: 7 or more

*If pregnancy is assessed as a **high or severe risk** status, refer the pregnant woman to an OB specialist.*

Attachment 2
Fundal Height Measurement[2]

Measuring the Baby's Growth

The uterus moves up in the mother's abdomen as the baby grows. The uterus grows about two fingerbreadths in a month. At 12 weeks, the top of the uterus is usually just above the pubic bone. When the baby is about 20 weeks old, the top of the uterus is usually at the

mother’s umbilicus. Use a centimeter tape to measure the distance from the top of the pubic symphysis over the curve of the abdomen to the top of the uterine fundus. Fundal height in centimeters correlates well with weeks of gestation until the 34th week of pregnancy.

The figure illustrates fundal height at different stages of pregnancy:

Attachment 3
Lie & Presentation

Feel for the baby’s head and body. By 30-32 weeks, the baby is usually lying with the head down towards the mother’s pelvis. (Vertex presentation). Most babies lie more on one side of the mother than the other.

Look and feel for movement of the baby as shown in the diagrams below:

Step 1: Feel what part of the baby is in the upper uterus.

Step 2: Feel for the baby’s back.

Step 3: Feel what part of the baby is in the lower uterus.

Step 4: Feel for descent of baby's presenting part.

Attachment 4
Pelvic Examination

In preparing to perform the pelvic examination:

- Confirm that the client has recently emptied her bladder.
- Explain to the client what you are going to do and answer questions.
- Layout all instruments and equipment that you will need.
- Ensure that the examination space is private, that the examining table does not face the door; that curtains or a barrier protects the client from exposure.
- Position woman appropriately on examination table with feet in stirrups.
- Drape the client's abdomen and pelvis with a cloth, towel or her own clothing. In all cases, respect her modesty and treat her with dignity.
- Position light for good illumination of the cervix.
- Open instruments or examination pack with instruments.
- Wash your hands, dry them with a clean towel or air-dry, and put on high-level disinfected gloves.

Step 1: Inspection of External Genitalia:

Purpose: to check for any inflammation, discharge, growth or lesions.

Ask the client to separate her legs and look at the external genital structures:

- Mons pubis – presence and distribution of hair; presence of lice or nits.

- Labia majora and minora – presence, intact; color; presence of discharge, mass (growth), or discoloration.
- Bartholin glands opening – normally not visible; abnormal finding include, presence of redness or discharge.
- Perineum – smooth and unbroken, presence of mediolateral episiotomy scar; presence of fistula or abnormal mass.

Gently separate the labia major and labia minora and look at the deeper external structures (tell the client you will be touching her **before** your touch her):

- Clitoris – presence, size; abnormal masses.
- Hymen – presence or absence; if present, open, closed, presence of a mass.
- Para-urethral gland openings – normally invisible; if visible, look for **redness, discharge, or masses**.
- Urethral opening – color without discharge; abnormal findings include **redness, discharge, or masses**.
- Vaginal opening – visible; abnormal findings include protrusion of the vaginal walls (rectocele, cystocele).

Step 2: Inspection of Internal Structures:

Purpose: to inspect vagina and cervix for inflammation and/or discharge, growths or lesions.

Inform the client of what you are going to do next.

Separate the labia minora and gently insert a closed speculum obliquely into the vaginal opening, directing it downwards until you meet gentle resistance. Gently open the blades, lock them in position, and look at:

- Cervix – shape, color; if the ectocervix is smooth with a colorless discharge; abnormal finding include discharge, masses, irregular borders around the cervical opening; blood of unknown origin, ulceration.
- Cervical os – for presence of masses protruding from the opening (abnormal).

- Vaginal mucosa – intact, color, without odor; presence of discharge, blood of unknown origin, redness, fistula, areas of white coloration, ulcerations.

Take specimens for Pap smear and/or culture, if indicated and available (gonorrhea, chlamydia, wet mount).

When finished with this step, loosen the screws to allow the spreading of the speculum. Gently remove the speculum obliquely, rotating it to a partially open position to inspect the vaginal mucosa while withdrawing the speculum. If abnormal discharge was present, put a few drops of KOH (potassium hydroxide) solution on the accumulated discharge in the lower blade to determine the presence of a fishy odor consistent with Bacterial vaginosis.

Place the speculum in a container with decontamination solution.

Step 3: Palpation of External Genitalia

Gently separate labia major and minora with the first two fingers of one hand, gently insert the forefinger of the examining hand at the opening of the vagina about one inch, press the anterior vaginal wall and draw it toward the vaginal opening. Look for presence of discharge (abnormal).

Rotate the examining hand downward and place the forefinger at the 4 o'clock position with the thumb on the same area on the vulva. Palpate the right Bartholin gland. Repeat this maneuver at the 8 o'clock position to palpate the left Bartholin gland. Feel for enlargement, mass, or painful response by client.

Tell the client that you will insert your fingers deeper to feel her internal organs.

Step 4: Palpation of Internal Structures

Insert the first two fingers of the examining hand, until resistance is felt.
Place the other hand on the client's abdomen just above the pubis.

- Feel the cervix – consistency, smoothness, condition of the cervical opening, and presence of pain when gently moved.
- Gently palpate the anterior and posterior fornices to examine the uterus. Feel for shape, size, smoothness of surface, consistency (firm or soft), and position (anteverted/retroverted/midposition).

- Gently palpate the right and left fornices to examine the ovaries and tubes. Feel for masses, tenderness.

Use the hand you placed on the client's abdomen to gently push the internal organs down toward the fingers in the vagina to help feel the organs completely.

Assess the Pelvic Muscles

- Withdraw fingers from the vagina halfway and ask the client to squeeze your fingers. Feel the strength of her pelvic muscles during this part of the examination.
- Rotate the vaginal hand palm-down and separate the fingers lightly, asking the client to cough or bear down. Look for bulging of the anterior and/or posterior vaginal walls, or loss of urine.

Withdraw the fingers completely from the vagina and look at the gloves for any blood or abnormal discharge that may have collected. Evaluate any abnormal discharge.

Step 5: Recto-Vaginal Palpation

After palpation of the internal organs, inspect the anal opening, and palpate the anal sphincter and the rectum.

- Inspect the anal opening: it should be free of blood, without tissue protruding. Abnormal findings include red, swollen mass (hemorrhoids) or brownish mass (prolapse of the rectum).
- Inform the client of what you are going to do next. Ask her to bear down while you gently insert your index finger into the anal opening. Note the tone of the sphincter (tight). Confirm a retroverted uterus that was felt during the vaginal examination by feeling it through the anterior wall of the rectum. Feel all surfaces of the rectal wall for masses.
- Gently withdraw your finger and discard the glove.
- Wipe the client's genitalia and assist her to a sitting position. Share your findings with her.
- Document your findings immediately in the client record.

Attachment 5
Indications for Ultrasound[3]

Ultrasound is an excellent means of assessing fetal well being; however, it can be inappropriately used, leading to excessive reliance on technology and increasing health care costs. Consequently, it is crucial to know the indications for ultrasound, its true value and limitations.

- Estimated gestational age for clients with uncertain dates of LMP.
- Evaluation of fetal growth.
- Vaginal bleeding of undetermined etiology in pregnancy.
- Determination of fetal presentation.
- Suspected multiple gestation.
- A support to amniocentesis.
- Significant uterine size and clinical dates discrepancy.
- Pelvic mass.
- Suspected Hydatidiform mole.
- Suspected ectopic pregnancy.
- A support to special procedures; *e.g.*, fetoscopy, chorionic villus sampling, cervical cerclage placement.
- Suspected fetal death.
- Suspected uterine abnormality.
- Localization of IUD.
- Surveillance of ovarian follicle development.
- Biophysical evaluation for fetal well being.
- Observation of intrapartum events; *e.g.*, extraction of second twin.
- Manual removal of placenta.
- Suspected polyhydramnios or oligohydramnios.
- Suspected abruptio placenta.
- A support to external cephalic version.
- Estimation of fetal weight.

- Abnormal serum alpha-fetoprotein value.
- Follow-up observation of identified fetal anomaly.
- Follow-up evaluation of placenta location for identified placenta previa.
- History of previous congenital anomaly.
- Serial evaluation of fetal growth in multiple gestation.
- Evaluation of fetal condition in late registrants for antenatal care.

Attachment 6
Rh Incompatibility[4]

Rh Incompatibility Screening

The mother's blood and Rh type should be identified through routine laboratory tests during the first antenatal visit.

Women with the following history indicate Rh type testing:

- History of previous blood transfusion.
- History of previous "yellow baby" or a baby needing a blood transfusion.
- History of stillbirth or neonatal death resulting from causes unknown to the mother.
- History of receipt of RhoGAM (Rh immune globulin) after previous deliveries or pregnancy losses.

If the woman is Rh negative, order an indirect Coombs' test to screen for Rh antibodies.

Rh Negative, Coomb's Negative	**Rh Negative, Coombs' Positive (presence of Rh anitibodies)**
If the Coombs' test is negative, repeat the Coombs' test at 28 weeks.	Consult with obstetrician for medical management.
If Coombs' test is negative at 28 weeks, offer RhoGAM injection, it decreases the risk of developing antibody titers during the antenatal period in the event of maternal-fetal transfusion that can	

occur during placenta previa or abruptio placenta, and during the intrapartal period.	
If the client accepts RhoGAM, no further testing is necessary before delivery (RhoGAM provides protection against antibody formation for 12 weeks).	

Attachment 7
Gestational Diabetes Mellitus (GDM) Screening[5]

GDM Screening

All pregnant women for whom there are no initial risk factors for diabetes mellitus should be screened at 28 weeks gestation. If the screening test is normal, no further testing is needed.

A woman who shows any of the following should be screened three times during the course of her pregnancy in the first trimester or at the first visit, at 28 weeks, and at 34 to 36 weeks:

- Family history of diabetes mellitus (parents, siblings, grandparents).
- History of previous unexplained stillbirth.
- Poor obstetrical history (spontaneous abortions, congenital anomalies).
- Previous delivery of newborn weighing nine pounds (>4 kg) or more.
- Non-pregnant weight greater than 180 pounds, depending on body build and height.
- Recurrent monilial infection (if this is the only factor, screen only at 28 weeks)
- Recurrent glucose in the urine in a clean-catch specimen, not explained by dietary intake.
- Signs and symptoms of diabetes (excessive urine output, excessive thirst, excessive eating, weight loss, and poor healing).
- Pre-eclampsia or chronic hypertension.

- Polyhydramnios.
- Age 25 or older.
- Gestational diabetes in previous pregnancy.

Attachment 8
Drug Classification Table

Drugs by category. *Refer to the Drug Classification Scale (Table 5)* when using this table.

Classification of Drugs

A. No fetal risks.

B. Fetal risks not demonstrated in animals but there are no human studies.

C. No adequate studies, fetal risks unknown.

D. Some evidence of fetal risks.

	Drugs	**A**	**B**	**C**	**D**
Antibacterial					
	Penicillin		X		
	Erythromycin		X		
	Cephalosporins		X		
	Tetracyclines (Doxycycline)				X
	Monobactam			X	
	Carbapenum			X	
	Aminoglycosides:				
	Gentamicine			X	
	Streptomycine				X
	Clindomycin		X		
	Chloramphenicol			X	
	Sulfonamides		X		
	Trimethoprim			X	

	Nitrofurantoin		X		
	Vancomycin			X	
	Ciprofloxacin			X	
	Rifampicin		X		
	Rifabutin				
	Drugs	**A**	**B**	**C**	**D**
Antiparasitic	Metronidazole		X		
	Lindane		X		
	Chlorquine			X	
	Quinine				X
	Spiramycin		X		
	Mebendazole			X	
Antifungal	Fluconazole			X	
	Itraconazole			X	
	Nystatin		X		
	Amphotericin		X		
Antiviral	Acyclovir			X	
	Zalcitabine (ddc)			X	
	Stavudine (d4t)			X	
	Amantadine				X
Cardiovascular & Antihypertensive	Digoxin			X	
	Quinidine			X	
	B-adrenergic blockers			X	
	Local anesthetic antiarrhythmics		X	X	
	Calcium antagonists			X	
	Methyldopa			X	
	Hydralizine			X	
	ACE inhibitors			X	X
	Amiodarone				X
	Adenosine			X	
	Furosemide			X	
	Thiazide				X
	Warfarin				X

Anticoagulants	Heparin		X		
	Coumarine				X
Thrombolitics	Urokinase (thrombolite)		X		
	Streptokinase			X	
	Drugs	**A**	**B**	**C**	**D**
Asthma	Corticosteroids		X		
	Epinephrine		X		
	Terbutaline		X		
	Albuterol			X	
Anticonvulsants & Antidepressant	Phenytoin				X
	Carbamazero				X
	Trimethadine				X
	Diazipam			X	
	Phenobarital			X	
	Desipramine			X	
	Monoamineoxidase inhib.				X
	Chlorpromasine			X	
	Thioridazine			X	
	Clozapine		X		
Mild analgesics	Paracetimol or Acitaminophen		X		
	Aspirin			X	
	Ibuprophin or Indometacime			X	
	Piperazine (meclizine, cyclizine)		X		
Others	Androgens				X
	Danazol				X
	Diethylstilbesterol (DES)				X
	Lithium				X
	Methotrexate				X
	Radioactive Iodine				X
	Cyclosporine			X	

	Vitamin A			X	

Attachment 9

Preparing the Pregnant Woman for Labor and Delivery

Introduction

This section introduces a number of issues that will help minimize your pain and fear during labor and delivery. In addition, it summarizes what happens and what is expected to happen during each phase of labor and delivery, and what is expected from the woman during each phase.

Objective

To reduce the woman's fears, which may be due to lack of knowledge of what happens during labor and delivery.

To provide the mother and her baby the best of health and safety.

Delivery Free from Fear and Pain

Delivery should be free from any significant pain. This section describes how to promote an easier labor and delivery for you and your baby.

What is the relationship between fear and pain?

- Fear leads to tension, and tension leads to cramps, which in turn cause pain, while pain increases fear.

It is essential to eliminate fear in order to reduce pain, and considering that fear is usually born of the unknown, it is fundamental to introduce you to the characteristics of labor and the delivery process. This will help you overcome many of your fears. This pamphlet presents you with some information on delivery that is free from fear and with minimal pain.

How can the pain of labor and delivery be reduced?

- Learn the art of relaxation.

Relaxing the muscles of the body is of vital importance while having contractions during labor. The contractions lead to dilation of the cervix, thus allowing the fetus to pass through. When the mother relaxes between periods of contractions, she is helping her body by preventing exhaustion. Therefore, it is advisable to practice relaxation techniques daily during your pregnancy up to the time of delivery. Relaxation thereby becomes a habit that can be easily applied during labor and delivery.

Relaxation Technique

- During relaxation, close your eyes and breathe slowly. Clear your mind of thoughts that may hinder relaxation by counting breaths or by counting to 100 (or another method.
- Practice relaxation on a daily basis, so that you can relax quickly at the onset of labor and delivery, when you need it most.
- Regular breathing during labor and delivery helps both relaxation and the movement of the abdominal muscles; hence enabling you to benefit from the relaxation exercises.
- During labor and delivery, inhale deeply during each contraction. This raises the abdominal muscles, thereby facilitating uterine dilation during contractions. Begin exhalation (*i.e.*, releasing air from the lungs, and thus abdominal muscles) at the end of each contraction.

Methods and medications used to reduce the pain of delivery

In the beginning of labor, contractions occur at long intervals; which become gradually shorter until the interval between each contraction is less than two minutes. Sometimes, labor (uterine contractions during delivery) causes such pain and discomfort that it necessitates assistance for the alleviation of this discomfort.

There are many medications that help reduce the pain of labor and delivery without harming the mother or the fetus, and which do not affect the progress or course of labor and delivery. There is no need to worry—the doctor will provide the appropriate medication, if needed, to alleviate pain without affecting the mother or the baby.

The less fear there is, the easier and less painful the delivery will be. Ask your doctor or nurse any questions that you have, as they will be with you during delivery; they have the knowledge and experience to help you overcome all your fears.

How will you tell your children about your new pregnancy?

As your belly becomes noticeably bigger, or beginning about the fifth month, use a tactful and pleasant way that is appropriate to your child's age to explain why your belly is getting bigger, that a happy event awaits the family and that the new baby will not replace anyone in it but will be just like other family members.

What to Bring to the Hospital

A pregnant woman should prepare a suitcase for herself and her new baby's requirements at the beginning of the ninth month of pregnancy. It is appropriate to inform the husband where the suitcase is kept. It is recommended to include the following in the suitcase:

- Mother's requirements:
  - *A non-maternity, loose, comfortable gown suitable to wear when leaving the hospital.*
  - *Two or three suitable and comfortable nightgowns.*
  - *Bathrobe and slippers (without heels).*
  - *Toothbrush and toothpaste.*
  - *Deodorant, perfume or eau de cologne.*
  - *Comb and/or hairbrush.*
  - *Two or three towels.*
  - *Tissue paper.*
  - *Hand mirror and daily cosmetics.*
  - *Under wear, such as two bras in the size used during pregnancy.*
  - *Soap.*
  - *Shampoo.*
  - *An appropriate loofah [washcloth].*
- Baby's requirements:
  - *An appropriate number of diapers.*
  - *Sleeping garments.*

- *Wrap (Kofaliyyeh)—a square light cotton cloth used to wrap the infant: the cloth is folded into an inverted triangle, the infant is wrapped in an envelope-shaped bundle with arms stretched alongside the body with the wrap fixed in place with a safety pin. This practice is believed to make carrying the infant easier and molding a better posture with a straight back. Often times the practice is carried to extremes.*
- *Bonnet or stocking cap*
- *Blanket.*

How do you know you've started labor?

Delivery may take place one or two days or even weeks before or after the date determined by the doctor as determined by the date of your last menses.

Knowing what labor means will help you know what will happen, this in turn helps you feel comfortable and assured during the last days or weeks of your pregnancy.

What happens in this phase?

The fetus begins changing its position in preparation to come into the world. The urinary tract is lowered down and forward. This is the time when we hear the use of the traditional phrase "the baby is down." During this period, the same clothes will fit you but in a kind of awkward way. You may notice an increased vaginal discharge too; this means that the fetus has taken the position required to come into the world, its head pushing down on the uterus. This may cause you some discomfort or some mild pain. If this is your first pregnancy, you may think this pain is the pain of delivery. If you call on the doctor or the health center, the doctor or nurse can examine you and inform you about your progress. These false unpleasant pains may continue for a day or more.

Real labor and delivery pains may begin on the same night or within one to two weeks. No one can absolutely determine the time of delivery. A few things can help decide the time of delivery, however, such as:

1. *The regularity of contractions*
   Contractions may occur every 15 or 20 minutes and last for 45 seconds to a full minute. Within one or two hours, the intervals between contractions become shorter. These contractions can be easily

identified. They begin in the back and become stronger and extend towards the abdomen. The pain is caused by the vaginal muscles contracting in preparation for pushing the fetus out.

2. *Bloody discharge or blood clots*
   During pregnancy, clots play the role of a “plug” that closes the cervix. When labor contractions begin, these plugs fall through the vagina, thus they can be seen. This phenomenon may take place before or after the beginning of labor.

3. *Leaking of a watery vaginal fluid*
   The amniotic fluid protects the fetus. The amniotic sac usually ruptures during the last phase of delivery, but it may rupture before that phase. In this case, you should visit your doctor or the hospital because labor pains will begin immediately afterwards.

In addition to these signs, there are other signs that the doctor waits to see. Despite the breaking of the bag of waters, labor contractions may be delayed until the vagina is dilated enough for your baby to pass through. Sometimes, your waters “break,” but delivery does not take place until one day or possibly one week has elapsed, depending on how ready the vagina is.

When these signs appear, you should totally abstain from eating solid or dry foods; drinking only juice and eating only fluid foods as a precaution for a possible use of anesthesia during delivery, which can cause nausea on a full stomach.

Also remember to prepare yourself for delivery with regards to shaving or cleaning the hair around your genital area, and taking a hot bath within an appropriate time of the signs of labor appearing.

Phases of Labor

From a medical perspective, labor is divided into three phases. When labor starts, try to remain calm, and occupy yourself with something you enjoy, such as reading a book or a magazine or watching television. Try to ignore the contractions as much as you can.

First Phase

- At the onset of labor, the head of the fetus turns downwards, and presses against the vagina, which begins to dilate to allow the fetus

out. Then the bag of waters breaks and the contractions become closer while the vagina continues to dilate to the maximum (10 cm). Muscles contract to push the fetus out.

- Don’t try to exert pressure or bear down at this time, for this will only increase your fatigue; rather try to relax as much as you can even during contractions.
- Should your doctor find you in severe discomfort, the doctor shall give you medications to comfort you.
- The expansion and dilation of the cervix during labor is estimated by centimeters or finger widths. It is measured by the number of fingers that can be inserted through the cervical opening. When the cervix is fully dilated, its diameter reaches approximately 10 cm or five finger-widths.
- The first phase of labor (cervical dilatation) typically takes about 8-12 hours in a first delivery (primipara), and less than that in subsequent deliveries. The speed of cervical dilatation depends on the strength and regularity of contractions.
- Should the bag of waters fail to rupture in the beginning of this first phase, it may break when the cervix is fully dilated.
- A rectal enema is sometimes administered to the mother in order to clean the rectum; this is not accompanied by discomfort.
- The head of the fetus continues moving downwards with the increased dilatation of the cervix during the first phase of labor.
- During this phase, the doctor will measure the baby’s heartbeats from time to time, and will estimate the rate of cervical dilatation by rectal or vaginal examination.

Second Phase

- The baby is delivered in this phase. This phase begins with the completion of cervical dilatation (the end of the first phase), and is concluded with the baby coming to the outside world.

- When this phase begins, you will be taken to the delivery room on a bed or a mobile stretcher.
- The delivery room is somewhat similar to an operation theater. It is clean and contains shiny sterile equipment, with a lamp hanging from the ceiling. You will be moved from the bed or stretcher to the delivery table, which is a special type of surgical table, supplied with straps and supporters. The suitable position for delivery is lying on your back with your legs support by stirrups and spread apart. This is the position that you will be helped to take.
- The second phase of delivery usually lasts for about one half to one hour, during which time the baby gradually moves downward from the uterus to the vagina to the outside. The duration of this phase depends on uterine contractions and on how much you help yourself by following the instructions of the doctor or midwife. During this phase, you will feel the urge to bear down, and if you utilize bearing down (according to the contractions of abdominal wall muscles and bearing down with them), you will help yourself and your baby shorten the period of delivery. Meanwhile, your muscles act involuntarily to facilitate delivery.
- At the end of this phase, the doctor may resort to performing a perineal incision. This is a simple procedure that helps the head of the fetus out during delivery, protecting it from the increased pressure of tissues around the vaginal opening. The doctor performs a lateral or medial incision in the perineum (the outer vaginal opening) after injecting an anesthetic into the perineum. The incision is not very painful and heals quickly. The doctor sutures the incision while the anesthetic is still effective, and uses a silk material that goes away on its own to suture the incision.
- The fetus is pushed a little outwards with each contraction, with the head appearing first in most deliveries, followed by the neck and shoulders. The doctor holds the baby’s head and gently pulls it out.
- When the baby is delivered, the doctor holds it and a nurse removes the amniotic fluids from its mouth and nose. The doctor helps the baby take its first natural breath. The baby may be put on your breast to help

form a bond between the two of you, then the baby is wrapped with a cover to keep it warm, and the doctor puts a few drops in its eyes to protect them from contamination.

Third Phase

In this phase, the placenta separates and leaves the uterus. The placenta is a mass in the shape of a circular disc attached to the uterine wall and connected to the baby via the umbilical cord, which is cut once the baby is delivered. During pregnancy, the placenta supplies the baby with food and oxygen. The delivery of the placenta usually takes only a few minutes and the doctor will help you bring it out by giving you a special injection to stimulate the uterine muscles and cause them to contract, thereby reducing bleeding which accompanies the placenta's delivery. This phase is considered easy and free from pain.

- After delivery, you will be moved to the recovery or convalescence room, where you will remain under observation until your condition is stable, following which you will be moved to your room.

NOTE: *A small percentage of deliveries are done in ways other than that indicated by this pamphlet. This is due to the following reasons:*

- *Using artificial induction of labor to help the mother deliver when the term of pregnancy is completed without natural labor beginning, because the baby could be at risk if it remains in the uterus for a longer period.*
- *Delivery by cesarean section:*

This is a surgical operation whereby an incision is made into the abdomen and the baby is removed. It is an easy operation and does not pose many risks. Doctors resort to this operation in such cases, the mother has been in labor a long time and is too fatigued or exhausted to continue with normal delivery, or when the pelvis is narrow or contracted or when the size of the pelvis is disproportionate with the head of the fetus,

or in some cases of hemorrhage during delivery, or the presence of tumors in the pelvis or ovaries, or in the case of diseases accompanying pregnancy such as toxemia of pregnancy or diabetes, or abnormal fetal positions such as the transverse position, or the emergence of the umbilical cord preceding the head of the fetus during delivery.

After Delivery: What Now?

Once the dream becomes a reality, hold your baby in your arms and enjoy the arrival of your new child. At this point you will forget the troubles of pregnancy, labor and delivery; you will forget your fear of complications and of the unknown. It is essential that you focus on self-care during the postpartum period by following the instructions of the doctor, nurse and midwife, and that you return to visit the health center during the fist week from delivery and in the subsequent periods according to the previous instructions of the doctor. Remember that breastfeeding is best for your baby, and remember to follow up your baby's growth, development and care, and to maintain the baby's protection from infectious diseases by complying with the national immunization schedule. Should you need further information, do not hesitate to visit your doctor or the health center to obtain it.

Congratulations *and our best wishes for a normal and safe pregnancy and delivery of a beautiful, happy baby!*

Antenatal Care Performance Checklists

Performance Checklist 1: Pelvic Examination Checklist

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter NA ("not applicable") in the "Comments" column. Use the "Comments" column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	
All Clients			
1. Confirms that client has recently emptied her bladder.			
2. Explains pelvic examination procedure and answers questions.			
3. Positions woman appropriately on examination table with feet in stirrups.			
4. Drapes woman appropriately.			
5. Positions light for good illumination of cervix.			
6. Opens instruments or examination tools as necessary.			
7. Puts gloves on both hands.			
8. Inspects external genitalia for: · Inflammation. · Discharge. · Growths or lesions.			
9. Inserts vaginal speculum carefully and slowly, with pressure on lower vaginal opening.			
10. Inspects vagina and cervix for: · Inflammation and/or discharge. · Growths or lesions.			
11. Obtains Pap smear or vaginal swabs as necessary.			
12. Gently removes speculum and places in decontamination solution.			
Task	Achieved?		Comments
	Yes	No	

13. Performs bimanual examination for: · Tenderness on movement of cervix. · Position, size, and shape of uterus. · Evidence of pregnancy (enlargement of uterus, softening of lower uterus. · Mass or tenderness of adenexae (ovaries and tubes). · Perform rectal exam if necessary.			
14. Removes and disposes of gloves.			
15. Discusses findings of pelvic examination with woman.			
Recordkeeping			
1. Documents findings in the client record.			

Performance Checklist 2: First Antenatal Visit

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter NA ("not applicable") in the "Comments" column. Use the "Comments" column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	

All Clients			
1. Greets client respectfully and introduces self.			
2. Explains the benefits and purpose of antenatal care.			
History — Midwife			
1. Takes and records the client's health history including the following: • Client profile: name, address, emergency contact • Risk factors: age, number of children, spacing between children • LMP (calculates EDD), • Mode, place, and date of previous deliveries • Medications being taken • Outcomes of previous pregnancies • Time of initial quickening during current pregnancy • Fetal movement • Surgical history.			
History — Physician			
2. Takes and records the client's health history including the following: • Outcomes of previous pregnancies • Time of initial quickening during current pregnancy • Fetal movement • Medications being taken			
Task	Achieved?		Comments
	Yes	No	

Physical Examination			
1. Provides a private area for examination.			
2. Performs complete physical examination in a private area of the health center: • Takes BP, weight, height, and calculates BMI. • Examines HEENT for color of mucosa, palpates thyroid. • Inspects and palpates breasts; teaches client self breast examination. • Listens to heart and lungs. • Inspects extremities for color, swelling, and reflexes. • Palpates back for signs of kidney infection. • Inspects and palpates abdomen. • Counts fetal heart rate. • Measures fundal height. • Palpates the fetus to determine lie and presentation after 28 weeks.			
3.. Performs pelvic examination following the 5-step procedure: • Inspection of external genitalia • Speculum inspection. • Palpation of external genitalia • Bimanual palpation • Recto-vaginal palpation			
4. Identifies findings that require medical assessment and/or management and refers.			
5. Arranges for ultrasound, as indicated.			
Task	Achieved?		Comments
	Yes	No	

Laboratory Tests			
1. Performs or orders laboratory tests for: · Urine (glucose, albumin, acetone); urinalysis at the first visit and the second and third trimesters. · Blood (type, RH; antibody titres, if indicated; Hb/PCV; VDRL; Rubella antibody titre, Hepatitis screen, random blood sugar no later than 18 weeks and Gestational Diabetes Mellitus screening.			
2. Conducts initial health education for what to expect during pregnancy, how to manage common complaints of pregnancy, self-care, and diet. Teaches **danger signs** of pregnancy.			
All Clients			
1. Shares findings with client and encourages questions.			
2. Gives prenatal medication: iron, folic acid, vitamins.			
3. Administers tetanus toxoid aseptically.			
4. Sets date for follow-up visit.			
Recordkeeping			
1. Records findings in client record.			

Performance Checklist 3: Antenatal Return Visits

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter NA ("not applicable") in the "Comments" column. Use the "Comments" column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	

All Follow-up Clients			
1. Greets client and introduces self.			
2. Reviews client record findings from previous visit, checks laboratory results.			
3. Asks client how she is feeling (physically and emotionally) and if she has had any problems since last visit.			
4. Asks specifically about: · Bleeding · Headache · Eye problems · Swelling of face & hands · Abdominal pain · Movement of the fetus			
5. Asks about common complaints such as pain with urination, tiredness, nausea/vomiting, unusual vaginal discharge with or without itching.			
6. Asks if client has been taking her supplements (iron, folic acid).			
7. Encourages client to discuss her concerns or questions.			
8. Checks urine for albumin, glucose, and acetone.			
9. Performs limited examination, including: · Blood pressure · Weight · Abdomen – palpates fetus for lie and presentation, fetal heart rate; measures fundal height · Hand, legs for swelling, pitting edema; reflexes if indicated · Back for kidney tenderness			
Task	Achieved?		Comments
	Yes	No	

10. Shares findings with client, answers her questions.			
11. Orders scheduled blood tests at 2nd and 3rd trimesters.			
12. Gives second tetanus toxoid dose at least 4 weeks after first dose.			
Client Education			
1. Covers health education topics appropriate for gestation of pregnancy, according to reproductive health standards. Covers, at the minimum: · Birth planning · Family planning · Infant feeding · Preparation for labor and birth			
2. Reviews **danger signs** of pregnancy and instructs client to come to clinic immediately should any sign occur.			
3. Resupplies vitamin supplements, if needed.			
4. Sets date for next follow-up visit.			
Recordkeeping			
1. Records findings in the client record.			

Postnatal Care

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Postnatal Care

Introduction

The postnatal period, or puerperium, is defined as the period beginning about one hour after the delivery of the placenta and extending through the next six weeks. The client should receive care after labor and delivery, when the pelvic organs return to their pre-pregnant condition. This period of involution typically takes six to eight weeks, though it may take much longer for some organs to return to normal.

Postnatal care is the attention given to the general mental and physical welfare of the mother and infant. Care should be directed toward prevention, and early detection and treatment, of complications and diseases. In addition, postnatal care should include counseling, advice, and services on breastfeeding, family planning, immunization, and maternal nutrition.

Objectives

The objective of postnatal care is to support the mother and her family in the transition to a new family constellation, and respond to their needs through:

- Prevention, early diagnosis, and treatment of common problems or complications in both mother and infant, including preventing mother-to-infant disease transmission.
- Referral of mother and infant for specialist care when necessary.
- Counseling and information for the mother on newborn care and breastfeeding.
- Support of optimal breastfeeding practices.
- Education of the mother and her family concerning maternal nutrition and supplementation if necessary.
- Counseling and provision of contraceptives before the resumption of sexual activity.
- Immunization of the infant.

Schedule of Postnatal Care

Postnatal care starts at the hospital and continues with home visits, according to the postnatal care schedule in MCH centers. Home visits help the family provide care for the mother and the infant, to ensure that the family knows the danger signs and to seek health care immediately. It is advised that a mother should visit the MCH Center twice during the postpartum period: an initial visit within the first two weeks, preferably during the first week; and the second visit at six weeks.

To protect the health of mothers and their newborns during the postnatal period (also referred to as the “recovery process for the mother”), a follow-up assessment schedule, described below, should be followed.

Immediate Care (within the first 24 hours at place of birth)

Immediate care should occur within 24 hours of delivery, preferably within the first six hours, at place of birth (usually in the hospital).

Objectives

- Help the mother adjust to the changes that have occurred as a result of pregnancy, delivery, and childbirth.

- Assess health status of mother and newborn.
- Provide guidance and information about breastfeeding and care of the newborn.
- Provide immunization for the mother: postpartum rubella or RH prophylaxis if indicated.

Care of the Mother

- Exclude postpartum hemorrhage: measure BP; assess whether the uterus is contracted and that the client is able to urinate and tolerate light food and drink.
- Exclude puerperal infection: prevention by ensuring cleanliness and hygiene during delivery. Fever is the main symptom of puerperal sepsis.
- Exclude eclampsia: a woman suffering from postpartum eclampsia or severe pre-eclampsia should be immediately referred to the hospital.
- Exclude thromboembolic diseases: pulmonary embolism after labor often comes unexpectedly. Most postnatal thromboembolic complications are clinically silent. However, if the woman suffers from dyspnoea, chest pain, cyanosis, she should be immediately transferred to the hospital for further investigations to rule out or manage pulmonary embolism.
- Provide guidance to the family on the needs of the mother and newborn (*e.g.*, keeping newborn warm, initiating and encouraging frequent breastfeeding).
- Provide immunization of mother: postpartum rubella or RH prophylaxis if indicated.
- Teach mother danger signs for self and newborn and actions to be taken.
- Arrange follow-up visit date.

Postpartum Rubella Vaccination

- If, during pregnancy, a rubella test has shown the woman not to be immune to rubella, give immunization in the early postnatal period. If given during this period, congenital malformations due to rubella in subsequent pregnancies may be prevented.

Note: *provide the mother with contraceptives for at least three months following postpartum rubella vaccination. Pregnancy is an absolute contraindication following this vaccination.*

Passive Immunization Postpartum against Rhesus-Sensitization

- This is the RH-prophylaxis in RH-negative women who did not produce anti Rh-D antibodies during pregnancy, and who gave birth to an Rh-positive infant. The mother should receive anti Rh-D within 24 hours or at the latest 72 hours postpartum.

Care of the Newborn

Immediate Physical Assessment (in the hospital within first 24 hours)

- Keep the infant warm and dry during the examination.
- Review the birth record.
- Infant’s general appearance; take note of whether or not the infant is small or large, fat or thin, tense or relaxed, active or still; are body and mouth blue or pink.
- Assess bladder and bowel function, and skin color.
- Care for the umbilical cord (keep clean and dry).
- Listen to the infant’s cry (high, piercing cry can be a sign of illness).
- Check the rate of breathing, heart rate, and temperature (especially important during the first six hours):

- *Breathing should be without difficulty; normal rate is 30-60 breaths per minute.*
- *Heart rate should be between 120-160 per minute (place two fingers over the infant's heart or use a stethoscope).*
- *Temperature usually between 36.5-37.2ºC when taken under the arm. Hypothermia is temperature below 36.5ºC. It is very important to prevent heat loss after delivery; dry and cover the infant especially its head, and by keeping the infant close to the mother.*

- Exclude preterm birth: delivery occurring before 37 weeks is defined as a preterm birth. A preterm newborn should be referred to a specialized pediatrics department for assessment.
- Exclude low birth weight: weigh the infant (usually between 2.5 and 4.0 kg). Tell the mother and family the infant's weight. A newborn weighing less than 2,500g is defined as a low birth weight. This could be a result of preterm delivery or smallness for gestational age, which in turn may be due to intrauterine growth retardation. A low birth weight newborn should be referred to the hospital for further assessment.
- Inspect the infant's body:

Head – Note the sizes of the fontanelles (soft spots), suture, and molding
Eyes – Clean the eyes and place 2 drops of antibiotic eye drops in each eye
Mouth – Look at the formation of the lips, feel the inside of the mouth; check suck reflex
Spine – Note swellings or depressions
Limbs – Note their ability to move and number of fingers and toes
Reflex – look for the infant's "startle" reflex (arms open normally when you clap your hand)

- *Exclude congenital anomalies and malformations.*
- *Exclude neonatal bacterial infection and neonatal tetanus.*

- *Exclude birth trauma.*

- Watch infant breastfeed: nipple and areola should be in the infant's mouth.
- Administer Vitamin K and antibiotic eye drops.

Danger Signs[1]

Refer to a doctor if an infant has any of these signs:

- Poor feeding or sucking
- Sleeping all the time
- Fever or hypothermia
- No stool by third day
- Blueness of the lips or skin
- Jaundice (yellow skin)
- Persistent vomiting; vomiting with a swollen abdomen
- Difficulty establishing regular breathing
- Eye discharge
- Watery or dark green stools with mucus or with blood

Counsel Mother about Infant Immunization Schedule

- BCG to prevent tuberculosis given 5-30 days following birth (New MOH policy; practice initiated July, 2001) only given at selected health centers. Provide information to the mother about where her baby can receive BCG injection and when to take the infant.
- Oral polio vaccine at two-month visit.
- DPT and Hepatitis B vaccine at the two-month visit.
- HIB (Haemophilus Influenza B) vaccine at the two-month visit.

Early Care (within the first 2 weeks)

Early care should occur within the first two weeks after delivery (preferably on the third day), at either the woman's home or at the health center, as feasible. During the first postnatal care visit, the focus is on:

Care of the Mother

- Assess the mother's breastfeeding skills, signs of engorgement, management of breastfeeding difficulties, and newborn's skill and ability to feed.
- Assess the progress of recovery (uterus just below the umbilicus), adequacy of rest, emotional feelings, and relationship with infant.
- Assess for signs of infection or heavy bleeding.
- Assess the mother's manifestation of danger signs and actions to be taken.
- Encourage prescribed supplementation; *e.g.*, iron tablets.
- Introduce exercises (*e.g.*, Kegel/vaginal, abdominal).
- Remind or give postnatal clinic visit appointment.
- Provide family planning counseling.
- Examine the infant.
- Answer both mother's and family's questions.
- If a problem is identified requiring management and follow-up, schedule a return visit before the six-week postnatal visit.
- Blood test for hemoglobin and urine analysis.

History

Take an intrapartum history (a registered nurse or midwife will complete and record findings from the intrapartum history and overall assessment of the mother's general condition and vital signs). The history should be complete, accurate, and include the following:

- Place of birth
- Outcome of pregnancy (live birth, stillbirth, pregnancy loss)
- Gestational age at confinement
- Mode of delivery
- The condition of the newborn after delivery: Did the baby cry immediately, did the baby suckle?

- Weight of newborn and sex
- Complication during and after delivery
- Feeding and illnesses
- Discomfort from sutures
- Breast engorgement and pain, colostrum/perceived quantity of milk supply
- Nipple soreness and condition
- Emotional state or symptoms of *postpartum depression*:
    - *Sadness*
    - *Lack of pleasure or interest*
    - *Sleep disturbance*
    - *Weight loss*
    - *Loss of energy*
    - *Agitation or slowness*
    - *Feelings of worthlessness or inappropriate guilt*
    - *Diminished concentration*
    - *Frequent thoughts of death or suicide*
    - *Fear of hurting the baby*
- Wound infection (abdominal, perineal/vaginal)
- Hemorrhage
- Leg or calf pain
- Problems in defecation or urination
- Fever
- Lochia (color, smel):
    - *Lochia rubra (red) lasts for five days, then*
    - *Lochia serosa (pale) lasts for five days, then*
    - *Lochia alba (white) lasts for five days, then*
    - *Persistence of red lochia means subinvolution of the uterus.*

- *Offensive lochia smell means infection.*
- *In severe infection with septicemia, lochia is scanty and not offensive.*

Management of Symptoms of Postpartum Depression

- Encourage the nurse or midwife working in MCH at the health center to counsel the mother that these symptoms sometimes occur after delivery. The hormonal cycle is readjusting and the mother may be suffering from sleep disruptions.
- Support the mother during this readjustment phase and encourage her to express her feelings and to ask for support from family members.
- If symptoms of depression continue or seem harmful to the mother, **refer her for specialized care (psychiatrist) at nearby hospital for continued care**.

Physical Assessment

Overall assessment of general condition and performance of vital signs:

- General appearance: pale, sad, fatigued; relaxed, anxious
- Take and record pulse, temperature, and BP measured using standard protocol. Pulse should be normal but may rise if there is hemorrhage or infection.
- Temperature measured using standard protocol: record and underline in red if above 38ºC. Temperature should be normal. However:
  - *A reactionary rise may occur after difficult labor. It does not exceed 38ºC and drops within 24 hours.*
  - *A slight rise may occur on the third day due to engorgement of the breasts.*
- Weight taken using protocol

REMEMBER: *Observe the mother and her relationship with the infant. Does she touch the infant with her full hand, hold infant towards herself, make eye contact with the infant?*

- Head and neck: document any abnormalities.
- Breasts: with the establishment of milk secretion at the third to fourth day, examine the breasts for engorgement.
- Chest and heart: examine completely and systematically, report any abnormalities.
- Abdomen: examine the level of the uterus and for bladder distention.
- Look for signs of thrombosis in lower extremities: check pulse, calf muscle for tenderness and swelling, and check for varicose veins.
- Neurological examination *if indicated*.
- Inspect pad and perineum: lochia (amount, color, odor), condition of episiotomy or laceration repair, and hemorrhoids, if present.
- Refer mother for medical management if she has:
  - *Fever (temperature higher than 38ºC)*
  - *Heavy vaginal bleeding (bright red bleeding or continuous bleeding, even a continuous small amount or clots the size of an apple are indications for referral)*
  - *Bleeding from uterus, from vaginal laceration or episiotomy*
  - *Soft uterus*
  - *Inability to urinate*
- Review danger signs with mother and family.
- Reinforce health education messages regarding breast self-examination (*Attachment 2*) and Kegel exercises (*Attachment 3*).
- Record findings and management in the client's health record.

Maternal Danger Signs

The mother should return to the health facility if she has:

- Heavy bleeding
- Fever or chills
- Abdominal pain or foul smelling lochia (vaginal discharge)
- Pain, tenderness, or heat in the leg(s)

Care of the Newborn

- Take a history from the mother about her newborn. Ask the mother about:

Breastfeeding:	How many times has the infant fed since sunrise? How many times during the night?
Sleep:	How much does the infant sleep?
Urination:	How often does the baby wet?
Stool:	What color is the stool and how often?
Cord:	Has there been any discharge from the cord? Is there any smell?

- Examine the infant and explain findings to the mother. Normal findings should include:

General Appearance:	active when awake
Breathing:	easily, 40-60 breaths per minute
Temperature:	skin warm to touch, temp. 36.5-37.2°C
Weight:	a newborn may lose some weight within the first few days after birth (10% of birth weight). By day three or four, the baby should begin to gain weight again and should regain the birth weight by the end of the week.
Head:	"soft spots" not depressed or bulging
Eyes:	no discharge
Mouth:	check suck by observing the infant breastfeeding; mucous membranes moist
Skin:	not yellow or blue
Cord:	no discharge or foul smell (the cord stump should fall off by two weeks after birth)

Follow-up Care (6 weeks after delivery)

Follow-up care should occur six weeks after delivery, at the health center.

Objectives

- Detect and follow up complications of pregnancy or delivery.
- Assess involution of the reproductive organs.
- Counsel regarding contraceptive method options.
- Ensure that lactation is well established and the infant is growing well; *i.e.*, gaining weight, height and head circumference increasing.

Care of the Mother

The focus is on:

- Assess completion of involution (uterus not felt abdominally, lochia scant); emotional feelings, and relationship with infant.
- Identify client, infant, and/or familial problems.
- Assess breastfeeding practices.
- Examine infant growth.
- Assess need for or experience with current (satisfaction, and/or need for problem-solving management or change of method) contraceptive method.
- Give a resupply of contraceptives as requested or needed.
- Give follow-up appointment, if needed.
- Answer mother’s and family’s questions.

History

Note: *A thorough intrapartum history should have been taken during the previous visit. If history was not taken previously, or if this was the first postpartum visit of the mother, then a complete intrapartum history should be taken (refer to the Early Care history above).*

Ask about:

- Emotional (adjustment to mothering, family support, depression) and physical feelings (appetite, rest, sleep).
- Condition of the breasts.
- Vaginal bleeding or discharge; bladder and bowel function.
- Urinary or gastrointestinal complaints.
- Resumption of menses, sexual activity, contraception.

Physical Assessment

Overall assessment of general condition and performance of vital signs:

- General appearance: pale, sad, fatigued; relaxed, anxious
- Blood pressure measured using standard protocol
- Pulse should be normal but may rise if there is hemorrhage or infection
- Weight taken using protocol
- Temperature measured using standard protocol:
  - *Record and underline in red if above 38ºC.*
  - *Should be normal. However:*

    A reactionary rise may occur after difficult labor. It does not exceed 38ºC and drops within 24 hours.

    A slight rise may occur on the third day due to engorgement of the breasts.

- Examine breasts for condition of nipples, areola, and breast tissue; milk engorgement; and axillary lymph nodes.
- Examine abdomen for: enlargements, muscle tone, and whether uterus has returned to normal condition (as before pregnancy).
- Examine extremities: check pulse; check calf muscle for tenderness and swelling; check for varicose veins.
- Inspect vulva and perineum: for healing of any laceration, tear, or episiotomy if present; gaping of the introitus, bleeding or discharge, stress incontinence.

Lab Tests

- Hematocrit/hemoglobin
- If indicated CBC, if indicated (for moderate to severely anemic women)
- Urinalysis

Care of the Newborn

Take a history from the mother by asking her about the following:

Breastfeeding:	How often does the infant feed (usually every two to four hours, including during the night)? How often does the infant wet? Is the infant taking anything besides breastmilk?
Sleep:	How much does infant sleep at night and during the day?
Stool:	What color is stool; how often does infant have stool?
Immunization:	Has infant received BCG, DPT, oral polio, and hepatitis B?

Examine the infant and explain finding to the mother. Normal findings should include:

General Appearance:	active when awake
Breathing:	easy
Temperature:	skin warm to touch, temp. 36.5-37.2°C
Weight:	more than at birth
Head:	“soft spots” not depressed or bulging

Eyes:	no discharge
Mouth:	check suck by observing infant breastfeed
Skin:	not yellow or blue or dry
Cord: discharge, or odor[2]	off by second week after birth; no redness,

Administer infant first dose of oral polio vaccine and DPT and hepatitis B immunization.

Health Education and Counseling

Breastfeeding

As providers of MCH services, it is important to support successful breastfeeding practices. The benefits of breastfeeding can promote and protect the health of both infant and mother.

- Breastfeeding should be initiated immediately after delivery.
- Booklets and leaflets regarding breastfeeding should be distributed and explained for each mother during antenatal period and immediately postnatal

Encourage *Optimal Breastfeeding Practices* at the PHC level by teaching and helping mothers to:

- Breastfeed as soon as possible after birth, and to remain with the mother for at least several hours following delivery.
- Breastfeed frequently, whenever the infant is hungry, both day and night (generally at least eight times during 24 hours and at least once during the night).
- Breastfeed exclusively for the first six months, giving no water, other liquids, or solid foods.
- Give complementary feeds after six months (breastfeed before giving complementary feeds).
- Continue to breastfeed for up to two years, and beyond, if possible.
- Continue breastfeeding even if the mother or the baby becomes ill.

- Avoid using bottles, pacifiers (dummies), or other artificial nipples.
- Eat and drink sufficient quantities of available nutritious foods to satisfy her hunger and thirst.[3]

Due to short hospital stays after birth, many difficulties with breastfeeding may not be seen by providers. For mothers and their babies to benefit from breastfeeding, difficulties need to be identified early and managed promptly and effectively.

If possible, make postnatal home follow-up visits or schedule early postnatal assessments within the first week to assess breastfeeding practices.

A guide for supporting successful breastfeeding can be found in *Table 1*, which lists common difficulties, prevention signs and symptoms, and counseling and management.

Table 1. Common Breastfeeding Difficulties[4]

Signs, Symptoms/Conditions	Prevention	Counseling & Management
Low Milk Supply: · Poor infant weight gain. · Number of wet diapers fewer than 6 per day. · Sucking not satisfying infant.	· Increase frequency of breastfeeding. · Breastfeed exclusively day and night, on demand by infant. · Correctly position the baby on the breast. · Encourage family members to help with household tasks like cooking, cleaning, and shopping.	· Discontinue any feedings other than breastfeeding. · Breastfeed infant frequently, day and night; increase frequency of feedings. · Wake for additional feedings if infant sleeps through the night. · Make sure infant takes breast into mouth correctly. · Monitor infant weight gain.
Sore/Cracked Nipples: · Breast or nipple pain · Cracks in the nipple · Occasional bleeding · Nipples become reddened	· Correctly position the infant on the breast for feeding. · Remove infant from the breast by breaking suction with your finger first. · Increase frequency of breastfeeding. · Expose breasts to air to dry thoroughly after each feed.	· Apply drops of breastmilk to nipples and allow to air dry after feeding. · Make sure infant takes the breast into mouth correctly. Break suction with a finger before removing infant from breast. · Alternate infant's position for feedings to change pressure points on nipples. · Expose breasts to air, sunlight; keep nipples dry.

		· Apply ice to nipples after breastfeeding. · Begin breastfeeding on the side that hurts less. · DO NOT stop breastfeeding; feed frequently but for shorter periods of time. · If severely cracked, apply ointment with anti-inflammatory, anti-pruritic, vasoconstriction properties twice a day; remove before each feed. · Alternatively, apply A&D ointment or Vitamin E; the ointment does not have to be removed before infant feeds.
Signs, Symptoms/Conditions	**Prevention**	**Counseling & Management**
Engorgement: · Nipples and areola full and not possible to flatten for infant to attach for feeding. · Breast skintight. · Breast full and firm to touch.	· Breastfeeding frequently day and night. · Hold nipple flat between thumb and fingers to help infant attach correctly to the breast. · Avoid tight brassieres. · Avoid sleeping on stomach. · Use a variety of positions for holding the baby to change points of pressure on breasts.	· Apply warm compress before start of breastfeeding. · Massage breasts before breastfeeding. · Gently manually express small amounts of breastmilk to soften the areola so that it can be flattened for infant to attach correctly. · Place thumb and fingers at the junction of the areola and breast; flatten areola to encourage infant to take the entire nipple and areola into the mouth. · Wear a supportive bra. · Take warm showers and manually express milk before or after breastfeeding. · Cold compresses and pain-relievers may help if swelling has extended up chest and under arms.
Obstructed Ducts/Mastitis: · Breast pain. · Generally not feeling well. · Redness in one area of the breast, swollen, hot to touch,	· Breastfeeding frequently day and night. · Hold nipple flat between thumb and fingers to help infant attach correctly to the	· Seek medical care for antibiotic treatment (10-14 days). · Apply heat before the start of breastfeeding.

hard with a red streak. · Fever (at times), flu-like symptoms.	infant attach correctly to the breast. · Avoid tight bras. · Avoid sleeping on stomach. · Use a variety of positions for holding the baby to change points of pressure on breasts.	· Massage the breasts before breastfeeding. · Continue feeding on both breasts starting on the unaffected side. · Breastfeed frequently. · Increase maternal fluid intake. · Apply cold compress or warm pack to breasts after feeds. · Encourage maternal bed rest. · Wear a supportive bra.

Care and Counseling of the Mother

Diet

- Encourage the mother to eat a well balanced diet including the following: eat protein and energy rich foods, vitamins, mineral and fluids; continue taking supplements (*e.g.* iron).
- Encourage the mother to drink fluids every time she breastfeeds.

Rest

- Encourage the mother to take rest and encourage other family members to help her with the household tasks including preparing food, cleaning the house, and caring for the other children. A well-rested mother is a better mother and spouse.

Personal Hygiene

- The mother can and should bathe herself daily after giving birth. Bathing is not harmful following childbirth. In fact, women who let many days pass without bathing may develop an infection of the skin or perineum.
- Recommended bathing practice is to use a shower, if available, or to pour water over the body. Wash breasts and perineum as part of the daily bath.
- Wash hands before and after going to the bathroom.

- Wash the genital area with mild soap and water after passing urine or stool. Wipe or cleanse vulva from front to back, anus last. Change perineal pads every time you go to the bathroom for passing urine or stool and at least four times per day.

Exercise

- Encourage the mother to exercise daily, beginning with performing some small household tasks, and then establish a daily routine that includes pelvic floor/Kegel exercises as described in Attachment 3 and abdominal exercises. Begin the practice of a daily walk after one week. Staying inside the house for 40 days after delivery is not necessary.

“Baby blues” or Early Postpartum Depression

- Be alert to any changes in the mother’s mood, such as sadness, unexplained crying, or lack of maternal feeling. Explain to the mother that these symptoms and feelings sometimes occur after delivery.
- Encourage the mother to seek support and to express her feelings to her family; however, if symptoms of depression continue, become more severe, or seem harmful to the mother, refer the mother for specialized care from the psychiatrist at a nearby hospital.

Sexuality

- It is advised to abstain from sexual intercourse for six weeks after delivery, to prevent infection and also to allow the perineum to heal. However, if the vaginal area has healed and bleeding (lochia) has stopped, there is no medical risk in having intercourse.

Smoking

- For health reasons for both the mother and newborn, the mother should not smoke at all (including the arguila, a traditional water pipe). If the mother did not stop smoking during pregnancy and continues smoking after delivery, advise her not to smoke near the time of breastfeeding.

Danger Signs

- Advise the mother to return to the health center if she has any of the following: heavy bleeding, fever or chills, abdominal pain or foul smelling lochia (vaginal discharge), pain, tenderness or heat in the leg(s).

Care of the Newborn

Breastfeeding

- Should be encouraged whenever possible (Refer to the “Breastfeeding” section above.

Care of the Cord

- Keep the cord clean and dry. Normally, it falls off within 7-14 days. Do not cover the cord or apply any medicine or ointment to the cord area. If a bad smell, pus, or signs of infection occur in the navel (cord) area, take the infant to the health center for care.

Sleeping Arrangements and Position

- The baby should sleep in a clean, safe, smoke-free and warm area and not far from the mother. The preferred position for the newborn/infant is on the baby’s right side. From time to time, turn the baby’s head from the right side to the left. When putting the baby to sleep, advise the mother not to place the infant on his or her abdomen.

Temperature Regulation

- Protect the baby from cold, and also from too much heat. Dress the baby as warmly as you feel like dressing yourself.

Cleanliness

- Take special care in relation to cleanliness of the infant.
- Keep the infant in a clean place away from smoke and dust.
- Change the diaper or bedding each time the infant wets or dirties the diaper.

- If the infant's skin becomes red or irritated, leave the diaper off to promote healing, change more frequently, and keep the irritated area clean and dry.
- Bathe the infant daily with mild soap and warm water. *Avoid getting the cord wet.*

Parent-Child Attachment and Stimulation

- Promote early. This includes cooing, talking, holding, touching, rocking, singing, and looking and smiling at the infant. Encourage family members to hold the infant close to their hearts when carrying the infant.

Growth and Development

- Monitor using the infant height and weight chart and milestones for development. For additional information, see Volume 5 of these Standards of Care: Nursing Care.

Colic

- If the baby cries for no apparent reason (colic), look for the possible cause and consult the health center nurse. Try gently massaging the infant's abdomen or and rocking the infant. Examine your eating habits to determine and avoid the possible cause of the infant's discomfort.

Immunizations

- Review with the mother the recommended immunization schedule,which can be found in Volume 4: Preventive Care.

Danger Signs

- Advise the mother to be aware and to take the infant to a health care provider at the health center if the newborn has any of these signs:
    - *Poor feeding or sucking,*
    - *Sleeping all the time*
    - *Fever or hypothermia*
    - *No stool by third day*

- *Blueness of the lips or skin*
- *Jaundice*
- *Persistent vomiting*
- *Vomiting with a swollen abdomen*
- *Difficulty establishing regular breathing*
- *Eye discharge*
- *Water or dark green stools with mucus or blood*

Postnatal Contraception

Postnatal infertility usually lasts for approximately six weeks for the woman who does not breastfeed exclusively. Sometimes the infant's on-demand pattern of feeding may not support prevention of ovulation. For these reasons and to provide maternal recuperation before another pregnancy occurs, contraception should be offered during the postnatal period.

Table 2. Contraceptive Method Options

Breastfeeding Women	**Non-Breastfeeding Women**
Immediate (First Choice): · LAM · Condom · IUD · Tubal Ligation	**Immediate:** · Postnatal sterilization (male or female) · Norplant insertion · IUD · Depo-Provera injection · Progestin-only pills · Condoms (male) · Abstinence
Beginning 6 weeks after Delivery (Second Choice): · Progestin-only pills · DMPA · Norplant · Spermicides · Fertility Awareness (when an identifiable pattern of fertility signs returns)	**Beginning 3 Weeks after Delivery** (to reduce the risk of thromboembolism): · Combined oral contraceptive pills (COCs)
Beginning 6 weeks after Delivery (Third Choice):	**Beginning 6 weeks after Delivery:**

• Combined oral contraceptives	• Spermicides (foam, cream, jellies) • Diaphragm, where available • Fertility Awareness Method /Cervical Mucus Method (CMM), once menstrual cycles have resumed.
Advise all women about ECP and provide, if requested.	

Process

- Before discharge (preferably introduced during antenatal visits), review the contraceptive options.
- Review client's history and labor/delivery course; screen for factors that would keep the woman from safely using her preferred method.
- If the client's preferred method can be provided immediately:
  - *Give the contraceptives.*
  - *Give a contraceptive supply for the number of weeks until the next follow-up visit.*
- If the client's method of choice is best initiated four to six weeks after delivery, provide condoms with instructions.
- Give appoint for follow-up visit six weeks or when necessary, based on the client's needs.

Follow-up Visits

- Review postnatal course with client, review symptoms of infection; breastfeeding experience.
- Review postnatal course with chosen contraceptive.
  - *If satisfied and no precautions exist, provide re-supply.*
  - *If not satisfied, counsel for contraceptive options and provide client's chosen method.*
  - *If practicing LAM, assess whether client still fits the criteria for its use:*

LAM Criteria

A woman can use LAM if she answers "No" to ALL of these questions:

- Is your baby 6 months old or older?
- Has your menstrual period returned? (Bleeding in the first 8 weeks postnatally does not count.)
- Is your baby taking other foods or drink or allowing long periods of time (4 or more hours) without breastfeeding, either day or night?

If the woman answers "Yes" to **any one** of these questions, she **cannot** rely on LAM for prevention of pregnancy, but she can continue to breastfeed her baby while using a method of contraception that will not interfere with lactation.

- *If Yes and client wants to continue using LAM, support client and provide condoms and spermicide for possible change in criteria before the next visit.*
- *If No, or client wants to change method, counsel on contraceptive options and provide client's chosen method.*

- Give a follow-up visit based on when the client is due to return: six weeks, three months, or six months.
- Make necessary referrals if other reproductive health or other health needs are noted.

Referral Process

- Refer client to the physician, when indicated.
- Complete the referral form (by physician).
- Return feedback notes to the referral site or referring physician.

Follow-up

This is the responsibility of the clinic nurse. Standard schedule of visits during first six weeks following delivery are at one week and at six weeks postnatal.

Completion of Postnatal Client Records

Record and completely fill the client's record at the time when the client is seen.

Provide an appropriate, private place and conduct client interviews with respect for the client (client record may be completed by a trained midwife).

Attachment 1
Breast Examination Guidelines

1. General Approach
2. Appearance of Breasts
3. Feeling for Lymph Nodes
4. Feeling for Breast Lumps
5. Examination of Nipples
6. Self-Exam Guidance

1. General Approach

This section is written as if you were examining a woman's breasts. To reassure the client, do the following:

- Provide good light.
- Explain the breast examination procedure to client and answer questions.
- Keep the exam private. Have people leave the room, if not needed. If you are a man, you may want to have a female nurse or nursing assistant in the room with you.
- Ask client to uncover her chest from waist up, so that you can see the whole area well. Give the woman a drape to cover herself.
- Wash hands and dry completely.

As you examine:

Purpose: to examine breasts visually for: symmetry, identify any dimpled areas, localized skin changes, or nipple abnormalities.

- Explain to the client what you are doing. Teach the client and let her practice the self-exam.
- If there are abnormal findings, be sure to report to a referral doctor

2. Appearance of Breasts

- Compare one side of the body to the other.
- Look at the breasts, skin, and nipples.
- Look carefully and ask the client to do the following:
  - *Sit with arms at sides.*
  - *Raise arms over head.*
  - *Lean over, with arms stretched forward.*
  - *Tighten chest muscles by pushing palms of hands together*.

If breasts are large, lift them up to see all areas of skin.

Normal includes:

- Size and shape of breasts may not be exactly the same but are normal for the client.
- In adolescent girls, one breast may be enlarged more than the other or both breasts may appear equal size.

Abnormal includes:

- Change in shape of breast, skin change such as redness, thickening, scaliness, or skin in any spot looks pulled in (retraction, dimpling, puckering).
- Nipples discharge or bleeding.
- Nipple change, such as if one nipple sticks out more than the other (elevation), if nipple turns inwards or rash.

3. Feeling for Lymph Nodes

- Have client sit with arms at sides.

- Support the client's arms while you feel in each armpit area for lymph nodes:
    - *Insert your hand as far into the armpit as you can.*
    - *Press your hand against the chest wall, feeling for lymph nodes.*
- Continuing to feel for lymph nodes, slowly remove your hand from armpit.
- Note lymph nodes, size, mobility, and presence of tenderness.

4. Feeling for Breast Lumps

There are a number of ways to do this exam. Compare the way you have been taught with the following way that is recommended:

- Have client lie down on her back with arms behind her head.

If breasts are large, to make the breast lie flat, place a folded towel under the shoulder area on side you are examining, so that breast is tipped forward toward the center and flattened.

- Feel for lumps in each breast with you finger tips:
    - *Place the flat part of your fingertips on the skin.*
    - *Press gently but firmly.*
    - *Use the middle three fingers to move the skin over the tissue underneath. Use a circular motion.*
    - *Pretend that the breast is like the face of a clock as you examine the outermost part of the breast.*
    - *Begin feeling for lumps at the 12 o'clock position. Move to 1 o'clock, and move around the "clock," feeling for lumps. Include breast tissue near the armpit. It is normal to feel a ridge of firm tissue at the lower curve of each breast.*
    - *When you get back to 12 o'clock, move in an inch toward the nipple. Examine around the edges of a smaller clock.*
    - *Continue to feel for lumps in this way until you have examined every part of the breast, including the nipple area.*

- To do a complete exam of large breasts, feel for lumps with the woman in other position.
- If you feel a lump, carefully examine and report to the referral doctor. Document findings on referral form:
    - *Exact location: make a drawing with an "**X**" where the lump is.*
    - *Size and shape: measure in mm or cm.*
    - *Is it tender to the touch? If so, check for other signs of inflammation or infection. Is it warm, red, swollen?*
    - *What does it feel like? For example, is it soft, firm, hard?*
    - *It is mobile or attached to something?*
- Try to pick up or move skin over the lump:
    - *Mobile Lump – skin moves over the lump or attached to skin (lump moves with the skin). Try to move or slide the lump over the tissue underneath it.*
    - *Fixed Lump does not slide over tissue that is underneath it, feels attached to some thing or lump does not slide over tissue that is underneath it.*

If it is near the woman's period, plan to recheck the lump right after the period ends and report again to your referral doctor even if exam is normal.

5. Examination of Nipples

- If nipples are turned inward (inverted), try to manipulate them to turn back out:
    - *Gently press or pull on edge of nipple*
    - *Abnormal includes if nipple recently turned inward on one side and you cannot get it to turn back out.*
- Check each nipple for discharge or blood.
    - *Press around the edges of nipple (nipple line).*
    - *Gently squeeze nipple between your thumb and pointer finger.*
    - *Abnormal includes discharge or blood. If so, examine:*

How much is there?

What does it look like (color, clear or cloudy, thick or thin)?

What does it smell like?

6. Self-Exam Guidance

- Encourage client to do a self-exam; have her demonstrate how she will examine her breasts. Correct or reinforce client as necessary.
- Discuss findings of examination with client.

Attachment 3
Kegel Exercises[5]

Strengthening the Pelvic Floor Muscles using Kegel Exercises

Strengthening the pelvic floor helps to prevent problems controlling urine flow (urinary incontinence) and prolapse of the uterus).

Advise the pregnant woman that she can do the exercises anywhere—in the car, on the phone, even as a wake-up exercise. A good way to locate your pelvic floor muscles is while sitting on the toilet to spread your legs apart and start and stop the flow of urine, or tighten your vagina around one or two inserted fingers.

To start, tighten the muscles, holding for two to four seconds, and relax for ten seconds. Repeat five times. Do this three times a day. Work up gradually until you can hold the contraction for eight seconds and ten repetitions. Then you can add three or four short, fast but strong twitches at the end of each long contraction. Also, you can think of your bladder and uterus as an elevator, that you are raising little by little to the top floor. When you reach the top, go down floor by floor, gradually relaxing the muscles.

Be sure you do not contract your abdominal or buttock muscles, or hold your breath, while doing the exercises.

Postnatal Care Performance Checklists

Performance Checklist 4:

Early Care for Mothers (within 2 weeks of delivery)

Performance Checklist 5:

Follow-up Care for the Mother (6 weeks after delivery)

Performance Checklist 6:

Infant Physical Assessment (5-30 days after delivery)

Performance Checklist 4: Early Care for Mothers (within 2 weeks of delivery)

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter NA ("not applicable") in the "Comments" column. Use the "Comments" column to note details about why a particular activity was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	
All Clients			
1. Greets the client (and family, if present) and introduces self.			
2. Explains the purpose and frequency of postnatal visits.			
3. Reviews client record for antenatal and intrapartum history.			
4. Asks client to describe her labor and birth; condition and sex of infant; did she have stitches.			
5. Asks client how she feels (physically, emotionally) and if she has any questions or problems.			
Physical Examination			
1. Washes hands and performs physical examination: · Temperature, pulse, respirations, blood pressure. · Breasts, for presence of colostrums. · Abdomen for level and consistency of uterus, presence of bladder distention. · Pads for amount of bleeding, presence of clots. · Vulva for condition of perineum, stitches intact. · Calves for tenderness.			
2. Washes hands.			
Task	Achieved?		Comments
	Yes	No	

Client Education			
1. Discusses family planning needs and methods in anticipation of discharge.			
2. Teaches mother to: · Check her uterus to ensure that it is hard. · Change pads frequently, rinse vulva and wash from front to back each time she uses eliminates. · Drink plenty fluids and urinate frequently. · Practice exercises (*e.g.* Kegel/vaginal, abdominal)			
3. Encourages mother to eat plenty of body building food (protein) and energy food (fats, grains).			
4. Observes the mother and infant breastfeeding; correct practices, as needed.			
5. Teaches mother how to handle common breastfeeding difficulties.			
6. Encourages mother to breastfeed frequently/on infant's demand.			
7. Reinforces LAM, if it is the mother's chosen method.			
8. Teaches mother postnatal **danger signs**: · Heavy bleeding, · Fever, · Abdominal pain or foul-smelling vaginal discharge, · Pain or tenderness, heat in legs.			
9. Gives appointment for next follow-up visit.			
Recordkeeping			
1. Records findings in the client record.			

Performance Checklist 5: Follow-up Care for the Mother (6 weeks after delivery)

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter NA ("not applicable") in the "Comments" column. Use the "Comments" column to note details

about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	
All Clients			
1. Greets the client (and family, if present) and introduces self.			
2. Reviews client's record for antenatal, intrapartum, previous postnatal history.			
3. Asks client how she feels (physically, emotionally) and if she has any questions or problems.			
4. Asks mother how she is managing breastfeeding and/or LAM.			
5. Asks mother about appetite, rest, sleeping, level of activity.			
6. Asks mother about presence of postnatal **danger signs**.			
7. Asks mother if she has given any more thought to the FP method she would like to use, if not already using LAM or another method.			
8. If using LAM, asks mother if the 3 criteria are still present.			
Physical Examination			
1. Washes hands and performs a physical examination: · Temperature, pulse, blood pressure · Breast – condition of nipples · Abdomen – uterus, firm and barely or not felt abdominally · Vulva – amount of lochia, clots; condition of perineum · Legs – pain, tenderness, heat in calves			
2. At six-week visit, performs complete pelvic examination.			
3. Teaches mother exercises to strengthen the tone of abdominal and vaginal muscles.			
Task	Achieved?		Comments
	Yes	No	

4. Performs or orders laboratory tests: ·Hb/Hct ·CBC, if indicated ·Urinalysis			
5. Washes hands.			
Postnatal Contraception			
1. Provides client's chosen FP method consistent with breastfeeding status and absence of precautions.			
2. Gives FP method and/or back-up method with user instructions.			
3. Encourages mother to have husband use condoms if she might be at risk for STIs.			
4. Shares findings with mother.			
5. Gives appointment for next visit.			
Recordkeeping			
1. Records findings in the client record.			

Performance Checklist 6:
Infant Physical Assessment (5-30 days after delivery)

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter NA ("not applicable") in the "Comments" column. Use the "Comments" column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	

All Clients			
1. Greets the client (and family, if present) and introduces self.			
2. Opens MCH health record for new baby.			
3. Washes hands.			
4. Asks mother how the infant is behaving.			
Physical Examination			
1. While keeping the infant warm and dry, look at the infant's general appearance.			
2. Listens to infant cry (high, piercing cry can be a sign of illness).			
3. Checks infant's: · Heart rate (120-160) · Breathing (30-60/minute) · Temperature (36.5-37.2ºC)			
4. Weighs the infant (2.5-4.0 kg), shares findings with mother, records in record.			
5. Measures and records height and head circumferences.			
6. Inspects the infant's body: · Head – size and condition of soft spots · Mouth – formation of lips and palate; check suck reflex · Spine – for swellings or depressions · Cord – off by 2 weeks after birth, no redness, no discharge or odor · Limbs – ability to move and number of fingers and toes · Reflex – presence of "startle" reflex			
7. Observes infant breastfeeding, correct practices with mother as indicated.			
Task	Achieved?		Comments
	Yes	No	

All Clients			
1. Teaches mother infant danger signs: bring infant to clinic immediately if any sign occurs: · Poor feeding or sucking · Sleeping all the time · Fever/hypothermia (cold) · No stool by third day · Blueness of lips or skin · Severe jaundice (yellow skin) · Persistent vomiting; vomiting with a swollen abdomen · Difficulty establishing regular breathing · Eye discharge · Watery or dark green stools with mucus or blood			
2. Gives BCG immunization (infant) between 5-30 days at designated health center.			
3. Gives appointment for next follow-up visit.			
Recordkeeping			
1. Records findings in infant's record.			

Family Planning

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Family Planning

Definition

Family planning is a plan adopted by a couple that helps them to decide when, how often, and at what intervals they want to have children. Family planning allows couples to make a choice about methods based on accurate information and their own family planning goals.

Family Planning Depends on Informed Choice

- Ensuring that clients have clear, accurate, and complete information about contraceptive methods, benefits, risks, side effects, and costs to make their own family planning decisions.

- Giving access to a range of acceptable and affordable family planning methods from which to choose.

Benefits of Family Planning

Family planning has social, economic and health benefits for the individual, family, and society. By spacing pregnancies and reducing the number of pregnancies or preventing high risk or unwanted pregnancies, family planning offers the following benefits:

Benefits to the Mother

- Reduces the risk of maternal death.
- Decreases health risks associated with too many pregnancies too closely spaced for mothers who are either too young or too old.
- Promotes and protects maternal health through spacing the physical, mental, and nutritional status of the mother, giving a chance for health to be restored
- Decreases the incidence of high-risk pregnancies.
- Decreases the dangers of unsafe abortion sought for unwanted pregnancies.

Benefits to the Child

Through pregnancy spacing, family planning benefits the child by:

- Decreasing the rate of stillbirths, prenatal and infant mortality.
- Decreasing the rate of premature and low birth weight babies.
- Decreasing child morbidity due to infectious disease and malnutrition.
- Decreasing the rate of congenital abnormalities and mental retardation.
- Improving the child’s physical, mental, and intellectual growth, health and development, and academic achievement.
- Increasing the child’s chance for sufficient breastfeeding, care and love.

- Reducing the risk of maternal death, which negatively impacts child health and survival.

Benefits to the Family

- Improves physical health and emotional well being of family members.
- Decreases parents' physical and mental burden and provides sufficient time for childcare.
- Decreases the family's economic burden, enabling the provision of good nutrition, health care, education, clothes, recreation and other family needs for a healthy environment.
- Enables the family to participate in social, educational, and economic activities.

Benefits to Society

- Improves the health and nutritional status of the community.
- Improves economic status and decreases poverty.
- Protects the environment by decreasing demand on natural resources.
- Decreases demand for public services such as housing, water, energy, education, health and social services.

Elements of Quality of Care

To achieve the health promotion goal of reproductive health services, high quality services are required to encourage utilization and continuity.

Table 1. Elements of Quality of Care

Elements	Health Center Inputs
Interpersonal Relations	· Providers skilled in counseling and communication · Clients treated with respect and honesty and understanding · Clients satisfied with staff courtesy, information, and care
Contraceptive Methods	· Wide variety available · Clients receive their method or choice or are referred to an accessible alternative site

	· Full range of RH services
Information and Counseling	· Accurate, complete, and unbiased overview of methods to make free and informed choice* possible · Method specific counseling including how to use; advantages and disadvantages; possible side effects; and when to return · Client understanding is tested repeating information
Technical Competence	· Family planning service protocols available · Staff are trained and supervised · Providers follow clinical procedures
Continuity of Service	· Follow-up system in place to track and contact defaulter · Clients informed about return visits · Resupply readily available or clients referred to a source · Facilities for removal or change available and accessible
Appropriateness & Acceptability of Services	· Clients satisfied with access · Privacy and confidentiality ensured · Physical premises clean and hygienic

**Free and informed choice* means that clients are making a decision without constraints or pressure; clients are making decisions based on complete, unbiased information. Clients select a method and decide whether or not or when to use family planning methods.

General Family Planning Counseling

Family planning decisions are made through counseling sessions between a trained provider and the client. Effective counseling helps clients make and carry out their own choices about reproductive health, including family planning.

Definitions

Counseling is a two-way process of communication through which one person helps another identify reproductive health needs and make the most appropriate decisions concerning those needs. This is characterized by an exchange of information and ideas, discussion and deliberation.

Counseling is equally important for continuing clients who experience side effects, have concerns about the effectiveness of their contraceptives, or wish to change methods.

Counseling Objectives

- To help clients arrive at an informed decision about their reproductive health goals.
- To help clients to select a contraceptive method with which they can be satisfied.
- To help clients use the method safely and effectively.

Characteristics of a Good Counselor

- Understands and respects clients' rights.
- Earns clients' trust.
- Understands the benefits and limitations of all contraceptive methods.
- Understands the cultural and emotional factors that affect a woman's decision to use a particular contraceptive method.
- Encourages clients to ask questions.
- Uses a non-judgmental approach that shows clients respect and kindness.
- Presents information in an unbiased, client-sensitive manner.
- Actively listens to clients' concerns.
- Understands the effect of non-verbal communication.
- Recognizes inability to sufficiently help a client and refers to someone who can.

Requirements for Counseling Area

To ensure confidentiality and comfort during counseling, the area must be:

- Private
- Clean and attractive
- Comfortable and safe

- Well ventilated
- Spacious
- Equipped with supportive educational material, models and contraceptives

Principles of Counseling

These principles of counseling help give a quick guide to providers.

Remember[1]:

- Introduce yourself and greet clients with respect.
- Treat each client well.
- Listen to, learn from, and respond to each client.
- Adapt information to each client's personal situation.
- Avoid giving too much information at one time.
- Provide each client's preferred method if there are no absolute medical reasons against its use.
- Help each client understand and remember the instructions.

Counselor Approach and Attitude

- Greet clients politely and introduce yourself.
- Give clients your full attention as soon as you meet them.
- Explain that any information a client shares with you is confidential.
- Ask clients what the reason for their visit is and how you may help them.
- Listen attentively—demonstrate this through positive body language and non-verbal communication.
- Assist clients to talk about their needs and encourage them to ask questions.
- Explain that your questions to help them with their family planning needs.

Counseling Steps

To provide effective counseling, use the **GATHER** approach for family planning counseling:

G	**GREET** clients
A	**ASK** clients about themselves
	ASSESS client knowledge and needs
T	**TELL** clients about family planning methods
H	**HELP** clients choose a method
E	**EXPLAIN** how to use family planning methods
R	**RETURN** visits

GATHER helps sequence the information needed by each client, and helps clients move through the steps of decision-making. Information needed to choose a method is different from those needed to use a method.

TELL

Present basic information to familiarize clients with available contraceptive options. Include brief information about:

- Characteristics of each method
- How each method works
- Effectiveness of each method

Information presented should fill the gap in client knowledge that was identified during client assessment. Clients can apply this information in determining which method appeals to them or appears to suit their needs,

HELP

Provide more detailed information to help clients choose a family planning method. The counselor and the client use this information to match client needs with an appropriate method.

EXPLAIN

- How to use the method.
- Possible side effects and warning signs and what to do if warning signs occur.
- During this step provide the client with written instructions or information.
- Ask client to repeat the explanation using her own words. If the client has omitted or misunderstood any information, the counselor should review the information with her.

RETURN

Give client information about when to return for:

- Follow-up
- Re-supply
- Danger signs
- Desire to switch to another method or to stop using the method
- Questions

Counseling Clients with Special Needs

Men

- Encourage men to support women's use of family planning methods and/or to use contraception themselves.
- Create a comfortable, male-oriented environment for men to access sexual and reproductive health information, since they usually have less information than women in this area and fewer opportunities to talk with health personnel.
- Emphasize to men that the family planning method that offers the most protection against HIV infection and other sexually transmitted infections is a male method—the condom.

Women Who Have Had a Pregnancy Loss

- Immediately following a pregnancy loss, the woman may not be thinking about resuming sexual activity, but will be in need of contraception with early return of her fertility (two weeks following a first trimester loss). Make an appointment for a follow-up visit within the first week following discharge from the hospital or clinic.
- The emotional state of a woman following a pregnancy loss may not make her receptive to contraceptive counseling. Give the woman a referral that she might use at a later and offer condoms and/or spermicide.
- A woman who has become pregnant due to a contraceptive failure may be distrustful of contraception. Give the woman a referral that she might use at a later date and offer condoms and/or spermicide.

Adolescents

- During counseling, offer methods that will protect their health, such as condoms and spermicide. If privacy is a concern, Norplant or injectables may be offered.

IMPORTANT: Condoms should always be offered for additional protection against infection.

- Sexual activity among unmarried adolescents is unacceptable in Jordan. However, as a practitioner, adolescents may seek guidance about contraception. Unmarried adolescent sexual activity is usually spontaneous and infrequent; therefore counseling must be tailored to help adolescents be successful in protecting themselves from unwanted pregnancy and infections. Encourage the use of condoms for their dual protection and ease of access.
- Married adolescents may be under pressure to become pregnant shortly after marriage. Counseling must help the couple understand the implications of health risks to the young woman and the benefits of

being physically and psychologically ready for pregnancy. Counsel on all available methods.

Counseling Process

There are three essential parts to effective counseling:

1. Initial Counseling
2. Method-Specific Counseling
3. Follow-up Counseling

An effective counseling session covers the following steps:

Initial Counseling

Objective: Help Clients Decide on a Method

- Greet clients respectfully.
- Ensure privacy.
- Obtain biographical information, such as name and address.
- Find out what each client knows about family planning in general.
- Provide information about family planning in general.
- Discuss each client's reproductive health needs and goals.
- Explain the difference between spacing and limiting, temporary and permanent methods.
- Find out what each client knows about specific methods.
- Explain a variety of methods.
- Discuss advantages and disadvantages of each method.
- Clarify any misconceptions. See Table 2 for guidance.
- Explore any attitudes or religious beliefs that either favor or rule out one or more methods.
- Do a client assessment to determine the following:
    - *If client is pregnant (see "Attachment 1: Client Assessment for Pregnancy Before Contraceptive Use").*

    - *If client has any conditions that rule out a particular method.*
    - *Whether additional assessment or treatment is required.*
- Help clients choose appropriate methods according to their needs.
- When STI prevention or protection is indicated, use educational videos to show clients how to introduce condom use to their partners.

Method-Specific Counseling

Objective: Describe How to Use the Method

- Review client assessment data to see if there is a reason why a client should not use the desired method.
- State method effectiveness.
- Explain how to use the method.
- State when to start.
- Explain how to manage side effects and any changes expected in menstrual bleeding.
- Describe under what circumstances a client should return immediately for care.
- Ask clients to repeat instructions for use.
- Remind clients that they can return at any time for advice.
- Record information in client records.

Follow-up Counseling

Objective: Provide Proper Follow-up

- Discuss clients' satisfaction with method.
- Review any problems that may have occurred and management according to guidelines.
- Repeat usage instructions.
- Be prepared to change or stop a method upon client request or medical need.

- Refer as appropriate for complications and ensure there is a mechanism to document referral results.

Table 2. Rumors and Misinformation about Family Planning

Method	Rumor	Response
IUD	1. The IUD will travel throughout the body. 2. The woman can become pregnant with the IUD and the baby will be born with it in its hand. 3. The IUD will give you infections.	1. The IUD is inserted into the uterus, which is like putting something into your pocket—there is only one opening out of the vagina. It cannot travel outside of the uterus. It may be expelled from the uterus, in which case it will come out through the vagina. On rare occasions during insertion, the IUD might be passed through the uterus, but can be retrieved by the provider. 2. The IUD is highly effective in preventing pregnancy, so it is not likely that the woman will become pregnant with the IUD in place. If the woman should become pregnant, the provider will remove the IUD to prevent uterine infection during the pregnancy. Therefore, it is very important to tell your provider immediately if you have any signs or symptoms of pregnancy. However, if the IUD is not removed, it will come out with the uterine contents after the baby is delivered. 3. The IUD will not give you infections. Your provider will be very careful to keep the insertion procedure free of organisms that would cause infection. Your provider will also ask you questions to see if you are at risk or have been exposed to sexually transmitted infections—this will make it inadvisable for you to use the IUD. Your provider will not insert an IUD if you already have a pelvic infection or if you are at risk of becoming infected.
Hormonal Pills	1. Birth control pills will cause cancer. 2. Birth control pills accumulate in your belly and cause pain. 3. You need to take a “rest” from taking the pills.	1. Oral contraceptives have been shown to provide protection against ovarian and uterine cancers. 2. When oral contraceptive pills are swallowed, they dissolve in the fluids of your stomach and are an absorbed (taken up) into the blood stream, making the changes in the hormones so that you cannot become pregnant. They do not stay as little pebbles in your belly and cause pain. 3. There is never a need to take a “rest” from the pills as long as you are satisfied with the method. Interrupting successful pill taking will put you at unnecessary risk of becoming pregnant. Oral

		contraceptives are very safe for long-term use.
Method	**Rumor**	**Response**
DMPA	1. You will bleed heavily. 2. You will have no more menses and the blood will collect in your belly.	1. Very rarely, some women may experience heavier than normal menstrual bleeding during the first few months of use. It is not dangerous and will go away. If the bleeding is annoying, the provider can offer you medication such as anti-inflammatory agents, *e.g.*, Ibuprofen or a 7-21 day course of combined oral contraceptives, if there is no contraindication to estrogen use. 2. It is to be expected that some women will no longer have their menstrual periods the longer they use DMPA, *e.g.*, one year or more. This is not dangerous to your health and some women see it as an advantage. There is no need to stop taking DMPA for this reason. DMPA causes less and less of the lining in your uterus to develop, meaning that less and less blood is produced. Since the menstrual cycle hormones are no longer changing and causing menses, there is no uterine lining and blood to be released.
Norplant	1. You will have more bleeding. 2. You will have heavy bleeding.	1. Irregular and prolonged bleeding is common especially in the first 3-6 months of use. It is not dangerous to your health and will improve with time. If the bleeding is persistent or annoying, your provider can offer anti-inflammatory agents or a 7-21 day course of combined oral contraceptives. 2. Heavy bleeding with Norplant is rare but can be managed with anti-inflammatory agents or oral contraceptives.
Condoms (male)	1. Condoms will reduce the pleasurable sensations during sex. 2. Condoms break too often to be reliable.	1. Condoms can reduce the sensations for some men but applying a small amount of spermicide or lubricant to the head or the penis before putting on the condom might help. Also, for some men, the reduced sensations help them enjoy sex longer—which could also be a benefit for the woman. The benefit of protection from STIs that condoms provide far outweighs the imperfections of the method. 2. The main cause for condom breakage is insufficient lubrication. Generous use of water-based lubricants such as spermicides or vaginal lubricants will help reduce the risk of breakage. Taking more time in foreplay will help the woman produce more lubrication and can increase the pleasure for both the man and the women.
Method	**Rumor**	**Response**
Spermicide	1. Spermicide (creams, gels,	1. For some women (and men), spermicides

	and foams) is very messy.	increase wetness to a degree that is not acceptable, especially when additional spermicide must be used with each act of intercourse. Using foam can reduce the wetness. However, the increased wetness can help reduce condom breakage.
LAM	1. You can still get pregnant even when you breastfeed.	1. The use of LAM requires a woman and her baby to have a certain pattern of breastfeeding. Absence of menstruation indicates that she is not fertile and won't get pregnant. In addition, for LAM to be effective, the baby must be less than 6 months old. When any one of these 3 criteria for LAM use changes, prevention of pregnancy can no longer be assured and another method of contraception must be used. Your provider will review the rules for LAM use with you and will check with you at each visit to see if it is still appropriate for you to continue using LAM.
Female Sterilization	1. The woman will no longer have periods. 2. Female sterilization will cause changes in the menstrual period; *e.g.* heavier bleeding spotting, and change in regularity or length.	1. Female sterilization or tubal ligation only stops the egg from traveling to the uterus. It does not change hormones that would cause menses to stop. 2. Studies have shown no increase in the risk of menstrual change and no changes in hormonal levels that would cause those symptoms.

Contraceptive Methods
Method 1: Combined Oral Contraceptive (COCs)

Definition

Combined oral contraceptives are preparations of synthetic estrogen and progesterone that are highly effective in preventing pregnancy.

Types of COCs

- **Monophasic**: a fixed concentration of estrogen and progesterone hormone through out the cycle.
- **Multiphase**: biphasic or triphasic variations of concentration of estrogen and/or progesterone throughout the cycle.

How it Works

COCs prevent pregnancy by stopping ovulation and thickening the cervical mucus making it difficult for sperm to pass through.

Effectiveness

COCs are very effective when correctly and consistently used: 1 pregnancy per 1,000 women in the first year when used perfectly. In typical use, 6-8 pregnancies per 100 women in the first year can be seen.

Who Should Use COCs?

COCs are appropriate for women of all ages, including women who:

- Require an easy, temporary method for spacing or limiting pregnancies.
- Have no problem remembering to take daily pills.
- Have or have not children.
- Are fat or thin.
- Do not smoke* (See "Who Should Not Use COCs" below).
- Blood pressure of 140/90 or less.
- Have just experienced a pregnancy loss including those having an abortion.

Who Should Not Use COCs?

Under the following conditions, COCs are not an appropriate contraceptive method:

- Pregnant women (see "*Attachment 1: Client Assessment for Pregnancy*")
- Breastfeeding women of less than 6 months.
- Smokers over 35 years of age.*
- Women with diagnosed active liver disease.
- Women with diagnosed heart disease or cerebrovascular accident (stroke).
- Women with a history of or diagnosed breast cancer.

- Women with a history of or diagnosed blood clots in the vein (thromboembolic disorder).
- Women with blood pressure greater than 160/100.

Advantages

- Very effective when used correctly.
- Monthly periods are regular and lighter, with milder menstrual cramps.
- No rest period needed.
- Can be used by women who have and do not have children.
- Users can stop taking pills at any time.
- Fertility returns soon after stopping.
- Can be used as emergency contraceptive after unprotected sex.
- Users are less likely to develop iron deficiency anemia due to significantly reduced menstrual flow.
- Helps prevent endometrial and ovarian cancer.

Disadvantages

- Common side effects:
  - *Nausea, most common in the first three months*
  - *Spotting or bleeding between menstrual periods*
  - *Mild headaches*
  - *Breast tenderness*
  - *Slight weight gain*
  - *Amenorrhea*
- Difficult for some women to remember everyday.
- Not recommended for breastfeeding women (affects the quality and quantity of the milk)
- May cause mood changes including depression, less interest in sex.
- Does not protect against sexually transmitted infections (STIs).

Client Assessment

Screen clients for medical eligibility for COCs by asking the following questions. If she answers no to all of the questions, she can use COCs. If she answers yes, help her choose another effective method.

- Do you think you are pregnant?
- Do you smoke cigarettes and are you age 35 or older?
- Do you have high blood pressure?

NOTE: *If yes, and blood pressure is below 140/90 give COCs. If BP is between 140 -159/90-99, provide COCs and check BP at next visit. If BP is 160/100 or higher, help her choose a method without estrogen.*

- Are you breastfeeding a baby less than 6 months old?
- Do you have serious problems with your heart or blood vessels?
- Do you have or have you ever had breast cancer?
- Do you often get bad headaches with blurred vision?
- Are you taking medicine for seizures, rifampin or griseofluvin?
- Do you have vaginal bleeding that is unusual for you?
- Do you have gall bladder disease?
- Have you ever had jaundice?

Client Instructions

1. Hand the client a packet of the same pills that she will use. Show and tell the client to:
    - *Start with combined monophasic preparations that contain 30-35 micrograms of estrogen (see Table 3).*

- *Feel free to discuss the need to change the type of pill if there are side effects significant enough to make you want to stop taking the pills or making you want to consider changing the pills.*
- *Review the instructions given. Provide the instructions clearly in a language appropriate to the background of the client.*
- *Start taking pills:*
    - Anytime (once the provider has determined that the woman is not pregnant)
    - Days 1-7 of the menstrual cycle (if the woman wishes to start the pills on a particular day that is beyond the seventh day of her menstrual cycle, she must use a back-up method for the next seven days.
    - Postpartum after six months if using LAM.
    - After 3-6 weeks postpartum, if not breastfeeding.
    - Immediately after pregnancy loss (or within the first seven days, since fertility can return within the first two weeks of a first trimester pregnancy loss).
- *Take one pill every day until the pill pack is finished.*
- *If using a **21-day** pill pack, skip seven days before starting a new pill pack. Do not let more than seven days pass between the end of one packet to beginning the new packet.*
- *If using a **28-day** pill pack, take the pill daily **without** skipping any days. Start the new packet the next day after you have taken the last pill from the old packet. In the 28-day pill packet, the last seven days do not contain hormones; they are reminder pills and are a different color from those taken from the first three rows. Since the last seven pills (in the pill packet) are not hormones, you will be protected if you forget to take one.*
- *If you miss one or more pills in a row, you may have spotting or break-through bleeding. Missing pills puts you at risk of pregnancy.*
- *If you miss **one pill**, take that pill as soon as you remember.*

- *If you miss two **pills**, take two pills as soon as you remember and two pills the next day. Continue the rest of the pack as usual, and use a back-up method for the next seven days.*
- *If you miss three pills in a row, you will probably have break-through bleeding. Whether you are bleeding or not, discard the packet of pills and begin a new packet of pills as you did when you first started the pills. Use a back-up method for at least seven days.*

IMPORTANT: If you consistently miss pills, consider another contraceptive method.

- *If you vomit or have severe diarrhea within one hour after taking your pill, take one pill from another packet.*
- *If severe diarrhea continues for more than 24 hours, keep taking the pills **and** use a back-up method until you have taken a pill for seven days in a row **after** the diarrhea has stopped.*
- *COCs do not protect against sexually transmitted infections (STIs); use condoms while taking COCs if you might be at risk of STIs.*

2. Ask client to repeat key instructions. Correct any errors.
3. Instruct the client to return if **any** of the following signs occur:
   - *Severe pain in the abdomen, chest, legs, shortness of breath*
   - *Severe headaches, dizziness*
   - *Loss of vision, blurring*
   - *Jaundice (eyes or skin become yellow)*
4. Provide client with at least a three-month supply of COCs. Provide client with condoms and/or spermicide.

5. Reassure client that she may change pills or try another method if she does not like these COCs. Reassure the client that the doctor is available to see her if she has any problems, questions, or needs advice.
6. Plan for a return visit and give the client a definite return date.
7. Document the visit in the client record.

Follow-up Visit

The client should be seen after the first cycle and then after three or six months. During the follow-up visit:

- Update the client's address and contact information.
- Assess the client's satisfaction with the method.
- Determine if the client has had any problems or side effects. If so, manage the problem or side effect and record management in her clinical record.
- Update the client's medical history and perform any indicated examinations, such as a blood pressure check.
- Provide appropriate counseling as required.
- Review the instructions for taking the pill with the client.
- Encourage the client to contact the clinic at any time if she has any questions or complaints.

Table 3. Interaction of Combined Contraceptives (COCs) with Other Drugs[2]

Commonly Used or Prescribed Drugs	Adverse Effects	Comments & Recommendations
Analgesics Acetaminophen (Tylenol, Paracetamol and others)	· Possible decreased pain-relieving effect (increased drug excretion)	Monitor pain-relieving response.
Antibiotics Griseofulvin and Rifampin *NO documented clinical effect or significance has been established*	· Decreased contraceptive effect with COCs, especially with low-dose COCs, 30-35 ug ethinyl estradiol (EE).	Help client choose another method or use higher estrogen pill (50 ug EE) or backup method (*e.g.*, condoms).

for penicillins, tetracyclines, cephalosporins and other commonly used antibiotics.		Hormonal methods may be used and no backup method is routinely necessary with these antibiotics.
Antidepressants (Elavil, Norpramin, Tofranil and others)	· Possible increased antidepressant effect.	Use with caution. Low doses are probably safe.
Antihypertensives Methyldopa (Aldoclor, Aldomet and others)	· Possible decreased antihypertensive effect.	Use COCs with caution, monitor BP.
Antiseizure Drugs Barbiturates (Phenobarbital and others) Carbamazepine (Tegretol) Phenytoin (Dilatin) Primidone (Mysoline)	· Decreased contraceptive effect with COCs, especially if lowest dose COC used. · Possible increased phenytoin effect.	Help client choose another method or use higher pill (50 ug EE) or backup method (*e.g.*, condoms).
Beta Blockers (Corgard, Inderal, Lopressor, Tenormin)	· Possible increased beta-blocker effect.	Monitor cardiovascular status.
Bronchodilators Theophlyline (Bronkotabs, Marax, Primatene, Quibron Tedral, Theor-Dur and others)	· Increased theophylline effect.	Monitor for symptoms of theophylline overdose.
Hypoglyceminics: (Diabinese, Orinase, Tolbutamide, Tolinase)	· Possible decreased hypoglycemic effect.	Monitor blood glucose as for any diabetic patient.
Tranquilizers: Benzodiazepine (Ativan, Librium, Serax, Tranxene, Valium, Xanax and others)	· Possible increased or decreased tranquilizer effects, including psychomotor impairment.	Use with caution. Commonly prescribed dosages are unlikely to result in significant effects.

Table 4. COC Brands Available in Jordan

Name	Progestin	Estrogen
Lo-Femenal	Norgestrel 0.3 mg	Ethinyl Estradiol 0.03 mg
Lyndiol	Lynestrenol 2.5 mg	Mestranol 0.05 mg
Marvelon	Desogestrol 0.15 mg	Ethinyl Estradiol 0.03 mg
Microgynon	Levonorgestrel 0.15 mg	Ethinyl Estradiol 0.03 mg
Neogynon	Levonorgestrel 0.25 mg	Ethinyl Estradiol 0.05 mg

Nordette	Norgestrel 50 mcg	Ethinyl Estradiol 30 mcg
Nordiol	Norgestrel 250 mcg	Ethinyl Estradiol 50 mcg
Ovral	Norgestrel 0.5 mg	Ethinyl Estradiol 0.05 mg
Triordiol	Levonorgestrel 0.05 mg	Ethinyl Estradiol 0.03 mg
Ologyn	Norgestrel 0.25 mg	Ethinyl Estradiol 0.05 mg
Norlestrin	Norethindrone acetate 2.5 mg	Ethinyl Estradiol 5 mcg

COCs: Management of Side Effects and Other Problems

Symptoms/ Situation	Assessment	Management
Spotting between periods, irregular bleeding	Ask about: · When the client started pills, · Symptoms of infection, · Vomiting or severe diarrhea, · Forgotten pills or irregular pill-taking · Taking Rifampicin or other medication that interferes with COCs. Perform pelvic exam if history suggests infection.	If infection, treat according to clinical guidelines. If due to vomiting or diarrhea resulting in poor absorption of hormones, continue with pills but use a back-up method until 7 days after the last episode of vomiting or diarrhea. If drug interaction, encourage use of condoms and/or spermicide if drug use will be short term. If drug use will be long term, counsel for use of another method, *e.g.*, DMPA. Review pill-taking guidelines with client and explore ways for the client to remind herself to take the pills at the same time daily. Reassure the client that symptoms, in the absence of any other causes, are not serious and will go away on their own with continued use.
Symptoms/ Situation	**Assessment**	**Management**
Nausea, breast tenderness, and moodiness	Ask the client when she started using the pills.	Reassure the client that these symptoms are common during the first 3 months of COC use. Encourage the client to return if the symptoms worsen or extend beyond 6 months. Where feasible, change to a different formula pill may be required, if the client wishes to continue with COCs.
Amenorrhea (no menstrual period)	Ask about: · Forgotten pills, irregular pill taking,	If the client may be pregnant or is pregnant, ask the client to stop the pills. Provide condoms and/or spermicides and refer for antenatal

	missed more than 2 pills and has had unprotected sex. Perform pelvic exam and pregnancy test if the client has missed pills and has had unprotected sex.	services. If not pregnant, menstrual periods will return in a few months; therefore, continue with the pills, if the client is satisfied with the method. Assure the client that the absence of menstrual period is not dangerous to her health.
Taking medication that interferes with COCs.	Ask the client what she is taking or has been prescribed to take.	If the client is or will be taking Rifampicin or Griseofulvin, use a back-up method while taking the medication and for 4-8 weeks after taking the last dose of medication, while continuing the COCs. *There is no evidence that other antibiotics require a back-up method.* If the client will be or is using anticonvulsant medication, *e.g.*, Phenobarbital, primidone, carbamezepine, or ethosuximide, counsel for changing to DMPA or non-hormonal method.

Contraceptive Methods
Method 2: Progestin-Only Pills (POPs)

Definition

Progestin only contraceptives are preparations of synthetic progesterone.

Types of POPs

Name	Progestin
Femulen	Ethynodiol Diacetate BP 500 mcg (28 tablets)
Ovrette	Norgestrel 0.075 mg (28 tablets)

How it Works

The contraceptive thickens the cervical mucus, making it difficult for sperm to pass through and stops ovulation in about 50% of menstrual cycles.

Effectiveness

For breastfeeding women, between 0.5 and 1 pregnancy in 100 women occurs in the first year of use. Method effectiveness is enhanced by breastfeeding.

For all women, when POPs are used correctly and consistently, 5 pregnancies occur per 1000 women.

NOTE: *Effectiveness increases if the pill is taken at the same time every day.*

Who Should Use POPs?

POPs are appropriate for women who:

- Desire a safe, temporary method.
- Can remember a daily pill.
- Have or do not have children.
- Are breastfeeding (six weeks after childbirth or milk supply well established*).
- Are adolescents or over 40 years of age.
- Have just had abortion or miscarriage.
- Cannot use estrogen.

* *Studies have shown that POPs have no negative effect on breastmilk production or infant growth, even when started in the first week postpartum.*[3]

Who Should Not Use POPs?

Under the following conditions, POPs are not appropriate as a contraceptive method:

- During pregnancy (see "*Attachment 1: Client Assessment for Pregnancy*").
- For women who have been breastfeeding fewer than six weeks.

Who Should Be Monitored More Closely By a Physician?

A physician should monitor women using POPs who also:

- Have a history of or diagnosed breast cancer.
- Have diagnosed liver disease.
- Have unexplained vaginal bleeding.

IMPORTANT: Women using Rifampicin, Griseofulvin, or anticonvulsants should be advised to use a back-up method or another method, since these drugs will reduce the effectiveness of the POPs.

Advantages

- Rapidly effective.
- Can be used by breastfeeding women.
- Easier to understand and remember than 21-day combined pills since pills are taken daily without a break.
- No estrogen side effects.
- May help prevent:
  - *Endometrial and ovarian cancer*
  - *Pelvic Inflammatory disease*
  - *Benign breast disease*

Disadvantages

- Changes in menstrual bleeding:
  - *Irregular periods*
  - *Spotting or bleeding*
  - *Amenorrhea*
- Less common side effects include headache and breast tenderness.
- Must be taken at the same time every day to be effective.
- Does not prevent ectopic pregnancy.
- Does not protect against STIs, including HIV.

Client Assessment

Screen client for POP medical eligibility by asking the following questions. If she answers no to all of the questions than she can use POPs. If she answers yes, see guidance or help her choose another effective method.

a. Do you have or have you ever had breast cancer?

b. Do you have jaundice (are her eyes or skin unusually yellow)?

c. Are you breastfeeding a baby younger than six weeks?

d. Do you have vaginal bleeding that is unusual for you?

e. Are you taking medicine for seizures or any other medication?

f. Do you think you are pregnant?

Client Instructions

Hand the client a packet of the pills that she will be taking. Show and tell the client the following:

- Start the first cycle of POPs:
  - *Anytime (when the provider has determined that the client is not pregnant).*
  - *Within the first five days of the menstrual cycle, preferably the first day.*

- *Postpartum:*

  After six months, if using LAM

  After six weeks, if breastfeeding but not using LAM

  Immediately or within six weeks if not breastfeeding

- *Immediately following pregnancy loss, or during the first week following the pregnancy loss.*

- Take one pill every day **at the same time** until the cycle or packet is finished.
- Start a new cycle the day after you have taken the last pill from the old packet. There is never a break.
- If you miss one or more pills, you make have spotting, break-through bleeding, or risk pregnancy.
- If you miss one pill, take it as soon as you remember and continue taking one pill each day as usual.

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*IMPORTANT: If you are more than **three hours late in taking your pill**, take the pill as soon as you remember AND use a back-up method for the next two days at least.*

- If you miss two or more pills in a row, start using your back-up method **immediately** and restart taking your pills right away (take two pills for two days). If your menses does not begin within four to six weeks, come to the clinic for an exam and pregnancy test.
- Keep track of your menses while taking POPs. If you have more than 45 days with no period, come to the clinic for an examination and pregnancy test.
- If you have diarrhea or vomiting or both, use your back-up method with the POPs until two days after the diarrhea or vomiting are over.

- Feel free to return to the clinic if you have any side effects, concerns, or questions. Common side effects during the first three cycles may include break-through bleeding, nausea, dizziness, breast tenderness, and headaches (mild).
- Return to the clinic immediately if you develop abdominal pain.
- POPs do not protect against STIs; use condoms along with POPs if you might be at risk of STIs, including HIV.
- Give the client an appointment for a follow-up visit in one month.

Follow-up Visit

- Update the client's address and contact information.
- Assess the client's satisfaction with the method.
- Determine if the client has had any problems or side effects. If so, manage the problem and record management in her clinical record.
- Update the medical history and any other examinations, as indicated.
- Provide appropriate counseling, as required.
- Review the pill, Warning Signs and the instructions for taking the pills with the client.
- Encourage the client to contact the clinic any time she has questions or complaints.
- Schedule the client for a visit in six months if she is satisfied with the method and experiences no side effects.

POPs: Management of Side Effects and Other Problems

Symptoms/ Situation	**Assessment**	**Management**
Amenorrhea (no menstrual periods), irregular bleeding/spotting (non-breastfeeding)	**Ask** if she has: . Forgotten pills, irregular pill-taking, . Had regular periods then suddenly missed a period.	If not pregnancy, reassure the client that irregular bleeding or absence of period can occur with POP use; it is not harmful. Review pill-taking guidelines.

	· Symptoms of pregnancy, · Had exposure to STI.	If due to other underlying causes, *e.g.*, infection, treat according to clinic protocol. If suspected ectopic pregnancy, refer immediately for medical management. If pregnant, refer to antenatal services.
Severe **Headache** with blurred vision	**Ask** if: · Headaches have become worse since POPs were started. · Headaches are associated with blurred vision, temporary loss of vision, seeing flashing lights or trouble speaking and moving.	Reassure client that although women with migraine headaches can safely use POPs, she may want to consider changing to another method without hormones. If symptoms include visual changes and trouble speaking and moving, refer **immediately** for medical management.
Taking **medications** that interfere with POPs	**Ask** the client what she is taking or has been prescribed to take.	If the client is or will be taking Rifampicin, use a back-up method while taking the medication and for 4-8 weeks after taking the last dose of medication, while continuing the POPs. *There is no evidence that Griseofulvin or other antibiotics require a back-up method with POP use.* If the client will be or is using anticonvulsant medication (*e.g.*, Phenobarbital, primidone, carbamezepine, or ethosuximide), counsel for changing to DMPA or non-hormonal method.

Contraceptive Methods
Method 3: Intrauterine Devices (IUDs)

Definition

The intrauterine device (IUD) is a small flexible plastic frame inserted in women's uterus through the vagina. The IUD can have copper wire or copper sleeves or hormones. All brands have one or two strings or threads tied to them to enable removal.

Types of IUDs

- Copper Bearing IUDs
- Inert: unmedicated plastic IUDs
- Hormone-releasing IUDs: steadily release small amounts of the hormone progesterone or levonorgestrel, synthetic progesterone.

How it Works

Although the exact mechanism of action is not known, IUDs are assumed to prevent the sperm and egg and from meeting. Hormonal IUDs cause thickening of the cervical mucus or changes in the endometrial lining making implantation difficult.

Effectiveness

Between 0.6 and 1.5 pregnancies occur per 100 women in the first year for copper IUDs. The rate varies with the type of IUD.

Who Should Use IUDs?

IUDs are appropriate for women who:

- Want a temporary method and do not like daily pills or using methods associated with sexual intercourse.
- Are of reproductive age.
- Are breastfeeding.
- Do not want or cannot use a hormonal method.

Who Should Not Use IUDs?

Under the following conditions, IUD is not an appropriate contraceptive method for:

- Women with PID currently or in last three months.

- Women at risk of having or have sexually transmitted infection, unless a condom is also used consistently.
- Women with a Sexually Transmitted Infection (STI) currently or in the last three months.
- Women with distorted uterine cavity.
- Women with genital tract cancer prior to treatment.
- Following septic pregnancy loss.

Advantages

- Long-term prevention from pregnancy (at least 10 years for copper devices, indefinitely for non-medicated, plastic devices).
- Very effective, little to remember.
- No interference with sex.
- No hormonal side effects.
- Immediate return of fertility after removal (reversible).
- Copper-bearing and inert IUDs have no effect on amount or quality of breastmilk.
- Can be used through menopause (one year amenorrhea after the last menstrual period).
- No interactions with any medicines.
- Can be inserted immediately postpartum or following a pregnancy loss in the absence of infection.

Disadvantages

- Side effects:
    - *Menstrual changes (common in the first three months)*
    - *Longer and heavier menstrual periods*
    - *Spotting between periods*
    - *More cramps or pain during periods*

- Does not protect against STIs.
- Some pain and bleeding or spotting may occur after insertion.
- Client requires access to health provider for removal.

When to Insert

- Any time during the menstrual cycle when:
  - *Pregnancy has been ruled out.*
  - *Insertion is easier.*
  - *Minor bleeding caused by insertion is less likely to upset the woman.*
  - *Less pain.*
- Within 48 hours after childbirth (the best time is within 10 minutes after delivery of the placenta).
- Four weeks after childbirth for copper devices, six weeks for others.
- After pregnancy loss (immediately, if no infection is present).
- Immediately after stopping another method.
- Anytime if the woman is an eligible candidate and is not pregnant.

Steps for IUD Counseling and Clinical Skills

Pre-Insertion Counseling

1. Greet client in a friendly and respectful manner.
2. Ask client about her reproductive goals.
3. Reaffirm that the client's contraceptive choice is the IUD.
4. If IUD counseling was not done, provide or arrange for counseling prior to performing procedures.
5. Interview client to rule out pregnancy following the pregnancy assessment guidance in Attachment 1.
6. Assess client's knowledge about the IUD's major side effects. Describe as necessary.

7. Be responsive to client's needs and concerns about the IUD, answer her questions.
8. Describe the insertion procedure and what to expect.

Pre-Insertion

1. Obtain or review brief reproductive health history.
2. Wash hands with soap and water.
3. Ask client if she had emptied her bladder.
4. Palpate abdomen and check for suprapubic or pelvic tenderness and adnexal abnormalities.
5. Tell client what is going to happen before you do it and encourage her to ask questions.
6. Put new examination (disposable) or HLD or sterile (reusable) gloves on both hands.
7. Perform speculum examination.
8. Collect specimens or vaginal and cervical secretions, if indicated.
9. Perform bimanual examination.
10. Perform rectovaginal examination, if indicated.
11. Remove gloves and dispose (single use) or immerse (reusable) in chlorine solution, according to Infection Prevention Guidelines.
12. Perform microscopic examination, if indicated (and if equipment is available).
13. Wash hands thoroughly with soap and water and dry with clean cloth or allow to air dry.
14. Load IUD through into the sterile package without contaminating the device.
15. The period of time between loading the IUD and insertion should not be more than five minutes.

IUD Insertion

1. Put examination (disposable) or HLD or sterile (reusable) gloves on both hands.
2. Insert vaginal speculum (and vaginal wall elevator if using single-valve speculum).
3. Swab cervix and vagina with antiseptic.
4. Gently grasp cervix with tenaculum.
5. Sound uterus (see "*Attachment 2: IUD Insertion Techniques*").
6. Set blue depth gauge on the loaded IUD inserter to the depth on the sound.
7. Insert the IUD using the withdrawal technique (see *Attachment 2*).
8. Cut strings and gently remove tenaculum and speculum.

Post-Insertion

1. Place used instruments in chlorine solution for decontamination.
2. Dispose of waste materials according to guidelines.
3. Remove reusable gloves and place them in chlorine solution.
4. Wash hands with soap and water.
5. Complete client record.

Post-Insertion Counseling

1. Teach client how and when to check for string.
2. Tell the client to:
   - *Wash hands.*
   - *Sit in a squatting position.*
   - *Insert one or two fingers into the vagina until you feel the strings. Do not pull the strings or you can pull the IUD out of place.*
   - *Wash hands again.*
3. Assure the client that she can have the IUD removed at any time.
4. Observe the client for at least 15 minutes before sending her home.

5. Provide the client with a written record of the date of IUD insertion and when it should be removed.
6. Remind the client she may return at any time if she experiences problems.
7. Return immediately to the clinic if the following **Warning Signs** occur:
   - *Delayed menstrual period with symptoms of pregnancy (ectopic, intrauterine).*
   - *Abnormal vaginal bleeding, bleeding between periods.*
   - *Increasing or severe abdominal pain, and/or tenderness.*
   - *Fainting, not feeling well; fever and chills.*
   - *String missing or string seems shorter or longer.*
   - *Feel something hard in the vagina or at the cervix (part of the IUD).*
   - *Husband feels the IUD string during sex (come to clinic to have the string cut shorter).*
   - *Heavy, prolonged bleeding.*
8. Give the client a return visit appointment four to six weeks (following first post-insertion menses) for check up and pelvic examination after insertion.
9. Remind the client that she must use condoms consistently if she might be at risk of STIs or HIV infection.

When to Remove the IUD

Remove the IUD in the following situations:

- Client wants the device removed.
- Client desires pregnancy.
- Acute PID.
- Perforated uterus.
- IUD out of place; partial expulsion.
- Abnormal, very heavy bleeding.
- Lifespan of copper or hormonal bearing IUD has expired.
- Woman has reached menopause (one year since last menstrual period).

Pre-Removal Counseling

1. Greet woman in friendly and respectful manner.
2. Ask client reason for removal and answer any question she may have.
3. Review client's present reproductive goals and other options for contraception.
4. Describe the removal procedure and what to expect.

Removal of IUD

1. Wash hands thoroughly with soap and water and dry with clean cloth.
2. Put new examination (disposable), high-level disinfected (HLD) or sterile (reusable) gloves on both hands.
3. Perform bimanual examination.
4. Insert vaginal speculum and look at length and position of strings.
5. Swab cervix and vagina with antiseptic.
6. Grasp strings close to cervix and pull gently but firmly to remove IUD.
7. For routine removals, take out the IUD during menses—it is easier then.
8. To avoid breaking the string, apply gentle, steady traction and remove the IUD slowly. If the IUD does not come out easily, refer to a specialist.

Post-Removal

1. Place used instrument in chlorine solution for decontamination.
2. Dispose of waste materials according to guideline.
3. Remove reusable gloves and place them in chlorine solution.
4. Wash hands with soap and water.
5. Record IUD removal in client record.

Post-Removal Counseling

1. Discuss what to do if client experiences any problems.
2. Counsel client regarding a new contraceptive method, if desired.

3. Assist client in obtaining a new contraceptive method or provide a back-up method. The new method can be started immediately in the absence of pregnancy or other precautions.

IUD: Management of Side Effects and Other Problems

Symptoms/ Situation	Assessment	Management
Irregular bleeding, prolonged or heavy bleeding	**Ask** client about: · When IUD was inserted. · Number of bleeding days. · Number of pads more than usually used. · Abdominal pain, fever. · Possible risk of STI. **Perform** pelvic exam if history suggested infection.	If history does not suggest infection and insertion was less than 3 months ago, reassure client that menstrual changes will diminish with time. Counsel client to eat iron-rich foods (dried fruit, dark leafy green vegetables, red meats). Offer iron supplements if indicated. If bleeding is annoying, offer client ibuprofen, or any other non-steroidal anti-inflammatory drug (**NOT** aspirin) to help reduce the bleeding. If client is unsatisfied with management and wants the device removed, counsel for another method, provide it immediately, and remove the IUD. If history and physical exam suggest pelvic infection, follow management for "*Lower Abdominal Pain*."
Lower Abdominal Pain (suggesting pelvic infection)	**Ask** client about: · Missed period. · Recent birth or pregnancy loss. · Pain or tenderness when abdomen is pressed. · Vaginal bleeding. · Foul-smelling vaginal discharge. **Take** temperature (fever, 38.3ºC). **Perform** pelvic exam looking for: · Abnormal cervical or vaginal discharge. · Pain when cervix is moved during exam.	If the client shows one or more of these symptoms during the history or physical exam, refer to a provider who knows how to manage this complication. Management should include: · Immediate treatment of gonorrhea, chlamydia, **AND** trichomonas (all at the same time). · Removal of the IUD (with counseling for another method and provision of condoms). · Follow-up appointment given for 48-72 hours after antibiotic treatment has started, evaluating improvement. If no improvement or development of an abscess, hospitalization is indicated. · If client improves after starting treatment, give follow-up appointment after client has completed all the medication.

	· Adnexal tenderness (area of F. tubes and ovaries). · Recent sex partner with urethral discharge or treated for STI.	· Treat sex partner(s)/husband.
Symptoms/ Situation	**Assessment**	**Management**
Pregnancy (missed period; late, abnormally lighter period)	**Ask** client about: · LMP (normal). · Current period, if different. · Presence of symptoms of pregnancy. **Note:** *Symptoms of ectopic pregnancy include missed period, nausea, breast tenderness; abnormal vaginal bleeding, abdominal pain or tenderness, anemia, fainting (suggesting shock).* **Do** pregnancy test, if possible. **Perform** pelvic exam looking for uterine or adnexal enlargement.	**If client is <13 weeks pregnant and IUD strings are visible:** · Explain that it is best to remove the IUD to avoid severe infection. · Explain that she will have a slightly increased risk of spontaneous abortion. · If client consents, remove IUD or refer for removal. · Counsel client to come to the clinic immediately if she has heavy bleeding, cramping, pain, fever, and/or abnormal vaginal discharge. **If the IUD strings cannot be seen and/or the pregnancy is beyond the first trimester:** · Explain to the client that she is at risk of serious infection that could be life threatening. · If the IUD cannot be removed, emphasize that the risk of spontaneous abortion **AND** infection is significantly increased. She must be observed closely by a physician and must come to the clinic **immediately** if she has heavy bleeding, cramping, pain, fever, and/or abnormal vaginal discharge. *If ectopic pregnancy is suspected, refer **immediately** to medical management for immediate surgery.*
Cramping and pain, (in the absence of infection or pregnancy)	**Ask** client when the cramping occurs in relation to insertion; ask questions to determine presence of infection or pregnancy.	If immediately following insertion or associated with menses, give mild pain relievers, paracetamol every 4 hours, or ibuprofen 400 mg, every 4 hours, as needed.

Contraceptive Methods

Method 4: DMPA Injectable Hormone (Depo-Provera)

Definition

Depot medroxy progesterone acetate (trade name: Depo-Provera) is a highly effective, reversible contraceptive method. It is a three-month injectable contraceptive that contains a synthetic progestin resembling the female hormone progesterone. Each dose contains 150 mg of depot-medroxyprogesterone acetate that is released slowly into the blood stream from the site of the intramuscular injection that provides the user with a safe and highly effective form of contraception.

Types of Depo-Provera

- Depo-Provera 150 mg every three months.

How it Works

The injectable prevents pregnancy by stopping ovulation and thickening the cervical mucus, making it difficult for sperm to pass through.

Effectiveness

Depo-Provera is very effective: 0.3 pregnancies per 100 (1 pregnancy in 333 women) women in first year of use when injections are regularly spaced three months apart.

Who Should Use Depo-Provera?

Depo-Provera is appropriate for women who:

- Desire convenient, long- term method and do not want a daily pill or a method associated with sexual intercourse
- Cannot tolerate estrogen or combined oral contraceptives
- Are of any reproductive age or parity and want highly effective reversible contraception.
- Breastfeed (six weeks after childbirth).
- Just gave birth or had a miscarriage
- Smoke cigarettes
- Have a history of ectopic pregnancy

Who Should Be Monitored More Closely By a Physician?

A physician should monitor and follow-up women who wish to use Depo-Provera who also have:

- A history of or diagnosed benign breast disease (not to be used when breast cancer is current)
- Serious liver disease
- Undiagnosed abnormal vaginal bleeding
- Amenorrhea not related to pregnancy or lactation
- Heart disease (Ischemic)
- Acute liver disease, *e.g.*, viral hepatitis
- Diabetes with vascular disease or for more than 20 years
- Hypertension, severe (greater than 160/100)

Advantages

- Effective, long-acting, reversible method.
- Requires no preparation before intercourse.
- Convenient and confidential method.
- Helps prevent uterine fibroids.
- Reduces frequency of ovarian cysts.
- Protects against ectopic pregnancy.
- Reduces incidence of pelvic inflammatory disease.
- Relieves premenstrual tension.
- Less likely to develop anemia due to significantly reduced menstrual flow.
- Reduces symptoms of endometriosis.
- Reduces sickle cell crisis.
- Decreases the frequency of epileptic seizures in women with epilepsy.

Disadvantages

- Requires injections every three months.
- Slower return to fertility: occurs after approximately six to eight months.
- Does not protect against HIV and STIs.
- Changes menstrual pattern (light spotting or heavy bleeding at first or amenorrhea after the first year of use).
- May cause weight gain, breast tenderness, mood changes such as depression, loss of interest in sex.

When to Start Depo-Provera

- Depo-Provera can be started any time as long as back up method is given.
- Within the first seven days after menstrual bleeding has started (no back-up will be required).
- Immediately or six weeks postpartum, if not breastfeeding.
- After six months if the client is using LAM.
- Immediately following a pregnancy loss.
- Whenever you can be sure that the client is not pregnant (see "*Attachment 1: Client Assessment for Pregnancy*").

How to Administer Depo-Provera

Prepare and administer Depo-Provera injection using the following procedure:

1. Wash hands.
2. Check vial for contents (dosage).
3. Gently shake Depo-Provera vial.
4. Open sterile package.
5. Attach a sterile or high-level disinfected (HLD) needle to syringe (21 or 23 gauge IM needle with 2 or 5 ml syringe).

6. Draw Depo-Provera into syringe.
7. Wipe site of injection with antiseptic.
8. Allow antiseptic to dry.
9. Administer 150 mg deep IM in deltoid (arm) or gluteal (hip) muscle. Do not massage the injection site.

Client Assessment and Counseling

1. Screen client for Depo-Provera medical eligibility by asking the following questions. If she answers "no" to all of the questions, she can use Depo-Provera. If she answers "yes", seek guidance or help her choose another effective method.
    a. *Are you breastfeeding a baby less than six weeks old?*
    b. *Do you have problems with your heart or blood vessels?*
    c. *Do you have or have you ever had breast cancer?*
    d. *Do you have cirrhosis of the liver, liver infection or tumor (Are her eyes unusually yellow)?*
    e. *Do you think you are pregnant?*
    f. *Do you have vaginal bleeding that is unusual for you?*
2. Ask client what she knows about Depo-Provera, and correct any myths, rumors, or misinformation.
3. Explain how Depo-Provera works and its effectiveness in preventing pregnancy.
4. Explain the potential side effects of Depo-Provera:
    - *Causes changes in menstrual bleeding pattern, such as irregular bleeding, menses, or spotting (60-70% of women); no periods (amenorrhea, 50-80% of women with Depo-Provera).*
5. Explore with the client how irregular or increased bleeding may affect her daily life, and if delay in return of fertility will concern her; if problematic, she may need to consider another method.

6. Explain that she will return to fertility approximately six months after her last injection.
7. Explain that she will need an injection every three months
8. Ask the client if she has any questions and respond to them.
9. Record findings in the client record.
10. Client Instructions
    - *Use a back-up method for one week after your first injection (not necessary if injection is given during the first seven days after the beginning of a normal menstrual period). Have back up method ready for client to select.*
    - *Return to the clinic every three months for the next injection (client may be up to two weeks late in returning and still be protected from pregnancy; if more than two weeks late for injection, advise client that she should use a back-up contraceptive method).*
    - *Remind client of menstrual changes that she may experience and possible weight gain.*
    - *Remind client to inform other health care providers she is on Depo-Provera.*
    - *Reassure client she may return at any time if she has questions or concerns.*
    - *Discuss with client to return immediately if she has any of the following early **Warning Signs**:*
        - Heavy vaginal bleeding
        - Excessive weight gain
        - Repeated, severe headaches (if beginning or getting worse with DMPA use AND involving blurred vision, temporary loss of vision, seeing flashing lights or spots, or trouble speaking or moving)
        - Severe abdominal pain
    - *Have client repeat important instructions back to you.*

- *Give client time and date of next appointment.*
- *Document the visit in client record.*

Follow-up Visit

- Update client's address and contact information.
- Ask about any problems, complaints, or warning signs.
- Repeat the history checklist.
- Assess the client's satisfaction with method:
  - *If client is satisfied with Depo-Provera method, no warning signs exist, and she wishes to continue, give Depo-Provera injection.*
  - *If client has developed any warning signs or wants to discontinue Depo-Provera, help her make an informed choice for other methods.*

Depo-Provera: Management of Side Effects and Other Problems

Symptoms/ Situation	**Assessment**	**Management**
Amenorrhea (no menstrual period)	**Ask** the client for the date of her last normal menstrual period; date of her last injection; when she started using the injection.	Reassure the client that: · Amenorrhea is normal among women using DMPA and is not dangerous to her health. · She is not pregnant nor is she sterile. It does not mean she will not be able to become pregnant when she stops. It may take up to 9 months for her periods to return after stopping DMPA. · Menstrual blood is not building up in her body.
Spotting or bleeding between monthly periods.	**Ask** the client if she has had any exposure to STI.	Reassure the client that spotting or bleeding between periods is common during the first months of DMPA use. It is not dangerous to her health and will improve over time. If irregular bleeding is caused by STI, she can continue with DMPA; treat the infection according to clinic protocols. Provide condoms, if the client is able to have her partner use them.

Heavy or prolonged bleeding (twice as long or as much as usual period)	**Ask** about exposure to STI or other possible causes for heavy bleeding.	If caused by STI, treat according to clinic protocols. If caused not related to DMPA and cause is not known, refer to medical management. Though rare, it can occur. However, if bleeding may be due to DMPA, and the are no precautions to estrogen use: · Offer anti-inflammatory drug such as Ibuprofen, **not** aspirin, or · Offer COC for 7-21 days (may require 2-3 cycles of COCs), or · If the previous injection was given more than 4 weeks ago, give another injection. Counsel client to eat foods that are rich in iron (dried fruit, dark leafy greens, beef, beets).

Contraceptive Methods
Method 5: Lactational Amenorrhea Method (LAM)

Definition

LAM is a modern, natural, temporary family planning method that encourages a state of infertility by suppressing ovulation through a sustained, high frequency pattern of breastfeeding.

How it Works

LAM stops ovulation (prevents the release of the egg from the ovary).

Effectiveness

LAM can be more than 98 percent effective in preventing pregnancy, when the following criteria are met:

1. The woman is fully or nearly fully breastfeeding, and
    - *No more than four hours pass between any two daytime feeds.*

- *No more than six hours pass between nighttime feeds.*
- *Other foods or drink are not substituted for breastmilk.*

2. The woman's menstrual period has not returned.
3. The baby is less than six months old (See "*Attachment 3: Algorithm for LAM*").

Advantages

- Available to all breastfeeding women and has no side effects.
- Immediately protective.
- No commodities or supplies are required.
- Breastfeeding has proven health benefits for mother and infant.
- Is a bridge to using other contraceptives.
- Consistent with religious and cultural practices.
- Can improve breastfeeding and weaning patterns.
- Allows breastfeeding mothers to postpone use of hormonal contraceptive until the infant is more mature.

Disadvantages

- Only effective until menses returns or up to six months (effectiveness after six months is not certain).
- Breastfeeding pattern may be difficult to maintain, especially for working women.
- Can be used only by breastfeeding women.
- Provides no protection against STIs and HIV.

Initiating LAM and Client Instructions

Support the mother in starting LAM as soon as possible after the infant is born. Early and frequent breastfeeding helps a woman produce enough milk for her infant's health and well-being.

Encourage breastfeeding often and on demand (8-10 times in each 24-hour period). Daytime feedings should not be spaced more than four hours apart and nighttime feedings should not be spaced more than six hours apart.

Explain to the mother that she should introduce other food and drinks when the infant is six months old. At that point, she should breastfeed first, and then give the other food and drink. Complementary contraceptives will need to be introduced just before introducing the infant to other foods.

Advise the mother to begin complementary contraceptives immediately if any of the following occurs:

- Her menstrual period returns.
- The infant feeds less frequently or begins taking other food and drink.
- The infant is six months old.
- She wants to change to another method (See Table 5).

Set up an appointment with the client for a return visit at two weeks postpartum, six to eight weeks postpartum, three months postpartum, and six months postpartum.

Follow-up Visit

1. Assess the client's satisfaction with LAM. Ask her if she has any questions or concerns.
2. Ask the client if she is having any difficulties with breastfeeding. If yes, manage according to guidelines or refer.
3. Ask the mother the three criteria questions:
    - *Has your menstrual period returned?*
    - *Has the infant been feeding less frequently or started taking other food and/or drink? Is the infant sleeping through the night?*
    - *Is the infant 6 months old or beginning to sit up?*
4. If the client is ready for a change of contraceptive method, counsel and initiate her on her chosen method and supply her with the method.
5. Offer and/or provide a back-up method (condom, spermicide, ECP).

6. Give an appointment for the next visit, depending on whether she is continuing with LAM or will be starting a new method.

Table 5. Contraceptive Options for Breastfeeding Women

First Choice	Second Choice	Third Choice
· Non-hormonal method	· Progestin-only methods [After 6 weeks postpartum]	· Combined estrogen/progestin methods [Use after 6 months postpartum or after weaning]
· LAM · Condom · Spermicides · IUD · Fertility Awareness Methods (CMM or Symto-thermal)* · Voluntary Surgical Contraception	· Minipills · DMPA · Norplant	· Combined oral contraceptives

**Requires an identifiable pattern of signs of fertility.*

Contraceptive Methods
Method 6: Condoms

Definition

A condom is a sheath or covering to fit over a man's erect penis.

Types of Condoms

Most condoms are coated with dry lubricant or with a spermicidal gel. They may be made of latex, plastic, or animal products. Different sizes, shapes, colors, and textures may be available.

IMPORTANT: Condoms made of animal products DO NOT protect against STIs, including HIV.

Effectiveness

Must be used correctly every time to be highly effective. Three pregnancies for 100 couples in the first year of near-perfect use. Fourteen pregnancies for 100 couples in the first year of typical use.

Who Should Use Condoms?

Condoms are an appropriate method of contraception for:

- Men who want to participate in family planning.
- Couples who want a temporary method, need a back-up method, or are just starting a new method.
- Couples at risk for STIs, including HIV.

Who Should Not Use Condoms

Condoms are not appropriate for:

- Men with severe allergy to latex.
- Men who desire a more long-term and effective method.
- Men who are not willing to be consistent users.
- Men who cannot consistently maintain an erection during condom use.

Advantages

- Prevention of STIs, including HIV/AIDS, and pelvic infections.
- Immediately effective, easily available, and economical.
- No side effects.
- No effect on breastmilk.

- Helps prevent ectopic pregnancies.
- Helps prevent premature ejaculation (last longer during sexual intercourse).
- Can be used by men of any age.

Disadvantages

- Effectiveness is dependent on correct use.
- Must be used with every act of sexual intercourse to be effective.
- May reduce sensitivity of penis during intercourse.
- Supply must be available when needed.
- Condoms (latex) weaken if oil-based lubricant is used.

IMPORTANT: Urge clients at risk of STIs including HIV and AIDS to keep using condoms despite any dissatisfaction. Help clients problem-solve their difficulties with the condom. Alternatively, make female condoms available for interested couples, if possible.

Initiation and Client Instructions

1. Ask if client has any questions or concerns and respond appropriately.
2. Ask client about prior experience with condoms. Check if the client knows how to use a condom. Ask the client to demonstrate by putting the condom on a penis model, banana, stick, or two fingers. Have the client repeat the demonstration, if necessary.
3. Show the client the condom and tell the client:

- *Condoms should be lubricated to prevent tears. Use water-based lubricants include spermicides, or glycerin*
- ***Do not use** lubricants made from oil, such as cooking oil, baby oil, coconut oil, mineral oil, petroleum jelly (such as Vaseline), skin lotions, suntan lotions, cold creams, butter, cocoa butter or margarine.*
- ***Remember**, generous lubrication prevents condom breakage during sexual intercourse.*

4. To use condoms effectively:
   - *Handle condoms carefully. Fingernails and rings can tear them.*
   - *Do not unroll condoms before use; this may weaken them and make them more difficult to put on. Before vaginal entry, place the condom on the tip of the penis and unroll it to the base of the penis.*
   - *After ejaculation, hold the rim of the condom at the base of the penis so it will not slip off as you remove your penis. Remove the penis from the vagina before completely losing your erection.*
   - *Take off the condom without spilling the semen on or near the vaginal opening.*
   - *Throw the condom away in a garbage, latrine, or burn or bury it. Do not leave it where children will find it and play with it.*
   - ***Do not use a condom more than once.***
5. If a condom breaks:
   - *Immediately insert a spermicide, if available, into the vagina. Washing both the vagina and penis with soap and water may also reduce the risk of STIs.*
   - *Some clients may want to use emergency oral contraception to prevent pregnancy. Go with your partner to the clinic for ECP, if available.*
6. Explain to clients that a new condom is required when the one they have:

- *Has torn or has damaged packaging.*
- *Has a manufacturing date on the package that is more than five years past.*
- *Is uneven or changed in color.*
- *Feels brittle, dried out, or very sticky.*

7. Explain that condoms should be stored in a cool, dark place, if possible, since heat, light, and humidity will damage condoms.
8. Remind clients that they can return at any time for resupply or for answers to questions.
9. Urge clients to return to the clinic if they or their sex partner experience:
   - *Symptoms of STI – sores on genitals, pain while urinating, or discharge (drip).*
   - *An allergic reaction to condoms (itching, rash, irritation).*
10. Give each client a three-month supply or more (approximately 60 or more condoms) or ask the client how many are needed.
11. Provide spermicide or ECP as back-up and give the necessary instructions for use.

Follow-up Visit

- Ask clients if they are satisfied with the method or have questions.
- Ask clients if they are using the condoms with every act of sexual intercourse.
- Confirm clients' knowledge of how to put on and remove the condom by asking each client to demonstrate using a penis model, banana, fingers or a stick.
- If a client is satisfied with the method,
  - *Give a generous resupply of condoms.*
  - *Remind the client to return if either partner has any symptoms of STI.*
  - *Offer spermicide for extra protection or ECP for emergency use, giving appropriate instructions.*

- *Give a return visit at the client's convenience or need.*

Condoms: Management of Side Effects and Other Problems

Symptoms/ Situation	Assessment	Management
Breakage of condom	**Ask** client: · How he uses the condom, · Whether he uses lubricant; if he uses lubricant, what it is.	If not using lubricant, explain that lubrication will significantly reduce the risk of breaking. Suggest that the client allow more time for foreplay to encourage the woman to naturally lubricate and/or use a water-based lubricant or a spermicide before penile-vaginal contact. If the client is using lubricant, make sure it is not oil-based. Oil-base lubricants will cause the condom to break more quickly. Suggest water-based products or a spermicide that are water-based for lubrication and additional contraceptive protection. Encourage continued use of condoms if client is at risk of STI.
Condom allergy (or allergy to the lubricant, itching or rash on genitals in contact with condom or lubricant.	**Ask** client what condom he has been using and/or lubricant his partner has been using. **Inspect** genitalia if complaining of itching and rash.	Suggest that the client change the brand of condom and/or the brand of spermicide or lubricant. Explore availability of plastic condoms. If itching and/or rash continue, re-evaluate for possible infection. For clients at risk of STIs, urge continuation of condom use since it is can help prevent STI transmission.
Erectile difficulty with condom use	**Ask** the client to describe the circumstance when he has difficulty achieving or maintaining an erection while using condoms.	Counsel the client to explore ways to make condom use with his partner more pleasant, less embarrassing, more creative. Suggest using a small amount of water-based lubricant on the penis and extra lubricant on the outside of the condom to help increase the sensation to maintain an erection.

Reduced sensation		Suggest using a small amount of water-based lubricant on the penis and extra lubricant on the outside of the condom to help increase the sensation to maintain an erection.

Contraceptive Methods
Method 7: Vaginal Spermicides

Definition

Spermicides are non-prescription preparations made of a carrier material or base such as foam, cream or gel, and a chemical agent that kills sperm.

Types of Spermicides

Spermicides include foaming tablets or suppositories, melting suppositories, foam, melting film, jelly, and cream.

How it Works

Spermicides kill sperm or make sperm unable to move toward the egg.

Effectiveness

- In perfect use, 6 pregnancies occurred per 100 women using spermicides in the first year.
- In typical use, 26 pregnancies occurred per 100 women using spermicides in the first year.
- Effectiveness is dependent on the woman using the method correctly **every time** she has sex, and on the type of spermicide used. The spermicide must be correctly placed in the vagina no more than one hour before intercourse.

Who Should Use Spermicides?

Spermicides are an appropriate method of contraception for couples who:

- Want additional contraceptive protection with use of male condoms.
- Need lubrication during intercourse due to hormonal changes (breastfeeding, perimenopausal women).
- Want an economical, over-the-counter contraceptive.

Who Should Not Use Spermicides or Be Monitored More Closely By a Physician?

Spermicides may not be appropriate under the following conditions:

- Couples who are allergic to the chemicals in spermicides.
- Women who are at risk of HIV and STIs.
- Women who need to use the method very frequently (more than every other day).

Advantages

- A safe, easy-to-use method that the woman can control.
- Helps prevent **some** STIs (*e.g.*, conditions causing PID).
- Provides contraceptive protection only when needed.
- Has no hormonal side effects.
- Can be stopped any time.
- Can be used following pregnancy loss or postpartum.
- Provides lubrication.
- Use does not require a health care provider.

Disadvantages

- Common side effects include:
  - *Irritation to woman or her partner if used several times per day.*
  - *Allergic reaction by woman or her partner.*
  - *Can cause more frequent occurrence of urinary tract infection.*
- Requires following instructions correctly and consistently.

- May need to interrupt sex if not inserted before hand.
- Spermicides may be considered messy.
- Must time the insertion of spermicide into the vagina before having intercourse.

Initiation and Client Instructions

1. Show the client the particular spermicide she will be using.
2. Demonstrate insertion using a pelvic model.
3. Explain to the client to:
    - *Wash her hands with soap and water.*
    - *Allow time for the suppository to melt or foam.*
    - ***Foam:*** *Shake the foam at least 20 times.*
        - Fill the applicator by pressing it down on the nozzle of the container until the applicator is full.
        - Insert the applicator deeply into your vagina close to the cervix, then push the plunger to release the foam.
    - ***Cream or Jelly:*** *Fill the applicator by attaching it to the mouth of the tube and squeezing the tube until the applicator is full.*
        - Insert the applicator deeply into your vagina close to the cervix, then push the plunger to release the cream or jelly.
    - ***Suppository:*** *Remove the wrapping and slide the suppository into your vagina.*
        - Push it along the back wall of the vagina until it rests near the cervix.
    - *Use spermicide every time you have sex and with each act of sexual intercourse.*
    - *After intercourse:*
        - Do not douche. Wait for at least 6 hours, if you choose to douche.

- Wash the applicator in warm soap and water and allow to air-dry.

4. Give the client an adequate supply of spermicide for the time until her follow-up visit. Schedule the follow-up visit at the client's convenience.
5. Encourage the client to return when she needs more spermicide.

Follow-up Visit

- Ask the client if she is satisfied with the method; if she has any questions or problems
- Ask the client whether she has symptoms of urinary tract infection. If symptoms are present, refer for management.
- Give resupply of spermicide, if she is satisfied with the method, or counsel and initiate her preferred method.

Vaginal Spermicides: Management of Side Effects and Other Problems

Symptoms/ Situation	Assessment	Management
Allergic reaction (itching, burning of genitalia)	**Ask** client for: · Signs of allergy (itching, burning, genital swelling since beginning to use spermicide), · Signs of infection (abnormal vaginal discharge, foul odor, itching of vulva. **Perform** speculum and bimanual exam if history suggested infection.	If history and/or pelvic do not indicate infection, suggest that the client use a different type of spermicidal product. If history and/or pelvic indicate infection, treat or refer for appropriate management.

Contraceptive Methods
Method 8: Norplant Implant

Definitions

The Norplant implant system is a set of six small plastic capsules the size of a matchstick, containing progestin. The capsules are inserted under the skin of a woman's upper arm, slowing and steadily releasing hormones for at least five years.

How it Works

Norplant implants prevent pregnancy by:

- Inhibiting (stopping) ovulation.
- Thickening and decreasing the amount of cervical mucus, making it more difficult for sperm to penetrate.
- Thinning the uterine lining (endometrium).
- Disrupting normal functions of the corpus luteum.

Effectiveness

Norplant is very effective, with one pregnancy per 1,000 women using the method in the first year, and 1 in 62 women using the method over the five years.

Who Should Use Norplant?

Norplant is an appropriate contraceptive method for:

- Women breastfeeding (after six weeks; **does not interfere with milk production**)
- Women who do not want more children, but do not want or cannot access voluntary surgical contraceptive services.
- Women who can not use estrogen.
- Women who smoke.
- Women with high blood pressure, headaches, benign breast disease; heart disease; diabetes; sickle cell, pelvic inflammatory disease (PID), epilepsy, gallbladder disease.

Who Should Not Use Norplant or Be Monitored More Closely By a Physician?

Norplant may not be appropriate for:

- Pregnant women (see "*Attachment 1: Client Assessment for Pregnancy*")
- Women with unexplained vaginal bleeding
- Women with a history of or diagnosed current breast cancer
- Diagnosed acute and chronic liver disease

Advantages

- Highly effective.
- Effective after 24 hours of insertion.
- Reversible, long-term method with immediate return of fertility at removal.
- Not associated with sexual intercourse; requires no daily behavior.
- May help prevent endometrial cancer.
- May make sickle cell crises less frequent and less painful.
- Reduces or stops menstrual blood flow.

Disadvantages

- Possible side effects:
  - *Menstrual changes: light spotting or bleeding between periods; prolonged bleeding (decreases after first few months); amenorrhea (considered an advantage by some women)*
  - *Headache, dizziness*
  - *Breast tenderness*
  - *Nausea*
  - *Nervousness*
  - *Acne and/or skin rash*
  - *Appetite change*
  - *Weight gain or loss*

- *Hair loss or growth on face*

- Requires removal by provider; may be difficult to remove.
- Minor surgical procedure required for insertion and removal of capsules.
- Does not protect against STIs, including HIV.

When to Insert

- Anytime it is reasonably certain that the client is not pregnant.
- First seven days of menstrual period (no back-up is required).
- After day eight of the menstrual cycle, use back-up method for 48 hours after insertion.
- Immediately or six weeks postpartum, if not breastfeeding or partially breastfeeding.
- Six months postpartum, if breastfeeding full.
- Immediately or within seven days following a pregnancy loss.

IMPORTANT: Women choosing Norplant must have convenient access for insertion and removal.

Initiation and Client Instructions

1. Counsel client regarding this method and answer the client's questions.
2. Help client understand that she can have the implants removed at anytime she wants.
3. Explain the insertion procedure to client.
4. Follow infection prevention procedures.
5. Give local anesthetic at insertion site.

6. Insert the six capsules according to the manufacturer's instructions.
7. Close incision with adhesive bandage, cover with gauze.
8. Inform client that bruising and slight bleeding at insertion site is normal and common during the first few days after insertion.
9. Give the client the following instructions:
    - *Keep the area dry for four days (take off gauze after two days, adhesive after five days).*
    - *You may experience soreness and/or swelling after anesthesia wears off.*
    - *Return to the clinic if pain continues without improvement after the first few days.*
    - *Return for removal when desired or when the five years is going to expire.*
    - *Return to the clinic immediately if you experience any of the following:*
        - Symptoms of pregnancy (missed period after several regular cycles)
        - Abdominal (severe) pain, tenderness, fainting (ectopic pregnancy)
        - Infection at insertion site
        - Very heavy menstrual bleeding
        - Severe headaches
        - Skin and/or eyes becoming yellow (jaundice).
10. Give the client a card with the date of implant insertion and date for its removal.
11. Give the client a follow-up visit appointment within four weeks of insertion.

Follow-up Visit

- Assess the client's satisfaction with the method; ask questions regarding concerns, problems.
- Ask about the client's bleeding pattern.
- Encourage the client to return when problems arise, or when removal is desired or indicated.

Drug Interactions

Certain drugs may affect the effectiveness of Norplant. A back-up method must be used when the following drugs are prescribed:

- Rifampicin
- Barbiturates
- Phenytoin (anticonvulsant)
- Phenybutazone.

Norplant: Management of Side Effects and Other Problems

Symptoms/ Situation	Assessment	Management
Amenorrhea (no menstrual periods)	**Ask** the client for the date of her last normal menstrual period; whether she has taken any medication that would interfere with Norplant without using a back-up method.	Reassure that client that she is not: . Pregnant. Absence of periods is not dangerous to her health. . Sterile. She will be able to become pregnant when capsules are removed. . Building up blood in her body. If client is dissatisfied with amenorrhea, and wants the capsules removed, refer for removal and counsel for another method.
Spotting or bleeding between periods	**Ask** about: . Exposure to STI. . Symptoms of pregnancy.	Explain that irregular periods and prolonged bleeding are common and can be expected during the firs 3-6 months of use. It is not harmful to the woman's health. If caused by STI, treat according to clinic protocols. If suspected pregnancy, refer for removal of capsules and antenatal care. If spotting and bleeding is likely to be due to Norplant and is unacceptable and there are no precautions to the use of estrogen: . Offer anti-inflammatory drug such as Ibuprofen, **not** aspirin, or . Offer COC for 7-21 days (1 cycle).
Heavy or prolonged	**Ask** about:	Explai]hs of use, but heavy bleeding

bleeding	· Exposure to STI. · Symptoms of pregnancy.	is rare. · Offer anti-inflammatory drug such as Ibuprofen (**not** aspirin); or · Offer COC for 7-21 days (may need to use a 50 mcg COC). · Check for anemia and treat or refer if anemic. · Give dietary counseling for increasing iron-rich foods.
Severe **abdominal pain**	**Ask** about: · Exposure to STI. · Symptoms of pregnancy	Check or refer for evaluation of possible ovarian cyst or tumor, twisted ovarian follicle, or ectopic pregnancy. If due to STI exposure, treat according to clinic protocol or refer for medical management.

Contraceptive Methods

Method 9: Fertility Awareness Methods (Cervical Mucous Method)

Definition

Fertility Awareness Methods (FAM) are methods for preventing or planning pregnancy by observing naturally occurring signs and symptoms of the fertile days and infertile days within the menstrual cycle.

Cervical Mucus Method (CMM) is a FAM based on identifying and interpreting cervical mucus secretions and vaginal sensations as they change before, during, and after ovulation.

Types of Fertility Awareness Methods

FAM includes CMM, calendar method, basal body temperature, and symptothermal methods. From this category of contraception, CMM is the method of choice.

How it Works

FAM in general and CMM in particular prevent pregnancy by avoiding sexual intercourse in the presence of signs and symptoms of ovulation (fertile days) and during menstrual bleeding, to avoid the possibility of sperm meeting an egg.

Effectiveness

For CMM, three pregnancies in 100 women with perfect use during the first year. Pregnancy rates may be higher in typical use. For CMM, as well as the other fertility awareness methods to be effective, **the couple** must be committed to following the rules of use, since it requires periodic abstinence.

Who Should Use CMM?

CMM is an appropriate contraceptive method for couples who:

- Are willing to work together in preventing unwanted pregnancy.
- Are concerned about side effects associated with scientific methods of contraception.
- Have religious beliefs or practices that prohibit “artificial” contraception.

Who Should Not Use CMM?

CMM is not appropriate for:

- Couples for whom prevention of pregnancy is critical.
- Couples for whom there is absence of male cooperation in following the rules.
- Those who are unable to identify and/or interpret and record signs of fertile and infertile days.
- Women not willing to touch their vaginal fluids/cervical mucus.
- Women in unstable relationships.
- Couples who are unable to abstain from sexual intercourse.

Advantages

- No hormonal or physical side effects

- Increased knowledge of woman's body and its function
- Increased self awareness and self-reliance
- No cost
- Involves men's active participation
- Can be used to achieve a desired pregnancy.

Disadvantages

- Requires a specially trained provider to teach the method.
- Couples usually need three months of practice to use CMM with frequent follow-up. The commitment and cooperation of both partners is crucial.
- Requires privacy to observe and note signs and symptoms of fertility.
- Does not prevent or protect against STI, HIV, and AIDS.

Initiation and Client Instructions

Instruct the Client to:

- Avoid sex during days of menstruation.
- Avoid sex during early infertile days of the menstrual cycle (days before ovulation)
- Have sex every other day when there is no cervical mucus or when not feeling any vaginal wetness (Semen changes the characteristic of mucus so it is necessary to check cervical mucus on days that semen is NOT in the vagina).
- The first day of cervical mucus or vaginal wetness begins the fertile phase; avoid sex until the end of the fertile phase.
- The last day of cervical mucus or vaginal wetness is called "peak" day. Continue to abstain for sexual intercourse for three days after the "peak" day.

- Resume sex on the third day of no cervical mucus or vaginal wetness until the next menstrual bleeding begins (See *Table 6*).

Follow-up Visit

1. Ask the client/couple if they are satisfied, have questions or problems.
2. Review instructions with the client/couple, correct and reinforce as necessary.
3. Remember:
   - *Abstinence may be difficult, help the couple to discuss feeling and to come to solutions. Discuss alternative methods of pleasuring.*

IMPORTANT: During fertile days, genital contact must be avoided.

- *If the method's rules result in marital disputes, counsel the couple for use of another method.*

Table 6. Summary of Cervical Mucus Method[4]

Phase of the Menstrual Cycle (Days)	**How to Identify**	**Intercourse Allowed?**
1-5: menstruation*	Bleeding **The menstrual cycle begins on the first day of menstrual bleeding.*	No
6-9: Dry Days	Absence of cervical mucus or vaginal wetness.	Yes, on alternate nights only
10: Fertile Period Begins	Onset of sticky mucus secretion, gradually becoming slippery over the following days.	No
16: "Peak" Fertile Day	Last day on which slippery mucus, resembling raw egg white, is seen.	No
20: Fertile Period Ends	Evening of the 4th day after the "peak" day.	Yes
21-29: Safe Period	From end of fertile period until the onset of the	Yes

	next menstrual bleeding.	

Contraceptive Methods
Method 10: Emergency Contraception (EC)

Definition

A method of preventing an unwanted pregnancy after unprotected intercourse or contraceptive accident has taken place.

IMPORTANT: Emergency contraception is NOT suitable or effective as an on-going method of contraception.

How it Works

ECPs cause temporary changes in the lining of the uterus (endometrium), making it unsuitable for implantation. If taken in the first half of the menstrual cycle, they also cause changes in the ovary, possibly delaying ovulation. If taken after ovulation, they alter the function of the corpus luteum.

Effectiveness

When used within 72 hours of unprotected intercourse, ECPs are at least 75% effective in preventing pregnancy (1 in 5 pregnancies in 100 women being treated in one cycle).

When to Use ECPs

- To prevent pregnancy after unprotected intercourse.
- After a contraceptive accident, such as a broken condom, an expelled IUD, or an error in using a contraceptive method.

SPECIAL NOTE: *There are no absolute precautions against the use of ECPs unless pregnancy is suspected or has already been diagnosed. The advantages of using ECP outweigh the theoretical risks, even for women who would have one or more conditions making ongoing use of estrogen-containing contraceptives not recommended. Progestin-only pills are an alternative to ECPs containing estrogen.*

Advantages

- Readily available and accessible
- Convenient
- A back-up to regular method
- Safe

Disadvantages

- Must be used within 72 hours of intercourse.
- Estrogen-containing pills may cause nausea (30-60%) and vomiting (12-20%), which may reduce effectiveness of the method.
- May cause headache, dizziness, and/or breast tenderness.
- May cause changes in amount, duration, and timing of the next menstrual period.
- Effect of high dose hormones on a developing embryo (if pregnancy does occur) is unknown, although no definite risk to the fetus has been seen.
- Pregnancy may still occur in up to 25% of cases.

How to Administer ECPs

Confirm that unprotected intercourse during a potentially fertile period (*i.e.*, client is not within 5 days of completing menses) has occurred within the past 72 hours.

Instruct the client to:

- Take two tablets (each containing Ethinyl Estradiol 0.05 mg and DL-norgestrel 0.5 mg [Ovral]) immediately and take another two tablets 12 hours after taking the first dose for a total of four tablets (See *Table 7 for COCs that can be used for EC*).
- Take a prescribed oral anti-emetic (promethazine 25 mg, metoclopramid 5-10 mg) 30 minutes before each of the two doses of hormone.
- Expect to have a menstrual period within the next 21 days. If not, return to the clinic for examination and pregnancy testing.
- Do not have unprotected intercourse in the days or nights after ECP treatment.
- Use a back-up method until your next menstrual period or following the instructions for beginning a new method after ECP.

NOTE: *A single course of ECPs is unlikely to have a significant effect on the quantity and quality of breastmilk. Some hormone will pass through the breastmilk, but it is not believed to have an adverse effect on the infant.*

See *Table 7* for guidance in starting routine contraception following EC.

Progestin-Only Pills for Emergency Contraception[5]

· EC can be provided by giving 0.75mg of levonorgestrel (20 yellow pills, Ovrette) within 72 hours after unprotected sex and a second does (20 yellow pills, Ovrette) 12 hours after the first dose.

· The advantage of progestin-only pills for ECP use is that the side effects of nausea and vomiting are significantly less than with combined pills.

·Follow-up and post-ECP contraceptive options are the same as for ECP with combined pills.

- Provide a resupply of the client's regular contraceptive method or provide the new method.
- Counsel if ECPs need was for a method accident or error in contraceptive method use.
- Give appointment for follow-up visit in three to four weeks.

REMEMBER: ECPs can be provided with instructions in advance of need. ECPs are most effective when taken within 24 hours of unprotected intercourse.

ECPs can delay ovulation resulting in an increased risk of pregnancy after treatment. Women should use contraception during the remainder of the cycle. The woman can use the following methods, outlined in Table 7 below:

Table 7. Guidelines for Contraception after EC Treatment[6]

Method	When to Begin
Condoms	Immediately after EC.
Spermicides	Immediately after EC.
COCs	Start a new packet at the beginning of the next menstrual period OR begin a

	new packet the day after ECPs have been completed.
DMPA	Within the first 7 days of beginning the next menstrual period.
IUD	Within the first 7 days of beginning the next menstrual period.
VSC	Anytime after beginning of the next menstrual period.
CMM	After onset of next menstrual period.
Implants	Within the first 7 days of beginning the next menstrual period.

Follow-up Visit

If the client has already adopted a contraceptive method for ongoing contraception and wants to continue the method, no further follow-up is needed unless the client has:

- Delayed menstrual period.
- Suspects she may be pregnant.
  - *Record date of menses, perform pregnancy test if indicated.*
  - *If pregnant, refer for necessary services.*

If client has not already adopted a contraceptive method, discuss contraceptive options, and provide the method. Give a follow-up appointment according to guidelines.

Table 8a. Combined Oral Contraceptive Pills for Emergency Contraception

Trade Name	**Formulation**	**Number of Pills to Take***
Ovral	0.05 mg Ethinyl Estradiol 0.05 mg Norgestrel	2
Lo-Ovral	0.03 mg Ethinyl Estradiol 0.03 mg Norgestrel	4
Nordette	0.03 mg Ethinyl Estradiol 0.15 mg Levonorgestrel	4
Levlen	0.03 mg Ethinyl Estradiol 0.15 mg Levonorgestrel	4
Triphasil	(yellow pills only) 0.03 mg Ethinyl Estradiol 0.125 mg Levonorgestrel	4
Trilevlen	(yellow pills only) 0.03 mg Ethinyl Estradiol 0.125 mg Levonorgestrel	4

Microgynon	0.03 mg Ethinyl Estradiol 0.15 mg Levonorgestrel	4
Lo-femenal	0.03 mg Ethinyl Estradiol 0.3 mg Norgestrel	4

**Take 2 doses 12 hours apart*

Table 8b. Progestin-only Contraceptive Pills for Emergency Contraception

Trade Name	Formulation	Number of Pills to Take
Ovrette	Levonorgestrel 0.075 mg	20

**Take 2 doses 12 hours apart*

Contraceptive Methods

Method 11: Voluntary Surgical Contraception: Female Tubal Occlusion

Definition

Tubal Occlusion is a permanent, surgical contraceptive method for a woman who is part of a couple that decides they want no more children.

Types of Voluntary Surgical Contraception (VSC)

Tubal Occlusion: tubal occlusion by clip, laparoscopy, mini-laparotomy under local anesthesia procedures.

How it Works

Tubal Occlusion closes off both Fallopian tubes, which allow the egg to pass from the ovaries. This keeps the egg from meeting with sperm. Menstruation and orgasm continue.

Effectiveness

Pregnancy rate runs 0.5 per 100 women in the first year after the procedure (1 in 200 women). 1.8 pregnancies per 100 women (1 in 55) within 10 years after the procedure. Postpartum sterilization is the most effective, at 0.05 pregnancies per 100 women (1 in 2,000 women).

Who Should Use VSC?

VSC is appropriate for:

- Men and women who do not want more children.
- Women who have medical conditions that make future pregnancies high risk or would worsen the condition, threatening the woman's life.

Who Should Not Use VSC?

Anyone who is not sure whether they will want more children should not use VSC.

Advantages

- Highly effective
- Permanent
- Nothing to remember
- One-time cost for long-term protection from pregnancy
- No activity associated with sex
- No hormonal side effects
- No effect on breastmilk
- Can be provided immediately following pregnancy loss or postpartum
- Helps protect against ovarian cancer

Disadvantages

- Post-procedure discomfort
- Bleeding or infection at site; damage to internal organs
- More involved surgical procedure

- Requires surgically skilled provider
- Reversal is difficult, expensive, and not available
- Offers no protection against STIs including HIV
- There is an anesthesia risk, if general is used (general anesthesia is not the preferred anesthetic for this procedure)

Initiation and Client Instructions – Tubal Occlusion/Tubectomy

Tubal Occlusion/Tubectomy

Can be performed:

- Immediately following pregnancy loss or within 48 hours.
- Immediately postpartum, if the client made an informed choice decision in advance of delivery.
- Six weeks or more postpartum.
- Upon discontinuing another method.
- When a woman decides she will never want more children.
- When a woman is reasonably certain she is not pregnant (see "*Attachment 1: Client Assessment for Pregnancy*").

IMPORTANT: Female sterilization procedure should not be done between seven days and six weeks postpartum due to difficulty in accessing the tubes and increased risk of infection.[7]

Before the Procedure

Instruct the client to:

- Not eat or drink anything for eight hours before the surgery.

- Not take medication for 24 hours before surgery unless instructed otherwise.
- Bathe thoroughly the night before the procedure, especially the belly, genital area, and upper legs.
- Wear loose-fitting clothes.
- Not wear nail polish or jewelry to the clinic.
- Bring a friend or family member to help her go home after the procedure.

See *Jordan Procedural Standards for Female Sterilization.*

After the Procedure

1. Instruct the client to:

- Rest for two to three days and avoid heavy lifting for one week.
- Keep the incision clean and dry. Do not rub or irritate the incision for one week.
- Take paracetamol or another safe, pain-reliever as needed. **DO NOT** take aspirin or ibuprofen, which slows the clotting of blood.
- Not have sex for at least one week or until the pain is gone.
- Return to the clinic at once if she has any of the following **Warning Signs**:
    - *High fever (more than 38C), in the first four weeks.*
    - *Bleeding or pus from the wound.*
    - *Pain, heat, swelling, or redness at the incision that becomes worse or does not stop (sign of infection).*
    - *Abdominal pain, cramps, or tenderness that becomes worse or does not stop.*
    - *Diarrhea or fainting or extreme dizziness.*
- Return to the clinic immediately if she thinks she might be pregnant (has missed her period, has nausea and breast tenderness—first symptoms of pregnancy).

- Return to the clinic immediately if you have the following **Warning Signs**:
    - *Lower abdominal pain or tenderness on one side.*
    - *Abnormal or unusual vagina bleeding.*
    - *Faintness (indicating shock); signs of ectopic pregnancy.*

2. Give the client a follow-up visit within seven days or at least within two weeks and to have stitches removed if, necessary.
3. Answer any questions the client may have.

Follow-up Visit

- Ask the client if she has any questions, has had any problems.
- Check the incision site for complications and remove stitches if present.
- Offer the client condoms if she might be at risk for STI, including HIV.

Tubal Occlusion: Management of Other Problems

Symptoms/ Situation	**Assessment**	**Management**
Infection (pus, heat, redness, pain at the incision site)	**Ask** client when symptoms began. **Take** temperature (fever, >38.3C.) **Inspect** incision site for redness and/or pus at incision. Feel the abdomen for tenderness and/or enlargement (mass).	If infection, clean the site with soap and water or antiseptic solution. Refer for appropriate management or treat with oral antibiotics for 7 to 10 days. Give follow-up appointment upon completion of antibiotics. Instruct the client to return immediately if symptoms do not improve with 48-72 hours.
Pain	**Inspect** for signs of infection or abscess.	If infection, treat as above. If abscess, refer for medical management, which will include incision and drainage of abscess, followed by 7-10 days of antibiotic.

		If no infection or abscess, most likely post procedure discomfort. Suggest the client use paracetamol, not aspirin, for pain relief.
Missed period	**Ask** about: · LMP: was it normal? · Symptoms of pregnancy; abnormal spotting since missed period, cramps, pain, feeling faint. **Perform** pelvic exam to assess for uterine or adnexal enlargement.	Refer immediately for medical management, which will include immediate surgery, if ectopic pregnancy is diagnosed.

Contraception Following Pregnancy Loss

Definitions

The provision of contraception is the second element in a comprehensive approach to protecting reproductive health by providing contraceptives to women or couples immediately following a pregnancy loss. Contraception following pregnancy loss gives the woman's body a chance to recuperate. Recuperation allows the woman to begin a subsequent pregnancy in optimal health for good health outcomes—for herself and her infant.

Elements of care following pregnancy loss include:

- Management of incomplete pregnancy loss to prevent death and illness.
- Immediate provision of contraception.
- Referral to other needed health services.

Considerations

- All women experiencing pregnancy loss need information about fertility and contraception.

- Fertility may return within two weeks in first trimester pregnancy loss, putting a client at risk of an untimely pregnancy before her next menstrual period.
- Several contraceptive methods can be safely used immediately after pregnancy loss or at a time in the future, at the client's preference.
- The client has a right to choose, refuse, or delay contraception.
- A client is more likely to successfully use contraception if she receives counseling and her preferred method **BEFORE** being discharged from the hospital.[8]

Guidelines for Contraceptive Counseling Following Pregnancy Loss *(see also Table 9)*

In all cases, provide STI prevention counseling; offer condoms for protection against STIs and HIV with methods, if acceptable to the client. *See also Table 9.*

NOTE: *Following second trimester pregnancy loss, tubal sterilization may be more difficult to perform immediately. IUDs have a higher expulsion rate with immediate insertion following pregnancy loss.*

Initiation and Client Instructions

- Following management of incomplete pregnancy loss and/or related complications, provide post pregnancy loss care.
- When the client is stable or before preparing for discharge, counsel client regarding:
  - *Return of fertility within two weeks, and*
  - *Benefits of delaying subsequent pregnancy and use of family planning method.*
- Explore client's knowledge and experience with family planning.

- Present appropriate, available methods based on absence or presence of infection and/or hemorrhage.
- Assist the woman or couple to select a method and provide it.
- Provide method instructions to the client according to RH standard.
- Accept the client's decision to refuse or defer family planning use.
- Review the following **Warning Signs** for care following pregnancy loss and advise the client to return to the clinic immediately if she experiences any of the following:
    - *Fever*
    - *Chills*
    - *Muscle aches*
    - *Tiredness*
    - *Abdominal pain, cramping, or backache*
    - *Prolonged or heavy bleeding*
    - *Foul-smelling vaginal discharge*
    - *Delay of six weeks or more in resuming menstrual period*[9]
- Give the client a follow-up appointment for four weeks after pregnancy loss care.

Follow-up Visit

1. Review the client history.
2. Explore with the client her recovery course, presence of warning signs, satisfaction with method, if provided before discharge.
    - *If satisfied, provide resupply if needed and review instructions for use.*
    - *If not satisfied, or if the client did not choose a method before discharge, provide counseling about method options and initiate the client's preferred method.*

Table 9. Selecting a Family Planning Method Following Pregnancy Loss

Method	Considerations

Oral Contraceptives	- Can be used immediately. Good for women who may have had genital tract trauma or infection. - Good option for women who have experienced hemorrhage.
DMPA	- Can be used immediately. Good for women who may have had genital tract trauma or infection. - Good option for women who have experienced hemorrhage.
Condoms	- Can be used immediately. Good for women who may have had genital tract trauma or infection. - Good option for women who have experienced hemorrhage.
Spermicides	- Can be used immediately. Good for women who may have had genital tract trauma or infection. - Good option for women who have experienced hemorrhage.
Implants	- Can be used immediately. Good for women who may have had genital tract trauma or infection - Good option for women who have experienced hemorrhage.
IUD	- Can be used immediately in the absence of infection. - Avoid with women who have experienced hemorrhage.
Tubal Sterilization	- Can be provided immediately if the woman is sure she never wants more children. If concerned about potential for regret, offer long-tem or temporary method until the client has a chance to reconsider or be certain of her decision. - Avoid with women who have experienced hemorrhage.

Attachment 1
Client Assessment for Pregnancy Before Contraceptive Use[10]

How to be Reasonably Sure a Client is not Pregnant

1. You can be reasonably sure a client is not pregnant if she has no signs or symptoms of pregnancy (*e.g.*, breast tenderness or nausea) and any one of the following:
   - *Has not had intercourse since her last menses.*
   - *Has been correctly and consistently using a reliable contraceptive method.*
   - *Is within the first seven days after the start of her menses (days 1-7).*

- *Is within four weeks postpartum (for non-breastfeeding women).*
- *Is within the first seven days following pregnancy loss.*
- *Is fully breastfeeding, less than six months postpartum and has had menstrual bleeding.*

2. When a woman is more than six months postpartum, you can still be reasonably sure she is not pregnant if these three conditions apply:
   - *She has kept her breastfeeding frequency high.*
   - *She has still had no menstrual bleeding (amenorrheic).*
   - *She has no clinical signs or symptoms of pregnancy.*

   A pelvic examination is seldom necessary, except to rule out pregnancy of greater than 6 weeks, measured from the last menstrual period (LMP).

   Pregnancy testing is unnecessary except in cases where:
   - *It is difficult to confirm pregnancy (i.e., six weeks or fewer from the LMP).*
   - *The results of the pelvic examination are equivocal (e.g., the client is overweight, making sizing the uterus difficult).*

   In these situations, a sensitive urine pregnancy test (*i.e.*, detects <50 mIU/mI of hCG) may be helpful, if readily available and affordable. If pregnancy testing is not available, counsel the client to use a temporary contraceptive method or abstain from intercourse until her menses is finished or pregnancy is confirmed.

Attachment 2
IUD Insertion Technique

I. Passing a Uterine Sound

Sounding the uterus is recommended for all IUDs inserted by the "withdrawal" technique to ensure fundal placement.

Objectives of Sounding the Uterus

1. To check the position of the uterus and obstructions in the cervical canal.

2. To measure the direction of the cervical canal and uterine cavity, so that the inserter can be shaped appropriately to follow the canal.
3. To measure the length from external cervical os to the uterine fundus so that the blue depth gauge on the insertion tube (Tuck 380A IUD) can be set correctly, for placement in the uterine fundus.

Procedure

Use a gentle, no-touch (aseptic) technique throughout the procedure.

IMPORTANT: Before attempting to sound the uterus, a screening speculum and bimanual exam should be performed to rule out the possibility of vaginal and cervical infection and to determine the size of the uterus.

Step 1:

- Put on high-level disinfected (HLD) or sterile gloves.

Step 2:

- Insert the speculum. Thoroughly clean the cervix with an antiseptic *e.g.*, Chlorhexidine Gluconate (Hibiclens, Hibiscrub, Hibitane or Savlon (concentrations of Savlon may vary) or iodophors (povidone iodine, Betadine, Wesodyne).

Step 3:

- Apply the HLD or sterile tenaculum at the 10 o'clock and 2 o'clock positions on the cervix. Slowly close the tenaculum one notch at a time, and no further than necessary.

NOTE: *All persons learning to do IUD insertions should use the tenaculum. Very experienced clinicians may find a tenaculum is only needed when the fundus is sharply flexed.*

- Gently pull either the anteverted or retroverted uterus toward you with constant smooth traction on the tenaculum in a downward and outward direction.

Step 4:

- Gently pass the sterile tip of the uterine sound into the cervical canal while maintaining traction with the tenaculum. If there is an obstruction at the level of the os, use a smaller sound, if available.
- Insert the sound carefully and gently into the uterine cavity while pulling steadily downward and outward on the tenaculum. Be careful to not touch the vaginal walls during passage of the sound to the cervical os. From the bimanual exam, you should know the general direction of the uterus, so direct the sound gently toward where you expect the fundus to be. Gentle traction on the tenaculum may enable the sound to pass more easily.
- If the client begins to show symptoms of fainting, or pallor with slow heart rate, **STOP**.

Step 5:

- When a slight resistance is felt, the tip of the uterine sound has reached the fundus. Do not remove the tenaculum, but leave it attached to the cervix.

Step 6:

- Remove the sound and determine the length of the uterus by noting the mucus and/or blood on the sound. The average uterus will sound to a

depth of 6-8 cm. Do not attempt to insert an IUD into a uterus that measures 6.0 cm or less in depth.

Step 7:

- Set the depth gauge to the level on the sound. If the uterus sounds to a depth of 10 cm or more, the sound may have perforated the uterus, or the uterus may be enlarged due to tumors or pregnancy. DO NOT insert an IUD.

If perforation is suspected, observe the client in the clinic carefully:

- *For the first hour, keep the woman at rest and check the pulse and blood pressure every 5 to 20 minutes.*
- *If the woman remains stable after one hour, check the hematocrit/hemoglobin, if possible, allow her to walk; check vital signs as needed, and observe for several more hours.*
- *If she has no signs or symptoms, she can be sent home, but should avoid intercourse for two weeks. Help her make an informed choice for a different contraceptive.*
- *If there is a rapid pulse and falling blood pressure, or new pain or increasing pain around the uterus, hospitalization for further management is necessary.*

II. IUD Insertion using the Withdrawal Technique

Procedure

Step 1 Load the IUD into the inserter barrel without breaking its sterility.

Step 2 Insert the IUD into the uterus to the set depth of the gauge (based on "sounding") or until resistance is felt.

Step 3 Hold the inserter rod at fundus while retracting (drawing back) the outer barrel over the inserter rod.

Step 4 Release the IUD, withdrawing the insertion tube no more than 1 cm while the solid rod is held stable (this movement releases the arms of the device).

Step 5 Withdraw the rod inserter while holding the insertion tube stationary.

Step 6 Withdraw the insertion tube from the cervix.

Attachment 3
Algorithm for Lactational Amenorrhea[11]

Ask the mother (or advise her to ask herself) these three questions:

Attachment 4
Health in Jordan[12]

Indicator	Value
Estimated Population	5.1 million
Crude Birth rate/1,000 population	28
Crude Death rate/1,000 population	5
Infant Mortality rate/1,000 live births	28
Child mortality rate (1-4 years)/1,000	4.5
Maternal mortality rate/100.000 live births	41.4
Population Growth Rate	3%
Life expectancy at birth: female	71 years
Life expectancy at birth: male	69 years
Family size	6 children

Attachment 5
Progress In Reproductive Health Indicators for Jordan[13]

Indicator	1990	1997	2000
Women (15-49) with no education	24%	9%	
Median age at first marriage	19.6	21.5	
Median age at first birth	21.2	23.2	
Teen age pregnancy and mother hood	7%	6%	
Median birth interval (months)	24	25.6	
Births occurred before 24 months of previous child	50%	44%	

Contraceptive prevalence rate (all methods)	40%	53%	56%
Contraceptive prevalence (modern methods)	27%	38%	39%
Unmet need for family planning services	22%	14%	
Total demand for family planning services satisfied	66%	80%	
Unwanted pregnancies	32%	37%	
Antenatal care by physician or nurse/midwife	80%	96%	
Timing of ANC visit (median) months	3	2.2	
Median number of ANC visits	7.5	8	
Pregnant women receiving 4+ visits	67%	86%	
Tetanus toxoid vaccination one/2 or more doses	22/20	24/16	
Medical assistance during delivery	87%	97%	
Delivery in health facility	78%	93%	
Infant mortality rate/1000 live births	37	29	28
Under five mortality rate/1000 live births	42.4	34	
Child mortality rate (1-4years)/1000 live births	5.8	5.1	4.5
Maternal mortality rate/100.000 live births	60	41.4	

Family Planning Performance Checklists

Performance Checklist 7:
General Counseling

Performance Checklist 8.
Counseling Following Pregnancy Loss

Performance Checklist 9.
Combined Oral Contraceptives (COCs)

Performance Checklist 10.
Progestin-Only Pills (POPs)

Performance Checklist 11.
Intrauterine Devices (IUDs)

Performance Checklist 12.
DMPA Injectable Hormone (Depo-Provera)

Performance Checklist 13.
Lactational Amenorrhea Method (LAM)

Performance Checklist 14.
Condoms (Male)

Performance Checklist 15.
Vaginal Spermicides

Performance Checklist 16.
Norplant Implants

Performance Checklist 17.
Fertility Awareness Method-Cervical Mucus Method (CMM)

Performance Checklist 18.
Emergency Contraceptive Pills (ECPs)

Performance Checklist 19.
Voluntary Surgical Sterilization: Tubal Occlusion

Performance Checklist 7: General Counseling

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter NA ("not applicable") in the "Comments" column. Use the "Comments" column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	

All Clients			
1. Greets client with respect: · Introduces self. · Shows respect for client. · Gives full attention without distractions. · Assures client of privacy and confidentiality.			
2. Provides a private space for client.			
3. Makes clients from special needs groups feel welcome, *e.g.*, adolescents, men, following pregnancy loss.			
4. Informs client of family planning services available at the facility.			
All New Clients			
1. Confirms with patient purpose of visit: to explain various methods of birth spacing and help her determine which might be best for her.			
2. Asks patient about her objectives and desires in birth spacing.			
3. Asks patient about her past history and experiences with birth control and her fears and concerns.			
4. Asks client about medical and surgical problems/history.			
5. Interviews client to determine pregnancy status.			
6. Asks client if she is currently breastfeeding.			
7. Explores with client her/his risk of exposure to STIs.			
8. Explains the benefits of family planning for client, children, family, community, and society at large.			
Task	Achieved?		Comments
	Yes	No	

9. Explains the basic elements of each family planning method: · Uses language appropriate to the understanding of the patient. · Uses demonstration chart or samples of pills, IUD, condoms, etc. · Periodically confirms that the patient understands information – does not overwhelm client with too much information; watches for non-verbal communication and asks client to clarify her feelings.			
10. Briefly explains the various methods (description, how it works, effectiveness, advantages, disadvantages, side effects, and risks.			
11. Briefly demonstrates how to use each method or where it is located in/on the body.			
12. Encourages client to handle each method and ask questions.			
13. Clarifies rumors or misinformation about family planning or specific methods.			
14. Asks patient if she is interested in a specific method.			
15. If specific method selected, gives complete explanation of this method: · How it works. · Contraindications for use of this method. · Other beneficial effects of this method. · Specific use of this method.			
16. Asks for and answers questions, and clarifies misconceptions.			
17. Schedule follow-up visit appropriate to method selected (or, if patient uncertain, for further counseling and discussion).			
Task	Achieved?		Comments
	Yes	No	

All Follow-up Visit Clients			
1. Asks client about satisfaction with method.			
2. Asks client about problems or questions with method.			
3. Reviews user instructions for method.			
4. Offers condoms for STI protection.			
5. Gives re-supply of family planning method.			
6. Schedules follow-up visit appropriate to method selected (or, if patient uncertain, for further counseling and discussion).			
Physical Assessment			
1. Conducts physical assessment or refers for further care if appropriate.			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 8: Counseling Following Pregnancy Loss

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A ("not applicable") in the "Comments" column. Use the "Comments" column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	

All Clients			
1. Provides appropriate emotional support to client experiencing pregnancy loss.			
2. Before discharge, counsels client regarding (a) return of fertility within 2 weeks of first trimester loss, (b) benefits of delaying subsequent pregnancy.			
3. Explores client's knowledge and/or experience with family planning methods.			
4. Explains characteristics of each available method to client.			
5. Accepts a woman's right or decision to refuse FP or to postpone using FP until a later time.			
6. Assists client in selecting a method.			
7. Provides client's selected method, including instructions.			
8. Reviews side effects for client's selected method.			
9. Assesses client for risk of STIs and offers condoms.			
10. Asks client to repeat instructions and encourages client's questions.			
11. Gives follow-up appointment according to the standard for client's selected method.			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 9: Combined Oral Contraceptives (COCs)

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A ("not applicable") in the "Comments" column. Use the "Comments" column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	
All Clients			
1. Interviews client to determine pregnancy status			
2. Interviews client to determine medical eligibility for method			
3. Hands the client a packet of the same pills she will use.			
4. Tells client the possible side effects of COCs.			
5. Shows and tells client how and when to start the pills: · During first 7 days of menstrual cycle. · 6 months postpartum, if using LAM. · 3 weeks postpartum, if not breastfeeding. · Immediately following pregnancy loss or during first week following pregnancy loss. · Anytime she is not pregnant.			
6. Instructs client to take one pill every day until the packet is finished.			
7. If using a 21-day packet, tells client to wait 7 days after taking the last pill before starting the new packet.			
8. If using a 28-day packet, tells client to take the pills daily **without** stopping or skipping any days. Start the new packet the next day after taking the last pill from the old packet.			
9. **Forgotten pills** (1 pill) – Tells client to take the forgotten pill as soon as she remembers.			
10.**Forgotten pills** (2 pills) - Tells client to take 2 pills as soon as she remembers and 2 pills the next day, continuing the rest of the packet as usual.			
Task.	Achieved?		Comments
	Yes	No	

11. Tells client to use a back-up method (condom, spermicides) for 7 days if more than one pill is forgotten.			
12. **Forgotten pills** (3 pills in a row) – Tells client to throw away the packet, begin new packet of pills, as when first starting the pills, and use a back-up method for at least 7 days; she may have bleeding.			
13. Counsels client to consider another method if forgetting pills becomes recurrent.			
14. **Vomiting**: Tells client if she has vomiting or diarrhea within 1 hour of taking pills, to take 1 pill from another packet.			
15. **Severe diarrhea or severe vomiting:** Tells client to continue taking pills and to use a backup method until she has taken a pill for 7 days in a row **AFTER** diarrhea or vomiting has stopped.			
16. Counsels client that COCs do not protect against STI and encourages use of condoms while taking COCs, if she might be at risk of STIs.			
17. Counsels client to always tell other health care providers that she is taking COCs to avoid possible drug interaction with prescriptions.			
18. Gives client a 3-month supply of COCs.			
19. Tells client about problems that require care and to return if any problems arise.			
20. Asks client repeat instructions and encourages client's questions.			
21. Gives client a follow-up visit appointment within 3 months.			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 10: Progestin-Only Pills (POPs)

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A ("not applicable") in the "Comments" column. Use the "Comments" column to note details

about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	
All Clients			
1. Interviews client to determine pregnancy status.			
2. Interviews client to determine medical eligibility for method.			
3. Hands the client a packet of the same pills that she will use.			
4. Tells client the possible side effects of POPs.			
5. Shows and tells client how and when to start the pills: · During first 7 days of menstrual cycle. · 6 months postpartum, if using LAM. · 6 weeks postpartum if breastfeeding but not using LAM. · Immediately or within 6 weeks postpartum, if not breastfeeding. · Immediately following pregnancy loss.			
6. Tells the client to take one pill every day **at the same time** until the packet is finished.			
7. Tells client to start a new packet the day after taking the last pill in the old packet. There is never a break.			
8. Forgotten pills (1 pill) – Tells client take pill as soon as remembered and continue taking one pill each day, using a back-up method for the next 2 days; she may have spotting.			
9. Informs client that **taking the pill more than 3 hours later than the regular time** can put her at risk of pregnancy; use a back-up method for the next 2 days.			
Task	Achieved?		Comments
	Yes	No	

10.**Forgotten pills** (2 or more pills in a row): Tells client to start using a back-up method **immediately**; restart taking pills right away (take 2 pills for 2 days). If menses does not come in 4-6 weeks, come to the clinic for exam and pregnancy test.			
11. Tells client to keep track of menses when taking POPs; if more than 45 days late, come to clinic for examination and pregnancy test.			
12**. Diarrhea/vomiting**: Tells client to use a back-up method with the POPs until 2 days after the diarrhea or vomiting are over.			
13. Counsels client that POPs do not protect against STI and encourages use of condoms while taking POPs, if she might be at risk of STIs.			
14. Counsels client to always tell other health care providers that she is taking POPs to avoid possible drug interaction with prescriptions.			
15. Give client a 3-month supply of POPs.			
16. Tells client to return if any problems arise.			
17. Has client repeat instructions and encourages client's questions.			
18. Gives client a follow-up visit appointment within 3 months.			
Recordkeeping			
1. Records visit information in client record.			

Performance Checklist 11: Intrauterine Devices (IUDs)

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A ("not applicable") in the "Comments" column. Use the "Comments" column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	
All Clients			
1. Confirms that patient has received adequate counseling about family planning methods, and that she has selected the IUD as best for her situation.			
2. Confirms that patient does not have contraindications: · Pregnancy (using pregnancy questionnaire or pregnancy test). · Recent or high risk for STI or PID. · Cancer of cervix, uterus or ovaries, or hydatid mole. · Pregnancy-related infection (infected abortion or delivery). · Endometriosis (persistently painful menstrual periods). · Unexplained vaginal bleeding. · Anemia · Postnatal anemia (48 hours and up to 4 weeks).			
2. Interviews client to determine medical eligibility for method.			
3. Shows the client the IUD that will be inserted.			
4. Tells the client possible side effects of IUD use.			
5. Reconfirms that client is not at risk for STIs.			
6. Tells the client the device can be inserted: · During the menstrual cycle. · 4 weeks after childbirth (copper T IUD), 6 weeks (other IUD). · Immediately following pregnancy loss. · Immediately after stopping another FP method. · Anytime she is not pregnant.			
7. Explains to client the insertion procedure and answers questions.			
Task	Achieved?		Comments
	Yes	No	

Insertion Technique			
1. Inserts the IUD using aseptic technique and following recommended insertion steps.			
2. Asks patient to empty her bladder.			
3. Positions woman appropriately on examination table with feet in stirrups.			
4. Drapes woman appropriately.			
5. Positions light for good illumination of cervix.			
6. Opens IUD insertion instrument package.			
7. Puts gloves on both hands.			
8. Performs pelvic examination, Pap and specimen collection as appropriate, and bimanual examination for uterine size and position according to protocol.			
9. Removes and disposes of gloves.			
10. Wears sterile gloves.			
11. Using sterile, no-touch technique, bends IUD arms into inserter tube through package, and opens package.			
12. Inserts sterile vaginal speculum.			
13.Swabs vagina and cervix with appropriate antiseptic solution twice.			
14.Grasps anterior os of cervix with tenaculum.			
15.Sounds uterus with appropriate instrument.			
16.Sets depth gauge of IUD inserter according to measured uterine depth and confirms that gauge is in same plane as the IUD arms.			
17. Inserts IUD slowly and gently into uterus without touching speculum or vaginal walls. Stops if any significant resistance is felt.			
Task	Achieved?		Comments
	Yes	No	

18.Holds white rod in one position and release IUD arms by pulling inserter tube toward you, NOT by pushing on white rod.			
19.Once IUD arms are released, gently pushes inserter tube into uterus until slight resistance is felt – to seat IUD at top of uterus.			
20.Remove inserter tube and white rod, and cut strings to 3-4 cm. with scissors.			
21.Removes tenaculum and apply pressure with cotton ball on ring forceps if any significant bleeding.			
22. Removes speculum – places all instruments in disinfectant solution.			
23. Observes the client for at least 15 minutes.			
24.Teaches client how to check for IUD strings.			
25.Assures client she can have the IUD removed whenever she wants it to be removed.			
26.Gives client a card with date for IUD removal.			
27.Instructs client to return to the clinic if she has the following: · Delayed menstrual period bleeding between periods, or symptoms of pregnancy. · Abnormal, foul-smelling vaginal discharge. · Severe abdominal pain, pain with intercourse. · Strings missing, shorter or longer; cannot palpate IUD strings in vagina.			
28.Has client repeat instructions and encourages client's questions.			
29.Gives client a follow-up visit within 6 weeks of insertion.			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 12:
DMPA Injectable Hormone (Depo-Provera)

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A ("not applicable") in the "Comments" column. Use the "Comments" column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	
All Clients			
1. Interviews client to determine pregnancy status.			
2. Interviews client to determine medical eligibility for method.			
3. Shows client the vial of injectable hormone she will use.			
4. Tells client possible side effects of DMPA.			
5. Explores how irregular or increased bleeding or absence of menses will affect client's daily life.			
6. Tells the client she can receive DMPA: · During the first 7 days of menses. · Immediately or within 6 weeks postpartum if not breastfeeding. · 6 months postpartum, if using LAM. · 6 weeks postpartum if breastfeeding but not using LAM. · Immediately following pregnancy loss. · Anytime she is not pregnant.			
7. Tells the client she will not need a back-up method when receiving the first injection during the first 7 days of her menstrual cycle.			
8. Tells the client she will need to use a back-up method for 2 weeks when receiving the first injection after the 7th day of her menstrual cycle.			
9. Tells client to return to clinic every 3 months for reinjection (may be up to 2 weeks late and return for reinjection), and to use a back-up method for one week.			
Task	Achieved?		Comments
	Yes	No	

10.Give the client the injection of DMPA into the deltoid or the gluteus maximus muscle using aseptic technique and not massaging the injection site.			
11. Counsels client that DMPA does not protect against STI and encourages use of condoms while taking DMPA, if she might be at risk of STIs.			
12.Tells client to return if she has any of the following: · Heavy vaginal bleeding. · Severe headache with blurred vision. · Severe abdominal pain.			
13.Has client repeat instructions and encourages client's questions.			
14.Gives client an appointment for Follow-up visit within 3 months			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 13: Lactational Amenorrhea Method (LAM)

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A ("not applicable") in the "Comments" column. Use the "Comments" column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	

All Clients			
1. Supports the client in starting LAM as soon as possible after birth of infant.			
2. Explains the criteria for LAM use: · Menses have not returned. · Infant is breastfeeding fully day and night, taking not other food or drink. · Infant is less than 6 months old.			
3. Encourages woman to breastfeed often and on demand day and night.			
4. Tells the woman not to introduce any other food or drink before 6 months postpartum.			
5. Instructs client to use a back-up method or come to the clinic immediately if any one of the criteria changes.			
6. Instructs client how to handle difficulties that might interfere with breastfeeding; encourages client to return for help.			
7. Gives client back-up method.			
8. Has client repeat instructions and encourages client's questions.			
All Follow-up Visit Clients			
1. At follow-up visit, asks client: · Have menses returned? · Is the infant still breastfeeding fully day and night, not taking other food or drink? · Is infant 6 months old yet?			
2. If criteria for use is still present, support client to continue LAM.			
Task	Achieved?		Comments
	Yes	No	
3. If criteria for use are not present, or client wants to change the method, counsels client to use a complementary method of FP that does not interfere with breastfeeding.			
4. Give client follow-up visit appointment or encourage her to return whenever she feels the need.			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 14: Condoms (Male)

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A ("not applicable") in the "Comments" column. Use the "Comments" column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	

All Clients			
1. Shows client the condom he will use.			
2. Praises client for choosing a method that protects against pregnancy **and** STIs.			
3. Demonstrates while telling client how to put on and remove the condom.			
4. Instructs client to: · Use water-based lubricant to prevent breakage. · Roll condom onto the penis all the way to the base. · Hold the rim of the condom at the base of the penis so it will not slip off when removing the penis from the vagina after ejaculation, before completely loosing his erection. · Throw the condom away in the garbage, burn or bury it. Do not leave where children will find and play with it.			
5. Tells client to encourage his partner/wife to use a spermicide while he uses condoms.			
6. Instructs client that if condom breaks, to immediately insert a spermicide into the vagina and bring his partner/wife to clinic for ECPs within 72 hours—the sooner the better.			
7. Advises client never to re-use condoms.			
8. Encourages client to return to clinic for resupply of condoms.			
Task	Achieved?		Comments
	Yes	No	
9. Offers client a spermicide or ECPs as back-up, with necessary instructions for use.			
10.Gives client 3-month supply (~40 or more) of condoms.			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 15: Vaginal Spermicides

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A ("not applicable") in the "Comments" column. Use the "Comments" column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	
All Clients			
1. Interviews client to determine medical eligibility for the method			
2. Shows client the spermicide she will use.			
3. Demonstrates insertion using a pelvic model.			
4. Instructs client to: · Wash hands with soap and water before and after insertion spermicide. · If using suppositories, allow time for it to melt before having sexual contact.			
5. **Foam:** Tells client to shake foam at least 20 times; fill the applicator from the container; insert the applicator deeply into the vagina close to the cervix, then push the plunger to release the foam.			
6. **Cream or Jelly:** Tells client to fill the applicator from the tube, insert the applicator deeply into the vagina until it is near the cervix; push plunger to release the cream or jelly.			
7. **Suppository:** Tells client to remove the wrapping and slide the suppository into the vagina, pushing it along the back wall of the vagina until it rest near the cervix.			
8. Instructs client to use the spermicide every time she has sex and with each act of sexual intercourse.			
Task	Achieved?		Comments
	Yes	No	

9. Advises client not to douche or rinse vagina after sex; if she must, wait at least 6 hours.			
10. Tells client to wash applicator with warm soap and water and allow to air-dry.			
11. Gives client adequate supply of spermicide for time until the next visit; encourages client to return when she needs more.			
12. Has client repeat instructions and encourages client's questions.			
13. Schedules a follow-up visit at the client's convenience.			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 16: Norplant Implants

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A ("not applicable") in the "Comments" column. Use the "Comments" column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	

All Clients			
1. Interviews client to determine pregnancy status			
2. Interviews client to determine medical eligibility for method			
3. Shows client the Norplant implants and where in her arm it will be placed.			
4. Tells client possible side effects of Norplant use.			
5. Explains the procedure for insertion to client.			
6. Assures client that the implants can be removed whenever she wants.			
7. Tells client the implants can be inserted: · During the first 7 days of the menstrual cycle. · 6 weeks postpartum, if not breastfeeding. · 6 months postpartum, if breastfeeding and using LAM. · Immediately or within 7 days following pregnancy loss. · Anytime she is not pregnant (must use back-up).			
Insertion Technique			
1. Inserts Norplant implants using sterile technique.			
2. Tells client there may be bruising and slight bleeding at the insertion site during the first few days; this is normal.			
Task	Achieved?		Comments
	Yes	No	

3. Instructs client to keep the area dry for 4 days (remove gauze after 2 days, adhesive after 5 day). · May have soreness and/or swelling after anesthesia wears off.			
4. Tells client to return to clinic immediately if she experiences any of the following: · Symptoms of pregnancy. · Abdominal pain (severe). · very heavy menstrual bleeding. · Severe headache. · Yellow skin and/or eyes (jaundice).			
5. Counsels client that Norplant does not protect against STI and encourages use of condoms while taking Norplant, if she might be at risk of STIs.			
6. Counsels client to always tell other health care providers that she is taking Norplant to avoid drug interaction with possible prescriptions.			
7. Has client repeat instructions and encourages client's questions.			
8. Give client a card with date for Norplant removal.			
9. Give client a follow-up visit within 4 weeks of insertion.			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 17: Fertility Awareness Method-Cervical Mucus Method (CMM)

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A ("not applicable") in the "Comments" column. Use the "Comments" column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	
All Clients			
1. Displays graphic of woman's reproductive system including anatomy, menstrual cycle, and process of conception; shows fertile days.			
2. Explores the presence or absence of partner support for this method with client.			
3. Using a graphic, explains reproductive physiology covering woman's reproductive system, anatomy, menstrual cycle, process of conception.			
4. Explains to the client the pattern of fertile and infertile days.			
5. Explains rules of CMM: · Avoid sex during menstrual days. · Avoid sex during early infertile days before ovulation. · Have sex every other day when there is no cervical mucus or vaginal wetness. · Avoid sex from the first day of cervical mucus or vaginal wetness (beginning of the fertile phase) until the end of the fertile phase. · The last day of cervical mucus or vaginal wetness is the "peak" day. Continue abstaining from sex for 3 days after the "peak" day. · Resume sex on the 3rd day of no cervical mucus or vaginal wetness until the next menstrual bleeding begins.			
6. Encourages client/couple to ask questions.			
Task	Achieved?		Comments
	Yes	No	

7. Asks client/couple to repeat instructions.			
8. Gives client a chart to record CMM changes over 2 cycles and advises client to abstain during the learning period.			
9. Reminds client/couple that CMM does not protect against STI; a condom must be used if they might be at risk of infection.			
10. Gives client/couple follow-up visit in 6 weeks.			
Recordkeeping			
1. Records visit information.			

Performance Checklist 18: Emergency Contraceptive Pills (ECPs)

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A ("not applicable") in the "Comments" column. Use the "Comments" column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	

All Clients			
1. Explains to client how ECPs are used, how it works, and how to adopt regular contraception.			
2. Gives client 2 pills of Ovral* for 2 doses within 12 of each other. * *Use chart to give the correct number of pills for the combined contraceptive pills available for EC use.*			
3. Offers client anti-nausea medication to take before taking the hormones.			
4. Gives client instructions for follow-up visit as follows: · Return to clinic in 4 weeks, · Avoid unprotected sexual intercourse after ECP use; use condoms or spermicides.			
5. Counsels client for selection of an ongoing family planning method.			
6. Gives client new or resupplies client's regular family planning method.			
7. Gives condoms and/or spermicides **immediately**; or within first 7 days of cycle COC, POP, DMPA, IUD, or Norplant implant.			
8. Asks client to repeat instructions and encourages client's questions.			
9. Instructs client to return to clinic **immediately** when symptoms such as delayed menstrual period, suspected pregnancy occur.			
Task	Achieved?		Comments
	Yes	No	
10. Reminds client that condoms are the only protection against STIs; she should use them if she may be at risk of infection.			
11. Gives client follow-up appointment within 4 weeks of ECP treatment.			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 19:
Voluntary Surgical Sterilization: Tubal Occlusion

Instructions: For each of the tasks listed below, place a check in the "Yes" or "No" box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A ("not applicable") in the "Comments" column. Use the "Comments" column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		Comments
	Yes	No	

All Clients			
1. Interviews client to determine pregnancy status			
2. Interviews client to determine medical eligibility for method			
3. Gives client instructions for preparing herself for procedure.			
4. Refer client to the specialist and ask her to come for follow-up visit one week after the procedure.			
5. After procedure, instructs the client on the following: · Rest 2-3 days, avoid heavy lifting for 1 week. · Keep incision clean and dry for 1 week. · Take paracetamol for pain relief (not aspirin or ibuprofen). · Avoid sex for at least 1 week or use a back-up method for family planning.			
6. Advises client to return to the clinic if any of the following symptoms occur: · High fever in the first 4 weeks. · Bleeding or pus from the wound. · Pain, heat, swelling, or redness at the incision that becomes worse or does not stop. · Abdominal pain, cramps, or tenderness that becomes worse or does not stop. · Diarrhea, or fainting or extreme dizziness.			
7. Instructs client to return to clinic immediately if she thinks she might be pregnant (missed period, nausea, breast tenderness).			
Task	Achieved?		Comments
	Yes	No	

8. Reminds client that tubal sterilization does not prevent STIs; encourage client to use condoms if she may be at risk.			
9. Asks client to repeat instructions and encourages client's questions.			
10. Gives client condoms, if she wants them.			
11. Gives client follow-up visit appointment for 7-14 days after the procedure.			
Recordkeeping			
1. Records visit information in the client record.			

HIV and AIDS Care

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HIV and AIDS Care

Definitions

HIV *Human immunodeficiency virus*

The organism that causes AIDS. A person can be infected with HIV for many years and not know it. HIV is carried in the blood, semen, and vaginal secretions of infected persons. HIV can be passed on (transmitted) whether symptoms of AIDS are present or not.

AIDS *Acquired immunodeficiency syndrome*

A condition caused by HIV that attacks the body's immune system and makes it unable to fight disease and infection that ultimately results in death.

Antibody

A protein produced in the blood to fight infection.

At Risk

People who practice behaviors that may result in becoming infected with HIV. For example, unprotected sex with persons who may be infected with HIV/AIDS and sharing of needles that have not been sterilized between uses.

Condom

A latex sheath used to cover the penis during intercourse to help prevent pregnancy and/or the transmission of sexually transmitted diseases, including HIV.

HIV Negative *(also called sero-negative)*

A person who has been tested for HIV antibodies and found not to have any present in their blood.

HIV Positive *(also called sero-positive)*

A person who has been tested for HIV antibodies found to have them present in their blood. A person who is HIV positive can infect other persons with HIV, even if they have no symptoms of illness.

HIV Testing

Screen the blood for HIV antibodies. The two tests currently available are called the ELISA and Western Blot. The ELISA is done first to screen the blood for HIV antibodies. If the person tests positive for HIV then a Western Blot is done to confirm the diagnosis. As with any laboratory tests there can be errors (false negative or false positive results).

HIV Transmission

The passing of HIV from a person who is HIV positive to a person who is not infected with HIV, through the exchange of semen, blood or vaginal fluids.

Opportunistic Infection

An infection caused by a microorganism that causes disease only in a host with a poorly functioning immune system, such as a person with HIV.

Safer Sex

Engaging in sexual intercourse with the protection of a latex condom; having fewer sexual partners; keeping to one sexual partner whose sexual history is known to you and is HIV negative.

Window Period

The time between transmission of infection and the appearance of HIV antibodies in the blood. This usually occurs within six to eight weeks, but in some rare cases may occur as late as six months after infection.

How HIV is Contracted

HIV can be contracted through:

- Sexual contact (vaginal, anal, or oral intercourse) with an infected person. HIV in the fluids of the genitals can then get into the blood stream. HIV can enter the blood through the vagina, penis, open genital or oral sores or cuts.

- Transfusions or treatments with infected blood products.
- Needles or skin-piercing instruments that have been in contact with infected blood or body fluids and have not been properly disinfected.
- In infants from an infected mother during pregnancy, childbirth, or breastfeeding, if the mother acquired the primary infection during pregnancy or breastfeeding or by exposure to infected blood during childbirth.

How HIV is Not Contracted

HIV cannot be contracted from:

- Sharing food or dishes
- Sharing clothing
- Non-sexual social contact such as hugging and kissing
- Shaking hands
- Insect bites
- Contact with tears, sweat, or saliva
- Toilet seats

Symptoms of HIV Infection and AIDS

After infection with HIV, most people do not immediately notice any symptoms of illness. Some infected people become ill with fever, sore throat, enlarged lymph nodes, rash, and general fatigue (tiredness) a few weeks after the initial infection/transmission. However, symptoms disappear within a week. After this episode, the infected person will feel healthy again, living without symptoms for a period of 6 months to more than 10 years.

A person will generally test positive for HIV between 6 weeks to 2 months after infection. In rare cases, a person may not test positive until up to 6 months after infection.

When the HIV infection progresses to AIDS, the body’s ability to fight other diseases is weakened. The early symptomatic period of AIDS is characterized by candidiasis of the mouth or vagina, worsening skin rashes, diarrhea, and fatigue. Once HIV weakens the

immune system, bacterial infections become more severe, including tuberculosis, bronchitis, and pneumonia.

Other symptoms include:

- Unexplained weight loss lasting at least one month
- Persistent diarrhea
- White coating on the tongue
- Enlarged or sore glands in the neck and/or armpit
- Cough that persists for more than one month
- Persistent fever
- Persistent symptoms of Vaginitis

Survival after development of AIDS varies widely, from a few months to many years. Anti-retroviral drugs can reduce the amount of virus in the body as well as prolong and improve the infected person's quality of life. However, these drugs are very expensive, require careful and routine monitoring by qualified health personnel, must be taken consistently and correctly with certain foods, and may not be available to persons infected with HIV/AIDS.

Who is at Risk?

Persons at increased risk include:

- People who have multiple sexual partners or whose sexual partner(s) have had sexual relations with others, especially without the protection of latex condoms.
- Users of intravenous drugs who share needles.
- People who have received unscreened blood products.

Health care personnel who have direct contact with infected blood are at increased risk, especially if they do not follow adequate infection prevention measures.

Preventing HIV Infection

A person can help prevent HIV infection by avoiding high-risk behaviors. To prevent HIV infections:

- Maintain a faithful relationship with one sexual partner who has not had other partners. In polygamous marriages, partners should remain faithful to each other within the marriage.
- Use latex condoms with every act of sexual intercourse (unless the couple has had a mutually faithful relationship and all partners have tested HIV negative at least six months after their last possible exposure.
- Use latex condoms for protection against infection, while using the primary contraceptive (if the primary method is other than a condom).
- Avoid sharing needles or using any skin-piercing instruments that have not been disinfected.

Breastfeeding for the HIV Positive Woman

HIV passes via breastfeeding to about 1 out of 7 infants born to HIV-infected women. But, in many situations where there is a high prevalence of HIV, lack of breastfeeding is also associated with a three- to five-fold increase in infant mortality.[1] Consequently, providers must weigh the client's circumstances when counseling for breastfeeding. To do this, the client must have access to confidential HIV testing. Once a woman knows her status, an informed decision can be made regarding infant feeding.

The current guidance is as follows:

- **IF** a mother knows she is infected, and
- **IF** breastmilk substitutes are affordable and can be fed safely with clean water, and
- **IF** adequate health care is available and affordable,
- **THEN** the infant's chances of survival are greater if fed with breastmilk substitutes.

HOWEVER,

- **IF** infant mortality is high due to infectious diseases such as diarrhea and pneumonia, or

- **IF** hygiene, sanitation, and access to clean water are poor, or
- **IF** the cost of breastmilk substitutes is unaffordable, or
- **IF** access to adequate health care is limited,
- **THEN** breastfeeding may be the safest feeding option, even when the mother is HIV positive.[2]

REMEMBER: The safest way to breastfeed during the first six months is to breastfeed exclusively. The addition of liquids and food items into the baby's diet may cause irritation or inflammation in the gut that, in turn, could increase the risk of HIV transmission.

Table 1. HIV & Infant Feeding
Counseling Guidelines in Low-Resource Communities

Situation	Health Personnel Guidelines
Mother's HIV Status Unknown	• Promote the availability and use of confidential HIV testing. • Promote breastfeeding as safer than artificial feeding. • Teach mother how to avoid exposure to HIV.
HIV Negative Mother	• Promote breastfeeding as safest infant feeding method (exclusive breastfeeding for first 6 months, introduction of appropriate complementary foods at about 6 months, and continued breastfeeding to 24 months and beyond). • Teach mother how to avoid exposure to HIV.
HIV Positive Mother Who is Considering Her Feeding Options	• Treat with anti-retroviral drugs, if feasible. • Counsel mother on the safety, availability, and affordability of feasible infant feeding options. • Help mother choose and provide safest available infant feeding method • Teach mother how to avoid sexual transmission of HIV.
HIV Positive Mother Who Chooses to Breastfeed	• Promote safer breastfeeding (exclusive breastfeeding up to 6 months, prevent and treat breast problems of mothers and thrush in infants, and shortened duration of breastfeeding

	when replacements are safe, feasible, and available.
HIV Positive Mother Who Chooses to Feed Artificially	• Help mother choose the safest alternative infant feeding for her situations. • Support her in her choice (provide education on hygienic preparation, health care, family planning services, child health services).

Health Provider's Role in HIV Prevention

- Screen the client for risk of HIV infection:
  - *Ask each client, "What do you do to protect yourself from AIDS?" as a way to begin the discussion of behaviors and prevention practices that the client feels able to carry out.*
- Teach the client and his or her partner about prevention behaviors.
- Encourage women and couples currently using contraceptives to use condoms along with their chosen contraceptive.
- Provide clients with condoms for use each time they have sex if they suspect that they might be at risk of infection.
- Encourage confidential HIV testing and refer for counseling and testing, where available.
- Screen for and treat sexually transmitted infections (STIs) as a means of minimizing HIV transmission.
- During pregnancy, treat any reproductive tract infection and counsel the mother on infant feeding options if the mother tests positive for HIV/AIDS.
- During labor and delivery, minimize exposure of the baby to maternal blood and secretions, and avoid invasive procedures; *e.g.*, internal fetal monitoring.
- During the postnatal period, counsel the mother on breastfeeding successfully and preventing cracked nipples, engorgement, and mastitis.
- Maintain strict infection prevention practices.

STI and HIV Prevention Messages[3]

In order to support effective behavior change, preventive health messages need to be specific without being offensive. Take the lead by discussing your client's sexual practices together. Use the following outline in presenting STI and HIV prevention counseling:

Risk

Tell the client that vaginal and anal sex without condoms carries a high risk of infection. Oral sex carries a lower risk, but it is not risk-free.

Discuss the sexual practices of the client and of the client's partner that might put the client at risk.

Safer Sex

Tell the client that practicing safer sex can prevent most future STIs. Safer sex practices include:

- Having sex only with an uninfected partner who has sex only with you.
- If that is not possible or if you do not know if your partner is infected:
  - *Use condoms each and every time you have vaginal or anal sex.*
  - *For oral sex, use plastic wrap or cut open a condom to cover the vagina and anus, and use a condom to cover the penis.*
  - *Engage in other forms of sexual activity; e.g., using hands to stimulate your partner. Wash hands immediately after these activities.*
- Ensure that the client knows that sores or warts in the genital area that cannot be covered by condoms can cause transmission of infection.

Communicating with Partners about Sex

Ask the client the following:

- Have you ever discussed sex or safer sex with your partner? If so, what happened?
- If not, how might you bring it up with your partner?
- What would you say and how do you think your partner would react?

- Can you think of any ways to increase pleasure with condom use?

Role-play with the client how to begin the conversation and what to say to a partner.

Reducing Risk

If the client is unable to practice safe sex, help the client develop strategies to reduce the risk of infection; *e.g.*, reducing the number of partners, making condoms available to partners for use with relationships outside the primary one. *Have STI symptoms evaluated and treated immediately.*

HIV Testing

Check what the client knows about HIV.

- Inform the client that people with STIs are more likely to become infected with HIV.
- Ask if the client would like to get tested for HIV. If yes, direct the client to the testing center. If no, counsel the client with regard to recommendations for risk reduction and safer sex practices.

References

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