



The Republic of Uganda

# **The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights**

**Reproductive Health Division  
Department of Community Health  
Ministry of Health**

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# Preface

The Government of Uganda recognises that its population is the most valuable asset and is an integral component of the development process. The development goals are therefore geared towards the improvement of the quality of life of its population. The attainment of these goals however, is being hampered by high fertility, maternal and infant morbidity and mortality rates.

In 2001, the maternal mortality ratio was estimated at 505:100,000 live births, Infant Mortality Rate (IMR) was 88/1000 live births, the total fertility rate was 6.9 births and the contraceptive prevalence rate was 23%. The major causes of maternal morbidity and mortality are preventable and treatable using the technology available to us. One of the major strategies for reducing Infant/Maternal Mortality as well as reducing fertility is ensuring access to quality integrated Sexual and Reproductive Health services. The development of the national policy guidelines and service standards for RH service delivery is therefore geared towards the attainment of this objective.

The document has been developed by the Ministry of Health, Reproductive Health Division together with the concerted effort of different professionals and partners interested in the promotion of sexual and reproductive health. The MOH is very grateful for their inputs.

It is, therefore, my hope that this document will be utilised by all stakeholders for the improvement of the quality and coverage of sexual and reproductive health services.

Thank you,

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Dr. Sam Zaramba,  
Director General of Health Services  
Ministry of Health

# Acknowledgements

This document was prepared jointly by the MOH, Population Secretariat, representatives of Protestant and Catholic Medical Bureaus, Makerere Medical School, and the Ministry of Gender, Community Development and Labour. The MOH-Reproductive Health Division, therefore, wishes to acknowledge the contributions of development partners, NGO's, agencies and individuals who made the document a reality.

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It is hoped that this Policy Guideline will help to deliver quality integrated sexual and reproductive health services and contribute to reduction of maternal morbidity and mortality.

For God and my country

-----  
Dr. Anthony K. Mbonye,  
Assistant Commissioner for Health Services  
(Reproductive Health)

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# Acronyms Used

ARH	Adolescent Reproductive Health
ANC	Ante-natal care
BBT	Basal Body Temperature
BP	Blood pressure
CBC	Community-Based Care
CBD	Community-based distribution
CBDA	Community-based distribution agent
CHW	Community health worker
CIN	Cervical intraepithelial neoplasia
COC	Combined oral contraceptive
CRHW	Community reproductive health worker
DDHS	Director of District Health Services
DHMT	District health management team
DHT	District health team
EC	Emergency contraceptives
ECP	Emergency contraceptive pill
FGM	Female genital mutilation
FP	Family planning
GOP	Gynecological out patients
HIS	Health information system
HMIS	Health management information system
HSD	Health sub district
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
IU	International unit
IUD/IUCD	Intra-uterine device/intra uterine contraceptive device
IV	Intravenous
LAM	Lactational Amenorrhoea Method
LC	Local Council
LMIS	Logistics Management Information System
MOH	Ministry of Health

MMR	Maternal Mortality Ratio
MTCT	Mother to Child Transmission
NGO	Non-Governmental Organization
PAC	Post-Abortion Care
PDC	Parish Development Committee
PID	Pelvic Inflammatory Disease
PNC	Post-Natal Care
POP	Progesterone Only Pill
PWA	People living with AIDS
RH	Reproductive Health
RHS	Reproductive Health Services
SDP	Service Delivery Point
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
TSS	Toxic Shock Syndrome
TV	Television
UNHRO	Uganda National Health Research Organization
UVI	Unaided Visual Inspection
VCCT	Voluntary Confidential Counseling and Testing
VCT	Voluntary Counseling and Testing
VIA	Visual Inspection with Acetic Acid
VSC	Voluntary Surgical Contraception
VVF/RVF	Vesicle Vaginal Fistula/Recto Vaginal Fistula
WHO	World Health Organization

# Chapter 1: Introduction

The mission of the Reproductive Health Division is to attain the highest possible level of health for all the people in Uganda through the development and implementation of appropriate Sexual and Reproductive Health (SRH) policies, objectives and strategies.

By 1993, Uganda had a Family Planning and Maternal Health Policy Guidelines. In 2001 the second RH Policy took into consideration the recommendation of the International Conference on Population and Development (ICPD) of 1994. The ICPD recommended that Governments address the comprehensive SRH Components and not only focus on Family Planning and Maternal Health. This policy addresses the current technological updates, emerging issues (such as the Millennium Development Goals), arising needs as well as considerations within the Health Sector Strategic Plan (HSSP) II.

The components of Sexual and Reproductive Health are: Safe Motherhood; Family Planning; Adolescent Health; Prevention and Management of Adolescent Ill-health; prevention and management of unsafe abortion, RH tract infections including STI/HIV/AIDS, infertility, reproductive organ cancers; menopause and andropause, obstetric fistulae, gender issues (gender based violence and female genital mutilation).

## 1.1 What the document contains

This document has two sets of guidelines: service policy guidelines' and service standards that aim at making explicit the direction of reproductive health at all levels of health care.

The service policy guidelines spell out the general rules and regulations governing reproductive health services, components of reproductive health services, target and priority groups for services and basic information education and communication (IEC) for the target and priority groups. It also identifies those eligible for, services, who will provide what services, and how in-service training, logistics, supervision and evaluation activities will be planned and implemented.

The service standards set out the minimum acceptable level of performance and expectations for each component of reproductive health services, expected functions of service providers, the various levels of service delivery and basic training content required for the performance of these functions.

In this document, service delivery refers to the combination of technical, organisational and managerial activities. The Document outlines tasks that guide service provision and evaluation.

## 1.2 Purpose of the document

The document is to provide explicit direction and focus, as well as to streamline the training and provision of reproductive health services.

The document clarifies the roles of various Ministries, Development Partners, communities and other stakeholders involved in planning, implementation, service provision, monitoring and evaluation. This document will guide the implementation of a coherent and coordinated reproductive health programme.

The policy guidelines and standards presented in this document reflect the current national goals and priorities in the National Health Policy and HSSP II.

### **1.3 Who may use these Guidelines**

These guidelines are to be used by public, private and development partners who participate in sexual and reproductive health planning, promotion and service delivery. These include planners and managers, supervisors, service providers and trainers at all levels in the pre- and in-service training programmes.

### **1.4 How to use these Guidelines**

Planners will adopt the guidelines to guide national service targets for various components of reproductive health, set service objectives and identify the required resources including categories and numbers to be trained for specific service components. Service managers and providers shall use the guidelines to identify types of services to be provided at each level and how to organize them to meet the established standards. Trainers at all levels in pre- and in-service and programme planners shall use the guidelines to set training targets and priorities, identify required resources and prepare training strategies that respond to service needs and service standards. The guidelines shall be used to monitor and evaluate service availability, accessibility, quality and utilisation.

### **1.5 Dissemination and Distribution:**

This document should be made available and accessible at all levels of RH training and service delivery and should be disseminated to all users and development partners.

### **1.6 Monitoring the implementation of these policy guidelines:**

The Ministry of Health and Stakeholders will be responsible for monitoring the implementation of this policy at all levels and will provide progress reports annually for the next 5 years to the senior and top management of the Ministry of Health.

# Chapter 2: Sexual and Reproductive Health and Rights

## 2.1 Definition of Reproductive Health

Reproductive health is a state of complete physical, mental, emotional and social well-being in all matters related to the reproductive system, its functions and processes. It includes sexual health, the enhancement of life and personal relations, counseling and care related to reproduction and sexually transmitted diseases. Reproductive health, therefore, implies that people are able to have a satisfying and *safe* sex life, the capability to reproduce and the freedom to decide if, when and how often to do so.

## 2.2 Definition of Sexual Health, Sexuality and Sexual Rights

### 2.2.1 Sexual health:

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

### 2.2.2 Sexuality:

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies or perception.

### 2.2.3 Sexual rights:

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence related to being male or female.

## 2.3 Reproductive Rights

Reproductive rights embrace certain human rights that are already recognized in international human rights documents and national laws. The reproductive rights include:

- the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children;
- the right to information regarding sexual and reproductive health;
- the right to attain the highest standard of sexual and reproductive health;
- the 'right to make decisions concerning reproduction, free of discrimination, coercion and violence.

## 2.4. Components of Reproductive Health

In 1999 the Ministry of Health developed a minimum Sexual and Reproductive Health Package adopted from the 1994 ICPD in Cairo, being a reflection of the national priorities. However priorities will keep changing depending on prevailing circumstances, evidence/best practices and global agenda. This Package includes:

- safe motherhood, including post-abortion care;
- family planning;

- adolescent health
- STIs including HIV/AIDS;
- reproductive organ cancer;
- gender based violence;
- menopause and andropause;
- infertility prevention and treatment;
- obstetric fistulae.

## **2.5 Policy Goals and Objectives**

The goal of the Reproductive Health Policy is to improve the sexual and reproductive health of everyone in the country.

The objectives are to:

- guide planning, implementation, monitoring and evaluation of quality, integrated, gender sensitive and rights- based RH services;
- standardize the delivery of RH services;
- ensure optimum and efficient use of resources for the sustainability of RH services;
- promote sexual and reproductive health rights.

## **2.6 Implementing Reproductive Health Services**

The major focus of the RH policy guidelines is to improve and ensure the provision of quality, accessible and equitable RH services. The reproductive health care delivery system will operate at the national, district, health sub-district and community levels. The policy recognizes the important roles of other stakeholders in implementation and therefore a need for a multi-sectoral approach. The implementation of these policy guidelines will be in harmony with the other existing policies.

### **2.6.1 At the national level**

The Reproductive Health Division under the Department of Community Health will perform the following tasks:

- policy formulation, setting standards and quality assurance;
- resource mobilization for SRH programs;
- capacity development and technical support;
- coordination of SRH services and stakeholders' activities;
- monitoring and evaluation of overall SRH sector performance;
- coordination of reproductive health research in collaboration with National Research Council;
- strengthening the linkage between the national, regional and district referral hospitals in relation to SRH services;
- coordination and ensuring of inter-sectoral linkage with line ministries, NGOs, and the private sector;
- coordination of IEC interventions in collaboration with the Health Promotion and Education Division.

### **2.6.2 National and Regional Hospitals:**

- offer emergency obstetric care
- offer integrated reproductive health services
- offer specialized reproductive health services such as management of VVF, infertility and reproductive health cancers;
- plan and manage SRH services;
- offer promotional, preventive, curative and rehabilitative SRH services;
- mobilize resources;
- implement IEC and behavioural communication programmes

- Implement training
- conduct operations research;
- receive and transfer referrals to higher and lower levels;
- supervise lower level health facilities.
- collect, analyse, utilise and disseminate gender disaggregated health data
- Conduct relevant outreaches (specialized)

### **2.6.3 Training Institutions will:**

- Implement training
- Conduct operations research;
- Mobilise resources

### **2.6.4 The district level will:**

- guide planning, implementation, monitoring and evaluation of quality integrated gender sensitive and rights- based SRH services;
- monitor and support supervision to ensure quality of care;
- resource mobilization;
- coordination of activities of the NGOs, private sector and line ministries;
- provide guidance to district councils and advocate for support for SRH services;
- promote community participation and involvement in SRH service delivery;
- ensure liaison between the center and lower levels;
- collect, analyse, interpret, disseminate and utilize gender disaggregated health data
- do capacity building for lower levels.
- coordinate and implement IEC activities

### **2.6.5 The health sub-district level will:**

- guide planning, implementation, monitoring and evaluation of quality integrated gender sensitive and rights-based SRH services in HSD catchment area;
- provide technical, logistical and capacity development support to the lower health unit and the communities including procurement and supply of drugs.

### **The general hospitals will:**

- offer emergency obstetric care
- offer comprehensive family planning services
- offer integrated reproductive health services
- offer specialized reproductive health services such as VVF, infertility and cancer of the cervix.
- plan and manage SRH services;-
- offer promotional, preventive, curative and rehabilitative SRH services;
- mobilize resources;
- implement IEC and behavioural change communication programmes
- Implement training
- conduct operations research;
- collect, analyse, utilize and disseminate gender disaggregated SRH data;
- receive and transfer referrals to higher and lower levels;
- supervise lower level health facilities;
- promote community participation and involvement;
- provide gender sensitive/rights-based SRH services;
- intensive care for the newborn.

**The Health Center IV will:**

- provide comprehensive emergency obstetric care;
- offer comprehensive family planning services
- provide integrated SRH services;
- plan and manage SRH services;
- implement gender-sensitive and rights-based SRH services;
- offer promotional, preventive, curative and rehabilitative SRH services;
- mobilize resources;
- provide IEC / behavioural change communication;
- conduct operational research;
- collect, analyse, utilize and disseminate gender desegregated SRH data;
- receive and refer to higher and lower levels;
- supervise lower level health facilities;
- promote community participation and involvement in SRH services;
- conduct community outreaches;
- intensive care for the newborn.

**The Health Center III will:**

- serve sub-county catchment area;
- provide preventive, promotional, curative and maternity care including basic emergency obstetric care;
- offer basic family planning services
- implement gender-sensitive and rights-based SRH services;
- provide community outreach SRH services;
- supervise and work with Village Health Teams (VHTs) and other SRH CORPs including TBAs.
- refer clients to Health Center IVs or district hospitals;
- provide IEC/BCC on SRH;
- promote community participation and involvement in SRH services.

**The Health Center II:**

In line with the Rural Development Strategy (RDS) adopted by the government and also the Medium Term Expenditure Framework (MTEF) HC II shall:

- provide preventive, promotional and curative SRH services
- maternity care including basic emergency obstetric care;
- offer basic family planning services
- implement gender-sensitive and rights-based SRH services;
- provide community outreach SRH services;
- supervise and work with Village Health Teams (VHTs) and other SRH CORPs including TBAs.
- refer clients to Health Center IVs or district hospitals;
- provide IEC/BCC;
- promote community participation and involvement in SRH services.

**The Community level:**

In line with the Health policy, community participation is key to the success and sustainability of the SRH program. There are different resource persons at the community level. These include the TBAs, CBDAs, CRHWs, VHTs, peer providers, herbalists, families and individuals whose role should be to:

- mobilize people for SRH services;
- mobilize resources;
- distribute commodities i.e. Contraceptives (condoms, pills, Depo), Maama Kits, IPTs;
- disseminate SRH information/messages;

- promote cultural practices that enhance reproductive health while discouraging the negative ones;
- facilitate emergency preparedness at household level;
- establish and maintain working relationships with the nearest health unit/health worker;
- collect and submit community data to the supervising health units.

## **2.7 The Policy on TBAs:**

Government recognizes the role of TBAs in providing care to the mothers and children. 17% of mothers deliver with TBAs. Because of their continuous engagement with mothers, government and development partners will do the following:

- support TBAs to identify pregnant women and refer them;
- provide them with essential supplies to conduct emergency safe delivery;
- continue to supervise and link them to the health unit;
- orient them on responsible fatherhood and male involvement;
- encourage formation of TBA associations and register at district level

The TBAs will:

- conduct safe clean deliveries in emergency situations;
- keep the newborn warm and practice proper cord care,
- refer mothers to formal health care for family planning, antenatal care, delivery and post-delivery care;
- encourage mothers and spouses to seek PMTCT and HCT services;
- refer mothers and infants for immunization;
- collect and submit data to the supervising health units.
- Participate in other health promotion activities like malaria prevention, sanitation and hygiene.

The TBAs shall be members of the village health team.

## **2.8 Service integration**

SRH services shall be provided as an integrated health care package. Clients should be able to receive/access various SRH services during one visit at a given static health unit or outreach.

In line with the MOH health policy, the integration of SRH services into all existing health services will be facilitated through:

- capacity building (training);
- improvement of infrastructure;
- increasing the range of commodities and sustaining availability;
- integrated supervision (monitoring and evaluation).

## **2.9 Training**

Since the adoption of the ICPD recommendations, it has been necessary to orient health care providers to implement the Minimum Reproductive Health Care Package while at the same time maintaining quality. In order to improve the quality of health care, training will be carried out at all levels.

The Reproductive Health Division in collaboration with the Human Resource Division and Training Institutions is to ensure that adequate numbers of health workers are appropriately qualified and skilled to provide a full range of health services.

It identifies reproductive health training needs for service providers and addresses them through appropriate integrated continuing education. In addition, the Division gives technical guidance and support to the Human Resource Division, professional councils and Ministry of Education and Sports during the development, review and updating of training manuals and curricula for pre service training as the need arises. In order to standardize RH-related training and quality of care, programs implementing reproductive health activities will use only the Ministry of Health approved curriculum and manuals.

## **2.10 Infrastructure Improvement**

All service delivery points (SOPs) providing SRH services will be remodeled to enhance smooth client flow and ensure privacy to patients and clients. The policy supports creation of more space to cater for emerging needs such as postnatal care and PMTCT. An important consideration will be to make them friendly to the adolescents, youth and men.

## **2.11 Logistics and Supplies**

The Reproductive Health Division will ensure the availability of the standard commodities and supplies at all levels, in optimum quality and quantities, at all times as an incentive to the implementation of the Sexual and Reproductive Health Package.

### **2.11.1 Procurement**

The procurement of SRH commodities and supplies into the country will be carried out in accordance with the approved national MOH standards and procedures and within the guidelines laid down by the National Drug Authority. Within the country, it will be carried out in accordance with the stipulated national MOH and local government guidelines. The RH Division will work closely with procurement department.

### **2.11.2 Storage**

The National Medical Store and Joint Medical Store will provide storage facilities and distribute commodities and supplies according to the national guidelines. At the district level, they will be received and stored at the District Medical Store / Health sub-district store and at the health facility level, they will be received and stored in an approved storeroom and the inventory management will be carried out according to approved guidelines.

### **2.11.3 Distribution**

The distribution of commodities and supplies will be according to district requirements on request and follow a regular schedule as developed by the National Medical Store. From district to lower level facilities, it will be demand driven. In all cases, distribution of commodities and supplies will be according to approved maximum/minimum principles.

### **2.11.4 Equipment**

Procurement, distribution and maintenance of equipment will be according to the MOH national guidelines.

## **2.12 Monitoring, Evaluation, Supervision and Research**

Monitoring, evaluation, supervision and research are essential aspects of sexual and reproductive health aspects and important in determining the quality and efficiency of the SRH services.

### **2.12.1 Monitoring and evaluation**

The aim of monitoring and evaluation of the sexual and reproductive health services is to assess:

- the scope, effects and impact of training health workers and implementation of services;

- the quantity and quality of services provided at various service delivery points to ensure adequate/appropriate response to the sexual and reproductive health needs of all clients;
- the response levels and trends to the SRH services as a factor of the quantity and quality of services.
- maternal and perinatal mortality auditing will be institutionalized in all hospitals and HCIVs offering Emergency Obstetric Care.

Regular monitoring will be carried out at every level and results used to influence decision and practice at that level. Standard indicators will be used for monitoring and evaluating the process and impact as laid down by the national supervision requirements.

### **2.12.2 Supervision**

Supervision is an essential component of program evaluation and ensures adherence to guidelines in the provision of services. Support and facilitate supervision at all levels will be carried out in accordance with the national supervision guidelines for health services using standard instruments developed by the MOH and RH division. The performance improvement concept will be mainstreamed in all supervision guidelines.

### **2.12.3 Research**

Research is a critical tool for evidence-based policy and decision-making. In collaboration with UNHRO and the district directors of health services, SRH research agenda will be identified, implemented and utilized to guide SRH planning and further policy articulation and changes.

The RH Division will:

- Ensure establishment of a Research Database on SRH;
- Influence research being done;
- Facilitate for dissemination of research results and findings;
- Incorporate research findings into clinical service standards and guidelines;
- Support research on SRH services;
- Collaborate with other research institutions.

# Chapter 3: Family Planning and Contraceptive Service Delivery

## 3.1 Definition

### 3.1.1 Family Planning:

Family Planning is the practice of spacing children that are born using both natural (traditional) and modern (artificial) birth control methods. Birth spacing promotes the health of the mother, children and the father. There are two types of birth control methods: natural and modern (artificial). The modern methods are further sub-divided into short-term, long-term and emergency contraception methods.

### 3.1.2 Contraceptive:

A device, drug, or chemical agent that prevents conception.

## 3.2 Background

Implicit in the ICPD definition of Reproductive Health is the right of men and women to be informed and have access to *safe*, effective, affordable and acceptable method of family planning of their choice. Family planning, offers individuals and couples the ability to anticipate and attain the desired number of children through spacing and timing of their births.

## 3.3 Policy Goal and Objectives

The goal is to provide information and services that will enable individuals and couples to decide freely and responsibly when, how often and how many children to have. While the objectives are to:

- increase access to quality, affordable, acceptable and sustainable family planning services to everyone who needs contraception;
- promote strong integrated family planning information and services in the health sector at all levels and within various ministries.

## 3.4 Target and Priority Groups

Every individual who is sexually active can receive family planning and contraceptive services irrespective of age or mental status. Everyone in need of contraception is to be targeted however the priority groups will be:

- women who have had 1 or more pregnancies;
- post abortion and post-partum clients;
- women who are over 35 years old;
- adolescents;
- women with current or past obstetric, medical and surgical conditions likely to worsen with pregnancy and child birth e. g sickle cell disease, hypertension, diabetes mellitus, psychiatric conditions and cesarean sections etc;
- couples who want to limit or space their families;
- couples in polygamous union;
- women who have had unprotected or unwanted sex;
- individuals/couples infected/affected with HIV;
- people in difficult circumstances such as commercial sex and those in conflict areas.

### **3.5 Strategies**

To achieve the set objectives the following strategies will be strengthened:

- IEC/BCC, using all modalities of communication to reach everyone;
- counseling;
- provision of quality family planning services with a wide range of method mix;
- capacity building;
- Reorganization of service sites to accommodate youth and men;
- Strengthen logistic management
- Integrate family planning in all health services

These will be realized through the:

- expansion of service delivery points;
- improvement of communication through community based and social marketing approaches;
- training of service providers to enhance technical skills and improve attitudes;
- guaranteeing the availability of family planning commodities and supplies at all levels;
- improvement of family planning logistics management (LMIS/HMIS);
- enhancement of political and community support and participation in family planning activities;
- improvement of record keeping;
- strengthening of the follow-up, supervision and referral systems.

### **3.6 Eligibility for Family Planning Services**

All sexually active males and females in need of contraception are eligible for family Planning services provided that:

- they have been educated and counseled on all available family-planning methods and choices;
- attention has been paid to their current medical, obstetric contra-indications and personal preferences.

### **3.7 Consent for family planning services**

No verbal or written consent is required from parent, guardian or spouse before a client can be given family planning service except in cases of incapacitation (intellectual disability). Clients should give written consent to long-term and permanent family planning methods.

### **3.8 Family Planning Service Standards**

Family planning service standards describe:

- service delivery outlets;
- basic family planning services to be provided;
- basic family planning methods to be provided at each service delivery point;
- provider cadres;

### **3.8.1 Information Education and Communication:**

IEC aims at increasing everyone's understanding of family planning and contraception so as to increase the utilization of the FP services. The following settings and channels will be used for the dissemination of FP information:

#### **Settings**

- service delivery points where a health provider comes into contact with a potential or actual client;
- social mobilization for any health services;
- youth clubs and schools through family life education activities;
- women and men organized clubs/groups; .
- work places.

#### **Channels**

- billboards;
- symposium
- campaign events
- radio and television
- training;
- drama
- cultural gatherings;
- press conferences;
- public addresses;
- public debates;
- sensitization meetings
- peer groups;
- testimonies of users;
- electronic and print media;
- local council meetings;
- group discussions;

The basic FP **messages** should include:

- definition of family planning and contraceptive;
- health benefits of family planning;
- benefits of pre-conception care and counseling;
- benefits of post-partum and post-abortion FP and counseling;
- types of FP methods available for females and males and where to obtain them; .-
- prevention of STD and HIV/AIDS;
- dangers of grand multiparity;
- dangers of pregnancy in persons with medical conditions and disorders;
- risks of conception and pregnancy in persons with HIV infection and AIDS;
- non-health benefits of family planning:
- socio-economic and demographic benefits of FP;
- where to access services;
- fertility awareness;
- who should use and who should not use;
- common side effects of different methods;

Both health and non-health personnel will be actively involved with IEC activities after they have been well trained or oriented in respective subjects, counseling and communication for FP services.

### **3.8.2 Service delivery outlets**

In line with the health policy of the MOH, services will continue to be provided through government, non-governmental and private sector facilities, units and outlets. The following being the recognized outlets of FP service provision:

- facility based outlets such as hospitals, health centers and dispensaries;
- outreach services including mobile clinics;
- community-based outlets e.g. community-based distribution (CBD), drug shops and dispensing machines;
- social marketing;
- private sector facility such as clinics, maternity and nursing homes, pharmacies and drug retail shops.

**Table 1: FAMILY PLANNING SERVICE PROVISION BY CADRE OF STAFF**

Family Planning Service Provision by Cadre of staff							
Type of Service	Social marketing agents	Community Health Worker	Nursing Assistants	Nurse	Midwife	Clinical Officer	Doctor
Counselling		✓	✓	✓	✓	✓	✓
Home visits		✓	✓	✓	✓	✓	
Health Education talks		✓	✓	✓	✓	✓	✓
Print media messages				✓	✓	✓	✓
Electronic media messages				✓	✓	✓	✓
Combined Oral contraceptives		✓	✓	✓	✓	✓	✓
Progesterone only Pill		✓	✓	✓	✓	✓	✓
Condoms		✓	✓	✓	✓	✓	✓
Depo provera inj.				✓	✓	✓	✓
Noristerat inj				✓	✓	✓	✓
Intra uterine Device				✓	✓	✓	✓
Foam tablets		✓	✓	✓	✓	✓	✓
Creams/ jellys		✓	✓	✓	✓	✓	✓
Bilateral tubal ligation					✓	✓	✓
Vasectomy					✓	✓	✓
Implant insertion				✓	✓	✓	✓
Emergency contraception		✓	✓	✓	✓	✓	✓
Periodic abstinence methods		✓	✓	✓	✓	✓	✓
LAM		✓	✓	✓	✓	✓	✓
Supervision of lower cadres				✓	✓	✓	✓

**Note: Natural FP methods officially known for their effectiveness will be encouraged at every level by all service providers.**

All personnel involved in the provision of FP services must be adequately trained and equipped to provide quality service. The training in the FP and RH will be based on the curriculum approved by the MOH and MOH. The training of FP service providers will be conducted at two levels: pre-service at recognized institutions and in-service by recognized institutions and NGOs and by trainers certified by the MOH.

### **3.8.3 Basic family planning services to be provided**

These will consist of counseling, screening, provision of methods, management of complications, referral and follow-up.

#### **Counseling:**

In order to promote informed choice, all clients seeking contraceptives will be given adequate information about all methods available in the country. This is important for the initiation and continuation of FP practice. Methods (of choice) of clients will be done individually and in a dignified manner. The discussion between the service provider and client must be private, confidential and should never include incentives or coercion for the adoption of any method.

Initial counseling will include the following:

- a discussion of a client's reproductive goals, previous knowledge and/or experience with any method;
- showing the FP methods available;
- information on how each method prevents pregnancy;
- how effective the method is and what conditions make it effective;
- method failure;
- common side effects;
- the follow-up regarding each method;
- where the method can be obtained;
- importance of physical and pelvic examination;
- information on HIV/AIDS/STIs in relation to FP
- HIV testing and screening of STIs;
- Symptoms of breast and cervical cancer including available services for screening.
- clarification of misconceptions or rumors the client may have about each type of method;

**Subsequent** counseling will aim at promoting and encouraging continued use of a method and should include:

- a review of the client's satisfaction or problem with the method;
- a review of the client's understanding of user instructions;
- dispelling rumors and/or misconceptions, if any;
- if indicated, a review of change of the client's reproductive goal necessitating the need for a long-term or permanent method;
- counseling on STI and HIV/AIDS;
- possible method failure;
- information of common symptoms breast and cervical cancer including available services for screening.

Counseling is also important:

- where a contraceptive method has failed;
- there is regret for having had a permanent method;
- in cases of rape or defilement;
- where there is need for referral for appropriate care.

### **Screening:**

After a thorough counseling a client should then be ready to choose a contraceptive method. The next step is to screen for contraceptive use.

- Clients opting for hormonal method should have relevant health, social history taken and physical assessment carried out on the first or subsequent visits. Where indicated, do a complete physical check-up to rule out contra-indication to method use. Where it is not possible or necessary to perform routine physical assessment, the client should be screened by a qualified staff or FP trained service provider using a standard checklist to initiate or resupply oral contraceptive or Depo provera.
- After the screening, important findings will be communicated to the client including any issues she/he may want clarification on. The client will then be provided with the appropriate or preferred method and important findings should be recorded according to the guidelines.

Routine physical or pelvic examination is not obligatory for initiating or re-supply of oral contraceptives or Depo provera. However, an examination could be valuable for reproductive health and may help to rule out contra-indications to method and/or establish the presence or absence on infections or cancer.

Where selected physical assessment or laboratory tests are indicated and is not possible to carry them out at a particular clinic, clients should be referred to a health unit equipped to provide the assessment test.

- In case of **community based distribution services**, the CBD agent should obtain the client's health and social history during the initial encounter using the standard checklist. The agent will then initiate or provide the appropriate oral contraception or barrier method if no problems are identified.
- In **social marketing outlets**, the screening will depend on the level of the service, the competence of the provider and resources available.

## **3.9 Types of Family Planning Methods To Be Made Available**

In order to increase the method mix and promote informed choice, all methods, both temporary and permanent, will be provided and made available in the country. The following methods are available in Uganda: hormonal, intra-uterine device, barrier, permanent, and fertility awareness based. Some of the methods require authorization for use by a qualified health worker. On the other hand, other methods can be offered by trained non-skilled personnel as shown in Table 1.

### **3.9.1 The Methods Available:**

#### **Hormonal contraceptives:**

- oral contraceptive, both combined (COP), Progesterone only pills (POP), Levonorgestrel Progesterone only emergency contraceptive pills;
- Injectables e.g. Depo provera and Noristerat.
- Implants e.g. Norplant;

#### **Intra-uterine contraceptives:**

- Copper T 380 A
- Multiload;

#### **Permanent methods:**

- tubal ligation;
- vasectomy.

Re-supply of pills may be carried out by non-skilled and social marketing agents without revisiting a qualified health worker.

### **3.9.2 Natural methods:**

- Ovulation methods (Billing method or cervical mucus)
- Basal Body Temperature
- Sympto-thermal (body temperature mucus)
- Standard days (Calendar or Beads)
- Abstinence
- Lactational Amenoria

### **3.9.3 Barrier methods:**

- condoms (both female and male);
- spermicidal foam and jelly;
- foaming tablets.

Family Planning clients have the right to be referred to another SDP if their preferred method of choice is not available at the health unit of call or the provider lacks the skills needed to provide such services safely. During the referral, appropriate counseling and alternative temporary contraception should be provided to prevent unwanted pregnancy.

Most family planning methods do not protect against STI/HIV. If there is a risk of STI/HIV the correct and consistent use of condoms is recommended either alone or with another contraceptive. Male/female latex condoms protect against STI/HIV and pregnancy. The use of a condom and another FP method to protect HIV/AIDS and pregnancy is referred to as dual protection.

## **3.10 Eligibility for Family Planning Methods**

This spells out persons who are eligible for particular family planning methods.

### **3.10.1 Combined oral contraceptives (COC)**

*Who can use COC?*

- all women of reproductive age who desire to use COCs;
- women with anemia, but the basic problem causing anaemia must be evaluated and treated;
- women with dysmenorrhoea;
- women with irregular cycles;
- women with history of ectopic pregnancies;
- diabetics lasting less than 20 years or without evidence of hypertension;
- women with BP less than 160/100 mmHg;
- women with trophoblastic disease (on treatment and follow-up);
- Varicose veins or superficial thrombophlebitis;
- unexplained vaginal bleeding (although evaluation should be done as soon as possible)

- Benign ovarian tumours (including cysts)
- ovarian cancer awaiting definitive treatment
- Thyroid disease
- Benign breast disease
- Depressive disorders
- Undergoing treatment with the antibiotic griseofulvin
- Undergoing treatment with ARVs (although effectiveness may be reduced)
- STIs, including HIV/AIDS

### **Who should not use COC?**

The following contra-indicate administration of COC:

- Pregnancy (although there is known harm to the woman or the foetus if COCs are accidentally used during pregnancy);
- complications or side effects that a service provider is not capable of handling;
- breast feeding mothers less than 6 weeks post partum;
- women due for major surgery within four weeks;
- history of current deep vein thrombosis;
- vascular disease;
- migraine with focal neurologic symptoms;
- liver disease e.g. hepatitis, cancer, cirrhosis;
- jaundice;
- Active viral hepatitis.
- Undergoing treatment with drugs that affect the liver enzymes (rifampicin and certain anticonvulsants such as phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine);
- history of all ischaemic heart disease;
- stroke or history of stroke;
- major surgery with prolonged immobilization;
- hypertension greater than 160/100 mmHg;
- known thrombogenic mutations (e.g. factor V Leiden: prothrombin mutation: protein S, protein C and antithrombin deficiencies) due to higher risk of thrombosis;
- women judged to be forgetful or mentally retarded;
- diabetes with vascular complications or diabetes of more than 20 years duration;
- Smoking more than 15 cigarettes a day whatever the age
- Smoking when older than 35 years;

To date there is no concrete evidence that oral contraceptives have any effect on the transmission of HIV or the course of AIDS once a person is infected.

### **When can the client start taking COCs?**

The client can start taking the COC:

- within the first five days after the start of her menstrual bleeding (no additional contraceptive protection needed);
- any other time if it is reasonably certain she is not pregnant: if it has been more than five days since menstrual bleeding started, she will need to abstain from sex or use condoms as a back-up method for the next seven days;
- three weeks after delivery, if not breast feeding;
- six months post partum if breast feeding;
- immediately following abortion.

### **How many packets of COC can a client be supplied with at a time?**

-

### 3.10.2 Progesterone only pill (POP)

#### **Who can use POP?**

- Postpartum or postabortion (any time)
- breast feeding mothers;
- women in whom oestrogens are contra-indicated;
- women with BP more than 180/110 mmHg;
- women with sickle cell disease;
- diabetics without evidence of hypertension or history of a heart attack;
- women who have isolated history of pregnancy-induced hypertension;
- smokers;
- those due for major surgery;
- known thrombogenic mutations (e.g. factor V Leiden: prothrombin mutation, protein S, protein C and antithrombin deficiencies) due to higher risk of thrombosis.
- Headaches, including migraines
- Benign breast disease
- those with congenital heart disease;
- unexplained vaginal bleeding (although evaluation should be done as soon as possible to rule out underlying malignancy [pregnancy])
- Cervical, endometrial or ovarian cancer (awaiting definitive treatment)
- Depressive disorders
- Undergoing treatment with griseofulvin
- Undergoing treatment with ARVs although effectiveness may be reduced

#### **Who should not use POP?**

- pregnant mothers (although there is no harm to women or the foetus if POPs are accidentally used during pregnancy);
- women deemed forgetful or mentally retarded;
- women with current breast cancer or history of breast-cancer;
- women undertaking treatment for epilepsy with phenytoin or TB with Rifampicin.
- Current deep venous thrombosis
- Active viral hepatitis
- Severe cirrhosis or liver tumors
- Undergoing treatment with Rifampicin, anti-convulsants e.g. phenytoin

POPs are good method of choice for breastfeeding women. Women who are not breastfeeding and want to use oral contraceptives should consider using COCs rather than POPs because POPs are less effective in nonbreastfeeding women in typical use when strict regular pill-taking is not maintained.

#### **When can the client begin to use POP?**

- any time provided pregnancy has been ruled out;
- the first 7 days of the menstrual cycle;
- immediate post-partum period if not breast feeding;
- immediately following an abortion;
- after 6 weeks post-partum if breast feeding.

#### **How many packets of POP can a client be supplied with at a time?**

- If 28 pills in pack: five cycles
- If 35 pills in pack: four cycles

For frequency and content of check-ups for COC and POP users, see the Procedure Manual.

The client should be encouraged to return to the facility any time in the event of problems, concerns, or new needs.

### **3.10.3 Injectable contraceptives- Depo- medroxyprogesterone acetate (DMPA)**

#### ***Who can use injectable methods of contraception?***

*In general most women can use injectable contraceptive safely and effectively, especially by women who:*

- Are any age including adolescents and over 40 years
- Smoke cigarettes
- Those who have children and those without children
- Are fat or thin
- Have just had an abortion
- women who want a long term method of family planning;
- women with sickle cell disease;
- women who are HIV-positive or suspected to be HIV-positive and want an effective contraception to protect themselves from pregnancy;
- breast feeding mothers after 6 weeks post-partum;
- anytime for non-breast feeding mothers;
- major surgery without prolonged immobilization;
- superficial thrombophlebitis;
- epilepsy;
- valvular heart disease;
- epilepsy;
- Endometriosis.
- PID
- STIs

#### ***Who should not use injectable method of contraception?***

- as for POPs;
- women who want a pregnancy within less than two years after discontinuing the injection;
- women who cannot cope with possible disruptions in their menstrual cycle;
- breast feeding mothers before six weeks post-partum.
- Current breast cancer disease

Diabetes mellitus is not an absolute contra-indication to injectables but in absence of facilities for medical consultation they should not be given.

#### ***When should the injectable family planning method be started?***

- As for POPs.

#### ***What is the dose, route and interval of the injection?***

**Depo provera**

- Initial - 150 mgs, administered deep intramuscularly.
- Subsequent visits - 3 months after each injection is the optimal interval.
- Interval between one injection - clients who return after 10 weeks and before 14 weeks will also be given their usual dose of Depo provera.

**Noristerat**

- Initial - 200 mgs, administered intramuscularly.
- Subsequent dose(s) - 8 weeks
- Interval between one injection and the next - clients who return any time between 9 and 12 weeks shall be given the usual dose of Noristerat without having to be tested for pregnancy exclusion.

For women on Niverapine the allowance of 2 weeks after return date is discouraged because of over metabolism of DPMA or Noristerat because for them fertility may return earlier.

**3.10.4 Implants*****Who can use implants?***

Norplant implants can be used without restrictions or generally used by women with the following conditions:

- Heavy smoking (>20 sticks per day)
- Nulliparous (have no children)
- Breastfeeding (more than six weeks postpartum)
- Post-abortion
- Obesity
- Multiple risk factors for cardiovascular disease
- Hypertension
- Headaches
- Irregular and/or heavy menstrual bleeding
- Cervical, endometrial, or ovarian cancer
- Benign breast disease
- Diabetes of any type and duration
- Sickle cell disease or other types of anaemia
- Depressive disorders
- Undergoing treatment with antibiotics griseofulvin
- Undergoing treatment with ARVs

Note: There is no restriction on Implants use by adolescents or women over 45 years

### ***Who should not use implants?***

Norplant implants are not generally recommended or are contraindicated for women with the following conditions:

- Pregnancy (although there is no known harm to the woman or the foetus if implants are accidentally used during pregnancy)
- Breastfeeding less than six weeks postpartum
- Current deep venous thrombosis
- Unexplained vaginal bleeding (before evaluation)
- Current breast cancer or history of breast cancer (with no active disease for five years)
- Diabetes with vascular complications or diabetes of more than 20 years duration
- Severe cirrhosis, active viral hepatitis, or liver tumours

### **3.10.5 Intra-uterine contraceptive devices (IUCD)**

- CoperT 380A
- Mult-load 385

### ***Women who may want to consider an IUCD include:***

- Women of reproductive age who prefer a nonhormonal, highly reliable method of contraception that does not require daily action
- Women and couples who have reached their desired family size and do not want to undergo sterilization
- Women who have trouble with correct and consistent use of other contraceptive methods (e.g., remembering to take pills on time, negotiating condom use with a partner)
- Women at low risk of STI

### ***Who can use an IUD?***

The IUCD can be used without restrictions or generally used by women of any age and parity who may also have the following conditions:

- Breastfeeding
- Current or history of cardiovascular disease or stroke
- Headaches, including migraine

The following category of people may use IUCD after evaluation of a trained health worker:

- Irregular, heavy, or prolonged menstrual bleeding patterns
- Severe dysmenorrhea
- Cervical ectopy
- Breast disease, including breast cancer
- History of pelvic inflammatory disease (PID)
- Increased risk of STI <sup>1</sup>
- High risk of HIV or infection with HIV (no symptoms of AIDS)
- AIDS, and doing clinically well on ARV therapy

### ***Who should not use the IUCD?***

The IUCD is not generally recommended or is contraindicated for women with the following conditions:

- Pregnancy
- Distorted uterine cavity incompatible with IUCD insertion (including uterine fibroid)
- Unexplained vaginal bleeding (before evaluation)
- Trophoblast disease
- Cervical, endometrial, or ovarian cancer
- Known pelvic tuberculosis

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<sup>1</sup> "Increased risk" is defined by epidemiological and demographic factors, such as high prevalence of STIs in the area where client lives, young age, marital status, education level, etc.

- Current PID
- High individual likelihood of exposure to gonorrhea and chlamydia <sup>2</sup>
- Current purulent cervicitis, gonorrhea, or chlamydia
- AIDS (without ARV treatment)

IUCD users who develop PID should be treated with the IUCD in place if they want to continue using it. If no improvement within 72 hours, remove it.

***Timing of IUD insertion:***

- Any time provided pregnancy is ruled out
- The first seven days of the menstrual cycle
- Immediately following delivery or any time within 48 hours after childbirth
- Any time beyond four to six weeks after childbirth
- Immediately or within seven days after an uncomplicated abortion
- during caesarean section

***Subsequent visits/follow-up for IUCD users:***

- At four to six weeks after insertion
- whenever the need arises

For procedures on insertions and check-up see the Procedure Manual.

***When to remove IUCD?***

- When it has expired
- Menopause
- pelvic infection not responding to treatment
- Desire to have a baby
- Intolerable side effects

**3.10.6 Barrier Methods**

Barrier methods must be used consistently and correctly in order to be effective.

**Condoms (male and female)**

***Who can use condoms?***

Condoms can be used by any man or woman regardless of his or her health status. People who may want to consider condom use include:

- Men wishing to participate more actively in family planning
- Couples who have sexual intercourse infrequently
- People in casual sexual relationships where pregnancy is not desired

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<sup>2</sup> Is defined by a presence of individual high-risk behaviors or recent infection. For example, when a woman or her partner has had more than one partner within the past three months, or when a woman or her partner has been told within the past three months that he or she has STI, or when a woman's partner has STI symptoms, such as penile discharge. High likelihood of exposure to STIs should also be considered when the woman herself believes she is at high risk of STI.

- Couples needing a back-up method while waiting for another contraceptive method to become effective
- Couples who need a temporary method while waiting to receive another contraceptive method
- Those who are at increased risk of STIs, (e.g., when one or both partners have other partners)
- Couples where one or both partners are HIV positive

The effectiveness of condoms for both pregnancy and STI/HIV prevention depends greatly on clients' ability to use them consistently and correctly. Condoms, if used correctly and consistently, have been shown to provide a high degree of protection against STI/HIV transmission. In typical use, condoms are less effective; thus, it is important for providers to offer thorough counselling and instructions on use to encourage consistent condom use.

***Who should not use condoms?***

Individuals allergic to latex (material of which male condoms are made) should consider other contraceptive options. However, for those at risk of STI/HIV, condom use is still appropriate as there are no other methods that offer STI/HIV protection.

**Spermicides and diaphragms**

***Who should use spermicides or diaphragm?***

- Women of any age and parity
- Women who are breastfeeding
- Women who want a female-controlled method of contraception
- Couples who have sexual intercourse infrequently
- Women whom hormonal contraception are contraindicated

***Who should not use spermicides or diaphragm?***

- Women who are at risk of HIV or are already HIV infected
- Women with AIDS
- Women allergic to latex or spermicides
- Women with some anatomical abnormalities that may interfere with appropriate diaphragm placement (e.g., uterine prolapse, vaginal stenosis)

**3.10.7 Voluntary surgical contraception**

Because male and female sterilization are permanent methods of contraception, thorough counselling procedures must be followed to ensure that the client fully understands his or her choice and to minimize chances of regret. Clients younger than 30 years old or with fewer than three children require particularly careful counselling and exploration of other long-term method options.

**Tubal ligation**

***Who can have tubal ligation?***

In general, the majority of women who want tubal ligation can have a safe and effective procedure in a routine in a health facility equipped to provide the service, provided they have been counselled. They should also be able to give informed consent. Women who may consider tubal ligation include:

- Those who are certain that they have achieved their desired family size
- Women who want a highly effective permanent method of contraception

- Women for whom pregnancy presents unacceptable risk

***Who should not have tubal ligation?***

There are no medical conditions that would absolutely restrict a woman's eligibility for tubal ligation. Some conditions and circumstances indicate that the procedure should be delayed, or that certain precautions be taken.

Tubal ligation should be delayed in case of:

- Pregnancy
- Postpartum (between day seven and six weeks)
- Immediately/early postpartum if woman had severe pre-eclampsia/eclampsia, prolonged rupture of membranes (24 hours or more), sepsis, severe antepartum hemorrhage, or severe trauma to genital tract
- Complicated abortion (infection, haemorrhage)
- Current deep venous thrombosis
- Current ischemic heart disease
- Unexplained vaginal bleeding (before evaluation)
- Malignant trophoblast disease
- Current PID or purulent cervicitis
- Current gall bladder disease
- Severe anaemia
- Acute respiratory disease
- Acute systemic infection or gastroenteritis
- Abdominal skin infection
- Evidence of peritonitis

***Timing of the tubal ligation:***

- Immediately after childbirth or within first seven days (if she made voluntary informed choice in advance)
- Six weeks or more after childbirth
- Immediately after abortion (if she made voluntary informed choice in advance)
- Any other time provided pregnancy is ruled out (but not between seven days and six weeks postpartum)
- During caesarean section

**Vasectomy**

***Who can have vasectomy?***

In general, the majority of men who want vasectomy can have a safe and effective procedure in a routine setting, provided they have been counselled. They should also be able to give informed/written consent. Men who may consider sterilization include:

- Those who are certain that they have achieved their desired family size
- Men who want a highly effective permanent contraceptive method
- Men whose wives face unacceptable risk in pregnancy

### **Who should not have vasectomy?**

There are no medical conditions that would absolutely restrict a man's eligibility for vasectomy. Some conditions and circumstances indicate that the procedure should be delayed, or that certain precautions be taken.

Vasectomy should be delayed in case of:

- Local infections (scrotal skin infection, balanitis, epididymitis, or orchitis)
- Current STI
- Systemic infection or gastroenteritis

Clients with following conditions will require a provider with extensive experience:

- Previous scrotal injury
- Cryptorchidism (undescended testes)
- Diabetes
- Inguinal hernia

### **3.10.8 Natural methods**

#### **Lactational amenorrhea method (LAM)**

The effect of breastfeeding on reducing fertility is well known. However, LAM is a temporary (short-term) method of contraception. It is highly effective for the first six months postpartum, provided the woman breastfeeds fully and remains amenorrheic. When **all three criteria of LAM are met**, it is about 98% effective.

#### **Who can use LAM?**

- Women:
  - who are fully breastfeeding **and**
  - who are amenorrheic (no menses) **and**
  - whose baby is not older than six months

Fully breastfeeding means:

- Breastfeeding whenever the baby desires (at least every four hours)
- Night-time feeding (at least every six hours)
- Not substituting other food or drink in place of breast milk

#### **Who cannot use LAM?**

- Women whose menses have returned
- Women whose babies have turned six months old
- Women who have introduced supplementary feeding (for various reasons)

Women with HIV should be counselled about infant feeding options to reduce risk of mother-to-child transmission, and be supported in their choice. Women without reliable access to safe alternative feeding options should be encouraged to breastfeed exclusively for six months.

### **3.10.9 Fertility awareness methods**

Fertility awareness methods of family planning involve identification of the fertile days of the menstrual cycle (when pregnancy is most likely to occur) and avoiding sexual intercourse (or

using barrier methods) during these days. The fertile days of the menstrual cycle can be determined by one of the following methods:

- Basal body temperature (BBT)
- Cervical mucus
- Sympto-thermal (a combination of cervical mucus and BBT methods)
- Calendar (rhythm) or Standard Days Method

A woman or a couple who are planning to use these methods need special training from a trained counselor in family planning.

#### ***Who can use fertility awareness methods?***

- Any woman or couple who is willing and motivated to observe, record, and interpret fertility signs daily
- Women who find other contraceptive methods unacceptable for various reasons, including religious beliefs
- Women who are unable to use some other methods for health reasons
- Couples who are willing to abstain from sexual intercourse (or use condoms) for more than one week during each cycle

#### ***Who should not use fertility awareness methods?***

There are no medical conditions that are worsened with the use of fertility awareness methods. However, there are some conditions that make their use more difficult. If these conditions are present, the method can either be delayed or the provider should offer special counselling to ensure the correct use.

These conditions include:

- Breastfeeding (especially until menses return)
- Less than three postpartum menses
- Irregular vaginal bleeding
- Abnormal vaginal discharge
- Disease that elevates body temperature

#### **3.10.10 Emergency contraception (EC)**

Emergency Contraceptive refers to the type of method used as a procedure to prevent unintended pregnancy following unprotected sexual intercourse. However, it should not be used as a routine contraceptive method.

An **intrauterine device (IUD)** can be inserted and used as an emergency contraceptive, and continued as a regular method.

A skilled service provider can insert an IUD for emergency contraception within five days of unprotected intercourse. When the time of ovulation can be estimated, the copper IUD can be inserted beyond five days after intercourse, if necessary, as long as the insertion does not occur more than five days after ovulation. When used for emergency contraception, the copper IUD prevents pregnancy in 99 percent of cases.

IUD insertion for emergency contraception is not recommended for women at high risk for sexually transmitted infection at the time of insertion. Also it should not be used in women who may already be pregnant.

**Emergency contraceptive pills (ECPs)** should be started within 120 hours (five days) of unprotected intercourse, **but the sooner the better**. ECPs prevent about 75 percent of

expected pregnancies (the progestin-only regimen is more effective than the combined oral contraceptive pills regimen). **The sooner ECPs are taken, the more effective they are (e.g., the progestin-only regimen taken within 24 hours after unprotected intercourse prevents 95 percent of expected pregnancies).**

Any contraceptive method can be used as a regular FP method immediately following ECP use. However, ECPs should not be used as a routine contraceptive method.

#### **ECP regimens:**

**Progesterone-only pills regimen** (progesterone-only pills are the preferred ECP regimen as they are more effective and have fewer side effects than combined oral contraceptive pills):

- **Postinor – 2 (LNG 750 mcg) – [also called Vikela] or Levonelle-2 or NorLevo Plan B:**
  - One Tablet per dose: each tablet contains 0.75mg levonorgestrel. First dose (as soon as possible, but not later than 120 hours(5 days) after unprotected intercourse):
  - Second dose (12 hours after the first dose) 1 pill.

#### **Regular progesterone-only pills:**

- **Ovrette:**
  - 20 tablets per dose: Each tablet contains 0.375mg levonorgestrel. First dose (as soon as possible, but not later than 120 hours after unprotected intercourse): 20 pills
  - Second dose (12 hours after the first dose): 20 pills.
- **Microval:**
  - 25 tablets per dose: each tablet contains 0.03mg levonorgestrel. First dose (as soon as possible, but not later than 120 hours after unprotected intercourse): 25 pills

**Combined oral contraceptive pills regimen** (low-dose pills such as Lo-Femina, Microgynon, Nordette, or Pilplan):

- First dose (as soon as possible, but not later than 120 hours after unprotected intercourse): four pills
- Second dose (12 hours after the first dose): four pills

#### **Who can use ECPs?**

- Any woman who has had unprotected sexual intercourse
- Women who have been raped
- Any woman whose contraceptive method has failed (e.g., condom broke or slipped)
- Any woman who has forgotten to take her contraceptive pills for more than two days or by more than two weeks
- Any woman who has missed her contraceptive injection for more than two weeks

Women who need emergency contraception should be counselled about regular contraceptive options and encouraged to use regular methods consistently and correctly.

Do not provide emergency contraceptive pills to a woman who has the diagnosis of pregnancy, primarily because there will be no effect, even though some women may think otherwise.

***Follow up counseling:***

- ECP should not be used as regular contraceptive method;
- Women should be counseled for regular contraceptive methods.
- Relevant information on STIs including HIV
- The client should be encouraged to return for check up if the menstrual period does not come within 14-28 days.

***Referral:***

- Women should be referred for other relevant services such as HIV Counselling and Testing (HCT), Post-Exposure Prophylaxis (PEP) and treatment for STIs.
- Women should be referred to specialized services such as for sexual and gender-based violence.

### **3.11 Record Keeping System**

Health workers and auxiliaries providing FP services, both within government and non-governmental organizations, will use the national standard formats for record keeping and reporting to ensure the availability of core FP information. The formats have adequate space to record essential information on each FP service area as outlined in the Service Standards. Data from these records will be used to feed the national Health Management Information System (HMIS) for continuous monitoring and improvement of service delivery. Each level of FP service delivery site should analyze, interpret and compile data collected and use it for improving the quality of its services. It should also submit it as per reporting procedures and requirements.

### **3.12 Equipment and Supplies**

Basic equipment and supplies for FP/RH service provision will be provided according to the health unit level and its functions or service provided.

### **3.13 Supervision of Family Planning Services**

Supervision will be done in accordance with supervision guidelines and shall be carried out as an integral part of the routine reproductive health services supervision system at all levels. It will be the responsibility of the central, district, HSD and health unit in-charges. It will be done using developed standardized supervision indicators as agreed on by MOH, NGOs and other partners.

# Chapter 4: Safe Motherhood: Maternal and Newborn Health Care

## 4.1 Policy Goal and Objectives

The goal of the Safe Motherhood Program is to ensure that no woman or newborn dies or incurs injuries due to pregnancy and/or childbirth. This can be made possible by providing timely, appropriate and comprehensive quality obstetric care during preconception, pregnancy, childbirth and puerperium to women, men, adolescents and newborn babies with special emphasis to emergency obstetric care.

Ante-natal and post-natal services will be provided on a daily basis at all levels of the reproductive health service delivery. While delivery of maternity services will be provided 24 hours everyday in units licensed and equipped to provide them.

The objectives are to:

- provide guidance to health care providers in the delivery of quality maternal and newborn care services at all levels;
- enhance quality of safe motherhood services thereby reducing maternal and newborn morbidity and mortality in the country;
- integrate maternal and newborn care services at all levels of service delivery in the national health system.
- Provide adequate and accurate information education and counseling services.
- To reduce the proportion of infants born with HIV.

## 4.2 Components of Maternal and New born Health Services (Safe Motherhood)

The following comprise the maternal and newborn health services commonly referred to as safe motherhood services:

- preconception care;
- ante-natal care including PMTCT;
- post abortion care;
- intra-partum care;
- emergency obstetric care;
- care of newborn;
- post-natal care.

## 4.3 Target and Priority Groups

The target for all maternal services are all women of childbearing age, newborns, male partners, care givers, family members and community. While the priority groups are:

- pregnant women and their partners;
- women in labor;
- post-natal and breast feeding mothers;
- adolescents;
- women who are HIV-positive or suffering from AIDS and are pregnant;
- women with abortion related problems;
- women whose pregnancy is a result of sexual abuse;
- vulnerable and disadvantaged groups (disabilities, poor access, displaced persons);

- newborn babies who are:
  - sick;
  - have low birth weights;
  - have congenital abnormalities;
  - born to HIV-positive mothers;
  - babies whose mothers die during childbirth;
  - unwanted/abandoned babies

#### 4.4 Pre conception Care

This is health care information and services given to an individual or couple before biologically fathering or mothering a child. The objective is to promote safe and responsible sexual behavior and parenthood during the preconception period as well as reducing transmission of diseases and familiar conditions.

The services will include:

- immunization with tetanus toxoid;
- family planning;
- iron and folic acid supplementation;
- deworming;
- screening and-management of anemia;
- screening and management of STI /HIV/AIDS;
- voluntary counseling and testing for HIV;
- check for anaemia, sickle cell disease, hypertension, diabetes and physical abnormalities.

The information provided will include:

- proper nutrition practices;
- good hygiene practices;
- responsible motherhood and fatherhood;
- contraception and family planning;
- STI/HIV/AIDS prevention and treatment;
- malaria prevention and treatment;
- sexuality education;
- life skills;
- schedule for tetanus toxoid;
- genetic and familial diseases;
- pregnancy and child birth.

#### 4.5 Ante-natal Care

i) **Ante-natal care** is defined as a planned programme of medical management of pregnant women directed towards making pregnancy and labour a safe and satisfying experience.

ii) **Goal or Focused ANC:**

Focused ANC is an approach to ANC that emphasizes evidence-based, goal-directed actions; individualized, woman-centred care; quality versus quantity of visits and care by skilled providers.

It ensures provision of adequate care to a pregnant woman from the time Pregnancy is diagnosed up to the time of delivery. During this time the pregnant woman is prepared for a safe delivery of a mature normal baby.

The objectives are to:

- detect and maintain physical, mental and social health of the mother and the unborn baby;
- detect and treat pre-existing condition or complication arising during pregnancy, whether medical, surgical or obstetric;
- prepare the mother for safe childbirth and successful infant feeding;
- achieve delivery of a full term healthy baby or babies with minimal morbidity to mother;
- help the mother to experience normal puerperium and in conjunction with the partner, take good care of the child physically, psychologically and socially;
- promote couple dialogue and partner notification as appropriate;
- encourage community participation in antenatal service delivery.

#### **4.5.1 Basic services to be offered during ante-natal:**

- Information, Education and communication on risk factors and warning signs and symptoms during pregnancy.
- checking for and management of anemia and worms;
- provision of iron and folic acid supplement;
- screening for pre-eclampsia (BP , protein in urine and oedema);
- urine testing for sugar and protein;
- Examination of the mother to evaluate the pregnancy (fetal growth and maternal well being);
- early detection and referral or management of high risk pregnancies;
- immunization against tetanus;
- syphilis screening and treatment;
- HIV testing, treatment and referral;
- presumptive anti-malarial treatment and provision of ITNs.

#### **4.5.2 Information given during ante-natal should include:**

- proper nutrition and hygiene;
- malaria prevention;
- infant feeding and child welfare;
- prevention of STI/HIV/AIDS;
- warning signs of pregnancy complications;
- preparation for delivery (birth-plan) and emergencies;
- post-natal care and family planning;
- responsible fatherhood;
- HIV testing and counseling;
- dangers of self medication and use of traditional medicines during pregnancy, labor and puerperium;
- importance of delivering at the health facility (skilled attendance);
- care of the newborn.

#### **4.5.3 Minimum frequency and timing of ante-natal care visits**

A minimum of 4 visits should be made as follows:

- first visit - early (0-16 weeks) in first trimester after two missed periods;
- second visit - at <16 >28 weeks;
- third visit - between <28 >36 weeks;
- fourth visit - after 36 weeks.

The concept of focused or goal –oriented Antenatal Care where every visit made aims at achieving specific goal in health promotion and pregnancy management will be emphasized at all service delivery points.

#### 4.6 Labor and Delivery Care

Labor is the onset of regular, rhythmic, painful uterine contractions increasing in frequency, duration and strength leading to progressive dilation of the cervix and descent of presenting part, resulting in complete expulsion of the baby, placenta and membranes. The main **objective** for care is to ensure a safe delivery for the mother and baby.

**Services** offered during labor will include:

- monitoring labor using a partograph;
- identification and management of abnormal events;
- involvement of the father and other relatives according to the mother's wishes;
- ensuring the comfort of the mother and re-hydration;
- ensuring a clean and safe delivery of the baby, placenta and membranes;
- giving relevant anti-retrovirals according to the PMTCT guidelines to HIV positive mothers and newborns;
- ensure adequate nutrition as appropriate.

#### 4.7 Care of the Newborn

This is health care given to a baby immediately after birth up to the first 24 hours.

Its **objectives** are to:

- ensure the well being of the newborn in the first 24 hours of life;
- identify, manage, and/or refer problems in the newborn child;
- screen for congenital abnormalities and refer;
- give appropriate information on newborn care to the mother and members of family

**Services** should include:

- clearing the airway and ensuring normal breathing;
- weighing the baby;
- applying tetracycline ointment to the eyes with the first 30 minutes as prophylaxis;
- applying cord ligature to ensure there is no bleeding;
- initiating breast feeding within the first 30 minutes except where the mother chooses not to breast feed;
- keeping the mother with the baby "bedding in";
- providing training and support for the mother and father to use breast milk alternatives when breast feeding is not possible;
- conducting a full physical examination of the baby and ruling out congenital abnormality;
- providing necessary referral;
- giving immunization such as BCG and Polio 0 according to the MOH guidelines;
- giving Niverapine to babies born of HIV positive mothers.

The following **information** to the mother on care of the newborn

- continue exclusive breast feeding;
- continue to keep the baby warm;
- observe for general condition (color, breathing and abnormal movements) and report danger signs immediately to health unit;
- Keep the cord dry and don't apply any medicine

#### 4.8 Immediate Puerperium Care

This is the care given to the mother during the first 24 hours after childbirth.

**Services** offered will include:

- monitoring general maternal condition;
- ensuring the bladder is empty;
- ensuring the uterus is well contracted and no excessive bleeding;
- monitoring the blood pressure, pulse and temperature;
- relieving pain;
- keeping the mother comfortable and warm;
- giving Vitamin A 200,000 IU international unit;
- giving iron and folic acid, deworm and give TT according to schedule.

The following information should given:

- importance of continuing on demand breast feeding if appropriate otherwise information on how to prepare supplementary feeding;
- maintaining proper hygiene;
- proper nutrition;
- when to resume sex after childbirth;
- danger and warning signs of mother and child;
- infection prevention;
- immunization and growth monitoring for the baby;
- importance and benefits of attending post-natal clinic;
- information on contraceptives (dual protection should be encouraged for breast-feeding mothers as early as possible);
- proper care of the baby;
- HCT services for both mother and spouse and how to access them.

The partner should be encouraged to participate in this session on care during the puerperium.

## **4.9 Emergency Obstetric Care**

This is an urgent medical care given to a woman for complications related to pregnancy, labor, delivery and puerperium.

The **objectives** are to:

- manage obstetric complications and conditions likely to cause morbidity, injury or death to the mother and/or baby;
- to reduce the negative impact of the obstetric complication on the life of the mother and child;
- to improve survival and quality of life of the mother and child who have experienced an obstetric complication.

### **4.9.1 Common obstetric emergencies**

- During pregnancy:
  - ectopic pregnancy;
  - ante-partum hemorrhage;
  - severe pre-eclampsia and eclampsia;
  - cord prolapse;
  - severe malaria or fever;
  - severe anemia;
  - premature rupture of membrane;
  - abortion complications.
- During labor:

- hemorrhage;
- pre-eclampsia and eclampsia;
- prolonged labour
- obstructed labour;
- prolapsed cord;
- foetal distress;
- ruptured uterus;
- malpresentation.
- During delivery:
  - hemorrhage;
  - pre-eclampsia and eclampsia;
  - delayed second stage;
  - fetal distress;
  - maternal exhaustion;
  - uterine rupture;
  - impacted shoulders;
  - amniotic fluid embolism;
  - retained placenta;
  - retained second twin;
  - perineal, vaginal and cervical tears and lacerations.
- During puerperium:
  - post-partum hemorrhage;
  - puerperal sepsis;
  - pre-eclampsia and eclampsia;
  - hypoglycemia/dehydration
  - severe anemia.
  - Inversion of the uterus, shock and collapse

#### **4.9.2 Emergency obstetric services**

This will depend on the cause and nature of the emergency presenting and may include any of the following:

- anticipate and refer from previous history
- resuscitate and/or refer as necessary;
- IV fluids;
- blood transfusion;
- surgical and anaesthetic interventions as necessary;
- antibiotics, anticonvulsants and oxytocics including Misoprostol as required;
- emergency transport and communication according to level of care.

#### **4.9.3 Information on emergency obstetric care**

This should include:

- danger signs during pregnancy, labour, delivery and puerperium;
- risk factors in pregnancy;
- family planning to avoid high risk pregnancy; .
- Early ANC booking;
- birth and emergency preparedness;
- preventive e.g. good nutrition to prevent of anemia, deworming, malaria prevention;
- previous interventions that have possibility of interfering with obstetric outcomes.

#### **4.10 Post-natal Care**

This is a health care given to a mother and baby after childbirth up to six-eight weeks. Given the new needs of mothers and babies within the PMTCT programme, PNC services shall extend up to 6 months. The **objectives** are to:

- maintain physical and psychological well being of the mother and baby;
- detect or screen for complications of mother and baby, congenital abnormality of the baby and manage or refer;
- provide health education on nutrition, infant feeding, immunization, family planning, hygiene, STD/HIV/AIDS prevention and when to resume sexual intercourse;
- promote couple dialogue, partner notification and responsible fatherhood;
- link mothers and newborns to relevant support groups in the community, services and referral.

The basic **services** are:

- general examination and treatment of the mother according to national guidelines ( special attention to the state of involution of the uterus);
- provision of FP services to the couple (dual protection);
- examination and screening for cervical and breast cancer;
- general health education;
- general examination of the baby, growth monitoring and immunization;
- treatment of sick infants according to national guidelines;
- non-traditional health services such as psychosocial support groups.

The basic **information**, preferably given to couples, at post-natal care should include:

- exclusive breast feeding for up to 6 months;
- infant feeding options as outlined in the Infant Feeding Policy Guidelines;
- proper nutrition for the mother;
- proper hygiene for the mother and baby;
- resumption of sexual intercourse;
- family planning with emphasis on dual protection;
- STI/HIV/AIDS prevention and treatment;
- malaria prevention for the mother, new baby and her family;
- immunization and growth monitoring;
- Vitamin A supplementation and Multi-Vitamins;
- general care of the baby;
- screening for cervical and breast cancer;
- danger signs for the mother and baby;
- maternal and child bonding;
- excessive workload for the mother.

#### 4.11 Referral

All mothers and newborn babies presenting with problems or issues which the service provider cannot handle at her/his work site should be referred to the next higher level without delay, according to the guidelines on referral:

- a referral note should be completed and given to the mother;
- all relevant documents, ANC card, partograph or post-natal card, should be included with the referral note;
- in case of obstetric emergency, the mother should be accompanied by a qualified health worker and transport provided;
- the partner and relatives should be informed and encouraged to accompany the patient;
- the partner and relatives should be informed of what may be needed at the referral point;
- referral unit should be informed by radio or telephone, where possible;
- a feedback from the referral to referring unit should be ensured;
- all referrals from TBAs, communities/community resource persons, and private clinics should be handled professionally and ethically.

## 4.12 Community Outreach Reproductive Health activities

The following basic services for sexual and reproductive health are to be provided during community outreach:

education on:

- proper nutrition and benefits of exclusive breast feeding;
- proper hygiene;
- STI/HIV/AIDS prevention including voluntary counseling and testing;
- benefits of ANC and PNC delivery under skilled personnel;
- family planning;
- birth planning and preparedness;
- danger of self medication for pregnant mothers;
- danger signs and risk factors during pregnancy, labor and after child birth;
- causes, signs and symptoms of abortion;
- dangers of unsafe abortion;
- importance of timely self-referral;
- prevention of anemia;
- prevention and management of malaria in pregnancy;
- immunization of pregnant mothers, adolescents and children;
- routine iron and folic acid supplementation for all pregnant women;
- de-worming of pregnant women as appropriate;
- provision of contraceptives including female and male condoms;
- syndromic management of STIs and other reproductive tract infections;
- malarial prevention, treatment and prophylaxis;
- registration of vital events at community level e.g. "near miss" and "death" audits (through VHTs);
- effects of harmful traditional practices and taboos e.g. female genital mutilation;

During community outreaches, priority should be given to newly delivered mothers, disabled pregnant mothers, breast feeding mothers, men, adolescents and women with pregnancy related complications such as loss of baby.

## 4.13 Comprehensive Abortion Care Services

This is health care provided to a woman or a couple seeking advice and services either for terminating a pregnancy or managing complications arising from an abortion.

People who can get services for termination of pregnancy:

- severe maternal illnesses threatening the health of a pregnant woman e.g. severe cardiac disease, renal disease, severe pre-eclampsia and eclampsia;
- severe foetal abnormalities which are not compatible with extra-uterine life e.g. molar pregnancy, anencephaly;
- cancer cervix;
- HIV-positive women requesting for termination;
- Rape, incest and defilement.

### 4.13.1 Post-Abortion Care:

This is health care given to a woman who has had an abortion of any cause. The care, to be provided on a 24-hour basis, is to be an integral part of SRH services. The services are to be provided in all hospitals and health centers where there are doctors, midwives and clinical officers trained in comprehensive abortion care and where the minimum hygienic standards are met. These facilities should observe the patients' rights.

The **objectives** of comprehensive abortion care are to:

- manage and/or refer abortion complications;
- create public awareness of the dangers of unsafe abortion and educate;
- clients on complications and where to obtain help or treatment;
- prevent repeat unwanted pregnancies through the provision of family planning counseling services;
- promote community involvement in the prevention of unprotected sex and unsafe abortion, especially among adolescents;
- change negative attitudes towards abortion.

#### **4.13.2 Services to be offered under PAC include:**

- emergency care of abortion complications including resuscitation, evacuation of a uterus for incomplete abortion (including the use of a manual vacuum aspiration if gestation is 12 weeks and below);
- appropriate referral;
- post abortion counseling including self care, post treatment expectations, post abortion family planning and services. This will include information on emergency contraception.
- linking of PAC clients to other existing RHS including STI/HIV treatment and counseling, infertility and screening for gynecological cancer, among others.

PAC services will be an essential part of life saving skills training.

#### **4.13.3 Target and priority groups for PAC**

The target will be all women who have had abortions and abortion complications and their partners. The following will be the priority for PAC services:

- adolescents;
- women with repeated abortions who need contraception;
- women with repeated abortions who desire to have babies.

#### **4.13.4 PAC IEC Information:**

This will emphasize on:

- common causes of abortions and their prevention;
- awareness of the dangers of unsafe abortion;
- post abortion FP and counseling (breaking the cycle of abortions through using proper contraception).
- where to seek assistance and compliance to proper management;
- early recognition and reporting of abortion and abortion-related complications;
- self care and expectations;
- availability of other SRH services;
- rumours, myths and misconceptions on abortion.

Target groups:

- community
  - adolescents;
  - health providers (e.g. private clinics, drug shops);
  - traditional healers
  - male partners;
- providers
  - managers;
  - administrators;
  - implementers.

#### **4.13.5 Consent for PAC services**

Written or appropriate consent should be obtained from the patient or legal guardian for:

- evacuation for incomplete abortion;
- examination under general anesthesia;
- any surgical interventions.

For a patient whose physical condition does not enable her to give a written consent, the procedure should be performed to save life.

**Table 2: CAC SERVICES AVAILABILITY**

Type of service	Facility					
	Comm.	Outreach	HCII-III	HC IV	General hospital	Referral hospital
IEC	✓	✓	✓	✓	✓	✓
Psychosocial support and counseling	✓	✓	✓	✓	✓	✓
Prevention information	✓	✓	✓	✓	✓	✓
History taking	✓	✓	✓	✓	✓	✓
Examination		✓	✓	✓	✓	✓
HIV serology		✓	✓	✓	✓	✓
High vaginal swab				✓	✓	✓
STI management		✓	✓	✓	✓	✓
Anti-tetanus			✓	✓	✓	✓
Termination of pregnancy (medical induction).			✓	✓	✓	✓
Termination of pregnancy (Surgical induction)				✓	✓	✓
Resuscitation (shock/sepsis)			✓	✓	✓	✓
Evacuation for incomplete abortion			✓	✓	✓	✓
Preparation of tissue for histology				✓	✓	✓
Post-abortion family planning services including information	✓	✓	✓	✓	✓	✓
Rehabilitation	✓	✓	✓	✓	✓	✓
Referral to relevant SRHs	✓	✓	✓	✓	✓	✓

**Table 3: CAC SERVICE PROVISION BY HEALTH WORKERS' CATEGORY**

Type of service	Cadre									
	CRHW	Nurse aide	Mid-wife/ Nurse	Clinical officer	Medical officer	Gynae /Surgeon	Physiotherapist	Radiologist	Lab tech/ Cytologist	Social worker
IEC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Psychosocial support and counseling	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prevention information	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
History taking		✓	✓	✓	✓	✓	✓	✓	✓	
Examination		✓	✓	✓	✓	✓	✓	✓		
HIV serology			✓	✓	✓	✓			✓	
High vaginal swab									✓	
STI management			✓	✓	✓	✓				
Anti-tetanus		✓	✓	✓	✓	✓	✓	✓	✓	✓
Termination of pregnancy (medical induction).			✓	✓	✓	✓				
Termination of pregnancy (Surgical induction)					✓	✓				
Resuscitation (shock/sepsis)			✓	✓	✓	✓				
Evacuation for incomplete abortion			✓	✓	✓	✓				
Preparation of tissue for histology			✓	✓	✓	✓			✓	
Post-abortion family planning services including information	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rehabilitation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Referral to relevant SRHs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓