

CHO-0003

Public Health and Primary Health Care Skills



Reproductive and Adolescent Health Skills

5

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**Reproductive and Adolescent
Health Skills**

5

Block

5

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Appreciation of Collaborative Efforts

The development of this Training Module for Community Health Officers (CHOs) is the result of a collaborative effort led by the Department of Medical, Health & Family Welfare, Government of Rajasthan, with valuable technical support from development partners. We sincerely thank all Directors, Project Directors, State Nodal Officers, and technical partners including Jhpiego, WHO, UNICEF, UNFPA, UNDP, IPE Global, IPAS, Evidence Action, JSI and others for their contributions. Their expertise, evidence-based inputs, and field insights have ensured the relevance and quality of this resource. This module aims to strengthen CHOs' capacity to deliver comprehensive, people-centered care at the community level, advancing our shared goal of improved health outcomes for all.

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May, 2017

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ISBN :

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Further information about the School of Health Sciences and the Indira Gandhi National Open University courses may be obtained from the University's office at Maidan Garhi, New Delhi-110 068.

Printed and published on behalf of the Indira Gandhi National Open University, New Delhi by **Prof. Pity Koul, Director**, School of Health Sciences.

We acknowledge the reference of material and figures from various sources like NNF, AIIMS, WHO, UNICEF, IGNOU, Govt. of India etc.

Laser Typesetting and Printed at : Rajasthan State Cooperative Press Ltd., Jaipur

BLOCK INTRODUCTION

Sexually transmitted infections (STIs) spread through person-to-person sexual contact. However, infections like HIV, Syphilis and hepatitis B can also be transmitted via mother-to-child transmission during pregnancy and childbirth, blood products or tissue transfer.

This block focuses on providing practical guidelines for identification, management and referral of cases of Reproductive Tract Infections (RTIs) including Human Immuno Deficiency Virus (HIV) and Intrauterine Contraceptive Device (IUCDs) which are more effective, last longer and are safer. The focus is also on skills required for insertion and removal of IUCDs, counseling the clients to select appropriate IUCDs as per their choice, various methods of abortions, laboratory test required before undergoing abortion, precaution and components of post abortion care.

This Block is consists of four units as given below

Unit 1 deals with Assessment and Management of STIs/RTIs

Unit 2 focuses on Insertion and Removal of IUCDs

Unit 3 relates to Management of Abortion -Natural and Medical

Unit 4 focuses on Adolescent Counselling

We hope the information given in this Block will help you in improving your knowledge and skills related to STIs/RTIs/IUCDs, abortion and adolescent counseling, so as to provide effective health care to the individuals, families and communities living in their natural environment.

UNIT 1 ASSESSMENT AND MANAGEMENT OF STIs/RTIs

Structure

- 1.0 Introduction
- 1.1 Objectives
- 1.2 Reproductive Tract Infections (RTIs)/RTIs
 - 1.2.1 Definition
 - 1.2.2 Risk Factors
 - 1.2.3 Signs and Symptoms
 - 1.2.4 Assessment
 - 1.2.5 Screening
 - 1.2.6 Prevention
 - 1.2.7 Management
 - 1.2.8 Human Immune Deficiency Virus (HIV)
- 1.3 Let Us Sum Up
- 1.4 Activity
- 1.5 References

1.0 INTRODUCTION

Sexually transmitted infections (STIs) are infections that spread through person-to-person sexual contact. However, infections like HIV, syphilis and hepatitis. B can also be transmitted via mother-to-child transmission during pregnancy and childbirth, blood products or tissue transfer. The term STIs and RTIs partly overlap. RTIs are defined as infections of the genital organs and include endogenous infections such as bacterial vaginosis and vulvovaginitis candidiasis. These two infections are mostly not sexually transmitted and they can occur in women who have never had a sexual relationship. The concept of STI refers to the way of transmission, and the concept RTI to the site where the infection develops.

This unit will focus on providing practical guidelines for treatment and management of a case of STI/RTI/HIV and counselling that should be done for the patient.

1.1 OBJECTIVES

On completing this unit, the student should be able to:

- define Sexually Transmitted Diseases;
- list the risk factors for sexually transmitted infection;
- identify the signs and symptoms;
- elicit history;
- conduct examination of the patient;

- enumerate screening methods for STIs/RTIs;
- know the preventive measures; and
- provide management and follow up.

1.2 REPRODUCTIVE TRACT INFECTIONS (RTIs)/ RTIs

Let us now discuss RTI/HIV in details as given below:

1.2.1 Definition

Sexually transmitted disease is an infection that can be transferred from one person to another through sexual contact. Reproductive tract infections are also interchangeably pertains to sexually transmitted infections.

There are Common curable STIs:

- Gonorrhoea (*Neisseria gonorrhoeae*)
- Chlamydia infection (*Chlamydia trachomatis*)
- Syphilis infection (*Treponema pallidum*)
- Trichomoniasis (*Trichomonas vaginalis*)
- Chancroid (*Haemophilus ducreyi*)

Common viral infections:

- HIV/AIDS (human immunodeficiency virus)
- Genital herpes (herpes simplex virus type 2)
- Genital warts (HPV predominantly types 6 and 11)
- HPV types 16 and 18

1.2.2 Risk Factors

Risk factors for sexually transmitted infections (STIs) include both sexual behaviour that increases the risk of exposure to STIs and risk groups that have a high prevalence of STIs.

Behavioural risk factors include:

- New sex partner in past 60 days
- Multiple sex partners or sex partner with multiple concurrent sex partners
- No or inconsistent condom use outside a mutually monogamous sexual partnership
- Sexual contact (oral, anal, penile, or vaginal) with sex workers

Risk groups are demographic groups identified as having a high prevalence of STIs:

- Young age (15 to 24 years old)
- Men who have sex with men (MSM)
- History of a prior STI

- Unmarried status
- Lower socioeconomic status
- Illicit drug use

1.2.3 Signs and Symptoms

Common symptoms and signs (syndromes) are:

- Genital ulcer
- Vaginal discharge
- Lower abdominal pain in women
- Neonatal conjunctivitis
- Inguinal bulbo
- Scrotal swelling and Urethral discharge in men

1.2.4 Assessment

Assessment for STIs/RTIs involves history taking and examination as discussed below:

History and examination may lead to the detection of STI which may be entirely unsuspected by the patient.

History Taking

A sexual history is essential to guide decisions about management, or additional examinations or tests that might benefit the patient with suspected STI. It is essential that privacy be maintained. Sexual history should include:

Checklist for Assessment of STIs

Points to be Asked	Yes	No	Remarks
Information about partners			
Any new sexual partner			
History of multiple sexual partners			
Sexual partners with concomitant partners			
Practices			
History of sexual intercourse with trauma			
Protection from STIs			
Frequency of condom use			
Past history of STIs			
History of any STIs, including genital ulceration, which can increase the risk of HIV acquisition			

Examination : While doing examinations of a woman you should adhere to the following points:

- Explain the procedure to the patient
- Maintain privacy
- Avoid the possibility of others walking in on the examination
- Record vital signs
- Wash hands well (water and soap)
- Use a sheet or clothing to cover the patient
- Place the patient in a comfortable position
- Put on gloves
- Carry out the examination in good light.

Now after all the preparation let us discuss to examine female and male patients as given below:

Female patients

There are three components to the female genital examination (assuming speculum/equipment are available):

- i) External genital examination:
 - Inspect the perineum and anus – using the gloved hand.
 - Look for lumps, swelling, lymphadenopathy, abnormal discharge, sores, ulcers, tears and scars around the genitals and in between the skin folds of the vulva.
- ii) Speculum examination for:
 - Vaginal discharge and redness of the vaginal walls (vaginitis).
 - Ulcers, sores or blisters.
 - Cervical abnormalities (tumours, contact bleeding or discharge).
- iii) Bimanual examination:
 - Lower abdominal tenderness (when pressing with the outside hand).
 - Cervical motion tenderness (often evident from facial expression) when the cervix is moved from side to side with the fingers of the gloved hand in the vagina.
 - Uterine tenderness when pressing the outside and inside hands together.
 - Any abnormal swelling (remember pregnancy, uterovaginal prolapse, ovarian cysts, tumours, etc).

Male patients

Needs to be examined as per SOP/policy laid down in your health facility.

- Ask the patient to stand up and lower his underpants to his knees (or examine with the patient in a lying position if preferred).
- Palpate the inguinal region for enlarged lymph nodes or buboes.
- Palpate the scrotum, feeling for the testis, epididymis and spermatic cord on each side.
- Examine the penis, noting any rashes or sores.

- Ask the patient to pull back the foreskin if present and look at the glans penis and urethral meatus.
- If there is no obvious discharge, ask the patient to milk the urethra.
- Ask the patient to turn his back to you and bend over, spreading his buttocks slightly. This can also be done with the patient lying on his side with the top leg flexed up towards his chest.
- Examine the anus for ulcers, warts, rashes, or discharge.

1.2.5 Screening

STIs are frequently asymptomatic and can lead to various complications. The immediate goal of screening for STIs is to identify and treat infected persons before they develop complications and to identify, test, and treat their sex partners to prevent transmission and reinfections. The approach to STI diagnosis and management is based upon disease or symptom-specific syndromes, including vaginal discharge, urethral discharge, ulcerative genital disease, nonulcerative genital disease, and pelvic pain. However, many patients have asymptomatic disease, which increases the risk of complications and sustained transmission in the community.

Screening methods — Testing for sexually transmitted infections generally involves a blood test and/or self-collection of relevant body fluid specimens as discussed below:

Testing for the following involves a blood sample:

- **Testing for HIV:** is ideally performed with a combination antigen/antibody immunoassay, which requires a blood draw. At the point-of-care, other options for testing can be performed on oral secretions or finger stick samples.
- Syphilis — either a nontreponemal (VDRL) or treponemal test (TPHA)
- HBV — HBV surface antigen (HBsAg), surface antibody (HBsAb) and core antibody (HBcAb)
- HCV — HCV antibody

Testing for other STIs can be performed on relevant non-blood specimens:

- *N. gonorrhoeae* – nucleic acid amplification testing (NAAT) on urine (preferred for men) or vaginal swabs (preferred for women), urethral swabs, endocervical swabs, rectal and oropharyngeal swabs
- *C. trachomatis* – NAAT on urine (preferred for men) or vaginal swabs (preferred for women), urethral swabs, endocervical swabs, and rectal swabs
- *T. vaginalis* – NAAT on vaginal swabs (preferred) or urine
- Screening for HPV-associated disease is performed by cytology and/or HPV testing of cervical specimens or cytology of anal specimens.

The advent of urine-based tests and the utility of self-collected vaginal swabs has increased the acceptance of STI screening among patients and providers since it allows for routine specimen collection without a pelvic examination or swab of the urethra.

Point of care testing: A major barrier to sexually transmitted infections (STIs) control and prevention is the unavailability of reliable, low-cost, point-of-care tests (POCTs) which allow diagnosis and treatment in a single visit. Table 1.1 shows point of care testing options in various STIs.

Table 1.1: Overview of point-of-care Technologies for Selected Sexually Transmitted Infections

Pathogen	Specimen	POC Technologies			
		NAAT	Antigen	Antibody	Multiplex
HIV	Blood (fingerprick), oral swab	In development	Yes	Yes	Duplex antibody tests with syphilis
Syphilis	Blood (fingerprick)	NA	NA	Yes	
HCV	Blood (fingerprick) oral swab	NO	No	Yes	With HIV tests in development
Gonorrhoea	Urethral/ vaginal swab	In development	yes	NA	NAAT with chlamydia
Chlamydia	Urethral/ vaginal swab	In development	yes	NA	NAAT with gonorrhoea
Trichomonas	vaginal swab	NO	Yes	NA	NO
Bacterial vaginosis	vaginal swab	NO	Enzyme detection	NA	NO

(HCV, hepatitis C virus;), (NA, not applicable;), NAAT, nucleic acid amplification tests; (POC, point-of-care.)

1.2.6 Prevention

The basis for effective STI control – “Treatment is Prevention”.

For communicable diseases such as STIs, case identification and treatment is the most effective form of prevention in the absence of a vaccine. You shall follow the measures mentioned below:

- **Clinic-based symptomatic STI case management:** Effective case management assumes etiologic or syndromic diagnosis of STIs, choice and availability of effective drug therapies, education about compliance, counselling about STI risk reduction and provision of condoms with instructions on their correct use (WHO, 2006).
- **Partner management:** Because STIs are communicable diseases, sex partners must be treated to eliminate chance for re-infection of the index patient. Partner management also helps break the chain of STI transmission in the community (Centers for Disease Control and Prevention, 2006).
- **Asymptomatic screening:** Screening asymptomatic individuals (typically women) who are at high risk for certain STIs reduces the most serious STI-related consequences (e.g., syphilis screening among pregnant women to reduce adverse pregnancy outcomes, routine Pap smear screening to reduce cervical cancer) (Berman and Kamb, 2007).

- **Targeted STI control interventions:** Interventions focused on core groups (e.g., sex workers) or bridge populations (e.g., clients of sex workers, mobile men) prevent STI spread into the general population and reduce subsequent morbidity (WHO, 2006).
- **Vaccines:** Safe and effective vaccines against HBV and HPV, although not yet well implemented into basic public health programmes, hold the promise of eliminating a substantial proportion of the world's STI-related cancers and chronic diseases.

1.2.7 Management

The traditional method (and gold standard) for diagnosing a specific STI/RTI is by laboratory tests. But, tests for STIs are mostly not available at first-line health facilities and often not at district hospital level in low-resource settings. Some laboratory investigations for diagnosing STIs are expensive or demand advanced techniques. That is why WHO has recommended a syndromic approach to diagnosis and management of STIs in low- and middle-income countries since the 1990s.

Syndromic Approach:

The syndromic approach is a scientifically derived approach. The antimicrobial regimens are chosen to cover major pathogens responsible for the syndromes in a specific geographical area. STI case management using the syndromic approach is a feasible, adaptable, and cost effective approach (Table 1.2).

Table 1.2: Syndromic approach related to STIs/RTIs

Syndrome	Symptoms	Signs	Most common Causes
Vaginal discharge	Unusual vaginal discharge; vaginal itching; dysuria (pain of urination); dyspareunia (pain during sexual intercourse)	Abnormal vaginal discharge	<i>Vaginitis:</i> • Trichomoniasis (Fig. 1.1) • Bacterial vaginosis • Candidiasis <i>Cervicitis:</i> (Fig. 1.1) • Gonorrhoea • Chlamydia (Fig. 1.2)
Lower abdominal pain	Lower abdominal pain; dyspareunia (painful intercourse)	Vaginal discharge; lower abdominal tenderness or palpation; temperature >38°C	Gonorrhoea Chlamydia Mixed anaerobes
Genital ulcer	Genital sore	Genital ulcer	Syphilis Chancroid Genital herpes (Fig. 1.3)



Fig. 1.1: Trichomonas Vaginitis



Fig. 1.2: Chlamydial Cervicitis



Fig. 1.3: Herpes Simplex Genital Ulcer

Early diagnosis and effective treatment of STIs is an essential component of STI control programmes. Management is simplified by the use of clinical flowcharts and standardised prescriptions.(Table 1.3)

Table 1.3: Overview of Common Infections and Treatment (WHO guidelines 2005)

Vaginitis	Vaginitis: Bacterial vaginosis, Trichomoniasis	Metronidazole 2 g orally (single dose) or Metronidazole 500 mg orally twice a day for 7 days
	Candidiasis (yeast)	Miconazole 200 mg vaginal suppository, once a day for 3 days or Clotrimazole 100 mg vaginal tablets, 2 times a day for 3 days or Fluconazole 150 mg oral tablet (single dose) or Nystatin 100,000 units, vaginal tablets once a day for 14 days
Cervicitis	Gonorrhoea	Cefixime 400 mg orally (single dose) or Ceftriaxone 125 mg, by intramuscular injection or Spectinomycin 2 g by intramuscular injection
	Chlamydia	Azithromycin 1 g orally (single dose) or Doxycycline 100 mg orally twice a day for 7 days (Pregnant women: azithromycin 1 g orally (single dose) or erythromycin 500 mg 4 times a day for 7 days)
	Pelvic inflammatory disease (PID)	Treat for gonorrhoea and chlamydia (see above) plus for anaerobic infections with Metronidazole 500 mg orally twice a day for 7 days or Ampicillin 2 g by intravenous or intramuscular injection, then 1 g every 6 h plus Gentamicin 80 mg by intramuscular injection every 8 h plus Metronidazole 500 mg or 100 ml by intravenous infusion every 8 h
Genital ulcers	Syphilis	Benzathine penicillin G 2.4 million units intramuscular injection
	Genital herpes	Aciclovir 400 mg orally, 3 times a day for 7 days
	Chancroids	Ciprofloxacin 500 mg twice a day for 3 days or Azithromycin, 1 g orally (single dose) or Erythromycin 500 mg orally 4 times a day for 7 days (also if patient pregnant) or Ceftriaxone 250 mg intramuscular injection (single dose)
	Lymphogranuloma venereum (LGV)	Doxycycline 100 mg orally twice a day for 14 days or Erythromycin 500 mg 4 times a day for 14 days
	Granuloma venereum (donovanosis)	Azithromycin 1 g orally (single dose) or Doxycycline 100 mg orally twice a day
Infections following miscarriage, induced abortion or delivery	Septic abortion, post-partum endometritis	Ampicillin 2 g intravenously or intramuscularly, then 1 g every 6 h plus Gentamycin 80 mg intramuscularly every 8 h plus Metronidazole 500 mg orally or intravenously every 8 h

1.2.8 Human Immune Deficiency Virus (HIV)

HIV treatment: The two main goals of HIV treatment are to:

- prevent the virus from damaging the immune system
- halt or delay the progress of the infection

Antiretroviral (ARV) drugs are used for treating and preventing HIV infection. They stop or interfere with the reproduction of the virus in the body. ART does not cure HIV infection. It controls replication of the virus thereby strengthening an individual's immune system to fight off infections. These drugs must be taken at the right time every day. Incorrect or inconsistent therapy can mutate the virus causing resistance to treatment.

ART should be initiated among all adults with HIV regardless of WHO clinical stage and at any CD4 cell count (strong recommendation, moderate-quality evidence).

- As a priority, ART should be initiated among all adults with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and adults with CD4 count < 350 cells/mm³ (strong recommendation, moderate-quality evidence).

(WHO 2015 guidelines)

People with HIV need counselling and psychosocial support in addition to antiretroviral treatment. A high quality of life needs to be maintained with basic hygiene, adequate nutrition and safe water.

1.3 LET US SUM UP

The importance of STIs has been more widely recognised since the advent of the HIV/AIDS epidemic, and there is good evidence that their control can reduce HIV transmission. Although many cost effective tools such as condoms, effective drugs, and the syndromic approach to case management are already available for STI control, there is an urgent need for research into more interventions such as vaginal microbicides, vaccines, and behaviour change.

1.4 ACTIVITY

Mrs Deepika aged 35 years has reported to your clinic with complains of vaginal discharge and genital ulcer since 4 months.

- 1) Take history from the patient and do an examination of the patient.
- 2) What investigations should be done for the patient.
- 3) Discuss the treatment and management of the case.
- 4) Discuss what are the issues and concerns you would consider while counselling the patient.

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UNIT 2 INSERTION AND REMOVAL OF IUCDS

Structure

- 2.0 Introduction
- 2.1 Objectives
- 2.2 IUCD insertion
 - 2.2.1 Basic Information on IUCD
 - 2.2.2 Timing of IUCD Insertion
 - 2.2.3 Setting for IUCD Insertion
 - 2.2.4 Client Assessment
 - 2.2.5 Preparing for IUCD Insertion
 - 2.2.6 Equipments and Supplies Recommended for IUCD Insertion
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2.0 INTRODUCTION

By now, you have gained theoretical knowledge about various family planning methods including intrauterine contraceptive device (IUCD) in Unit 2 of Block 3. IUCD is one of the safe and long lasting modern contraceptive methods. It has evolved over time, from a simple plastic with loop design, copper wired to the latest hormone based IUCDs. These newer IUCDs are more effective, last longer and are safer than their predecessors. However, it is one of the most underutilised methods of safe and long lasting contraception. In India, it is used by only 2% of married women. One of the main reasons for this low usage is lack of expertise among the health care providers to insert IUCD.

This unit will focus on providing practical guidelines for insertion and removal of IUCD, assuming that the client has been counselled and she has selected IUCD as her choice of contraceptive method, and category 3 and category 4 conditions have been ruled out.

2.1 OBJECTIVES

On completing this unit, you should be able to:

- identify parts of an IUCD;
- list the settings and equipments and supplies needed for IUCD insertion;

- elaborate the steps of inserting an interval IUCD and postpartum IUCD; and
- explain how to manage the side effects and complications of IUCD.

2.2 IUCD INSERTION

Let us now learn, IUCD insertion in terms of time, setting, client assessment, preparation for IUCD insertion etc. as given below:

2.2.1 Basic Information on IUCD

The copper bearing intrauterine device (Cu IUCD) is a small flexible plastic frame, containing copper, which a specifically trained provider inserts into a women's uterus. IUCD provides very effective, safe and long-term, yet reversible protection from pregnancy.

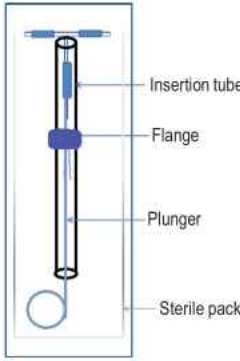
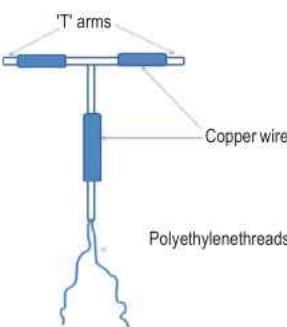
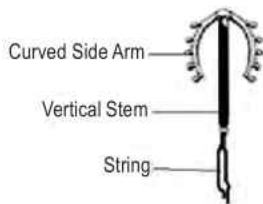
Currently there are two types of Cu IUCD available under the national programme -

- 1) Cu IUCD 380 A which is effective upto 10 years
- 2) Cu IUCD 375 which is effective upto 5 years

Mechanism of action: Copper bearing IUCDs (Cu IUCD 380 A and Cu IUCD 375) have same mechanism of action and act by :

- Preventing fertilisation as the copper ions decrease sperm motility and function by altering the uterine and tubal fluid environment, thus preventing sperms from reaching the fallopian tubes and fertilising the egg.
- Preventing implantation as it stimulates foreign body reaction in the endometrium that releases macrophages.

Table 2.1 : Comparative Features of Cu IUCD 380A and Cu IUCD 375

Feature	Cu IUCD 380A	Cu IUCD 375
 Fig. 2.1: IUCD inside the sterile cover	 Fig. 2.2: Cu T 380A	Fig. 2.5 Copper IUCD 375  Fig. 2.3: Copper IUCD 375
Shape	"T" shaped device	Inverted U shaped flexible arm
Material	Polyethylene impregnated with barium sulphate	Polyethylene impregnated with barium sulphate
Dimensions	3.6 cm long and 3.2 cm wide	3.5 cm long and 1.8 cm wide and 5 stubs on each side on the "U"

Copper bands/wire	Vertical stem and horizontal arms are wound with copper wire	Only vertical stem is wound with copper stem
Surface area of Copper	380 sq mm	375 sq mm
Material of strings	Thin polyethylene strings	Monofilament nylon threads
Colour of string	White	Flourescent green
Effectiveness duration	10 years from the day of insertion	5 years from the day of insertion
Content in sterile packet	Cu IUCD 380A Insertion Tube - clean tube to guide the loaded IUCD through the cervical os into the uterus. Cervical Guard/depth gauge on insertion tube – To set the appropriate measurement of the insertion tube corresponding to the length of the uterus and to ensure that the arms of the T unfold in the proper direction (horizontal plane) when they are released from the insertion tube. Measurement insert - It is used to set the blue length gauge to the appropriate measurement, obtained by sounding the uterus. Plunger rod - White rod, which is put inside the insertion tube containing loaded IUCD and the tip of the rod remains just below the IUCD. The rod is held stationary while the insertion tube is pulled back to release the IUCD into the uterus (withdrawal technique).	Cu IUCD 375 Insertion tube – Clear tube to guide the IUCD through the cervical os into the uterus. Cervical guard/ depth gauge on insertion tube – To set the appropriate measurement of the insertion tube corresponding to the length of uterus and to ensure that the IUCD is inserted as high in the fundus as possible without perforating the uterine wall. Measurement insert - It is used to set the blue length gauge to the appropriate measurement, obtained by sounding the uterus,

Contraceptive effectiveness – The IUCD is effective as soon as it is inserted. The IUCD is one of the most effective and long-lasting contraceptive methods.

Advantages of Cu IUCD

- Offers long term, highly effective reversible protection against pregnancy

- Is effective immediately after insertion
- Suitable for use by most women
- Can be used as an emergency contraceptive if inserted within five days of the first act of unprotected pregnancy
- It can be replaced, without any gap, as many times as she desires, during her reproductive life
- Does not require daily attention from the user or special attention before sexual intercourse
- Insertion is one time procedure and is cost effective
- Can be used by lactating women
- Does not interact with any medicines the client may be taking
- Fertility returns promptly on removal

Limitations

- Pelvic examination before IUCD insertion is mandatory which is not so for other spacing methods
- Requires a skilled provider for insertion and removal of the device
- Does not protect against STIs/RTIs/HIV
- Cannot be inserted in women with active RTI/STI

Side Effects

Side effects of IUCD may be unpleasant but are not harmful and in most women these subside or resolve within a few months after insertion. Some women may experience the following:

- Menstrual changes: There may be increase in the duration/amount of menstrual bleeding or spotting or light bleeding during the first few days or months after insertion. These usually subside with symptomatic treatment.
- Discomfort or cramps during insertion and for the next few days which subside in due course.

2.2.2 Time of IUCD Insertion

This is important enough to reiterate here despite being covered in theory, as timing is of essence in IUCD use. Clients should not be turned away due to lack of knowledge regarding when to insert an IUCD.

- 1) The best time for inserting IUCDs should be when one is sure that the woman is not pregnant and the cervical os is preferably, open. Therefore, within seven days of menstruation is the best time to insert IUCD.
- 2) IUCD can also be inserted in postpartum period, within the first 48 hours. At this time, the woman is motivated for contraception as well as the os will be open after delivery. However, after 48 hours, there will be higher chances of perforation and postpartum infection. Hence, if the window period of 48 hours is over, then one should wait for complete involution of uterus i.e. six weeks before insertion of IUCD.
- 3) Insertion can also be done till 5th day after unprotected intercourse, which will not only prevent present pregnancy but also provide continued protection.

- 4) It can also be inserted after first trimester medical termination of pregnancy.
- 5) After spontaneous/second trimester abortion, it can be inserted only if there is no infection present.
- 6) A woman in lactational amenorrhoea can also have an IUCD inserted provided its sure that she is not pregnant.

2.2.3 Setting for IUCD Insertion

Where can one insert IUCD? It can be inserted in a sub-centre, primary health centre, community health centre or hospital setting. Whatever the level of institution, space should be adequate and hygienic. It should be in an area, which is

- Clean and free of dust and insects
- Well lit and well ventilated but secluded enough for her privacy
- Equipped with a procedure table with washable surface
- Having tiled floor should for easy cleaning
- Provided with leak proof containers for segregating waste
- Having adequate supply of clean water and hand wash facility near by

2.2.4 Client Assessment

Before actual insertion of IUCD, detailed history has to be taken to rule out the presence of conditions that would caution or contraindicate its use. History should be detailed enough to rule out Category 3&4 conditions, which precludes nursing personnel and medical officers from inserting IUCD without specialist's help.

Important points in history to be taken from the client as given below:

- Parity
- LMP and Menstrual history
- Past history of ectopic pregnancy
- History of abortions
- Time since last childbirth
- History of/symptoms suggestive of STD/RTI
- History of/symptoms of anaemia
- History of LSCS
- Contraceptive history
- History of postpartum infections

Presence of Category 4 conditions should exclude insertion and categories 2 & 3 require referral to higher level for assessment and insertion by specialist.

Examination:

- General physical examination including pallor for anaemia
- Abdominal examination for tenderness, mass and size of uterus
- Local examination of external genitalia, per vaginum (PV) and per speculum (PS)

Nursing personnel should **NOT** insert IUCD and refer clients to higher level if these are the findings on examination.

- Per speculum examination reveals profuse and/or yellow discharge suggestive of infection
- Uterus feel large, irregular or immobile and cervix soft
- If movement of cervix is tender
- Presence of mass or tenderness in the adnexa
- If ulcers, thick or purulent discharge, polyp or other growths

2.2.5 Preparing for IUCD Insertion

The room for insertion should be clean and secluded for woman's privacy. Examination table should be clean and covered. Client can wear her own clothes. There is no need to change. Health care provider need not change but it is preferable for them to wear gown, mask and cap, though not essential.

There should be a sterile cloth to cover her pelvic area. Sterile gloves should be used by the staff. There should be an assistant to help so that asepsis can be maintained throughout the procedure, especially if Sim's speculum is being used, which needs to be pulled down for proper visualisation, unlike Cusco's which can be fixed in place.

2.2.6 Equipment and Supplies Recommended for IUCD Insertion

- 1) Examination table with clean cover
- 2) Linen/ cloth to cover the woman's pelvic area
- 3) Cheatle's forceps
- 4) Sponge holding forceps
- 5) Sim's/Cusco's speculum
- 6) Anterior vaginal wall retractor
- 7) Volsellum/Allis forcep
- 8) Uterine sound
- 9) Long Sharp cutting scissors (Preferably curved 7–8" long)
- 10) Long artery straight forceps (for IUCD removal)
- 11) Kidney tray
- 12) Stainless Steel (SS) tray with cover
- 13) Gloves (high-level disinfected surgical gloves or examination gloves)
- 14) Dry gauze or cotton swabs
- 15) Stainless Steel Bowls - 2
- 16) Antiseptic solution (chlorhexidine or povidone iodine)
- 17) Plastic bucket for decontamination
- 18) Clean sanitary pads

- 19) Autoclave/Steriliser/Boiler/Container with lid for boiling
- 20) Light source sufficient to visualise cervix (e.g., flashlight)
- 21) IUCD (in an unopened, undamaged, sterile package that is not beyond its expiry date and has been stored in a cool dry place.) as shown in Fig. 2.4.

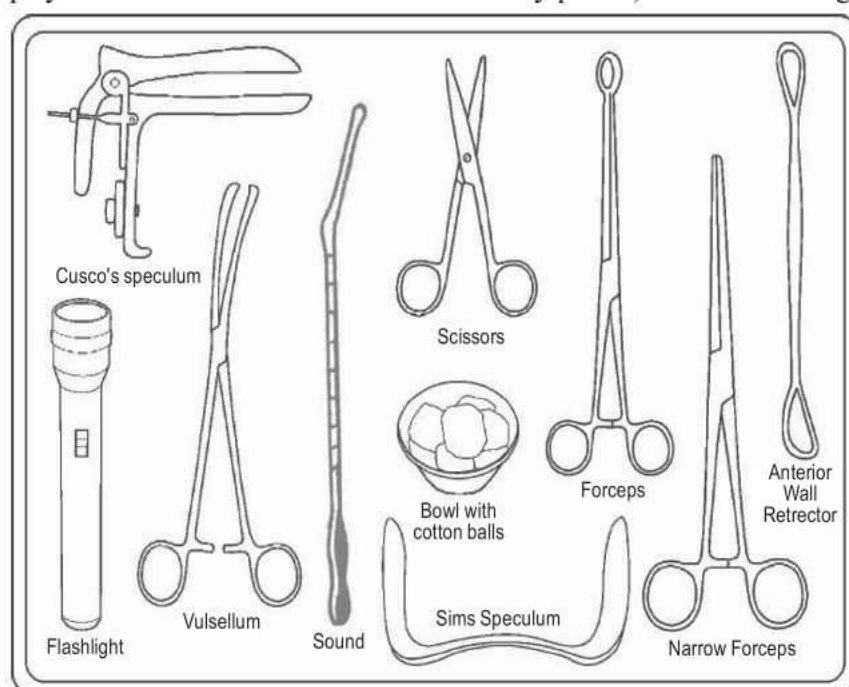


Fig. 2.4: Equipments required for IUCD insertion

For postpartum IUCD (PPIUCD) insertion, most of the instruments and supplies needed are same except for two things:

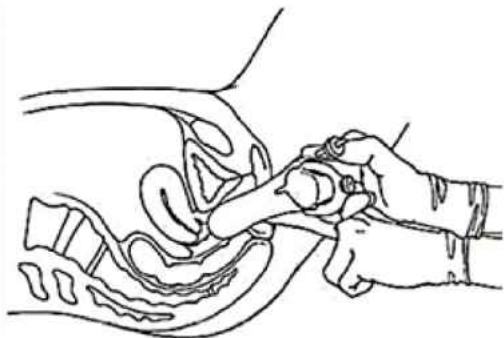
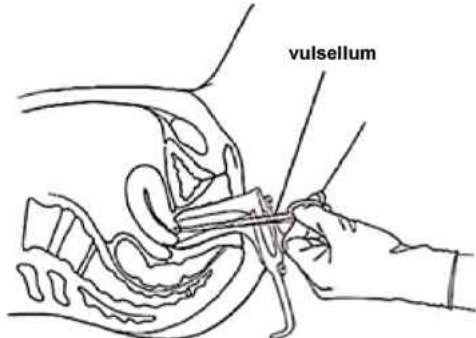
- Sponge holding forceps instead of vulsellum should be used to hold anterior lip of cervix. Cervix is soft and more vulnerable to trauma at this stage; hence, vulsellum should not be used.
- A special instrument i.e. PPIUCD insertion forceps is required for holding and inserting the device into the postpartum uterine cavity.

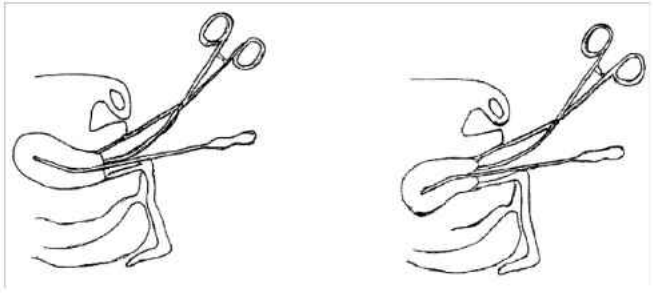
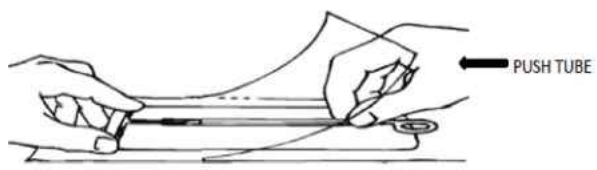
2.2.7 Technique of IUCD Insertion

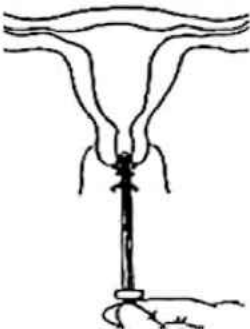
The safest and most commonly used technique is the “withdrawal” technique.

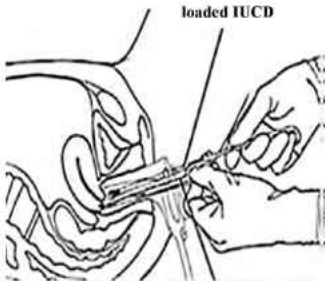
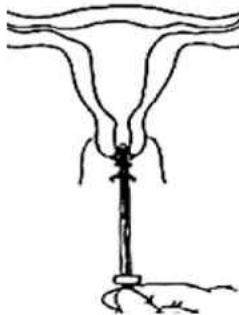
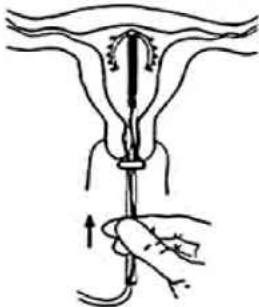
Steps for IUCD Insertion:

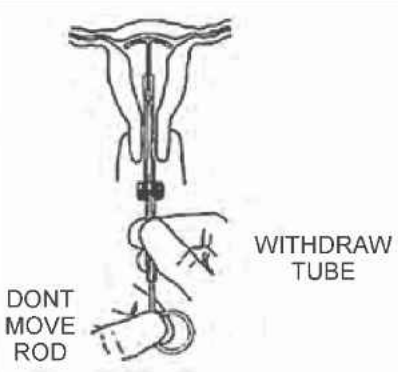
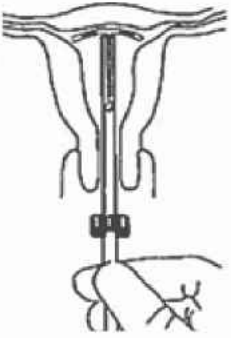
Step 1: Prepare the client	• Give the woman a brief overview of the procedure, encourage her to ask questions, and provide reassurance as needed. • Remind her to let you know if she feels any pain. • Confirm that the woman has undergone appropriate counselling and assessment to ensure she is eligible for IUCD insertion at this time.
Step 2: Insert a sterile speculum to visualise the cervix	Keeping the already inserted high-level disinfected (or sterile) speculum in the vagina to visualise the cervix. If cervix bleeds easily on touch or purulent vaginal discharge is seen or any other abnormal signs found the IUCD should not be inserted.

	
Step 3: Clean the cervix and vagina with an appropriate antiseptic	Thoroughly apply an appropriate antiseptic (e.g., povidone iodine or chlohexidine) two or more times to the cervix and vagina starting with the cervical os. • If povidone iodine is used, ensure that the woman is not allergic to iodine and wait 2 minutes for the solution to act.
Step 4: Grasp the anterior lip of cervix with HLD/sterile volsellum and apply gentle traction	Gently grasp the anterior lip of cervix with the high-level disinfected/sterile volsellum and apply gentle traction (i.e., pull gently) • This will help straighten the cervical canal for easier insertion of the IUCD • Close the volsellum only to the first notch to minimise discomfort 
Step 5: Insert the Sterile sound to measure the length of uterus	While maintaining gentle traction on the volsellum, carefully insert the tip of the sound into the cervical os. Hold the sound between the finger and thumb • The curve of the sound facing upward in case of anteverted uterus • The curve of the sound facing backwards in case of retroverted uterus • Be careful not to touch walls of vagina or the speculum blades with the tip of the sound
Step 6: Advance the sound into the uterine cavity, and STOP when a slight resistance is felt	Gently advance the sound carefully and gently into the uterine cavity at the appropriate angle (based on your assessment of the position of the uterus during bimanual examination). Continue to pull steadily downward and outward on the volsellum, which should enable the sound to pass through the os more easily

	• If any resistance is felt at the level of the internal os, use a smaller sound, if available. • Do not attempt to dilate the cervix. • If the woman begins to show signs of fainting, STOP advancing the sound into the uterine cavity. • When you feel a slight resistance, STOP advancing the sound into the uterine cavity. (A slight resistance indicates that the tip of the sound has reached the fundus). • Do not use force at any stage of this procedure. • If a sudden loss of resistance is felt, the uterine length is greater than expected, or the woman is experiencing unexplained pain, STOP advancing the sound into the uterine cavity. 
Step 7: Determine the angle/direction of the uterine cavity	Determine the angle /direction of the uterine cavity and also rule out any obstruction in the cervical canal. • Gently remove the sound • Do not pass the sound into the uterus more than once
Step 8: Determine the length of the uterus	• Determine the length of the uterus by noting the level of mucous or wetness on the sound. • The average uterus is between 6 and 8 cm in length. • If the uterus is less than 6.5 cm in length, the woman may be at increased risk for IUCD expulsion.
Step 9: Loading the IUCD in its Sterile Package	Loading required in Cu IUCD 380 A 1) Loading should be done using 'no touch' technique. a) Ask the assistant to open the lower end of the sterile pack. b) Fold the limbs of the 'T' from outside the pack and insert them into the insertion tube, without touching them.  c) Insert the plunger into the insertion tube from the other end, careful not to push the limbs of the T out of the insertion tube.

	 d) Slide the flange/guard around the insertion tube according to length of uterus as measured by the uterine sound. Normally uterus length is between 6-8 cms. If uterus is <6.5 cms, there is higher chance of expulsion. Care should be taken that the limbs of the 'T' and the flange are both horizontal. This facilitates proper placement inside the uterus. While loading, one should be careful not to bend the arms of the T inside the insertion tube for more than 5 minutes. Loading not required in Cu IUCD 375. In case of Cu IUCD 375, there is no plunger. Only the length of the gauge has to be set.	
Step 10: Keep the client comfortable	Keep communicating with the client to keep her comfortable	
Step 11: Apply gentle traction on the cervix with the vulsellum	• Hold the loaded IUCD with one hand so that the blue length-gauge is in the horizontal position. • Grasping the vulsellum (still in place after sounding the uterus) with the other hand and gently pull outwards and downward. (This will help straighten the cervical canal for easier insertion of the IUCD). 	
Step 12: Insert the loaded IUCD Cu IUCD 380 A	Cu T 380A • Carefully insert the loaded IUCD into the vaginal canal • Gently push it through the cervical os and into the uterine cavity at the appropriate angle	Cu IUCD 375 • Carefully insert the already loaded IUCD (holding the string and the inserter tube) into the vaginal canal, • Gently push it through the cervical os into the

	(based on your assessment of the position of the uterus when sounding the uterus). Be careful not to touch the walls of the vagina or the speculum blades with the tip of the loaded IUCD. 	uterine cavity at the appropriate angle (based on your assessment of the position of the uterus when sounding the uterus). - Be careful not to touch the walls of the vagina or the speculum blades with the tip of the Cu IUCD 375. - During insertion, the flexible arms of the IUCD will fold inward, accommodating the shape of the cervical canal. 
Step 13: Gently advance the loaded IUCD into the uterine cavity	Gently advance the loaded IUCD into the uterine cavity - STOP when the blue length-gauge comes in contact with the cervix or - Gently advance the device into the uterine cavity. - STOP when the cervical guard comes in contact with the cervix or slight resistance is felt. - Be sure that the cervical guard is still in the horizontal position. - Do not pass the device into the uterus more than once 	
Step 14: Release of IUCD arms in the uterine cavity	While holding the vulsellum and plunger rod stationary, withdraw the insertion tube downwards (with your free hand) until it touches the circular thumb grip of the white plunger rod. This will release the IUCD arms in the woman's uterus. This is the withdrawal technique to minimize perforation.	

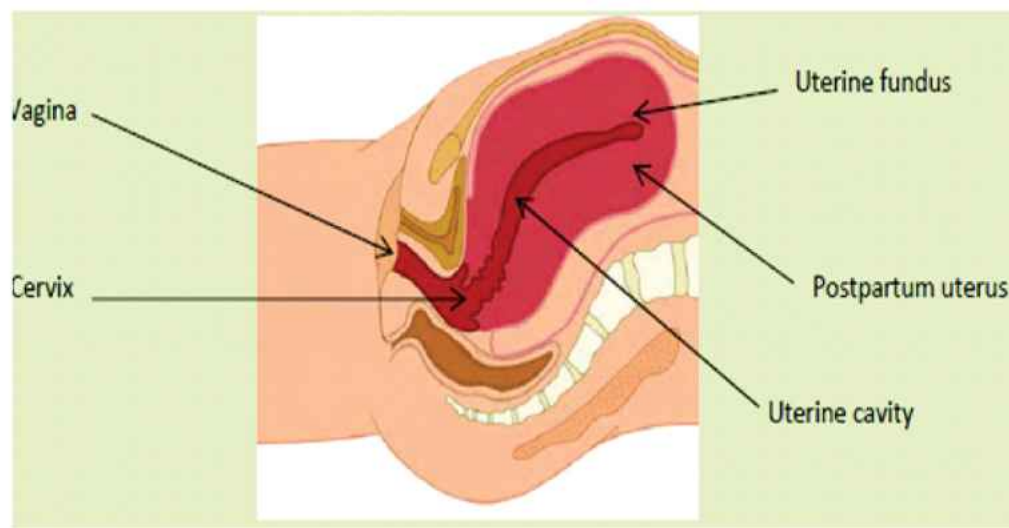
	 • Remove the white plunger rod, while holding the insertion tube stationary. • The plunger should be removed before the insertion tube is pulled out, otherwise the threads may be caught between the tube and the plunger resulting in downward displacement or expulsion of the IUCD from the uterus. • The arms spring back into shape once it passes through the os in to the uterine cavity.
Step 15: Ensure that the arms of the T are as big has possible in the uterus	• Gently push insertion tube once the plunger rod has been removed. • Very gently and carefully push the insertion tube upward again, toward the fundus of the uterus, until you feel a slight resistance. 
Step16: Removal of the insertion tube	Continuing to hold and apply gentle downward traction to the vulsellum • Remove the insertion tube from the cervical canal • Continuing to hold and apply gentle downward traction to the vulsellum • Remove the insertion tube from the cervical canal • Do not pass the Cu IUCD 375 into the uterus more than once
Step 17: Use high level disinfected (or sterile) sharp scissors to cut the IUCD strings at 3 to 4 cm of length	Partially withdraw the insertion tube from the cervical canal until the strings can be seen extending from the cervical os • Use sharp scissors to cut the strings at 3 to 4 cm from the cervical opening
Step 18: Removal of the volsellum	Gently remove the volsellum with open ends and place it in 0.5% chlorine solution for 10 minutes for decontamination

Step 19: Examine the woman's cervix for bleeding	If there is bleeding where the cervix was being held by the vulsellum, • Use high-level disinfected /sterile forceps to place a cotton (or gauze) swab on the affected tissue • Apply gentle pressure for 30 to 60 seconds and ensure that the cotton is removed after the bleeding stops
Step 20: Removal	Gently remove the speculum
Step 21: Allow the woman to rest	Advise the woman to remain on the examination table for 5-10 minutes since occasionally a fainting spell may occur on getting down from the table immediately after insertion. Begin performing the post-insertion steps while she is resting.

2.3 POSTPARTUM IUCD INSERTION (PPIUCD)

Postpartum IUCD insertion is different than inserting other times. Uterus is large in size, soft, and vascular. Uterine walls are thicker, fundus is high in the abdomen and axis of uterus is almost perpendicular to vaginal canal. Cervix is wide and softer. Due to the changed contour of uterus, IUCD placing becomes difficult and it may be placed in the lower uterine section, rather than near the fundus. Common pitfall is mistaking posterior wall of uterus for fundus and depositing the device at that place, from where it will be easily expelled.

Important: PPIUCD insertion should take place within 48 hours after delivery. Should this period be crossed, one should wait for complete involution i.e. 6 weeks before attempting to insert IUCD in such women.



PPIUCD insertion should be preceded by proper

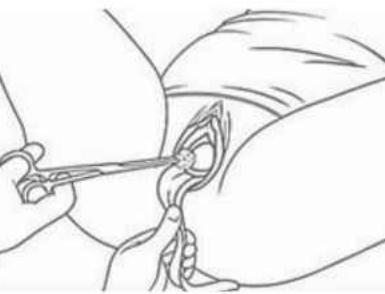
- History to rule out conditions that will preclude its use
- There should be no evidence of postpartum haemorrhage, chorioamnionitis or premature rupture of membranes.
- Proper consent from women
- Reassurance about any apprehensions

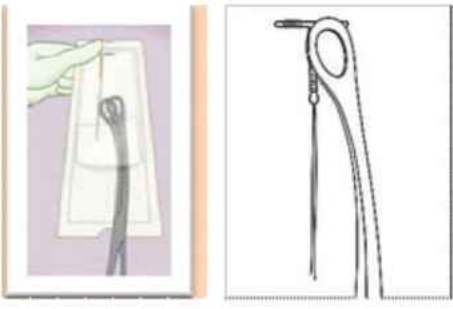
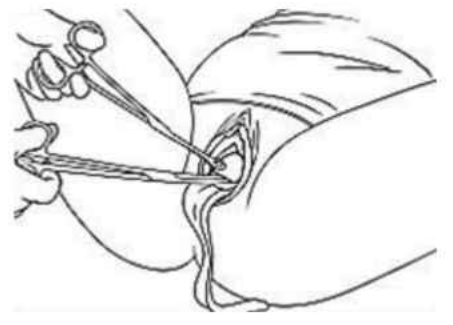
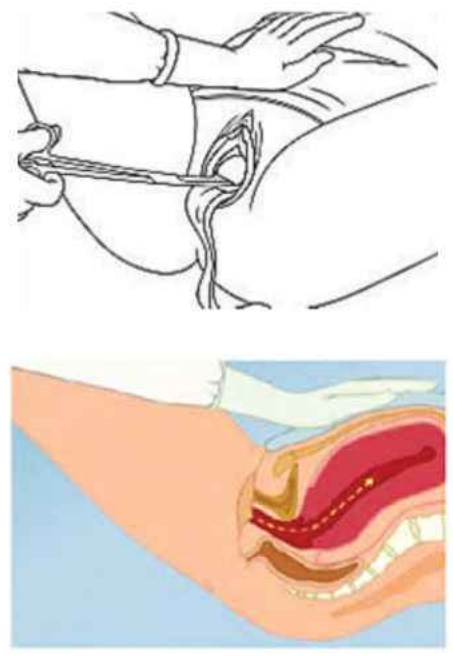
2.3.1 Technique for PPIUCD

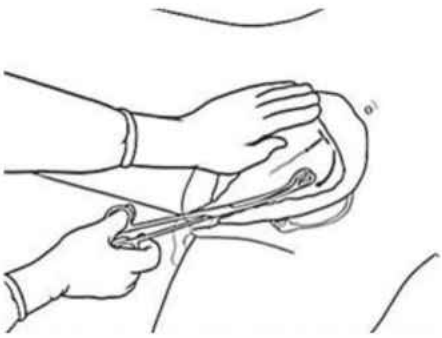
If insertion is done within 10 minutes after placenta expulsion (post placental), then she should not be moved from the labour table. All the required instruments and supplies should be made available there itself. Staff should change and wear sterile gloves for the procedure.

If it is done later in the next 48 hours, preceding conditions like PPH and infections should be ruled out, hygiene has to be observed and she should empty her bladder. Technique of insertion is like in post placental insertion. Place for insertion is same as given under sub-sedron 2.2.3 and instruments and supplies same as post placental insertion.

Steps of PPIUCD insertion:

1. Reassure the woman and explain to her the procedure.	
2. Drape her with sterile towel, clean the genital area as described before.	
3. Inspect the perineum for lacerations. If there is no heavy bleeding in them, one should proceed with the insertion.	
4. Insert Sim's speculum and visualise the vaginal walls and cervix for lacerations. If there is no heavy bleeding from these lacerations, one should proceed for insertion.	
5. Use a sponge holding forceps with sterile gauze dipped in povidone iodine or chlorhexidine to clean the cervix and surrounding area, at least twice. Wait for two minutes for it to act.	
6. Use the same sponge holding forceps or another sterile one to hold anterior lip of cervix	

7. Grasp the sterile IUCD with the PPIUCD insertions forceps following the “no touch” technique. It should be held just at the tip of the forceps so that when it is released, it is placed against the fundus and not midway into the uterine cavity.	
8. With a gentle traction on the anterior lip of cervix, insert PPIUCD and advanced till the lower uterine cavity.	
9. Once the PPIUCD is in the lower uterine cavity, release the anterior lip of cervix place left hand on the sterile towel on the woman’s abdomen and push uterus superiorly (upward) to straighten the angle of the uterus. This will aid in advancing the device to its proper place at the fundus.	
10. With the uterus straightened, move the PPIUCD further into the uterine cavity till a resistance is felt, which will be the fundus. This will also be felt by the hand over the abdomen, which will further confirm that the device has reached its correct place. Release the device. The PPIUCD inserter forceps should always be closed to avoid dropping the device in the lower part of the uterine cavity, from where it will be expelled easily.	

11. With the insertion forceps open, sweep it to one side of the uterine wall and keeping it open throughout, withdraw it from the uterus. While doing this, uterus should be stabilised with left hand till the forceps is out. If the forceps is placed centrally or at any time it is closed, it might drag the device lower down or even pullout if thread is caught between the closed forceps, hence the necessity to move it to the side wall and to keep it open.	
12. If IUCD is seen protruding from the cervix or if the thread is too long, it means that the device is not properly placed. It should be taken out and replaced again.	

2.3.2 Post-insertion Care and Advice

- 1) Do not let her get up immediately after the procedure. Let her sit for 5–10 minutes to avoid fainting spells that occur sometimes.
- 2) Tell her again about the mild pain and bleeding problems, which will last for few months and subside of its own. Give her mild analgesics and anti-spasmodics.
- 3) She should be advised to come for follow up visit after her first menstrual period after placing IUCD, then at 3 and 6 months. However, after post placental insertion, visits should be as per requirement of postpartum care.
- 4) She should check the thread after menstrual bleeding as there is chance that it would have been expelled during menstrual bleeding.

2.3.3 Potential Problems after IUCD Insertion and their Management

- 1) **Mild pain:** This can be controlled by analgesics like NSAIDs given for a few days. Pain should subside after that.
- 2) **Mild menstrual irregularity:** There is nothing to be done as it will stabilise in a few months. However, if her haemoglobin level is compromised, she should receive iron tablets till few months after her haemoglobin returns to normal.
- 3) **Displacement of IUCD is another** problem, which may become evident if its visible at the cervix, or the thread is too long. Under such circumstance, it has to be taken out and reinserted, maintaining full aseptic precautions. If the device gets contaminated before re-insertion then use a new one.

2.3.4 Complications of IUCD and Red Flags for Referral

Complications-

- 1) Infection: IUCDs can be a source of infection if proper asepsis is not maintained during insertion or if the woman already has an infection and IUCD is inserted without first treating it; in which case infection will be introduced further into the uterus. They require adequate investigation and treatment with antibiotic. However, there is no need to give antibiotic cover for every woman who has IUCD inserted.
- 2) Rarely, IUCD may penetrate the uterine wall and either lie embedded in the uterine musculature or migrate to the abdominal cavity; with or without signs of irritation. If perforation is suspected, it needs referral for finding its site and removal.
- 3) Although, not strictly a complication of IUCD, but at times, women may conceive with IUCD still inside the uterus. If thread is visible, it should be taken out. If not visible and not expelled, refer them for further management, which needs gynaecologist's expertise.

Red flags-

- 1) Severe abdominal pain and tenderness with/without vomiting and/or dizziness and low BP.
- 2) Severe bleeding is also a sign that it might have caused trauma and needs referral.

Start such patients on IV fluids and refer to higher facility.

2.3.5 Technique of IUCD Removal

IUCD removal should be done after its period of action is over and change is required or if and when the woman wants to conceive again or if she attains menopause. If she is getting removed because the time duration over and she needs further protection and willing, a new one can be inserted at the same sitting.

Steps in removing an IUCD

- 1) Let the woman empty her bladder and lie down in supine position as was done for insertion of IUCD and clean the area.
- 2) Insert the speculum and examine the vagina and cervix. Clean the cervix and vaginal walls with povidone iodine or chlorhexidine.
- 3) Look for threads that will be coming out of the cervix.
- 4) Insert the straight artery forceps or alligator forceps, hold the nylon threads and gently pull the threads to remove the IUCD. It should be pulled out with gentle traction. Too much force should not be used. If it gets difficult to remove, it is better to refer than use force.

The client has to be counselled that she may have cramps and slight bleeding and its normal. She should not worry. She may be given mild analgesics.

*IUCD should not be removed if there is evidence of infection in the vagina or cervix as there is danger of introducing the infection into the uterine cavity during manipulation.

Common Myths & Misconceptions regarding IUD	
Myth	Fact
An IUD that is discolored in the package is aneorous and can not be used	Tha copped on IUDs some time changes the color in the package as it react to air. The IUDs can still be used safely, as long as it is within the expiary data, and the package is not damaged or open.
IUDs/IUS cause infections	The risk of the infection among IUS/ IUDs useres is very low. The main cause of infection is related to poor infection prevention duing the insertion process.
IUDs/ IUS makes the client infertile	A client fertility returns to normal very soon after the device is removed. Studies have shown that most clietns who discontinue the IUDS/ IUS become pregnant as rapidly as those who have never used contraceptions
If a client with an IUD/IUS becomes pregnant it gets embedded in the babies forehead.	The babies very well procted by sac filled with amniotic fluid inside the womb. If a clietn gets pregnant with an IUD/IUS in place, the provider will remove the device immediately due to the risk of infection. If for some reason the IUD/IUS is left in place during the pregnancy, it is usually expelled with placenta or with the baby at birth.
Antibiotics should be routinely given before IUD/IUS insertion	Routine Antibiotics are not needed for IUD / IUS insertion except for: 1. Clients found to be infected with group A streptococcus in the vagina. They should be treated and IUD/IUS insertion delayed. 2. Clients with syptoms or signs suggestive pf STI should be treated or reffred an asked to return for IUD/IUS insertion after the infection has treated. 3. Clients at risk of STI e.g. those with a partner who has STI symptoms should be screened and treated before insertion if necessary.

2.4 LET US SUM UP

IUCD is a safe and long lasting method of contraception, which is underutilised in India, one of the main reasons being lack of expertise among health care providers to insert IUCD. This unit intends to provide the health functionary with relevant information and step by step approach on how to insert and remove IUCD; starting from how the area should be, who should not receive, what instruments are required and how the insertion should be carried out.

2.5 ACTIVITY

Select eligible client for CuT insertion, perform assessment and examination before the procedure, document the finding of assessment.

- Prepare articles required for insertion of CuT.
- Explain the procedure and counsel the mother for accepting the device.
- Insert CuT as per the technique listed.
- Give need based advice to the client.

2.6 REFERENCES

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Acknowledgement

Declaration:

Most of the specific steps in inserting IUCDs have been taken directly from the reference manual, in order to stick to standard guidelines.

UNIT 3 MANAGEMENT OF ABORTION & COUNSELLING

Structure

- 3.0 Introduction**
- 3.1 Objectives**
- 3.2 Counselling**
- 3.3 Methods of Abortion**
 - 3.3.1 Medical Methods of Abortion
 - 3.3.2 Surgical Methods of Abortion
- 3.4 Role of CHO in abortion Procedure**
- 3.5 Post Abortion Care**
 - 3.5.1 Immediately after the abortion procedure
 - 3.5.2 Post Abortion Contraception
- 3.6 Assessment of Abortion Complications**
- 3.7 Key Message**
- 3.8 References**

3.0 INTRODUCTION

Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Family planning is one of the most successful public health intervention in this regard. However, women facing unintended pregnancy needs to be managed by appropriate safe procedure. Abortion is a very safe procedure when properly performed by trained health personnel. Hence, to ensure reduced maternal morbidity and mortality, access to safe abortion services is pertinent to women's health. With this background the present unit discusses all the important issues regarding management of abortion (particularly medical abortion) necessary for health workers to learn.

Abortion is an important challenge to women's health. Although abortion services in India were legalized in 1971, safe services are still hard to find for many women. To address this, safe abortion care is now a vital part of maternal and child health programmes in the country.

Role of CHO to Help Women get Safe Abortion Services

- Provide respectful, private and confidential counseling & referral
- Provide complete and correct information on safe abortion to women including young women, families and other community members
- Provide guidance and support to those who need abortion and post-abortion care
- Provide counselling on a range of choices for abortion procedures, emergency and regular contraceptive services
- Be sensitive, understanding and responsive to the circumstances of the women
- Be considerate towards special situations of young women and

adolescents

- Maintain referral records and report regularly
- Make women aware of their rights in terms of abortions and the quality of care for services
- Motivate women to seek, demand and utilize available safe services
- Dispel taboos/myths and misconceptions associated with abortions
- Highlight positive efforts and good practice stories
- Generate awareness and sensitivity on abortion care services
- Orient ASHA's and field functionaries on safe abortion services

3.1 OBJECTIVES

After completing this unit, learner will be able to:

- Provide information regarding abortion;
- Provide information about abortion method;
- Know important components of post abortion care; and
- Provide information & counsel women for post abortion contraception.

3.2 COUNSELLING

Let us discuss about pre-abortion information and counselling related details:

As a health worker, it is necessary for you to provide adequate information regarding various abortion procedures. This aids women in making decision regarding which option to choose. Following information must be provided to all women considering abortion:

- Abortion methods and pain management options available that she can choose from.
- Complete description of abortion process including investigations to be done.
- Description about what she is going to experience (e.g. pain and bleeding) and how long the process is likely to take.
- How to recognise potential complication and how and where to seek help, if required.
- Follow up care including use of contraception for future prevention of unintended pregnancy.

Counselling

When providing counselling, remember to follow:

- GATHER Approach-Greet, Ask, Tell, Help, Explain, and Return
- Use simple language for communication
- Maintain privacy
- Support and ensure adequate response to the questions and needs of the woman
- Avoid imposing personal values and beliefs

Decision Making

In case women chooses to have an abortion, she should be allowed to choose

among available methods that are appropriate, based on the duration of pregnancy and her medical condition.

Counselling is an important element in providing quality abortion care services. It is a two-way communication between a healthcare worker and a woman seeking care, for the purpose of confirming or helping a decision by the woman to address her problems or concerns.

Abortion is a sensitive issue and when a woman comes for abortion she is likely to be under physical as well as mental stress. Therefore, effective counselling is necessary to address both these aspects while providing services.

Qualities of a Good Counsellor

The qualities of a good abortion care counsellor include the following:

- Warm and respectful
- Good listener
- Knowledgeable
- Non-judgmental
- Sensitive to cultural and psychological issues
- Compassionate to all women regardless of their reproductive behavior and decisions
- Encourages women to ask questions and summarizes information in simple and non-technical language
- Always maintains confidentiality and privacy

Essential Elements of Counselling

To make communication effective between the healthcare provider and the woman, it is important to understand the essential elements of counselling:

- Active listening
- Verbal communication
- Non-verbal communication

A. Appropriate Place for Counselling

An appropriate place for counselling should have the following pre-requisites:

- Private
- No one else can hear or see
- Accessible
- Comfortable to the woman
- Clean and well kept

The aim is to create a safe, confidential and comfortable space for the session.

B. Pre-procedure Counselling

It focuses on providing general information to the woman and helps her clear any doubts and thoughts about terminating pregnancy. She should be provided the following information:

- An early abortion is safe
- Abortion is legal up to 20 weeks of gestation under certain indications and this limit has been increased upto 24 weeks of special category of women. Termination is allowed anytime during the pregnancy in cases of substantial foetal malformation after the permission of Medical Board

- It is available in government health facilities and therefore she should not approach an unqualified abortion provider or providers at unapproved private sites, which can pose risk to her health
- At the end of the counselling session, she should be in a position to select the method for termination, give informed consent and take a decision on accepting a contraceptive method
- She should also be informed that she can become pregnant as soon as she resumes sexual activity after an abortion

C. Post-procedure Counselling

Key messages to be included in the post-procedure counselling are:

i. Self Care

- Rest for a few days
- Change sanitary pads every four to six hours
- Do not have sexual intercourse until the bleeding stops

ii. Danger Signs and Symptoms

If the woman has any of the following symptoms she needs to go to the health centre immediately and **SHOULD NOT** wait:

- Increased bleeding or continued heavy bleeding
- Fever, feeling ill
- Dizziness or fainting
- Abdominal pain
- Foul-smelling vaginal discharge
- Next periods are not resumed even upto 6 weeks after the abortion

iii. Referral for Other Reproductive Health Aspects, if Required Counsel woman/spouse/relatives, in case of referral to higher facility, on:

- Reasons for referral
- Which facility (referral site) she has to be taken to
- What procedure will be done there and by whom

Note: The woman should be given a referral slip and the referral should be recorded at the facility.

D. Counselling During the Follow-up Visit

- Ask the woman if she has any questions to discuss about her health or condition, or if there is any problem
- Check if she is using the contraceptive method correctly
- Address problems or side effects related to the contraceptive method or treatment

Contraceptive Counselling

The use of a contraceptive method is effective only when the user feels comfortable with the choice, has enough information on how to use the method and is aware that she could change or switch to another method if not satisfied.

Some of the elements of effective contraceptive counselling include:

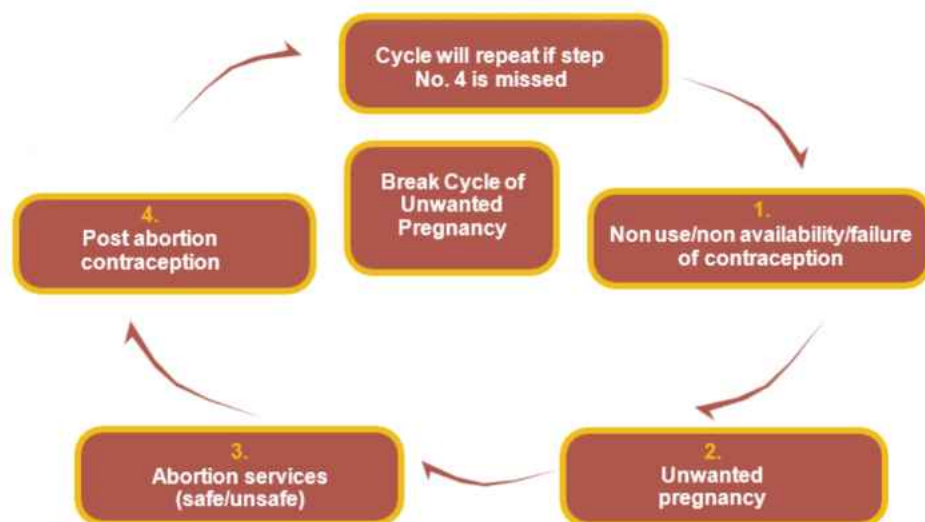
- **Assess individual situation:** Consider both, the woman's clinical condition and personal situation and discuss the use of contraception in a sensitive manner

- **Availability of contraceptive methods:** It is important to determine which contraceptive methods are available and accessible to a woman, both at the facility and within her community
- **Use of the methods; effectiveness; side effects:** Explain the characteristics, use (how it works), side effects and effectiveness of the available methods
- **Support the selected method:** Support the woman in selecting the contraceptive method that suits her and her partner's situation the best. It is important to help the woman make her own, informed choice

Post-abortion contraception should not be forced, as it can have a negative impact on the woman. In case of any pressure, a feeling of dislike about using the method may lead to a higher rate of discontinuation, resulting in more unwanted pregnancies, abortions and maternal deaths. Women may avoid coming to the healthcare system. They may not receive the much-needed services for contraception and safe abortions.

Importance of Contraceptive Counselling

Providing contraceptive counselling and services as a part of abortion care can improve contraceptive acceptance. It helps to break the cycle of repeated unwanted pregnancies and their consequences, as shown in the diagram below.



Role of the CHO in Counselling for Abortion and Post-abortion Care

- Be polite, understanding, sensitive, maintain privacy and confidentiality
- Inform her that, if needed, early abortions are safer; counsel her to utilize the services of trained providers at approved centres
- Give her a list of the approved centres providing safe abortions
- Counsel her on the methods of abortion
- Explain procedures, address anxieties/fears or concerns patiently
- Warn her of the dangers of unsafe abortions by untrained providers or in unhygienic settings
- Tell her about the early return of fertility after abortion, which may be as early as 10 days, even before the next period
- Counsel for post-abortion contraception, also inform her that abortion is not a method of family planning, hence she should adopt a reliable family

planning method post-abortion to prevent unwanted pregnancy and repeated abortions

- During and after the abortion, the staff nurse can provide emotional support and information on warning signs, where to go for care, preparation for transportation and post-abortion contraception
- Provide information and support during follow-up care
- They are autoclavable and reusable plastic cannulae

3.3 METHODS OF ABORTION

Let us now go through medical and surgical methods of abortion in detail as :

3.3.1 Medical Methods of Abortion

It is a type of non-surgical abortions in which drugs are used to induce abortion upto 9 weeks

It is safe procedure with high percentage of success rate. It offers privacy and anaesthesia and instruments are not required. It takes 8-13 days for the abortion process to get completed. Detailed history taking, physically pelvic examination and laboratory investigations are done by the provider for clinical assessment before prescribing MMA, a combination of drugs is used for MMA and is available at government facilities providing MTP services.

3.3.2 Surgical Methods of Abortion

Surgical abortion Up to 12 weeks is conducted by Vacuum Aspiration (which can be electric or manual)

Different methods of abortion are described in this section. A comparison of the various methods in terms of clinical safety and effectiveness, cost and acceptability to women has also been done.

Overview of the Different Methods

A. Manual Vacuum Aspiration (MVA)

- MVA is safe and effective
- It does not require electricity, can be used in rural settings with intermittent electric supply
- It can be reused after proper processing of the instrument so the cost per procedure is relatively low
- It is a better accepted method for many women due to reduced waiting time and increased local availability of safe care
- Women like it as it creates little noise during the procedure
- Both have low complication rates

B. Electric Vacuum Aspiration (EVA)

- EVA uses an electric pump or suction machine attached to a cannula to evacuate the uterine contents
- Since the initial cost of an EVA machine is high, it is typically used in centralised settings with high caseloads
- EVA is less appropriate for settings with intermittent electric supply

Comparison between MVA and EVA

a) Similarities

- Both have high levels of safety and effectiveness

b) Differences

- No electricity required in MVA. The vacuum is created manually in MVA and by electricity in EVA
- MVA is convenient for health centres where supply of electricity is not regular
- Being small in size, MVA is easier to handle than EVA
- No noise of machine during MVA as compared to EVA
- MVA is more cost-effective per procedure

3.4 ROLE OF THE CHO IN THE ABORTION PROCEDURE

- Inform the woman about the available and safe methods for the termination of pregnancy
- Refer the woman, including young women, to an appropriate health centre for abortion services
- Accompany the woman or request an Accredited Social Health Activist (ASHA) to accompany her to the nearest centre for services, if possible

3.5 POST ABORTION FAMILY PLANNING (PAFP)

Let us now discuss the post abortion care and follow up of complications given below:

3.5.1 Immediately after the abortion procedure

- Sexual intercourse, should be avoided till stoppage of vaginal bleeding.
- Vaginal bleeding for 2 weeks after completed surgical or medical abortion is normal. Women experience light bleeding or spotting following surgical abortion, heavier bleeding occurs with medical abortion and can generally last for 8-13 days.
- Woman should report back to the health facility in case she experiences:
 - Heavy bleeding
 - Increase intensity of cramping abdominal pain
 - Fever
- Woman should be told about her risk of becoming pregnant before her next menses due to return of fertility within 10 days of abortion.
- Contraceptive information and counselling
- Provide IFA tablets, sanitary napkins and pain medications if needed.
- Refer to other services as determined by assessment of her needs, such as STI/HIV counselling and testing, abuse support services, psychological or social services, or other physician specialists.

3.5.2 Post Abortion Contraception

There is quick return of fertility after abortion, even before the next menstrual period. A woman can ovulate as early as 10 days after an abortion and can conceive before resuming next periods. Hence, it is important that the couple uses reliable method of contraception soon after abortion, to avoid a future unwanted pregnancy.

Contraceptive use could prevent 90% of maternal mortality associated with unsafe abortions. World Health Organization (WHO) recommends spacing of at least 6 months between abortion and the next pregnancy. It reduces the chances of pregnancy related complications like low birth weight, premature birth and maternal anemia in the next.

Immediate post abortion period, when woman is still at facility or in contact with health care provider, is the opportune time to provide postabortion contraceptive counseling and services.

Eligibility for Contraceptive Methods

In general, all modern contraceptive methods can be used immediately following an abortion. After an abortion, when providing contraception to a woman, her eligibility for each method must be considered.

Ensure:

- There are no severe complications requiring further treatment
- The woman receives adequate counseling and gives informed consent
- Woman is screened for her eligibility for a particular contraceptive method

Contraceptive Methods Available

Contraceptive Methods Available Temporary/Spacing methods:

- Barrier methods such as condoms 
- Hormonal methods such as oral contraceptive pill, Injections, Implants 
- Non-hormonal pills - Centchroman 
- Intrauterine Contraceptive Devices (IUCD-380A, 375) 

Injectables, IUCD and Implant come under Long Acting Reversible Contraception (LARC)

Permanent methods:

- Male sterilization 
- Female sterilization 

(For details please refer Unit 2 family planning methods, spacing techniques and counselling, Post partum and post abortion family planning)

Misconceptions and Facts about Contraceptive Methods

- When a woman mentions a rumor/misconception, always listen carefully.
- Don't laugh.
- Explain the facts with visual aids.
- Use strong scientific facts about contraceptive methods to counter misinformation.
- Always tell the truth. Never try to hide side effects or problems that might occur with various methods.

3.7 KEY MESSAGE

Appropriate management of abortion is an important contributor to reduction of maternal morbidity and mortality. Empowering women with decision-making ability to choose right method of abortion care is urgently required on the part of health care providers. Depending upon the duration of pregnancy, there are two methods of abortion. The health care provider should provide adequate information about different methods of abortion. Medical Methods of abortion uses a combination of two drugs– mifepristone and misoprostol. Surgical method includes newer technologies like Vacuum Aspiration– Electrical and Manual. Efforts should be made to practice standard precautions and practice infection prevention and control. After the abortion, appropriate post abortion contraception should always be offered and important instructions regarding post abortion care must be provided to the women before discharge from the health facility.

3.8 REFERENCES

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UNIT 4 ADOLESCENT COUNSELLING

Structure

- 4.0 Introduction
- 4.1 Objectives
- 4.2 Definitions, Aims and Need of Adolescent Counselling
- 4.3 Types of Counselling
 - 4.3.1 Individual Counselling
 - 4.3.2 Family Counselling
 - 4.3.3 Group Counselling
- 4.4 Requisites of Adolescent Counselling
 - 4.4.1 Qualities of a Counsellor
 - 4.4.2 Providing Safe Counselling Environment
 - 4.4.3 Joining the Adolescent
- 4.5 Counselling Techniques for Adolescents
- 4.6 Aspects of Adolescent Counselling
 - 4.6.1 Need for Body Image Counselling
 - 4.6.2 Sexuality and Sexual Health Counselling
 - 4.6.3 Need for Substance Abuse Counseling
 - 4.6.4 Career Development
- 4.7 Let Us Sum Up
- 4.8 Key Words
- 4.9 Activity

4.0 INTRODUCTION

Adolescence is a phase of rapid growth and development during which physical, physiological and behavioural changes occur. They constitute more than 1.2 billion worldwide, and about 21% of Indian population. Morbidity and mortality occurring in this age group is mostly due to preventable causes. Young and growing children have poor knowledge and lack of awareness about physical and psychological changes that occurs during adolescence and the ill health affecting them. They face challenges like poverty, lack of access to health care services, unsafe environments etc. It is a period of preparation for undertaking greater responsibilities like familial, social, cultural and economic issues in adulthood. They have many emotional challenges, issues and concerns to deal with on a day-to-day basis. It is therefore extremely important to provide them with proper emotional care and counseling.

4.1 OBJECTIVES

At the end of this practical, you will be able to:

- define adolescent counselling;
- discuss the aims, need and types of adolescent counselling;
- enumerate essential requisites to conduct counselling for adolescents;

- review techniques of adolescent counselling; and
- discuss various counseling strategies for counsellors applicable in different aspects of adolescent developmental needs.

4.2 DEFINITIONS, AIMS AND NEED OF ADOLESCENT COUNSELLING

Lets go through the definition, aim and need for adolescent counselling.

Adolescent: Adolescents are the young people aged between 10 to 19 years.

Adolescent counselling : Adolescent counselling is a process between an adolescent and a counsellor in a trusting relationship to help that child or adolescent explore and make sense of a traumatic experience that has happened to them (e.g. death of a parent, abusive situations).

Aims of Adolescent Counselling

- Adolescent counselling is aimed at helping young people make sense of their feelings, thoughts and behaviors.
- It focuses on supporting the behavioural, emotional and social growth of adolescents.
- It is to assist children and adolescents recover their self-esteem and confidence.
- It helps them understand that the trauma was not their fault and to address any fear or anger they are feeling.

Need of Adolescent Counselling

- Adolescence is the stage when we make the transition from child to adult, this usually occurs between 10 and 19. This is a time which a great deal of both physical and mental changes take place, the physical changes often referred to as puberty. These changes may predispose adolescents to be sensitive, to experience mood swings and to have swings in confidence levels. For this reason, adolescent counselling should ensure that they take into account this period of vulnerability when engaging in therapy with an adolescent.
- Adolescents struggle with different issues than younger children and adults such as identity struggles, extreme peer pressure and fitting in. They often feel stuck between wanting independence and still needing guidance. Adolescents are more likely than adults to make decisions without considering the consequences and feel invincible.
- Unfortunately about 4 in 10 adolescent become seriously depressed each year. That alone is a shocking figure, but in light of developmental changes and the numerous pressures on young people, those affected and in need of therapy can be much higher, hence the need for counselling aimed towards adolescents.
- Adolescence is a period of storm and stress characterised by moodiness, inner turmoil and rebellion. During adolescents, a person's self-concept is almost fully developed. However, frequently, the ideas one has about oneself are based on what others (parents, friends, relatives, teachers, counsellors and so on) think one is or should be.

4.3 TYPES OF COUNSELLING

Typically there are three main types of counselling:

4.3.1 Individual Counselling

When one individual is counselled, then it is called individual counselling. Working with children and adolescents, counsellors sometimes also use Play, Art or Music Therapy, which encourages young people to express them in other ways apart from speech. This training focuses on skills for individual counselling.

4.3.2 Family Counselling

Family counselling is a type of therapy that can help families with any of the issues they may be facing. Different families may have different needs when it comes to family counselling, but there are many tips and techniques that can help families get along better. Reasons for Family counselling might be better communication, less fighting and stronger family relationships.

4.3.3 Group Counselling

Group is a therapy format that approaches issues of personal growth through the use of interpersonal interaction – to interact with others to identify and understand our maladaptive patterns and how to change them. Group interactions provide an opportunity to build relationships and receive interpersonal feedback about how they experience one another. One can gain specific skills and strategies to meet personal goals, explore areas that present personal challenges, and gain support and encouragement from others. Group is one of the most effective ways to explore and support changes one wish to make in his/her life.

4.4 REQUISITES OF ADOLESCENT COUNSELLING

Let us go through the requisites before starting the Counselling session. First of all a Counsellor should have following qualities as given below:

4.4.1 Qualities of a Counsellor

There are some qualities, attitudes and behaviour required to make a good counsellor. It also explores some of the personal issues that you will need to be aware of when providing counselling. Some important personal qualities might include:

- **Being sincere:** Being able to show genuine interest in an adolescent's problems.
- **Empathy:** Being to understand and connect with an adolescent's feelings and emotions.
- **Warmth:** Showing compassion, kindness and gentleness in face and voice.
- **Respect:** Appreciating the adolescent's importance as a human being.
- **Democratic:** Avoiding being authoritative when interacting with the adolescent.
- **Helpful and unhelpful counselling behaviour:** Helpful behaviours should encourage the child or adolescent you are working with to open up, share

their feelings and assist in building a trusting relationship with you. Unhelpful attitudes and behaviour can damage that relationship and confuse the adolescent, making them feel more isolated and unwilling to ask for help.

4.4.2 Providing Safe Counselling Environment

Children and adolescents that are experiencing situations need to feel safe before they share their stories with someone else, especially an adult. Providing them with a safe environment is not only about the venue, but it is about the way you act too. Following are important in creating a safe space for child and adolescent counselling:

- Find a quiet, private place to talk with the adolescent, but one where they will feel safe and comfortable.
- Do not go into rooms with where adolescent might naturally feel afraid (e.g. head's office or staff room).
- The good place would be one where adolescent knows there are other people nearby, but not close enough to hear.
- Make sure the adolescent understands issue of confidentiality before you start.
- Make sure there will be no interruptions or distractions (e.g. other staff walking in and out).
- Switch off your cell phone.

4.4.3 Joining the Adolescent

Few points while starting counselling with the adolescent are as follows:

- Making the adolescent or child feel comfortable as soon as she/he arrives.
- Don't keep them waiting, greet them, smile and chat to put them at their ease. Remember to explain your role and what to expect.
- Do not sit facing the child or behind a desk. This might make the child or adolescent feel they are in a classroom situation. Sit at an angle to each other. Where possible make sure you are seated at the same height; if you are on a chair, he/she should also be seated on a chair.
- Look at the adolescent, but give them the chance to turn their head away if they are feeling shy – try to avoid taking notes unless absolutely necessary. Make sure you appear relaxed and friendly.
- An adolescent who has a difficult experience might feel worse being touched by people – even those they know well. There are other ways of expressing your sympathy.

4.5 COUNSELLING TECHNIQUES FOR ADOLESCENTS

Many challenges and rewards come from counselling adolescents. Therapists have to understand the developmental challenges of adolescents to provide effective counselling to them.

i) **Replacing Negative Self-Talk**

Many times, adolescents who struggle with mental health disorders such as depression and anxiety experience a lot of negative self-talk, which means that the thoughts they have about themselves are usually negative. Instead of looking at a tough situation as a challenge, they already believe they will fail. They might see things as hopeless and have a pessimistic outlook on life. So while counselling adolescents to help them change these negative thoughts to positive ones have the adolescent write down what he is thinking every hour the day before his counselling session. Go over the list with him, assisting him in changing all the negative thoughts into positive ones.

ii) **Engaging in group counselling**

Another technique many therapists who work with adolescents use is encouraging their clients to try out group counselling. Techniques that can be used as a group counsellor include making the adolescents realise that they are not alone in their problems and getting the adolescents to help each other out. An adolescent might not respond to an adult, even if she is a therapist, when she tries to tell him that drinking until he passes out is dangerous, but he might listen to one of his peers. Using other adolescents who have struggled with the same problems can be extremely effective when working with an adolescent population.

iii) **Repeating information through questions**

When working with adolescents, counsellors have to be careful not to push their clients away by combating them over every issue. Instead, he/she can repeat information that sounds irrational and unreasonable back to a adolescent in the form of a question. For example, a adolescent might say, “I do not care that I get teased every day.” Instead of saying, “Of course you care,” and pushing the client away, a therapist could respond by asking, “So it does not bother you that your peers make fun of you on a daily basis? How does it make you feel?” When put into a question, many adolescents think about the statement they just made and it sounds different, and possibly irrational, coming from someone else. In this case, counsellor is not objecting to what the adolescent said. Instead, he is asking following up questions.

iv) **Technique for Questioning the adolescents**

a) **Ask the adolescent** to write the questions in chits and put them in the box provided.

b) **Engage adolescents with nonthreatening questions**

Choose one or two questions at a given time and ask questions that help them define their identities. For example, What do you like to do in your free time? What are your hopes for the future? Listen non judgmentally and listen more than you speak. This enables the adolescent to realise that you value his or her opinions, and thus to trust you more.

c) **Asking open-ended questions**

Questions that require more than a yes or no response must be preferred. This helps the adolescent think through ideas and options.

d) **Avoid “why” questions**

These types of questions tend to put people on the defensive. Try to rephrase your questions to get at what the adolescent is thinking rather

than the reason for something the adolescent has said or done. For example, instead of asking, “Why did you say that?” say instead: “You seemed to be really trying to get across a point when you did that. Can you tell me more about what you mean?”

v) **Match the adolescent’s emotional state**

Adolescent’s emotional state should be matched, unless it is hostile. If the adolescent seems enthusiastic or sad, let your responses reflect his or her mood. Reflecting helps a person feel understood.

vi) **Casually mould rational decision-making strategies**

Counsellor can discuss experience, how he/she once arrived at a decision. Explain, for example, how you defined a problem, generated options, anticipated positive and negative consequences, made the decision, and evaluated the outcome. Adolescents have relatively short attention spans, so be brief, and choose a topic relevant to adolescents.

4.6 ASPECTS OF ADOLESCENT COUNSELLING

As children and adolescents grow, they are constantly in the process of developing the social skills and emotional intelligence necessary to lead healthy, happy lives. When children experience emotions or engage in behaviours that interfere with their happiness and ability to thrive, they may benefit from meeting with a mental health professional such as a therapist or counsellor. The topics for counselling of adolescent boys and girls are summed up in Table 4.1.

Table 4.1: Topics for counselling of Adolescents

Group		Topics
Adolescent Boys and Girls	Physiological	Leading healthy life style Need for Regular exercise Prevent life style diseases like obesity, hypertension, diabetes mellitus Intake of nutritious diet Maintain body image Avoid consumption of alcohol, tobacco and drugs
	Psychological	Emotional conflict Prevent stress and strain leading to depression Intolerant behaviour Stress management Attention Deficit Hyperactivity Disorder (ADHD) Do meditation regularly
	Sexual or Reproductive	Reproductive health issues and sexual orientation Sexual behaviour and sex counselling Prevention of HIV and AIDS
	General	Relationship education Responsibility assumption Higher education Career challenges Role confusion

		Problem solving Self help group activities Communication – non verbal, non violent, interpersonal and intrapersonal
Adolescent girls		Menstrual hygiene Teenage Pregnancy

Some important aspects of adolescent health are discussed below:

- 1) Body image
- 2) Sexuality and sexual health
- 3) Substance abuse
- 4) Career development

4.6.1 Need for Body Image Counselling

Body image is the dynamic perception of one's body – how it looks, feels, and moves. It is shaped by perception, emotions, physical sensations, and is not static, but can change in relation to mood, physical experience, and environment. Because adolescents experience significant physical changes in their bodies during puberty, they are likely to experience highly dynamic perceptions of body image. Body image is influenced strongly by self-esteem and self-evaluation, more so than by external evaluation by others. It can, however, be powerfully influenced and affected by cultural messages and societal standards of appearance and attractiveness.

Adolescents receive the most criticism regarding their physical appearance and the most efforts to change their appearance. Parental over-concern with children being thin or encouragement to avoid being fat can influence young people to become constant dieters and use unhealthy weight control methods leading to body image dissatisfaction among adolescents. While the contributing factors may vary, the outcomes are similar. Health professionals should work with parents to help them encourage their children to be healthy in a manner that supports healthy body image development.

Strategies for Counsellors

- 1) Discuss changes that occur during adolescence. Assess weight concerns and body image.
- 2) If a child or adolescent has a distorted body image, explore possible causes and discuss potential consequences.
- 3) Discuss how the media can negatively affect a child's or adolescent's body image.
- 4) Discuss normal variation in body sizes and shapes among children and adolescents.
- 5) Educate parents, physical education instructors, and coaches about realistic and healthy body weight and healthy eating.
- 6) Emphasize the positive characteristics (appearance- and non-appearance-related) of children and adolescents.

- 7) Take extra time with an overweight child or adolescent to discuss psychological concerns and weight control options.
- 8) Educate parents regarding the impact of their weight, food, and appearance-related attitudes and behaviours on their children. Mothers in particular should be aware of the strong effects of modelling on their daughter's developing body image.
- 9) Inform adolescents and parents of the negative effects of dieting (e.g., slowed metabolism, increased likelihood of binge eating, and eventual weight gain), and discourage diet talk and ways to take a no dieting approach to healthful eating. Do not focus on educating adolescents specially girls regarding the signs and symptoms of eating disorders, as this approach can often result in girls' adoption of these behaviours.
- 10) Provide girls in early adolescence with information regarding the physical and psychological changes that occur with the onset of puberty. Girls can learn of the normative nature of their weight gains and begin to challenge the inconsistencies between the thin ideal and their maturing bodies.
- 11) Because girls are being socialised to suppress their feelings in order to maintain relationships, assist girls in developing the skills to assertively, express anger, conflict, and power in their relationships.
- 12) Rather than comparing their appearances to others in striving to achieve interpersonal success, counsellors should reinforce adolescent's acceptance of each individual's unique body type. Expose girls to female role models representing a diversity of shapes and sizes who are praised for both their accomplishments and their appearances.
- 13) Because boys also are exposed to pervasive images regarding how women should look, they also need assistance in developing an appreciation for attractiveness that includes an array of body types.
- 14) To help build girls' self-esteem in adolescence, encourage girls to become involved in a variety of school, volunteer, or work activities that are not focused on physical appearance or achievement of the thin ideal.
- 15) Reinforce adolescents' skills in developing an internally-derived value system and internal locus of control so they can begin to rely less on others' opinions about the importance of appearance. They can begin to explore what it would be like to trust their own values regarding how they should look and act.

4.6.2 Sexuality and Sexual Health – Counselling

Children and adolescents need accurate and comprehensive education about sexuality to practice healthy sexual behaviour as adults. Early, exploitative, or risky sexual activity may lead to health and social problems, such as unintended pregnancy and sexually transmitted diseases, including human immunodeficiency virus infection and acquired immunodeficiency syndrome. Thus sex counselling may be a necessary end in the development of adolescents. It should be seen as part of the formal education that every child needs to survive in the society. This will reduce the number of embarrassment they will receive when they begin to experience developmental changes. Apart from this, the knowledge of sex counselling will help young adults to differentiate fables from realities.

Phases of sex counselling

- a) **Pre-adolescence sex counselling:** Sex counselling should begin as soon as a child is conscious of his or her sexuality. The basic instructions and training on sex will depend on the age and maturity of the individual child. The counselling on sex becomes more obvious at adolescence period. A child should be told the names the sex organs are called. And what he or she should not do with the sex organs. The child should know the little functions of the sex organ like using it to urinate and limit it to that until he is more mature to know other functions.

b) **Adolescence Sex Counselling**

The adolescence period is a turbulent one because the child is moving from childhood to adulthood. This period which acts as a bridge between childhood and adulthood for some children usually begins between 11 and 14 years and continues to about 19 years.

c) **Pre-Marital Sex Counselling**

Parents can introduce sex counselling to teach their young adolescents to accept themselves, their complexion, physique, height, family background and so on because they are unique and should not compare themselves with others around them.

Another method of pre-marital sex counselling is good communication line between parents and their young adolescents. The communication between parents and their children should be open because communication may be everything to them. Sometimes, there are conflicts of opinions or ideas. Parents should let their children see them as friends at all times. In this way, they may not want to keep anything bothering them away from their parents.

Strategies for Counsellors

Counselling approaches in sex counselling depend on the client age, sexual orientation and present problems. Sex counselling is a very important aspect of education that must not be ignored or handled carelessly. Counsellors too who are giving the counsels are expected to be role models showing good examples to their clients to emulate. Counsellors can establish a productive relationship with adolescents through the following steps:

- 1) Assess the individual adolescent's ability to understand the consequences of risky behaviour
- 2) Assess the role of the parent
- 3) Clarify expectations about confidentiality
- 4) Meet privately with the adolescent and raise sensitive topics
- 5) Use the counsellor-adolescent relationship to personalise risk-reduction messages. Counsellors should also actively seek to collaborate with community programmes that address adolescent violence, sex, and overall health. Adolescents should be invited to independently access the counsellor's office, and should be provided with other resources appropriate for their individual needs.

Counsellor can also motivate or encourage parents to discuss sex counselling with their children. Following are some activities that can enhance/promote healthy sexual behaviour among adolescents:

- 1) Parents should shower their children with love. A child who is denied love at home can find it elsewhere and most times at the wrong places.
- 2) Parents should let their daughters know about their private body parts and what they are meant for. The uniqueness of their physique and structure should be emphasized. It is also important to let them know that it is of no use changing the natural structure. Parents should teach their daughters to understand that their virginity is their pride and nobody has the right to violate them. Parents should teach their daughters how to react to any immoral advances towards them. They should not allow anyone to take advantage of their sexuality.
- 3) Parents should instill a strong sense of self-discipline and responsibility in their children.
- 4) Parents should encourage their adolescent girls to dress properly by not exposing the sensitive parts of their bodies.
- 5) Parents should not be shy or embarrassed to discuss sex counselling with their children.
- 6) Parents should not leave the caring and upbringing of their children to outsiders, house-helpers, relatives and the likes.
- 7) Parents should ensure the security of their children in respect to whom and where to send them to.

4.6.3 Need for Substance Abuse Counselling

Being an adolescent and raising an adolescent are individually, and collectively, faces enormous challenges. For many adolescents, illicit substance use and abuse become part of the landscape of their adolescent years. Although most adolescents who use drugs do not progress to become drug abusers or drug addicts in adulthood, drug use in adolescence is a very risky proposition. Even small degrees of substance abuse (for example, alcohol, marijuana, and inhalants) can have negative consequences. Typically, school and relationships, notably family relationships, are among the life areas that are most influenced by drug use and abuse. One of the most telling signs of an adolescent's increasing involvement with drugs is when drug use becomes part of the adolescent's daily life.

One should be aware about the factors/causes leading adolescent's to indulge in drug problems. These factors/causes are as follows:

- 1) insufficient parental supervision and monitoring
- 2) lack of communication and interaction between parents and kids
- 3) peer pressure
- 4) poorly defined and poorly communicated rules and expectations against drug use
- 5) inconsistent and excessively severe discipline
- 6) family conflict
- 7) favourable parental attitudes toward adolescent alcohol and drug use, and parental alcoholism or drug use

There is need to also pay attention to individual risk factors, which includes:

- 1) high sensation seeking

- 2) impulsiveness
- 3) psychological distress
- 4) difficulty maintaining emotional stability
- 5) perceptions of extensive use by peers
- 6) perceived low harmfulness to use

Strategies for Counsellors

- 1) Help the client admit that he or she suffers from the disease of addiction.
- 2) Teach the client about addiction and about the tools of recovery.
- 3) Encourage and motivate the client.
- 4) Provide support and encourage development of a support network.
- 5) Understand how adolescents perceive and react to treatment of is crucial in developing appropriate counselling techniques to address their substance use.
- 6) Treat an adolescent like an adult will likely result in failure—counselling adolescents requires sensitive yet firm approaches. An adolescent treatment programme should have explicit and impartially administered standards for behaviour. It should emphasize treatment of every participant in a personal, respectful, and hopeful manner.
- 7) Counsellor should maintain an optimistic tone and be dedicated to serving and helping its clients, while exercising authority without seeming authoritarian.
- 8) The staff should also ensure that every participant is protected from possible harassment, such as teasing and hazing, by other programme clients.
- 9) During counselling if youths do not abide by the treatment programme guidelines, they must be held responsible for their conduct, but in a manner that avoids a confrontational style or indicators of mistrust.
- 10) It is also important that youth be helped in fulfilling their responsibilities in a way that would typically be inappropriate for adults. For example, if an adolescent does not show up on time for an outpatient programme, he should be called immediately and reminded to attend.

4.6.4 Career Development

Need for Career Counselling: Professional career counsellors can support people with career-related challenges. Through their expertise in career development and labour markets, they can put a person's qualifications, experience, strengths and weakness in a broad perspective while also considering their desired salary, personal hobbies and interests, location, job market and educational possibilities. Through their counselling and teaching abilities, career counsellors can additionally support people in gaining a better understanding of what really matters for them personally, how they can plan their careers autonomously, or help them in making tough decisions and getting through times of crisis. Finally, career counsellors are often capable of supporting their clients in finding suitable placements/ jobs, in working out conflicts with their employers, or finding the support of other helpful services.

Definition: Vocational/career counselling assesses an individual's intelligence, aptitude, interests, abilities and skill levels in order to create and follow a career path.

Skills Required by Career/Vocational Counselor: General skills needed to become a successful vocational counselor include communication skills, an aptitude for testing and assessment, and good organisational skills. Counsellors also need to commit to keeping up with developments in the field of employment. This can involve formal professional development as well as informal networking, study and reading of relevant journals and publications.

Strategies for Vocational Counsellor:

Vocational counsellors, sometimes called school or career counsellors, are available for providing advice and direction on career-related decisions and help people decide on and take the next steps in their careers. They do this by helping clients to assess and understand their strengths and capabilities, and encourage their clients to devise appropriate career goals based on these. This requires counsellors to assess and work with clients and keep up-to-date with employment options to provide timely advice. Following are few strategies:

- 1) Develops, implements and evaluates training plans in a variety of work settings designed to meet clients' vocational, social and daily living goals.
- 2) Identifies clients' interests, skills and abilities by conducting interviews and consulting caregivers.
- 3) Develops, with the participation of clients, training plans, including pre-employment skill development, designed to meet the individual's goals in the areas of daily living and social skills and job readiness.
- 4) Trains, supports and monitors clients in a variety of work settings in areas such as work skills, proper hygiene, product quality, and quantity and service expectations.
- 5) Provides reports on clients' skill level and progress to the supervisor and other caregivers and makes recommendations on modifications to the goals.
- 6) Locates employers in local businesses, industries and community agencies that match the interests, skills and abilities of clients. Encourages employers to participate in placements.
- 7) Encourages client participation in community activities and encourage relationships and friendships in the community.
- 8) Follows up job placements by assisting employers to work with clients through problem solving and troubleshooting. Liaises with community service providers in order to promote the programme.

4.7 LET US SUM UP

In this practical, we have reviewed the concept, definitions, aims and need of adolescent counseling, its types, requisites and techniques of adolescent counselling. You have also learned about some important aspects of adolescent counselling and strategies for counsellors which are applicable in adolescents' developmental needs.

4.8 KEY WORDS

- 1) **Adolescent:** Adolescents are the young people aged between 10 to 19 years.
- 2) **Adolescent counselling:** Adolescent counselling is a process between an adolescent and a counselor in a trusting relationship to help that child or adolescent explore and make sense of a traumatic experience that has happened to them.

- 3) **Addiction:** The fact or condition of being addicted to a particular substance or activity
- 4) **Body Image:** Body image is a person's perception of the aesthetics or sexual attractiveness of their own body.
- 5) **Counselling:** Counselling is a learning-oriented process, which occurs usually in an interactive relationship, with the aim of helping a person learn more about the self, and to use such understanding to enable the person to become an effective member of society.
- 6) **Career:** An occupation undertaken for a significant period of a person's life and with opportunities for progress.
- 7) **Career development:** Career Development is the lifelong process of managing learning, work, leisure, and transitions in order to move toward a personally determined and evolving preferred future.
- 8) **Guidance:** Guidance is help or advice that tells you what to do: the act or process of guiding someone or something.
- 9) **Sexuality:** A person's sexual orientation or preference.
- 10) **Sexual Health:** Sexual health is a state of physical, mental and social well-being in relation to sexuality.
- 11) **Substance abuse:** Substance abuse, also known as drug abuse, is a patterned use of a drug in which the user consumes the substance in amounts or with methods which are harmful to themselves or others, and is a form of substance-related disorder.

4.9 ACTIVITY

Activities

- 1) Select adolescent from School/community in need of counselling. Identify the areas in which need based counselling was done.
- 2) Answer the following as per case to care counselling.
 - i) How many sessions per adolescent helped in solving the individual clients problems.
 - ii) Document your findings in the work book.
- 3) Discuss how counselling is helpful for adolescents.
- 4) Select a case and Identify the areas of adolescent counselling while conducting.
- 5) Sessions using techniques of adolescent counselling.
 - Find out the major problems arise during counseling process.
 - Discuss and suggest remedial measures to prevent/control various developmental problems of adolescents.

Certificate in Community Health for Nurses (BPCCHN)

Practical Course

CHO - 0003 Public Health and Primary Health Care Skills (10 Credits)

Block – 1 : Public Health Skills

Unit 1	:	Community Need Assessment and Identification of Common Health Problems
Unit 2	:	Nutritional Assessment
Unit 3	:	Investigation of an Outbreak
Unit 4	:	Organizing and Conducting Special Clinics
Unit 5	:	Social Mobilisation Skills
Unit 6	:	Health Education and Counselling
Unit 7	:	Report Writing and IT Skills including Interpretation and Use of Data

Block- 2 : General Skills and Laboratory Skills

Unit 1	:	Universal Precautions and Bio Medical Waste Management
Unit 2	:	Procedures for Basic Tests
Unit 3	:	Common Blood Tests and Preparation of Peripheral Smear
Unit 4	:	Examination of Swelling, Lump and Joint
Unit 5	:	Eye and ENT Examination
Unit 6	:	Screening and Management of Common Dental Conditions
Unit 7	:	Suturing of Superficial Wounds
Unit 8	:	Drugs Dispensing and Injections

Block – 3 : Skills for Management of Common Conditions and Emergencies

Unit 1	:	Basic Life Support (BLS)
Unit 2	:	Assessment and Management of Fevers
Unit 3	:	Management of Common Aches and Pains
Unit 4	:	First Aid Techniques and Stabilization Care in Common Emergencies – 1
Unit 5	:	First Aid Techniques and Stabilization Care in Common Emergencies – 2
Unit 6	:	Geriatric and Palliative Care

Block – 4 : Maternal Health Skills

Unit 1	:	Assessment of Health Status of Women
Unit 2	:	Antenatal, Intranatal, Postnatal Examination and Care
Unit 3	:	Organising Labor Room
Unit 4	:	Conducting Normal Deliveries and Partograph
Unit 5	:	Identification, Care and Referral of Complications during Labour
Unit 6	:	Postnatal Examinations and Care
Unit 7	:	Emergency and Injectable Contraceptives and Follow - up Care
Unit 8	:	Understanding Continuum of Care (CoC) and the Use of Digital Interventions in Rajasthan

Block 5 : Reproductive and Adolescent Health Skills

Unit 1	:	Assessment and Management of STIs / RTIs
Unit 2	:	Insertion and Removal of IUCDS
Unit 3	:	Management of Abortion and Counselling
Unit 4	:	Adolescent Counselling

Block 6 : Newborn and Child Health Skills

Unit 1	:	Newborn Resuscitation
Unit 2	:	Assessment of the Newborn
Unit 3	:	Kangaroo Mother Care
Unit 4	:	Infant and Young Child Feeding and Counselling
Unit 5	:	Promoting and Monitoring Growth and Development and use of Growth Chart
Unit 6	:	Immunisation and Safe Injection Practices
Unit 7	:	Use of Equipments
Unit 8	:	National Child Health programmes