Training Manual on Family Planning and Reproductive Health Care Services for Community Health Officer

at Ayushman Bharat - Health and Wellness Centres

2021

Chapter

Annexure

LIST OF ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
ARV	Anti-Retro Viral
CHC	Community Health Centre
CHO	Community Health Officer
CMO	Chief Medical Officer
COC	Combined Oral Contraceptive
DH	District Hospital
EC	Economic Census
ECP	Emergency Contraceptive Pill
FDS	Fixed Day Static
FP	Family Planning
FP-LMIS	Family Planning- Logistics Management Information System
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
HTSP	Healthy Timing and Spacing of Pregnancy
HWC	Health and Wellness Centre
IUCD	Intra-Uterine Contraceptive Device
LARC	Long Acting Reversible Contraceptive
LLIN	Long Lasting Insecticidal Nets
MLHP	Mid-Level Health Provider
MMA	Medical Method of Abortion
MO I/C	Medical Officer In-Charge
MPA	Medroxy Progesterone Acetate
MPW	Multi-Purpose Worker
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration

OCP	Oral Contraceptive Pill
PAIUCD	Post-Abortion Intra-Uterine Contraceptive Device
PAS	Post-Abortion Sterilization
PHC	Primary Health Centre
PID	Pelvic Inflammatory Disease
PLHA	People Living with HIV/AIDS
PPIUCD	Post-Partum Intra-Uterine Contraceptive Device
PPS	Post-Partum Sterilization
PRI	Panchayati Raj Institution
RTI	Reproductive Tract Infection
SDH	Sub-District Hospital
SHC-HWC	Sub-Health Centre- Health and Wellness Centre
SHG	Self Help Group
SMS	Short Message Service
SN	Staff Nurse
SRS	Sample Registration System
STI	Sexually Transmitted Infection
ULB	Urban Local Bodies
UPHC	Urban Primary Health Centre
VHSNC	Village Health Sanitation Nutrition Committee
VHSND	Village Health Sanitation Nutrition Day
WHO	World Health Organization

Chapter 1: Introduction to Family Planning Services

1.1 Contraception scenario in India

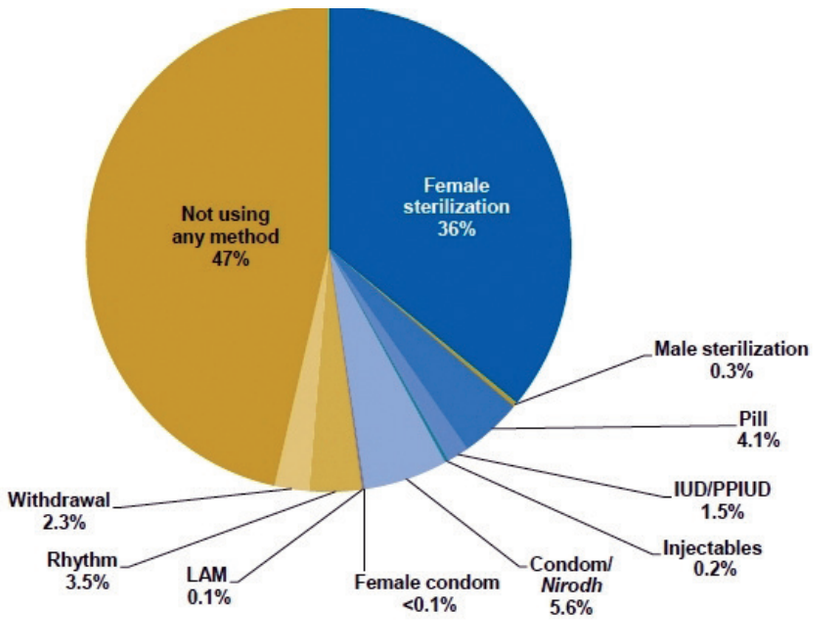
India was the first country in the world to launch a National Family Planning Programme way back in 1952 and the programme is now positioned as not only a means to stabilise population but as the most cost-effective way to reduce maternal and infant mortality. Integration of family planning with maternal and child health care, including nutrition, has a huge potential to improve the health of women and children in a community. The use of modern methods of contraception has seen an increase in the past few years, resulting in a steady decline in fertility.

Quality of care in delivering contraceptive services is an important determinant for contraceptive acceptance, method continuation and ultimately beneficiary satisfaction. Knowledge of contraceptive methods is almost universal in India, with 99% of currently married women and men aged between 15-49 years knowing about at least one method of contraception (NFHS, 4). Yet, the acceptance of contraceptives remains low, especially for spacing methods. Female sterilisation remains the most widely used family planning (FP) method despite the efforts to popularise male sterilization (figure 1a). The current unmet need for family planning is about 13%, of which the unmet need for spacing is about 5.5% and unmet need for limiting methods is 7.2% (NFHS IV). For the married adolescent group, the unmet need is as high as 22.1%. Thus, ensuring access to quality family planning services is crucial to reduce unmet need for family planning.

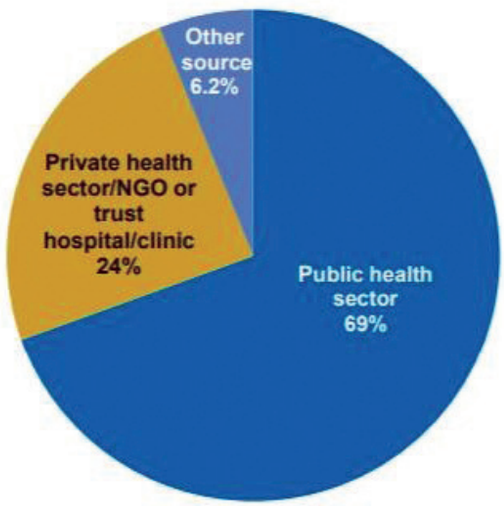
Around 69% of modern contraceptive users obtain FP services from public sector (figure 1b). Sterilisation (female and male) and IUCDs/ PPIUCDs are primarily delivered through public health system whereas pills, injectable contraceptives and condoms are mostly delivered through private health system. It is important for the service providers at all levels of care to know about the recent developments in family planning programme to provide quality services to those voluntarily accepting contraception.

Figure1: a. Contraceptive methods used by currently married eligible couples in India.

b. Source of modern contraceptive methods (NFHS 4, 2015-16)



1. a.



1. b.

As you are aware, the fourth essential package of services to be provided as a part of Comprehensive Primary Health Care encompasses family planning, contraceptive and other reproductive health care services.

You have already learnt in the Induction Module, that each of these services will be organised at the level of the community, Health and Wellness Centres and at the first referral centre – PHC/CHCs, as appropriate. Broadly, for the fourth package of services mentioned above, the services at the AB-HWC level will include:

- Identification and management of RTIs/STIs
- Family planning counselling
- Insertion and removal of IUCD by trained CHO
- Provision of other spacing contraceptive methods
- Appropriate referrals for sterilisation services
- Counselling & facilitation of safe abortion services
- Ensuring treatment adherence, follow-up for any complications
- Ensuring continuity of care by appropriate referrals
- Optimal home and community follow-up
- Health promotion and prevention

You, as the leader of the Primary Health Care Team at Sub Centre-Health and Wellness Centre, would provide the first level of management, triage and refer the patient to the appropriate health facility for treatment and follow up, if required. You will also support ASHAs and Multi-Purpose Workers of your AB-HWC service area in providing home-based or community level out reach service for family planning to beneficiaries and provide appropriate referral for abortion care services.

1.2 Importance of family planning services in improving maternal and newborn health

Family planning means that the couples decide and plan when and how many children they want to have. Family planning methods help to prevent unwanted pregnancies and preventable deaths occurring due to 'too soon/ too many' births, thus impacting maternal, newborn, and child health outcomes. Therefore, as mentioned earlier, family planning is considered a maternal and child health intervention instead of population stabilisation alone.

Healthy Timing and Spacing of Pregnancy:

Family planning can have different meaning for different beneficiaries, based on their reproductive needs, such as planning to delay the birth of first child, planning for healthy spacing between two children, planning to limit the number of children once the desired family size is achieved, etc.

- Delaying the birth of first child provides time to the woman to become physically and emotionally ready for a healthy childbearing. It also provides time for the couple to plan and prepare themselves for childrearing.

- Healthy spacing between children leads to better health and nutritional outcomes for both mother and children, and also reduces the risk of maternal death and complications following delivery.
- Limiting the family size enables couples to focus on growth and development of the children.

Healthy Timing and Spacing of Pregnancy (HTSP) – recommendations
A woman considering using a family planning method before trying to become pregnant should:

- Wait until the age of 18 years before she conceives for the first time.
- Wait at least 24 months after childbirth to become pregnant again (the recommended birth interval between two births is minimum 36 months).
- Wait at least 6 months after miscarriage or abortion to conceive again.

You shall learn more about the above HTSP and its relation to nutrition in the next chapter.

Benefits of using Family Planning Methods:

- Mothers and babies are healthier when high risk pregnancies including unintended pregnancies are avoided.
- Smaller family means availability of more money for expenditure per family member on health, nutrition, and education, especially for children.
- Parents have more time to work and spend time with family.
- Adolescents, below the age of 18 years are still in growing phase of their development and are particularly vulnerable to malnutrition. Pregnancy and lactation can increase this risk. When adolescents are still growing, pregnancy can induce competition for nutrients between the mother and foetus, which can result in adverse outcomes for both.

1.3 Quality Components of Contraceptive Services

Delivery of care in accordance with the beneficiary's reproductive rights is fundamental to the quality of care. Beneficiaries should be offered a range of contraceptive methods and be empowered to select, switch, and discontinue a method as per their needs. Availability of skilled providers and appropriate supply chain management is critical for provision of quality family planning services.

Skilled Providers

- To provide high-quality family planning services to the beneficiaries and help them make informed and voluntary decisions about their fertility, you as a CHO must be trained in different contraceptive methods.
- Counselling is a key element in quality of care and is also an important part of both service delivery and follow-up visits and should respond to the beneficiary's needs, not only in contraception but also in relation to sexuality and the prevention of Sexually Transmitted Infection (STIs), including the Human Immunodeficiency Virus (HIV).
- In addition to counselling skills, you should also have access to periodic updates on the recent advances in contraceptive technology and medical eligibility criteria. At the sites where sterilisations and Intra-Uterine Contraceptive Device (IUCD) services are provided, the providers should have necessary clinical skills for adhering to existing service delivery guidelines.

Physical infrastructure, supplies and commodities

- Being posted at SHC-HWC, you should ensure that adequate and appropriate equipment and supplies are available at your AB-HWC as well as with your team for community level services (for example, contraceptive commodities, condom boxes, equipment and supplies for infection prevention procedures).
- You should also ensure the availability of appropriate instruments, adequate and appropriate informative materials for beneficiaries at SHC-HWC in order to provide opportunities for making informed choice.

Follow-up including management of side effects

For ensuring correct and consistent use of the chosen contraceptives, ensure that the beneficiaries are given appropriate and adequate information about the follow-up schedules and management of side effects.

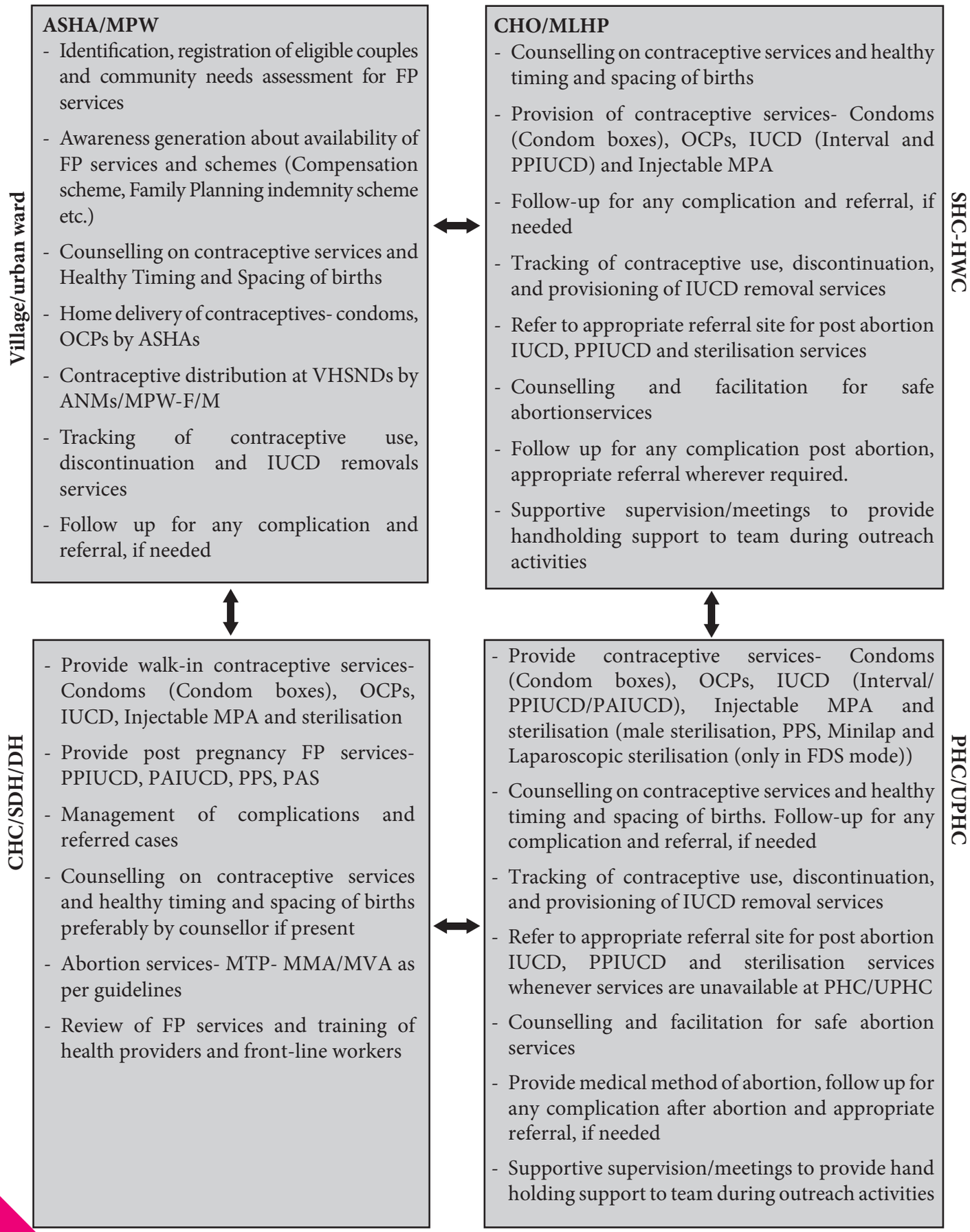
1.4 Continuum of care for family planning and reproductive health services

Care must be ensured from community level to facility level. Figure 2 explains how delivery of family planning services is provided at all levels of care.

Planning of referral linkages with higher facilities:

You should undertake the mapping of referral facilities to ensure the continuum of care. You must obtain the details of secondary health facilities where family planning services such as PPIUCD, PAIUCD, PPS, PAS and Interval Sterilization etc. are available. Arrange referral transport for the beneficiary and accompany him/her if possible, especially if the beneficiary seeks abortion care services.

Fig 2: Continuum of Care for Family Planning services and Reproductive Health



Chapter 2: Family Planning Counselling and Nutrition

Counselling: In providing family planning services, a face-to-face interaction between the beneficiary and service provider or counsellor is key to meeting the needs and forms the cornerstone of good quality services.

The key points to be followed for family planning counselling:

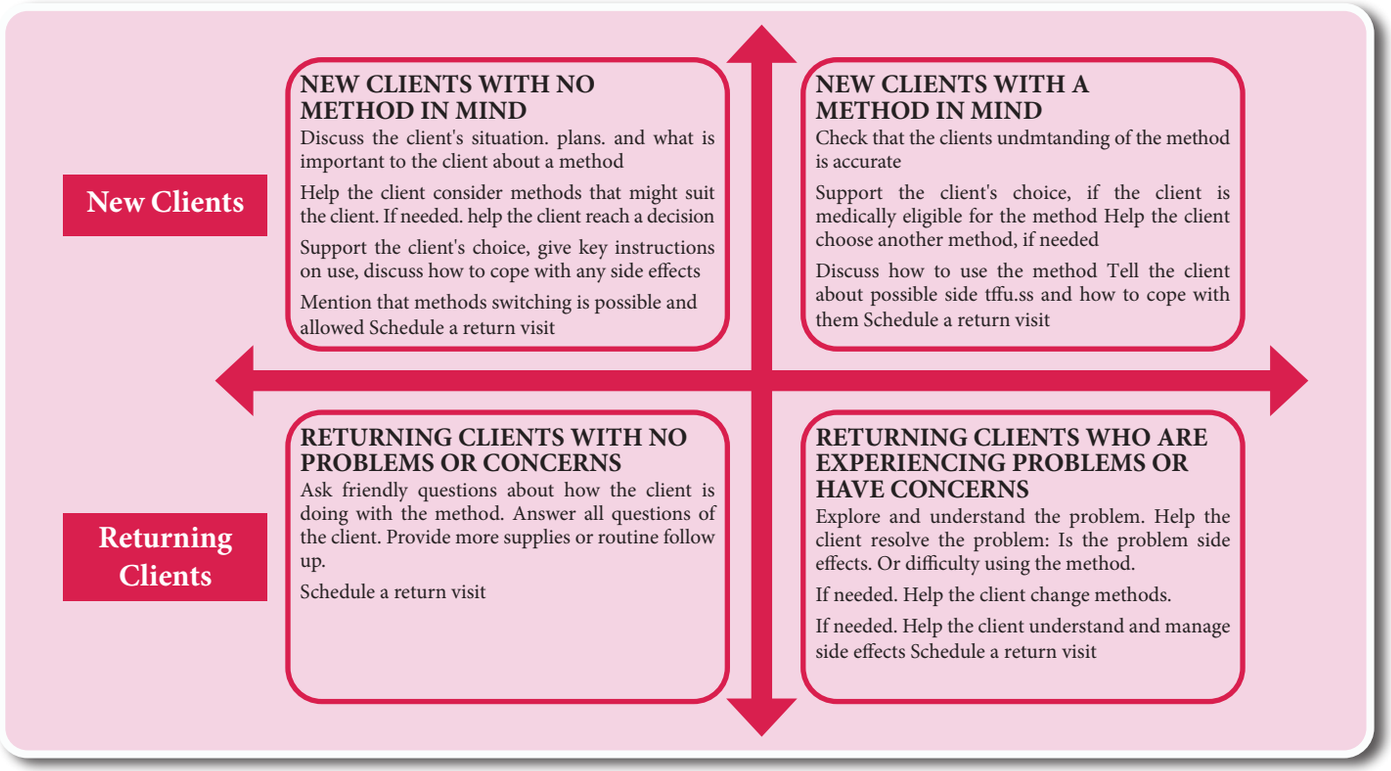
- Keeping in view the sensitive nature of reproductive health/family planning, you should ensure that the rights of the beneficiary to privacy, confidentiality, respect, and dignity are always maintained.
- The decision to adopt a method must be a voluntary and an informed decision and must be made by the beneficiary.
- It is your responsibility to ensure that the beneficiary is fully informed and freely chooses and consents to use a contraceptive method.

Counselling of four types of beneficiaries:

Counselling should be flexible to accommodate beneficiary's individual needs (beneficiary-centred counselling). Family planning beneficiaries typically fall into one of the following four categories:

- New beneficiaries with no method in mind
- New beneficiaries with a method in mind
- Returning beneficiaries with no problem or concerns
- Returning beneficiaries with problems or concerns

Fig 3: Counselling for four types of Family Planning Beneficiaries



Steps in family planning counselling – GATHER approach:

When you counsel an individual about family planning, you should follow a step-by-step process. GATHER is an acronym that will help you remember the 6 basic steps for family planning counselling. It is important to know that not every beneficiary in your village needs all the steps

You need to use the GATHER approach sensitively so that it is appropriate to each beneficiary's needs. Within your community you may need to give more attention to one step over the other.

<u>The GATHER approach:</u>

G Greet the beneficiary respectfully.

A Ask them about their contraceptive needs.

T Tell them about different contraceptive options and methods.

H Help them to make decisions about choices of methods.

E Explain and demonstrate how to use the methods.

R Return/refer; schedule and carry out a return visit and follow up.

Counselling on Healthy Timing and Spacing of Pregnancy (HTSP):

Healthy Timing and Spacing of Pregnancy (HTSP) helps women and families in delaying and spacing the pregnancies to achieve the healthiest outcomes for women, newborns, infants, and children. Healthy timing refers to first pregnancy between 18-35 years of maternal age. Teenage pregnancies and pregnancies beyond 35 years of age carry a high risk of maternal and neonatal mortalities and morbidities.

Spacing refers to the amount of time a woman should wait after a live birth, abortion, or miscarriage before attempting the next pregnancy. For the health of the mother and baby, counsel the beneficiary to wait at least 24 months after a live birth, but not more than 5 years, before trying to become pregnant again. For women/couples who decide to have a child after a miscarriage or abortion the beneficiary should wait at least 6 months before trying to become pregnant again. You should begin discussing HTSP routinely as a part of family planning counselling. The messaging for pregnant women should begin in the antenatal period. Pregnant women also need to know that if they are not exclusively breastfeeding, they can get pregnant as early as four weeks after the birth of their baby, even if they have not yet started their menstrual cycle. Several methods of family planning can be started immediately after birth, but some may need to be delayed if the woman is breastfeeding.

Counselling of male partner: The male partner should be encouraged to take part in family planning counselling sessions, especially if the chosen method involves his cooperation, for example, condoms. First, ask the woman whether she would be happy if her partner is involved. In some cases, women may feel more comfortable if their partners are not present or if their partners are counselled separately and/or by a male counsellor. Involving men is important to remove the barriers of spousal communication so that they can share the responsibility for family planning and birth spacing. You may also suggest the female beneficiaries that they tell their partners about health services available for men and provide them with the informational materials to take home, if available. Additionally, information can be provided through outreach activities or through discussion with men when they accompany their wives or partners to the SHC-HWC.

Family Planning Counselling:

The counselling for family planning services can be done in three phases:

- **General FP counselling**
  - Explain the benefits of family planning to the beneficiary:
  - It is the key to the happiness of entire family.
  - Fewer the children better is the scope for nutritional, health, educational and emotional care of the children.
  - Ensuring love and care for the child irrespective of the gender.
  - Reinforce that Healthy Timing and Spacing of Pregnancy is important:
  - When births are delayed, spaced and family size is limited, the mother and children remain healthy
  - Explain the danger signs of early/teenage/late pregnancy such as preterm baby, malnutrition, anemia, mortality etc. You should also focus on increasing women's access to basic nutrition and health services, counselling on adopting appropriate sanitation and hygiene practices including menstrual hygiene during the family planning counselling. (Refer the sub-section on family planning and nutrition at the end of the chapter)
  - You should also counsel Women of Reproductive Age (WRA) group planning for pregnancy to check Hemoglobin status at the HWC/VHSND and if found anemic (mild and moderate), she has to be provided with IFA supplements as per protocol for correction of anemia. Thereafter, she needs to be counselled to stop IFA and initiate Folic Acid (400mcg) supplementation in the pre-conception period and up to the first trimester of pregnancy, to reduce the incidence of neural tube defects in the foetus.
  - Ask the beneficiary about their preference for any method/previous contraceptive use etc.
  - Provide information about the government schemes on family planning and available FP services.
- **Method specific counselling:**
  - Explain the health benefits and advantages, side effects, health risks and complications of the method.
  - Tell them how to use the method correctly. Clarify the misconceptions and myths associated (for myths and misconceptions regarding IUCD and MPA refer Annexure I, II).
  - Provide additional information about prevention of STIs including HIV.
  - Explain the importance of follow-up visits and when to come for follow-up.
- **Counselling post contraception adoption:**
  - Reinforce the key messages related to the method adopted by the beneficiary.
  - Emphasize on the necessity for follow up visits.
  - Address any issue /concern raised by the beneficiary with the method.

VHSNDs as a platform for group counselling on Family Planning and Reproductive Health Care Services

You, as the CHO, along with your AB-HWC team could take up the responsibility of providing counselling support on the following topics during VHSNDs:

- Timing, initiation, and options of post pregnancy family planning methods – IUCD/PPIUCD/PAIUCD/ Combined Oral Contraceptives/Centchroman/Injectable MPA/Condom/sterilisation
- Importance of Healthy Timing and Spacing of Pregnancy (HTSP)

Family Planning and Nutrition:

You have learnt in Maternal, Child and Adolescent health modules about the importance of nutrition. However, nutrition is also a major part of FP services, largely in terms of the following:

- Spacing of pregnancies
- Unintended pregnancies

In the previous sub section on Healthy Timing and Spacing of Pregnancy, you were introduced to the concept of adequate spacing between pregnancies and will learn more about it in the next chapter.

Healthy Timing and Nutrition:

Family planning can help women avoid high-risk pregnancies and have children at the healthiest times in life, when they are 18–35 years old. This reduces the poor nutritional outcomes associated with high-risk pregnancies. On the other hand, women who conceive after the age of 35 years are also at risk of poor nutritional outcomes for both the mother and the baby which could result in low birth weight of the baby, pre-term birth etc.

Healthy Spacing and Nutrition:

It is important to understand that pregnancies that are too closely spaced have harmful effects on both the mother and the child. One common theory explaining this is maternal depletion, whereby women experience a negative change in nutritional status due to the diversion of nutritional reserves during pregnancy and lactation. When spacing is adequate, it gives the mother the required time to revive these nutritional reserves. Short time intervals between pregnancies could also put the mother at the risk of nutritional anemia and micronutrient deficiencies. Malnutrition in mother in turn leads to poor birth outcomes. Hence, it is of prime importance that young Women in Reproductive Age, married women and pregnant women are provided with nutritional counselling and appropriate interventions are provided at each of these stages of life so that timely rehabilitation is received.

Role of CHO in Nutritional Management in Reproductive Age

You should encourage and educate WRA (Women of Reproductive Age) and their partners regarding the following:

1. Intake of iron rich food like green leafy vegetables (chaulai and drumstick leaves etc.), whole grains, meat, fish, jaggery, nuts etc. (You shall learn about nutrient-rich food in detail in modules for care during Pregnancy, Child Care and Adolescents).

2. Tannins in tea and caffeine in coffee and calcium supplements should be avoided with or immediately before or after meals as they reduce iron absorption.
3. Adding vitamin C rich foods (such as amla, lemon, tomato, guava etc.) to regular diet can improve the absorption of iron.
4. Refer severely anemic WRA to the linked PHC/CHC/DH for further management and treatment. Review follow up of cases by ASHA and ANM.
5. Counselling for improving the quantity and nutrient level of food consumed in the household must be prioritised during the family planning visits. The provision of Iron Folic Acid Supplementation, deworming for adolescent age groups, pre and peri-conceptional Folic Acid supplementation and universal access to iodized salt are the essential nutrition interventions to be focused during the span of reproductive age.
6. In areas endemic for haemoglobinopathies, sensitisation of the population on screening for haemoglobinopathies through Complete Blood Count (CBC) and monitoring treatment compliance to be ensured by ANM.
7. Refer the identified cases of haemoglobinopathies to higher centres for further confirmation and treatment.
8. In areas endemic for malaria, with the help of ASHA and ANM, ensure every household in the village is provided with Long Lasting Insecticidal Nets (LLIN) (You shall learn more about Malaria Management in module on Communicable Diseases).
9. Newlywed/married women of 20-24 years who are not pregnant or non-lactating are also to be provided biannual deworming during National Deworming Day (NDD).

You will learn more about the relationship between nutrition and unintended pregnancies in Chapter 5.

Chapter 3: Family Planning Methods and Schemes

3.1 Different Types of Contraceptives

A range of contraceptive methods – both spacing and limiting, are available at different levels of health care facilities. The situations and needs of beneficiaries may differ and a single method may not be suitable for all. Considering the preference and medical eligibility, you may help the beneficiary to choose a method. The different available methods of contraception are given in figure 4:

Permanent/Limiting Methods:

- Male Sterilisation (Conventional and Non-Scalpel Vasectomy)
- Female Sterilisation (Minilap and Laproscopic)

Spacing Methods:

- Oral Contraceptives – Combined Contraceptive Pills (Mala-N), Centchroman Pills (Chhaya)
- Injectable Contraceptives – Medroxy Progesterone Acetate (MPA) (Antara Programme)
- Intra Uterine Contraceptive Devices –Copper containing IUCD 375 and 380 A
- Condoms (Nirodh)

Emergency Contraceptives:

- Emergency Contraceptive Pills – Levonorgestrel Pills (EZY pill)

Figure 4: Timing of Initiation of various contraceptive methods

Method	Timing of initiating the method			
	Breastfeeding Women	Non-Breastfeeding Women	Post Abortion	Interval (any other time)
Female Sterilisation	√	√	√	√
Male Sterilisation	√	√	√	√
IUCD	√	√	√	√
Injectable MPA	√ (can be initiated at 6 weeks)	√	√	√
Combined Oral Contraceptive Pills (Mala N)	×	√	√	√
Centchroman (Non-Hormonal pill) (Chhayya)	√	√	√	√
Condoms	√	√	√	√

3.2. Oral Contraceptive

Oral Contraceptive methods, both hormonal and non-hormonal, offer women and couples a wide range of options for delaying, spacing, and limiting births. Oral contraceptives are safe, effective, reversible methods to prevent pregnancy and need to be taken regularly. They do not disrupt an existing pregnancy and do not interfere with sexual intercourse. However, they do not protect a woman from HIV or other Sexually Transmitted Infections (STIs). Women using oral contraceptives must use condoms to prevent HIV and other STIs.

Types of Oral Contraception:

Hormonal	Non-Hormonal
• Combined Oral Contraceptives (COCs)	• Centchroman (Ormeloxifene)
• Emergency Contraceptive Pill (ECP)	

Hormonal Oral Contraceptives:

a. Combined Oral Contraceptives:

Combined Oral Contraceptives pills (COCs) contain low doses of two synthetic hormones, progestin and estrogen which are similar to the natural hormones in a woman's body.

Key Points
- COCs are safe and effective.
- COCs have several non-contraceptive benefits, like protection against endometrial and ovarian cancer, iron deficiency anemia, polycystic ovarian syndrome and endometriosis.
- COCs should not be given to breast feeding women till 6 months post partum.
- One pill is to be taken every day. For greatest effectiveness, a woman must take pills daily without any break (28 pills packet).

The available COC pills in the public sector is Mala-N (Fig 5)

- Mala N contains Levonorgestrel (0.15mg) + Ethinyl estradiol (30 micrograms). Mala-N is supplied free of cost through government health centres and hospitals.

- Each strip of Mala-N contains 21 hormonal tablets and 7 non hormonal (iron)tablets.

Figure 5: Mala-N in Public Sector

Table 2: Combined Oral Contraceptives		
Who can use the method	**Who should not use this method**	**How to use COCs**
• Women and couples who want an effective, reversible method • Women having anemia due to heavy menstrual bleeding • Women with an irregular menstrual cycle • Women with HIV/AIDS • Women who are on ARVs • Sexually active adolescents	• Breastfeeding women <6 months postpartum and Non Breastfeeding <3 weeks postpartum • With advice of a clinician, in case of following conditions: - Women with hypertension (BP 140/90) - Diabetes, (advanced or long standing), with vascular problems, or central nervous system, kidney, or visual disease - Women who smoke > 15 cigarettes/day and more than equal to 35 years old - Women with the following conditions: - Deep Vein Thrombosis - Heart disease, Bleeding disorders - Liver disease - Recurrent migraine, headaches with focal neurological symptoms - Unexplained abnormal vaginal bleeding - Breast cancer - Currently taking anticonvulsants for epilepsy	• One pill should be taken every day, even if there is no intercourse, until the pack is empty. • Linking pill intake to a daily activity such as after dinner may help the beneficiary remember and reduce some side effects. • 28-pill packs: When she finishes one pack, first pill from the next pack should be taken on the very next day without any break. Pills should be continued, irrespective of the menstrual bleeding. • It is very important to start the next pack on time. There is risk of pregnancy, if pack is started late. • If she vomits within 2 hours of taking a pill, another pill from the pack should be taken as soon as possible and rest of the pills should be continued as scheduled. • In case the woman misses one or two hormonal pills advise them to take the pill immediately and if more than two hormonal pills are missed, she should be advised to use a backup method and wait for next menstrual cycle to start the pack.

Possible Side effects and its management:

Side effects affect woman's satisfaction and hence, her compliance to COCs. If she reports side effects or problems, listen to her concerns, give advice and if appropriate, provide treatment. Encourage her to keep taking a pill every day as missing pills can risk pregnancy. If she experiences side effects, explain to her that many side effects subside after a few months of use, and she should continue taking the pills. Offer help to choose another method if she wishes to discontinue or cannot overcome the problems. (Table 3)

Table 3: Side Effects of COCs and its Management	
Side Effects	**How to manage**
Irregular and unexpected bleeding	• Reassure her that many women using COCs experience irregular bleeding. It is not harmful and usually becomes less or stops after the first few months of use. • Other possible causes of irregular bleeding: Missed pills, taking pills at different times every day; vomiting or diarrhoea, taking anticonvulsants or Rifampicin. • To reduce irregular bleeding: - Take a pill each day and at the same time. - Make up for missed pills properly, including after vomiting or diarrhoea. - If irregular bleeding continues or start safter several months of use or some other conditions unrelated to method use is suspected, refer to higher facility for further evaluation (the PHC MO should be informed, irrespective of the facility the referral is made to).
Ordinary Headaches	• Give Paracetamol (500–1000 mg) or other pain relievers. • Some women get headache during the hormone-free week (those 7 days when a woman does not take hormonal pills). • If any headache that gets worse or occurs more often during COC, refer to the DH/CHC/PHC.
Nausea/Dizziness	• Suggest taking COCs at bedtime or with food for better compliance. • If symptoms continue, refer to DH/CHC/PHC.
Breast tenderness	• Recommend wearing a supportive bra (including during strenuous activity and sleep). • Try hot or cold compresses. • Paracetamol (500–1000 mg) or other pain reliever.
Mood changes or changes in sex drive	• Some women have changes in mood during the hormone free week (those 7 days when a woman does not take hormonal pills). • Ask about changes in her life that could affect her mood or sex drive (including changes in relationship with her partner). Give her support as appropriate.
No monthly bleeding	• Ask her if she experiences any spotting (which she may not recognise as a monthly bleeding) or no bleeding at all. Reassure and tell her that some women using COCs stop having monthly bleeding and this is not harmful. She is not infertile. Blood is not building up inside her. • Ask if she has been taking a pill every day. If so, reassure that she is not likely to be pregnant and can continue taking COCs as before. • If she skipped the 7 non-hormonal pills (28-day pack), reassure that she is not pregnant and can continue using COCs. • If she has missed hormonal pills or started a new pack late, COCs can be continued.

	• Ask her to return for check-up if she has signs and symptoms of early pregnancy after missing 3 or more pills or starting a new pack 3 or more day slate.
Acne	• Acne usually improves with COC use. It may worsen for a few women.If she has been taking pills for more than a few months and acne persists give a different COC formulation, if available. Ask her to try the new pills for at least 3months. • Women who have serious mood changes such as major depression should be referred for care.

b. Emergency Contraceptive Pills (ECPs)/Morning-after pills or post coital contraceptives

- Emergency contraceptive pills are used to prevent pregnancy after unprotected sexual intercourse, if sex was coerced or contraceptive accidents like condom rupture or missed pills.
- In the public health facilities, EC pills that contains only progestin–Levonorgestrel (1.5mg per tablet) are available.
- ECPs are safe for all women including those who cannot use combined hormonal contraceptive methods.

Figure 6: EZY Pill

- ECPs do not disrupt an existing pregnancy and provide an opportunity for women to start using a regular contraceptive method.
- ECPs help to prevent pregnancy when taken up to 3 days (72 hours) after unprotected sex. The sooner they are taken, the more is the efficacy.

Emergency contraceptive pills are meant to be used for emergency only. These are not appropriate for regular use as a contraceptive method because of the higher possibility of failure compared to other contraceptive methods.

In addition, frequent use of emergency contraception can result in side-effects such as menstrual irregularities. The repeated use poses no known health risks but is less effective than a regular method in preventing pregnancy.

How to Use?

Take the pill immediately after unprotected/accidental intercourse or as soon as possible within next 3 days (72hours).

Explain that ECPs can at the most avert pregnancy resulting from the episode of unprotected/ accidental sex after which the pill was taken. It cannot protect her from future pregnancies if unprotected sex occurs again any time.Therefore, it should not be used as a regular contraceptive method.

Copper IUCD can also be used as an emergency contraceptive method if inserted within five days of unprotected intercourse.

Table 4: Side Effects of ECPs and its Management	
Side effects	**Management**
Nausea	Routine use of anti-nausea medication is not recommended. If the woman has had nausea with previous ECP use or with the first dose of a 2-dose regimen, she can take antiemetic 1½ to 1 hour before taking ECP.
Vomiting	If the woman vomits within 2 hours of taking ECP, she should take another dose (she can take an anti-emetic with the repeat dose). If vomiting occurs more than 2 hours after taking ECPs, she does not need to take extra pills. If vomiting continues, she can take the repeat dose by placing the pills high in her vagina.
Bleeding	Slight bleeding or change intiming of monthly bleeding, which gradually subsides.

Non-Hormonal Oral Contraceptives:

a. Centchroman Pills

Centchroman (Ormeloxifene) is a non-steroidal, non-hormonal pill. It has been introduced in the public health system in the name of 'Chhaya'. Chhaya pills need to be taken twice a week for the first three months and once a week thereafter. These pills are a safe spacing option for both breastfeeding and non-breastfeeding mothers.

When to start and how to use Centchroman (Ormeloxifene)

- For initiation of Centchroman, the first pill is to be taken on the first day of period (as indicated by the first day of menstrual bleeding) and the second pill three days later. This pattern of days is repeated through the first three months.
- Starting from fourth month, the pill is to be taken once a week on the first pill day and should be continued on the weekly schedule regardless of her menstrual cycle. Refer table below to decide for fixed day(s).

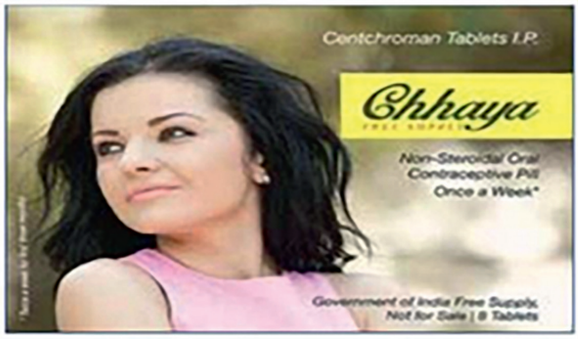


Figure 7: Centchroman in Public Sector

Table 5: Schedule of Centchroman		
If the first day of pill is taken on	First three months	After three months
	Pill to be taken on	Pill to be taken on
Sunday	Sunday and Wednesday	Sunday
Monday	Monday and Thursday	Monday
Tuesday	Tuesday and Friday	Tuesday
Wednesday	Wednesday and Saturday	Wednesday
Thursday	Thursday and Sunday	Thursday
Friday	Friday and Monday	Friday
Saturday	Saturday and Tuesday	Saturday

Possible Side effects and Management

- Centchroman causes delayed periods in few women. This may occur in around 8% of users and usually in the first three months. The periods tend to settle down to a rhythm once the body gets used to the drug.
- Periods can get scanty over time in some women. Counsel and reassure her that some women using Centchroman have such problems. This is not harmful and will subside on its own.

How to manage missed pills

- Take a pill as soon as possible after it is missed.
- If pill is missed by 1 or 2 days but lesser than 7 days, the normal schedule should be continued, and beneficiary needs to use a back-up method (e.g. condoms) till the next period starts.
- If pill is missed by more than 7 days, beneficiary needs to start taking it all over again like a new user that is twice a week for 3 months and then once a week.

If period is missed with Centchroman: With this pill, occasionally the menstrual cycle may get prolonged in some users. The contraceptive makes periods lighter and the interval longer, which is not harmful and can actually be helpful for anemic women, as she loses lesser amount of blood. However, if periods are delayed by more than 15 days, pregnancy needs to be ruled out.

3.3 Injectable Contraceptive: Medroxy Progesterone Acetate (MPA)

Figure 8: Antara Programme

Injectable contraceptive MPA is a three-monthly injection containing synthetic hormone progestin and is available at government health facilities under the Antara Programme. First dose is given only after the screening by trained doctor (MBBS and above) and subsequent doses may be given by trained health provider (AYUSH/MBBS Doctor/CHO/SN/ANM) in the health facility. Injection MPA prevents pregnancy over a longer period of time and helps in achieving spacing between children. It can be safely given to women of all reproductive age groups after proper screening. Under National Family Planning Program, single dose vials (150 mg) is available.

Benefits of MPA:

- Needs to be taken only once in three months rather than daily.
- Does not interfere with sexual intercourse.
- Safe for breastfeeding mothers as it does not affect the quality and quantity of milk.
- Can be used by women who are not able to take hormonal oral contraceptives like Mala-N.
- It does not cause problems with getting pregnant after discontinuation.
- Reduces menstrual cramps (some cases).

- It causes changes in menstrual cycle sometimes by stopping the monthly cycle which is not harmful. This actually takes care of anemia by reducing menstrual blood loss.
- Does not interfere with any medicine.
- Protects from uterine and ovarian cancer.
- Does not require any laboratory investigation before starting the dose.

Possible side effects post injection:

- Menstrual irregularities: Irregular bleeding, prolonged bleeding or amenorrhoea. These changes are temporary and reversible on stopping the use of method.
- Weight gain
- Headache
- Mood changes

Limitation:

- It does not protect from HIV and RTI/STI
- It takes 7-10 months from last date of injection for return of fertility. Since one injection is effective for 3-4 months, the return of fertility takes 7-10 months from date of last injection (Average 4-6 months after 3 months effectivity of last injection is over).

- To provide MPA, you must undergo specific training on MPA.
- If you are trained, then you can give first dose after the screening by medical officer. For this, the woman may be called to visit the SHC-HWC on the day of visit of the doctor or accompany the woman to PHC and inject dose under the supervision of MO.
- Second dose and subsequent doses can be given by you after 3 months at SHC-HWC.
- Follow up with the woman, to understand if she has any side effects and to remind her the scheduled date for her next dose.
- Record all details in the MPA card and handover the client section. Retain the facility section of MPA card.
- Ensure that beneficiary carries MPA card every time she visits for MPA injection or for any complaints related to the method.

Schedule: One injection provides contraception for three months.It is better to take second dose on the due date (at completion of 3 months). However, it can be taken within 2 weeks before and up to 4 weeks after the due date. If the subsequent dose is not taken within this grace period, the beneficiary would be treated as a new beneficiary.

Dose and site: The injection is given intramuscularly in the upper arm, buttocks, or thigh, as per the beneficiary's preference.

After the woman gets the injection, she should be cautioned not to massage the injection site or apply hot fomentation.

MPA Card: MPA card should be given to the women after injection. The card should have information about the details of the woman, it includes date of current dose and next dose. Every beneficiary should be encouraged to carry this card to the facility every time. The counterfoil of this card is maintained at health facility providing the first dose of injectable MPA. (Figure 9)

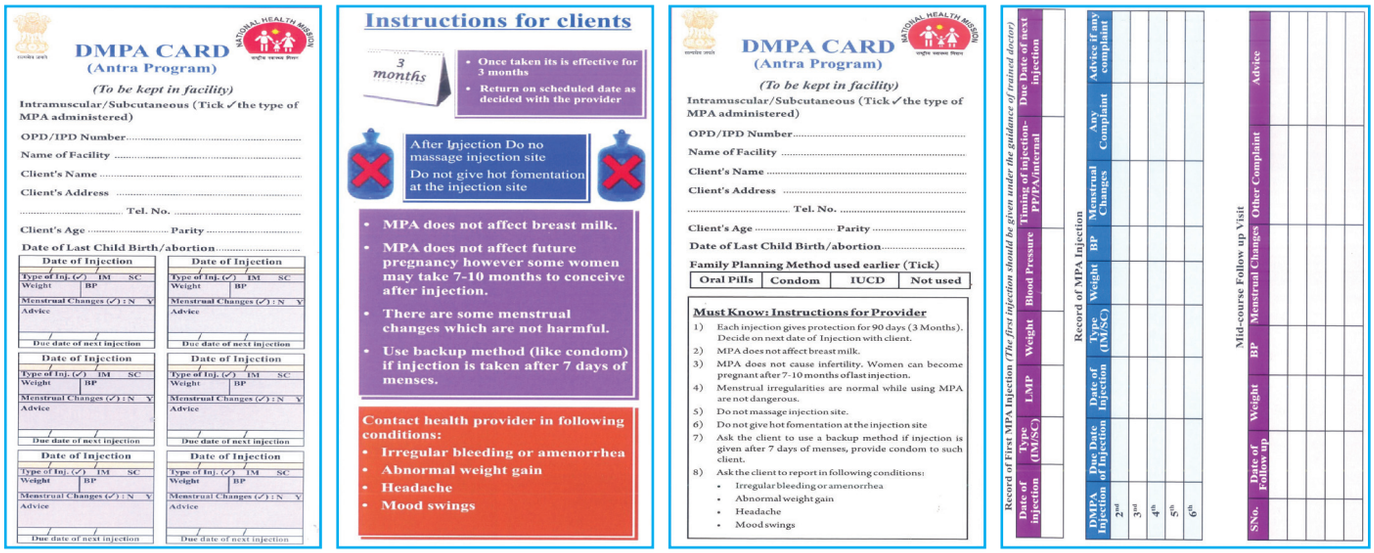


Figure 9: (a) MPA beneficiary card (b) Counterfoil of MPA card kept at health facility

3.4. Intra Uterine Contraceptive Device (IUCD)

The copper bearing intra-uterine contraceptive device, popularly known as IUCD, is a small, flexible plastic frame containing coiled copper impregnated with barium sulphate. It is inserted in the uterus by a trained service provider after proper screening and obtaining informed verbal consent from the beneficiary.

The IUCD is a Long Acting Reversible Contraceptive (LARC) which can be inserted in post-partum period (PPIUCD), Post Abortion period (PAIUCD), or Interval period (Interval IUCD)

- Interval period - At any time during the menstrual cycle or after 6 weeks of delivery or after 12 days of completion of abortion (Interval IUCD).

- Post pregnancy period - Within 48 hours of vaginal delivery/concurrently with C-Section (Postpartum IUCD) or within 12 days of completion of abortion (Post Abortion IUCD).

Currently two types of IUCDs are available under the National Family Planning Programme viz. IUCD 380 A, effective up to 10 years, and IUCD 375, effective up to 5 years. Both copper IUCDs (375 and 380 A) may be used for interval and postpartum/post abortion insertion.

The IUCD is effective immediately after insertion. The IUCD can also be used for emergency contraception if inserted within 5 days of unprotected intercourse. Once inserted, the IUCD can be left in place to prevent pregnancy for as long as the woman wants, until the IUCD remains effective.

Follow-up: Explain the importance and schedule of routine follow up visits and when to return to the health facility in case of emergency. IUCD users should have a routine check-up at 6 weeks or after their first menstruation, whichever is earlier.

Benefits:

- Long-term, highly effective reversible protection against pregnancy
- Effective immediately after insertion
- Suitable for use by most women
- Safe for use in breastfeeding women
- Acts as an emergency contraceptive if inserted within five days of unprotected sexual intercourse (in case of multiple unprotected sexual contacts, within five days of first unprotected intercourse)
- One-time effective procedure
- No requirement of daily attention or special attention before sexual intercourse
- Immediate return of fertility upon removal of IUCD
- No drug interaction may help protect against endometrial and cervical cancer

Possible Side effects:

- There may be an increase in the duration/amount of menstrual bleeding or spotting, abdominal cramps during the first few days or months after insertion.
- The woman should be reassured that these will subside within few months and if required, analgesics may be given.

Limitations: IUCD is suitable for most women but requires mandatory pelvic examination before insertion. Also, IUCD does not provide protection against RTIs/STIs and HIV infection.

Return of Fertility: A woman's fertility returns promptly after an IUCD is removed. Therefore, another IUCD should be inserted immediately after removal or an alternate contraceptive method can be adopted by the beneficiary unless she wants to conceive.

IUCD Card: IUCD card should be given to the women after insertion. The card should have information about the details of woman, date of insertion, type of IUCD and follow-up schedule. Every beneficiary should be encouraged to carry this card to facility. The counterfoil of this card is maintained at health facility. (Figure10)

Figure 10: IUCD Card

3.5 Condoms

Condom is a simple but very effective method of contraception if used correctly and consistently. It is the only contraceptive method that provides dual protection both from unwanted pregnancies as well as STIs including HIV infection. It is one of the methods of contraception which ensures male involvement in preventing unwanted births. The higher failure rate of condoms is mostly due to its inappropriate use by the beneficiaries, which in turn is partly due to inadequate beneficiary instructions by the FP providers. (Figure11)

Figure 11: Condom-mechanism of action, effectiveness, side effects and its management

CHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first Year)	EFFECTIVENESS AND BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Condoms • Condoms are barrier methods that physically prevent sperms from uniting with the egg as they do not allow ejaculated semen to bedeposited in the vagina • There are both male and female condoms* • Condoms are made of latex and are worn on the erect penis	• Condoms Consistent and correct use: 2 Typical use: 15	• Moderately effective • Effective immediately • Only method that prevents STIs, including HIV/AIDS, as well as pregnancy (dual protection), when used correctly during intercourse • No effect on breast milk production • effects No hormonal side effects • Can be stopped at any time • Easy to keep stock handy, can be used by men of any age • Can be used without initially seeing a health care provider • Enables a man to take responsibility for preventing pregnancy and disease • Condoms are-readily available free of cost at the government health facilities or home delivered by ASHA at a nominal cost.	• Condoms should not be reused and should be discarded after every act of intercourse • Supplies must be readily available before intercourse begins • Some men or women may feel that it interferes with their sexual pleasure • Latex condoms may cause itching for a few people who are allergic to latex	• Men - of all reproductive ages are good candidates for using condoms.	• People allergic to latex

Note: *Female condoms are also available nowadays in the market, but it is not included in Government of India's family welfare program.

3.6. Home Delivery of Contraceptives by ASHA

To improve access to contraceptives, it has been decided to utilise the services of ASHA to deliver contraceptives at the doorstep of the beneficiaries.

As you are aware, ASHA would make a list of all the eligible couples of her village mentioning the preferred type of contraception and share the data of users with your SHC-HWC as well as the PHC as per format 'A' attached in Annexure 3.

The ASHA shall collect the consignment/replenish her stock every month from the Block PHC/CHC/PHC as per the system put in place by the state. Monthly meetings could be one of the opportunities to give the required stock of contraceptives to ASHAs. No transport cost for carrying the contraceptives is admissible as the monthly stock requirement per village would be small enough to be carried in a normal ASHA bag.

Calculation of monthly contraceptive requirement:

Following information is important before calculating requirement of condoms, Oral contraceptive pills

1.	Number of eligible couples using condoms, Oral contraceptive pills (Current Users): ASHA can get this information from EC survey register/Contraceptive distribution register. *Note: If the data is unavailable, use district mCPR for the same.*	E.g.: In a population of 1000 (covered by an ASHA), 17% are assumed to be eligible couples (170 eligible couple). Considering condom usage as 10%, the number of condom users will be 17 and Oral contraceptive usage as 5%, the number of OCP users will be 9.
2.	Number of eligible couples showed intention of using condom (New Users): ASHA can get this information from EC survey register. *Note: If the data is unavailable assume 10-15% of current users will be new users per year*	E.g.: Condoms – 17 current users*10%=approx. 2-3 new users; OCP-9 current users*10%=approx. 1 new user Total estimated users per month= Current Users+ New Users. E.g.: Condoms=17+3=20; OCP=9+1=10

Contraceptive use per eligible couple per month: It is estimated that 1 eligible couple uses:

- 72 pieces of condoms per year i.e., 6 per month or
- 13 cycles of COC (Mala N) per year i.e., approx. 1.1/month or
- 9 strips of Centchroman per year i.e., approx. 1/month

Contraceptive requirement per month

Condoms = Total estimated condom users *6 (=20*6=120)

COCs = Total estimated COC users *1 (=10*1.1=11)

For final requirement add 10% as buffer stock

E.g.: Final Requirement per month

Condoms = 120+ (120*10%) = 132 pieces of condoms

1 box of condom = 3 pieces ofcondoms

Number of condom boxes required = 132/3 = 44

COCs (Mala N) = 11+ (11*10%) = 12 strips

Important Note: It must be kept in mind that OCPs should be given by ASHAs only after due screening and on advice of CHO/ANM/ MO I/C.

Monitoring:

- MO I/C (Block PHC, CHC, Block Office etc.) would distribute contraceptives to ASHAs as per their demand (and also as per the availability of supplies).
- You shall keep a record (monthly) which would provide information such as stock received, commodities distributed, number of ASHAs who received stock etc.

Sterilisation services:

- If any beneficiary seeks sterilisation services, refer to the facility where sterilisation services are available.
- The sterilisation services are offered as a daycare surgery and beneficiary is not required to stay overnight in the facility unless medically indicated. However, after undergoing surgery it may be difficult for the beneficiaries to find comfortable and affordable transport. Thus, GoI supports the provision of drop back of the sterilisation beneficiary through the empanelled vehicles e.g., 102 or alternate vehicle.

You should inform all these benefits to the beneficiary before referring them to the higher centre for sterilisation and ensure that your team is also providing the same information in the community.

Family Planning Indemnity Scheme (FPIS)

In limiting methods like sterilisation, you as a CHO shall have public health role in terms of awareness generation, mobilisation etc. In this section, you shall be introduced to FPIS and the compensation that the government ensures to the beneficiaries. Even though, you do not have a clinical role in sterilisation, this information could help you manage sterilisation services in your community by addressing grievances of the beneficiaries.

The available benefits under the Family Planning Indemnity Scheme are as under:

➢ **For Beneficiaries**

Section	Coverage	Limits
1 A	Death following sterilisation (inclusive of death during process of sterilisation operation) in hospital or within 7 days from the date of discharge from the hospital	Rs. 2 lakh
1 B	Death following sterilisation within 8-30 days from the date of discharge from the hospital	Rs. 50,000
1 C	Failure of sterilisation	Rs. 30,000
1 D	Cost of treatment in hospital and up to 60 days arising out of complication following sterilisation operation (inclusive of complication during process of sterilisation operation) from the date of discharge	Actual not exceeding Rs. 25,000

➢ **For empanelled doctors under public and accredited private/NGO sector and health facilities under public and accredited private/NGO sector.**

II	Indemnity coverage up to 4 cases of litigations per doctor and per health facility in a year	Upto Rs. 2 lakh per case of litigation

To understand the incentive structure for ASHAs under Family Planning, you may refer to Annexure V.

Role of Community Health Officer in providing family planning services

➢ **Clinical Functions**

- Provide counselling services as per the reproductive needs of the eligible couples, emphasizing on importance of HTSP.
- Provide commodities like condoms (Nirodh) and Oral Contraceptive Pills- Combined Oral Contraceptive pills (Mala-N), Centchroman pills (Chhaya) and Emergency Contraceptive Pills (EZY pills) .

- Provide Injectable MPA under Antara Programme at the Health and Wellness Centre. (First dose of Injectable MPA to be given only after screening by trained Medical Officer and subsequent doses may be given at SHC-HWC).
- The beneficiary screening should be done thoroughly (as per Medical eligibility Criteria Wheel, 2015) before starting any contraceptive method.
- Provide IUCD (Insertion and Removal) services after the beneficiary assessment.
- Provide follow up care and referral support to the beneficiaries who have adopted IUCD, Injectable MPA, OCP and Sterilisation services (as per the standard schedule/if beneficiary notices some warning signs).
- Primary screening for sterilisation may be done by CHO at AB-HWC - Pregnancy, Hb, etc. before referring to higher centre for sterilisation.
- Provide clinical care and coordinate for case management of complications following IUCD/ Sterilisation/Injectable MPA/other contraceptives based on the treatment plan made by the Medical Officer/specialists who will initiate treatment.

➢ **Public Health Functions**

- Ensure that all eligible couples in the service area are listed and a database is maintained for service provision.
- Utilise community platforms such as the VHSNC/MAS/SHGs for information dissemination and counselling and work closely with PRI/ULBs to address social determinants of health and promote behaviour change for improved health outcomes.

➢ **Managerial Functions**

- Ensure indenting and issuance of stocks through FP-LMIS and update the stock position regularly.
- Supervise the service data reporting by frontline workers; collate and analyse data for planning and report the data to the next level in an accurate and timely manner.

Chapter 4: Family Planning Logistics Management Information System

Family Planning Logistics Management Information System (FP-LMIS) is a user-friendly web-based, mobile app-based and SMS-based application for strengthening the supply chain of family planning commodities. It is a unified computerised application developed to monitor and manage the family planning commodities at all levels. The application calculates annual demand, enables online indenting, distribution and stock management, and provides critical information on stockouts, over stock, expired and damage stock in the form of reports and graphs to decision makers to assist in monitoring of the family planning commodities supply chain system.

Salient features of FP-LMIS:

- Web-based, Mobile app-based and SMS-based application.
- Instant access to stock information from national level to ASHA level.
- Auto forecasting of contraceptives.
- SMS alerts for key indicators.
- Auto generated reports for program review.

FP-LMIS's requirement:

Since this application is web-based, mobile app-based and SMS-based, it requires computer, uninterrupted internet connection and electricity for web-based application, smart phone for app-based application and basic mobile phone for SMS application.

The FP-LMIS Mobile App is protected by a user ID and password. Only an authorised user can access it to operate the supply chain process for the assigned store.

Steps:

1. Enter the username and password and click on log in.
2. After successful login, the main screen would appear. Following three menus would appear

Enquiry: To enquire the stock position of own warehouse or facility or ASHA. Item wise current stock position along with details of batch no. and expiry date would be displayed.

Indent: All indent raised along with the status of indent would be displayed. To view details of a specific indent, click on that indent no.

Issue: To issue against an indent. Details of the indent received would be appeared.

Issue to Client: To issue contraceptives to a client/beneficiary (at community level can be done by ASHA and ASHA supervisor)

Stock Update: To update the current available stock of contraceptives at the end of the month or before raising an indent.

The FP-LMIS Mobile SMS can be used by an authorised user whose mobile no. is registered in FP-LMIS portal to operate the supply chain process for the assigned store or ASHA.

Enquiry: To enquire the stock position of any warehouse or facility or ASHA. Item wise current stock position would be displayed.

Indent: To raise indent for the FP commodities.

Issue: To issue against an indent.

Stock Update: To update the current available stock of contraceptives at the end of the month or before raising an indent.

Ideal Frequency of indenting for stock: 12 times in a year (one month quantity)

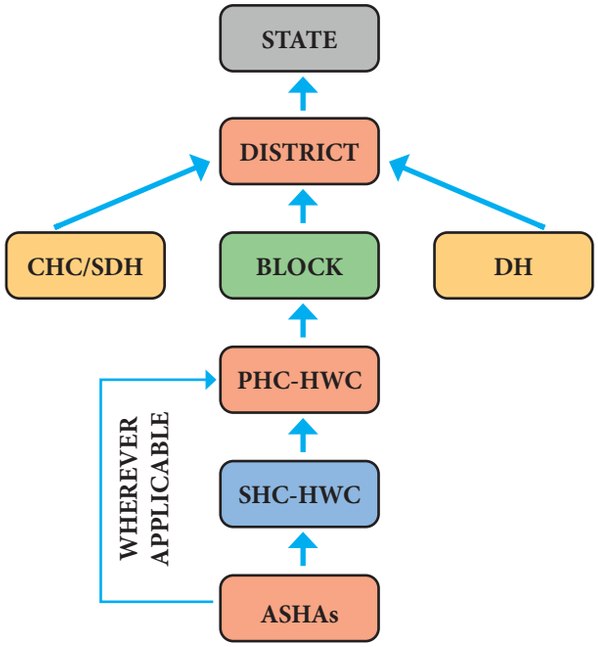


Figure 12: Indent and Demand Flow Chart

Distribution of Supplies:

As a store PHC/SHC-HWC should always have sufficient stock to meet the demand of ASHAs. Once receipt of the supplies is received by your SHC-HWC, ensure that the supplies are distributed to ASHAs based on their indent as well as to the beneficiary who are accessing the AB-HWC for FP services.

- You should always first assess the stock before placing any order. Stock in hand and the rate of consumption are two primary indicators for assessing stock status which help in deciding whether to place an order or not.
- Formula to assess the stock status:

Stock in Hand (How much quantity one has of a certian product) ÷ Consumption (How much one uses during a given period) = How long that product will last

Example:
1000 cycles of COC on hand + 200 cycles of COC used per month = 5 months period till when COC will last

Reporting, Reviewing and Monitoring:

- Monthly physical report can be viewed and generated from FP-LMIS application.
- You should review the supply status and distribution in monthly SHC-HWC meeting with your primary care team.

Roles & Responsibility of CHO with respect to the FP-LMIS is to ensure that:

- All contraceptives are available in the SHC-HWC in adequate quantity.
- Buffer stock of each contraceptive is maintained.
- ANM of AB-HWC is submitting indent on regular intervals (every month, if lower than the buffer stock) through FP-LMIS.
- ANM of AB-HWC is issuing supply to a beneficiary through 'Issue to Client' who are accessing as well as re-accessing AB-HWC for family planning commodities or updating stock availability before placing an indent every month through FP-LMIS (where SHC-HWC is not issuing any supplies to ASHAs). If ANM is unable to use 'Issue to Client' for issuing the FP commodities, then only she can update the current available stock through 'Stock Updation' available in Mobile App or in Mobile SMS.
- ANM of SHC-HWC is issuing the supply to ASHAs based on their indent through FP-LMIS (where ASHAs are receiving supplies from SHC-HWC).
- ASHAs are submitting their indent to SHC-HWC on monthly basis through FP-LMIS.
- ASHAs are updating their stock availability before placing an indent every month through FP-LMIS or issuing supply to the clients/beneficiaries through 'Issue to Client'.
- The user IDs of SHC-HWC and the ASHAs under your SHC-HWC are created in FP-LMIS application and the mobile numbers of ANM and ASHAs are updated in FP-LMIS.

Chapter 5: Comprehensive Abortion Care Services

5.1. Background

To improve the access to safe abortion services and provide a legal framework to the provider, abortion has been legalised in India under certain conditions through the passage of Medical termination of Pregnancy (MTP) Act in 1971. Despite this, unsafe abortions remain a challenge and deaths due to unsafe abortion constitute 8% of maternal mortality (SRS, 2002-03). Lack of awareness about legalisation of abortion in India, lack of knowledge about the availability of safe abortion services in the facility, social stigma associated with the abortion, and provider bias are some of the major barriers to access to safe abortion services.

Due to above mentioned reasons, women/girls may jeopardise their life by turning towards untrained providers/ dais/quacks for seeking abortion. The methods employed in termination may not be safe and the facilities may be unhygienic. Hence, there is a great risk to the life of these women. You can educate such women with unwanted pregnancies about the dangers of these illegal, unsafe abortions.

Your role as the Community Health Officer thus becomes very critical in reducing the incidence of unsafe abortion in the community by proper counselling of pregnant women. The counselling should focus on the availability of legal abortion services, various available methods of abortions, duration up to which the pregnancy can be legally terminated, place of abortion, availability of free services in public health facilities, and more importantly the confidentiality and privacy aspects of the abortion in health care facilities.

5.2 Medical Termination of Pregnancy (MTP) Act:

The Medical termination of pregnancy (MTP) act enacted in 1971 allows the termination of Pregnancy up to 20 weeks of gestational age for a broad range of indications and conditions as mentioned in the table below:

Who can terminate Pregnancy	• A registered medial practitioner who possesses a recognised medical qualification as defined in Indian Medical Council act, 1956; whose name has been entered in a State medical register; and who has such experience and training in gynaecology and obstetrics as prescribed by the MTP rules made under this act.
When can pregnancy be terminated	• The continuation of pregnancy involves a risk to the life of the pregnant woman or causes grave injury to her physical or mental health. The anguish caused by the unwanted pregnancy in the following situation is presumed to cause grave injury to the mental health of the pregnancy woman - rape or incest. • Failure of any device or method used by a married woman or her husband for the purpose of limiting the number of children. • There is substantial risk that, if the child was born, s/he would suffer from physical or mental abnormalities as to be seriously handicapped.
Where can a pregnancy be terminated	• A Hospital established or maintained by the government. • A place approved by the Govt. or District level Committee constituted by that government with the Chief Medical Officer (CMO) as the chairperson of the committee.

➢ **Important points to be followed when referring the woman to a higher level of facility**

- Explain the reason for the referral to the woman, spouse or relative accompanying the woman.
- Explain which facility (referral site) they should go to and explain the procedure that will be done at the site.
- Facilitate free transport to the next level of facility. Emergency transport facilities (108) can be used for referral, if required.
- Contact the provider at the referral site, if possible, giving information of the referral.
- Instruct the woman to report for a follow-up either at the referral site or this facility.
- Record the referral.
- Plan for a follow-up later for the woman to ensure her wellbeing.

5.3. Follow-up visit:

Follow-up visit after abortion provides a unique opportunity to CHO to assess the wellbeing and counsel the woman on following aspects:

➢ **Post abortion family planning:**

- Counsel the woman for contraception in case the woman has not accepted a contraceptive method at the abortion site. The focus should be on the consequences of repeated abortions.
- Inform her about the post abortion family planning method and help her to choose among them by explaining the method, its advantages and possible side effects.
- Refer/provide the post abortion family planning method as described in family planning section above.

➢ **Post abortion care:**

- Ask the woman about problems after abortion, if any.
- Assess the physical status and vital signs.
- Assess the bleeding per vaginum.
- Inquire about fever, pelvic or abdominal pain or cramps.
- Inform the woman that she should avoid intercourse till bleeding stops or condoms should be used.
- Inform her that she should return to the hospital in case of:
    - Severe abdominal pain
    - Heavy vaginal bleeding
    - Fever, fainting, abdominal distension, or severe vomiting.

Unintended pregnancies and nutrition:

- Unintended pregnancies could result in poor nutritional outcome for both the mother and the baby in both the cases i.e. where the mother decides to continue with it or chooses to terminate it, both of which could result in adverse outcomes.
- In the first case, women with unintended pregnancies may not adequately utilise prenatal care, which is an important determinant of nutrition outcomes, particularly with regard to anemia, low birth weight, and preterm birth.
- During pregnancy, the body needs nutrition to cater to the needs of the growing foetus and when it is terminated, vaginal bleeding occurs. The bleeding could result in depletion of important vitamins like B12, B9, and B2 along with riboflavin and iron which could result in iron-deficiency anemia or nutritional anemia.
- Unintended pregnancies could also affect the mental health of the woman which could lead to her neglecting diet.
- You, as a CHO could take steps in this direction and make it a point to provide basic nutritional counselling to every woman in reproductive age and post-abortion.

Role of Community Health Officer in providing Comprehensive Abortion Care Services

Clinical Functions:

- Early detection of pregnancies by using pregnancy testing kits
- Confidential counselling and facilitation of safe abortion services (methods)
- Refer to appropriate referral site for safe abortion
- Recognition of sign and symptoms of abortion complications
- Follow up for any complication post abortion and referral, if needed
- Post abortion contraceptive counselling
- Insertion of IUCD after abortion
- Ensure privacy and confidentiality of the women seeking abortion services is maintained

Managerial Functions:

- Ensure recording of abortion cases as per guidelines.

ANNEXURE

Annexure I: Misconceptions and Facts Regarding IUCD

S. no	Misconceptions	Facts
1	The IUCD might travel through the woman's body, maybe to her heart or her brain.	Explain that the IUCD usually stays in the uterus until it is removed. If it does come out by itself, it comes out through the vagina. In the rare event that the IUCD perforates the uterus (travels through the wall of the uterus) it will remain in the abdomen.
2	IUCDs prevent pregnancy by causing abortion.	Explain that studies show that copper IUCDs work by preventing sperm from fertilising a woman's egg, rather than by destroying a fertilised egg.
3	The IUCD causes discomfort during sex for both the woman and her husband.	Explain that because the IUCD is located in the uterus and not the vaginal canal, neither the woman nor her partner will feel it during sex. It is possible that the partner will feel the strings, but this can be easily corrected if it becomes a problem.
4	The IUCD may rust inside the woman's body.	Explain to the woman that the IUCD will not rust inside her body, even after many years.
5	IUCD increases the risk of pregnancy outside uterus (ectopic pregnancy).	The IUCD reduces the risk of ectopic pregnancy by preventing pregnancy. Because IUCDs are so effective at preventing pregnancy, they also offer excellent protection against ectopic pregnancy. Women who use Cu IUCDs are 91% less likely than women using no contraception to have an ectopic pregnancy (Sivin 1991).
6	IUCD increases the risk of infection or causes PID, and it needs to be removed to treat PID.	Documented evidence reveals that infection or PID among IUCD users is rare (ARHP2004; Grimes 2000). Women who have a history of PID can generally use the IUCD (the advantages generally outweigh the risks), provided their current risk for STIs is low.
7	IUCD causes infertility	Infertility caused by tubal damage is associated not with IUCD use, but with Chlamydia (current infection or as indicated by the presence of antibodies – past infection) (Hubacher et al.2001). Moreover, there is an immediate return to fertility after an IUCD has been removed (Belhadj et al. 1986). In one study,100% of women who desired pregnancy (97 of 97) conceived within 39 Months of IUCD removal (Skjeldestad and Bratt 1988).

8	The IUCD may cause cancer	The IUCD cannot cause cancer. If the IUCD caused cancer, it would have been discovered long ago. Studies have found IUCD use reduces the risk of endometrial cancer. The IUCD may also offer women protection against cervical cancer, according to a new study published in The Lancet.
9	The IUCD may cause birth defects in next baby	IUCD use neither causes multiple pregnancies after removal nor increases the risk of birth defects, whether the pregnancy occurs with the IUCD in place, or after removal. In the rare event that a beneficiary becomes pregnant with an IUCD in situ, there is no evidence of increased risk of foetal malformations.

Annexure II: Misconceptions and Facts Regarding MPA

S. no	Misconceptions	Facts
1	MPA causes infertility	MPA users can expect to become pregnant within a year after discontinuing their last injection. In a large study in Thailand, almost 70% of former MPA users conceived within the first 12 months following discontinuation. Moreover, 92% conceived within 24 months, compared with 93% of IUCD users and 94% of COC users. There is no difference in the time it takes fertility to return between long-term and short-term users and no difference between women with and without amenorrhea.
2	MPA causes cancer	Research has clearly proven that MPA does not cause cancer. In fact, it has been demonstrated that it protects against endometrial cancer. A WHO collaborative study of neoplasia and steroid contraceptives found no overall increased risk of breast cancer, no increased risk of invasive cervical cancer and no increased risk of ovarian or liver cancer.
3	MPA decreases amount of breast milk	Studies have shown that the amount of breast milk does not decrease when breastfeeding women use MPA. It has no effect on the composition of breastmilk, initiation, or duration of breastfeeding.
4	MPA affects women health by causing amenorrhea	Amenorrhea is an expected result of using MPA because women do not ovulate. This kind of amenorrhea is not harmful. It helps prevent anemia and frees women from the discomfort and inconvenience of monthly bleeding
5	MPA causes abnormal or deformed babies	There is no evidence that MPA causes any abnormalities in infants. Studies done on infants who were exposed to MPA in-utero showed no increase in birth defects. These infants were followed-up until they were teenagers and the research found that their long-term physical and intellectual development was normal. It is worth noting that before MPA was recognised as a contraceptive it was used in pregnant women to prevent miscarriage.
6	MPA causes abortion	MPA prevents ovulation. If no egg is released, no fertilisation takes place hence there are no chances of abortion.

7	MPA causes decrease in libido	There may be other factors that result in a decrease in libido (e.g., antihypertensive drugs, and exhaustion). However, MPA has a very minimal effect on libido. On the contrary, the sense of security of not getting pregnant may increase the libido of the beneficiary.
8	MPA causes anemia	During the first 3-6 months of MPA use, irregular bleeding may be experienced in the form of spotting or minimal bleeding. But this usually stops within a few months of continuous use of MPA. Since the bleeding is minimal, it rarely results in anemia. Anemia, which is caused by blood loss or iron deficiency, is actually prevented by MPA.
9	MPA causes blood toxicity due to amenorrhea	Amenorrhea is caused by MPA use since it results in an atrophic endometrium.

Annexure III: Format A for ASHAs to maintain list of all the eligible couples and type of contraception.

Community needs assessment

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
S. No.						Aadhaar No. and Bank Details of Woman		Aadhaar No. and Bank Details of Husband		Address	Religion	Caste (SC/ST/ Others)	BPL/APL	Total No. of Children Born		No. of Live Children	Details of Youngest Child			Current Users		Non-Users
MCTS/RCH ID No. of Woman						Aadhar No./NA	Bank Account No./ NA	Aadhar No./NA	Bank Account No./ NA					M	F	M	F	Age (Years)	Sex (M/F)	Current usage of contraceptive *	Clients currently using spacing method who want to change contraceptive method**	Non Users wanting to adopt contraceptive within one year (Mention the contraceptive choice as per the list below)*
Name of Woman																						
Age of Woman																						
Name of Husband																						
Age of Husband																						

Annexure IV: Service Delivery Framework

	Role of ASHA	Role of MPW/ANM	Role of CHO
General FP/ reproductive services	- Identification and registration of eligible couples (Community needs assessment) - Education and Mobilisation of the community for action on Gender Based Violence (GBV) - Early detection of pregnancies through pregnancy testing kits - Identification and referral of RTI/STI cases	- Ensuring awareness generation camps in the outreach e.g., celebrating world population day - Identifying high TFR area, arranging special outreach camps in consultation with CHO and Medical Officer PHC/UPHC - Mentoring ASHA, SHG members who will serve as peer counsellors for eligible couples for initiation, follow-up, and adherence of contraceptives. - Providing FP services in outreach and facilities. - Ensuring capacity building of MAS, ASHA, AWW social workers, SHG on FP Programmes and available services at HWCs.	- Ensure that all eligible couples in the service area are listed and a database is maintained for service provision. - Early detection of pregnancies through pregnancy testing kits - Screen the couples for eligibility of various contraceptive methods. - First aid for GBV related injuries - link to referral centre and legal support centre - Identification and management of RTIs/STIs - Identification, management (with referral as needed) in cases of dysmenorrhoea, vaginal discharge, mastitis, breast lump, pelvic pain, pelvic organ prolapse - Certify ANM's list of eligible couples and make corrections if necessary. - Supervise the service data reporting by frontline workers; collate and analyse data for planning and report the data to the next level in an accurate and timely manner.

			- Utilise community platforms such as the VHSNC/ SHGs for information dissemination and counselling and work closely with PRI to address social determinant so health and promote behaviour change for improved health out comes
FP and Reproductive Counselling Services	- Counselling for Healthy Timing and Spacing of pregnancies (Delaying birth of first child and ensure healthy spacing between 2 children) - Reach out to men for increasing their engagement in family planning as acceptors and act as agents of promoting family planning in the community with other men - Explaining different methods of contraception to the beneficiary - Postpartum and post-abortion, post-ECP contraceptive counselling - Counselling on prevention of RTI/STI	- Counselling for Healthy Timing and Spacing of pregnancies (Delaying birth of first child and ensure healthy spacing between 2 children) - Reach out to men for increasing their engagement in family planning as acceptors and also act as agents of promoting family planning in the community with other men - Explaining different methods of contraception to the beneficiary - Post-ECP Counselling of beneficiary in choosing a family planning method to start using after the emergency contraception, if she does not plan for pregnancy immediately	Routine FP counselling: - Counselling regarding HTSP - Counselling of male partner - Providing information regarding various government schemes to beneficiaries - Discussing with the beneficiary their preference regarding contraceptives - Explaining different methods of contraception to the beneficiary - Clarifying myths and misconception regarding contraceptives **Post-partum/post-abortion:** - Confidential counselling and facilitation of safe abortion services (methods), including adolescents **Post-partum and post-Post-ECP:** - Counselling of beneficiary in choosing a family planning method to start using after the emergency contraception, if she does not plan for pregnancy immediately.

Provisioning of Contraception	- Get the beneficiaries screened by the MO/ ANM before providing OCPs to them. - Deliver contraceptives at doorstep of the beneficiaries. - Provision of condom, oral contraceptive pills and emergency contraceptive pills and its reporting	- Facilitating compensation of beneficiary and ASHA - Provisioning of contraceptives (including IUCD/ PPIUCD) - Provision of condom, Oral Contraceptive Pills and Emergency Contraceptive Pills and its reporting	- Provision of short acting methods- condoms, oral contraceptive pills (Mala N, Chhaya) - Provision of long acting reversible contraceptive methods- Injectable Contraceptives and IUCD (Interval and PPIUCD) - IUCD removal and its reporting - Provision of emergency contraception, if required - Primary screening forsterilisation may be done at AB-HWC - Pregnancy, Hb, etc. before referring to higher centre for sterilisation
Abortion care Services	- Facilitation of safe abortion services including adolescents - Refer women to appropriate referral site for safe abortion care services - Identification and follow up for any complication- post abortion, and referral, if needed - Facilitate and accompany the woman during referral - Enabling environment in families for psychological support	- Facilitation of safe abortion services including adolescents - Enabling environment in families for psychological support - Identification and follow up for any complication- post abortion, and referral, if needed	- Facilitation of referrals to appropriate referral site for safe abortion and providing information of safe abortion services (methods) - Recognition of sign and symptoms of abortion complications - Ensure privacy and confidentiality of the women seeking abortion services is maintained - Ensure recording of abortion cases as per guidelines

Continuum of Care	- Follow up with contraceptive users - Ensuring continuity of contraceptive method and record method switching, if any - Follow up for any complication after abortion and appropriate referral, if need be - Follow up and support PLHA (People Living with HIV/AIDS) groups - Ensure regular treatment and follow-up of diagnosed cases	- Ensuring continuity of contraceptive method and record method switching, if any - Identifying complications among beneficiaries and referring them to HWCs/higher facility	- Follow-up, counselling, early management and referral (if required) for side effects of contraceptives, if any. - Ensuring continuity of contraceptive method and record method switching, if any - Follow up for any complication after abortion and appropriate referral if needed - Provide clinical care and coordinate for case management of complications following IUCD/ Sterilisation/ Injectable MPA/Other contraceptives based on the treatment plan made by the Medical Officer/ specialists who will initiate treatment
Recording and Monitoring (Including for supplies)	- Regularly collect stock from Block/CHC/ PHC after indenting through FP-LMIS.	- Regularly updating RCH register - Update stock position in FP-LMIS - Help ASHA with replenishment of her drug kit - Ensure provision of IUCD/MPA cards to the beneficiaries.	- Ensure all ASHAs collect supplies from designated places. - Verify ASHA's performance on a monthly basis. - Ensure provision of IUCD/MPA cards to the beneficiaries. - Regularly updating the respective service delivery records and reporting to higher level as suggested - Ensuring indenting and issuance of stocks through FP-LMIS and update the stock position regularly maintaining buffer stock of each contraceptive at SHC-HWC

Annexure V: ASHA Incentives under Family Planning

	INDICATOR	INCENTIVE
1.	Ensuring spacing of 2 years after marriage	Rs. 500
2.	Ensuring spacing of 3 years between 1st and 2nd childbirth	Rs. 500
3.	Ensuring adoption of limiting contraceptive method by couples after 2 children	Rs. 1000
4.	Counselling, motivating and follow up of the cases for Tubectomy	Rs. 200 in 11 states with high fertility rates (UP, Bihar, MP, Rajasthan, Chhattisgarh, Jharkhand, Odisha, Uttarakhand, Assam, Haryana and Gujarat) Rs.300 in 146 MPV districts Rs. 150 in remaining states
5.	Counselling, motivating and follow up of the cases for Vasectomy/NSV	Rs. 300 in 11 states with high fertility rates (UP, Bihar, MP, Rajasthan, Chhattisgarh, Jharkhand, Odisha, Uttarakhand, Assam, Haryana and Gujarat) and Rs. 400 in 146 MPV districts and Rs. 200 in remaining states
6.	Female Postpartum sterilisation	Rs. 300 in 11 states with high fertility rates (UP, Bihar, MP, Rajasthan, Chhattisgarh, Jharkhand, Odisha, Uttarakhand, Assam, Haryana and Gujarat) and Rs. 400 in 146 MPV districts
7.	Escorting or facilitating beneficiary to the health facility for the PPIUCD insertion	Rs. 150/case
8.	Escorting or facilitating beneficiary to the health facility for the PAIUCD insertion	Rs. 150/case

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Notes