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FAMILY WELFARE COMMITTEE

JABALPUR OBSTETRICS AND GYNAECOLOGICAL SOCIETY

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CONCEPT OF I CARE : INTEGRATED CONTRACEPTIVE APPROACH ACROSS REPRODUCTIVE AGES

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Integration of health care services at different levels is a an established concept with WHO,.

According to WHO : Integrated services means: **"The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system".**

It is therefore a systematic approach to care resulting in better patient experience, improved health at lower costs.

It requires strong communication and collaboration within an organization and a team effort to make the family planning and contraceptive services client centric and easily accessible. Such a service will be conducive for attaining goals for optimal reproductive health which depends highly on reproductive intent and healthy spacing of pregnancies.

WHO definition of Reproductive health

Reproductive health implies that couples have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Reproductive wellness is a reality and not merely the absence of diseases of the reproductive tract. Attainment of optimal reproductive health by couples will ensure attainment of several milestones for the Sustainable Development Goals.

Implicit to this need for: ensuring reproductive rights of couples to be informed of, and to have access to, safe, effective, affordable and acceptable methods of fertility regulation their choice.

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

- All women walking in to a health facility should be screened for an unmet need for family planning
- We must acknowledge that all women in reproductive age who are sexually active and not tubectomised or hysterectomised need contraception counseling and their reproductive intent must be enquired into, in a very delicate and non intrusive manner.
- It ensures women's autonomy in reproductive decision making,
- It addresses poor male participation in SRH matters.
- Assures Accessibilty .
- Unmet Needs are met.
- Improves Quality Of Care .Better Client experience /Satisfaction/ compliance/Retention. Improved outcomes at lower costs
- It creates unique opportunities to dispel client's and family's misconceptions about methods.
  Where all are the opportunities : **Integration can happen at every point of contact of the obstetrician gynaecologist and the client/patient.**
- Adolescent care with Contraceptive awareness.
- Preconceptional care with concept of reproductive planning.
- Antenatal care to be strengthened by integrating contraceptive counseling.
- Post partum care to be firmly ingrained with counseling and uptake for post partum contraception.

- Comprehensive abortion care includes the vital post abortal contraception provision.
- The opportunistic time: The interval situations of visits for screening of cancer, health checks, menstrual problems , premenstrual tensions etc. should have contraceptive advice with treatment of presenting symptom.
- The premenopausal women coming in for gynaec care will deserve a check and counsel on her contraceptive need.

Integration with other services

- Integrating immunization with family planning services
- Integrating ICTC/PPTCT with Family Planning
- Integrating RTI/STI clinics with FP.
- With Mental health care especially post partum.
- With menopausal care and medical co morbidities.
- Other consultants coming in contact with the woman, eg. Paediatriciana, physicians, endocrinologists etc. must also encourage the couple with positive messages for contraception.
- Other health care workers eg. Dietiticians, physiotherapists, midwives, nurses, counselors, ASHAs , ANMs etc must all encourage women to space pregnancies with use of suitable contraceptive methods.
- Use of a common language will reinforce the.

What is I Care clinic? Establishment of dedicated FP units a contraception I Care clinic (one unit / opd of 30 patients / day) to create an interphase between the couple and the health care worker.

What happens in the contraception clinic ? Skilled counsellors specially dedicated for contraception will interact in a brief, simple culurally sensitive manner.

Counselling; offer the basket of choices using the **GATHER approach.**

Greet clients in a friendly , respectful, manner assuring privacy and confidetiality for the couple/client.

Ask clients about family planning needs, concerns ,previous use.

Tell Effective use with help of audiovisual aids, anatomic models , contraceptive samples, present the basket identified by the consultant.

Help clients to make a choice.

Explain to clients details of the method, including how to use it correctly.

Return : Schedule for follow up visit.

Pamphlets in regional language with key information shared .

The most valuable part of this interphase is the client has an opportunity to look at the samples, understand methods and get a feel of what a device or pill or injection looks like.

Familiarity will remove the fear of unknown, bust the myths and misconceptions and create a conducive atmosphere for choice and acceptance.

Are we able to do this much during our consult ? We are often challenged for adequate time required for counseling. The quality time needed for creating a basket of choice for a given client has to be adequately supplemented via GATHER approach with counseling in general, enabling the choice and the the chosen method. It stands to reason therefore that the best way is for a trained counselor to be available in a dedicated cubicle with all IEC, all methods displays and chart materials.

Conclusions :

Provision of I CARE services effectively improves the counseling and uptake of contraceptive methods. The establishment of such centers in Obstetric units has the potential for revolutionizing reproductive autonomy and providing Indian women the freedom of choice which they fully deserve. Besides, it is our conviction that I CARE clinics will be an important tool for achieving SDG in our country.

LARC: EMPOWERING WOMEN'S REPRODUCTIVE CHOICES WITH LONG-ACTING REVERSIBLE CONTRACEPTIVES

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Access to reproductive healthcare and family planning is crucial for women's empowerment and well-being. Long-Acting Reversible Contraceptives (LARC) have emerged as a game-changer, providing highly effective, reversible, and convenient contraceptive options. LARC methods offer extended protection against unintended pregnancies while eliminating the need for daily or frequent contraceptive administration or intake.

This makes LARC methods suitable for women who may have difficulties adhering to a daily regimen or prefer a set-it-and-forget-it approach to contraception. This feature particularly benefits women who have limited access to healthcare services and logistical challenges can hinder consistent contraceptive supplies.

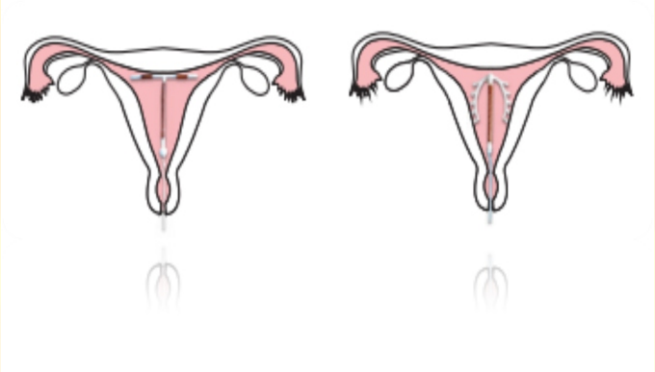
Two popular forms of **LARC are Injectables and Intrauterine Contraceptive Devices** (IUCDs).

Injectable contraceptives

- Also known as birth control shots, given every three months.
- Works by inhibiting ovulation, thickening the cervical mucus, and altering the endometrial lining.
- Highly effective, discreet, and hassle-free contraception option for women who prefer a non-daily approach.
- Flexibility to discontinue use whenever desired.
- **Intramuscular** MPA (mpa-im) is available as a single dose vial with disposable syringe and contains 150 mg/ml of aqueous solution of medroxy progesterone acetate
- **Subcutaneous** MPA (mpa-sc) is available as prefilled auto disable syringe in uniject system and contains 104 mg/0.65 ml.

MPA-SC should not be used for IM administration and similarly, MPA-IM should not be used for MPA-SC administration

Intrauterine Devices



- Work by altering the uterine environment, inhibiting sperm movement, and reducing the likelihood of fertilization.
- Convenient and long-lasting nature.
- Quick reversibility and quick fertility restoration upon removal.
- Can be inserted in the first 7 days of the menstrual cycle; immediately after delivery (postpartum) within 48 hours or after 6 weeks; and immediately or upto day 12 with surgical abortion care procedure and on day 15 with medical methods of abortion.
- Non-contraceptive benefits include reducing the risk of specific gynaecological conditions, including endometrial cancer and pelvic inflammatory disease.

Intrauterine contraceptive devices are of two types: Copper IUCDs and hormonal IUDs.

Copper IUCDs are small, T-shaped (IUCD 380A) and inverted U-shaped (IUCD375), devices that are inserted into the uterus by a trained healthcare professional. They are highly effective in preventing pregnancy and can provide protection for upto10 years and 5 years respectively.

Hormonal IUDs are the intrauterine devices which release hormones for enhanced effectiveness in addition to the usual contraceptive effect of an IUCD. Equal amounts of hormone is released each day till its duration of effectiveness. It is highly effective method. It has various non-contraceptive benefits too, which includes:help in reducing anaemia,protection against endometrial and cervical cancer, reducing menstrual cramps, heavy monthly bleeding and symptoms of endometriosis (pelvic pain, irregular bleeding).

Overall, LARC methods offer numerous advantages for women seeking effective birth control options. These methods provide a higher level of protection against unintended pregnancies than other forms of contraception. The failure rate of LARC methods is minimal, with IUCDs having a failure rate of less than 1% (0.6/100 women users) and injectable contraceptives too having a failure rate of less than 1% (0.3/100 women users).

Moreover, LARCs offer a sense of agency to women, enabling them to plan and space their pregnancies effectively, resulting in healthier outcomes for both mothers and children. LARC methods also offer flexibility, as they can be discontinued anytime if a woman wishes to conceive or explore alternative contraceptive methods. The government and non-governmental organizations (NGOs) have collaborated on various platforms to promote LARC methods by raising awareness, enhancing accessibility, and addressing barriers across different contexts. This is achieved through community-based outreach, healthcare provider training, policy/advocacy efforts, and leveraging technology. By promoting LARC services effectively, maternal mortality rates can be reduced, contributing to a healthier society where women have greater reproductive autonomy and choices.

SUBDERMAL CONTRACEPTIVE IMPLANTS

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The contraceptive Implant is over three decades old method which is an effective, long-acting reversible contraceptive (LARC) method. It has evolved over the years from 6 rods (Levonorgestrel containing - Norplant) to a single rod (Etonogestrel containing - Implanon NXT).

Global experience over the last three decades indicates that women readily accept contraceptive implants when these are available. More than 25 million women are using subdermal contraceptive implants as a choice for contraception (UN 2022) Implants are registered and approved for use in more than 100 countries, including theUnited States, Western European countries, as well as many middle and low-income nations.

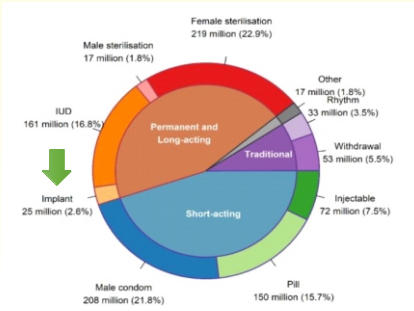

Fig 1-Sources: Calculations based on United Nations, Department of Economic and Social Affairs, Population Division , World Contraceptive Use 2022;

Types of Implants:

SNo.	Type of Implant	Trade names available	Composition	Number of Rods	Effective duration
1.	Etonogestrel releasing	Implanon NXT/ Nexaplanon	Etonogestrel- 68 mg (Barium sulphate-impregnated rod and improved trocar are its additional features.)	1 rod	3 years
		Implanon	Etonogestrel - 68 mg	1 rod	3 years (Extended duration up to 4 years)
2.	Nomegestrol Releasing	Uniplant	Nomegestrol- 38 mg	1 rod	1 year
3.	Levonorgestrel releasing	Norplant-2 (Jadelle)	Levonorgestrel- 75 mg/rod	2 rods	5 years
		Sino implant II	Levonorgestrel-75mg/rod	2 rods	4 years
		—	Levonorgestrel- 36 mg/rod	6 rods	5 years
4.	Elcometrine - Releasing	Nestorone	Elcometrine *- 50 mg	1 rod	6 months

Table: 1

Currently, two types of Implants are available:

1. Single rod with 68 mg of Etonogestrel – releases 60-70 µg/day declines to 25-30 µg/day by 3 years
2. 75 mg of Levonorgestrel with 2 rods, releases 40-50 µg/day at 1 year, declines to 25-30 µg/day in 5th year

Implants in India:

In 2018, the Drugs Controller General of India (DCGI) approved and licensed the product that is marketed and is being used extensively in the private sector from January 2019 onwards. Health Technology Assessment of Long-Acting Reversible Contraceptives in India" by NIRRH in 2019 acknowledged that the addition of Implants in the public health sector of India is cost-effective.

Govt of India took a policy decision to include Subdermal contraceptive Implant (single rod) in public health

facilities in a phased manner i.e. in 10 States of India (two districts in each state) in the 1st phase, and expand subsequently!

Composition

The implant is available in a preloaded Applicator (Fig 2), It is a single rod, 4 cm long and 2 mm in diameter, with a core and skin which contain active and inactive ingredients, and it contains Barium sulfate in the core, which makes it radiopaque. (Fig 3)

FIG 2: 1IMPLANON NXT PRELOADED APPLICATOR

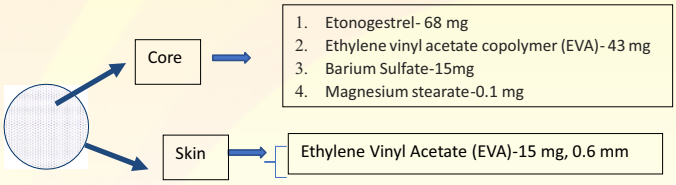

FIG 3. SIZE AND CROSS-SECTIONAL STRUCTURE OF IMPLANT

Pharmacokinetics

Absorption: Post-insertion, the hormone levels in Contraceptive Implants rise rapidly and are effective depending on timing of insertion per the woman's menstrual cycle or use of contraception. While hormone levels drop throughout the Contraceptive Implants' span of use, the mean levels remain well above the suggested pregnancy threshold. These results suggest that one-rod Contraceptive Implants are effective for 3 years.

Release rate of Etonogestrel	Absorption of Etonogestrel to provide contraceptive effect
Week 5-6 of insertion-60-70 mcg/day	Ovulation-inhibiting concentration reached within hour to one day (>90 pg/ml)
At the end of 2 years- 30-40- mcg/day	Max serum conc. Is reached within two weeks (472 to 1270 pg/ml)
At the end of 3 years- 25-30 mcg/day	By end of 3 years, serum concentration gradually decreases to 156 pg/ml & falls to 20 pg/ml within about 4 days. This is why return to fertility is early with Implant

Table: 2

Once the implant is removed, there is an early return to fertility as the plasma level falls quickly.

Mechanism of action

- Inhibiting ovulation, thickening cervical mucus and causes thinning of endometrial lining, making it unfavourable for implantation of fertilized ovum.
- 99.9% effective /less than 1 pregnancy per 100 women) which means that 999 of every 1000 women using Contraceptive Implant will not get pregnant.

Return to Fertility: Return to fertility is early, without any delay.

Recommended to follow WHO MEC criteria to assess potential users.

In a two-year study, in which the bone mineral density in 44 users has been compared to that in a control group of 29 IUD-users no adverse effects on bone mass have been observed on BMD.

Like other progestin-only methods, some women may experience changes in menstrual bleeding pattern, like irregular bleeding, prolonged/heavy bleeding or amenorrhea.

Although the menstrual changes gradually diminish over time and become less frequent and bothersome after 9–12 months, appropriate treatment should be provided to the client.

Irregular bleeding

- Reassure, NSAIDS, Treanexa
- If continues consider underlying conditions unrelated to the method used.

Prolonged or heavy bleeding (bleeding for 8 or more days OR twice as much as usual or with clots)

- Reassure, give NSAID

- If still no relief, give Combined oral contraceptives

Amenorrhoea

- no monthly bleeding, rule out pregnancy.
- In rare cases, if the woman is pregnant, the Implant needs to be removed. Also tell her that if she wants, she can continue with pregnancy because the Implant does not cause any ill effect on the growing fetus.
- Other possible non-menstrual side effects include headaches, acne, enlarged ovarian follicles, weight change, breast tenderness, dizziness, mood changes, nausea and abdominal pain.

Limitations

- Requires a minor procedure for insertion and removal by a trained service provider
- Changes in the menstrual bleeding patterns are common
- May be visible under the skin in some women
- Does not protect a woman from RTIs/STIs including HIV/AIDS

Implants for Adolescents and Youth

- Adolescents can safely use implants, without effect on future fertility.

Implant Use by Women with HIV

- Women with HIV or AIDS can use without restrictions
- Women on ARV therapy can generally use implants

Counsel that some ARVs, particularly efavirenz, can reduce implant effectiveness somewhat

Although clients with any of the following conditions may use implants, they may need more frequent or special follow-ups for their medical condition:

- Diabetes,
- Hypertension
- Severe vascular or migraine headaches

Initiation of Method

The Implant can be inserted at any time after proper screening and assessment. Table 3 provides information on the timing of initiation of the method for different situations of women.

Timing of Initiation of Implant

WOMAN'S SITUATION MENSTRUATING	WHEN TO START
Having menstrual cycles	Can be inserted any time of the month ◆ If within 7 days after the start of monthly bleeding, no need for a backup method. ◆ If more than 7 days after the start of monthly bleeding, and if it is reasonably certain that woman is not pregnant. A backup method will be required for first 7 days after insertion.
POST-PARTUM – BREASTFEEDING	
Less than 6 months post- partum	◆ Immediately after delivery irrespective of breastfeeding status ◆ Anytime upto 6 months if woman is fully/nearly fully breast feeding and her monthly bleeding has not returned. No need for a backup method. ◆ Partial breast feeding if on monthly bleeding, any time if it is reasonably certain that woman is not pregnant with a backup method for first 7 days after insertion. ◆ If monthly bleeding has returned, as advised for women having menstrual cycles. More than 6 months post- partum ◆ Any time if monthly bleeding has not returned and it is reasonably certain that she is not pregnant with a backup method is required for first 7 days after insertion.
POST-PARTUM: NON-BREASTFEEDING	
Less than 4 weeks after giving birth	◆ Any time. No need for a backup method.
More than 4 weeks after giving birth	◆ If her monthly bleeding has not returned, any time if it is reasonably certain that she is not pregnant with a backup method for first 7 days after insertion.

	◆ If her monthly bleeding has returned, as advised for women having menstrual cycles.
POST ABORTION	
After miscarriage or abortion (not related to childbirth or breastfeeding)	◆ After surgical abortion-Immediately or within 7 days after first- or second-trimester miscarriage or abortion, No need for a backup method. ◆ After medical abortion- on 3rd day of medical abortion protocol ◆ If being inserted after 7 days of first- or second-trimester miscarriage or abortion, implant can be inserted any time if it is reasonably certain that woman is not pregnant with a backup method will be required for first 7days after insertion.
OTHER SITUATIONS	
WOMAN'S SITUATION	**WHEN TO START**
No monthly bleeding	◆ Anytime if it is reasonably certain that woman is not pregnant. A backup method will be required for first 7 days after insertion.
After taking emergency) contraceptive pill (ECP	◆ Can be started on the same day or any day after taking ECP if it is reasonably certain that woman is not pregnant. ◆ A backup method will be required for the first 7 days after insertion.
SWITCHING FROM A METHOD	
Switching from a non-hormonal method	◆ From Cu IUCD 380A/375 -Can be inserted immediately, when Cu IUCD is removed. No backup method required if Cu IUCD is removed within 7 days of monthly bleeding & concurrent implant insertion is done ◆ From Weekly Pills (Chhaya)- Immediately, any day of the month, while taking weekly pills (if weekly pills are consistently and correctly used) or if it is otherwise reasonably certain that woman is not pregnant.
Switching from a hormonal method	◆ Immediately, if woman has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. 1. From Injectable contraceptives: can have the implant inserted when the next injection would have been given 2. From Combined Oral Pills/ Progestin only pill: on any day of the month, while taking COCs/POPs (if being taken correctly & consistently). The implant should be inserted within 24 hours after taking the last hormonal pill.

Table: 3

Insertion of Implant

Insertion of Implant is a minor procedure, which takes only a few minutes, by a skilled provider. It should be inserted just under the skin on the inner aspect of the non-dominant upper arm (Figure 4) 8-10cm proximal (towards the shoulder) to the medial epicondyle (elbow fold) and 3-5cm posterior to the sulcus or groove between the biceps and triceps muscles.

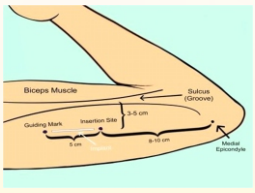

FIG 4: SURFACE MARKING FOR INSERTION OF IMPLANT

Removal of Implant

An Implant, which is inserted correctly at the subdermal plane, can be easily removed by standard removal procedures. However, difficult removal requires special skills and an equipped facility.

It is mandatory to locate the Implant immediately prior to the removal process. No attempt should be made to remove implant unless its exact location is identified.

A non-palpable implant should always be located prior to attempting removal. Confirm its presence in the arm with imaging techniques.

In rare circumstances, if the rod is not palpable or palpable deeply, 2-dimensional X-ray, Ultrasound scanning with a high-frequency linear array transducer (10 MHz or greater). An Implant is a small echogenic spot 2 mm, when viewed in a transverse position and appears as a sharp acoustic shadowbelow the implant in a transverse position Computed tomography (CT) scan or Magnetic resonance imaging (MRI) may also be used and the client may be referred to a higher-level facility.

STERILIZATION STANDARDS FOR FEMALE

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Superintendent: Rani Durgwati Hospital Jabalpur 2015-2019

Dr Sharda Mishra
Visiting Gynecologist at Police Hospital And Jail Hospital Jabalpur
National Master Trainer of BEMOC Foundation since 2010

Clinical Assessment and Screening of Clients

Prior to the surgery, compilation of the client's medical history, physical examination and laboratory investigations as specified below needs to be done in order to ensure the eligibility of the client for surgery.

Demographic Information

The ensuing information is required: Name of the client, spouse's name, age, address, marital status, occupation, religion, educational status, number of living children and age of the youngest child. If possible, contact telephone number of client.

History is an important part and should be taken in details as in case of any other surgical procedure.

- Rule out any febrile illness, coagulation disorder or diabetes.
- Immunization status for tetanus.
- Any known drug allergies especially to analgesics and other medications.
- Current medications and reason

When to perform Female Sterilization:

WOMAN'S SITUATION	WHEN TO PERFORM
Having Menstrual Cycles	◆ Any time within 7 days after the start of her menstrual bleeding. ◆ Any time of menstrual cycle, provided it is reasonably certain that she is not pregnant.
Switching from another method	◆ OCP: To be done any time, but she can continue the pill until the pack is finished to maintain her regular cycle. ◆ IUCD: To be done anytime, concurrently with removal of IUCD.
No monthly menstrual bleeding After childbirth	◆ Any time provided it is reasonably certain she is not pregnant. ◆ Within 7 days after giving birth (only Post-Partum Minilap tubectomy can be performed). ◆ Any time 6 weeks or more after childbirth if it is reasonably certain she is not pregnant. (Interval Sterilization).
After MTP	◆ Concurrently with surgical MTP or within 7 days post MTP . ◆ In case of Medical Abortion, the tubectomy should be done after next menstrual cycle. ◆ Laparoscopic tubal occlusion procedure can be performed only in MTPs up to 12 weeks of gestation
After miscarriage or abortion After using emergency contraceptive pills (ECPs)	◆ Within 7 days, if no complications. ◆ Within 7 days after the start of her next monthly bleeding or any other time if it is reasonably certain she is not pregnant.

Laparoscopic tubal occlusion should not be done concurrently with second-trimester abortion and in the early post-partum period up to 42 days.

Physical Examination : After history taking through general and systemic examination must be performed.

Laboratory Examination

Blood test for haemoglobin, urine examination for sugar and albumin and pregnancy test, if needed.

Caution: Clients with Haemoglobin <7gm/dl should not be accepted for sterilization

Eligibility Criteria for Case Selection

(Self-declaration by the client will be the basis for compiling this information. No eligible client should be denied family planning services)

- ✓ Clients should be ever married.
- ✓ Female age of 22 - 49 years.
- ✓ Male age of 22 - 60 years.
- ✓ at least one child, whose age is above one year unless the sterilization is medically indicated.
- ✓ Clients or their spouses/partners must not have undergone sterilization in the past (not applicable in cases of failure of previous sterilization).
- ✓ Mentally challenged clients must be certified by a psychiatrist and a statement should be takenfrom the legal guardian /spouse regarding the soundness of the client's state of mind.

There are no absolute contraindications for performing Tubectomy/Vasectomy operation. There are certain conditions that require caution, delay or referral to a specially equipped centre.

The MEC can be reffered for case selection based on the clinical findings of the client.

Informed Choice and Informed Consent

The consent of the partner is not required for sterilization. However, the partner should be encouraged to come for counselling.

Documentation of Informed Consent

Consent for sterilization should not be obtained when physical or emotional factors may compromise a client's ability to make a carefully considered decision about contraception.

Documenting Denial of Sterilization

When a client evaluation indicates sterilization to be unsuitable for her/him either onmedical or non-medical reasons, the client record should specify the reasons (e.g., the client has a condition that precludes surgery, client is uncertain about her/ his choice, etc). The action taken by the provider should also be described (e.g., referral, treatment, etc). These records should be kept at the service facility where the client was evaluated and the sterilization found unsuitable for her/ him.

All cases of failures and complications, major or minor and deaths arising out of surgery or post-surgery must be documented. The major complications that required hospitalization, deaths and all cases of failures must be reported to the District Quality Assurance Committee (DQAC). The District Quality Assurance Committee (DQAC) will in turn be responsible for processing the claims as per the guidelines of the Family Planning Indemnity Scheme.

Certificate of Sterilization

A certificate of sterilization should be issued **one month after the surgery or after the first menstrual period, whichever is earlier.**

If the client does not resume her period even after one month of surgery, rule out pregnancy before issuing sterilization certificate.

For payment of compensation for undergoing sterilization operation, discharge slip/card will be considered a valid proof of undergoing Sterilization.

In case the surgeon was unable to identify the tube on one side and thereby could not occlude/ligate it, he/she should document it on the case sheet and inform the client accordingly that the sterilization procedure has not been successful. This documentation on the case sheet should also be countersigned by the client or their thumb impression taken (if illiterate). In such cases sterilization certificate should not be issued even if she resumes her menstrual cycle.

Such cases where sterilization certificate has not been issued are not eligible for compensation for 'failure' under FPIS.

Failure of Operation Leading to Pregnancy

Female Sterilization is one of the most effective methods but carries a small risk of failure. The incidence of failure is less than one pregnancy per 100 women over the first year after having the sterilization procedure (5 per 1000)

and is about two pregnancies per 100 women over 10 years of use. Ectopic pregnancy must be ruled out as female sterilization predisposes to this condition.

In case of missed menstrual period, the clients are advised to report to the health care facility within two weeks for confirmation about the failure of her sterilization procedure. She should be offered MTP and repeat sterilization procedure free of cost or be medically supported throughout the pregnancy if she wishes to continue.

Report on Sterilization Failures

Sterilization failure is defined as any pregnancy that occurs after certification of the sterilization operation.

The report on failure attributable to sterilization is to be filled in by the District QAC of the district where the client has reported within two weeks of reporting The District QAC will conduct a field investigation /enquiry, review the case record and report the findings to the state committee.

A final report of the audit is to be sent to all those who are involved in the audit process. The audit records should be kept for ten years for the purpose of comparison and for facilitating future audits.

The processing and settlement of the death, failure and complication claim should be done by the District QAC where the client has reported.

Family Planning Indemnity Scheme

Family Planning Indemnity Scheme indemnifies all clients of sterilization as also doctors/ health facilities conducting sterilization operation in both public and accredited private/NGO sector health facilities for unlikely events of complications/failures/deaths attributable to sterilization operations.

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

SECTION	COVERAGE	LIMITS
IA	Death attributable to sterilization (inclusive of death during process of sterilization operation) in hospital or within 7 days from the date of discharge from the hospital.	Rs. 2 lakhs
IB	Death attributable to sterilization within 8 - 30 days from the date of discharge from the hospital.	Rs. 50,000/
IC	Failure of sterilization	
ID	Cost of treatment in hospital and up to 60 days arising out of complication attributable to sterilization operation (inclusive of complication during process of sterilization operation) from the date of discharge.	Actual not exceeding Rs.25,000/
II	Indemnity per Doctor/Health Facilities but not more than 4 in a year.	Up to Rs 2 lakh per claim

Standards for Male Sterilization

Clinical Assessment and Screening of Clients is same as that of female client.

Timing of the Surgical Procedure - at any convenient time.

Certificate of Sterilization

Issued only after three months once the semen examination shows no sperm.

Unable to identify the vas on one side and thereby could not occlude/ligate it, he/she should document, inform the client also countersigned by the client or sterilization certificate should not be issued.

Certificate can be delayed till 6 months if the semen shows sperm after 3 months of semen examination but even if after 6 months semen shows sperms then the certificate should not be issued

Failure of Vasectomy

Male Sterilization (both NSV & Conventional method) is not effective till the seminal fluid is completely sperm free, which takes almost about a period of three months or more, after the procedure. Pregnancy may occur after vasectomy, if the couple does not use condoms or another effective contraceptive method consistently and correctly before the seminal fluid is devoid of all sperms and semen examination proves no sperm.

Reference : Standards and Quality Assurance in Sterilisation Services Given by Family Planning Division Ministry of Health and Family Welfare Government of India November 2014