

Family Planning Protocols for Merrygold Health Network

Vol: II
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Uttar Pradesh Social Franchising Project

A project supported by USAID & SIFPSA. Implemented by HLPFPT



Preface

HLFPPT is an organization committed to work with various partners pioneering innovations for bettering health outcomes for the poor. Merrygold Health Network is one of such innovations in the field of Social Franchising.

Merrygold Health Network, aims towards achieving an objective of improving Maternal and Child Health through increased access to low cost – high quality healthcare services, for rural and urban working poor in Uttar Pradesh. In U.P. Social Franchising Project (supported by USAID and SIFPSA), HLFPPT as an implementing agency, will be establishing 70 fully franchised Merrygold Hospitals at district level, 700 partially franchised Merrysilver Clinics at block level and will be working with more than 10,000 Tarang partners (ASHAs, Chemists, Fare price shop owners, Tarang health committee members, Opinion leaders, Anganwadi workers, Depot holders) and AYUSH practitioners at the village level by 2010. Two model hospitals are already established in Kanpur and Agra focusing on maternal and child health care.

In our endeavour to make this a successful model, it was felt that training as well as development of some protocols, for doctors, nurses and other team members will be a key component to improve the quality of service delivery and equip the staff with appropriate knowledge and skills.

Quality of care in delivery of contraceptive services plays important influence on acceptance of any method, continuation and ultimately client satisfaction. Understanding the need for evidence-based practice of family planning the training team of UPSF with technical experts has designed “*Family planning protocols for Merrygold Health Network - 2008*” for the family planning service providers. It has been pre-tested with Merrygold LO hospital staff at Kanpur and Agra. The inputs and feedbacks from the hospital staff and comments of review committee members from SIFPSA and ITAP, has given this manual the present shape.

I am sure that these protocols along with the Manual on Family planning when used by service providers in the Social Franchising Project, will work as an enabling tool towards excellent service delivery.

HLFPPT

Acknowledgement

Family planning means that a couple decides when to have children and when not to have them. It is the right of a couple to have children by choice and not by chance. I present this “*Family Planning Protocols for Merrygold Health Network - 2008*” for the doctors of Merrygold Health Network to improve their skills through standard guidelines for providing Family Planning Services. This manual is the result of sincere intent, aspirations and hard work of all those who are an integral part of the network.

I am grateful to Mr. G. Manoj, (CEO, HLFPPPT) who has shown faith in my entire team to undertake this task.

My sincere thanks to Mr. Rajeev Kapoor I.A.S. (Executive Director - SIFPSA & Mission Director - NRHM), Mr. S. Krishnaswamy (General Manager Private Sector - SIFPSA), Dr. M. K. Sinha (General Manager Public Sector – SIFPSA), Ms. Savita Chauhan (Dy. General Manager Private Sector - SIFPSA), Dr. Lovleen Johari (Senior Reproductive Health Advisor, USAID) and Ms. Shuvi Sharma (Manager - Social Marketing & Franchising, ITAP) for their support and encouragement for developing these protocols.

I thank Dr. Brinda Frey and Dr. Amrita Kansal, from HLFPPPT for developing and designing of these protocols. I also thank Ms. Divya Babbar for providing secretarial assistance.

I express deep appreciation and thanks to Dr. Manju Shukla, Dr. Veena Bajpai, Dr. Humaira Aquil, Dr. Ravi Anand, Dr. Nisha Gupta for reviewing these protocols and providing their valuable comments.

This manual has been pre tested by training team at both L0 hospitals at Kanpur and Agra. Efforts made by Mr. Alok Tabelabux, Mr. B. K. Mishra from HLFPPPT, in organizing the trainings and involvement of entire Merrygold hospital staff in trainings was commendable.

Special mention needs to be made of Mr. Sharad Agarwal, Dr. Sanjeev Yadav, Dr. Brinda Frey, Mr. Rajeev Shukla, Mr. Gajendra Verma,, Ms. Preeti Dwivedi and entire U.P. Social Franchising team for their efforts, valuable time and support for arranging and organizing training program based on these protocols.

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1. Protocol on Family Planning Counselling

- Follow **GATHER** Approach (Please refer Family Planning manual).
- A client should be treated with respect and her/his dignity, privacy and confidentiality should be maintained always.
- The clients should be provided a wide range of contraceptives to choose from (**Cafeteria approach**).
- **Informed choice** The choice of client should be informed. S/he should be told about all the methods available, how they work, their advantages, disadvantages, common side effects and effectiveness, correct use, health risks, warning signs and symptoms, information on return to fertility once the method is stopped the extent to which it protects from STIs, including HIV / AIDS, so as to be fully informed before making a choice.
- **To ensure voluntarism** the provider should give the above information and help the client choose a method, **without** any pressure, force or coercion.

2. Protocols on Spacing Methods of Contraception:

2.1 Combined Oral Contraceptive Pills (COCs)

Client Screening Guidelines for COCs

Combined Oral Contraceptive Pills can be given to all women except in the following conditions

1. Pregnancy (suspected or confirmed)
2. Breastfeeding infant less than six months
3. Heavy smoker whose age is 35 years or more
4. High blood pressure = > 140/90 mm Hg
5. Vascular Disease
6. Current or history of Deep Vein thrombosis or Pulmonary Embolism
7. Current or history of Ischaemic Heart Disease or complicated Valvular Heart Disease
8. History of Stroke
9. Migraine with aura or without aura
10. Current or past history of Breast Cancer
11. Diabetes of more than 20 yrs duration or complicated with nephropathy/retinopathy/neuropathy
12. Current Gall Bladder Disease
13. Active viral hepatitis/ benign or malignant liver tumors/severe cirrhosis
14. Taking medicines like rifampicin, phenytoin, carbamezine and barbiturates.

Source: WHO Medical Eligibility Criteria for Contraceptive Use, 2004, category 3 and 4

When to Start Pills (See the table given below)

Table 1: When to start combined oral contraceptives

Phase	Recommended Guidelines
Having a menstrual cycle	Within 5 days after the start of her menstrual bleeding.
Amenorrhoea	Any day if she is reasonably certain that she is not pregnant
Breastfeeding	<p>For women who are less than 6 months postpartum and primarily breastfeeding, use of COCs is usually not recommended.</p> <p>If not breastfeeding, she can start COCs at any time, if she is reasonably certain that she is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.</p> <p>If she is more than 6 months postpartum and ammenorrhoeic, she can start COCs as advised above.</p> <p>If she is more than 6 months postpartum and her menstrual cycles have returned, she can start COCs as advised for other women with menstrual cycles</p>
Switching to another hormonal method	<p>Women using the hormonal method consistently and correctly, who are reasonably certain that they are not pregnant, can start COCs immediately. There is no need to wait for the next menstrual period.</p> <p>If her previous method was an injectable, she should start COCs when the repeat injection would have been given. No additional contraceptive protection is required.</p>
Switching from non-hormonal method	She can start COCs within 5 days after the start of her menstrual bleeding. She can also start immediately or at any other time, if it reasonably certain that she is not pregnant. If it has been more than 5 days after the menstrual bleeding started, she will need to abstain from sex or use additional contraceptive protection for the next 7 days
Switching from IUD (including hormonal)	<p>She can start COCs within 5 days after the start of her menstrual bleeding. No additional contraceptive protection is required. The IUD can be removed at that time.</p> <p>She can also start immediately or at any other time, if it reasonably certain that she is not pregnant. If she has been sexually active during this menstrual cycle, and it has been more than 5 days since menstrual bleeding started, it is recommended that IUD should be removed at the time of her next menstrual period.</p>

Source:

- Family Planning – A global Handbook for providers, A WHO family planning cornerstone, 2007.
- Contraceptive Updates, Reference manual for Doctors, Oct. 2007, MOHFW, Govt. of India.

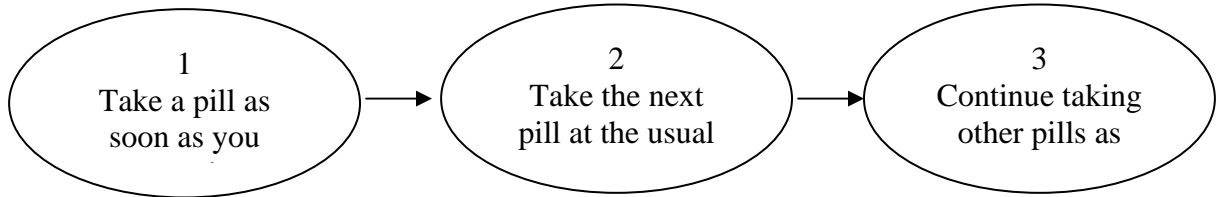
How to use the 28 pills packet

- Advise the client to follow the direction or arrows on the packet, one each day. Taking the pill at the same (fixed) time of the day might help her to remember taking them.
- With the 28-pill packets, last 7, dark coloured pills (Reminder Pills) do not contain hormones. Even if she forgets to take the reminder pills she is still protected from pregnancy.
- When she finishes one pack, she should take the first pill from the next pack on the very next day.
- Instruct her on what to do in case she misses a pill (see the protocol for missed pill given below).
- Tell her that using OCPs does not protect against transmission of HIV/ STIs.

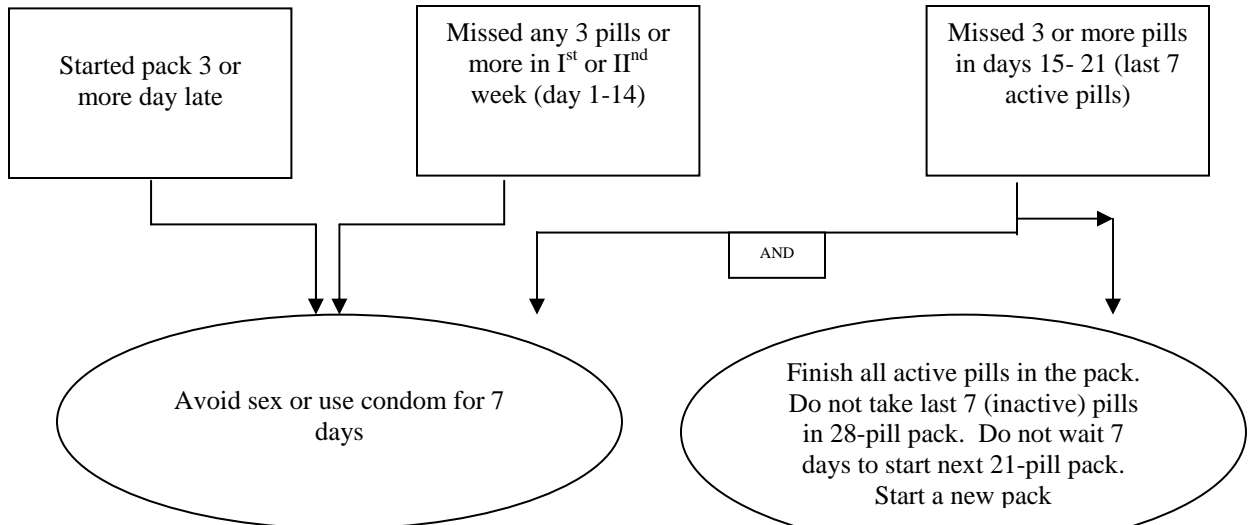
Protocol for Missed pill

Fig 1: Protocol for missed pill

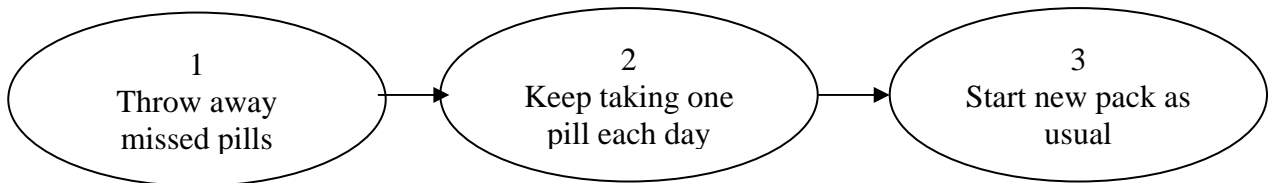
If one or more active pills (1-21) is missed:



In these special cases, ALSO follow these special rules.



If any of the 7 inactive pills is missed (in a 28 pill pack only):



2.2 Progesterone only Pills:

Client Screening Guidelines for Progestin only Pills (PIPs)

POPs can be given to all women except in the following conditions-

1. Pregnancy (suspected or confirmed)
2. Breastfeeding infant less than six weeks
3. Current Deep Vein thrombosis or Pulmonary Embolism
4. Current or history of Ischemic Heart Disease
5. History of Stroke
6. Migraine with aura
7. Current or past history of Breast Cancer
8. Active viral hepatitis/ benign or malignant liver tumours/severe cirrhosis
9. Taking medicines like rifampicin, phenytoin, carbamezine, barbiturates, Primidone, Topiramate, Oxcarbazepine.

Source: WHO Medical Eligibility Criteria for Contraceptive Use, 2004, category 3 and 4

When can a woman start POPs: (See the table given below)

Table 2: When can a woman start the POPs

Women's situation	When to start
During menstrual cycle	She can start POPs within 5 days after the start of her menstrual bleeding. No additional contraception is needed. She can also start POPs at any other time, if she is reasonably certain that she is not pregnant.
Breastfeeding	<p>If her menstrual bleeding has not returned and it is reasonably certain that she is not pregnant, she can start POPs anytime after 6 weeks of giving birth. If POPs are started after 6 month of giving birth, she should be advised to abstain from sex or use additional contraceptive protection for the next 2 days.</p> <p>If her menstrual cycle has returned, she can start POPs as advised for any other woman with a menstrual cycle.</p> <p>For women who are less than 6 weeks postpartum and primarily breastfeeding, use of POPs is not recommended.</p>
Switching from another hormonal method	<p>She can start POPs immediately, if she has been using her hormonal method consistently and correctly, or if she is otherwise reasonably certain that she is not pregnant. There is no need to wait for the next menstrual period.</p> <ul style="list-style-type: none"> • If her previous method was an injectable, she should start POPs at the time when the repeat injection would have been given. NO additional contraceptive protection is needed. • She can start POPs within 5 days after the start of her menstrual bleeding. No additional contraceptive protection is

	needed.
Switching from a non-hormonal method (other than IUD)	<ul style="list-style-type: none"> • She can also start immediately or any other time, is if is reasonably certain that she is not pregnant. If it has been more than 5 days since menstrual bleeding started, she will need to abstain from sex or use additional contraceptive protection for the next 2 days.
No Monthly Bleeding	<ul style="list-style-type: none"> • She can start POPs anytime it is reasonably certain that she is not pregnant. She will need a backup method for the first two days of taking pills.
After miscarriage or abortion	<p>Immediately. If she is starting within 7 days after first or second trimester miscarriage or abortion, no need for backup method.</p> <p>If it is more than 7 days after first or second trimester miscarriage or abortion, she can start POPs anytime it is reasonably certain that she is not pregnant. She will need a backup method for the first 2 days of taking pill</p>

Source:

- Family Planning – A global Handbook for providers, A WHO family planning cornerstone, 2007.
- Contraceptive Updates, Reference manual for Doctors, Oct. 2007, MOHFW, Govt. of India.

Explaining how to use POPs:

- The client should always take one pill every day.
- It s best to take the pill at the same time each day if possible, as even taking a pill more than a few hours late increases the risk of pregnancy. Missing two or more pills in a row greatly increases the risk of pregnancy.

Starting the next packet

- There is to be no gap between packets, she should take the first pill from the next package on the very next day (All pills are active, hormonal pills)

Managing Missed Pills:

If a woman is 3 or more hours late in taking a pill or misses one completely she should take a missed pill as soon as she remembers and then keep taking one pill every day as usual.

- A breastfeeding woman using POP for extra protection is still protected if she misses the pill.
- A woman who is not breastfeeding or who is breastfeeding but whose menses have resumed is 3 hours late or misses one completely should also use condoms or else avoid sex for two days. She should also take last missed pill as soon as she can. Then she should keep taking one pill every day as usual.

2.3 Centchroman (Saheli)

- Nonsteroidal, highly effective, safe and easy to use oral contraceptive.
- It is free of the side effects commonly associated with contraceptives containing both estrogen and progestin.

- However, it should be avoided in polycystic ovarian disease, liver and kidney diseases and tuberculosis.

How to Use:

It is taken orally twice a week for the first three months and then once-a-week.

2.4 Injectable Contraceptives

- Progestin - only injectables. They do **not** contain oestrogen. They are **3-monthly**-DMPA (Depo-Provera ,Depo Progestin, Khushi) and **2-monthly**-Noristerat(Net-En)
- Combined injectables containing **both** oestrogen and progestin. They are **one-Monthly Injectables** (Cyclofem, Cyclo- Provera).

Progestin only Injectable (DMPA):

Client Screening Guidelines for DMPA

DMPA can be given to all women except in the following conditions

1. Pregnancy (suspected or confirmed)
2. Breastfeeding infant less than six weeks
3. Multiple risk factors for arterial cardiovascular disease(age above 35 years, smoking, diabetes and hypertension)
4. High blood pressure $\geq 160/100$ mm Hg
5. Vascular Disease
6. Current Deep Vein thrombosis or Pulmonary Embolism
7. Current or history of Ischaemic Heart Disease
8. History of Stroke
9. Migraine with aura
10. Unexplained Vaginal Bleeding(suspicious for serious condition) before evaluation
11. Current or past history of Breast Cancer
12. Diabetes of more than 20 yrs duration or complicated with nephropathy/retinopathy/neuropathy
13. Active viral hepatitis/ benign or malignant liver tumours/severe cirrhosis

Source: WHO Medical Eligibility Criteria for Contraceptive Use, 2004, category 3 and 4

When to start DMPA:

- Any day between first to seventh day of menstrual cycle or any day the provider is reasonably sure that the client is not pregnant.
- Immediately after abortion or within seven days post abortion, even if infection is present.
- After delivery - after six weeks if breastfeeding; after three weeks if not breastfeeding. DMPA becomes effective immediately.

Key messages about DMPA:

- DMPA should be taken once in three months.
- DMPA causes change in menstrual pattern, mainly absence of period.

- It usually takes 5-6 months after the effect of last injection is over for the woman to become pregnant.
- Women of all ages and parity may use it.
- Women who cannot use pills due to oestrogen-related precautions can use DMPA e.g. breastfeeding women, smokers.

Do not take injection with unclean syringes or from an untrained person.

2.5 Copper Bearing Intra Uterine Contraceptive Device (IUCDs or IUDs)

Client Screening Guidelines for IUDS

IUDS can be given to all women except in the following conditions:

1. Pregnancy (suspected or confirmed)
2. Nulliparity
3. Immediate post septic abortion
4. Unexplained vaginal bleeding (suspicious for serious condition) before evaluation
5. Benign or malignant trophoblastic disease
6. Cervical cancer, Endometrial cancer or ovarian cancer
7. Uterine fibroids with distortion of uterine cavity
8. Current Pelvic Inflammatory Disease
9. Increased risk of OR Current STI (purulent cervicitis, chlamydia or gonorrhoea) or AIDS
10. Known Pelvic Tuberculosis

Source: WHO Medical Eligibility Criteria for Contraceptive Use, 2004, category 3 and 4

Women can begin using IUDs:

- Without STI testing
- Without an HIV test
- Without any blood tests or other routine laboratory tests
- Without cervical cancer screening
- Without a breast examination

When to start an IUCD – (See the table given below)

Table 3: When to start an IUCD

The Scenario	When to start
Having menstrual cycle	<p>Any time during the menstrual cycle</p> <ul style="list-style-type: none"> • If she is starting within 12 days after the start of her monthly bleeding, no need for a backup method. • If it is more than 12 days after the start of her monthly bleeding, she can have the IUD inserted any time it is reasonably certain she is not pregnant. No need for a backup method.

	<p>During menstruation, possible advantages: -</p> <ul style="list-style-type: none"> - Pregnancy is ruled out - Insertion may be easy - Any minor bleeding caused by insertion is less likely to upset the client - Insertion may cause less pain <p>Possible disadvantages during menstruation: -</p> <ul style="list-style-type: none"> - Pain from pelvic infection may be confused with pain of menstrual period. IUD should not be inserted if the woman has a pelvic infection. - May also be harder to identify other signs of infection
Switching from another method	<ul style="list-style-type: none"> • Immediately, if she has been using the method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. • If she is switching from injectables, she can have the IUD inserted when the next injection would have been given. No need for a backup method.
Breast feeding	<ul style="list-style-type: none"> • If her menstruation has not returned. She can have IUD inserted after 6 weeks of delivery or more, when it is reasonably certain that she is not pregnant. No need for a back up method. • If her menstruation has returned, she can have the IUD inserted as advised for woman having menstrual bleeding.
After miscarriage or abortion	<ul style="list-style-type: none"> • Immediately, if the IUD is inserted within 12 days after first- or second-trimester abortion or miscarriage and if no infection is present. No need for a backup method. • If it is more than 12 days after first- or second trimester miscarriage or abortion and no infection is present, she can have the IUD inserted any time it is reasonably certain she is not pregnant. No need for a backup method. • If infection is present, treat or refer and help the client choose another method. If she still wants the IUD, it can be inserted after the infection has completely cleared. • IUD insertion after second-trimester abortion or miscarriage requires specific training. If not specifically trained, delay insertion until at least 4 weeks after miscarriage or abortion.
No monthly bleeding (not related to child birth or breastfeeding)	Any time if it can be determined that she is not pregnant. No need for a backup method.
For Emergency Contraception	Within 5 days after unprotected intercourse.
After taking emergency contraceptive pills	The IUD can be inserted on the same day that she takes the ECPs. No need for a backup method.

Source:

-Family Planning – A global Handbook for providers, A WHO family planning cornerstone, 2007.

Explaining how to use the IUD:

Plan with the client for **Post- Insertion Follow- Up visit in 3 to 6 weeks** – for example, after a menstrual period - for check up and pelvic examination, to make sure that her IUD is still in place and that no infection has developed. The visit can be at any time convenient to the client when she is not menstruating. After this one return visit, no further routine visits are required.

Make sure she knows:

- Exactly what kind of IUD she has and how it looks like
- When to have IUD removed or replaced (for TCU-380A IUD, 10 years after insertion).
- Discuss how to remember the year to return. If she wants a new IUD, it can be inserted as soon as the old IUD is removed.
- When she visits health care providers, she should tell them that she has an IUD.

Important: Provide the client with a written record of the month and year of IUD insertion and the month and year of when it should be removed.

Give specific instructions:

- About the common side effects.
- How and when to check the IUD

When to Check:

- Once a week during the first month after insertion
- After noticing any possible symptoms of serious problems.
- After a menstrual period, from time to time. IUDs are more likely to be dislodged with menstrual blood.

How to Check:

- Wash her hands
- Sit in the squatting position
- Insert 1 or 2 fingers in her vagina as far as she can until she feels the strings. She should return to the health care provider if she thinks the IUD might be out of place.
- Wash hands again

Important:

- She should not pull the strings, as the IUD may be dislodged.
- After postpartum insertion, the strings do not always come down through the cervix.

‘Come back anytime’: Reasons to return to a health care provider:

- Missed menstrual cycle
- If she thinks that she might have been exposed to STIs or has HIV/AIDS.
- Strings missing or strings seen shorter or longer
- Something harder in her vagina at the cervix. It may be part of the IUD.
- Increasing or severe pain in the lower abdomen, especially if there is also fever and/or bleeding between menstrual periods.
- Heavy or prolonged bleeding
- IUD has reached the end of its effectiveness
- She wants the IUD to be removed for any reason.
- She has questions.
- She wants to opt for another family planning method.

Post-Insertion Follow-Up Visit (3 to 6 Weeks)

1. Ask how the client is doing with the method and whether she is satisfied. Ask if she has any questions or anything to discuss.
2. Ask especially if she is concerned about bleeding changes. Give her any information or help that she needs (see Managing Any Problems)
3. Ask her if she has:
 - Increasing or severe abdominal pain or pain during sex or urination
 - Unusual vaginal discharge
 - Fever or chills
 - Signs or symptoms of pregnancy
 - Not been able to feel strings (if she has checked them)
 - Felt the hard plastic of an IUD that has partially come out
4. A routine pelvic examination at the follow-up visit is not required. It may be appropriate in some settings or for some clients, however. Conduct a pelvic examination particularly if the client’s answers lead you to suspect:
 - A sexually transmitted infection or pelvic inflammatory disease
 - The IUD has partially or completely come out

Possible reasons for removal:

- Client’s request
- Any side effects that make client want her IUD
- Any medical reason e.g. Pregnancy, Acute PID, Perforation of uterus
- IUD has come out of place (partial expulsion)
- When the effective lifespan is finished
- When the woman reaches menopause (at least 1 year after her last period)

2.6 Male Condoms

All men can use condoms. If the client complains of severe allergic reaction after using it then only, condoms are not recommended. But if the client is at risk of STIs or HIV, she/he should continue to use condoms during sexual intercourse despite allergy.

How to use condoms

1. Demonstrate the client how to put on and take off a condom by using a model or 2 fingers.
2. The condom is fitted on the erect penis before intercourse.
3. Hold the pack at its edge and open by tearing from a ribbed edge.
4. Hold the condom at the tip, so that the air is expelled from the teat end to make room for the ejaculate.
5. Unroll the condom all the way to the base of erect penis. The condom should unroll easily. If it does not, it is probably backwards. If more condoms are available, throw this one away and use a new condom.
6. Most of the condoms are already lubricated; hence there is no need to apply any additional lubricant. This may damage the condom.
7. After sexual intercourse (ejaculation), hold the rim of the condom to the base of the penis so it will not slip. The man should pull his penis out of the vagina before completely losing his erection.
8. Move away from vagina and take off the condom without soiling semen on the vaginal opening.
9. Tie a knot at the rim of the condom. Dispose it off by burying or burning it.

2.7 Female Condom (FC)

How to Use Female Condom

1. FC is a strong, loose-fitting polyurethane sheath that is 17 centimeters long (about 6.5 inches) with a flexible ring at each end.
2. While holding the sheath at the closed end, grasp the flexible inner ring and squeeze it with the thumb and second or middle finger so it becomes long and narrow.
3. With the other hand, separate the outer lips of the vagina.
4. Gently insert the inner ring into the vagina. Feel the inner ring go up and move into place.
5. Place the index finger on the inside of the condom, and push the inner ring up as far as it will go. The outer ring should remain on the outside of the vagina.
6. The female condom is now in place and ready for use with your partner. Now gently guide your partner's penis into the sheath's opening with your hand to make sure that it enters properly – be sure that the penis is not entering on the side, between the sheath and the vaginal wall. It has special advantages in that it does not require an erect penis to insert the female condom into the vagina.

7. To remove the condom, twist the outer ring and gently pull the condom out. It need not be removed immediately after ejaculation.
8. Wrap the condom in the package or in tissue, and throw it in the garbage.

- FC comes pre-lubricated with a non-spermicidal, silicone-based lubricant that is needed for ease of insertion and for easy movement during intercourse.
- Lubrication reduces noise during sexual intercourse and makes sex smoother.
- Additional lubricant, either oil-based or water-based, can be used.

2.8 Lactational Amenorrhoea Method (LAM)

A temporary family planning method based on the natural effect of breastfeeding on fertility. Effectively prevents pregnancy at least 6 months and maybe longer if a woman keeps breastfeeding often, day and night. The only conditions that limit use of LAM are conditions that make breastfeeding difficult or that rule out breastfeeding.

LAM requires 3 conditions. All 3 must be met:

- The baby is less than 6 months old
- After last childbirth mother's menstrual period has not returned
- The baby is fully or nearly breastfed and is fed often, day and night i.e. at least 8-10 times a day, at least once in 4 hours, and at least once at night (night feeding regularly not more than 6 hours apart), and at least 85% of her baby's feeding should be from breastfed milk.

A woman must switch to another method as soon as any of the 3 LAM criteria no longer applies.

2.9 The Standard Days Method (SDM)

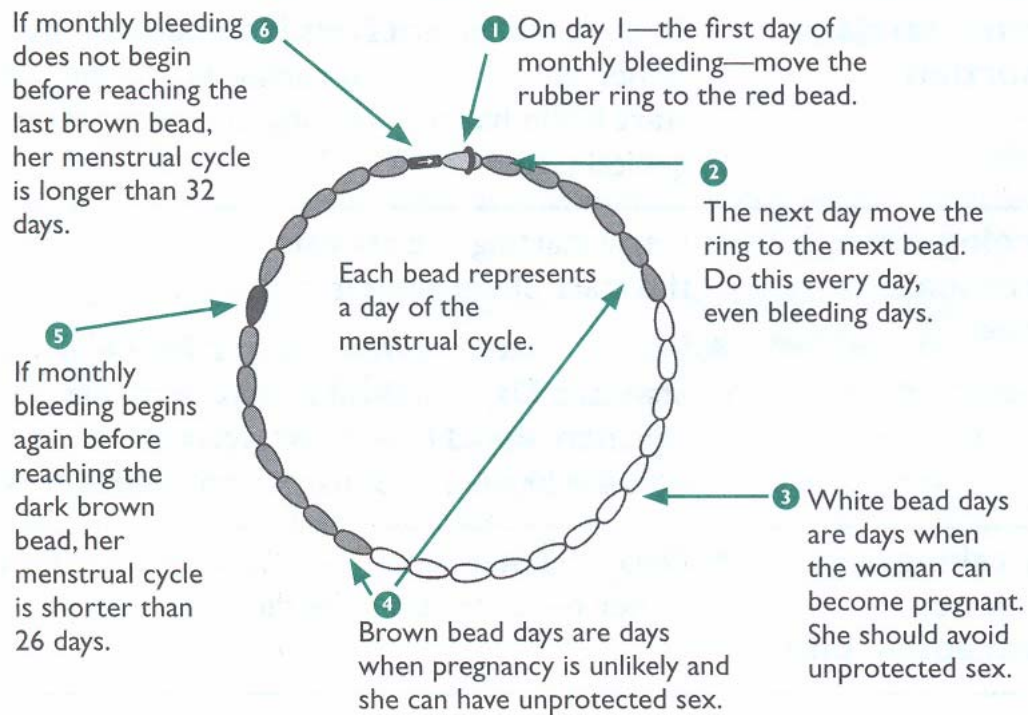
- Natural family planning method,
- Useful for women with menstrual cycles ranging between 26 and 32 days
- Advice on avoiding unprotected sexual intercourse from day 8 to 19 of menstrual cycle is given.

How to use SDM

- For easy and correct use of SDM a device called **Cycle Beads**- a string of colour coded beads is given to client (see the diagram below).
- On the first day of menstrual period, start moving the rubber ring onto the first red bead. Simultaneously, mark the day on calendar provided with the cyclebeads.
- Each day, move the rubber ring onto the next bead, moving in the direction of the arrow.
- All white beads mark the days when she is likely to get pregnant. Advise to avoid sexual intercourse or use condoms on the days when the rubber ring is on any of these white beads.
- All brown beads mark the days when the woman is not likely to get pregnant if she has unprotected intercourse.

- The dark brown bead helps her to know if cycle is less than 26 days long. If her period starts before she moves the ring to the dark brown bead, her cycle is shorter than 26 days.
- If her period does not start by the day she moves the ring to the last brown bead, her cycle is longer than 32 days.

Fig 2: Standard days Method.



3. Protocols on Terminal Methods of Contraception

3.1 Male Sterilization

- Vasectomy, especially no-scalpel vasectomy (NSV), is one of the safest, permanent and most effective contraceptive methods
- Simple, minor surgical procedure that takes 5-15 minutes to perform, after 5-10 minutes of pre-operative preparation and administration of local anaesthesia.

Table 4: Eligibility of providers for performing Male Sterilization

Service	Basic Qualification Requirement of Provider
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Conventional vasectomy	Trained MBBS doctor
No-scalpel vasectomy (NSV)	Trained MBBS doctor

The state has a district-wise panel of doctors for performing sterilization operations in government institutions and government-accredited private/NGO centres based on the above criteria. Only those doctors whose names appear in the panel are entitled to carry out sterilization operations in government and/or government-accredited institutions. The panel is updated quarterly.

Medical eligibility

- Most men can have a vasectomy in routine settings.
- **DELAY** the vasectomy and refer the client to treatment if he has:
 - Active sexually transmitted infection
 - Inflamed (swollen and tender) tip of penis, ducts or testicles
 - Scrotal skin infection or mass in the scrotum
 - Acute systemic infection or significant gastroenteritis
 - Filariasis or elephantitis
- If he has any of the following, refer him to a centre with experienced staff and equipment that can handle potential problems:
 - Hernia in the groin (provider if able, can perform vasectomy at the same time as repairing hernia. If this is not possible, the hernia should be repaired first)
 - Undescended testicles on both sides
 - Current AIDS-related illness
 - Coagulation disorders

If he has any of the following, use **CAUTION**:

- previous scrotal surgery or injury
- Large varicocoele or hydrocoele (swollen veins or membranes in the spermatic cord or testes, causing swollen scrotum)
- Undescended testicles on one side only (vasectomy is performed on the normal side only. Then if any sperm remains in the semen after 3 months, vasectomy must be performed on the other side too.
- If he has diabetes.

Requirements for a safe procedure

1. Counselling:

- It should be provided only to men who have decided on their own that they do not want children any more.
- Clients should be counselled about other available methods of contraception before deciding on sterilization.

2. Client assessment:

- **Medical history**
 - **Physical examination**-including genital examination; the penis, scrotum and the inguinal region should be inspected visually; and the scrotum should be palpated.
 - **Laboratory tests**- Reserved for specific cases in which a condition that would make it necessary to make extra preparation is suspected.
3. **Informed consent:** The form should be signed after confirming that the client has made an informed choice.
 4. **Infection prevention:** Proper aseptic technique is essential. Shaving or clipping the hair at the operation site is no longer recommended.
 5. **Anaesthesia:** Both, conventional and no scalpel vasectomy are done under local anaesthesia. General anaesthesia may be necessary when there are scrotal abnormalities (such as large varicocele, large hydrocoele or chryptorchidism).
 6. **Instructions to the client:** After the procedure, the man should-
 - Put a cold compresses on the scrotum for 4 hours to lessen swelling
 - Rest for 2 days. He should not do any heavy work or vigorous exercise for a few days.
 - Keep the incision clean and dry for 2-3 days. He can use a towel to wipe his body clean but should not soak in water.
 - Wear snug underwear or pants for 2-3 days to help support the scrotum.
 - Take paracetamol or another pain-relief medication as needed. He should not take aspirin or ibuprofen, which slow blood clotting.
 - Use condoms or another effective family planning method for 3 months after the procedure.
 - He can have sex within 2-3 days after the procedure. Vasectomy does not affect man's ability to have sex.

7. Return to the clinic for a **follow-up** and for any of these reasons:

A health worker should visit all clients who undergo a vasectomy within 48 hours. **First follow-up:** seven days after the surgery for removal of stitches (in cases of conventional vasectomy), to have the wound examined and to have his questions answered. **Second follow-up:** the client should undergo semen analysis after three months. **Emergency follow-up:** this can be done at any time after the surgery if:

- His wife misses her menstrual period or thinks she is pregnant.
- He has questions or problems of any kind.
- If he has high fever (greater than 38°C) in the first 4 weeks and especially in the first week, or
- If he has bleeding or pus from the wound, or
- If he has pain, heat, swelling, or redness at an incision that becomes worse or does not stop (signs of infection)
- If the clinic cannot be reached quickly, he should go to another doctor or health care provider at once.

3.2 Female Sterilization

Female sterilization is one of the safest operative procedures that involve permanently blocking the fallopian tubes to prevent fertilization.

Table 5: Eligibility of providers for performing Female Sterilization

Service	Basic Qualification Requirement of Provider
Minilap services	Trained MBBS doctor
Laparoscopic sterilization	DGO, MD (Obst. & Gynae.), MS (Surgey) (Trained in Laparoscopic sterilization)

The states constitute a district-wise panel of doctors for performing sterilization operations in government institutions and accredited private/NGO centres based on the above criteria. Only those doctors whose names appear on the panel are entitled to carry out sterilization operations in the government and/or government-accredited institutions. The panel is updated quarterly.

Medical eligibility for female sterilization

In general, most women who want sterilization can have safe and effective procedures in routine settings. With proper counseling and informed consent, sterilization can be used in any circumstances by women who:

- Just gave birth (within 7 days)
- Are breastfeeding

Also, women with the following conditions can have sterilization in a routine setting in any circumstances:

- Mild pre-eclampsia
- Past ectopic pregnancy
- Benign ovarian tumours
- Irregular or heavy vaginal bleeding patterns, painful menstruation
- Vaginitis without purulent cervicitis
- Varicose veins
- HIV positive or high-risk of HIV or other STIs
- Malaria
- Non-pelvic tuberculosis
- Caesarean delivery (surgical delivery) at same time.

In the following conditions, use the instructions below:

1. Gynaecological / obstetrical conditions:

If the woman has any of the following, **DELAY** female sterilization and treat as appropriate or refer:

Pregnancy

- Postpartum or second trimester abortion (7-42 days)
- Serious postpartum or post-abortion complications
- Unexplained vaginal bleeding that suggests a serious condition
- Severe pre-eclampsia, eclampsia
- Pelvic inflammatory disease within past 3 months
- Current STI
- Pelvic cancers
- Malignant trophoblast disease

If she has any of the following, **REFER** her to a centre with experienced staff and equipment that can handle potential problems:

- Fixed uterus due to previous surgery or infection
- Endometriosis
- Hernia (umbilical or abdominal wall)
- Postpartum uterine rupture or perforation or post-abortion uterine perforation

If she has any of the following, use **CAUTION**:

- Past PID since last pregnancy
- Current breast cancer
- Uterine fibroid

2. Cardiovascular conditions

If she has the following, **DELAY** female sterilization:

- Acute heart disease due to blocked arteries
- Deep vein thrombosis or pulmonary embolism

If she has the following, **REFER** her to a centre with experienced staff and equipment that can handle potential problems:

- Moderate or severe high blood pressure (160/100 or higher)
- Vascular disease including diabetes-related
- Complicated vulvular disease

If she has any of the following, use **CAUTION**:

- Mild high blood pressure (140/90 – 155/99 mm)
- History of high blood pressure where blood pressure can be evaluated, or adequately controlled high blood pressure where blood pressure can be evaluated
- Past stroke or heart disease due to blocked arteries.

- Vulvular heart disease without complications.

3. Chronic disease conditions:

If she has any of the following, **DELAY** female sterilization:

- Gall bladder disease with symptoms
- Active viral hepatitis
- Severe iron deficiency anaemia (haemoglobin below 7g/dl)
- Acute lung disease (bronchitis or pneumonia)
- Systemic infection or severe gastroenteritis
- Abdominal skin infection
- Abdominal surgery for emergency or infection at time sterilization is desired, or major surgery with prolonged immobilization.

If she has any of the following, **REFER** her to a centre with experienced staff and equipment that can handle potential problems:

- Severe cirrhosis of liver
- Diabetes for more than 20 years
- Hyperthyroid
- Coagulation disorders
- Chronic lung disease
- Pelvic tuberculosis

If she has any of the following, use **CAUTION**:

- Epilepsy Or taking medicines for seizure
- Taking antibiotics or griseofulvin
- Diabetes with vascular disease
- Hypothyroid
- Mild cirrhosis of liver, liver tumours or schistosomiasis with liver fibrosis
- Sickle cell disease
- Inherited anaemia
- Kidney disease
- Diaphragmatic hernia
- Severe lack of nutrition
- Obese (Is she extremely overweight?)
- Elective abdominal surgery at time sterilization is desired. Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.

Requirements for a safe procedure

Counselling:

Clients should be counselled about all available methods of contraception before deciding on sterilization. It should be provided only to women who have decided on their own that they do not want children any more.

Client assessment:

- **History** (medical and obstetrics and gynaecological history)
- **Physical examination** (vital signs, heart, lungs, abdomen, and pelvic and speculum examination).
- **Laboratory tests:** To screen for anaemia and to rule out current pregnancy.

- Criteria to minimize the chances of pregnancy, one should perform the procedure:
 - within 7 days of the menstrual period
 - within 7 days of abortion
 - within 7 days of term delivery
 - in women using reliable method of contraception e.g. IUCD, Injectable hormonal method.

- Informed consent: The form should be signed after confirming that the client has made an informed choice.
- Infection prevention: Proper aseptic technique is essential. Shaving or clipping the hair is no longer recommended.
- Anaesthesia: Three choices of anaesthesia regimen—local, general, or regional. Factors to be considered in the choice of anaesthesia include the type of surgical technique, the skill of surgeon, the availability of appropriate drugs, and the safety and conformity of the client, and the ability of the surgeon to manage complications, should they occur.

Explaining self-care for minilaparotomy or laparoscopy

- Before the procedure, the woman should:
 - Not eat or drink anything for 8 hours before surgery;
 - Not take any medication for 24 hours before surgery (unless the doctor performing the procedure tells her to do so);
 - Bathe thoroughly the night before the procedure, especially her belly, genital area, and upper thighs;
 - Wear a clean, loose fitting clothing to the health facility if possible;
 - If possible, bring a relative to help her go home.
- After the procedure, the woman should:
 - Rest for 2 or 3 days and avoid heavy lifting for a week;
 - Keep the incision clean and dry for 2-3 days;

- Be careful not to rub or irritate the incision for 1 week;
- Take paracetamol or another safe, locally available pain-relief medicine as needed. She should not take aspirin or ibuprofen which slow blood clotting.
- Not have sexual intercourse for at least one week. If pain lasts for more than one week, do not have sex until all pain is gone.

Specific reasons to see a doctor or nurse:

A woman should return to the clinic for any of these reasons:

- For a follow-up, if possible, within 7 days or at least 2 weeks and to have stitches removed, if necessary.
- Follow-up can also be done at home or at any other suitable facility.
- She has questions or problems of any kind.
- Return at once if she has: -High fever (more than 38 degrees C) in the first weeks and especially in the first week or -Pus or bleeding from the wound, or -Pain, heat, swelling, or redness of the wound that becomes worse or does not stop (signs of infection), or
- Abdominal pain, cramping, or tenderness that becomes worse or does not stop, or Diarrhoea, or Fainting or extreme dizziness

If the clinic cannot be reached quickly, she should go to another doctor at once.

- She thinks that she might be pregnant. First symptoms of pregnancy are:-
Missed periods
- Nausea, and
- Breast tenderness

She should come to the clinic at once if she also has any one of the signs of possible ectopic pregnancy:

- Lower abdominal pain or tenderness on one side-Abnormal or unusual vaginal bleeding,
- Faintness (indicating shock)

Pregnancies among users of voluntary sterilization are few. But when pregnancy occurs, it is more likely to be ectopic than average pregnancy. Ectopic pregnancy is life-threatening. It requires immediate treatment.

Two methods can be used to prevent failures:

- The incidence of unintended pregnancy can be decreased by scheduling this procedure within the first 7-10 days of the start of a menstrual cycle.
- The fallopian tubes can be identified properly by tracing it to the fimbrial end prior to occlusion.

Meticulous attention should be paid to technique, whichever method is used.

Follow-up within 7 days or at least 2 weeks is strongly recommended to check the site of the incision looks for any sign of complications and removes any stitches.

4. Protocol on Emergency Contraception:

It should be used only in the emergency situations described below:

1. Sex was forced (rape) or coerced
2. Any unprotected sex
3. Contraceptive mistakes, such as:
 - Condom was used incorrectly, slipped, or broke
 - Couple incorrectly used a fertility awareness method (for example, failed to abstain or to use another method during the fertile days)
 - Man failed to withdraw, as intended, before he ejaculated
 - Woman has missed 3 or more combined oral contraceptive pills or has started a new pack 3 or more days late
 - IUD has come out of place
 - Woman is more than 2 weeks late for her repeat progestin-only injection or more than 7 days late for her repeat monthly injection

To summarize, emergency contraception can be used in all those circumstances in which a woman has reason for concern that she may become pregnant.

4.1 Methods of Emergency Contraception

There exist 3 methods of EC-

1. Levonorgestrel only EC pills (A dedicated product) Available as over the counter drug. Brand names:

1. E pill
2. ECee2
3. Norlevo 0.75 mg
4. Pill 72
5. Pregnon
6. Preventol
7. I Pill

Dosage: One pill of LNG 0.75 mg to be taken as soon as possible after unprotected coitus (within 72 hours), followed by another pill 12 hours later.

2. High Doses of Oral Contraceptive Pills as Emergency method

OCPs (containing 30 or 35 microgram oestrogen e.g. Mala-N, mala-D, Overall, Pearl etc): 4 tablets as soon as possible (within 72 hours of unprotected coitus), followed by another 4 pills 12 hours later.

Make certain that the client does not want to become pregnant, but that she understands that there is still a chance of pregnancy even after using ECPs. Explain that the ECPs will not cause any harm to the foetus if it fails to prevent pregnancy.

3. IUCD as an emergency contraception:

- IUCD can be effectively used as an emergency method of contraception within 5 days of first act of unprotected intercourse.
- Eligibility criteria are the same as when IUCD is used for regular contraception but special care should be taken in the case of sexual assault cases as presence of STIs increases the risk for PID.
- Follow- up of all the woman after the first menstrual period is critical to make sure that the client is not pregnant and that IUCD is in situ.

Note: Emergency contraception should not be used in place of other family planning methods.

5. Protocols for Special Groups

5.1 After Delivery

A woman should not wait until the return of monthly bleeding to start a contraceptive method, but instead she should start as soon as guidance allows in the table given below:

Table 6: Earliest time that a woman can start family planning method after childbirth.

Family Planning Method	Fully or nearly fully breastfeeding	Partially Breastfeeding or not breastfeeding
Lactational Amenorrhea Method	Immediately	(Not applicable)
Vasectomy	Immediately or during partners' pregnancy*	
Male or Female condom	Immediately or when sex is resumed	
Copper-bearing IUD	Wait 6 weeks, Post Placental insertion (only by trained providers)	
Female sterilization	Within 7 days, otherwise wait 6 weeks	
Fertility awareness methods/SDM	Start when normal secretions have returned (for symptoms-based methods) or she has had 3 regular menstrual cycles (for calendar-based methods). This will be later for breastfeeding women than for women who are not breastfeeding.	
Progestin-only pills	6 weeks after childbirth**	-Immediately if not breastfeeding**
Progestin-only Injectables		-6 weeks after childbirth if partially breastfeeding.
Implants		
Combined oral contraceptives	6 months after childbirth**	21 days after childbirth if not breastfeeding**
Injectables		

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

** Earlier use if not usually recommended unless other, more appropriate methods are not available or not acceptable.

5.2 Family Planning in Post abortion Care

- Counsel with Compassion
- To make decisions about her health and fertility, she needs to know:
- Fertility returns quickly—within 2 weeks after a first-trimester abortion or miscarriage and within 4 weeks after a second-trimester abortion or miscarriage.
- She can choose among many different family planning methods that she can start at once (see next page). Methods that women should not use immediately after giving birth pose no special risks after treatment for abortion complications.
- She can wait before choosing a contraceptive for ongoing use, but she should consider using a backup method* in the meantime if she has sex. If a woman decides not to use contraceptives at this time, providers can offer information on available methods and where to obtain them. Also, providers can offer condoms, oral contraceptives, or emergency contraceptive pills for women to take home and use later.
- To avoid infection, she should not have sex until bleeding stops—about 5 to 7 days. If being treated for infection or vaginal or cervical injury, she should wait to have sex again until she has fully healed. If she wants to become pregnant again soon, encourage her to wait.

**Backup methods include abstinence, male or female condoms and withdrawal.*

Combined oral contraceptives, progestin-only pills, progestin-only injectables, monthly injectables, male condoms, female condoms, and withdrawal can be started immediately in every case, even if the woman has injury to the genital tract or has a possible or confirmed infection.

IUDs, female sterilization, and fertility awareness methods can be started once infection is ruled out or resolved.

IUDs, female sterilization, and fertility awareness methods can be started once any injury to the genital tract has healed.

Special considerations:

- IUD insertion immediately after a second-trimester abortion requires a specifically trained provider.
- Female sterilization must be decided upon in advance, and not while a woman is sedated, under stress, or in pain. Counsel carefully and be sure to mention available reversible methods).
- Fertility awareness methods: A woman can start symptoms-based methods once she has no infection-related secretions or bleeding due to injury to the genital tract.

5.3 Adolescents

- All Contraceptives Are Safe for Young People
- Male and female condoms (provides triple protection which many young people need)
- Hormonal contraceptives (oral contraceptives, injectables)
- Emergency contraceptive pills (ECPs)
- Copper Bearing Intrauterine device
- Fertility awareness methods/ Standard days Method
- Withdrawal
- Female sterilization and vasectomy (Provide with great CAUTION)

5.4 Male Participation in family Planning

- Providers can give support and services to men both as supporters of women and as clients.
- Important services that many men want include:
 - Condoms, vasectomy, and counselling about other methods
 - Counselling and help for sexual problems STI/HIV counselling, testing, and treatment
 - Infertility counselling
 - Screening for penile, testicular, and prostate cancer
- Like women, men of all ages, married or unmarried, have their own sexual and reproductive health needs. They deserve good-quality services and respectful, supportive, and non-judgemental counselling.

5.5 Women near Menopause

- It is recommended to use a family planning method for 12 months after last bleeding
- To prevent pregnancy until it is clear that she is no longer fertile, an older woman can use any method, if she has no medical condition that limits its use. By itself, age does not restrict a woman from using any contraceptive method.

Special Considerations about Method Choice:

When helping women near menopause choose a method, consider:

Combined hormonal methods (combined oral contraceptives [COCs], monthly injectables,

- Women age 35 and older who smoke—regardless of how much—should not use COCs,
- Women age 35 and older who smoke 15 or more cigarettes a day should not use monthly injectables.
- Women age 35 or older should not use COCs, monthly injectables, if they have migraine headaches (whether with aura or not).

Progestin-only methods (progestin-only pills, progestin-only injectables)

It is a good choice for women who cannot use methods with estrogen. During use, DMPA decreases bone mineral density slightly. It is not known whether this decrease in bone density increases the risk of bone fracture later, after menopause.

Emergency contraceptive pills

- Can be used by women of any age, including those who cannot use hormonal methods on a continuing basis.

Female sterilization and vasectomy

- May be a good choice for older women and their partners who know they will not want more children.
- Older women are more likely to have conditions that require delay, referral, or caution for female sterilization.

Male and female condoms and withdrawal

- Protect older women well, considering women’s reduced fertility in the years before menopause.
- Affordable and convenient for women who may have occasional sex.

Copper Bearing Intrauterine device

- Expulsion rates fall as women grow older, and are lowest in women over 40 years of age.
- Insertion may be more difficult due to tightening of the cervical canal.

Fertility awareness methods

- Lack of regular cycles before menopause makes it more difficult to use these methods reliably.

When a Woman Can Stop Using Family Planning

Because bleeding does not come every month in the time before menopause, it is difficult for a woman whose bleeding seems to have stopped to know when to stop using contraception. Thus, it is recommended to use a family planning method for 12 months after last bleeding in case bleeding occurs again.

Hormonal methods affect bleeding, and so it may be difficult to know if a woman using them has reached menopause. After stopping a hormonal method, she can use a

nonhormonal method. She no longer needs contraception once she has had no bleeding for 12 months in a row.

Copper-bearing IUDs can be left in place until after menopause. They should be removed within 12 months after a woman’s last monthly bleeding.

5.6 Contraceptives for Clients with STIs, HIV, and AIDS

Advice should be given on choosing a **Triple Protection Strategy-** (i. e. protection against pregnancy, STIs and HIV) - The strategy is mainly to use a male or female condom correctly and consistently with every act of sex despite of using another method of contraception for extra protection. See the table given below for special consideration regarding various family planning methods for them.

Table 7: Special family planning considerations for clients with STIs, HIV, AIDS, or on Antiretroviral Therapy

Method	Has STIs	Has HIV or AIDS	On anti-retroviral (ARV) Therapy
Intrauterine device (Copper -bearing or hormonal IUDs)	Do not insert an IUD in a woman who is at very high individual risk for gonorrhea and Chlamydia, or who currently has gonorrhea, Chlamydia, purulent cervicitis, or PID (a current IUD user who becomes infected with gonorrhea or Chlamydia or develops PID can safely continue using an IUD during and after treatment	A woman with HIV can have an IUD inserted. A woman with AIDS should not have an IUD inserted unless she is clinically well on ARV therapy (a woman who develops AIDS while using an IUD can safely continue using the IUD).	Do not insert an IUD if client is not clinically well.
Female sterilization	If client has gonorrhea, Chlamydia, prulent cervicitis, or PID, delay sterilization until the condition is treated and cured.	Woman who are infected with HIV, have AIDS or are on antiretroviral therapy can safely undergo female sterilization. Special arrangements are needed to perform female sterilization on a woman with AIDS. Delay the procedure is she is currently ill with AIDS-related illness.	
Vasectomy	If client has scrotal skin infection, active STI,	Men who are infected with HIV, have AIDS, or are on antiretroviral therapy can safely	

	swollen, tender tip of penis, sperm ducts, or testicles, delay sterilization until the condition is treated and cured	undergo vasectomy. Special arrangements are needed to perform vasectomy on a man with AIDS. Delay the procedure if he is currently ill with AIDS related illness.
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Source:

- *Family Planning – A global Handbook for providers, A WHO family planning cornerstone, 2007.*
- *Contraceptive Updates, Reference manual for Doctors, Oct. 2007, MOHFW, Govt. of India.*

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