Quality of care in Copper –T 380A services

A practical manual for service providers

Action Research & Training for Health (ARTH), Udaipur

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PART 1
COPPER-T: CLINICAL INFORMATION

I. INTRODUCTION TO IUDS

- An intrauterine device (IUD) usually is a small, flexible plastic frame. It often has copper wire or copper sleeves on it. It is inserted into a woman's uterus through her vagina.
- Almost all brands of IUDs have one or two strings, or threads, tied to them. The strings hang through the opening of the cervix into the vagina. The user can check that the IUD is still in place by touching the strings. A provider can remove the IUD by pulling gently on the strings with forceps.
- IUDs are also called IUCDs (intrauterine contraceptive devices). Specific IUDs are called "the loop" *Lippes Loop* (no longer available in most countries), copper T200B, Copper-T-380A, Multiload copper-375 *(*MLCu-375), Nova T, Progestasert, and LNG-20.

The type now most widely used is:

- **Copper-bearing** IUDs (made of plastic with copper sleeves and/ or copper wire on the plastic). Tcu-200B, TCu-380A and MLCu-375 are this type. This chapter focuses on copper-bearing IUDs.

Less widely available are:

- **Hormone-releasing** IUDs (made of plastic, steadily release small amounts of the hormone progesterone or another progestin such as levonorgestrel). LNG-20 and Progestasert are this type.
- **Inert,** or unmedicated IUDs (made of plastic or stainless steel only). Lippes Loop was this type - all plastic.

How Effective?

TCu-380A IUD: Very effective as commonly used - 0.8 pregnancies per 100 women in first year of use (1 in every 125). Slightly more effective when used correctly - 0.6 pregnancies per 100 women in first year of use (1 in every 170).
Rates of the MLCu-375 are nearly as low.

Various other copper-bearing and inert IUDs: Effective as commonly used - 3 pregnancies per 100 women in first year of use (about 1 in every 30).

Duration of use:

TCU 200B	4 years
Tcu380A	At least 10 years
MLCuT 375	At least 5 years

LNG releasing IUDs	At least 5 years

How Does it Work?

The evidence now suggests that copper bearing IUDs prevent pregnancies by a combination of mechanisms of action, including:

- Inhibition of sperm migration in the upper female genital tract: perhaps the IUD makes it hard for sperm to move through the woman's reproductive tract
- Inhibition of ovum transport
- Possibly could prevent egg from implanting in wall of uterus.

II. ADVANTAGES AND DISADVANTAGES OF COPPER-TS

Advantages

- Long-lasting. The most widely used IUD (outside China), the TCu-380A, lasts at least 10 years. Inert IUDs never need replacement.
- Very effective. Little to remember.
- No interference with sex.
- No hormonal side effects with copper-bearing or inert IUDs.
- Immediately reversible. When women have their IUDs removed, they can become pregnant as quickly as women who have not used IUDs.
- No effect on amount of quality of breast milk.
- Can be inserted immediately after childbirth or after induced abortion (if no evidence of infection).
- No interactions with any medicines.
- Helps prevent ectopic pregnancies (Less risk of ectopic pregnancy than in women not using any family planning method).

Disadvantages

- *Common side effects (not signs of sickness*):

Menstrual changes (common in the first 3 months but likely to lessen after 3 months):

  - Longer and heavier menstrual periods,
  - Bleeding or spotting between periods,
  - More cramps or pain during periods.

- *Other, uncommon side effects and complications*:
  - Severe cramps and pain beyond the first 3 to 5 days after insertion.
  - Heavy menstrual bleeding or bleeding between periods, possibly contributing to anemia.
  - Perforation of the wall of the uterus (very rare if IUD properly inserted).

- Does not protect against sexually transmitted diseases (STDs) including HIV/AIDS. Not a good method for women with recent STDs or with multiple sex partners (or partners with multiple sex partners).
- Pelvic inflammatory disease (PID) is more likely to follow STD infection if a woman uses an IUD. PID can lead to infertility.
- Medical procedure, including pelvic exam, needed to insert IUD. Occasionally, a woman faints during the insertion procedure.
- Some pain and bleeding or spotting may occur immediately after IUD insertion. Usually goes away in a day or two.
- Client cannot stop IUD use on her own. A trained health care provider must remove the IUD for her.
- May expel from the uterus, possibly without the woman's knowing (more common when IUD is inserted soon after childbirth).
- Does not protect against ectopic pregnancy as well as it does against normal pregnancy.
- The woman should check the position of the IUD strings from time to time. To do this, she must put her fingers into her vagina. Some women may not want to do this.

III. MANY WOMEN CAN USE IUDS

In general, women CAN use IUDs safely and effectively even if they:

- Smoke cigarettes
- Have just had an abortion or miscarriage (if no evidence of infection or risk of infection)
- Take antibiotics or anticonvulsants,
- Are fat or this
- Are breastfeeding.

Women with these conditions also generally CAN use IUD:

- Benign breast disease,
- Breast cancer,
- Headaches,
- High blood pressure,
- Irregular vaginal bleeding (after evaluation),
- Blood clotting problems,
- Varicose veins,
- Heart disease (disease involving heart valves may require treatment with antibiotics before IUD insertion),
- History of stroke,
- Diabetes,
- Liver or gallbladder disease,
- Malaria,
- Thyroid disease
- Epilepsy,
- Nonpelvic tuberculosis,
- Uterine fibroids (unless fibroids badly distort the uterine cavity),
- Past ectopic pregnancy,
- Past pelvic surgery.

IV. CONTRAINDICATIONS

Permanent contraindications

IUDs should not be provided to women with:

- Cancer of uterus, cervix or ovaries
- Congenital uterine anomalies or benign uterine tumors (fibroids) which distort the uterine cavity in a manner incompatible with proper IUD placement
- Recurrent or chronic pelvic inflammatory disease, or history of IUD related PID

Temporary contraindications

Do not advice the use of IUD or provide it to women with

- Known or suspected pregnancy
  until certain she is not pregnant
- Pelvic inflammatory disease which is acute or recent
  until at least 3 months after successful treatment
- Recent puerperal or postabortal sepsis
  until 3 months after the infection clears completely
- Severe infection of the lower genital tract, including cervicitis and vaginitis
  until 3 months after successful treatment
- Undiagnosed abnormal genital tract bleeding
- Malignant gestational trophoblastic disease
  until 1 year after successful treatment
- Known pelvic tuberculosis
  until 3 months after successful treatment

CONDITIONS REQUIRING CAREFUL CONSIDERATION

There are conditions which require careful consideration when advising a client on the possible use of an IUD because the potential risks may outweigh the benefits of using the method. When any of these conditions is present, explain to the client the potential risks and recommend alternative contraceptive methods. If the client chooses the IUD because other contraceptive options are not available or acceptable, it is particularly important to advice her that close medical follow-up is required. The conditions include:

- History of PID (severity of infection, adequacy of treatment and resolution should be considered).

- Increased risk of STDs (e.g. multiple partners or partner who has multiple partner). In such situations, if client chooses to use IUD, advice the use of condoms in addition to IUD.

- AIDS or HIV positive (there may be increased risk of PID due to suppressed immunological response). If after proper counseling and discussion on other contraceptive methods, the client chooses to use IUD, recommend the use of condoms, in addition to the IUD, for prevention of STD and HIV transmission.

- Benign gestational trophoblastic disease (there might be increased risk of perforation, and the disease may require multiple uterine curettage).

- From 48 hours to 4 weeks postpartum.

If the method is provided, record the woman's condition in clinical record and advice her of warning signs relevant to her condition. The IUD should only be inserted by a well trained medical doctor.

SPECIAL SITUATIONS

Nulliparity
Nulliparity is not a contraindication for the use of IUD but a history of pelvic infection, a previous ectopic pregnancy or multiple sexual partners make the choice of IUD inappropriate for such women. Clearly explain to the nulliparous women increased risk of PID and of subsequent infertility related to the use of IUD before they choose this method.

Abnormal vaginal bleeding

Irregular bleeding patterns are common among healthy women. If there is no reason to suspect a pathological condition, insertion of IUD should not be withheld. If a woman has vaginal bleeding which is suggestive of a condition related to pregnancy or a pathology such as pelvic malignancy, it should be investigated before an IUD is inserted.

V. HEALTH ASSESSMENT

The purpose of health assessment is to determine the clients' suitability for the use of the method. A checklist should be filled before inserting IUDs.

History	
1. Do you think you could be pregnant?	Y/N
2. Did you have vaginal discharge in last 3 months, which is excessive or troublesome or yellowish /greenish or white and itchy in the last 3	Y/N

months?

3. Have you had ulcers in the genital area in the last 3 months? Y/N
4. Did you have lower abdominal pain with abnormal vaginaal discharge / fever / urinary burning currently or in last 3 months? Were you diagnosed to have pelvic inflammatory disease (PID) in the last 3 months? Y/N
5. Do you have excessive or prolonged bleeding (more than 7 days) during periods? Y/N
6. Do you have severe pain during periods? Y/N
7. Do you have bleeding in between periods or after sex currently or in last 3 months? Y/N
8. Did you have an abdomial surgery for tubal (ectopic) pregnancy? Y/N
9. Did your partner have discharge grom penis or ulcer in penis or swollen groin glands in last 3 months? Y/N
10. Do you have more than one sexual partner? Y/N
11. Does your partner has sexual partners other than you? Y/N
12. Do you think you may be infected with HIV? Have you or your partner been diagnosed to have HIV infection? Y/N

Physical examination

General examination

- Does she look very anemic? (If she looks anemic, estimate her hemoglobin level; if less than 8 gm%, don't insert IUD) Y/N

Abdomial examination

- Lower abdominal tenderness Y/N
- Mass in lower abdomen Y/N

Enlarged inguinal nodes Y/N

External Genitalia

- Genital ulcers Y/N

Speculum examination

- Vagina red and inflammed Y/N
- Vaginal discharge which is abnormal Y/N
- Cervix bleds on touch Y/N
- Purulent diuscharge from cervical os Y/N
- Growth / ulcer on cervix Y/N

Bimanual examination

- Uterus size bigger than normal Y/N
- Fornicial swelling or mass Y/N
- Fornician or uterine or cervical motion tenderness Y/N

How to tell that a woman is not pregnant

A health care provider can usually tell if a woman is not pregnant by asking her certain questions.

- It is reasonably certain that a woman is not pregnant if:
  - Her menstrual period started within the last 7 days

- She had an abortion or miscarriage within the last 7 days
- She gave birth within last 4 weeks
- She gave birth within the last 6 months, is breastfeeding often, and has not had a menstrual period.

➢ If a woman does not fit any of the these categories, it is still reasonably certain that she is not pregnant if:

- She has not had sexual vaginal intercourse since her last menstrual period OR
- If she has had sex since her last menstrual period, she used family planning methods correctly and her last menstrual period was less than 6 months ago

If she has had sex and her lkast menstrual period was 5 weeks ago or more, pregnancy canot be ruled out, even if she used effective contraception. Has she noticed signs of pregnancy?

If she has any of the signs of pregnancy, she may be pregnant. Try to confirm by physical examination.

If her answers cannot rule out pregnancy, she shouldeither ave a laboratory pregnancy test, or wait till the next menstrual period before inserting IUD.

VI. TIMING OF INSERTION

Woman's situation	**When to start**
Having menstrual cycles	
•	Any time during the menstrual cycle if it is reasonably sure that the women is not pregnant. If a woman has been using a reliable contraceptive or has not been having sex, the best time to insert her IUD is when she asks for it.
•	During menstruation. Possible advantages: - If true menstrual bleeding, pregnancy is ruled out. - Insertion may be easier. - Any minor bleeding caused by insertion is less likely to upset the client. - Insertion may cause less pain Possible disadvantages of insertion during menstruation: - Pain from pelvic infection may be confused with pain of menstrual period. IUD should not be inserted if a woman has pelvic infection. - May also be harder to identify other signs of infection.
If pregnancy is a possibility	
•	A pregnancy test should be done before inserting the IUD, OR
•	the IUD should be inserted during the next menstrual period

After childbirth

- During hospital stay after childbirth, if she has decided voluntarily in advance. The IUD is best inserted within 10 minutes after delivery of the placenta. Can be inserted any time within 48 hours after childbirth. (Special training required to ensure proper placement and to avoid perforation)
- If not immediately after childbirth, as early as 4 weeks after childbirth for copper T IUD such as TCu-380A.

During lactational amenorrhea

- If the child is less than 6 months old and the woman is exclusively breatfeeding the child, and her periods have not resumed after delivery, then IUD can be inserted without pregnancy testing
- If the child is more than 6 months old, or the weaning has been started, then pregnancy testing should be done before IUD insertion.

After miscarriage or abortion

- Immediately if no infection present.
- If infection present, treat and help the client choose another effective method. After 3 months, if no infection remains, reinfection is not likely, and she is not pregnant, the IUD can be inserted.

When stopping another method

- Immediately

VII. COUNSELING AND INFORMATION

IMPORTNAT: **A woman who chooses the IUD benefits from good counseling**.
A provider who listens to a woman's concerns, answers her questions, and gives clear, practical information about side effects, especially probable bleeding changes and possible pain after insertion, will help the woman use the IUD with success and satisfaction.

VII. INSERTING THE IUD

Learning IUD insertion takes training and practice under direct supervision. The following description of procedures is a summary and not detailed instructions. All family planning providers should know about IUD insertion to that they can tell their clients about it.

1. Proper **infection-prevention procedures** are followed. Generally, the health care provider will insert a new, presterilized IUD that was individually packaged.
2. The woman is **asked to tell the provider if she feels discomfort or pain** at any time during the procedure. Ibuprofen may be given 30 minutes before insertion to reduce cramping and pain.

3. The health care provider conducts a careful **pelvic examination** (speculum and bimanual) and checks the position of the uterus to make sure that the women can use an IUD safely and effectively.
4. The provider carefully **cleans the cervix and vagina** several times with an antiseptic solution such as iodine.
5. Working slowly and gently, the provider **inserts the IUD**, following the manufacturer's instructions.
6. After the insertion, the provider asks the client how she feels and, if she feels dizzy when sitting, suggests that she lie quietly for 5 or 10 minutes. Any cramping probably will not last long.

IMPORTANT: **Postpartum insertion**: Only providers who have special training should insert IUDs after childbirth. Proper insertion technique is important to reduce the risk of expulsion. An IUD can be inserted just after delivery of the placenta or up to 48 hours after childbirth. An IUD can be inserted after vaginal delivery or after cesarean section (surgical delivery)

VIII. REMOVING THE IUD

All women who choose IUDs must have access to IUD removal. All family planning programmes that offer IUDs must have qualified staff to remove them.

Possible reasons for removal:

i. The client requests removal.
Providers must not refuse or delay when the client asks to have her IUD removed, whatever her reason, whether it is personal or medical.

ii. Any side effects that make the client want her IUD removed, including pain.
iii. An medical reason for removal:
- Pregnancy,
- Acute pelvic inflammatory disease (endometritis or salpingitis),
- Perforation of the uterus,
- IUD has come out of place (partial expulsion),
- Abnormal, very heavy bleeding that puts the woman's health at risk.

iv. When the effective lifespan of a copper-bearing or hormone releasing IUD has passed.
v. When the woman reaches menopause (at least one year after her last period).

To remove the IUD:

- Removing an IUD is usually simple. It can be done any time throughout the menstrual cycle. Removal may be somewhat easier during menstruation, when the cervix is dilated.
- Proper infection-prevention procedures are followed
- The health care provider pulls the IUD strings slowly and gently with forceps.

IX. INSTRUCTIONS TO THE CLIENT

Follow this procedure

1. Plan with the woman for a return visit in 3 to 6 weeks or after for checkup and pelvic examination. This checkup and exam make sure that her IUD is still in place and no infection has developed. The visit can be at any time convenient for her when she is not menstruating. After this one return visit, no further routine visits are required.
2. Makes sure she knows:
   - Exactly what kind of IUD she has and what is looks like.
   - When to have her IUD removed or replaced. (For the TCu-380A IUD, 10 years after insertion.) Discuss how to remember the year to return. If she wants a new IUD, it can be inserted as soon as her old IUD is removed.
   - When she visits health care providers, she should tell them that she has an IUD.

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

Give Specific Instructions

A woman who chooses an IUD should know what will happen during the insertion procedure. She also should understand the following:

1. She can expect:
   - Some cramping pain for the first day or two after insertion. She can take aspirin, paracetamol, or ibuprofen.
   - Some vaginal discharge for a few weeks after insertion. This is normal.
   - Heavier menstrual periods. Possible bleeding between menstrual periods, especially during the first few months after IUD insertion.
2. Checking the IUD. Sometimes IUDs come out. This can happen especially in the first month or so after insertion or during a menstrual period. An IUD can come out without the woman feeling it.

   A woman should check that her IUD is in place:
   - Once a week during the first month after insertion.

- After each menstrual period, if possible. IUDs are more likely to come out along with menstrual blood.
- After noticing any possible symptoms of serious problems.

To check her IUDs, a woman should:

1. Was her hands.
2. Sit in a squatting position.
3. Insert 1 or 2 fingers into her vagina as par as she can until she feels the strings. She should return to the health care provider if she thinks the IUD might be out of place.

IMPORTANT : She should not pull on the strings. She might pull the IUD out of place.

4. Wash her hands again

Note : After postpartum insertion, strings do not always come down through the cervix.

Explain specific reasons to see a nurse or doctor

Describe the possible symptoms of serious problems that require medical attention. Serious complications of IUD use are rare. Still, a woman should see a doctor or nurse if she has any of these symptoms of more serious problems. The IUD may or may not cause these problems.

- Missed menstrual period, or thinks she might be pregnant, especially if she also has symptoms of ectopic pregnancy: abnormal vaginal bleeding, abdominal pain or abdominal tenderness, fainting. A woman who develops these symptoms must seek care at once.
- Thinks she may have been exposed to a sexually transmitted disease, or she has HIV/AIDS.
- When checking her IUD strings, she thinks the IUD might be out of place. For example, she finds:
  - Strings missing or strings seem shorter or longer.
  - Something hard in her vagina or at the cervix. It may be part of the IUD.
- Increasing or severe pain in the lower abdomen, especially if also fever and/or bleeding between menstrual periods (signs and symptoms of pelvic inflammatory disease).

Other specific reasons to return to the clinic

- Her sex partner feels the IUD strings during sex and this bothers him. At the clinic she can have the strings cut shorter.
- Heavy or prolonged bleeding that bothers the client.
- She or her partner is not pleased with the IUD.

- Copper-bearing or hormonal IUD has reached the end of its effectiveness: She needs it removed or replaced.
- She wants the IUD removed for any reason at any time.
- She has questions.
- She wants another family planning method.

Following up

Helping clients at the routine return visit (3 to 6 weeks after IUD insertion)
Follow this procedure
Conduct a pelvic exam in case of :

1. Suspicion of sexually transmitted disease or pelvic inflammatory disease.
2. Suspicion that the IUD is out of place.

Ask Questions

1. Ask if the client has any questions or anything to discuss.
2. Ask the client about her experience with the IUD, whether she is satisfied, and whether she has any problems. Give her any information or help that she needs and invite her to return again any time she has questions or concerns. If she has problems that cannot be resolved, help her choose another method.
3. Remind her of the reason for returning.
4. Remind her how long her IUD will keep working and when it should be removed.
5. Ask if she has had any health problems since her last visit.
   - If she has developed any condition that means she should not use an IUD, take out the IUD. Help her choose another method.
   - She may be able to keep using the IUD, however, even if she has developed (1) unexplained abnormal vaginal bleeding that may suggest pregnancy or an underlying medical condition or (2) cervical, endometrial, or overian cancer.

Managing Any Problems
If the client reports any of the common side effects of IUDs, such as menstrual changes:

1. Do not dismiss the woman's concerns or take them lightly.
2. If the woman is worried but wants to continue the method, reassure her that such side effects are not usually dangerous or signs of danger.
3. If the woman if not satisfied after treatment and counseling, ask her if she wants the IUD removed. If so, remove the IUD or refer for removal even if her problems with the IUD would not harm her health. If she wants a new method, help her choose one.

For this problem	Try this suggestion
Irregular bleeding, prolonged or heavy	Evidence of infection or other abnormality? - Conduct a pelvic exam to look for cervical disease,

bleeding (Prolonged bleeding = more than 8 days. Heavy bleeding = twice as long or twice as much as usual for her)	ectopic pregnancy, or pelvic inflammatory disease (PID). Refer for care if appropriate. - She can continue using her IUD while her condition is being evaluated. No evidence of infection or other abnormality, LESS THAN 3 MONTHS since IUD insertion, and bleeding is within normal and expected range? - Reassure her that her changes in menstrual bleeding are normal and will probably lessen over time. - Name foods containing iron and suggest that she eat more of them if possible. If possible, give her iron tablets (ferrous sulfate up to 200 mg 3 times a day for 3 months) - Ask if she wants to keep her IUD. • If she does, ask her to return in about 3 months for another checkup. If the bleeding bothers her, you may give her ibuprofen or other nonsteroidal anti-inflammatory drugs (but NOT aspirin) to help reduce it. • If not, remove the IUD and help her choose another method. No evidence of infection or other abnormality and MORE THAN 3 MONTHS since IUD insertion? - If the client wishes or if bleeding or pain is severe, remove the IUD. Help her choose another method. - If an abnormal condition is causing irregular or heavy bleeding, treat or refer for care. - If very heavy bleeding, check for signs of severe anemia - pale under fingernails and inside eyelids. If found: • Recommend IUD removal and help her choose another method. • Give her enough iron tablets for 3 months. • If she wants to keep using an IUD but has an inert IUD, replace it with a new copper bearing IUD. Ask her to come for a checkup in 3 to 6 weeks.
Unexplained abnormal vaginal bleeding that suggests pregnancy or an underlying medical condition	- She can continue using her IUD while her condition is being evaluated. - Evaluate and treat any underlying medical problems, or refer for care.

Lower abdominal pain that suggests pelvic inflammatory disease (PID)	1. Diagnose. Take history and do abdominal and pelvic exams. If pelvic exam is not possible, do an external genital exam. If one or more of the following is found, refer to a capable provider at once: - Missed a menstrual period, her period is late, or she is pregnant, - Recently given birth or had an abortion, - Pain or tenderness when pressure is put on the abdomen during exam, - Vaginal bleeding, - A pelvic mass If she has none of the above conditions, diagnose as PID if she has one or more of the following (the more conditions she has, the stronger the diagnosis): - Oral temperature of 38.3^0 C (100^0F) or higher, - Abnormal cervical or vaginal discharge, - Pain when moving the cervix during pelvic exam, - Tenderness in the area of fallopian tube or ovary, - Recent sex partner with urethral discharge or treated for gonorrhea. Note : Diagnosis can be difficult. PID signs and symptoms may be mild or absent. Also, the common signs and symptoms of PID often also occur with other abdominal conditions, such as ectopic pregnancy or appendicitis. 2. Treat or immediately refer for treatment. Treat for gonorrhea, chlamydia, and anaerobic infections such as trichomoniasis - all 3 3. Generally, remove the IUD if physical examination or laboratory tests point to PID. If possible, wait 2 to 4 days for the treatment to take effect. Then remove the IUD and help the client choose another method. If diagnosis is uncertain, treat with antibiotics without removing the IUD and observe carefully for results of treatment. Some clinicians may allow continued IUD use if the woman is successfully treated and will have little risk of STD infection. 4. Follow up. If the woman does not improve in 2 or 3 days after starting treatment, or if she develops a tubal abscess, she should be sent to hospital. Otherwise, schedule another follow-up for just after she has finished taking all of her medicine. 5. Treat sex partner (s). Urge the client to have her sex partner or partners come for STD treatment.

Active sexually transmitted disease (STD) now or in the last 3 months, or acute purulent cervicitis (a pus- like discharge from the opening of the cervix).	- Remove the IUD. - Diagnose and treat the STDs, or refer.
Cervical, endometrial, or ovarian cancer (awaiting treatment)	- The IUD may be removed at time of treatment. Until then, the client can keep her IUD if she wishes (following the clinical judgement of a trained practitioner). If there is risk of the IUD damaging delicate tissue, however, the IUD should be removed.
Pregnancy	- If the IUD strings are visible and pregnancy is in the first trimester (less than 13 weeks): • Explain that it is best to remove the IUD to avoid severe infection. Explain that she spontaneous abortion. • If she consents, remove the IUD or refer for removal. Explain that she should see a nurse or doctor if she has excessive bleeding, cramping, pain, abnormal vaginal discharge, over fever. • If she strings cannot be found and/or the pregnancy is beyond the first trimester: - Explain that she is at risk of serious infection, which could threaten her life. Given this risk, if she does not want to continue the pregnancy, and if therapeutic termination of pregnancy is legally available, refer according to clinic guidelines. - If client wants to or must continue her pregnancy, make clear that she faces increased risk of spontaneous abortion and infection. Her pregnancy should be followed closely by a nurse or doctor. She should see a nurse or doctor if she has excessive bleeding, cramping, pain, abnormal vaginal discharge, or fever.

IMPORTANT: Note on ectopic pregnancy: Pregnancies among users of IUDs are few. When pregnancy occurs, however, 1 in every 30 is ectopic. IUDs, especially the TCu-380A, offer significant protection against ectopic pregnancy, but they still sometimes occur. Ectopic pregnancy is life-threatening and requires immediate treatment.

Signs of ectopic pregnancy: amenorrhea, nausea, breast tenderness (first symptoms of pregnancy); abnormal vaginal bleeding, abdominal pain or tenderness, anemia, fainting (suggesting shock). Symptoms may be absent or slight.

Care: Anemia and/or fainting indicate a possible ruptured ectopic pregnancy, an emergency condition requiring immediate surgery. If nonruptured ectopic pregnancy is suspected, perform a pelvic exam only if facilities for immediate surgery are available. If they are not available, refer at once for definitive diagnosis and care.

Partner complains about IUD strings	- Explain to woman (and partner, of possible) that what her partner feels is normal. Recommend that they try again. - Describe other options to the client: • Strings can be cut shorter. • The IUD can be removed.

IMPORTANT: When a woman seeks help, make sure you understand what she wants. After counseling and discussion, ask her directly whether she wants to continue using her IUD or to have it removed. Help her make her own decision without pressure.

If you do not find out and heed her true wishes, people may say that you forced her to continue using the IUD or that you refused to remove it. To avoid such rumors, find out what your client wants, and do it.

TCu-380A IUD

Little to do once the IUD is in place.

- You may have cramps for the first few days, vaginal discharge or spotting for a few weeks, and somewhat heavier menstrual periods.
- Check the IUD strings to be sure the IUD remains in place. Always wash hands first. With your fingers, feel the IUD strings in the vagina. Check once a week for the first month, then after each menstrual period. If you think the IUD might be out of place, come to the clinic.

IUDs do not prevent sexually transmitted diseases (STDs) including HIV/AIDS. If you think you might get an STD, use condoms regularly.

Please come back:

- In 3 or 6 weeks after insertion for a routine checkup.
- If you have very heavy bleeding or bad pain in the belly (especially pain with fever), if you might get or have sexually transmitted disease (STD), if you might be pregnant, or if the IUD might be out of place.
- Any time you want help, advice, or another method.
- Any time you want the IUD removed, for any reason.

You can keep your TCu-380A IUD for 10 years. The TCu-380A IUD may become less effective after 10 years. It needs to be taken out in _____[month, year]. A trained family planning provider can take out your IUD. You can get a new IUD put in the same time if you want.

Questions and Answers

1. Can the IUD travel from the woman's uterus to other parts of her body, such as her heart or her brain?
   The IUD normally stays within the uterus like a seed within a shell. Very rarely, the IUD may come through the wall of the uterus and rest in the abdomen. This is probably due to a mistake during insertion and not to slow movement through the wall of the uterus. The IUD never travels to any other part of the body.

2. Will the IUD prevent a woman from having babies after it is removed?
   In general, no. A woman can become pregnant after her IUD is removed. But the IUD does not protect her from sexually transmitted diseases (STDs). A woman should understand that the IUD may somewhat increase her chances of getting pelvic inflammatory disease if she get STDs. These infections could make her infertile. Therefore, it is important for a woman who uses an IUD to have sex with only one, uninfected man and for him to have sex only with her.

3. Can a woman who has never had a baby use an IUD?
   Yes, as long as she does not have sexually transmitted diseases and there is little chance that she will get any. The IUD is not the best method for a woman who has not had a baby and wants a baby in the future. Also, the uterus of a woman who has not had children is sometimes too small for an IUD.

4. Can a woman get an IUD just after she has a baby?

Yes, if the person who inserts her IUD has been properly trained. The IUD can be inserted after a vaginal delivery or through the abdominal incision after a cesarean section (surgical delivery).

5. Can a woman get an IUD just after abortion or miscarriage?
Yes. An IUD can be inserted after an abortion or miscarriage unless she has a pelvic infection. Insertion following miscarriage after 16 weeks gestation requires special training.

6. Must an IUD be inserted only during a woman's menstrual period?
No. An IUD can be inserted at any time during her menstrual cycle if it is reasonably sure that the woman is not pregnant. During her period may be a good time because she is not likely to be pregnant, and insertion may easier for some women. It is not as easy to see signs of infection during menstruation, however. Some providers like to insert the IUD midway through the menstrual cycle because the mouth of the cervix is a little wider then.

7. Should antibiotics be given before IUD insertion to prevent infection?
Not necessarily. When IUD insertion is done correctly with well-screened clients, there is little risk of infection for healthy women, and antibiotics are not necessary for IUD insertion. In any case, most recent research suggests that antibiotics do not significantly reduce the risk of pelvic inflammatory disease (PID).

8. Can a woman be too young or too old to use an IUD?
No. There is no minimum or maximum age, so long as the woman is not at risk for a sexually transmitted disease and is properly counseled about the advantages and disadvantages of the IUD. An IUD should be removed from the woman after menopause - at least one year after her last menstrual period.

9. Can a woman get her IUD on the same day that she has her initial counseling?
Yes. If it is reasonably certain that she is not pregnant and has no infections, there is no medical reason for a separate visit. It may be inconvenient for a woman to come back again. Also, she may become pregnant before she returns to have her IUD inserted.

10. Can a woman with diabetes use an IUD?
Yes. IUDs are safe for women with diabetes. Women with diabetes are at greater risk of many infections, however. They should see a nurse or doctor if they notice possible signs of sexually transmitted disease or other infection, particularly just after IUD insertion.

11. Should a woman have a "rest period" after using her IUD for several years or after the IUD reaches its recommended time for removal?

No. This is not necessary, and it may be harmful. There is less risk of pelvic infection in replacing an IUD at one time than in 2 separate procedures. Also, a woman could become pregnant before her new IUD is inserted.

12. When does a copper IUD need to be replaced?
The latest models of copper-bearing IUDs are effective for many years. The TCu-380A has been approved by the US Food and Drug Administration for 10 years of use. (It probably can prevent pregnancy even longer.)

13. Will the IUD cause discomfort to woman's partner during sex?
Generally, no. Sometimes a man can feel the strings. If this bothers him, cutting the strings shorter should solve the problem. The woman should be told beforehand, however, that this will mean she will not be able to feel the strings to check her IUD and removing her IUD may be more difficult. A man may feel discomfort during sex if the IUD has started to come out through the cervix. If a women suspects this, she should see a doctor or nurse immediately.

Part 2: Counseling Skills

Introduction

A major factor contributing to high mortality and morbidity of women and children in India is high fertility. Family Planning is an important intervention in reducing this. However the acceptance of family planning is largely dependent on the quality of services provided and an informed choice as provided to clients. It has been found that counseling in family planning helps to effectively increase acceptance.

Why is counseling essential in family planning?

Counselling helps the client sort out issues related to reproductive health viz. sexuality, pregnancy, responsible parenthood, abortion, STDs and HIV/AIDS. These are issues that are frequently not discussed because of embarrassment. However, these are issues that have an important bearing on our lives.

Counseling is an integral part of family planning because it

- enables people to decide on whether to adopt family planning and if so, then how to do it
- helps decide which method is most suitable for client
- increases continuation rates
- promotes user-satisfaction
- emphasises spacing methods rather than permanent methods
- address other reproductive health concerns such as STDs
- fits family planning into the client's lifestyle.

Common reasons for rejection of family planning methods

To be able to effectively counsel clients and to enable them to use family planning techniques, it is important to know why some people do not use or reject these techniques. Some possible reasons are:

1. Aversion to the idea of birth control: Birth control is seen as unnatural.
2. Birth control is seen as intrusion: Using a method such as condoms or an IUD is also seen as interference in the sex act and as a deterrent to intimacy.
3. Embarrassment and guilt: There is embarrassment and guilt over obtaining supplies or seeking information regarding family planning methods.
4. Lack of information: Inadequate or wrong information discourages people from using family planning.

5. Infrequent sexual activity: Irregular sexual activity for some leads to the feeling that there is no need to adopt a family planning method.
6. Social pressures: Social pressures of having a child within the first few years of marriage or of having a son prevent some from using family planning.
7. The option of abortion: Sometimes people do not use contraception because they feel that they have the option of abortion in case they have an unwanted pregnancy.
8. Obtaining supplies: Obtaining supplies of a contraceptive method may be difficult because of lack of availability, cost or embarrassment.
9. Coercion by health personnel: In cases where clients have been forced into using a method that later proved to be unsuitable, the clients would be understandably hesitant to return to the provider for another method.

What is counseling?

Counseling is a specialised process of communication, enabling a person to make an informed choice regarding a course of action. People, throughout their lives are faced with choices. A counselor is a trained person who uses certain techniques to help people make decisions. Counseling is not merely advice giving or motivation. The element of persuading or coercing a client is absent in counseling.

It is a helping relationship, a relationship that helps people to grow, to change and to be capable of making their own decisions. Each person knows his/her own situation and is best equipped to choose between various alternatives. However there are times when it is difficult to decide on what to do, especially when decisions have far reaching consequences on their lives. Counseling helps in such situations. A Counselor never makes decisions on behalf of the client (the person who is seeking help) but simply steers the discussion in such a way that the client is able to take decision.

Definition

Counseling is an interactive relationship between two individuals (Counselor and Client) whereby the counselor helps the client to better understand him/herself with respect to his/her relationship to his/her present and future problems/situations. Counseling in family planning is an interactive relationship between the M.O./Health Paramedic and client which helps the client to decide whether to adopt a family planning method and if so, to make an informed choice of a particular family planning method. Counseling is also defined as face-to-face communication in which one person helps another make decisions and act on them.

Counseling and health education

Though counselling and health education have much in common, they are not the same.

Similarities between Counseling and Health Education-

- Both aim at changing behaviours in order to reduce risk.
- Both use two-way interactions between provider and client.
- Both rely heavily on communication skills.

Differences between Counselling and Health Education-

1. Counseling is usually initiated by a client in need of help while health education is usually initiated by the educator. e.g., when a MO or Health Worker decides to persuade a client to adopt family planning, the process is one of motivation or health education. But when a person himself/herself or a couple requests help from a Medical Officer or Health Worker about spacing, limited births etc., the stage is set for counseling.
2. Counseling is primarily a coping process in which the client is helped to make a decision regarding a problem situation or make a choice.
3. Counseling aims to reduce stress by means of a dialogue with the client whereas health education aims at the dissemination of information via discussion.
4. Counseling is usually done in a one-to-one situation or in very small groups while health education is usually for a small group or larger audience. e.g., When a client or couple approaches the medical officer to decide or choose a method of family planning, it is a counseling situation. However when a Lady Health Visitor (LHV) or Multi-purpose Worker (MPW) holds a talk in a village about sanitation, nutrition or reproduction, she is giving health education.

Counseling and motivation

Counseling is more effective than motivation as it is initiated by the client while motivation means the M.O./Health Worker initiates the conversation. A motivator highlights the advantages while a counselor talks of both the advantages and disadvantages. The motivator often makes the decision while the counselor facilitates the client to take a decision. There is an element of pressure in motivation. Family planning counseling does not imply that the counselor persuades or coerces the client to accept a particular method. It merely facilitates the client to decide which method to adopt. It also dispels the myths and beliefs as well as attitudes that the client may be harbouring within him/her, towards the various contraceptive methods. The primary advantage of counseling is that of gaining the active participation of the client on the course of action which is eventually decided upon. A client who has chosen a particular family planning method after considering all the information and implications is more likely to be a satisfied and a long term user of that method.

Why counseling is not mere information giving

Family planning decisions are made by individuals who live within families and societies. Therefore, such decisions are complicated by family and social pressures in addition to the person's own fears and apprehensions. Information about services available is also inadequate. Men and women come to know of family planning techniques from their friends or relatives who themselves may be misinformed.

Merely providing factual information in an educational way is not enough. Potential users of family planning services benefit by discussing their anxieties, fears and doubts. In a counseling situation, these negative feelings are resolved. This obviously takes more time and effort of the M.O. or health worker than an information giving exercise, but it yields many advantages and leads to satisfied and long term use. If the client decides on the method to be adopted after understanding its implications, the responsibility of action is also with him/her. After all, the effects of the choice are going to be felt by the client, not the M.O. or health worker. It is unethical to push the client to accept a method that the client is uncomfortable with.

Counseling Skills

Counseling, as mentioned earlier, is a specialised process of communication. It is a skill that develops and grows with practice. Certain techniques are used during counseling in order to make the client comfortable so that communication is facilitated. Before starting the counseling process, it is necessary to ensure that the physical setting is conducive to counseling.

The physical setting for counseling

The physical setting should be-

i) **Private**: to assure the client of confidentiality. Counseling is most effective when it is done in a separate room/chamber where the couple/client feels free to bring up personal matters such as family planning. In a Primary Health Centre this can be the MO's room or the family planning room, provided these are not being used for registration etc. and frequent interruptions by other clients/staff do not take place. Privacy has physical and social dimensions. Physical privacy is ensured by restricting the entry of others in the room, shutting doors, using curtains etc. Social privacy or confidentiality is ensured by not sharing a client's experience with anyone else (not even the spouse, unless the client agrees), keeping records secret, and not even talking so loudly in a clinic that everyone outside can hear.

Privacy is important because unless the client is assured of confidentiality, it is likely that counseling will be incomplete and method rejection higher. Sometimes counseling may take place in the open e.g. when the Medical Officer sits out in the sun during winters. Such situations reduce confidentiality and few clients can feel comfortable discussing family planning or other reproductive health issues. It is likely that counseling in such settings will be inadequate.

ii) **Comfortable:** with adequate seating space. The physical setting of the room should provide for a friendly atmosphere where the client can speak freely. The M.O. should also keep visual aids and literature such as pamphlets, sample charts, leaflets, contraceptive samples etc. in the room to explain various family planning techniques to the client.

Counseling skills

There are several skills that the M.O. should use during counseling for family planning.

1. **Active Listening:** Listening is the most important skill a service provider must possess. The M.O. should pay total attention to what is being said, observe non-verbal messages the client is sending and encourage the client to talk by nodding the head and saying "go on".

   Some counseling behaviors representative of active listening skill are-
   - good eye contact
   - head nodding at relevant places
   - saying "hmmm"
   - saying "go on"
   - not rushing the client during pauses while the client may be finding words to express oneself
   - not interrupting when the client is talking
   - ask questions to facilitate conversation

2. **Summarising and Paraphrasing:** This means restating by the service provider in her/his own words what the client has said so far to check whether it has been correctly understood. This indicates to the client that the provider has been following and understanding what has been said by the client.
3. **Empathy:** In empathising with a client, the M.O. is able to leave aside his/her own frame of reference, and, for the time being adopt the frame of reference of the client. The M.O. can then appreciate how the client experiences the events in his/her world. For example, with empathy, the M.O. can appreciate the awkwardness a young man may feel in using a condom during his first sexual experience.

The service provider experiences the client's feelings as if they are one's own. This "as if" quality is extremely important to keep some distance between the provider and client, to ensure professionalism and to prevent the provider from being overwhelmed by the client's feelings. For empathy to have an impact, it is essential that the health personnel must communicate or reflect back to the client that the client's feelings are being understood and his/her emotional state is important. The client must feel understood. Empathy may be communicated verbally, nonverbally or by a mixture of both.

It is necessary to distinguish between sympathy & empathy. Empathy involves the power of understanding and imaginatively entering into another person's feelings. There is more involvement in this situation than in sympathy, where one shares or experiences an affinity with the emotions of another. When a woman describes the problems she faces with the IUD, a sympathetic M.O. shares the problem but is not involved. On the other hand, an empathetic M.O. will understand her feelings as if they were his/her own. Empathy implies a position of equity between the counsellor/M.O. and client. In case of sympathy, the M.O. will be assuming a position of superiority.

4. **Positive Regard for the Client:** The M.O. relates to the client as a person of equal status and accepts that the client has a right to accept or reject family planning. Confidentiality is also a part of showing respect for the client and his problem. The M.O. assures the client that no one else will be told about the client's problem.

   Also, the M.O. behaves in a non-judgmental and non-threatening manner. Very often, we feel that an illiterate woman will not listen to instructions or understand them and so we don't give complete information. We also tend to judge people, if their sex lives don't fit in with our ideas of what is acceptable. This is particularly true with regard to premarital sex or extra marital relations. The M.O. should be non-judgmental while counseling for family planning, even if his/her values differ from those of the clients.

   Frequently, a client is offered a method of family planning with a condition. For example, "You can have an IUD inserted now as I have the time. Otherwise you will have to come next week.", "Immunization of the child will be done if the mother accepts a family planning method". Such situations make the client feel threatened and even if a method is accepted, the rate of rejection is likely to be much higher. Along with respect for the client, comes respect for the decisions that the client makes.

5. **Giving Correct Information in a Simple Manner:** Information about various methods, their advantages and disadvantages is to be given in comprehensible, unbiased manner. All information relevant to the client's situation must be given. The M.O. should make certain that the client has understood the information and its implications. It is incumbent on the M.O. to provide the clients information so that they can accept or reject family planning.
6. **Analysing Each Option with the Client:** The service provider uses the problem solving technique, which is a non-directive approach to help the client adopt a suitable family planning method. Along with giving information, the implications of using the method are explored and the costs to the client are calculated. Costs are in terms of money spent, time spent in using the method, intrusiveness into sexual and other activities, degree of comfort with the method and side effects experienced. The information includes possible adverse reactions/failures and ways to tackle them. Obviously, the method with the least cost and maximum benefits to the client will be the method chosen by the client.

   The client must be actively involved in this process of checking out the gains and costs of various methods. The techniques mentioned earlier are useful in establishing a relationship in which problem solving can effectively happen.

Six steps for family planning counseling

So far we have discussed the techniques of counseling and the skills necessary for counseling. The following six steps may be used while counseling a client for Family Planning.

There are six steps that may be remembered with the English word **"GATHER"** where each letter stands for a step or stage in counseling. Remember, each client is an individual and the techniques you use must suit the client. Also, all the stages do not have to come in strict sequence.

G. Greet clients.
A. Ask clients about themselves.
T. Tell clients about family planning methods.
H. Help clients choose a method.
E. Explain how to use a method.
R. Return for follow-up.

1. Greet Clients

- As soon as you meet clients, give them your full attention.

- Be polite: greet them, introduce yourself, and offer them seats to make them feel comfortable.
- Use attending behavior and positive gestures to indicate interest and attention.

The next 4 sections Ask, Tell, Help and Explain are essential for informing the client to enable him or her to make a correct choice.

2. Ask clients about themselves

- Ask questions to elicit information in a non-confronting way.
- Help clients to talk about their needs, wants and any doubts, concerns or questions they have about family planning.
- Use "open ended questions". These are questions that draw out more information from the client and cannot be answered merely by "Yes" or "No". e.g. How do you feel about using condoms? What have you planned about having another baby?
- Ask your clients what information they have about the methods that interest them. You may learn that a client has wrong information. It is important to gently correct the mistake and dispel all myths.
- If the client is new, obtain a history. Write down client's
    1. age
    2. marital status
    3. number of pregnancies
    4. number of live births
    5. number of living children
    6. family planning methods used presently and in the past
    7. relevant information on general and reproductive health (major chronic illness, reproductive tract infection etc.)

Explain that you are asking this information to help them choose the best family planning method. Keep questions simple and brief and look at your clients as you speak to them.

3. Tell clients about family planning methods

All clients need to know about the family planning methods that are available. How much they need to know depends on which methods interest them and on what information they already have.

- Tell your new clients which methods are available and where.
- Do not forget to include natural family planning methods. In some situations, this may be the best method of choice.
- Address any anxieties or myths that the client may have about any particular family planning method.

- Briefly describe each method that the client wants to know about. Talk about:
    1. how it works
    2. advantages and benefits
    3. disadvantages and possible side effects.
    4. impact of each method on health.

4. Help clients choose a method

- Ask clients if there is any particular method they would like to use. Some would have already decided what they want and others will need help analysing their choices.
- To help clients, ask them about their family circumstances and their reproductive intentions. e.g. Till when does the client wish to delay pregnancy? How frequently does the couple have sexual contact?
- Ask the clients which method their sex partner would prefer. Some methods are not safe for some clients. When a method is not safe, tell the client so and explain clearly. Then help the client choose another method.
- Ask clients if there is anything they do not understand. Repeat information if necessary.
- Confirm whether the client has made a clear decision. Ask 'Have you decided to adopt a contraceptive method. If yes, which one?'

5. Explain how to use a method

After the client has chosen a method:

- Explain how to use the method. Show them samples of condoms, pills and IUDs. Demonstrate how a condom is used and ask for a return demonstration.
- Give her or him supplies, if appropriate.
- If the method cannot be given immediately, tell the client how, when, and where it will be provided. Remember, contraceptive supplies are widely available through the Social Marketing Programme.
- For some methods, such as voluntary sterilisation, the client may have to sign a consent form. Help the client understand and fill the consent form.
- Describe any possible side effects and warning signs. Clearly tell the client what to do if these occur.
- Ask the client to repeat the instructions, listen carefully to make sure she or he remembers and understands.
- If possible, give the client printed material about the method to take home.
- Tell the client when to come back for a follow-up visit.

- Tell the client to come back sooner fi she or he wishes or if side effects or warning signs occur.

Referral: When the problems presented by the client are beyond the scope of the M.O. to handle, the client should be referred for further information or consultation/investigation. If a particular method (such as vasectomy or tubectomy) is not available at the PHC, the client should be referred to a hospital or camp.

6. Return for follow-up

Good follow-up is essential for maintaining continuity of use of family planning method.
At the follow-up visit:

- Ask the client if she or he is still using the method.
- If yes, ask the client if she or he is satisfied with the method or has any problems with the method.
- Ask how the client is using the method. Check to see that it is being used correctly.
- Ask if the client is having any side effects, actually mentioning them one at a time.
- If so, find out how severe they are. Reassure clients with minor side effects that they are not dangerous. Suggest what they can do to relieve them. If side effects are severe, refer for further treatment. Do not deny the problem even if it appears to be unlikely.
- If the client is still dissatisfied about continuing to use the method, counsel him or her about switching to another method.
- Ask if the client has any questions.

Counseling the continuing client

When counseling a continuing client, it is important to check correct usage, time for procuring supplies of condoms, change of IUD/implant, time for the next shot of injectable.

A client who is having problems with a particular family planning method will need to talk about his/her problem. Such clients, if they feel their problems are being understood, are open to using other family planning methods. In many cases, the problem nay be with the client not having fully understood how the method works in actual practice or that some side effects are expected and are no cause for undue alarm. Patient listening and reassurance go to a long way in dealing with such clients.

If a client wants to try out another method (Method Switching):

Tell the client about other methods again and help the client to choose another suitable method. Remember changing method is not bad and is normal. No one really can decide on a method without trying it. Also a person's situation may change, whereby another method may become more suitable.

If a client wants to have a child, help her to stop the method she is currently using. As an M.O. it is your responsibility to arrange for antenatal care as and when she gets pregnant.

Even if the client is not satisfied with a particular method, he/she should be able to return to the same service provider for another method. To make this possible, the provider must be seen as someone who is approachable, who will not be "disappointed" or "angry" that the client has not continued with the initially decided on method.

Part 3: Quality Services In Family Planning

What do we mean by "Quality of Care"?

"Quality of Care" is not a new concept. It is a basic requirement of any service for it to be acceptable to clients, to attract them, and to make them come back for follow up. Quality is not a waste of money but lack of quality eventually is, because it deters clients and thus causes inefficiency. Therefore, continuous concern for quality is an essential requirement for the survival and growth of any service, including family planning services.

Service quality may be defined as "those attributes of a service that reflect adherence to professional standards by the provider, and satisfaction on part of the client of user". Quality is thus seen as being "**client oriented and provider efficient (COPE)**". The underlying principle behind quality is "to act in the interest of those who need the service". Since women form the majority of family planning clients, and since they very often lack the power to make decisions in their own interest, quality is also women oriented and supportive of women's health interests.

Why is quality of care important for family planning?

In many countries, it has been noted that contraceptive prevalence rates rise till about 35% as services become more accessible, after which prevalence rates level off, because new acceptors merely replace those who have discontinued use. To raise contraceptive prevalence further, improvements in quality of care becomes necessary, so as to retain current users while reaching out to new clients. In India, the national family planning programme has since 1951 been implemented through an extensive network of health institutions in all states, by involving several hundred thousand service providers. However, in the effort to utilise family planning for slowing down the growth in population, "quality of service" has not been accorded as much priority as "quantity of services".

Quality of Care is important to family planning programmes for two reasons:

1. It enables clients to exercise their basic right to control their reproductive lives.
2. It contributes to increased adoption and sustained use of contraception.

   Quality services enable a client to reach and implement a family planning decision that meets his or her reproductive needs. Promoting service quality may have other benefits for health and family welfare agencies, such as improved staff morale, reduced staff turnover, better community relations and increased programme efficiency.

Who should take the responsibility for improving service quality?

The real barrier to service quality improvement is often not lack of resources but lack of interest in the clients on the part of programme managers and service providers. Providing quality health and family planning services requires concerted efforts at all levels of the service delivery system i.e. from the planning stage upto follow up and evaluation. It involves all staff members, but the top management needs to be particular about quality and should place it high on the agenda. In the case of family planning services provided by a PHC, it is the attitude of MOs and their alertness in recognising and using opportunities for quality improvement that will greatly determine how far existing services can change for the better.

What are the elements of family planning service quality?

Meeting the client's personal family planning needs is the major focus of a quality family planning programme. By adapting the "Quality of Care Framework" developed by Judith Bruce in 1989, six elements have been identified as being fundamental in the working definition of family planning service quality in India. These elements are:

I. Client convenience and service environment
II. Client provider interaction
III. Choice of methods
IV. Equipment and supplies
V. Professional standards and technical competence
VI. Continuity of care

Each of these elements contributes to increased contraceptive use by increasing the client's options, their ability to use the chosen contraceptive effectively and then desire to continue contraception in future. Satisfied users generally help to recruit new clients. These elements also make it possible for quality to be measured by suitable indicators and for quality to be improved by appropriate interventions.

All persons providing services/products i.e., staff, suppliers and distributors must understand:

- The principles of quality care e.g. requirement in terms of physical infrastructure.
- The need to acquire the necessary technical and interpersonal skills.
- The need to be committed to changing practices in accordance with the changing needs of clients.
- That it is a never ending journey.
- That quality must be measured.

4.5. ACCESS TO CARE

Acceptance of family planning services is dependent on quality of services of which access to services is an important aspect. Some indicators to measure accessability or acceptability are:

- **Service is conveniently located**
  If a service is located so that it is easy to reach, clients will come for family planning services willingly. If a client has to change several buses to reach a PHC, she is likely to postpone her visit for a family planning method till it is most pressing, or after she has conceived.

- **Service staff are available**
  The availability of staff for family planning is also important. Sometimes, the ANM may not be available and MO and other staff may be busy with other tasks. This reduces accessability to the service. The MO should ensure that at any point of time any one person, preferably female is available for family planning clients.

- **Facility is adequate**
  The availability of adequate facilities of waiting room, examination area, clean water and sanitation facilities serves to reassure the client that he/she has gone to a competent service provider. The PHC should be well maintained and clean so that client will want to accept the services there. When the client has confidence in the PHC, the changes of dissatisfaction with services provided are less.

- **Hours/days of service provision are convenient**
  Sometimes, services are available on certain days or during certain hours in a working day. For operative procedures, it may be necessary to fix timings. However, all other services must be made available every day during working hours. If the hours/days of service are restricted, the acceptance of pills may be seriously affected as they have to be taken on the 5th day of the period. Again, sometimes if services are available only at certain times and clients cannot come during this time, it is worth rescheduling timings to suit clients, to promote family planning.

- **Waiting time is acceptable**
  If clients are made to wait for 1 hour before an IUD is inserted or condoms and pills are provided, they are not likely to return to the PHC for contraception. The MO should make arrangements for family planning clients to be seen as soon as they register for services or at the earliest. This is possible if each staff member is given specific responsibility for family planning services.

- **Staff is acceptable in terms of sex, ethnic group, age**
  Female clients often prefer female service staff such as doctors, nurses etc. The absence of a female doctor/ANM on a day when the client visits the PHC will certainly affect her acceptance of a method. The MO can ensure that on days the female doctor is on a visit elsewhere, any ANM is available to handle female clients. Similarly, for male clients, availability of male MO or health worker will enhance acceptability.

- **Frequency of outreach is adequate**
  An effective way of promoting contraceptive methods is through outreach. Door to door visits, educational camps in the villages help in building rapport and promoting family planning acceptance.

- **Privacy and confidentiality are ensured**
  Family planning is a private, personal matter for the client. Clients should therefore be counselled, examined and followed up in a place where privacy can be maintained. Other service providers or PHC staff should avoid entering the clinic unnecessarily when a client is present. Confidentiality, whereby the client feels assured that her/his case will not be revealed to others, is equally important.

4.6. MONITORING AND EVALUATION

The national family planning programme has since 1951, been implemented through an extensive network of health institutions in all states of India, by involving several hundred thousand service providers. Over the years, in the effort to utilise family planning for slowing down the growth in population, it has been recognised that "quality of services" has not been accorded as much priority as "quantity of services".

What are the elements of family planning service quality?

By adapting a "Quality of Care Framework" developed by Judith Bruce in 1989, six elements have been identified as being fundamental in the working definition of family planning service quality in India. The following elements or components make it possible for quality to be measured by suitable indicators and for quality to be improved by appropriate interventions:

I. Client convenience and service environment
II. Client provider interaction
III. Choice of methods
IV. Equipment and supplies
V. Professional standards and technical competence
VI. Continuity of care

I. **Client convenience and service environment:** This element refers to making family planning services convenient for the client in terms of location of service institutions (PHCs, CHCs, etc.), timings and cost of availing services, organising services so that clients do not have to wait for too long, keeping the premises, clinics, wards and toilets clean as well as ensuring privacy and confidentiality which are essential for making the service "client oriented".

II. **Client provider interaction:** Since providers basically have to share their knowledge and skills with the client, communication with clients is an essential element of service quality. This component broadly covers "how" the provider communicates with the client (building rapport, courtesy, empathy, active listening, respect for the client, etc.) and "what" the provider conveys to the client (clear, simply worded information on available options, how methods work, their benefits, risks, etc.)

III. **Choice of methods:** It is necessary that clients decide and the provider assists them in reaching a decision that is in their best interest. Their choice is based on reproductive needs adopt a method and which contraceptive method to adopt. Correct choice means longer and more regular contraceptive usage. This element also looks at whether complete information has been given, whether women (rather that husbands or mothers-in-law) take decisions on contraception, whether there are restrictions because of rules or disincentives, and whether or not clients are encouraged to switch methods, if they so desire.

IV. **Equipment and supplies:** This element refers to the availability, quality and maintenance of equipment for family planning. It also covers contraceptive supplies, consumables for asepsis (linen, disinfectants, etc.), screening (gloves, laboratory reagents, etc.) records and follow up (registers, drugs, etc.). Proper storage and inventory control are also required for maintaining service quality.

V. **Professional standards and technical competence:** Family planning is a technical service requiring skilled providers. This element covers the norms or standard guidelines established for institutions and personnel providing family planning services. Quality is dependent on the training, experience and skills of the providers, as well as protocols for asepsis, procedures, follow up and emergency management.

VI. **Continuity of care:** Family planning services should promote continuity of contraceptive use by clients. Both from the health and demographic points of view, it is beneficial to provide long term services to a finite number of clients, rather than to rope in more and

more short term acceptors each year. Spacing method users are crucially dependent on follow up, resupply, management of side effects of complications and periodic discontinutation or switching of methods. Contraceptive failures, which have an adverse effect on clients and programmes, can be prevented or managed by ensuring continuity of care.

How can service quality be measured?

In order to describe, monitor and improve the quality of family planning services, the above framework is not sufficient and measurement tools are also required. If service quality cannot be easily measured, then it is difficult to evaluate or improve it. A list of indicators to assess the quality of family planning services provided by a PHC, have been given in Table I-VI. The indicators correspond to each of the six elements of quality, and have been framed as questions to be applied to the PHC situation, by medical officers. Based on these indicators, measurement instruments (questionnaires/ checklists) can be designed for monitoring and improving quality on a routine basis.

Case situations illustrating the quality of family planning services provided by a Primary Health Centre

Case No. 1

Kamala Devi was called fasting at 9.30 a.m. for laparoscopic tubectomy in family planning camp at the PHC. It was a cloudy day in December. Since there was a crowd, she had to wait outside. Kamala Devi was 24th on the list. After a while, Dr. Sanjeev of the PHC interviewed her, meticulously examined her, arranged for blood and urine tests and filled out some forms. The surgical team arrived from the district headquarters at 1.00 p.m. When her name was called out at 3.30 p.m., Kamala Devi had gone some distance down the road to relieve herself. After surgery, the female health worker explained in detail what medicine she was to take, when to resume normal activity and also that she should return to the PHC after a week and follow up with Dr. Sanjeev.

Case No. 2

Twenty three year old Dharampal, who was planning to get married after a fortnight, went to the PHC for advice on how to delay the first child. He was unsure as to which room to enter and whom to approach. Both staff members in the MCH room were women. When approached, the pharmacist asked him to wait outside to OPD room. The door was open and Dharampal could see the doctor examining a patient. He waited till he heard to doctor loudly give instructions to the patient and then went in. It was almost lunch time and the doctor was in a great hurry. Dharampal could not ask all the questions he had in mind. The doctor told him to use condoms, but Dharampal felt too shy to ask him exactly when and how to wear

a condom. He went home and consulted his friend, Shravan Kumar - a shopkeeper, who told him all about the lubricated condoms he had in his shop.

Case No. 3.

When her first daughter was a month old, Shanti came to the PHC without her husband's or mother-in-law's knowledge, for advice on how to delay the next pregnancy. The elderly nurse told her only about the IUD and asked her to come on the following Thursday. Although there was a water shortage and gloves and not been washed that day, the IUD was somehow inserted without a pelvic examination being performed. A few weeks later, Shanti developed foul smelling vaginal discharge. Her husband became upset and brought her to the PHC. The doctor listened to them patiently, calmed the husband, examined Shanti, removed the IUD, and prescribed medication for the discharge. The doctor counselled the couple about condoms and oral pills. Shanti and her husband went home with a packet of condoms and with instructions to contact the local health worker for resupply.

Case No. 4.

Four months after PHC Kalyanpur had made an indent, an excessively large consignment of condoms and pills arrived in the month of July. These were kept in the balcony for a week, till space could be made in the MCH room. Condoms and pills were then alloted to the health workers for distribution. However, most of the health workers felt that pills caused too many side effects and so women did not prefer them. One of the workers recalled her experience of a woman who had forgotten the pill for three days and had later become pregnant. At the next meeting, health workers complained that since condom packets received by them had been damaged by rain, most of their continuing clients had avoided using them. Towards the end of the same year, a long delayed training programme on family planning for health workers was further postponed because "sterilisation performance was lagging behind".

Case No. 5.

Dr. Kalpana had recently joined as Block Medical Officer. Using a local donation, she decided to put up boards displaying timings outside all PHCs and subcentres in the block. She also got the PHC toilets cleaned and repaired. After observing the insertion of IUD's by health workers at two PHCs and three subcentres, she decided to reorient them in batches on monthly meeting days. She asked her staff to show sample condoms, pills and IUDs, to all clients who showed interest in family planning, during home visits and in clinics. She asked the health workers to keep a record of all new acceptors who had discontinued pills or IUDs within three months and reviewed the action taken in such cases, at sector meetings. Dr. Kalpana personally attended most family planning camps in the block, checked whether equipment was in working order, and made sure that each acceptor received a follow up card with instructions and the necessary drugs.

Indicators for assessing quality of family planning services in a primary health centre

Element I : Client convenience and service environment

PROVIDER LEVEL	CLIENT LEVEL
A. Is the PHC service or family planning camp organised in a way that clients do not have to wait for unusually long periods? B. Has the PHC publicised clinic timings and indicated room(s) to visit, for specific services? C. Are providers available on all working days at the scheduled timings? D. Is there adequate privacy for clients at PHC clinics and wards? E. Are PHC clinics/wards and toilets clean and hygienic? F. Do providers ensure confidentiality?	G. Is a visit to the PHC affordable for clients, in terms of time and money (transport, lost wages)? H. Are clients aware of PHC timings? I. Are clients satisfied with the following- 1. PHC timings 2. Waiting room and waiting duration 3. Adequacy of water and toilet facilities 4. Privacy for counselling and examination 5. Staff members experience and appropriate gender. 6. Confidentiality of their case.

Element II : Client - provider interaction

PROVIDER LEVEL	CLIENT LEVEL
A. Do providers establish a rapport with the clients and treat them courteously? Do they listen to clients with empathy? B. Do providers spend adequate time with clients? C. If possible, do providers follow up with the same client? D. During the counselling session, do providers use a checklist of essential steps to be covered? E. Are informational materials used by providers during counselling (booklets, models, contraceptive samples etc)? F. Do providers give adequate and accurate information to clients to enable them to decide on a suitable	H. Do clients receive adequate attention and feel comfortable while talking to the provider? I. Do clients get the opportunity to explain their own situation and ask questions from the provider? J. Do clients follow up regularly with the same provider? K. Can client correctly explain how the method of their choice works, its benefits and risks? L. Can client recall instructions to follow, possible side effects, when and where to follow up?

method? G. Do providers give clear and understandable instructions to clients who have decided upon a particular method?	

Element III : Choice of methods

PROVIDER LEVEL	CLIENT LEVEL
A. Do providers offer a choice of suitable methods available in the national family welfare programme to each client, depending upon their reproductive needs? B. If a method is not readily available at the PHC (eg. tubectomy, vasectomy), are clients referred to a suitable hospital/camp? C. Are clients restricted in the use of contraceptives (e.g. insisting on spouse's consent, parental consent for adolescents, denial of service to single or unmarried persons etc.)? D. Do providers encourage clients to switch methods, if desired? E. Do providers insist that clients undergoing MTP accept certain contraceptive methods? F. Do providers face disincentives if there is low acceptance of certain contraceptive methods by clients of their area?	G. Even if the provider were to help with the decision, is it the client who ultimately decides on a suitable method? H. Can clients explain why they chose a particular method? Can they describe at least one method in addition to the one chosen? I. Do clients receive more incentive for adopting certain contraceptive method? J. Can clients also obtain contraceptives from retail outlets or shops in their area?

Element IV : Equipment and supplies

PROVIDER LEVEL	CLIENT LEVEL
A. Are contraceptives available in sufficient quantity in the PHC? Are they stored properly? B. Are there sufficient supplies available to maintain asepsis (disinfectants, gloves, etc)? C. Are supplies replenished within reasonable time periods, on request	E. Are regular supplies of contraceptives available for continuing clients? F. Are clients aware of alternative sources of contraceptive supplies?

by the PHC? D. Is essential equipment for IUD insertion, sterilisation, asepsis, etc. available and functional?	

Element V : Professional standards and technical competence

PROVIDER LEVEL	CLIENT LEVEL
A. Have training and skill criteria been established for performing family planning procedures? B. Is the role of each provider in the PHC clearly delineated? C. Are standard guidelines for family planning services available in the PHC? D. Do providers routinely follow standard guidelines for family planning practice? E. Do providers undergo periodic refresher training? F. Do providers demonstrate satisfactory knowledge of available methods (use, benefits, contraindications, side effects/ adverse reactions) and of asepsis procedures? G. Do providers possess adequate skills for client screening, IUD/ sterilisation procedure, and follow up? H. Are essential laboratory tests for screening performed correctly at the PHC? I. Are complications detected and managed by the PHC? Are referrals made when appropriate? J. Are providers capable to handling clients who have reproductive tract infections, STDs or suspected HIV? K. Do providers periodically evaluate the quality of their services?	L. Do clients experience physical or emotional discomfort during sterilisation/ IUD procedures? M. Do side effects / complications occur in a significant proportion of clients? N. Has contraceptive failure occured in a significant proportion of clients? O. Do clients with complications follow up at the same PHC?

Element VI : Continuity of care

PROVIDER LEVEL	CLIENT LEVEL
A. Do providers maintain and monitor records on follow up? B. Do providers ensure linkage between PHC and outreach services for follow up purposes? C. Are the following indicators monitored by providers for reducing discontinuation, failure and complication rates? 1. Discontinuation rates per contraceptive 2. Method switch rates 3. Failure rates per contraceptive 4. Side effects and complications related to contraceptive use 5. Reasons for discontinuation 6. Proportion of pregnancies following discontinuation.	D. Do clients return to PHC for follow up care? E. Do clients continue using the method on a regular basis? F. Do clients return to the PHC if they wish to switch methods? G. Do clients with complications follow up at the same PHC?