UNIT 2 FAMILY PLANNING METHODS, SPACING TECHNIQUES AND COUNSELLING

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2.0 INTRODUCTION

In the previous unit, you have learnt about various gynaecological conditions, risk factors, signs, symptoms and management. This unit deals with family planning method, techniques and counselling.

India launched its first Family Planning Programme in 1952 in response to high fertility and population growth rate with an aim to achieve population stabilisation and reduce maternal, infant and child mortality and morbidity.

The National Population Policy 2000 provided a framework for prioritising the strategies to achieve net replacement levels of Total Fertility Rate (TFR) by 2010 through a comprehensive package of reproductive and child health services. Over the years TFR has constantly declined to a current value of 1.9 as per National Family Health Survey (NFHS III) data.
The factors that affect the population growth are Unmet Need of Family Planning (21.3% as per District level Household and facility survey, age at marriage and first child birth and spacing between the births. In India, 5.6% deliveries are contributed by girls between 15–19 years of age and 22.1% of girls are married at less than 18 years of age. Spacing between the births increases the chances of survival of infants and thus impact on the fertility. An ideal spacing of three years is recommended, however data from SRS 2013 shows that in 59.3% of births, the ideals spacing is not followed.

2.1 OBJECTIVES

After completing this unit, you will be able to:

- enlist various temporary and permanent methods of contraception along with the benefits, side effects and contraindications of each;
- detect complications, if any, at the earliest following each method for appropriate management and timely referral;
- provide support through counselling to the adopters (couples) of family planning method, their family and community; and
- supervise the ASHAs and ANMs while they offer services to the beneficiaries.

2.2 CURRENT FAMILY PLANNING PROGRAMME UNDER PUBLIC HEALTH

Both NFHS and District level Household and facility survey (DLHS) data shows that the small family norm is widely accepted nationwide and the general awareness of contraception is almost universal (98% among women and 98.6% among men). However the use of contraceptive among married women (age 15–49 years) has been reported to be as low as 56.3% in NFHS III, though an increase of 8.1% has been reported as against the NFHS II data.

Thus to narrow down the gap between the knowledge and use of contraceptives, Government of India under Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH Plus A) Programme has widened the basket of choice of contraceptives under its ambit, that are being provided at various levels, at no or minimum cost. The available methods of contraceptives can be divided into: (Table 2.1)

1) Temporary (Spacing) Methods for delaying first pregnancy or spacing the child births.

2) Permanent (Limiting) Methods for limiting the family after achieving the desired family size.

Table 2.1: List of Contraceptive Methods available Under RMNCH+A Programme

<table>
<thead>
<tr>
<th>Spacing Methods</th>
<th>Limiting Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUCD 380 A and Cu IUCD 375</td>
<td>Female Sterilisation:</td>
</tr>
<tr>
<td>Injectable Contraceptive DMPA (Antara)</td>
<td>Laparoscopic</td>
</tr>
<tr>
<td>Combined Oral Contraceptive (Mala-N)</td>
<td>Minilap</td>
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</tbody>
</table>
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<table>
<thead>
<tr>
<th>Spacing Methods</th>
<th>Limiting Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centchromen (Chhaya)</td>
<td>Male Sterilisation:</td>
</tr>
<tr>
<td>Emergency Contraceptive Pill (Ezy Pill/E-Pill)</td>
<td></td>
</tr>
<tr>
<td>Progesterone-Only Pill (POP)</td>
<td>No Scalpel Vasectomy (NSV)</td>
</tr>
<tr>
<td>Male Condoms (Nirodh)</td>
<td>Conventional Vasectomy</td>
</tr>
</tbody>
</table>

The manpower has been trained to provide all the services at various health facilities as per the guidelines. The Spacing and Limiting methods are provided at various health facilities by various health care providers as per the following guidelines: (Table 2.2)

**Table 2.2**

<table>
<thead>
<tr>
<th>Methods</th>
<th>Location where the Service has to be Provided</th>
<th>Service Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SPACING METHODS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUCD 380 A, IUCD 375</td>
<td>Sub centre &amp; higher levels</td>
<td>Trained &amp; certified ANMs, LHV's, SNs and doctors</td>
</tr>
<tr>
<td>Oral Contraceptive Pills (OCPs)</td>
<td>Village level Sub centre &amp; higher levels</td>
<td>Trained ASHAs, ANMs, LHV's, SNs and doctors</td>
</tr>
<tr>
<td>Condoms</td>
<td>Village level Sub centre &amp; higher levels</td>
<td>Trained ASHAs, ANMs, LHV's, SNs and doctors</td>
</tr>
<tr>
<td><strong>LIMITING METHODS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minilap</td>
<td>PHC &amp; higher levels</td>
<td>Trained &amp; certified MBBS doctors &amp; Specialist Doctors</td>
</tr>
<tr>
<td>Laparoscopic Sterilisation</td>
<td>Usually CHC &amp; higher levels</td>
<td>Trained &amp; certified MBBS doctors &amp; Specialist Doctors</td>
</tr>
<tr>
<td>NSV: No Scalpel Vasectomy</td>
<td>PHC &amp; higher levels</td>
<td>Trained &amp; certified MBBS doctors &amp; Specialist Doctors</td>
</tr>
<tr>
<td>Emergency Contraceptive Pills (ECPs) Nurses</td>
<td>Village level Sub centre &amp; higher levels</td>
<td>Through trained ASHAs, ANMs, LHV's, Staff and Medical Officers.</td>
</tr>
</tbody>
</table>

**Emergency Contraception Pills (ECPs):** This is not a regular method of Family Planning. It works by possibly inhibiting ovulation, thickening cervical mucous and affecting transport of sperm or egg depending on the phase of the menstrual cycle. Single dose is taken as soon as possible after an unprotected intercourse. These tablets are available at Village level, Sub-centre & higher levels through Trained ASHAs, ANMs, LHV's, SNs and doctors at a minimal cost of Rs 2 per pack. ASHA also delivers a pack of 3 condoms and a cycle of OCPs at the rate of Rs 1 each. (Fig. 2.1)
**2.3 NATURAL METHODS OF FAMILY PLANNING**

The natural methods of family planning have also been included in the basket of choice under the programme for the couples that are do not want to opt for the hormonal or barrier methods.

### 2.3.1 Lactational Amenorrhoea Method (LAM)

This method can be used for only first 6 months after delivery as long as the woman exclusively breastfeeds her baby including night feeds and also if her menses have *not* returned. This method is effective however 1 to 2 pregnancies per 100 women using this method during first six months have been reported. The additional benefits of this method are:

i) Immediate and Exclusive breastfeeding (EBF) promotes health benefits to the infant and increases the survival by providing additional protection against infections.

ii) Beneficial for the mother as it helps the uterus of the mother to return to normal size faster thus reducing the amount of blood loss besides promoting a bond between mother and infant.

iii) Has no systemic side effects hence no supervision is required. It also does not interfere with intercourse.

iv) Women who are infected with HIV or who have AIDS or taking antiretroviral (medicines for AIDS) can use LAM, however there is a chance that some percentage of infants will get HIV through breast milk.

This method is not suitable for women who are not exclusively breastfeeding, postpartum women whose menses have returned and those women who are more than six months postpartum.

### 2.3.2 Fertility Based Awareness Method

These methods are based on the awareness regarding body signs that change during menstrual cycle as a result of hormonal changes and release of ovum.
There are several methods by which a woman can predict the time of her ovulation. This can be done by:

a) **Basal Body Temperature (BBT) Method:** The temperature of body at rest is called as Basal Body Temperature (BBT). In most women, temperature of body increases by 0.5–1°F during ovulation and remains high till the end of her menstrual cycle. And thus her most fertile days start from 2–3 days before the increase in temperature. The women should be instructed to chart her temperature early morning before leaving her bed.

b) **Cervical Mucous Method:** This method is also known as Billings Method or the Ovulation Method. In this method, the women’s fertile days can be predicted by the pattern of mucous discharge from the vagina. The women can be instructed to wipe the opening of the vagina with a clean tissue before urinating or insert a clean finger into her vagina to study the pattern of mucous. The 3–4 days around ovulation are the unsafe days when the mucous will be copious, slippery and clear like white of a raw egg. The women can also chart her pattern of mucous on a calendar.

c) **Calendar Method:** The women should circle first day of her period on a calendar and count the total number days of the cycle for at least 8 cycles. Mark the number of days in the longest and shortest cycle. Subtract 18 and 11 from the shortest and longest cycle respectively. The period between these days is fertile and thus unsafe period. e.g. If the longest cycle of a woman is 30 days and shortest is 26 days then 30–11 and 26–18 i.e. her fertile period will be between day 8 upto day 19 during which she should use a method of contraception. (Fig. 2.2)

The above three methods are known as Symptothermal Method and are most effective if used together.

- **Fertility Awareness**

<table>
<thead>
<tr>
<th>Fertility Awareness</th>
<th>Calender Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Calendar Method" /></td>
<td><img src="image2.png" alt="Calender Method" /></td>
</tr>
</tbody>
</table>

d) **Standard Days Method:** The women can be trained to keep a track of her menstrual cycles and abstain from unprotected intercourse during fertile days.
Special string of beads can be used to track the cycles. There are 33 coloured beads and a rubber ring on the string. The first bead is black with a white arrow, followed by red. Next six are brown in colour. Then are 12 white (Unsafe Days) followed by 13 brown beads (Safe Days). Each bead represents a day except the black one. The women should put the ring on the red bead on the first day of her period. Then she should move the ring in the direction of the arrow each day. Whenever the red band is on the white bead, the couple must use a contraceptive method whereas when the ring is on the brown bead, the couple can safely have unprotected vaginal intercourse. (Fig. 2.3)

But to use this method, the cycles of the women must be regular, and ranging between 26 and 32 days.

All the methods involving Fertility Awareness are based on client support her educational status and regularity, thus may not be very effective for long term use.

### 2.4 ARTIFICIAL METHODS OF FAMILY PLANNING

Let us learn the artificial or basic methods which are used for male and female as condom.

#### 2.4.1 Condoms

There are Condoms for use by both men and women however only Male Condoms (Nirodh) are available under the programme. These are most effective when combined with spermicides. (Fig. 2.4)

Condoms are barrier contraceptive that do not allow the semen to come into contact with vagina. These are put on erect penis immediately before intercourse and are for one time use only. The client should be advised to leave about 1cm loose at the end of the condom to collect the semen after ejaculation, after which it should be carefully removed holding from the base of the penis ensuring that the semen doesn’t spill.

**The advantages of Condoms are:**

1) Besides increasing male participation, these are easily available, cheap and easy to carry.

2) Has triple protection against Sexually Transmitted Disease (STDs), pregnancy and HIV (Human Immunodeficiency Virus) and also thus has an indirect role in prevention against cancer cervix.

**Disadvantages are:**

1) It has high rates of failure due to slippage/breakage during intercourse or deterioration of quality in case of improper storage conditions like excess light and heat.

2) Some men may not find it convenient as it decreases the penile sensitivity and needs to interrupt the intercourse to be worn of the erect penis.
Female Condoms: These are not available under the programme, however are available over the counter and can be purchased from the chemist for use during intercourse. It has a triple advantage of preventing unwanted pregnancy, reducing the risk of STDs and HIV. It is a pre-lubricated plastic polyurethane tube that has a closed end. It functions by collecting sperm before, during and after ejaculation. (Fig. 2.5)

The advantages of Female condoms are safe, simple, and convenient. Both men and women can benefit from the use of female condoms for a variety of reasons, include:

- The sharing of responsibility as it relates to STD’s.
- Can be conveniently purchased from pharmacies and some supermarkets.
- Can be inserted by either partner before intimacy.
- They are a substitute for those with allergies to latex.
- They can be used with both oil and water based lubricants.
- Remains in place with or without an erect penis.

However, the disadvantages attached to these are that they do not feel natural, may cause slippage of penis causing a pause in intercourse. Sometimes, it may also cause irritation to the vagina or penis.

2.4.2 Intrauterine Devices (IUD)

There are two basic types of IUDs: Non Medicated and Medicated. The non medicated IUDs are made up of polyethylene or other polymers whereas in addition, medicated ones also have either metal ions(copper) or hormones (progesterone).
2.5 HORMONAL CONTRACEPTIVES

Hormonal Contraceptives are the safe and reversible methods of contraception wherein either estrogen and progesterone are used in combination or only progesterone can be used (Progesterone Only Pill-POP) through oral or injectable route.

2.5.1 Oral Contraceptive Pills (OCPs)

The commonly available combined pills are Mala D and Mala N. Mala N is available free of cost through all the PHCs, subcentres, urban family welfare centres and at a nominal rate of Rs 1 per pack through ASHAs in the community. It contains Levonorgestrel 0.15mg and Ethinyl estradiol 0.03 mg. Each packet contains 28 pills (21 white pills of contraceptive and 7 brown pills of iron). These tablets are given for a period of 21 days starting from the fifth day of the menstrual cycle followed by a break for 7 days during which the menstruation occurs. Since the menstruation occurs because of withdrawal of hormones, this is also called as ‘withdrawal bleeding’ and the loss of blood is much less than that occurs during normal menstruation. (Fig. 2.6)

The tablets should be consumed at the same time every day; preferably in the morning so that in case the women forgets to take them on some day, she can consume it over the day and can carry on with her normal schedule the next day. If a female missed two tablets on two consecutive days, she must use an alternative method of contraception for the cycle.

The mechanism of action of combined pills is to prevent the release of ovum from the ovary. Progesterone only pills (also known as Mini Pills) make the cervical mucous thick thus preventing the entry of sperms into the uterine cavity. These also inhibit tubal motility and thus delay the transfer of sperms in the tubes.

If taken as per the prescribed regimen, combined pills are almost 100% efficacious. Certain positive health benefits like prevention against Iron deficiency anaemia, Pelvic inflammatory disease, ectopic pregnancy, ovarian cancers and cysts and benign tumours of breast like fibroadenoma have also been reported in women consuming OCPs.

However since the mechanism of action of OCPs is by altering the hormonal milieu, these may have some adverse effects if consumed over very long time. The adverse effects could be
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i) Increased predisposition to cardiovascular events like Myocardial Infarction, thrombosis etc.

ii) Metabolic Effects like alteration in serum lipid levels, blood clotting and carbohydrate metabolism.

iii) Liver disorders like hepatocellular adenomas, cholestatic jaundice and gall stones.

Accordingly the use of OCPs may be contraindicated in patients suffering from liver diseases, history of thromboembolism, cancer of breast or genitals, hyperlipidemia, cardiac diseases and abnormal uterine bleeding. Special caution may be taken in case the OCPs are being prescribed in women more than 40 years of age, smokers more than 35 years, mild hypertension, epilepsy, chronic renal disease, migraine, diabetic women, lactating mothers with child less than 6 months of age, gall bladder disease, amenorrhoea, history of infrequent bleeding.

Thus women who is being prescribed OCPs for the first time thus needs to be screened for any of the factors/conditions mentioned above by the Medical Officer/Doctor/Nurse/trained health workers for fitness. A checklist has been developed for screening the women by the health worker before prescribing OCPs. And then the pills for subsequent cycles can be procured from ASHAs in the community or subcentre. Thereafter annual checkups are advised for continuation of the pills.

2.5.2 Injectable Contraceptives

There are two types of injectable contraceptives-Progesterone only injections and once a month combined injectables. These have an advantage of being highly effective, reversible, long acting.

i) Progesterone only Injections: These are estrogen free preparations in which single administration suffices for several months or years. These are given during the first five days of the menstrual period via deep intramuscular route in the gluteus muscle. The most suitable ones are:

A) DMPA (Depot Medroxy Progesterone Acetate): It gives protection in 99% of women for atleast three months and is given by intramuscular route in the dose of 150 mg every three months. It also acts through suppression of ovulation, effect of cervical mucous, endometrium and tubal motility. However it has no effect on lactation thus is suitable for women in post partum period. (Fig. 2.7)

Its use has adverse effects like weight gain, prolonged infertility and irregular menstrual bleeding.
B) NET-EN (Norethisterone Enanthate): NET EN is given every 60 days in the dose of 200 mg through intramuscular route and mechanism of action is similar to DMPA.

C) DMPA-SC 104 mg: is a low dose formulation given at three months interval. The injections are given in the upper thigh or abdomen subcutaneously.

The adverse effects of these injectable preparations are similar. These may cause disruption of normal menstrual cycle like episodes of unpredictable bleeding and prolonged amenorrhoea.

These should not be prescribed to women with cancer breast and genitals, undiagnosed abnormal uterine bleeding, suspected malignancy, high blood pressure (systolic>160, diastolic>100), history of disease of heart, liver and blood vessels, nursing mothers and deep vein thrombosis.

Certain other long acting contraceptives containing levonorgestrel have also been found to be effective like Norplant and Vaginal rings. Norplant is a subdermal implant that consists of six silastic capsules containing 35 mg of levonorgestrel each. These are implanted beneath the skin of upper arm or fore arm. These are effective for 5 years, however surgical procedure necessary to insert and remove them and irregularities in menstrual cycle are some disadvantages of the method.

The levonorgestrel containing vaginal rings can be worn for three weeks of the cycle and removed for the fourth. An additional advantage is that the hormone is absorbed via mucosal route thus preventing the systemic side effects.

### 2.6 NON HORMONAL ORAL CONTRACEPTIVES

1. Saheli:- Let us now discuss non hormonal contraceptives as given below:

   A non steroidal, non hormonal entity centchroman are available as ‘Chaaya’ and ‘Saheli’ under the programme. This is an anti implantation agent that exhibits weak estrogenic and potent ant estrogenic activity. These are available as 30 mg tablets. (Fig. 2.8)

   The first tablet is taken on the first day of the menstrual cycle and then one tablet biweekly for three months followed by one tablet weekly till the client does not want to get pregnant. The tablet should preferably be taken at the same time. The missed dose should be taken as soon as possible. In case a dose is missed by 2 or more days but less than 7 days, use a barrier method till next cycle. In case of a miss more than 7 days, the dosage regimen should be started a fresh; biweekly for 3 months and weekly thereafter.

   The advantages of non hormonal contraceptive tablets are that no hormone related adverse effects like amenorrhoea, nausea are reported as seen with other OCPs. However a few subjects have reported prolongation of menstrual cycle with its continuous use and missed doses due to irregular schedule.

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![Fig. 2.8: Non Hormonal Oral Contraceptives](image-url)
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These pills should not be given to women with recent history or clinical evidence of jaundice/severe hepatic dysfunction, cervical hyperplasia, polycystic ovarian disease, chronic illness like tuberculosis and renal disease. It should also be avoided in women with known hypersensitivity to centchroman and nursing mothers in first 6 weeks postpartum.

2. Copper T

Under National Family Welfare Programme, Cu T 200B was being used initially that has an efficacy of three years, however CuT 380A has been introduced from the year 2002 with an efficacy up to 10 years. Cu T 375 (Multiload) is also available under the programme with an efficacy of 5 years. These are T shaped devices made of polyethylene and copper wire is wrapped on the limbs of the ‘T’, that has an anti fertility effect. The numbers included in the names of devices refer to the surface area of the copper on the device. Fig. 2.9 shows parts of Copper T Fig. 2.9 Placement.

Another type of IUDs (Progestasert and LNG-20/Mirena) based on the principle of release of progesterone hormone are available for use by women that contains levonorgestrel. These reduce the menstrual blood loss in the users, have low pregnancy rates and lessen the chances of ectopic pregnancy.

Please refer Course BSNL-043, Block 5 Unit 2 for insertion and removal of IUD – details practical.
Interval IUCD can be inserted any time within 7 days after the menstrual period is over. Under the programme emphasis is on post partum/MTP IUCD insertion. Post partum/Post MTP IUCD insertion can be performed anytime within 48 hours of delivery before the women is discharged from hospital after delivery/MTP.

An ideal candidate for IUD insertion is a women who has born atleast one child, has no history of pelvic disease, has normal menstrual cycle, is willing to check the thread of the Cu T periodically, come for follow up and is into a monogamous relationship.

The advantages of these IUDs is that they have low expulsion rates and are effective for longer periods once in place. Since these are virtually free from any systemic metabolic side effects, these are well tolerated by most of the women and thus have been identified as an excellent method of spacing. However few women might experience slight discomfort and increased menstrual blood loss after insertion of Cu containing devices. This is managed in most cases by counselling and iron supplementation unless associated with an infection.

Common Side Effects of IUD insertion include Pain and Infection that can be managed with painkillers and antibiotics. Severe and non responding conditions may require removal. If a women gets pregnant with the CuT in the uterus, which is a rare possibility, she may be offered an MTP. However if she desires to continue pregnancy, there is no need to remove CuT. In case the women is unable to feel the thread and the health worker suspects a perforation, that might rarely occur in post abortive/partum insertions, the client should be referred to First Referral Unit (FRU) for management.

However it should not be used in women with suspected pregnancy, any Pelvic Disease, uterine abnormalities, history of ectopic pregnancy.

2.7 PERMANENT METHODS

The methods of family planning that are irreversible and involve surgical intervention. These are vasectomy for men and tubectomy (tubal ligation) for women.

2.7.1 Vasectomy

Vasectomy is a method wherein the ‘vas deferens’ (a duct that carries the sperms from testes to the seminal vesicle) is surgically cut and the two ends are tied to prevent the entry of sperms into the seminal vesicle and thereby the semen has no sperms. Fig. 2.11)

![Vasectomy Diagram](image)

Fig. 2.11: Vasectomy

Currently, two methods are being practiced: Conventional and No Scalpel Vasectomy (NSV). NSV is a minimum intervention procedure where the ‘vas
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deferns’ is reached through a small puncture in the scrotum that does not need stitching. Inclusion of NSV in the national family welfare programme and its availability up to the peripheral level is to increase male participation by motivating them to adopt this method. It requires low infrastructure setup and can be done by trained MBBS doctors in peripheral units with minimum logistics. NSV is a safe and simple procedure and there are no major after complications reported. The client can immediately be discharged after the procedure and can continue with routine work. Since the procedure does not affect the hormones, the enjoyment or drive for sex in the acceptors of this method are not affected.

In cases of vasectomy, all cases should be visited by the health worker within 48 hours. Since this procedure doesn’t render the client sterile immediately and it takes at least 20 ejaculations or 3 months, whichever is earlier, before the person stops ejaculating sperms in the semen. Thus the client should be advised to use an alternative method like condom before his semen analysis confirms absence of sperms, which should be done after three months of the procedure. The client must also be counselled on where to report for complications. Minor complications like pain, infection, fever and local swelling can be managed by analgesics, anti-inflammatory and antibiotics. For un-resolving complications, the client should be referred to the Medical Officer/FRU.

2.7.2 Tubal Ligation

It is a procedure done on women, who have completed their family, by cutting, sealing or blocking the fallopian tubes which carry an egg from the ovary to the uterus (womb). However there are other methods like rings, clips and coils that can be used to obliterate the fallopian tubes and thus preventing the fertilisation. As a policy, the emphasis has been laid on Minilap over Laproscopic sterilisation as it can be provided by trained MBBS doctors under local anaesthesia with simple, inexpensive and easily manageable surgical equipments that addresses the shortage of manpower and equipments also.

Interval tubectomy can be performed any time within 7 days after the menstrual period is over. Under the programme emphasis is on post partum/MTP sterilisation services. Post partum sterilisation can be performed within 48 hours upto 7 days of delivery whereas post MTP sterilisation can be performed concurrently along with MTP. (Fig. 2.12)

All married women, living with their partner, preferably less than 45 years of age and above 22 years of age, having at least one child more than one year of age, mentally sound with partner not using any method of contraception are eligible.
for tubectomy. There are no conditions that are absolute contraindications for the procedure except a few like psychiatric illnesses (where the women cannot give informed consent) or physical conditions like moderate to severe anaemia.

2.8 POST PARTUM FAMILY PLANNING (PPFP) CHOICES

Return of fertility after delivery varies markedly from one woman to other and may return as early as within 4 weeks of delivery/MTP even before she resumes her menstrual cycles. Thus during this period there are high chances of unwanted pregnancies. (Fig. 2.13)

![Fig. 2.13: PPFP Choices](image)

2.9 FAMILY PLANNING 2020

A national initiative/momentum for access to quality contraceptive services is called Family Planning 2020. This involves partnership of government with International agencies, civil social agencies and private sector for expanding access to voluntary family planning services. The strategy intends not only to strengthen the existing strategies but also emphasise on the indirect indicators of fertility like age of marriage, women literacy and other socio cultural barriers towards access to services. Follow the targets setup for sub centre specific input.

The current interventions include Post-partum family planning, Fixed facility strategy, increasing male participation, community based services through ASHAs like home delivery of contraceptives, rapid diagnostic pregnancy kits, spacing at birth, family planning counsellors, compensation scheme, Family Planning Indemnity Scheme and Public Private Partnership etc. To achieve these objectives, government is also harnessing the expertise of various partners in the field of advocacy, capacity building, IEC/BCC, Programme Management, quality assurance and provision of skilled human resource for successful implementation.

The **Area of Focus** under the RMNCH plus A is under following heads:
A) Community based promotion and delivery of services through ASHAs.

B) Promotion of Spacing Methods with emphasis on spacing methods like Interval IUCD including Post-partum IUCD (PPIUCD) with institutional deliveries. The counsellors have also been appointed at the facilities with high rate of institutional delivery. The demand for services are being increased through focused IEC/ BCC through posters, billboards and audio/videos along with better availability of contraceptives (OCPs, Condoms and Emergency Pills) at the doorstep by the ASHAs.

C) Sterilisation Services (Tubectomies and Vasectomies): Of the limiting methods, the focus is on Mini lap tubectomy and increased men participation through NSV. Accordingly training programmes have been designed to build institutional capacities with trained manpower. The Government has also made provision for compensation to the acceptors of family planning methods for the loss of wages for the day on which he/she attended the medical facility for undergoing sterilisation. In high focus States, a sum of Rs 1100 and 600 is given to all the men and women who accept the terminal method of family planning. Whereas in low focus states, all men who are acceptors of terminal method are given Rs 1100, whereas women from BPL/SC/ST are given Rs 600 for accepting the terminal method of Family Planning. The non SC/ST/BPL category of women are also given a token sum of Rs 250 in low focus states for accepting the terminal method of family planning. Under National Family Planning Indemnity Scheme (NFPIS), claims are being given to the acceptors of sterilisation in the event of death/failures/complications/Indemnity cover to doctors/health facilities. An amount of Rs 2 lakh is given in case of death during or within seven days following sterilisation and 50,000 in case of death from 8–30 days following procedure. The Government also pays a sum of Rs 30,000 in case of the failure of sterilisation and bears the cost of treatment on actual basis for any complication following sterilisation.

Quality Assurance Committees have been established at the State and District levels for accreditation of the private and non governmental Organisations (NGOs) to provide family planning services. Kindly refer to the GOI quality assurance guidelines.

Besides counselling the beneficiaries for various methods of contraceptives available under RMNCH plus A programme, the government is also emphasising on indirect methods like delaying the age of marriage of girls and birth of the first child along with use of terminal methods of family planning after second child through incentive based schemes like Prerna and Santushti.

**Prerna (Responsible Parenthood Scheme):** This strategy is for couples below poverty line (BPL) where the couples are awarded Rs 10,000/- at the time of birth of a Boy child or Rs 12,000/- if it is a Girl through Aadhar linked account under the given conditions:

1) Age of girl at the time of marriage should be 19 years.

2) The first child should be born to the couple after at least 2 years of marriage.

3) In case of spacing between the first and second child is at least 3 years and either of the parents voluntarily accept permanent method of family planning within one year of the birth of the second child, the couple will get an additional award of Rs.5,000/- (Boy child) / Rs.7,000/- (Girl child).

**Santushti** is a scheme of Jansankhya Sthirta Kosh (JSK) for high populated states namely Bihar, Uttar Pradesh, Madhya Pradesh, Chhattisgarh, Jharkhand,
Odisha, and Rajasthan wherein gynaecologists and vasectomy surgeons from private sector are accredited by government to conduct sterilisation in PPP mode.

D) Comprehensive Abortion Care

E) Prevention and Management of Reproductive tract and Sexually Transmitted infections.

**Check Your Progress 1**

1) Mention two conditions when IUD should not be inserted.
   ................................................................................................................
   ................................................................................................................

2) What are Symptothermal methods of Family Planning?
   ................................................................................................................
   ................................................................................................................
   ................................................................................................................

3) What is the focus of the Government in limiting methods of planning?
   ................................................................................................................
   ................................................................................................................
   ................................................................................................................

**2.10 COUNSELLING**

Counselling is a two way process of exchange of ideas between health worker and a client with an aim to facilitate the decision by the client or helping him/her address concerns/problems. For a successful counselling, there should be mutual trust between the provider and the client. The rights of the clients should be taken into consideration. These are right to information, access to safe and continuous services, informed choice, right to dignity, comfort, opinion, privacy and confidentiality.

The client and health care provider should share relevant, accurate and complete information so that the client is able to make the right decision. The objectives of counselling are:

i) Helping Clients to assess their needs for a range of health services, information and emotional support.

ii) Providing information as per the problems and need of the client.

iii) Assisting/Enabling clients in making voluntary and informed choices.

iv) Clearing myths, misconceptions and doubts regarding the available contraceptive methods.

An acronym CLEAR is used to briefly describe about the procedure of counselling- Communicate with clarity, Listen, Encourage/Emphathize, ask questions and respect the constraints and decision of the client.
Reproductive Health and Adolescent Health

For a counsellor to be effective, he/she should be:

i) accepting, respecting, non-judgemental and objective while dealing with clients.

ii) able to and psychological factors with sensitivity that may influence the client’s decision to adopt family planning methods.

iii) able to maintain client’s privacy and confidentiality.

iv) thorough with knowledge on the technical aspects of the services and be able to judge when and where the person has to be referred.

v) able to use audio visual aids and provide technical information to the client in a simple language that he can understand.

vi) confidently and comfortably handle questions on sex and sexuality, reproductive and personal matters, rumours and myths.

For effective counselling, the health worker should use **GATHER** approach.

**G**reet the client and build rapport in a polite, friendly and respectful manner.

**A**sk about their problem in simple, open and brief questions. Express empathy and avoid opinions and judgements.

**T**ell the client about available methods and possible choices in a personalised manner that suits his/her current needs put in terms of his own life.

**H**elp them to make decisions by choosing solutions that best fit their own personal circumstances.

**E**xplain the method, possible side effects and their management, when and where to report back for follow up.

**R**eturn: Schedule a return or follow up visit.

**2.10.1 Principles, Approaches and Techniques of Family Planning Counselling**

The principles of family planning counselling are similar to that of general counselling with a few differences:

i) Besides privacy and confidentiality, the counsellor should be caring, non-judgmental and accepting to the client’s social and personal constraints.

ii) Language should be simple and culturally appropriate with brief and specific key messages.

iii) Good interpersonal communication skills should be used.

iv) Client should be encouraged to ask more questions and the counsellor should cross verify if the client has understood what the counsellor intends to explain.

v) Appropriate anatomic models, audiovisual aids and contraceptive samples should be used to explain it better to the client. Appropriate feedback should also be provided to the client after the session and repeat the key messages.

**The Family Planning Counselling can be done for Individuals or for Groups.**

Counselling for family planning can be of three types:

a) General Counselling: To orient the client to the benefits of methods available for family planning. In this, the reproductive goals and needs of the clients
are discussed, myths and misconceptions are cleared and decision making is facilitated.

b) Method Specific Counselling is done after the client has made decision on the choice of method. This involves more information on the method chosen, screening for the method, detailed information on the procedure, common problems and adverse effects anticipated and methods to deal with them. The clients are given handouts and printed matter to carry back home after clearing the myths and misconceptions of the client with the method.

c) Return/Follow up Counselling is done to illicit the satisfaction and response of the client with the method prescribed. The problems and queries of the clients are addressed and solved. They are motivated and encouraged to use the method unless any major problem exists. The satisfied clients can be encouraged to motivate other couples to use this method.

In group counselling, you can provide the following:

- Give basket of choices for type of contraceptive use.
- Check for nutritional deficiency
- Identify anaemia, investigate and manage as per protocol

Counsel the patient / beneficiary.

- Give method specific counselling
- Have a follow up programme

2.10.2 Counselling and Motivating Men

Since increasing male participation is an important mandate of the programme, men must be involved in the family planning counselling. The providers should counsel and motivate men to make them feel responsible for the health of their family. They should be encouraged to adopt a family planning method themselves (NSV or Condoms). Usually either men are poorly informed or have myths and misconceptions about their reproductive functions, systems and organs. These need to be clearly discussed out and explained to them to motivate them to use a family planning method.

Give technical reasons to the family on the benefits of use of permanent method by men and women

Men  
- non invasive, simple procedure
- can go to work soon
- Family will not suffer

Women  
- Need bed rest
- She may have bleeding
- Family tend to go neglected

The counsellor can also use models to demonstrate correct method of use of condoms, whenever possible.

2.10.3 Common Myths and Misconceptions

The clients usually have myths and misconceptions about the family planning methods that pose a challenge towards adopting them. A few have been discussed below to enable the health worker to clear these up while counselling the clients for adoption of one or more methods of family planning.
A) **Regarding Oral Contraceptives:**

1) I only need to take the Pill when I sleep with my husband.

Ans: A woman must take her pills every day in order not to become pregnant. Pills only protect against pregnancy if she takes them every day. If she misses one pill, she should take two as soon as she remembers.

2) I will face difficulty in getting pregnant again if I have been using it long enough.

Ans: A woman is only protected for as long as she actually takes the pill every day.

3) Pills make you weak and can cause cancer.

Ans: MALA N and MALA D have hormonal pills for 21 days followed by Iron containing tablets for subsequent seven days. Regular consumption of these pills tablets would rather improve the general well-being of the women by decreasing the menstrual blood loss and also building up iron reserve. The pill is also known to protect women from some forms of cancer, such as those of the ovary, endometrium, and cervix.

4) The Pill causes the birth of twins or triplets.

Ans: The Pill has no effect on the tendency toward multiple births rather this usually happens in families or with the use of drugs for treatment of infertility like clomiphene. In case there have been multiple births in either the man’s or woman’s family, then the chances of having twins are greater.

B) **Regarding Condoms:**

1) If a condom slips off during sexual intercourse, it might get lost inside the woman’s body.

Ans: A condom cannot get lost inside the woman’s body because it cannot pass through the cervix. Usually the condom will not slip if put on properly i.e rolled down to the base of the erect penis. However, if it comes off accidentally, the client should pull it out carefully ensuring that the semen doesn’t spill leading to an unwanted pregnancy.

2) There is too much danger of condoms breaking or tearing during intercourse.

Ans: Condoms are made of thin but very strong latex rubber and they undergo extensive laboratory tests for strength. Condoms are meant to be used only once. There is less chance that a condom will break or tear if it is stored away from heat and placed on the erect penis leaving enough space at the tip for the ejaculate. A condom is more likely to break if the vagina is very dry, or if the condom is old (past the expiration date).

C) **IUDs**

1) The thread of the IUD can trap/irritate the penis during intercourse.

Ans: The cut thread of the IUD (Cu T) is short enough to be able to be grasped by a forceps, soft and flexible, clings to the walls of the vagina and are rarely felt during intercourse. Since the IUD is located within the uterine cavity and the penis is positioned in vagina during intercourse, it cannot trap the penis.
2) A woman who has an IUD cannot do heavy work.
Ans: Use of an IUD should not stop a woman from carrying out her regular activities in any way.

3) IUD might travel inside a woman’s body to her heart or her brain.
Ans: The IUD is placed in uterus and by no means cross the vault of the uterus to migrate to epigastrium or any other organ of the body. Even if the IUD is accidentally expelled, it comes out of the vagina, which is the only passage to the uterus.

4) The IUD causes ectopic pregnancy.
Ans: There is no risk of an ectopic pregnancy with use of IUD.

5) Placement of IUCD in uterus lets to the rottening of Uterus.
Ans: The IUD is made up of materials that cannot deteriorate or “rot”. Hence there is no question of rottening of uterus due to IUCD.

D) Vasectomy

1) Vasectomy is the same as castration. A man who undergoes vasectomy has his manhood taken away and he will no longer enjoy sex.
Ans: Castration is removal of testes whereas in vasectomy, the vas deferens are cut and tied so that sperms are not ejaculated in the semen ejaculated during sexual intercourse. Vasectomy does not alter the hormone status of an individual thus the man continues to produce hormones and stays “masculine” and heterosexual. Many men enjoy sex more after a vasectomy because they no longer need to worry about getting a woman pregnant.

2) Sperm that is not ejaculated during intercourse will collect in the scrotum and cause the scrotum to burst or will cause other problems in the body.
Ans: Sperm that is not ejaculated is absorbed by the body. It cannot collect in the scrotum or cause harm to a man’s body in any way.

E) Tubectomy

1) A woman who has undergone sterilisation loses all desire for sex (becomes frigid).
Ans: Tubal ligation has no effect on the hormones produced by the ovaries of the woman, but only prevents the egg from meeting the sperm thereby preventing fertilisation. The ovaries continue to release eggs and produce hormones, the woman will still continues to menstruate, but she no longer gets pregnant.

2) A woman who has undergone sterilisation becomes sickly and unable to do any work.
Ans: A woman who has been ligated can resume regular activities as soon as she is free from post-surgical discomfort. It does not affect her ability to work or make her weak or “sick”.

3) A woman who undergoes sterilisation has to be hospitalised.
Ans: There is no need for hospitalisation with a female sterilisation ligation. The procedure takes approximately 15 minutes. After the operation, the woman should rest for a few hours and then be allowed to go home in the company of a family member.
Check Your Progress 2

1) State True/False:
   a) Use of Oral Contraceptive Pills (OCPs) may cause weakness in the users…………………
   b) Use of Condoms have an additional advantage over contraception…………………..

2) Fill in the blanks:
   a) The aim of the family planning programme is to……………………..male participation.
   b) E-pills………………….be used as a regular contraceptive method.

2.11 LET US SUM UP

Under Family Planning component of RMNCHA programme, various spacing and limiting methods of family planning methods are available. These include natural methods, barrier methods (condoms, spermicidal creams, jellies etc), Hormonal (pills and injections) and non hormonal (pills) methods, Intrauterine devices (IUDs), Tubectomy and Vasectomy. The e-pills are available as a post coital pill for prevention of unwanted pregnancy.

Each method has its merits and demerits and the clients have a right to make informed choice depending on their need. It is the responsibility of the health worker to counsel the client to make the right decision about whichever method suits her/his need the best. The health worker must also ensure that the client is referred to the right facility for seeking the service he/she chooses and is then adequately followed up for continuation. The role of health worker is to provide a constant support to the client by clearing myths and misconception and handholding in case of initial period of acceptance after the choice of method has been made.
2.12 KEY WORDS

Total Fertility Rate (TFR) : The number of children who would be born per woman (or per 1,000 women) if she/they were to pass through the childbearing years bearing children according to a current schedule of age-specific fertility rates.

Unmet need of Family Planning : This includes the currently married women, who wish to stop child bearing or wait for next two or more years for the next child birth, but not using any contraceptive method.

PPP : Public Private Partnership

NFHS : National Family Health Survey

SRS : Sample Registration Survey

DLHS : District Level Household Survey

IEC : Information, Education, Communication

BCC : Behaviour Change Communication

2.13 MODEL ANSWERS

Check Your Progress 1
1) Pregnancy and Pelvic Inflammatory Disease
2) BBT, Cervical Mucous and Calendar Method are together known as Symptothermal methods.
3) NSV for men and Mini Lap for women

Check Your Progress 2
1) a) False b) True
2) a) Increase b) Should never