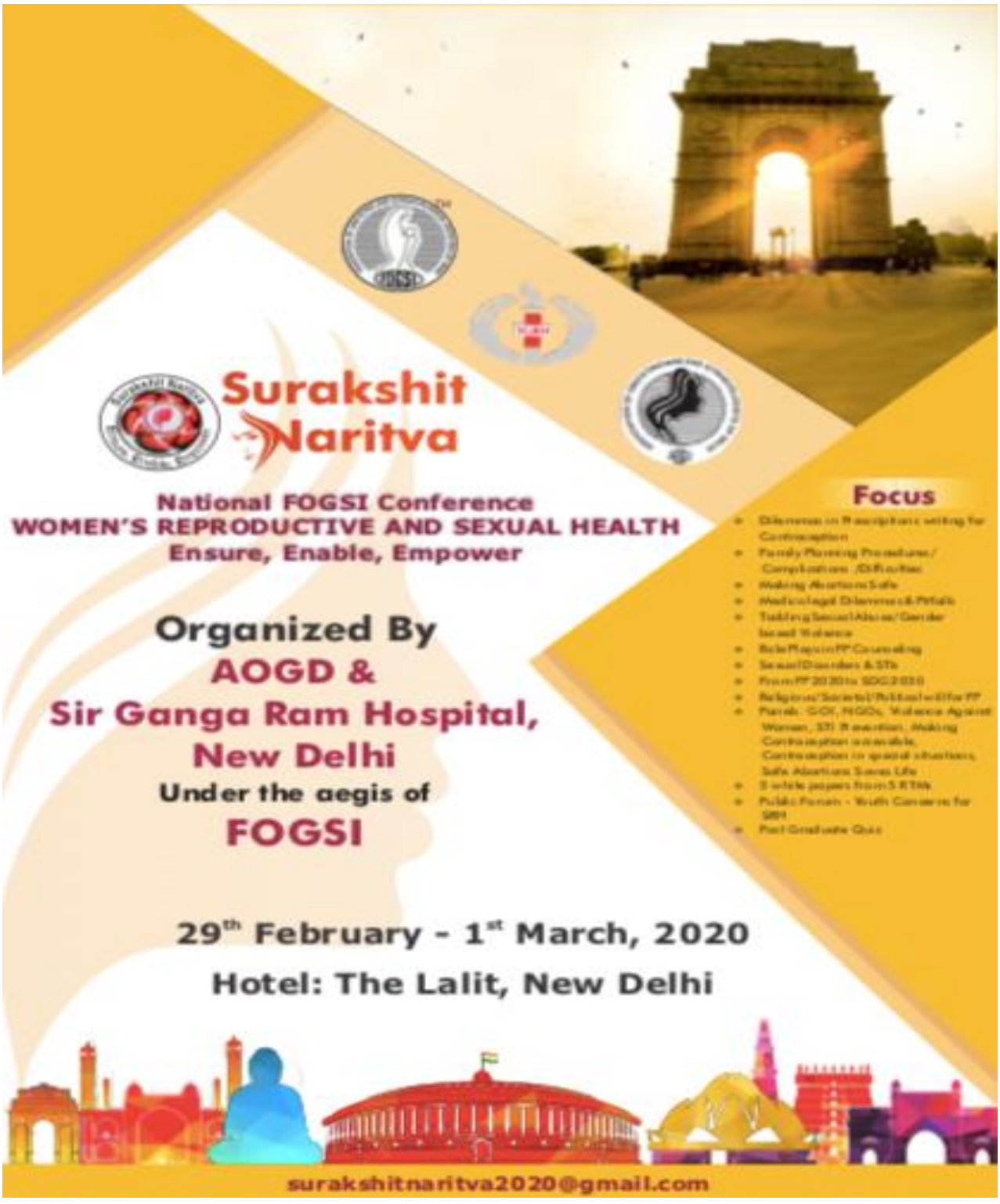
Volume

1

FOGSI FWC: White paper manual on sexual and reproductive health : Ensure, Enable ,Empower



KEY POINTS EMERGING FROM Round Table Meets

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RTMs on five core issues in SRH.

Table of Contents for RTMs

A. Comprehensive sexuality education for teens

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C. Post Partum contraception: when to begin the counseling, and how to improve uptake.

D. ACTS governing SRH practices : subtelities, pitfalls,crucial tips for practice,MTP, IPC, Evidence ACT.PCPNDT,

E. Ensuring universal access to High impact CAC service.

Introduction :

"*An equal world is an enabled world*" was the official theme of International women's day, 8thMarch for this year 2020. FOGSI has always strongly upheld the cause of gender equality. The societal, educational and economic equality for Indian women cannot be achieved unless their sexual and reproductive health needs are met. Ensuring reproductive rights has always been foremost in our minds. An important milestone to be achieved is Improving and refining abortion services and contraception uptake especially in the private sector .

Even though we are close to achieving replacement level fertility rate of 2.1(we are averaging 2.2 at present) the unmet need for contraception remains at 13% for several years now. So also the rate of unintended pregnancies remains at 49% and need for safe abortion services has never been higher. It is a matter of concern that practice in the field of contraception and safe abortion service provision has not improved at the same pace as in Infertility and Endoscopy, Imaging etc. especially in the private sector. To bridge this gap FOGSI has brought out a white paper manual on SRH services for women to be followed by FOGSIANS in everyday practice.

The deliberations on five key areas of SRH services took place as round table meets at a dedicated conference at New Delhi on the 28th of February 2020.

The two hour deliberations yielded a white paper concrete directive of key points for improvising practices in these complex area of SRH services.

RTM

A

A. Comprehensive SEXUALITY EDUCATION FOR THE TEENS.

What is Comprehensive sexuality education (CSE)?

It is a curriculum-based process of teaching and learning about cognitive, emotional, physical and social aspects of sexuality.

AIMS :

1. To equip adolescents and young people with knowledge, skills, attitudes and values that will empower them to protect their sexual rights throughout their lives with dignity and well being.
2. Gently overcome the controversies and opposition over introducing CSE in high Schools and intermediate (11th and 12th) colleges.
3. To function within the norms and rules implied in the POCSO Act 2012.

Who will benefit by FOGSI initiative on CSE ? ,

- The youth of the country. WHO defines adolescents as age group 10–19 years, young people as 10–24 years, youth as 15–24 years. and once they are taken through the curriculum in their teens, they benefit as young adults. Some compelling statistical facts(*IPPF, UNFPA):*
- 225 million adolescents comprise 22% of India's total population.
- One in every five Indian Teen aged 15–19 years, falls pregnant with higher maternal and neonatal morbidity and mortality.
- Adolescents and youth comprise 31% of AIDS burden in India. Only 1/3rd of young people know of HIV prevention.

The NGO TARSHI (Talking about Reproductive and Sexual Health Issues) in their project received over 59,000 calls on helpline, by young people , showing they lack adequate resources to receive appropriate information in a positive manner.

What are the Key SRH issues that affect young people which determine need for CSE

- Puberty, Menstruation, Masturbation
- Early marriage, pregnancy, abortions

- Unmet need for contraception
- Gender based violence
- Child sexual abuse
- STI/ HIV & AIDS
- Overexposed to social media, information and communication technologies.
- Mental health problems, suicide, depression leading to abnormal sexual behavior

Let us define the spectrum of unmet need for contraception in young people :

- Students in high school, and intermediate college.
- Married
- Unmarried
- Living with HIV
- Living in poverty/out of school
- With disability
- Living in humanitarian crisis
- Belonging to LGBT
- Cancer survivors

As identified by UNESCO's 2016 study School based , gender oriented interventions with involvement of teachers, parents and community gives excellent results.

The Current Indian status of Sex Education in Indian School is below par in few schools but non existent in majority. There is lack of evolved curriculum, with untrained staff and uncomfortable students who are non-participatory. Besides it does not sufficiently address emotional, moral , social and legal issues

Key Points for Implementation

KPP 1 :

- The curriculum for CSE- Knowledge should be framed based on their cognitive ability, it should be scientifically accurate, culturally relevant , age-appropriate.
- At high school basic anatomy, functioning and health related to puberty and sexual behavior can be discussed.
- At intermediate college, 11th and 12th when risk taking behavior begins and cognitive ability improves, we can teach sexuality, contraception and health risks

of unsafe sex. Adequate information about family planning, conception, contraception , condoms for dual protection, reproductive tract infections, sexually transmitted infections ,HIV and HPV, prevention, HPV vaccination, are all salient features of the proposed curriculum.

- Training, practice feedback, supervision, refresher training, research, audit and quality control of the CSE should be mandatory

KPP 2 ;

HEADSS SCORING ASSESSMENT

A participatory and interactive session to be built into the curriculum where adolescents can score themselves on following counts :

- Home environment
- Education : school grade performance
- Activities-sports , hobbies
- Drugs-use by family or peers
- Sexuality-orientation , experience, pregnancy ,abortion, contraception
- Suicide- depression, sleep disorder etc.

The self assessment score helps the teen to resolve doubts and dilemmas.

KPP 3 :

- Teachers/trainers - Willing, well trained, comfortable, respectful & non-judgemental
- Involvement of young people as peer educators to give them ownership, empowerment and motivation so they in turn sensitize the teens and act as referral points to experts and services.

KPP 4

- Collaborate with other GOI programs like RKSK and NACO

KPP 5 :

Gender sensitization programs to be developed by FOGSI. Teach the adolescent about consent and privacy - how to "SAY NO" and how to "ACCEPT NO". Respect others' right to bodily autonomy. 18% of high school students have been forced to have intercourse, while 1 in 10 have committed sexual violence. Teens must express dignity and respect for all people, regardless of sexual orientation or gender identity - equality for lesbian, gay, bisexual, and transgender (LGBT) individuals.

KPP 6

Information about local laws- POCSO, MTP important for both students and educators

KPP 7 :

All teens should be given options for training in physical fitness and skill for self defense preferably in martial arts. An immediate defence mechanism against violence .

KPP 8 :

CSE should be well accepted and respected universally, supported and reinforced by family, peers, religious groups, civic society ,reproductive health clinics and local media.

KPP 9 :

- New platforms created by FOGSI for reaching out to young people: Information ,communication technologies ,social media determine sexual behavior in teens :

1.Reducing impact of Harmful messages:

- Images related to sexual activity, Cyber bullying, Sexting, Alcohol/tobacco/drugs,

By creating positive messages about sexuality and sexual health through FOGSI Cyber café : Mobile Apps, websites, web telecast, Facebook, eLearning modules .

2. Helpline for youth, email and text messaging service allows young people to reach out anonymously.
3. Articles for Media literacy about safe sexual behavior in adolescents.

4. Encourage small group discussions and activities as a workshop approach – more participatory
5. Plays, songs, movies, radio & TV shows

KPP 10.

MONITORING THE CSE PROGRAM

- Ask school –take feedback from teachers, parents ,
- Pre and post test questionnaire.,Analyze the response
- Generate evidence based data
- Use indicators/check lists for quality control and bring about changes when necessary.

B. FOGSI – I CARE : INTEGRATED C,ONTRACEPTIVE APPROACH ACROSS REPRODUCTIVE AGE THROUGH CONTRACEPTIVE CLINIC.

The current world population of 7.8 billion and the pace at which it has escalated gives a clear message for better attempts at population stabilization. The country scenario in India of 1.37 billion population contributing to about 17% of world population tells us that we have underperformed in this sector and it is time to make a difference.

India ranks 2nd in the list of world's population(china being the 1st) but may be the first in population density. The complex factor is 65% of population is rural with low resource setting.

Today, it is a harsh reality that 44% of Indian women do not use any form of contraception. The onus of service delivery for contraception has so far been on public sector for 70% of the women aged 15 to 49 yrs using modern method of contraception and private sector accounts for only 24%. If FOGSI could enhance these numbers , we shall soon see a decline in the 13% unmet need.

Programmes/ Strategies to strengthen private sector:

FOGSI promotes **Integrated contraceptive approach across reproductive age:**

- To respect and promote reproductive rights of women who step into our clinics for any aspect of OB GYN care.
- Basic premise : Every couple has a right to decide on the number of children they want to bear and the spacing between two children.
- Conduct of training sessions for the staff ,doctors,nurses,paramedics, social welfare officers.
- Orientation sessions for doctors and residents(all specialities) eg. Paediaricians, physicians,family physicians, they all must learn to talk contraception.

Integrated services can be the backbone of service delivery in complex areas of public health. *According to World Health Organization: Integrated services means:*

"The management of health services in a way that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system".

Requires strong communication and collaboration within an organization, undoubtedly a team effort.

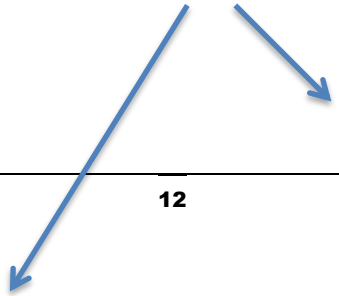
Rationale Behind Implementation of Integrated Family Planning : Every Opportunity Of Contact Is Utilised:

- All women in reproductive age who are sexually active and not tubectomised or hysterectomised need contraception counseling.
- It ensures women's autonomy in reproductive decision making,
- It addresses poor male participation in SRH matters.
- Assures Accessibilty .
- Unmet Needs met.
- Improves Quality Of Care .Better Client experience/Satisfaction/ compliance/Retention.
- Improved outcomes at lower costs

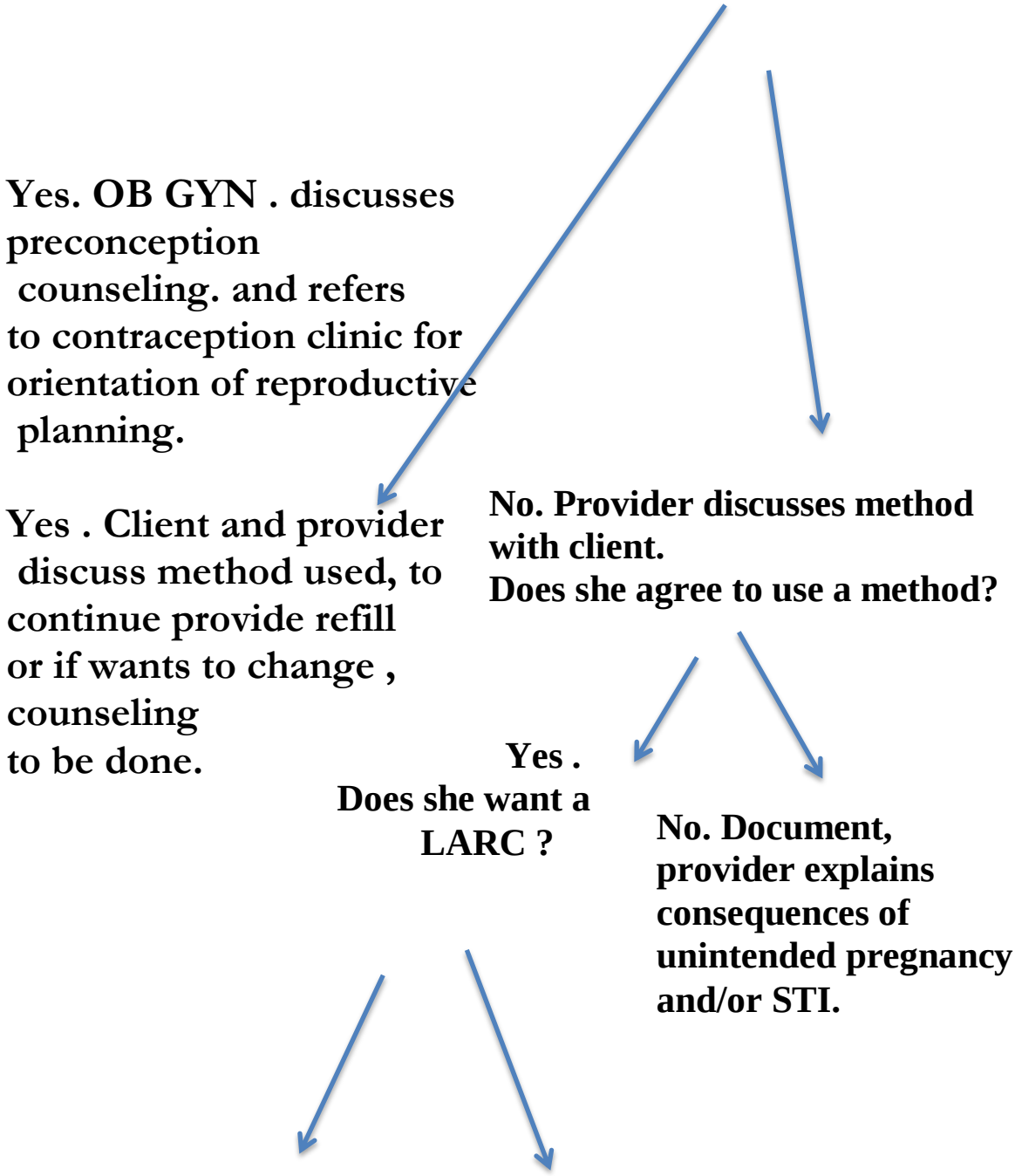
KPP 1 : INTEGRATED SERVICES- How to provide across reproductive age ? **An Example :**

Female patient aged 13 to 49 yrs registers for primary care visit for any health reason.

During primary care visit reproductive intention is systematically measured. Is she sexually active and is she planning to conceive ?



No. Is she using an effective method ?



KPP 2 :Integration can happen at every point of contact of the obstetrician gynaecologist and the client/patient.

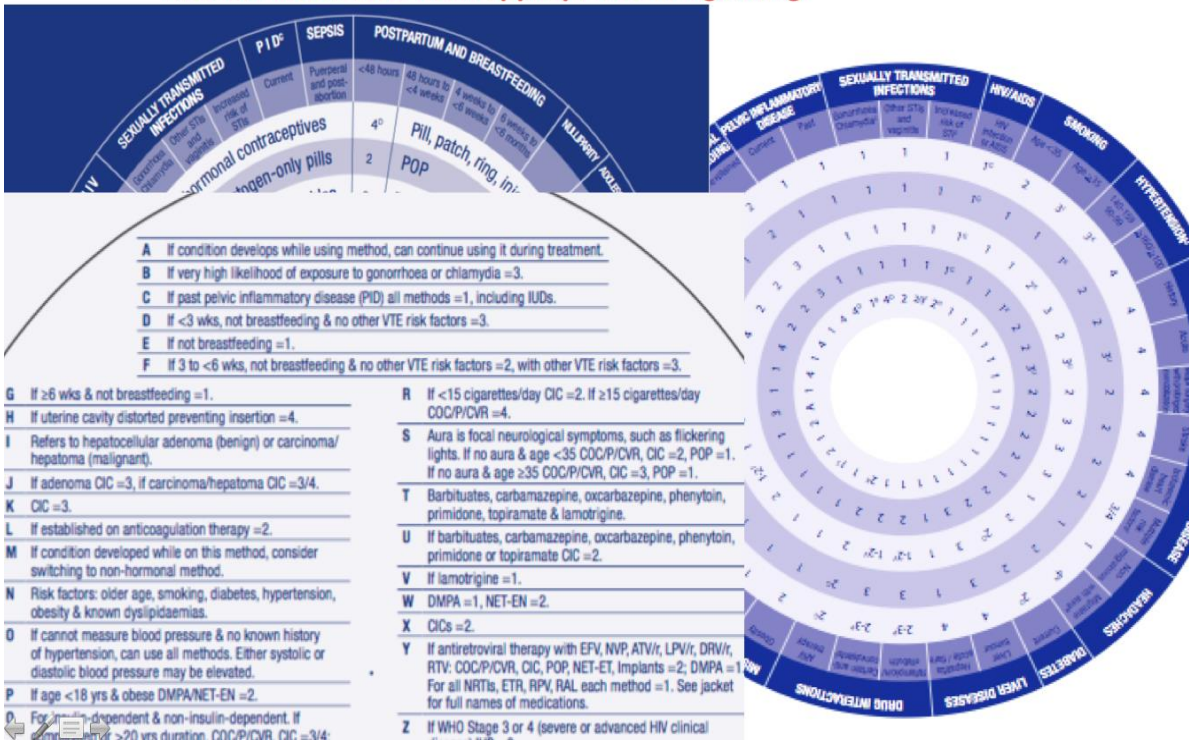
1. Adolescent care with Contraceptive awareness.
2. Preconceptional care with concept of reproductive planning.
3. Antenatal care to be strengthened by integrating contraceptive counseling.
4. Post partum care to be firmly ingrained with counseling and uptake for post partum contraception.
5. Comprehensive abortion care includes the vital post abortal contraception provision.
6. The opportunistic time: The interval situations of visits for screening of cancer, health checks, menstrual problems , premenstrual tensions etc. should have contraceptive advice with treatment of presenting symptom.
7. The premenopausal women coming in for gynaec care will deserve a check and counsel on her contraceptive need.
8. Integrating immunization with family planning services
9. Integrating ICTC/PPTCT with Family Planning
10. Integrating RTI/STI clinics with FP.

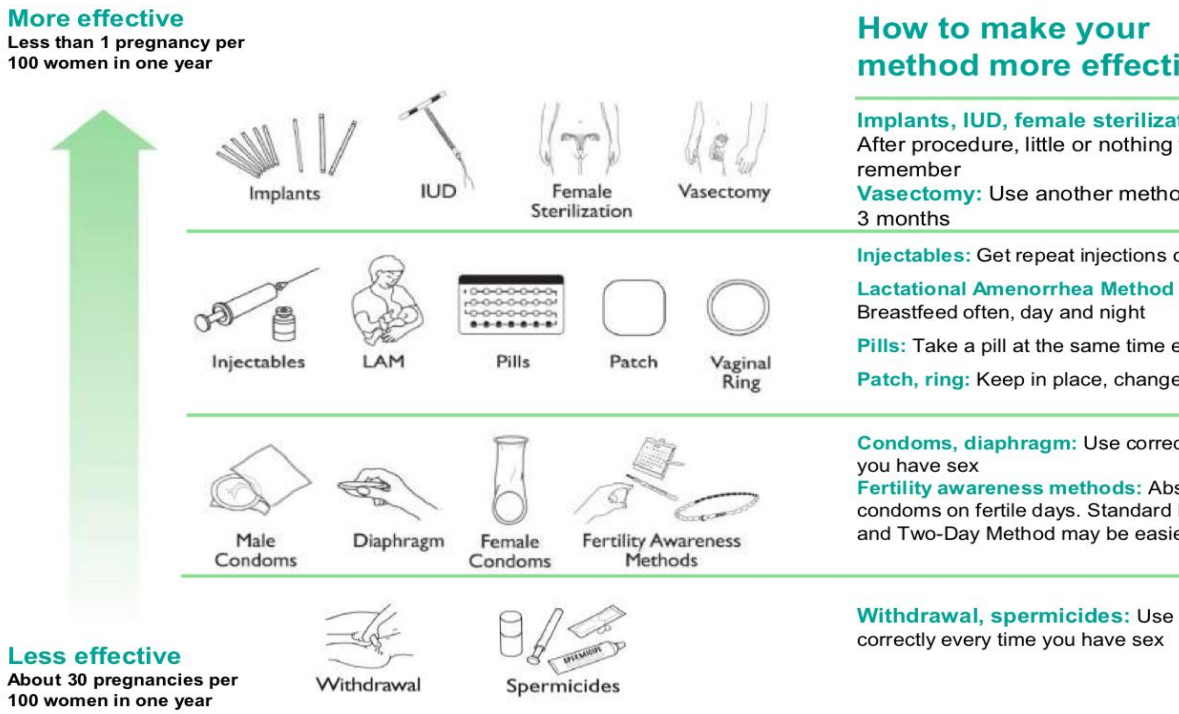
In all above clinical scenarios, after consult on the presenting problem, the OBGYN should explore the unmet need for contraception and apply Medical eligibility criteria and initial

advice on appropriate methods and refer the client for further counseling to the contraception clinic.

The tools used are the MEC wheel and the effectiveness chart :

MEC wheel guides usage of any contraceptive (hormonal) in various medical conditions with appropriate risk grading





KPP 3 : Establishment of dedicated **FP units,**a contraception **I Care** clinic (one unit/ opd of 30 patients/day) to create an interphase between the couple and the health cre worker.

What happens in the **contraception clinic** ?

- **Skilled counsellors** specially dedicated for contraception will interact in a brief, simple and culurally sensitive.
- Counselling ; defined as a process where a trained counselor uses his/ her skills to assist a client to choose from the basket of choices using the **GATHER** approach .
- **Greet** clients in a friendly , respectful, manner assuring privacy and confidetiality for the couple/client.

- **Ask** clients about family planning needs, concerns ,previous use.
- **Tell** Effective use with help of audiovisual aids , anatomic models ,and contraceptive samples and present the basket identified by the consultant.
- **Help** clients to make a choice.
- **Explain** to clients details of the method, including how to use it correctly.
- **Return :** Schedule for follow up visit.

Pamphlets in regional language with key information shared . The most valuable part of this interphase is the client has an opportunity to look at the samples, understand methods and get a feel of what a device or pill or injection looks like. Familiarity will remove the fear of unknown and create a conducive atmosphere for counseling and choice and acceptance.

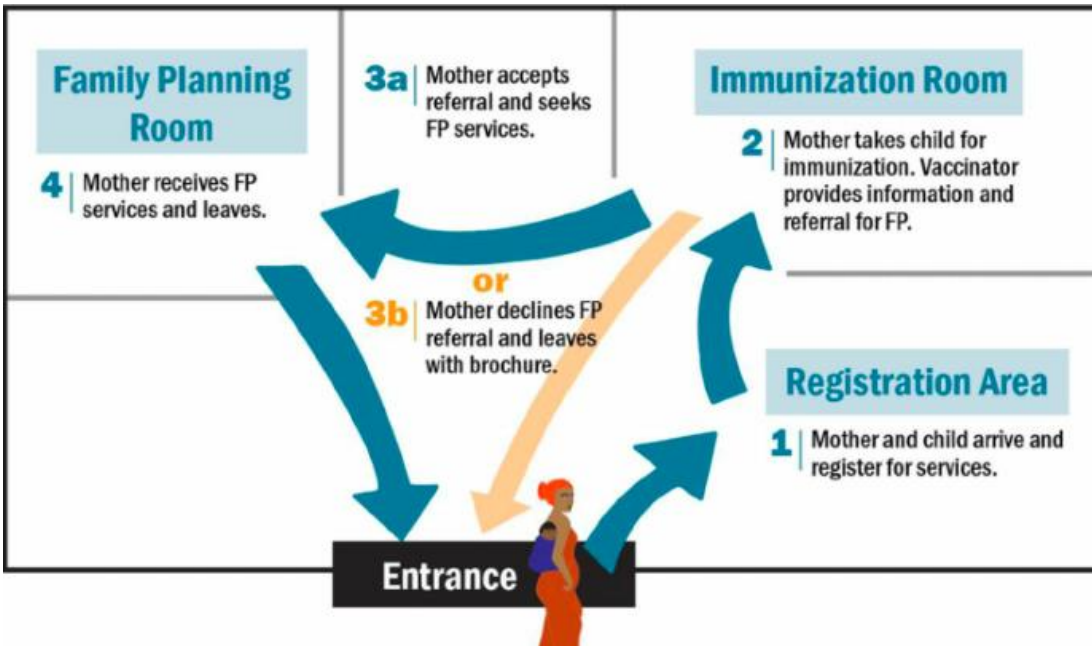
KPP 4 : Examples of Integrating services with FP .

- With immunization services.

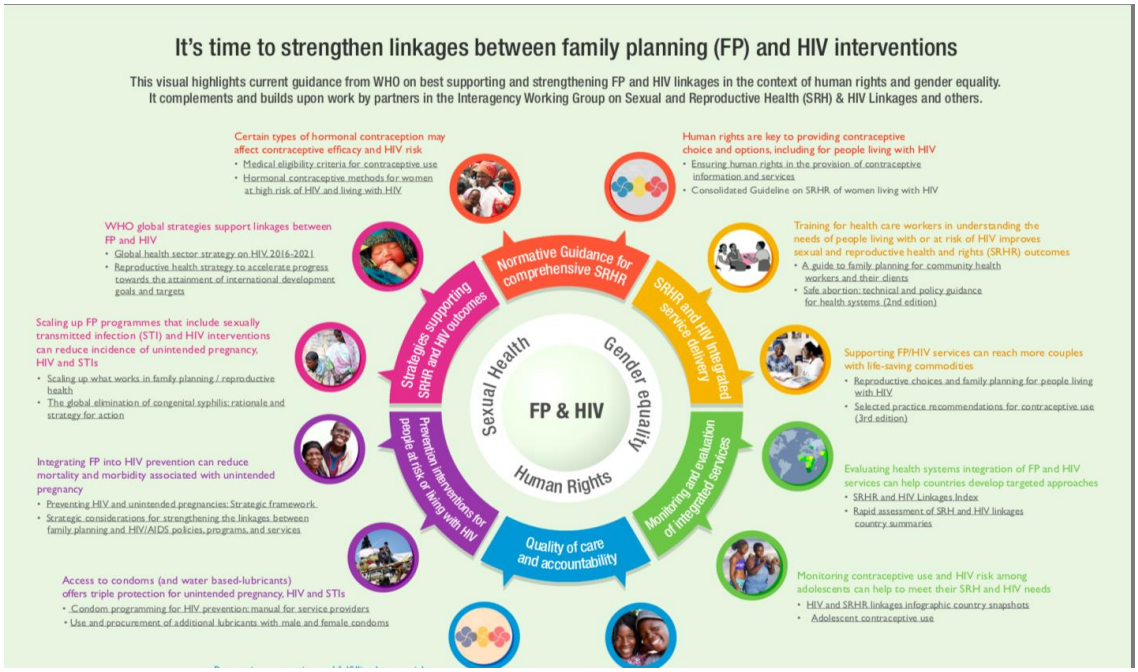
a. Entrance : Registration area : mother and child arrive and register for services.
b. Immunization room : mother takes child for immunization , vaccinator provides information and referral for FP
c. A . Mother accepts referral and seeks family planning services

3.B . Mother declines service and leaves with brochure

d. Family planning room : Mother receives FP service and she leaves.



Example of successful integrated care :FP and HIV intervention as WHO initiative.



- Bill & Melinda Gates Foundation in Bihar aimed at implementing integrated interventions included in developing the rubric of family health for reducing fertility as well as maternal, neonatal , child mortality and improving reproductive health and nutrition.

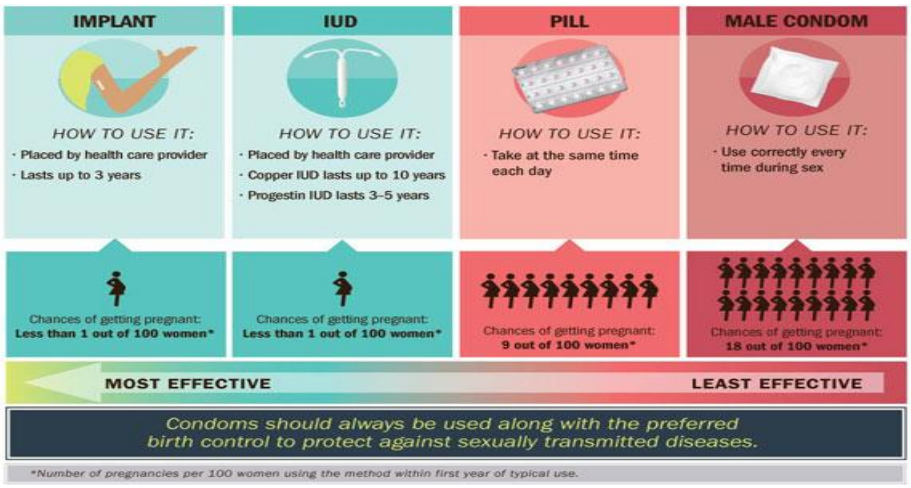
KPP 5 :

Integrating adolescent gynaecological care with contraception :

- 11% of worlds teenage pregnancies happen in India, translating to 16 million girls per year.
- Poor provider attitude, lack of access, confidentiality and choice, high cost and poor knowledge are the barriers identified.
- Non judgemental service provision, privacy, enhancing the basket of choices, subsidized cost may build up better attitudes about contraception.
- Clinical scenarios 1: 18 yr old unmarried reports dysuria, white discharge per vaginum and fever, clinical and lab evaluation , is indicated. A cervical secretion culture for gonorrhea, vaginal secretions test for trichomonas, chlamydia, vaginosis, Elisa test for Chlamydia, are offered, test for other STI (Syphilis, HIV, HbsAg) is discussed, Partner history,testing and counseling offered. Syndromic single dose antibiotic management to cover common infections in

the form of Azithromycin 1 gram and Cefixime 400mgs to be strongly considered. The couple is then strongly counseled for **dual** method of contraception, barriers (male condoms **and** IUD or pills, **sent to the I Care clinic**

- Teens most often use condoms inconsistently and incorrectly, discussed and reinforced by counselor.
- **PTL** : **Push towards LARC**, Worldwide less than 5% of teens on birth control use LARC and these are suitable as often these young girls need long term contraception. Many teens know very little about LARC and the method effectiveness can be explained with such charts. This will also emhasize the need for dual method as condom effectiveness is displayed. LARC plus condoms may be ideal for adolescents.



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KPP 6 : Integrating **preconceptional care** with family planning to avoid too-early, unwanted and rapid successive pregnancies.

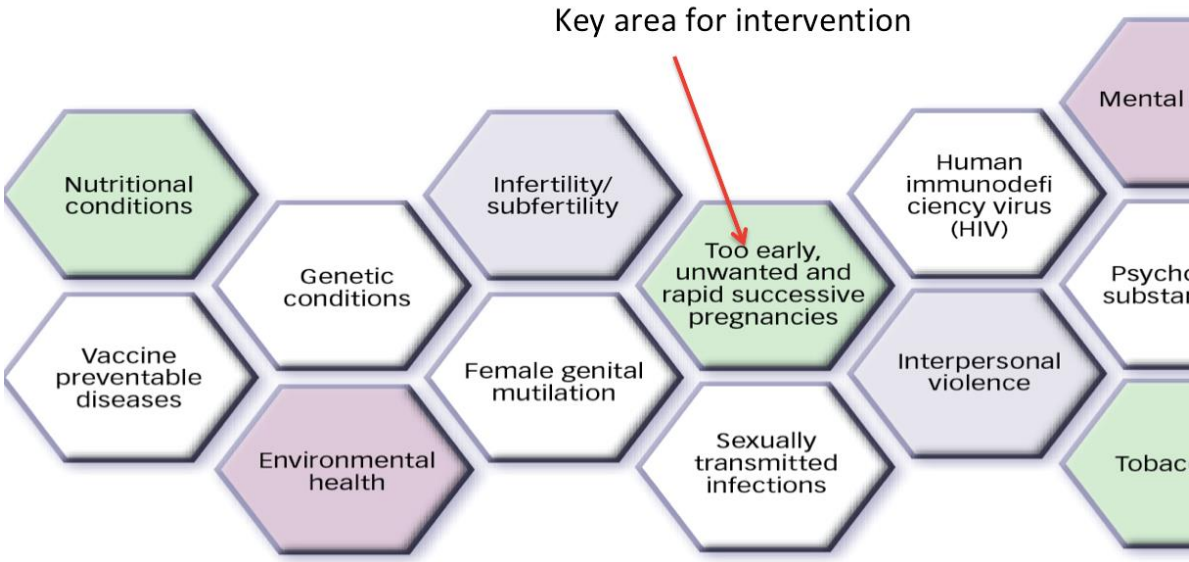
Clinical Scenario : A young recently married healthy couple come for pre-conceptional counseling. The following inputs needed:

- Monitoring nutritional status, Screening for anemia
  Supplementing iron and folic acid.
- Taking a thorough family history and Genetic counseling
- Screening for diabetes mellitus.
- Promoting exercise.
- Salt iodization

- Family planning as in reproductive planning on number of children and spacing between them
- Carrier screening for HIV, HbsAg etc.

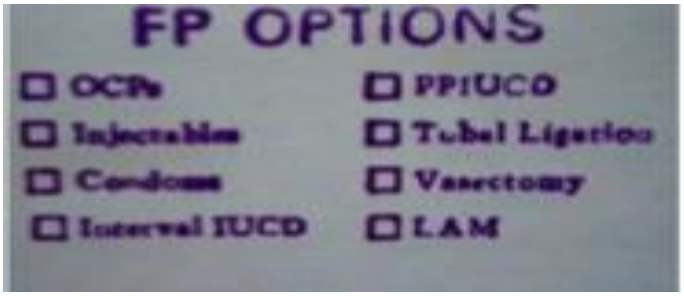
The consultant completes the history and examination and asks for basic tests. After evaluation , the woman is found to have nutritional anemia, she is started on therapy and accepts to delay conception by six months. She is then evaluated with MEC and offered the basket with choices of COC, POP, injectables , or barriers. The couple is sent to the I CARE clinic where she is counseled on all above methods and opts for COC for six months.

WHO has developed a package of preconception care interventions which includes family planning.



KPP 7 : Integrated contraceptive approach during pregnancy to improve post partum uptake :

- Discussing contraception prenatally lays the groundwork for initiation in the immediate postpartum period.
- Receipt of at least two prenatal contraceptive counseling sessions and delivery of the baby at the same hospital will improve uptake.
- Highlight advantages of individual methods with application of MEC criteria.
- All women with low risk pregnancies must visit the I care clinic at least once in the antenatal period preferably with spouse
- A consent form/seal for contraceptive service can be used to identify the couple's tentative choice after further counseling in the I care clinic.



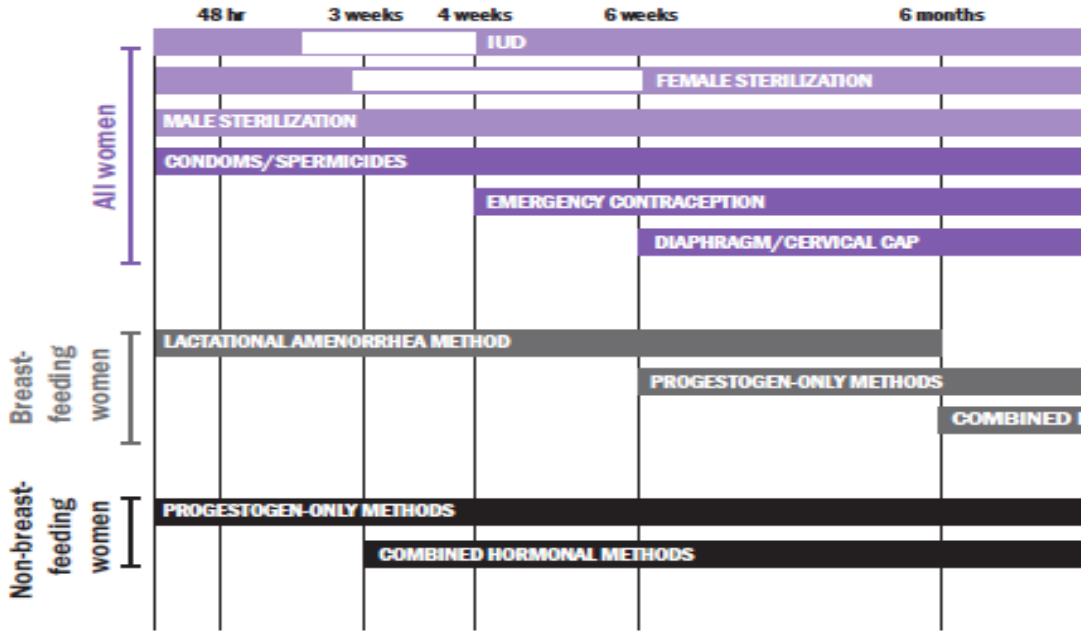
- Women with high risk pregnancy, the focus is of course on management of the primary illness, they must also absolutely recognize the need for delaying the next conception and can be informrd on methods at an opportune time.
- Women with GDM should be assured that all contraceptives are safe for them.
- Those women with APLA, hypertension , epilepsy on medication with enzyme inducers must be informed about the non hormonal methods of contraception and so on.

KPP 8 : PPFP : Post partum family planning.

- **Integrated contraceptive approach in the post partum period :**
- In India the unmet need for family planning among postpartum women during the first year is 65%.
- PPFP can avert more than 30% of maternal deaths and 10% of child mortality if couples space their pregnancies more than 2 years apart.
- Most receptive period to accept contraception

- Risk of pregnancy after childbirth(can be as early as 4 weeks in non breast feeding women)
- **PPFP can be Post placental** -within 10 minutes of delivery(for PPIUCD), **immediate post partum-** delivery to 48 hours, **post partum** -initial 6 weeks after delivery, **extended post partum** -6weeks to 1 year of delivery.
- **Counseling in the I Care clinic** can be in any of these situations, for the spouse or to the couple whichever feasible.
- ABCD of post partum care :

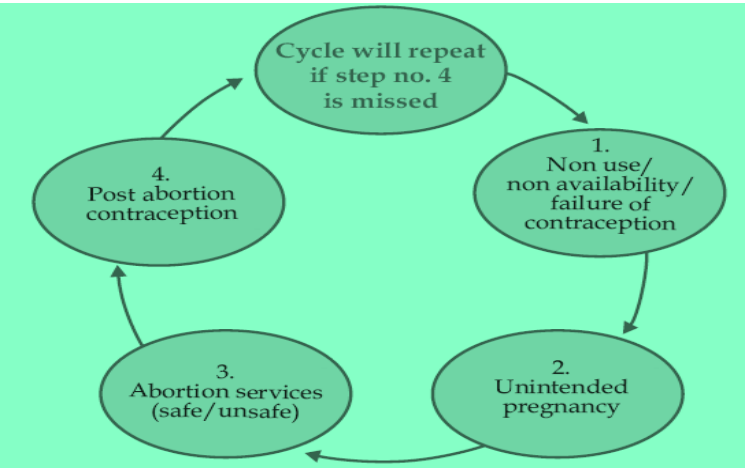
A bdominal Exercises
B reast feeding
C ontraception
D iseases – follow up
(Anaemia, HTN, DM, immunization HPVetc.)



	CONTINUUM OF POINTS OF CONTACT FOR PPFP →	→	→	→
STAGE	Pregnancy	Labour and delivery, Pre-discharge (0–48 hours)	Postnatal, including prevention of mother-to-child transmission of HIV (PMTCT) (48 hours–6 weeks)	Infant care (4–6 weeks through
SERVICE DELIVERY	Facility-based antenatal care (ANC) Community-based pregnancy screening	Facility-based or home-based with skilled birth attendant	Facility or household visits: - If birth at home, within 24 hours of birth - If birth in facility, prior to discharge - Day 3 (48-72 hours) - Between days 7-14 after birth - 6 weeks	Facility, home visit, o community-based: - Immunizations (di pertussis-tetanus Pentavalent 1, 2, 3 rotavirus; booster - Well child visits - Nutrition/growth - Event days (e.g. vi - Illness visits (e.g. I Community Case Management/Inte Management of C Illnesses [iCCM/IM - PMTCT/antiretrovi treatment

KPP 9: Integration of FP with Post abortal care : as part of CAC : comprehensive abortion services.

- Rationale : Return of fertility- as early as 10 days .of an abortion procedure.
- *Abortion to pregnancy interval- 6 months minimum (WHO recommendation)
- The post abortion period, when the woman is still at the facility, it is an opportune time for post abortion contraception counseling and couple can be sent to I Care clinic, helping her to choose from available methods that can be started immediately after abortion procedure



- Method specific counseling ;

Insertion of progestogen-only implants (IMP) at the time of abortion is convenient, acceptable ,high continuation rates

IUCD can be safely used by women after an uncomplicated abortion.

Women may be advised of benefit from reduced uterine bleeding with LNG-IUS.
PTL : Some LARC methods are as effective than female sterilization and may confer non-contraceptive benefits.
CHC should be avoided by women with REM (recurrent early miscarriage) until antiphospholipid syndrome (APS) has been excluded.

- **KPP 10 : The interval situation integrated with contraceptive advice :** Interval situations refer to – *Adoption or insertion of family planning methods at any time during cycle and is not in relationship to the end of pregnancy.*
- This situation includes those women who visit the clinic for other problems, menstrual disturbances, genitourinary infections and after treatment advice on presenting symptom the unmet need can be explored, MEC established and referred to I Care clinic.
- A woman can start using Contraception any time she wants if it is reasonably certain she is not pregnant.,using the Pregnancy Checklist **For which she can be sent to the I care clinic.**
- **One can be reasonably sure that the client is not pregnant, if she has no signs or symptoms of pregnancy (e.g., breast**

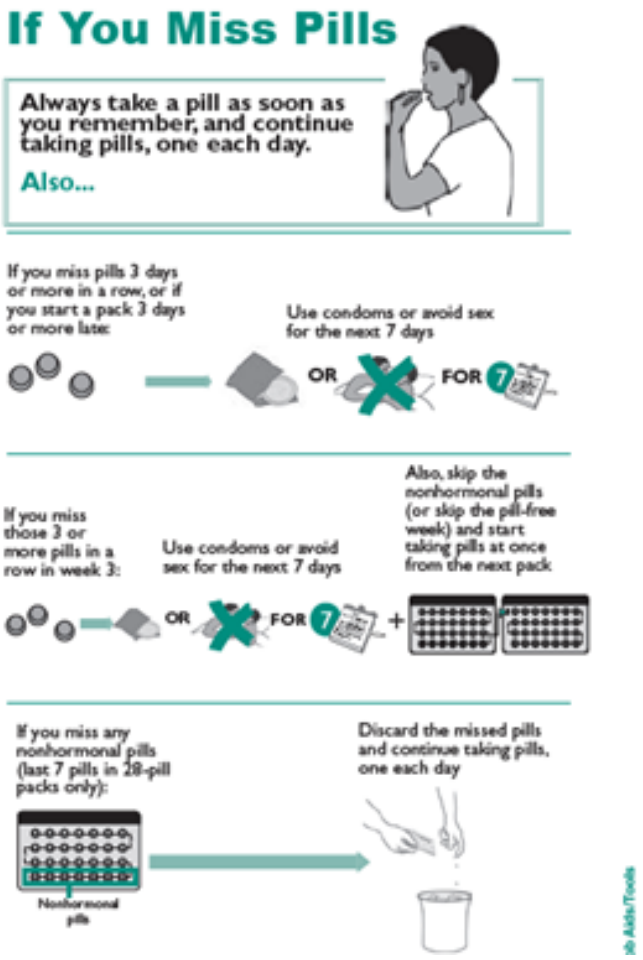
tenderness or nausea) and is taken through check list:

1. Has not had intercourse since her last menses; or
2. Has been correctly and consistently using a reliable contraceptive method; or
3. Is within the first 7 days after the start of her menses ; or
4. Is within 4 weeks postpartum (for women who are not breastfeeding); or
5. Is within the first 7 days post-abortion; or
6. Is fully breastfeeding, is less than 6 months postpartum and has had no menstrual bleeding.

** For copper-bearing IUD, the 7-day window is expanded to 12 days.*

- If the client answered **<u>NO</u> to *all of the questions***, pregnancy **<u>cannot</u>** be ruled out using the checklist. Rule out pregnancy by other means, ***a pregnancy test or wait till onset of next period***. If the client answered **<u>YES</u> to *at least one* *of the questions***, you can be reasonably **<u>sure</u>** she is not pregnant.

- COCs and POPs can be started within 5 days of period and later if she clears the checklist provided there is back up method for seven days.
- Women who are on COCs and POPs and need to consult for missed pills can be recruited for the I Care clinic.



- DMPA and LNG IUS can be given within 7 days of period, beyond which can be

given if she clears pregnancy checklist and back up method for 7 days.

- Cu IUD can be provided within 12 days of period or any time in cycle if she clears the pregnancy checklist and no back up method needed.
- ***Backup methods*** *include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods.*

KPP 11 : Integrated contraceptive care for the pre menopausal women :

- Women in this age group come for health check ups, or seek advice on AUB, cancer screening, medical disorders,
- The unmet need for non tubectomised sexually active women has to be assessed by the primary physician or gynecologist and referred to I Care clinic.
- Low dose COCs for women with no other CV risk factors can be prescribed for additional benefits of reduced uterine bleeding, preventing bone demineralization, reduced menopausal symptoms, in other words utilizing the window of opportunity. An age dependent increase in thrombotic risk

to be assessed using the MEC criteria. Non oral routes like patches and rings also are suitable.

- In women with cardiovascular risk ,POPs can replace COCs or women can opt for Cu IUDs if they are keen on a LARC method.
- LARC methods like LNG IUS can be used for women with heavy menstrual bleeds, and can be continued beyond menopause for HRT.
- Implants and injectables are also suitable in this age group especially in women with cardiovascular risk factors.

KPP 12 : The service : The I Care clinic :

- Dedicated cubicle or clinic in the OPD floor of every private maternity service.
- Counselors trained in family planning service should be posted, could be MSW, ANM, Nurse practitioner.
- The room to be equipped with charts, models ,samples, and take home materials like brochures, information leaflets.
- Nodal training centres for such counselors to be established in key private hospitals.
- Making all FP related services free or nominal cost .

RTM

C

C. POST PARTUM CONTRACEPTION
How to begin counseling and increase uptake?

What is Post partum contraception ?

According to WHO 2013, prevention of unintended pregnancy and closely spaced pregnancies through the first 12 months following childbirth using different contraceptive methods.

The Demographic and health survey data of 2001(Ross and Winfrey) tells us that 95% of women 0-12 mths postpartum wish to avoid pregnancy but 70% are not using contraception

It is also established that 30% of maternal deaths and 10% of child mortality can be averted if spacing of 2yrs (Cleland 2006, WHO 2005). An inter pregnancy interval of less than 6 months: will increase the odds for preterm and SGA >1.2.

- The aim of ideal post partum care is to define end points of service delivery, to ensure choice, enable acceptance and empower the woman towards reproductive planning.

- Post Natal Care is an opportune time when women can be counseled on birth spacing and family planning with two goals :

Firstly, Contraceptive options should be discussed, and contraceptive methods should be provided if requested.

Secondly, help women to decide on the contraceptive they want to use, to initiate that contraceptive, and to continue the method.

There are unique considerations for providing PPFP services to women during the 12-month postpartum period . It is the ideal time to discuss contraception, women are known to not be pregnant, can be motivated to initiate as they are already under care of expert medical help

KPP1: When ?:

- The significant change in practice : start counseling for Post Partum Contraception in the antenatal period.

- Antenatal card should have a column on post partum contraception options. Choice should be documented.
- If intranatal period is the point of first contact, initiate discussion in early labour.
- No opportunity to be missed for counseling. Including immunization visits of her infants.

KPP2 :Who should counsel ?

- The first counseling should be done by a medical practitioner, that includes availability, efficacy, usage and side-effects of the method
- Paramedical staff may be involved in providing information on methods concerning its usage. They may also be employed during follow up visits.

KPP3 : What to inform?

- Inform women of health benefit of post partum contraception and spacing.
- Inform women that EXCLUSIVE breast feeding is an effective contraceptive method for the first six months till the return of menses with a failure rate of 2%

- Inform women not able to exclusively breast-feed, of an early return to fertility and shouldneed to initiate early contraception.

KPP 4 : What to offer ?

- Offer the basket of contraceptives that do not affect breastfeeding process.
- MEC and Special medical conditions to be kept in mind while offering contraception options (WHO MEC 2015, edition 5)

KPP 5 : How to counsel ?

- Comprehensive, unbiased, pictorial, updated information with audiovisual aids to be provided
- The counseling should be in the language understandable to the couple.
- An individual approach needs to be maintained while providing contraceptive counselling
- No coercion should be applied during counselling
- Myths and misconceptions pertaining to contraceptive usage to be addressed.

- It is advisable to include spouse/family member in the counseling,

KPP6 : Method counseling :

- Couples : should be informed that barrier (condoms) remain a viable option.
- Couples should be informed that emergency contraception is safe in the breastfeeding period
- Couples should be informed of the safety of progesterone only contraceptives (implants, pills, LNG IUS and injectables) during breast feeding. can be started anytime after childbirth including immediately after delivery
- If POPs are chosen DSG containing pills score over LNG containing pills
- Intra Uterine Devices may be used within the first 48hrs of delivery irrespective of route or after 4 weeks.

KPP 7: PTL : Push towards LAARC

- A long acting reversible contraception method like PPIUD or progesterone implants or LNG IUS should be preferred

- If non-hormonal methods are preferred centchroman or ormeloxifene may be suggested

KPP8: LIMITING Methods :

- Female or Male Sterilisation is an option which may be considered if the family is complete
- Mini laparotomy in the immediate post partum period or clips at laparoscopy should be considered
- Issues of regret and increased failure rates should be discussed while considering post partum sterilisation .
- Accreditation of hospital for sterilization services and empanelment of doctors for the same with the district authorities and local medical council is mandatory for all legal purposes and eligibility for the indemnity schemes.

KPP 9 : Procedural consent :

- Consent to be taken before implementing contraceptive methods like implants, IUD, sterilization etc.

KPP 10 : Continuum of care :

- Ensure continuing care and support with the Health Care Provider
- Regular counselling/ trouble shooting helps in improving compliance
- Follow up visits essential
- Reassurance for side effects like menstrual disturbances .
- The clinician should be adept at managing side effects like excessive menstrual bleeding, breast tenderness, mood disturbances etc.
- If she insists on discontinuing, help her switch to other methods.

RTM

D

RTM D : . ACTS governing SRH practices : subtelities, pitfalls,crucial tips for practice, MTP, IPC, PCPNDT:

Liability under criminal law=Indian Penal Code (IPC)

A doctor can be punished under

- 269-272 = biomedical waste related
- 302= murder
- 304 = culpable homicide culpable homicide not amounting to murder
- 304A = causing death by a rash or negligent act
- 312-315= MTP related
- 337-338= grievous hurt/ complication
- Sections 87, 88, 89 and 92 of the IPC provide immunity from criminal prosecutions to doctors who act in good faith.

1: MTP ACT : The Medical Termination of Pregnancy Act 1971,

1971, amended 1975, 2002, Rules,

regulations : 2003. **The Act legalises abortion**

KEY PRACTICE POINTS

1. If the woman opting for MTP is >18years of age then consent of the woman alone is enough but if the girl is a minor or mentally unstable then signature of guardian is required.
2. If the girl is less then 18 years of age then as per the POCSO act police need to be informed even if the girl is married.
3. **Where can you provide the service ? Government approval needed. Government units or** A **Private** centre approved by **District level committee-**
   Separate approvals are required for performing MTP for first and second trimester, i.e upto 12 weeks and upto 20 weeks . Medical method of abortion can be prescribed at an unapproved clinics/site provided there

is an access/ referral linkage to MTP approved centre and a certificate from the owner of the approved centre should be displayed at the clinic.

4. **At What gestational age ? Up to 12wks- 1 RMP**-Up to 7 weeks by medical methods of abortion(MMA),**Up to 20 weeks- 2 RMP**
5. **Who can provide ? Registered medical practitioner (RMP)** registered with Indian Medical Council (1956) & State Medical Board with training in OBG as per MTP act.
6. **Record keeping :** All the records pertaining to MTP are confidential and they are not open for inspection except by the authority of law. Name of the woman opting for medical/ surgical abortion should not be mentioned in the discharge summary only the serial number [as per the MTP register maintained by the institution] should be mentioned

Reporting requirements and record keeping

Under the MTP Act, the following records are obligatory for all facilities (governm and private):

Form A	This form is for the approval of the site.
Form B	This is the certificate of the approval of the site.
Form C	This form records consent of the woman or her guardian (if she minor / mentally unstable).
Form I	This form records the consent of the RMPs and should be updat within three hours of termination.
Form II (Page 25)	This is a monthly statement of MTP cases carried out at a hospit approved place. The head of the hospital or owner of the approv place should send the monthly statement of MTP cases to the C the district.
Form III (Page 26)	This form keeps a record of all terminations. It needs to be kept period of five years from the end of the calendar year it relates t

7. In what ways can a practitioner be indicted and punished under MTP act.

- Done by an RMP but in any other place than an approved place
- Any person other than RMP – The Non RMP
  will be liable

Rigorous imprisonment for a term not less than 2yrs but may extent upto 7yrs
Any contravention of the requirement of record – keeping
Fine :which may extend to Rs.1000

2.Understanding POCSO Act : The Protection Of Child against Sexual Offences(POCSO) ACT, 2012(Amended 2019),

passed to strengthen legal provisions for the protection of children below 18 years of age from sexual abuse and exploitation. According to National Crime Records Bureau, 10,854 child rape cases happened in India in 2015 alone.Neighbours, friends, close relatives, and acquaintances and employers at workplaces are the most common abusers. CSA is usually repeated over varying periods and may cause serious short- and long- term adverse effects.

KEY PRACTICE POINTS

1. Every case of child sexual assault is to be treated as an emergency and free treatment is to be provided by all private and government hospitals.

2. Conduct a medical examination with the consent of child/parent/ guardian, depending upon the age of the child.
3. Doctor is bound to inform the police.
4. No body can force the survivor to undergo medical examination without informed consent of child/parent/guardian.
5. Make an MLC or take an informed refusal if the victim does not want to pursue any police case
6. MLC number and the police station number must be recorded if the victim has already lodged a complaint or if the victim wishes to lodge a complaint later.
7. For a child who is less than 12 years of age, consent of guardian is required but if the child is more than 12 years of age then only his/her consent is required for examination.
8. Any child who is less than 18 years of age comes to clinic seeking abortion or even if there is any suspicion of sexual activity like seeking contraceptive advice, the doctor is bound to inform the police as per POCSO act.

3.THE PRE-CONCEPTION AND PRE-NATAL DIAGNOSTIC TECHNIQUE ACT 1994

KEY PRACTICE POINTS

1. Certificate if registration is very important for all genetic clinic, genetic counselling centres and genetic laboratories.
2. FORM A is required to be filled and sent in duplicate to the Appropriate Authority for applying for registration.
3. Acknowledgement slip to be provided by the appropriate authority on the same day or next working day.
4. Certificate of registration is granted in FORM B in duplicate to the applicant
5. One copy of certificate of registration is to be displayed at the centre at a conspicuous place at its place of business.
6. If the applicant has not complied with the requirement of the ACT the rejection is specified to the applicant in FORM C.
7. The grant of certificate of registration or rejection shall be communicated within 90

days from the date of receipt of application.

8. Certificate is non-transferable.
9. In the event of change of ownership then a re-application is required.
10. Validity of registration is for 5 years and application of renewal should be sent to the appropriate authority within 30 days of expiry in duplicate in Form A.

E. Ensuring universal access to High impact CAC service. What has been done and what can be done in future.

Unsafe abortions account for 8% of maternal deaths in India. Lack of accessibility to safe abortion services by qualified providers in hygienic condition is one of the important reasons for this. Ensuring universal access to high impact CAC Service is an important goal for FOGSI towards optimal Sexual reproductive health of our women. We have about 16 million abortions an year, 81% of which are medical abortions. A sizable 73% of medical abortions happen outside medical facility, and more than half of them present as failures, incomplete abortions, ectopic pregnancies etc.

Recognizing the fact that unsafe abortion is a major concern, providing access to safe abortion is a key focus area under National Health Mission.

Comprehensive Abortion Care Components

KPP1 : Provide safe, high-quality services for abortion, post abortion care and contraception at multiple centers in the private sector , that are accessible, acceptable and affordable. Individualize and tailor the care, to include young clients,

unmarried, socially deprived and marginalized communities.

KPP 2 : CAC services should become an integral part of a sustainable health system reducing the number of unintended pregnancies and abortions and dealing with other sexual or reproductive health needs of women.

KPP 3 : A major function is to build awareness, remove myths and misconceptions around contraception. This can be accomplished with take home brochures, audiovisual messages in the waiting area and telephonic reminders for follow up and appointments etc.

KPP 4 : Practitioners need to be be aware of MTP,POCSO,PCPNDT acts completely as discussed in the previous segment.

KPP 5 : Training Requirements- Provider Base Categories should be known,

- RMP, registered in state medical register,Practice in Obs. and Gynae for 3 years
- RMP, registered in state medical register, 6 months house surgeon training in OBG, assisted an RMP in 25 cases of MTP, 5 performed independently,10 assisted and 10 observed.

KPP 6 : Record keeping, documentation, forms A,B,C and I, II, and III to be maintained meticulously. Consent with counseling will favour contraception uptake.

KPP 7 : Standard technique should be practised.
1st Trimester – Mifepristone+Misoprostol-63 days(9wks)

- Medical- method of abortion MMA - 9-12 weeks
  Efficacy highest before 7weeks.
- Surgical- 12-14 wks – Vacuum aspiration : Electric or MVA.

2nd Trimester- 12-20 weeks

- Medical- Mifepristone+Misoprostol
- Rare : Surgical : Evacuation
  Hysterotomy.

KPP 8 : A high ability for all staff in the centre to recognize Complications and Management there of :
Recognition of unsafe abortions, incomplete abortion, ectopic pregnancy,
Orientation to referral networks, with availabity of operation theatre,emergency services and blood bank.

KPP 9 : Patient Education about complications- Pictorial Chart ,bleeding, pain ,fever,dizziness, fatigue etc.

Early Recognition of complications so they can seek medical care promptly.

KPP 10 : The most vital component of care is ensuring effective contraception following the abortion to break the cycle of unmet need of contraception and unintended pregnanccies.

1st Trimester

Immediate contraception after medical and surgical abortion

All methods can be used and tubal ligation can be simultaneously done.

Oral Hormonal contraceptives can be provided immediately.

Injectables and condoms can be used after first period, IUDs can be fitted after MMA at first follow up at 12 days, povided there is no evidence of injury, infection or retained products.

2nd Trimester

Surgical abortion-immediate post abortion IUD-can be inserted,all other methods as above.

New Reporting Systems and online systems should be developed.Helpline numbers to be provided and stand alone clinics, with registration in line with PC PNDT Act, to come up for easier and more widespread access.

RTM FACULTY :

RTM A. Comprehensive sexuality education for the teens

- Dr Chandan Kachru
- Dr Anita Rajoria
- Dr Pikee Saxena
- Dr Neharika Malhotra
- Dr Tarini Taneja
- Dr Meena Samant
- Dr Kiran Pandey
- Dr Chandra Mansukhani
- Dr Neeti Tiwari
- Dr Amita Sinha
- Dr Nita Thakre
- Dr Manisha Bhise
- Dr Richa Hingorani
- Dr Aparajita

RTM B. INTEGRATED CONTRACEPTIVE APPROACH ACROSS REPRODUCTIVE AGE THROUGH CONTRACEPTIVE CLINIC.

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RTM C : POST PARTUM CONTRACEPTION

How to begin counseling and increase uptake?

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Dr. Neha Gupta
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RTM E : **Ensuring universal access to High impact CAC service. What has been done and what can be done in future.**

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Dr Kanika Jain
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Sources :
WHO Handbook- AICOG
WHO List of Providers
Indian Summary of WHO Guidelines
GOI Guidelines
MTP,PC-PNDT,POCSO Acts.

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Appeal to dear FOGSIANS.

Please keep this document in your clinic and implement KPP.

Dr Shobha N Gudi,

Chair , Family welfare committee, FOGSI.