The Republic of Uganda

THE NATIONAL POLICY GUIDELINES AND SERVICE STANDARDS FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

DRAFT

Reproductive Health Division

Department of Community Health, Ministry of Health

Fourth Edition
August, 2017

Preface

Achievement of Sexual Reproductive Health and Rights (SRHR) goals is critical for Uganda to reap the demographic dividend on the journey to achieving a middle income status. The Government of Uganda recognizes that its population is the most valuable asset and is a key component of the economic development process. As such, Uganda has continued to prioritize attainment of the Sustainable Development Goals (SDGs) that are geared towards the improvement of the quality of life of its population. The NDP's theme is "Strengthening Uganda's Competitiveness for Sustainable Wealth Creation, Employment and Inclusive Growth" and the thrust is to accelerate transformation of Ugandan society from a peasant to a modern and prosperous country within 30 years.

Attainment of the SDGs however, is being hampered by a multitude of community-related and health systems gaps indirectly leading to high fertility, maternal and infant morbidity, mortality and disability. The major causes of maternal and newborn morbidity and mortality are preventable and treatable using the technology available to us. We shall endeavor to increase community access to quality integrated SRH services in order to reduce infant and maternal mortality as well as reduce the national Total Fertility Rate. Through implementation of these SRHR Policy guidelines and service standards, Uganda further commits to join the rest of the world to achieve the SDGs.

The *National Policy Guidelines and Service Standards for Reproductive Health and Rights service delivery* should guide efforts towards the attainment of this noble cause.

This document has been developed by the Ministry of Health, Reproductive Health Division in collaboration with various professional bodies, NGOs and stakeholders in Sexual Reproductive Health. MOH is very grateful for their inputs.

It is, therefore, my hope that this document will be utilized by all stakeholders for the improvement of the quality and coverage of sexual and reproductive health services.

Thank you,

Prof. Anthony K. Mbonye

Ag. Director General Health Services

Ministry of Health

DRAFT

Acknowledgements

The Fourth edition of the *National Policy Guidelines and Service Standards for Reproductive Health and Rights* is a result of joint efforts by the MoH, Development partners, Civil Society and implementing partners. The MoH Reproductive Health Division wishes to acknowledge the contributions of the organizations that supported the process financially and technically.

Appreciation goes to those individuals who took part in reviewing the earlier editions and whose tireless efforts produced this edition.

Special thanks go to Health Policy Advisory Committee (HPAC) taskforce including Dr. Sam Orach, Dr. Lydia Mungherera and Dr. Peter Okwero. Prof. Anthony K. Mbonye, the Ag. Director General for Health Services for his able leadership and direction and Dr. Paul Kagwa, Ag. Commissioner for Community Health for steering the team to the end.

It is hoped that these *Policy Guidelines and Standards* will guide the delivery of quality integrated sexual and reproductive health services and contribute to reduction of maternal and newborn morbidity, disability and mortality.

For God and my country.

Dr. Blandinah Nakiganda
Ag. Assistant Commissioner for Health Services
(Reproductive Health)

DRAFT

Abbreviations

ADHO : Assistant District Health Officer
ADS : Alternative Distribution System
ANC : Antenatal care
BCC : Behavioural Change Communication
BEmONC: Basic Emergency Obstetric Newborn Care
CBDAs : Community Based Distribution Assistants
CEmONC: Comprehensive Emergency Obstetric Newborn Care
CHEWs: Community Health Extension Workers
CPR : Contraceptive Prevalence Rate
CRHWs: Community Reproductive Health Workers
CSO : Civil Society Organisations
DHIS : District Health Information System
eMTCT: elimination of Mother to Child Transmission
ESA : East and Southern Africa
FBOs : Faith Based Organisations
FGM : Female Genital Mutilation
HCIV : Health Centre IV
HMIS : Health Management Information System
HRBA : Human Rights Based Approach
HSD : Health Sub- District
HSDP : Health Sector Development Plan
ICPD : International Conference on Population and Development
IEC : Information, Education and Communication
LMIS : Logistics Management Information System
MDGs : Millennium Development Goals
MEC : Medical Eligibility Criteria
MNCH : Maternal Newborn and Child Health
MOH : Ministry of Health
NDA : National Drug Authority
NDP : National Development Plan
NGO : Non-governmental Organisation
PCPNC: Pregnancy, childbirth, postpartum and newborn care
QPPU : Quantification, Procurement and Planning Unit
RMNCAH: Reproductive Maternal Newborn Child and Adolescent Health
RVF : Recto Vaginal Fistulae
SDGs : Sustainable Development Goals
SDPs : Service Delivery Points
SGBV : Sexual and Gender Based Violence

DRAFT

SRHR	:	Sexual Reproductive Health and Rights
TBAs	:	Traditional Birth Attendants
UDHS	:	Uganda Demographic Health Survey
UHC	:	Universal Health Coverage
UNCST	:	Uganda National Council of Science and Technology
VHTs	:	Village Health Teams
VVF	:	Vesicovaginal fistula
WHO	:	World Health Organisation

DRAFT

TABLE OF CONTENTS

PREFACE I
ACKNOWLEDGEMENTS II
ABBREVIATIONS III
1. INTRODUCTION 1
1.1 General SRHR Context 1
1.2 Structure and contents of the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights 3
1.3 Purpose of the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights 3
1.4 Policy Goals and Objectives 3
1.5 Guiding Principles 4
1.6 How the Policy guidelines and Service Standards were developed 4
1.7 Who may use Guidelines 5
1.8 How to use the Guidelines 5
1.9 Implementation of the Policy guidelines and Service standards 5
1.10 Monitoring of Implementation of the SRHR Policy Guidelines and Service standards 14
1.11 References 15
2. SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS 16
2.1 Definitions 16
2.2 Reproductive health rights 16
2.3 Rights based approach 17
2.4 Legal framework supporting SRHR 17
2.5Rights and Responsibilities of different parties 18
2.6 Components of SRHR 19
2.7 References 19

3. SRHR THEMATIC AREAS 20

3.1 Introduction 20

3.2Sub-Theme 1: FAMILY PLANNING AND CONTRACEPTIVE SERVICE DELIVERY 21
3.2.1 Definitions 21
3.2.2 Context and Rationale 21
3.2.3 Policy goal 22
3.2.4 Specific objectives 22
3.2.5 Target audience 22
3.2.6 Implementation strategies 23
3.2.7 Family Planning Service Standards 24
3.2.8 Eligibility Criteria 28
3.2.9 Dialogue for family planning services (Married) 28
3.2.10 References 29
3.3 Sub-Theme 2: SAFE MOTHERHOOD: MATERNAL AND NEWBORN HEALTH CARE 30
3.3.1 Definitions 30
3.3.2 Context and Rationale 30
3.3.3 Policy goal 30

DRAFT

3.3.4 Implementation strategies 31
3.3.5 Target audience 31
3.3.6 Components of Safe Motherhood (Maternal and Newborn Health Services) 32
3.3.7 Referral for Mothers and newborn babies 48
3.3.8 Prevention of Abortion and Post-abortion care 51
3.4 Sub-theme 3: OBSTETRIC FISTULA 58
3.4.1 Definitions 58
3.4.2 Context and Rationale 58
3.4.3 Policy goals 58
3.4 4 Specific objectives 59
3.4.5 Target audience 59
3.4.6 Implementation strategies 59
3.4.7 Components of Obstetric Fistula Management 60
3.4.8 Service standards 61
3.4.9 References 65
3.5 Sub theme 4: ADOLESCENT SEXUAL REPRODUCTIVE HEALTH AND RIGHTS 66
3.5.1 Definitions 66
3.5.2 Context and Rationale 66
3.5.3 Policy goals 67
3.5.4 Specific objectives 67
3.5.5 Target audience 67
3.5.6 Implementation strategies 68
3.5.7 ASRH Service Standards 70
3.5.8 References 72
3.6 Sub-theme 5: INTEGRATING STI/HIV/AIDS AND SEXUAL AND REPRODUCTIVE HEALTH SERVICES 73
3.6.1 Definitions 73
3.6.2 Context and Rationale 73
3.6.4 Specific objectives 74
3.6.5 Target audience 74
3.6.6 Implementation strategies 74
3.6.7 References 76
3.7 Sub-theme 6: INFERTILITY 77
3.7.1 Definitions 77
3.7.2 Context and Rationale 77
3.7.3 Policy goals 77
3.7.4 Specific objectives 77
3.7.5 Target audience 78
3.7.6 Implementation strategies 78
3.7.7 Information and services 78
3.7.8 Service Standards 79
3.7.9 References 81
3.8 Sub-theme 7: REPRODUCTIVE TRACT CANCERS 82
3.8.1 Definitions 82
3.8.2 Context and Rationale 82
3.8.3 Policy goals 82
3.8.4 Specific objectives 82
3.8.5 Target audience 83
3.8.6 Implementation strategies 83
3.8.6.1 Cervical cancer screening service provision 84

DRAFT

3.8.6.2 Service provision for other Reproductive Tract cancers ... 84
3.8.7 Information and Service Standards for managing Reproductive Tract Cancers ... 84
3.8.8 References ... 88
3.9 Sub-Theme 8: MENOPAUSE AND ANDROPAUSE ... 89
3.9.1 Definitions ... 89
3.9.2 Context and Rationale ... 89
3.9.3 Policy goals ... 89
3.9.4 Specific objectives ... 89
3.9.5 Target audience ... 89
3.9.6 Implementation strategies ... 90
3.9.7 Service Delivery Points ... 90
3.10 Sub theme 9: SEXUAL AND GENDER-BASED VIOLENCE ... 91
3.10.1 Definitions ... 91
3.10.2 Context and Rationale ... 91
3.10.3 Policy goals ... 92
3.10.4 Specific objectives ... 92
3.10.5 Target audience ... 92
3.10.6 Implementation strategies ... 92
3.10.7 SGBV service package ... 93
3.10.8 Service Standards ... 94
3.10.9 References ... 96

4. CROSS CUTTING AREAS ... 97

4.1 Male sexual health and Involvement ... 97
4.1.1 Definition ... 97
4.1.2 Context and rationale ... 97
4.1.3 Service Interventions ... 98
4.1.4 Service delivery points and platforms ... 99

4.2 SRHR and Mental Health ... 99
4.2.1 Definition ... 99
4.2.2 Context and rationale ... 99
4.2.3 Policy goal ... 100
4.2.4 Target audience ... 100
4.2.5 Areas of focus ... 101
4.2.6 Implementation strategies ... 101
4.2.7 Services and interventions ... 101

4.3 Community Health ... 102
4.3.1 Definition ... 102
4.3.2 Context and rationale ... 102
4.3.3 Community health services and interventions ... 102

List of Figures

Figure 1: SRHR in Uganda- Components, Linkages and Rights ... 20
Figure 2: Schematic of Referral system for RH cancers ... 88

DRAFT

List of Tables

Table 1: FP Service standards ... 28
Table 2: Family Planning Service Provision by Cadre of Staff ... 29
Table 3: Information and Services provided during Preconception care ... 33
Table 4: Antenatal care: Levels and Cadre of Health Workers ... 36
Table 5: Labor and Delivery: Levels and Cadre of Health Workers ... 40
Table 6: Post Natal Care: Levels and Cadre of Health workers ... 49
Table 7: Type of Service by Level and Cadre of Health workers ... 50
Table 8: Post Abortion care and Therapeutic abortion services availability (who and where – level) ... 55
Table 9: Post Abortion care and Therapeutic abortion service provision by Health Worker Categories ... 56
Table 10: Provision of Obstetric Fistulae services by Level and Cadre of Health worker ... 64
Table 11: Infertility Service standards ... 80
Table 12: Availability of Services for Infertility ... 81
Table 13: RH Cancer Services Availability ... 86
Table 14: Standards for RH Cancer service provision ... 87
Table 15: SGBV Services Availability ... 94
Table 16: SGBV Service Provision by Cadre of Health workers ... 95

List of Annexes

Annex 1: Types of Family Planning Methods to be Made Available ... 104
Annex 2: Goal Oriented Antenatal Care Protocol ... 117

DRAFT

1. INTRODUCTION

1.1 General SRHR Context

The mission of the Reproductive Health Division is to attain the highest possible level of health for all the people in Uganda through the development and implementation of appropriate Sexual and Reproductive Health and Rights (SRHR) policies, guidelines and strategies.

Uganda, like the rest of the world, has committed to the post MDG agenda to embrace a new strategy of Sustainable Development Goals (SDGs). At the continental level, Uganda is a signatory to the Protocol to the African Charter on Human and People's rights on the Rights of Women in Africa, referred to as Maputo Protocol. The revised Maputo Plan of Action, 216-2030 is Africa's flagship policy framework for universal access to comprehensive sexual and reproductive health services. The full achievement of SRHR for all is integral to the achievement of all shared global development goals. Sexual and reproductive health and rights and empowerment of girls and women are central to sustainable development and creating a world that is just, equitable, and inclusive.

Uganda continues to grapple with high maternal, newborn and child mortality rates despite efforts to improve the health of children, adolescents and young people, women and men. Only 35% of currently married Ugandan women use a modern method. On the other hand, 47% sexually active unmarried women use a modern method. The unmet need for FP stands at 29.6% while that for currently married women stands at 28%.

As for adolescents aged 15 to 19 years, the Contraceptive prevalence is at 20.9% while teenage pregnancy has stagnated at 25% for the past 10 years, resulting in unsafe abortions that account for an estimated 26% of maternal death annually.

In order to support achievement of the SDGs and ensure universal access to health services including SRHR services, Uganda developed a Health Sector Development Plan (HSDP) 2015-2019 whose goal is "accelerating movement towards universal health coverage with essential health and related services needed for promotion of a healthy and productive life". In reference to the HSDP targets and the evidence of progress (UDHS 2016), the Health sector will have to further reduce maternal mortality ratio from 336 (in 2016) to 219/100,000, reduce fertility rate from 5.4 (in 2016) to 5.1 children per woman, increase the number of HCIVs offering CEmONC services to 50% and either maintain health facility deliveries at 73.4% (in 2016) or supersede this by the year 2020. Other thematic areas targeted include health promotion through Reproductive, Maternal, Newborn, Child and Adolescent health (RMNCAH) services.

The overarching goal is to save lives of women and children and help children to thrive through a multisectoral approach which in the long run will contribute to transformation of Uganda from a low income to a middle income country by implementing policies and standards that will lead to health for all.

Like other countries, Uganda is a signatory to key international treaties and commitments on Sexual and reproductive health and also emerged as global leader in promoting family Planning. This has enabled a policy environment aligned to national, continental and global actions (refer to the table below) that is very conducive and supportive of good SRHR environment.

Global documents	National documents
– Global Health Development Agenda – ICPD Point of Action – ICPD beyond 2014 – Ouagadougou Declaration – Sustainable Development Goals – UN Strategy for Women's, Children's and Adolescent's health – Revised Maputo Plan of Action, 2016-2030 – Beijing Declaration and Platform of Action	– Vision 2040 – National Development Plan II – National Health Policy II – Health Sector Development Plan 2015/16- 2019/20 – FP CIP (2015-2020) – Investment case for RMNCAH Sharpened Plan, 2016 – PMA 2020 reports – ADH policy, 2012 – SGBV policy, 2016 – Newborn services standards and newborn health implementation framework – QIF and Strategic Plan, 2015/16 – 2019/20 – Standards for Maternal and Newborn Care, 2016

These Policy Guidelines and Service Standards seek to operationalise policy statements in the different instruments to achieve national targets through quality SRHR service delivery at all levels reaching all those in need through implementing the Universal Health Coverage (UHC) agenda in health.

In line with the practice of the Ministry of Health, the SRHR Policy Guidelines and Service Standards will be revised every five years except if compelling circumstances arise then an addendum can be developed.

1.2 Structure and contents of the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights

This document has policy guidelines and service standards that aim at making explicit the direction of reproductive health and rights and how services should be provided at all levels of health care.

The policy guidelines spell out the general rules and regulations governing reproductive health services, components of reproductive health services, target groups for services and appropriate basic Information Education and Communication (IEC). In addition, the document identifies the services, those eligible for services, the service providers, and how training, logistics, supervision and evaluation activities will be planned and implemented.

The service standards set out the minimum acceptable level of performance and expectations for components of reproductive health services, expected functions of service providers, the various levels of service delivery.The service standards describe what a client or user can expect to receive from the service, and manner in which service will be delivered.

In this document, service delivery refers to the combination of technical, organizational and managerial activities. The Document outlines tasks that guide service provision and evaluation.

This edition of SRHR differs from the earlier ones in that:

- It has incorporated changes in Family Planning as per the updated WHO Medical Eligibility Criteria 2015, 5th Edition.
- It expounds more on the Rights-based approach to SRH service delivery.
- It brings out more highlights regarding legal framework for SRHR.

1.3 Purpose of the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights

Quality policy guidelines and service standards are important elements to ensuring provision of quality SRHR services and information. This document is aimed to provide explicit direction and focus in provision and implementation of sexual reproductive health service. The document further clarifies the roles of various Ministries, Development Partners (including CSOs), communities and other stakeholders involved in SRHR planning, implementation, service provision, monitoring and evaluation. The service standards in this document will, in addition, be used to develop protocols and standard operating procedures as well as assessing performance.

1.4 Policy Goals and Objectives

The overall goal of the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights is to ensure that every person living in Uganda attains the highest standard of sexual and reproductive health.

The objectives of these policy guidelines and service standards are to:

1. Guide planning, implementation, monitoring and evaluation of quality, integrated, gender-inclusive and rights-based SRH services which are well-coordinated
2. Standardize the delivery of SRHR services
3. Ensure optimum and efficient use of resources for sustainability of SRHR services
4. Promote sexual and reproductive health and rights

1.5 Guiding Principles

1. *Equity driven*: Human beings are heterogeneous with different needs for health information, education and services.
2. *Human rights based approach*: Reproductive health services are a basic human right.
3. *Participation and involvement*: Women, Men, Boys and Girls should participate in planning, implementation, monitoring and evaluation of SRHR programmes to ensure that their needs are fully addressed.
4. *Holistic*: SRHR services should encompass promotive, preventive, curative, rehabilitative and palliative care.
5. *Gender responsiveness and inclusiveness*: based on the needs of both men and women, boys and girls including vulnerabilities/disabilities.
6. *Integration*: SRHR service provision should be integrated at all service delivery points based on skills available.
7. *Accountability and leadership*: technical stewardship and political will at all levels are critical ingredients for effective delivery of SRHR services and information.
8. *Partnerships driven*: Delivery of SRHR services and information is multi-sectoral and requires joint public/private collaboration in planning, implementation and monitoring at all levels.

1.6 How the Policy guidelines and Service Standards were developed

The MoH had a series of consultative processes engaging different stakeholders over the period of review. These stakeholders included professional bodies, training institutions, NGOs and civil society organisations implementing SHRH, representation from other sectors such as education and subject.Furthermore, the process involved review of relevant documents such as HSDP (2015/16 – 2019/20), Essential Maternal and Neonatal Care Clinical Guidelines, The Uganda Treatment Clinical Guidelines, The Adapted Uganda MEC Wheel, PCPNC, ICPD, Beijing Platform of Action, MDGs, Global Strategy on Women, Children and Adolescents and now the SDGs, to mention but a few.

This policy review was informed by district consultations in order to take into account experiences of service providers and beneficiaries. Other key stakeholders consulted include the Inter-Religious Council, religious and cultural leaders, faith based organizations and the legal fraternity.

DRAFT

1.7 Who may use Guidelines

These policy guidelines and service standards are to be used by public, private and development partners who participate in sexual and reproductive health planning, promotion/advocacy and service delivery. These include policy makers, development partners, planners and managers, supervisors, service providers and trainers at all levels in the pre- and in-service training programmes.

1.8 How to use the Guidelines

This will be used as a reference document by policy-makers, development partners, reproductive health planners and managers, supervisors, service providers, trainers and students. Policy makers and Planners will adopt the guidelines to direct planning and implementation of various components of sexual reproductive health as well as monitor and evaluate service availability, accessibility, quality and utilization.

Development partners will support advocacy, resource mobilization and implementation of the SRHR program in line with these Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights.

1.9 Implementation of the Policy guidelines and Service standards

1.9.1 Dissemination and Distribution

This document will be widely disseminated to policy makers, legislators, planners, implementers, development partners and other stakeholders. It shall be made available and accessible at all levels of SRHR trainings and service delivery points.

1.9.2 Implementation of SRHR Policy guidelines and Service Standards

The major focus of the Reproductive Health Policy guidelines and service standards is to improve and ensure the provision of quality, accessible and equitable reproductive health services. The reproductive health care delivery system will operate at the national, district, health sub-district and community levels. The implementation of these policy guidelines and service standards will be in harmony with the other existing laws, regulations, policies and standards and will take into consideration the rights of both clients and service providers. The Ministry of Health has developed the Clients' Charter which is intended to raise the standard of health care by empowering clients and patients to responsibility demand good quality health care from health facilities.

Services at the HC II will further be guided by the National Community Health Extension Workers (CHEWs) Strategy, 2015/16 – 2019/20, and depend on the level of skills, competency, and infrastructure available.

At community level, VHTs/CHEWs provide SRHR services. The CHEWs will liaise directly with the VHTs (consist of different resource persons such as TBAs, CBDAs, CRHWs, MAGs, medicine distributors, peer providers etc.) at household level. These will receive basic SRHR training and equipment and will be supervised by CHEWs.

DRAFT

1.9.3 Roles and responsibilities at different service levels

National Level/Ministry of Health RH division	National Referral Hospital and Regional Referral Hospitals
The Reproductive Health Division under the Department of Community Health will perform the following tasks: • Formulate policy, set and harmonise standards and ensure quality of care including in emergency and conflict situations • Mobilise resources and ensure equitable allocation for SRHR programs • Capacity development and technical support • Coordinate SRHR services and stakeholders' activities • Monitor and evaluate SRHR sector performance • Coordinate reproductive health research in collaboration with National Research Council and other institutions • Strengthen the linkages between the national, regional referral and general hospitals in relation to SRHR services • Coordinate and ensure inter-sectoral linkages with line ministries, NGOs, CSOs, FBOs and the private sector • Coordinate IEC/ BCC interventions in collaboration with the Health Promotion and Education Division • Collaborate with other stakeholders, development partners, cultural and religious bodies in planning, implementation, monitoring and evaluation of the SRH services • Ensure that health financing strategies incorporate access to SRHR services, use of data for evidence based decisions • Strengthen capacity of districts to develop, implement and	• Plan and manage SRHR services • Ensure quality of care including in emergency and conflict situations • Provide information on available SRHR services in the health facilities • Provide comprehensive emergency obstetric and newborn care services • Provide integrated reproductive health services • Provide all recommended specialized reproductive, maternal and newborn care services including management of VVF, infertility and reproductive health cancers • Provide promotional, preventive, curative and rehabilitative SRHR services • Mobilize and equitably allocate resources for SRHR services • Implement IEC/BCC programmes • Implement pre- and in-service training program in SRHR • Conduct operations research • Receive and manage referrals from lower level health facilities • Supervise and support lower level health facilities • Collect, analyse, utilise and disseminate gender- and age-disaggregated SRH health data • Conduct relevant outreaches (specialized)

monitor SRHR programs	
General Hospitals	**District Health Office**
• Plan and manage SRHR services • Ensure quality of care including in emergency and conflict situations • Provide information on the SRHR services available in the health facilities • Provide comprehensive emergency obstetric care • Provide essential, resuscitation and intensive newborn care • Provide integrated reproductive health services • Provide specialized reproductive health services such as management of VVF, infertility and reproductive health cancers • Provide promotional, preventive, curative and rehabilitative SRHR services • Mobilize and equitably allocate resources for SRHR services • Implement IEC/BCC programmes • Implement pre- and in-service training program in SRHR • Conduct operations research • Receive and transfer referrals to lower and higher levels respectively • Supervise and support lower level health facilities • Collect, analyse, utilise and disseminate gender- and age-disaggregated health data • Conduct relevant outreaches (specialized)	• Mobilise resources and ensure equitable allocation for SRHR programs • Coordinate SRHR services and stakeholders' activities • Monitor and evaluate SRHR sector performance at district level • Strengthen the linkages between the different level of health facilities in the district in relation to SRHR services • Coordinate and ensure inter-sectoral linkages with other departments, NGOs, CSOs, FBOs and the private sector • Coordinate IEC/ BCC interventions in collaboration with the Health Promotion and Education focal person • Collaborate with other stakeholders including cultural and religious bodies in planning, implementation, monitoring and evaluation of the SRH services • Generate district and specific population strategic data to inform policies, development and funding frameworks for underserved populations •

Health Sub-district /HC IV	Health Centre III
• Guide planning, implementation, monitoring and evaluation of quality integrated gender responsive and rights-based SRH services • Conduct support supervision and mentoring of the lower health units to ensure quality of care • Resource mobilization and equitable allocation • Coordinate activities of the NGOs, and the private sector • Provide guidance to district councils and advocate for support for SRHR services • Promote community participation and involvement in SRHR service delivery • Ensure liaison between the center and lower levels • Collect, analyse, interpret, disseminate and utilize gender disaggregated health data • Conduct capacity building for lower levels • Coordinate and implement IEC activities • Provide technical, logistical, capacity development and support supervision to the lower health unit and the communities including procurement and supply of drugs • Provide comprehensive emergency obstetric and newborn care • Provide comprehensive family planning services • Conduct operational research, disseminate and use results • Conduct community outreaches	• Provide preventive, promotional, curative and maternity care including basic emergency obstetric care • Provide essential newborn care and resuscitation • Provide family planning services • Implement gender-responsive and rights-based SRHR services • Provide community outreach SRHR services • Supervise and work with CHEWS to refer clients to health center IVs or district hospitals • Organize outreaches and camps for the services requiring more skills than available • Provide IEC/BCC on SRHR • Promote community participation and involvement in SRHR services

Health Centre II	Community level
• Provide preventive, promotional and curative SRHR services • Maternity care including basic emergency obstetric care • Provide basic family planning services • Implement gender-responsive and rights-based SRHR services • Provide community outreach SRHR services • Supervise and work with Village Health Teams (VHTS) and other SRHR community resource persons • Refer clients to higher levels of health care • Organize outreaches and camps for the services requiring more skills than available • Provide IEC/BCC • Promote community participation and involvement in SRHR services	• Disseminate SRHR information/messages • Promote cultural practices that enhance reproductive health while discouraging the negative ones • Mobilize people and resources for SRHR services • Participate in health promotion and outreach activities such as Family Planning camps, child health days, malaria prevention and sanitation • Identify and refer: - pregnant women and their spouses to formal health care for family planning, antenatal care, delivery and post-delivery care, immunisation • Refer babies born at home to health facilities for check-up, immunization and birth registration • Mobilise adolescents and young people for SRHR services • Check and provide advice on care of mothers and babies after delivery • Submit community data to the supervising health facility • Encourage mothers and spouses to seek HCT and eMTCT services • Distribute commodities i.e. Contraceptives (condoms, pills, Depo provera IM, DMPA Subcutaneous), Maama Kits, Insecticide treated nets. • Facilitate emergency preparedness at household level • Establish and maintain working relationships with the nearest health unit/health worker

Training Institutions	
• Plan and implement training programs in SRHR • Conduct operations research, disseminate results including publications • Supervise and mentor trainees on-job • Mobilise resources • Work in collaboration with MoH for curricula updates	

DRAFT

1.9.4 Cross-cutting implementation functions

a) Service integration

In order to maximize use of resources, SRHR services shall be provided as an integrated health care package that is convenient to clients and service providers. Clients should be able to receive/access various SRHR services during one visit at a given static health unit or outreach depending on the facility's service capacity.

Services may be provided by the same provider in one visit, or the provider of one service may actively encourage the client to consider using another recommended service available within the same facility during that same visit, or, if the needed services are beyond the capacity of the facility or the skills of the attending provider, then appropriate referral should be effected. It is important to have an effective referral system in order to provide accessible, timely and affordable coordinated care. Integration of SRHR services into all existing health services is facilitated through:

- Capacity building
- Infrastructure improvement
- Increasing the range of commodities and sustaining availability
- Integrated supervision, motivation, monitoring and evaluation of health workers
- Facilitating effective referral across services
- Community sensitization about the existence of integrated services

b) Training

It is necessary to orient health care providers to implement the national SRHR policy guidelines and service standards. The Reproductive Health Division in collaboration with the Human Resource Division and Training Institutions will ensure that adequate numbers of health workers are competent to provide quality sexual and reproductive health services.

SRHR training needs for service providers shall be addressed through appropriate pre-service training and integrated continuing education. Reproductive Health Division will work closely with the Human Resource Division, Professional councils, Professional Associations and Ministry of Education and Sports to standardize training, review update and disseminate training materials as well as monitor and evaluate training.

c) Infrastructure Improvement

AII service delivery points (SDPs) providing SRHR services will be re-modeled to enhance smooth client flow and ensure privacy to patients and clients as well as the rights of clients and health workers. The policy supports creation of more space to cater for newer and neglected aspects such as adolescent health, pre-conception care, postnatal care, cancer screening, SGBV and eMTCT. An important consideration will be to make the services friendly to the adolescents, youth and men.

d) **Logistics and Supplies**

Total Market Approach: A total market approach will be adopted to ensure availability of SRHR essential medicines and health supplies in private and public sector mindful of elimination of inequitable access for vulnerable communities.

Forecasting and Quantification of SRHR products: The MOH Pharmacy division Quantification and Procurement Planning Unit (QPPU) will be tasked with the duty of ensuring that quantities to be procured are determined and that the commodities pipeline is monitored on regular basis to avoid stock outs and or overstocks at both national and district levels.

Regulation to ensure quality assured Medicines and health supplies: Availability of quality, safety and efficacy of medicines is a major importance to achievement of SRHR goals and outcomes. In order to achieve the aspirations of the SRHR guidelines to prevent morbidity and mortality, the end users/clients must receive quality medicines and health supplies. In Uganda, the National Drugs Authority established by an Act of parliament in 1993 is mandated to regulate importation and distribution of quality assured products. In order for Uganda to provide quality assured SRHR products, below are the policy directions:

- All SRHR commodities including contraceptives and maternal health commodities must be quality assured before importation into the country by NDA.
- NDA and other regulatory bodies should conduct regular post market survey to ensure quality during distribution of the SRHR commodities in public and private health facilities, pharmacies and drug shops.

Procurement of SRHR Essential Medicines and health supplies: Only quality, safe and efficacy SRHR medicines and health supplies should be procured and imported into the country. Where products have been prequalified by WHO, there procurement should be prioritized within the public sector. The PNFP sector is encouraged to prioritize procurement of WHO pre-qualified products to ensure quality along the supply chain.

Warehousing and distribution of SRHR products: The SRHR products will be stored and distributed according to the product guidelines of temperature, humidity and others. In the public sector, NMS shall warehouse and distribute the product to the health facility once every two months. The Alternative Distribution System (ADS) will distribute the SRHR products to private sector up to the health facility level every two months. The commodities distributed through the alternative distribution system shall not be sold to clients however, a consultation and diagnostics fee can be charged. Overstock of products must be redistributed following the Ministry of Health redistribution guidelines and expiries must be destroyed using the HMIS disposal forms and guidelines. During provision of SRHR services through outreaches around a public health facility, measures should be

undertaken to ensure that after the outreach, that particular health facility is stocked with SRHR commodities.

Logistics Management Information System: Whenever commodities are stored, there must be a stock keeping records updated and well preserved. All commodities in transit must be accompanied by transaction record and that includes movement from one storage facility to another, one health facility to another and from one unit within the health facility to another unit.

e) Quality Improvement and Control

Quality assurance and control is an essential aspect of sexual reproductive health and rights. To ensure quality SRHR services, standards of care have been set, and should be maintained, continuously monitored and evaluated. Deviations from the standards should be followed by appropriate and timely interventions to maintain and improve the quality of services. This will further be guided by the MoH Quality Improvement Framework and Strategic Plan, 2016/17 – 2019/20.

f) Record Keeping

Health workers and auxiliaries providing SRHR services, both within government and private sector including non-governmental organizations, will use the national health information management reporting forms/system (HMIS/DHIS2) for record keeping and reporting to ensure the availability of core SRHR information and performance/service data. Data from these records will be used for continuous monitoring and improvement of service delivery. SRHR service delivery sites will compile, analyze and interpret data collected and use it for improving the quality of its services. The facility will also submit reports as per procedures and requirements of MOH.

g) Research

Operational research is critical for evidence-based policy and decision-making. In collaboration with academia, research institutions, Uganda National Council of Science and Technology (UNCST) and the District Health Officers, SRHR research agenda will be set, implemented, monitored and utilized to guide SRHR planning and further policy articulation and change. Thus the MOH will:

- Ensure establishment of a Research Database on SRHR
- Influence and support research being done on SRHR services
- Facilitate dissemination and utilization of research results and findings
- Incorporate research findings into clinical service standards and guidelines
- Utilize research findings for SRHR planning and implementation as well as policy formulation and review.

1.10 Monitoring of Implementation of the SRHR Policy Guidelines and Service standards

The Ministry of Health has the overall responsibility of monitoring the implementation of the policy guidelines and service standards. The various stakeholders, in line with their mandate, will monitor the implementation of this policy at all levels and provide regular progress reports.

DRAFT

Communities shall be involved in monitoring the policy guidelines and service standards, using participatory monitoring methodologies including mTRAC reporting, scorecard implementation and the District League Table and have an avenue to present their findings and receive feedback supportive and facilitative supervision at all levels will be carried out in accordance with the national supervision guidelines for health services using standard instruments developed by the MOH and RH division. The performance improvement concept will be mainstreamed in supervision at all levels and Maternal and perinatal death surveillance and response will be institutionalized in all facilities offering Emergency Obstetric and Newborn Care.

Supervision will be the responsibility of the central, district, HSD and health facility staff and stakeholders. Communities, particularly people directly affected, have the opportunity to be meaningfully engaged in all aspects of SRHR programme and policy design, implementation and monitoring. The aim of monitoring and evaluation of the sexual and reproductive health services is to continuously assess:

- The scope, effects and impact of implementation of services
- The quantity and quality of services provided at various service delivery points to ensure adequate/appropriate response to the sexual and reproductive health needs of all clients
- The response levels and trends of the SRH services as a factor of the quantity and quality of services.

Regular monitoring will be carried out at every level and results used to influence decision-making and practice at that level. Standard indicators will be used for monitoring and evaluating.

1.11 References

1. MoH (2015 a). Health Sector Development Plan 2015/16 – 2019/2020
2. MoH (2015b). Community Health Extension Workers (CHEWs) Strategy – 2015/16 – 2019/20
3. MoH (2016a). Quality Improvement Framework and Strategic Plan, 2016/17 – 2019/20
4. MoH (2016b). Investment Case RMNCAH Sharpened Plan
5. MoH (2016c) Uganda Reproductive Commodity Security Strategy 2016/17 -2021/22
6. MoH (2016d) Uganda Alternative Distribution Strategy (ADS) for Contraceptives and Selected Reproductive Health Commodities (2016-2020)
7. MoH Patients' charter, 2016

2. SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

2.1 Definitions

a) A **human right** is a right inherent to all human beings, whatever our nationality, place of residence, sex, national or ethnic origin, color, religion, language or any other status. We are all equally entitled to our human rights without discrimination. These rights are all interrelated, interdependent and indivisible (UN Universal Declaration of Human Rights, OHCHR).

b) **Reproductive health** is a state of complete physical, mental, emotional and social well-being of an individual in all matters related to the reproductive system, its functions and processes. It includes sexual health, the enhancement of life and personal relations, prevention and care, counseling and rehabilitation related to reproduction and sexually transmitted diseases. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when and how often to do so.

2.2 Reproductive health rights

Reproductive health rights embrace certain human rights that are already recognized in international human rights documents and national laws. The reproductive rights include:

- The right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children
- The right to access health services
- The right to information regarding sexual and reproductive health
- The right to attain the highest standard of sexual and reproductive health
- The right to scientific progress and to consent to experimentation
- The right to make decisions concerning reproduction, free of discrimination, coercion and violence.
- The right to respect of bodily autonomy

DRAFT

2.3 Human Rights Based Approach

Mainstreaming of Human Rights Based Approach (HRBA) is regarded as an essential tool for achieving sustainable health and development outcomes e.g. reducing IMR, MMR and ensuring access to sexual & reproductive health care, and others[1].This is based on the following principles;

- ***Participation;*** all people have the right to participate in and access information relating to the decision making processes that affect their lives and well-being. This principle calls for active involvement from planning, implementation and evaluation stage.
- ***Accountability and rule of law;*** The State and other duty-bearers must comply with the legal norms and standards enshrined in the international human rights instruments. Where they fail to do so, aggrieved rights-holders are entitled to institute proceedings for appropriate redress before a competent court or other adjudicator, access to information and demand by the rights holders.
- ***Equality and Non-discrimination;*** No one should suffer discrimination based on race, color, ethnicity, gender, age language, religion, political or other opinion, national, social or geographical origin, disability, property, birth or other status.
- ***Empowerment;*** The full realization of human rights is dependent on the empowerment of the rights-holders to exercise his/her inherent claims and entitlements. This means that for any rights holder or duty bearer to attain the highest standards of health, every individual is empowered to exercise their choices in relation to sexual and reproductive health issues.
- ***Legality of rights;*** Human Rights are legally enforceable and must be linked from international, regional, national and local levels.

2.4 Legal framework supporting SRHR

Uganda has ratified a myriad of human rights instruments that include covenants, treaties, charters and made a number of commitments under various regional and global processes including; Revised Maputo Plan of Action, Maputo Protocol, East and Southern Africa (ESA) commitments, ICPD and the 2015 Sustainable Development Goals (SDGs). Common across most of these instruments, in the context of health, they impose upon the government an obligation to respect, protect and fulfill reproductive health as an element of the right to health.

At the national level, the Ugandan constitution, 1995 under National Objectives and directive principles of state policy;

Objective XIV: Imposes an obligation on the state to ensure that all Ugandans access health services, food and shelter among others.

Objective XX: Implores the state to take all practical measures to ensure the provision of basic medical services to the population.

Article 33(3): Creates an obligation upon the state to take the necessary steps to protect the rights of women, taking into account their unique status and natural maternal functions in society.

[1]Second National Development Plan (NDPII)2015/16 – 2019/20

Furthermore, Uganda has a vibrant policy framework that seeks to articulate the relevant standards, policy and human rights considerations that need to be born in mind by stakeholders in the course of the provision of SRHR services. These policies range from the broader National Development Plan II, the National Health Plan, the health Sector development Plan 2015/2016-2019/2020, to the more specific SRHR policy frameworks on SRHR that include the Family Planning Costed Implemented Plan, The National Adolescent Health Policy 2004, and the Reproductive Health Policy.

2.5 Rights and Responsibilities of different parties

2.1.1 Rights of Patients	**2.1.2 Responsibilities of patients**
• Right to medical care incl. emergency care; referrals; second opinion • Non discrimination • Participation in decision making • Clean and healthy environment • Appropriate and qualified medical care • Treated by identified health workers • Informed consent (verbal/written); exceptions • Access to adequate and accurate Information • Safety and Security • Receive visitors • Refusal of treatment – with conditions • Freedom from torture • Confidentiality and Privacy • Redress – complaints of violations/abuse; penalties and disciplinary action	• Provision of relevant and accurate information for treatment, counselling or rehabilitation • Compliance with instructions given • Refusal of treatment • Respect and consideration • Take responsibility for refusal of treatment/follow instructions • Will – free to express his/her wishes • Payment for services rendered
2.1.3 Rights of Health Workers	
• Respect and consideration • Favourable working conditions (prompt and adequate salaries and allowances; adequate number of skilled staff, accommodation, offices (space), transport, equipment, training opportunities), protective gear. • Fair hearing and appeal. • Leave (sick, maternity, paternity, annual) • Freedom of association (trade union) • Right to privacy and confidentiality • Terminal benefits • Adequate and accessible Information	

2.6 Components of SRHR

These policy guidelines and service standards are based on the 1994 ICPD in Cairo definitions and components of reproductive health. Countries prioritize within this package according to their resources. This Package includes:

- Safe Motherhood, nutrition and breastfeeding
- Prevention and management of unsafe abortion
- Family Planning
- Infertility
- Adolescent Health
- STIs including HIV/AIDS
- Cancers of the reproductive organs
- Menopause and andropause
- Gender issues (Gender-based Violence: Female Genital Mutilation (FGM), Rectal Vaginal Fistulae (RVF), Vesicle Vaginal Fistulae (VVF) and Male Involvement.

2.7 References

1. The Republic of Uganda (1995). The Constitution of the Republic of Uganda.
2. National Planning Authority (2015). National Development Plan II -2015/16 -2019/20
3. MOH Patients' Charter, 2016
4. ICPD 1994 – Cairo declaration – components of SRH

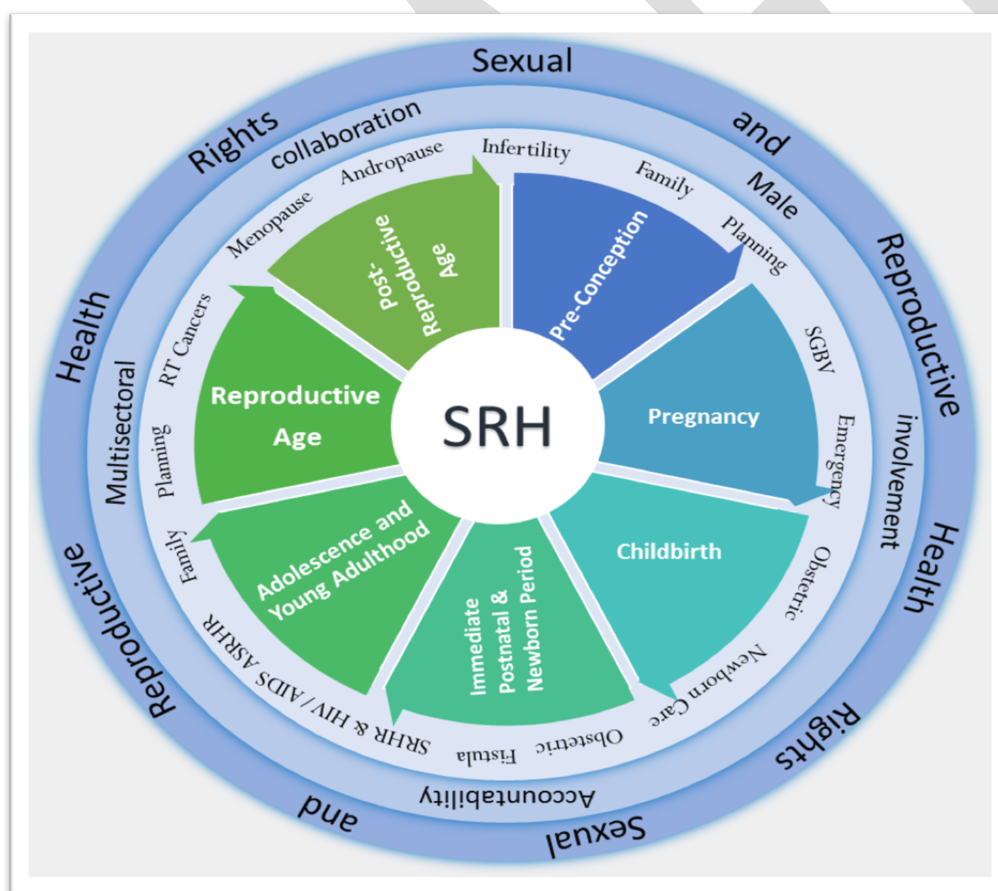
DRAFT

3. SRHR THEMATIC AREAS

3.1 Introduction

This chapter describes the different components constitute SRHR in these national SRHR policy guidelines and service standards. The components are arranged to address the different SRHR needs along the life cycle starting before pregnancy, during pregnancy, childbirth, adolescence, and conditions associated with aging (post reproduction). The thematic areas are; family planning and contraceptive service delivery, safe motherhood; obstetric fistulae; adolescent sexual and reproductive health and rights; integration of STIs/ HIV and AIDS; infertility, cancers of the reproductive tract; menopause and andropause and sexual and gender based violence.

Figure 1: SRHR in Uganda- Components, Linkages and Rights



3.2Sub-Theme 1: FAMILY PLANNING AND CONTRACEPTIVE SERVICE DELIVERY

3.2.1 Definitions

Family Planning is the practice of spacing children using both natural (traditional) and modern (artificial) birth control methods. There are two types of family planning methods: natural and modern (artificial). The modern methods are further sub-divided into short-term, long-term, permanent and emergency contraception methods.

Contraceptive is a device, drug, or chemical agent that prevents pregnancy.

Contraceptive Prevalence Rate (CPR) is the percentage of currently married women who are currently using a method of contraception.

Unmet Need for family planning refers to fecund women who are not using contraception, but who wish to postpone the next birth (spacing) or who wish to stop childbearing altogether (limiting).

Women with Unmet need for spacing	Women with unmet need for limiting
• At risk of becoming pregnant, not using contraception, and either do not want to become pregnant within the next two years, or are unsure if or when they want to become pregnant • Pregnant with a mistimed pregnancy • Postpartum amenorrhoeic for up to two years following a mistimed birth and not using contraception	• At risk of becoming pregnant, not using contraception, and do not want (more) children • Pregnant with an unwanted pregnancy • Postpartum amenorrhoeic for up to two years following an unwanted birth and not using contraception

Infecund Women are Women not at risk of becoming pregnant
Total unmet need is the sum of unmet need for spacing plus unmet need for limiting
Demand for family planning is the sum of total unmet need plus total contraceptive use
Proportion of demand satisfied is total contraceptive use divided by the sum of total unmet need plus total contraceptive use.

3.2.2 Context and Rationale

Uganda has one of the highest population growth rates in the world per year at 3.2% and a high fertility rate of 5.4 children per woman. This trend has been declining since the 1980s.
Building onto the recommendations of the International Conference on Population and Development (ICPD) – 1994 and the commitments of the Millennium Development Goals (MDGs),

the recently launched global Sustainable Development Goals (SDGs) 3 and 5 include direct and indirect outcomes related to family planning. Sustainable Development Goals (SDGs) definition of Reproductive Health is the right of men and women to be informed and have access to safe, effective, affordable and acceptable method of family planning of their choice.
Uganda's contraceptive prevalence rate among all married women (age 15-49 years) increased from 30% in 2011 to 34.8% in 2016 and the national commitment is to increase mCPR amongst married and women in union to 50% by 2020. Reaching this target however requires addressing certain implementation challenges including:

- Satisfying existing and creating additional demand for family planning by improving quality of family planning services
- Ensuring consistent availability of a reliable method-mix supply of high-quality contraceptives
- Priority financing for Family planning commodities and services
- Removing Bottlenecks in supervision, monitoring, and coordination include limited dedicated staffing resources at the national and district levels
- Implementing high impact FP interventions, such as, Post-partum Family planning (extending from the immediate post-partum period to 1 year post-delivery).

Policy Statement
Every sexually active individual should have access to quality Family Planning information and services whenever they need them

3.2.3 Policy goal

The goal is to provide information and services that will enable individuals and couples to decide freely and responsibly when, how often and how many children to have.

3.2.4 Specific objectives

- To increase access to quality, affordable, acceptable and sustainable family planning services to everyone who needs them in all service delivery points throughout the health care system
- To promote integrated family planning information and services in the health sector at all levels and within the various sectors
- Leverage the growing and improving public and private sectors and their contribution to provision of family planning information and services

3.2.5 Target audience

Every individual who is in reproductive age group can receive family planning and contraceptive services of their choice irrespective of marital status, disability or mental status (refer to Sec 3.2.10 on Dialogue for FP services).

Primary:	*Secondary:*
• Post abortion and post-partum clients • Adolescents and young people In and out of school • Women with current or past obstetric, medical and surgical conditions likely to worsen with pregnancy and child birth e. g sickle cell disease, hypertension, diabetes mellitus, psychiatric conditions and cesarean sections etc • Individuals/couples infected/affected with HIV • Persons in difficult circumstances such as commercial sex and those in conflict areas • Survivors of rape, defilement and other forms of SGBV • Women with five or more live births • Women who have undergone repair of a vaginal and or rectal fistula • Women who have a pregnancy interval of less than 2 years • Young and nulliparous women who want to delay their first pregnancy • Boys and men • Other populations	• Health care Providers • Parents • Traditional and opinion leaders • Political and religious leaders

DRAFT

3.2.6 Implementation strategies

To achieve the set objectives the following strategies will be strengthened:

- Linkage with the school health programs and health facilities
- Increase age-appropriate SRHR key information to ages 10-14 years
- Increase access to Information and use of family planning for women in reproductive age (15-49 years) and men in reproductive age
- Promote and nurture change in social and individual behaviour to address myths, misconceptions, and side effects and improve acceptance and continued use of family planning to prevent unintended pregnancies
- Implement task sharing to increase access, especially for rural and underserved populations

- Mainstream implementation of family planning policy, interventions, and delivery of services in multi-sectoral domains to facilitate a holistic contribution to social and economic transformation
- Improve forecasting, procurement, and distribution and ensure full financing for commodity security in the public and private sectors

These will be realized through the:

- Expansion of service delivery points
- Improvement of communication through community based and social marketing approaches
- Training of service providers to enhance technical skills and improve attitudes
- Guaranteeing the availability of family planning commodities and supplies at all levels
- Improvement of family planning logistics management information system (LMIS/HMIS)
- Enhancement of political and community support and participation in family planning activities
- Improvement of record keeping; guidelines for data capture in both public and private sector using the Health Management Information System (HMIS)
- Strengthening of the follow-up, supervision and referral systems
- Involvement of men and male support groups

Family planning services and information and services

3.2.7 Family Planning Service Standards

Family planning service standards describe:

- Service delivery outlets
- Family planning methods to be provided at each service delivery point
- Provider cadres
- Staffing norms (refer to the HSDP 2015/16-2019/20)
- Standards on provision and referral system

3.2.7.1 Information, Education and Behavior Change Communication (IEC / BCC)

IEC aims at increasing one's understanding of family planning and contraception so as to increase the utilization of the FP services. The following settings and channels will be used for the dissemination of FP information:

Settings

- Service delivery points where a health provider comes into contact with a potential or actual client
- Social mobilization events for any health services
- Youth clubs through family life education activities
- Organisations of people with disabilities

- Women and men organized clubs/groups
- Work places

The communication channels available are numerous. The most appropriate channel for the intended audience will be utilized.

The basic FP **messages** should include:

- Definition of family planning and contraceptives
- Health benefits of family planning
- Benefits of pre-conception care and counseling
- Benefits of post-partum and post-abortion FP and counseling
- Types of FP methods available for women and men and where to obtain them
- Prevention of STD and HIV/AIDS
- Dangers of grand multi parity
- Conception and pregnancy in persons with medical conditions and disorders
- Risks of conception and pregnancy in persons with HIV infection and AIDS
- Non-health benefits of family planning, including socio-economic and demographic benefits
- Fertility awareness
- Who should use and who should not use different methods
- Common side effects of different methods and what to do should a side effect manifest
- Risks of adolescent pregnancy / adolescent fertility
- Myths and misconceptions related to FP
- The important role of men in FP

Both health and non-health personnel will be actively involved with IEC/BCC activities after they have been well trained or oriented in respective subjects, counseling and communication for FP services.

3.2.7.2 Service delivery outlets

In line with the National Health Policy, services will continue to be provided through government, non-governmental and private sector facilities, units and outlets. The following being the recognized outlets of FP service provision:

- Facility based outlets such as hospitals, health centers and dispensaries
- Outreach services including mobile clinics and workplaces
- Community-based outlets e.g. community-based distribution (VHTs/ CHEWs), drug shops and dispensing machines;(refer to Addendum to Uganda National Policy guidelines and service stands for community based provision of injectables)
- Social marketing
- Private sector facility such as clinics, maternity and nursing homes, pharmacies and drug

DRAFT

retail shops

All personnel involved in the provision of FP services must be adequately trained and equipped to provide quality service. The training in the FP and RH will be based on the curriculum approved by the MoH. The training of FP service providers will be conducted at two levels: pre-service at recognized institutions and in-service by recognized institutions and NGOs and by trainers certified by the MoH. Task shifting to VHTs, nurses and midwives will be encouraged for selected methods, provided appropriate training using approved curricula; and adequate support supervision is ensured.

3.2.7.3 Family planning services to be provided

These will consist of counseling, screening, provision of methods, management of side effects and complications, referral and follow-up.

Counseling: In order to promote informed choice, all clients seeking contraceptives are entitled to being given age-appropriate, accurate and adequate information about Family Planning methods available in the country. This is important for the initiation and continuation of FP practice. Methods (of choice) of clients will be done individually and in a dignified manner. The discussion between the service provider and client must be private, confidential and should never include incentives or coercion for the adoption of any method.

Initial counseling will include the following:

- A discussion of a client's reproductive goals, previous knowledge and/or experience with any method
- Showing the FP methods available
- Information on how each method prevents pregnancy
- How effective the method is and what conditions make it effective
- Method failure
- Common side effects
- The follow-up regarding each method
- Where the method can be obtained
- Importance of physical and pelvic examination
- Information on HIV/AIDS/STIs in relation to FP
- HIV testing and screening of STIs
- Symptoms of breast and cervical cancer including available services for screening
- Clarification of misconceptions or rumors the client may have about each type of method

Subsequent counseling will aim at promoting and encouraging continued use of a method and should include:

- A review of the client's satisfaction or problem with the method

DRAFT

- A review of the client's understanding of user instructions
- Dispelling rumors and/or misconceptions, if any
- If indicated, a review of change of the client's reproductive goal necessitating the need for a long-term or permanent method
- Counseling on STI and HIV/AIDS
- Possible method failure
- Information of common symptoms of breast and cervical cancer including available services for screening

Counseling is also important:

- Where a contraceptive method has failed
- There is regret for having had a permanent method
- In cases of rape or defilement
- Where there is need for referral for appropriate care

Screening: After a thorough counseling a client should then be ready to choose a contraceptive method. The next step is to screen for contraceptive use.

- Clients opting for hormonal method should have the relevant health, social history taken and physical assessment carried out on the first or subsequent visits. Where indicated, do a complete physical check-up to rule out contra-indication to method use. Where it is not possible or necessary to perform routine physical assessment, the client should be screened by a qualified staff or FP trained service provider using a standard checklist to initiate or resupply oral contraceptive or Depo provera.

After the screening, important findings will be communicated to the client including any issues she/he may want clarification on. The client will then be provided with the appropriate or preferred method and important findings should be recorded according to the guidelines.

Routine physical or pelvic examination is not obligatory for initiating or re-supply of oral contraceptives or Depo provera. However, an examination could be valuable for reproductive health and may help to rule out contra-indications to method and/or establish the presence or absence on infections or cancer.

Where selected physical assessment or laboratory tests are indicated and is not possible to carry them out at a particular clinic, clients should be referred to a health unit equipped to provide the assessment test.

- In case of **community based distribution services**, the VHT should obtain the client's health and social history during the initial encounter using the standard checklist. The agent will then initiate or provide the appropriate contraceptive method (pills, condoms, depo-provera) if no problems are identified

DRAFT

- In **social marketing outlets**, the screening will depend on the level of the service, the competence of the provider and resources available

3.2.8 Eligibility Criteria

All sexually active males and females in need of contraception are eligible for family Planning services provided that:

- They have been educated and counseled on all available family-planning methods and choices
- Attention has been paid to their current medical, obstetric contra-indications and personal preferences, in line with the updated Uganda Medical Eligibility Criteria for Contraceptive Use. (See Annex 1)

3.2.9 Dialogue for family planning services (Married)

FP discussion and dialogue is encouraged between couples including couple counselling for consensus.

Table 1: FP Service standards

Category	Services delivery level
Infrastructure and equipment	**Community level**: A safety small box for keeping supplies, HMIS forms, Pen **HC II**: A counselling space that ensures privacy, two chairs and table **HC III**: All the above in HC III plus an injection room, a couch for use to insert IUDs, Minor surgery room for Implants **HC 1V**: All the above plus theatre for TL and Vasectomy **General Hospital**: All the above **Regional Referral Hospital**: All the above **National Referral hospital**: all the above
Management systems	
Infection control	**Community Level:** sharps box, gloves, soap **HC II:** All the above plus coded infection control bins, sterilizer **HC III**: All the above HC IV: all the above **General Hospital**: All the above

Table 2: Family Planning Service Provision by Cadre of Staff

Type of Service	Health promoter and Social Marketing Agent	CHEWs/ VHTs	Nursing Assistants	Nurses	Midwife	Clinical Officer	Doctor
Counselling		✓	✓	✓	✓	✓	✓
Home visits		✓	✓	✓	✓	✓	
Health Education talks	✓	✓	✓	✓	✓	✓	✓
Print media messages	✓			✓	✓	✓	✓
Electronic media messages	✓			✓	✓	✓	✓
Combined Oral Contraceptives (COCs)		✓	✓	✓	✓	✓	✓
Progesterone Only Pills (POPs)		✓	✓	✓	✓	✓	✓
Condoms	✓	✓	✓	✓	✓	✓	✓
DMPA Inj. (Dept provera and Sayana Press)		✓ *	✓ *	✓	✓	✓	✓
Noristerate Inj.				✓	✓	✓	✓
Norigynon inj.				✓	✓	✓	✓
Intra uterine Devices				✓	✓	✓	✓
Post-partum IUDs				✓	✓	✓	✓
Foam tablets		✓	✓	✓	✓	✓	✓
Creams/ Jellys		✓	✓	✓	✓	✓	✓
Bilateral tubal ligation				✓ *	✓ *	✓	✓
Vasectomy				✓ *	✓ *	✓	✓
Implant insertion and removal				✓	✓	✓	✓
Emergency contraception pill		✓	✓	✓	✓	✓	✓
Fertility Awareness methods		✓	✓	✓	✓	✓	✓
LAM		✓	✓	✓	✓	✓	✓
Supervision of lower cadres				✓	✓	✓	✓

* will require special training and close supervision

Note: Natural FP methods officially known for their effectiveness will be encouraged at every level by all service providers.

3.2.10 References

1. MoH (2015a). Uganda Family Planning Costed implementation Plan 2015-2020
2. MoH (2015b). Uganda Health Sector Development and Investment strategy 2015/16-2020/21
3. MoH (2015c). Annual Health sector performance report FY 2015/16
4. MoH (2016a). Investment Case for the RMNCAH Sharpened Plan 2016-2020
5. MoH (2016b). Health Ministerial policy statement FY 2016/17
6. UBOS (2016). Uganda Demographic Health survey 2016; Preliminary findings
7. WHO (2015) 5th Edition Medical Eligibility Criteria Wheel for Contraceptive Use

3.3 Sub-Theme 2: SAFE MOTHERHOOD: MATERNAL AND NEWBORN HEALTH CARE

3.3.1 Definitions

Safe motherhood means ensuring that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth. Safe motherhood encompasses a series of initiatives, practices, protocols and service delivery guidelines. It is designed to ensure provision of high-quality gynaecological, family planning, preconception, antenatal, labor, delivery and postpartum care services in order to achieve optimal health for the woman, foetus and newborn.

3.3.2 Context and Rationale

Thousands of women and millions of newborn babies, worldwide, die from preventable causes during pregnancy, childbirth and immediately after birth. In Uganda, the proportion of births supervised by a skilled health worker has risen from 58% in 2011 to 74% in 2016. The proportion of pregnant women who make the recommended minimum of four antenatal visits has remained low at 59.9% compared to 47.6% in 2011, against the national target of 75%. While 97% of women received antenatal care from a skilled provider at least once during pregnancy in 2016, the median duration of pregnancy for the first antenatal visit is 5.1 months.

Policy Statement

Every woman shall receive high-quality gynaecological, family planning, preconception, antenatal, labour and delivery and postpartum care services, in order to achieve optimal health for the mother, new-born and infant.

3.3.3 Policy goal

To ensure that no woman or newborn suffers morbidity or mortality related to pregnancy or childbirth.

Specific objectives are to;

- To provide guidance to health care providers in the delivery of quality maternal and newborn care services at all levels
- Integrate of maternal and newborn care services at all levels of service delivery in the national health system
- Provide timely adequate accurate information, education and counselling services on pregnancy care and related processes to mother and partner
- Involve men and women to demand for services that promote safe motherhood
- Eliminate vertical transmission of diseases to infants

DRAFT

3.3.4 Implementation strategies

The following strategies will be employed to achieve the above policy objectives;

- Putting emphasis on longer-term efforts to strengthen the health system
- Address the social determinants of health
- Expand the country measurement of skilled birth attendance from merely "skilled birth attendant" or "institutional delivery" to include conformity to quality of care standards
- Apply/scale-up innovative approaches to overcome this long inertia in coverage of at least four ANC visits
- IEC/BCC, using all modalities of communication to reach everyone
- Provision of quality emergency obstetric and newborn care services at all BEmONC service delivery points
- Supporting Integrated Community Based Safe Motherhood Programmes for information, service delivery and commodity distribution

These will be realised through the following interventions and in-line with the Safe Motherhood priorities of the national RMNCAH Investment Case;

- Improving quality from provider and client perspectives and, mobilising more mothers to start ANC within the first trimester
- Expansion of BEmONC service delivery points to improve coverage
- Improvement of communication through implementation of the key family care practices for maternal and newborn care
- Training of service providers to enhance technical skills and improve attitudes
- Guaranteeing the availability of essential maternal and newborn care commodities and supplies at all levels of information and service delivery
- Enhancement of political and community support and participation in safe motherhood activities
- Implementation of quality improvement practices including maternal and perinatal death surveillance and response at all levels
- Strengthening of the follow-up, supervision and referral systems

3.3.5 Target audience

Primary target:	*Secondary target:*
• Pregnant women and their partners • Women in labour • Post-natal and breast feeding mothers • Adolescents • Women who are HIV-positive or suffering from AIDS(pregnant and not pregnant) • Women with abortion related problems	• Health Workers • All women and men of childbearing age • Male partners • Care givers • Family members and community • Parents and caretakers of newborns [Pregnant women, mothers, fathers, family

• Women whose pregnancy is a result of sexual and gender based violence • Vulnerable and disadvantaged groups (disabled, displaced persons people living in hard-to-reach areas, prisoners, street women and children, children living with elderly caretakers • Newborn babies who are: ▪ normal but for routine examination and care ▪ sick and/or need resuscitation ▪ have low birth weights ▪ have congenital abnormalities ▪ born to HIV-positive mothers ▪ whose mothers die during childbirth ▪ unwanted/abandoned	members and community members] • Newborn Community health Service providers [Village Health Teams (VHTs), community-based and civil society organizations (CBOs and CSO)] • Family based health workers [public and private] handling newborns

DRAFT

3.3.6 Components of Safe Motherhood (Maternal and Newborn Health Services)

The following comprise the maternal and newborn health services commonly referred to as safe motherhood services:

- Family planning
- Preconception care
- Ante-natal care
- eMTCT
- Emergency obstetric and newborn care (EmONC)
- Post-natal care for both mother and newborn including cervical cancer screening
- Prevention of Abortion and post abortion care
- Essential newborn care including neonatal resuscitation and extra care for low birth weight babies

a) Pre conception Care

This is the provision of information and services (biomedical, behavioural, and social health interventions) to boys, girls, women and men, and couples before mothering and fathering a child. It aims at improving their health status, reducing behaviours and environmental factors that contribute to poor maternal and child health outcomes.

Fifty percent of women (UDHS 2011) report that their pregnancies are unintended which contributes significantly to induced abortions and its complications. Further, Uganda reports 25% teenage pregnancies. Uganda has the highest prevalence of sickle cell mothers and anaemia in pregnancy. This calls for preconception care as an essential component of safe motherhood at all levels of health care and all people should be informed about its availability to improve pregnancy and child birth outcomes.

Specific objectives for preconception care are to;

- Assess and prepare clients readiness for pregnancy and child birth
- Identify, treat and prevent medical conditions that affect pregnancy and the newborn (anaemia, malnutrition, HIV, STIs, DM, cardiac disease, sickle cells, etc.)
- Promote safe and responsible sexual behaviours
- Promote delay of age at first pregnancy
- Promote healthy timing of pregnancy in clients with life threatening medical conditions.
- Promote responsible parenthood

Table 3: Information and Services provided during Preconception care

Information	Services
• Proper nutrition practices • Hygiene • Responsible motherhood and fatherhood • Contraception and family planning • STI/HIV and AIDS prevention and treatment • Malaria prevention and treatment; use of ITNs • Life skills • Schedule for tetanus toxoid • Genetic and familial diseases • Pregnancy and child birth • Infertility • Gender and domestic violence • Reproductive health cancers	• Immunization with tetanus toxoid, Hepatitis B and Rubella • Family planning • Iron and folic acid supplementation • Screening and-management of anaemia including deworming • Screening and management of STI /HIV and AIDS • HIV counselling and testing • Screening and management of medical conditions such as sickle cell disease, hypertension, diabetes and Rhesus factor • Assessing for physical abnormalities • Routine screening for RH Cancers • Regular counselling on readiness for pregnancy • ITNS distribution and use

b) Ante-natal Care

Ante-natal care is defined as a planned programme of medical management of pregnant women directed towards making pregnancy, labour and puerperium a safe and satisfying experience.

The policy recommendations is 8 contacts through each pregnancy. The contacts should be made as follows:

First visit - early (0-12weeks) in first trimester after two missed periods

Second visit - 12 to 20 weeks

Third visit - between 20 to 34 weeks

Fourth visit - after 34 weeks

Consecutive visits at 36, 37, 38 and 40 weeks' gestation

A woman can attend more than 8 ANC visits according to the recommendation of the Service provider.

Goal-oriented or Focused ANC is an approach that emphasizes evidence-based, actions with a specific purpose or intention. The actions are individualized, woman-centred and aim at quality care by skilled health care provider rather than number of visits to the facility. It ensures provision of appropriate evidence based care at the most appropriate time, to a pregnant woman from the time Pregnancy is diagnosed up to the time of delivery. During this time the couple is prepared for a safe delivery of a live baby.

ANC shall be available to all pregnant women

The objectives are:

- To monitor the progress of pregnancy in order to ensure maternal health and normal foetal development
- To recognize deviation from normal and provide management or treatment as required, ensuring privacy at all times
- To ensure that the woman reaches the end of the Pregnancy physically and emotionally prepared for her delivery
- To prepare the mother for breastfeeding and give advice on infant feeding
- To offer nutritional advice to the mother
- To prevent, identify and manage any illnesses that occur during pregnancy
- To provide advice and information to the woman and/or couple on responsibilities during pregnancy, labour and delivery, parenthood and reproductive health choices
- Identify and appropriately deal with risk-pregnancy

Basic services to be offered during ante-natal

Please see Annex 2 for the ANC schedule.

Information given during antenatal should include;

- Conditions that give problems to women and babies during pregnancy, childbirth and soon after childbirth
- Importance of antenatal care, components and schedules

- Changes and common discomforts of pregnancy
- Rest and exercise
- Proper nutrition and hygiene during pregnancy, labour and lactation; Iron and Folic Acid supplementation respectively
- Malaria prevention
- Infant feeding and child welfare
- Prevention and care of STIs/HIV/AIDS
- Avoidance of alcohol, smoking and medicines that are not recommended by medical workers during pregnancy
- Warning signs of pregnancy complications
- Preparation for delivery (birth-plan) and emergencies- (Birth Preparedness and complication readiness)
- Information on the dangers of SGBV during pregnancy

The concept of focused or goal –oriented Antenatal Care where every visit made aims at achieving a specific goal in health promotion and pregnancy management will be emphasized at all service delivery points providing maternity services.

Antenatal services will be integrated and provided on a daily basis at all levels and service delivery (both static and mobile) of the reproductive health service delivery.

DRAFT

Table 4: Antenatal care: Levels and Cadre of Health Workers

PROVIDERS			LEVELS OF CADRE																	
	Comm	HC II		HC III			HC IV						General hospital				Referral			
ACTIVITY	VHTS/ CHWS	MW	NA	MW	CO	N / NA	MW	CO	MO	N	LA	NA	N	MW	MO	CO	LA	OBS	MW	MO
Registration	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓
History-taking	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓
Gen. Exam	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓
Obs. Exam				✓	✓	✓	✓	✓	✓	✓				✓	✓			✓	✓	✓
Vaginal Exam				✓	✓	✓	✓	✓	✓	✓				✓	✓			✓	✓	✓
Lab. Investigation											✓						✓	✓	✓	✓
Rapid and bedside tests[2]				✓	✓	✓	✓	✓	✓					✓	✓	✓	✓	✓	✓	✓

DRAFT

[2] Rapid tests include HIV, RBS, HCG pregnancy

Risk Assessment	✓			✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓
Ad. Routine Drugs				✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓
Immunisation				✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓
Client education	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓
Management of complications				✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓
Referral	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓		✓	✓	✓

✓ Activity is done CO – Clinical Officer (Medical Assistant) MW – Midwife
N – Nurse NA – Nursing Assistants (Nurse Aides) OBS – Obstetrician
CHEWs-Community Health Extension Workers ; MO – Medical Officer LA – Laboratory Assistant

DRAFT

c) Labour and Delivery Care

Labour is the process of regular, rhythmic, painful uterine contractions increasing in frequency, duration and strength leading to progressive dilation of the cervix and decent of presenting part, resulting in complete expulsion of the baby, placenta and membranes.

The proportion of births occurring in health facilities rose from 59% in 2011 to 73% in 2016 and by a skilled birth attendance from 57% to 74% in 2011 and 2016 respectively. This increasing trend in skilled birth attendance has occurred across all regions of the country including hard-to-reach rural areas. The increasing coverage in SBA is not commensurate with the reduction in MMR in Uganda. Quality management of labour including use of partograph to monitor progress of labour followed by timely interventions can improve birth outcomes for both mother and baby pair. Good quality care should be rights-centred, respectful and includes use of appropriate skills and technologies.

The **objectives** for labour and delivery care are to:

- Ensure a clean and safe delivery for the mother and baby
- Ensure early care seeking during labour
- Ensure accurate monitoring and documentation of progress of labour using partograph, and prompt action in case of poor progress.
- Eliminate Mother to child transmission of HIV
- Ensure health facilities are providing quality care and services for newborns and mothers during labour

Services offered during labour and delivery will include:

- VHTs/CHEWs identifying and immediately assisting labouring mothers to reach skilled health workers
- Monitoring labour using a partograph
- Identification and management of abnormal events and emergencies
- Ensuring the comfort of the mother
- Involvement of the partner and other relatives according to the mother's wishes
- Keeping the baby warm
- Assess the baby's Apgar score and if necessary, provide Neonatal resuscitation
- Use of antibiotics for pre-term premature rupture of membranes and antenatal corticosteroids in pre-term labour
- Early initiation of breastfeeding
- Ensuring a clean and safe delivery of the baby, placenta and membranes
- Giving relevant anti-retrovirals according to the eMTCT guidelines to HIV positive mothers and newborns
- Ensure adequate nutrition and re-hydration as appropriate
- Timely referral services to the next level of care in case of complications

Standards for labour and delivery care

The following basic conditions are required to offer quality labour and delivery services depending on the level of BEmONC facility;

- Health workers qualified, skilled and knowledgeable to:
    - monitor labour using partograph and take action as required
    - conduct delivery according to the national standards, including Active Management of Third Stage of Labour (AMTSL)
- Aseptic techniques when performing procedures during labour following the universal precautions for prevention of infections
- Adequate light, clean running water and reliable power source
- Health facilities with basic infrastructure to cater for both high risk and normal babies including resuscitation space, nursery space and beds for Kangaroo mother care
- Health facilities stocked with basic equipment for managing high risk and normal babies. These include complete set of delivery instruments, thermometers, Infant ambu-bags and masks, penguin suckers, baby weighing scale and baby oro-pharyngeal airway.

Every woman in labour has a right to skilled birth attendance.

DRAFT

Table 5: Labor and Delivery: Levels and Cadre of Health Workers

Service providers at each level of health care delivery system below will perform Labour and Delivery activities:

PROVIDERS	LEVELS AND CADRE															
	Comm	HC II and HCIII				HC IV					General Hospital			Referral		
ACTIVITY	CHEWs / VHTs	MW	CO	N	NA	MW	CO	MO	N	NA	MW	MO	OBS	M W	MO	OBS
Registration	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
History-taking		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Physical. Exam		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Obs. Exam		✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Vaginal Exam		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Diagnosis of labor		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Use of Partograph		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Risk Assessment		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Referral	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Normal delivery		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Active management 3rd stage		✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Episiotomy and repair		✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Vacuum Extraction						✓	✓	✓			✓	✓	✓	✓	✓	✓
CES/section						✓	✓	✓	✓	✓	✓		✓		✓	✓
Destructive operation												✓	✓			✓
Management of complications		✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

✓ Activity is done **CO** – Clinical Officer (Medical Assistant) **MW** – Midwife

N – Nurse **NA** – Nursing Assistants (Nurse Aides) **OBS** – Obstetrician

CHEWs- Community Health Extension Workers **MO** – Medical Officer

d) Emergency Obstetric Care

This is urgent medical care given to a woman for complications related to pregnancy, labour, delivery and puerperium with the purpose of preventing maternal death.

Every pregnant woman is at risk of developing complications during labour, childbirth and immediate postpartum. Although the majority of women get a spontaneous vaginal delivery without any complication, an estimated 15% of all pregnancies are likely to develop complications during labour and child birth thus the health system should be well prepared to address such eventualities. Families and communities need to be aware of complications and seek health care and help the pregnant woman when complications arise. The common complications are:

- Haemorrhage
- Infections
- Obstructed labour
- Abortion and abortion complications
- Hypertensive disorders
- Shoulder dystocia
- Cord prolapse

The common complications or causes of concern among in the newborn are:

- Asphyxia
- Prematurity
- Infection (through the cord stump)
- Hypoglycemia
- Hypothermia

Emergency obstetric and newborn care is categorized into Basic and Comprehensive.

Basic emergency obstetric and newborn care

This will be provided at all facilities offering delivery services while comprehensive EmONC will be provided by health centre IVs and hospitals.

DRAFT

BEmONC Services	CEmONC Services – perform signal functions 1 – 7, plus
1. Administer parenteral antibiotics (to treat puerperal sepsis or in septic abortion) 2. Administer uterotonic drugs (e.g. parenteral oxytocin, ergometrin, misoprostol) (to stop PPH or post-abortion bleeding) 3. Administer parenteral anticonvulsants [for pre-eclampsia and eclampsia (e.g. magnesium sulfate)"] 4. Perform manual removal of placenta (in retained placenta) 5. Perform removal of retained products (e.g. manual vacuum aspiration, use Misoprostol for PAC) 6. Perform assisted vaginal delivery (e.g. in breech delivery, vacuum extraction, forceps delivery) 7. Perform newborn resuscitation e.g. (i) For birth asphyxia: Newborns who do not start breathing on their own (birth asphyxia) by one minute after birth, should be supported with an ambu-bag to pump air into the lungs, as you clear the mucus from the throat using a Penguin sucker. If poor Apgar score and mucus in airway, clear airway by suction (ii) Prematurity: During antenatal period, give pregnant woman corticosteroids to enable lungs of the fetus to grow. If born premature, keep baby warm at all times (e.g. incubator; skin-to-skin contact with mother – Kangaroo baby care) (iii) Infection: Those who are exposed or infected by HIV (give Nevirapine syrup) or those with signs of infection give an antibiotic. At birth, apply Chlorhexidine to the tip of the cord stump to prevent cord infection. (i) Clamp the cord and cut it within the first few minutes after birth. (ii) Keep the baby warm at all times.	All the BEmOC signal functions plus: 8. Perform blood transfusion 9. Perform surgery (e.g. caesarean section) (iii) After the first hour of life, give the newborn eye care, vitamin K, and immunizations (OPV zero and BCG). (iv) Assess the newborn for birth weight, gestational age, congenital defects and signs of newborn illness. (v) Give special care for sick newborns, those who are preterm (see job aid for the Pre-term baby) and/or low birth weight, and The umbilical stump must always be kept clean and dry

Note: A BEmONC facility is one in which all functions 1 – 7 are performed and a CEmONC facility is one in which in addition to the BEmONC signal functions, Caesarean section and blood transfusion are added as signal functions.

The **objectives of BEmONC** are to:

- Monitor all mothers in active labour with a partograph in order to detect abnormalities of the 1st and 2nd stage of labor
- Manage properly 2nd and 3rd stages of labor
- Monitor all mothers appropriately within the golden hour (one hour following birth)

- Ensure immediate post-partum care for all newborn babies
- Manage obstetric complications and conditions likely to cause morbidity, injury or death to the mother and/or newborn
- To improve survival and quality of life of the mother and child who have experienced an obstetric complication

Information on emergency obstetric care should include:

- Danger signs during pregnancy, labour, delivery and puerperium
- Risk factors in pregnancy but emphasizing that every pregnancy carries a risk
- Family planning to avoid high risk pregnancy emphasizing postpartum FP contraception
- Early ANC booking and management of complications
- Birth and emergency preparedness
- Preventive e.g. good nutrition to prevent anaemia, deworming, malaria prevention-IPT and ITN use, eMTCT
- Previous interventions that have a possibility of interfering with obstetric outcomes
- Where to access EmONC services

Every maternal and newborn deaths occurring in a health facility shall be notified within 24 hours to the central Ministry of Health and audited within 7 days

e) Maternal and Newborn Postnatal Care

This is health care given to a mother and baby after childbirth up to 6 weeks. The first 6 weeks are critical period for the health and wellbeing of the mother and survival and thriving of the newborn baby. The UDHS 2016 states that 56.3% of mothers attended PNC within first 2 days after birth. Postnatal care is provided at both health facility and community level. The **objectives** are to:

- Maintain physical and psychological well-being of the mother, baby and family
- Detect or screen for danger signs in mother and/or baby, congenital abnormality of the baby and manage or refer
- Give appropriate information and support for caring for the mother and newborn to the mother herself and members of family
- Link mothers and newborns to relevant support groups in the community, services and referral

Provision of postnatal care should meet the needs of the mother-baby pair in a holistic manner. This applies to both facility and community levels.

***Information provided during postnatal care*;**

- responsible fatherhood
- HIV testing, counselling, care and eMTCT
- Dangers of self-medication and use of traditional medicines during pregnancy, labour and puerperium
- Counselling on birth spacing and postpartum family planning
- Importance of delivering at the health facility by skilled health workers
- Care of the newborn
- Reason for the mother to stay in health facility for at least 24hrs after delivery
- Newborn danger signs to look out for; not able to breastfeed or drink, vomiting everything, baby too hot or too cold, Cord reddened/smelling/discharging pus, many skin pustules, and difficulty in breathing
- Newborn care; keeping baby warm, early initiation of breast feeding, cord care and extra care for preterm and low birth weight babies including Kangaroo Mother Care. importance of Postnatal check up
- Good nutrition for the mother supplementation
- Emergency care for sick newborn
- Hygiene for both the mother and the Baby
- Immunization schedules

f) Postnatal care of the Newborn

A newborn is a baby aged upto 28 days. Therefore care of the newborn refers to health care given to a baby to ensure the well-being immediately after birth up to 28 days of life. Tis can be provided at facility and community levels. These are described below;

Facility-based PNC:

The first 24 hours after delivery are critical because this is when majority of newborn deaths occur. Even more important is the first minute (Golden Minute) and 6 hours after birth. Skilled attendance in a health Facility should be followed with immediate, early and late postnatal care:

- ✓ **Immediate:** Within the first 0-6 hours after delivery. Care should be provided every 1 hour
- ✓ **Early:** Within the first 6 days after delivery
- ✓ **Late:** At or shortly after 6 weeks

Postnatal Newborn Services[3]in the health facility should include:

- Clearing the airway and ensuring normal breathing
- Proper ligation of the cord to ensure there is no bleeding
- Dry and keep the baby warm
- Applying tetracycline ointment to the eyes within the first 30 minutes as prophylaxis and administer vitamin K
- Weighing the baby
- Initiating breast feeding within the first 30 minutes except where the mother chooses not to breast feed and support the mother to breastfeed properly
- Keeping the mother with the baby skin to skin and "bedding in"
- Conducting a full physical examination of the baby and ruling out congenital abnormality and danger signs by ensuring frequent checks
- Providing necessary referral
- Giving immunization according to the MOH guidelines
- Giving ARVs to babies born to HIV positive mothers according to the standard guidelines
- Dry clean cord care using chlorhexidine and leaving the cord dry"
- Temperature maintenance by appropriate covering
- Providing training and support for the mother, father and family to use breast milk alternatives when breast feeding is not possible
- Proper identification and management of danger signs in newborns
- Counselling on birth spacing
- Extra-care of low birth weight babies according to the MOH guidelines including Kangaroo Mother Care for stable babies
- Management of local infections and feeding problems

All low birth weight and stable preterm babies shall receive Kangaroo Mother Care for warmth if there are no contraindications.

g) Facility postnatal care of the Mother

Recommended schedule for Postnatal care of the mother should as follows:

- Within the first 6 hours.
- At 6 days.
- At 6 weeks.
- At 6 months.

[3]Refer to the Standards for maternal and newborn care, Ministry of Health, 2016 for further reading on routine immediate newborn care.

Immediately and up to 24 hours after birth, every mother should be carefully monitored for bleeding during the first hour following delivery (Fourth Stage/Golden hour) in order to avoid mortality and severe morbidity.

The services for the mother will include:

- Keeping the mother comfortable and warm
- General examination, treatment , and monitoring of maternal conditions according to national guidelines
- Ensuring the bladder is empty to aid contraction of uterus
- Giving medicines to prevent excessive bleeding
- Advise on workload
- Relieving pain
- Screening for HIV and syphilis for those mothers who missed during antenatal
- Screening for cervical and breast cancer
- Partner involvement in care and support of the mother and baby, household chores
- Giving Vitamin A
- Provision of iron and folic acid to the mother for 3 months after delivery at discharge
- Counsel women and couples on initiation of Lactation Amenorrhea method (LAM) of Family planning where needed/ or post-partum IUD and resumption of sexual intercourse
- Provision of preventive care such as Tetanus toxoid for those who missed

Follow up at 2 weeks for the HIV positive mothers

- Post Natal Care at 6-8 weeks (First DNA-PCR)
- Special attention to the state of involution of the uterus
- Follow up of mother-baby pairs for women living with HIV and linking them to other cares as found necessary e.g. HAART clinics, Nutrition, Psychosocial groups

h) Community-based maternal and newborn PNC

In the undesirable event that delivery does not take place in a facility, postnatal care should be given to both mother and baby either by a domiciliary midwife or CHEW or trained village heath team member. In such case the schedule will be as follows:

- On the day of delivery
- On the 3rd day and
- On the 7th day. An extra visit on day 10 for preterm and low birth weight babies will be required

Every effort should be made to ensure that a baby delivered outside the health facility is given postnatal care and followed up by a trained health worker including CHEWs and VHTs.

DRAFT

The following services and information will be provided for the mother baby care at community level by CHEWs and /or VHTs.

Newborn care during home visits in the first week of life	Maternal care during home visits in the first week after birth
• Promote and support early (within the first hour after birth) and exclusive breastfeeding • Help to keep the newborn warm – promote skin-to-skin care • Promote hygienic umbilical cord and skin care • Assess for danger signs and counsel on their prompt recognition and care seeking by the family (not feeding well, reduced activity, difficult breathing, fever or feels cold, fits or convulsions) • Promote birth registration and timely vaccination according to national schedule • Identify and support newborns who need additional care (e.g. LBW, sick, mother HIV infected)	• Ask about mother's well-being • Ask about excessive bleeding, headache, fits, feeding, feeling very weak, breathing difficulties, foul smelling discharge, painful urination, abdominal or perineal pain. If she has any of these symptoms, refer to the nearest health facility for care • Ask for swollen, red or tender breast or nipples, manage breastfeeding problems if possible. If not, refer her to the nearest health facility for care • Counsel about danger signs for mother and newborn and advise on where to seek early care when needed

Additional information provided during a home visit/at community level will include:

- Maternal and child bonding
- Adequate exercises and rest for the mother
- Prevention against malaria/sleeping a treated ITN
- Sex after childbirth
- Importance and benefits of attending postnatal clinic
- Prevention of STI/HIV and HCT services for both mother and spouse and how to access them

The partner, companion and family members should participate in the education session on care during the puerperium.

All relevant documents, ANC card, partograph immunization and treatment records, etc. should be included with the referral note. During referral, newborn babies should be kept warm during transportation and breastfed if they are able to.

3.3.7 Referral for Mothers and newborn babies

All mothers and newborn babies presenting with problems or issues which the service provider cannot handle at her/his work site should be referred to a higher level functional unit without delay, in order for these issues to be dealt with expeditiously according to the guidelines of referral:

- A referral note should be completed and given to the mother/ caretaker
- In obstetric emergency, the mother should be accompanied by a qualified health worker and transport provided or a VHT member
- The partner and relatives should be informed, counselled and encouraged to accompany the patient
- Referral unit should be informed by radio or telephone, as much as possible
- A feedback from the referral to referring unit should be ensured
- All referrals should be handled professionally and ethically
- Innovative communication

All relevant documents, ANC card, partograph, immunization and treatment records, etc should be included with the referral note. During referral, newborn babies should be kept warm during transportation and breastfed if they are able to

It is important to note that referral can be from higher to lower level of service delivery or cadre.

DRAFT

Table 6: Post Natal Care: Levels and Cadre of Health workers

Postnatal care activities will be performed by service providers at each level of the health care delivery system as follows:

PROVIDERS	LEVELS OF CADRE																		
	Comm.	HCII and HC III				HC IV						District hospital				Referral			
ACTIVITY	VHT/ CHW	MW	CO	N	NA	MW	CO	N	LA	NA	MO	MW	MO	OBS	LA	MW	MO	OBS	LA
Registration	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	
History-taking	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓	✓	
Gen. Exam		✓	✓	✓		✓	✓	✓			✓	✓	✓	✓		✓	✓	✓	
Obs. Exam		✓	✓	✓		✓	✓	✓			✓	✓	✓	✓		✓	✓	✓	
Lab.									✓						✓			✓	✓
Infant Exam		✓	✓	✓		✓	✓	✓			✓	✓	✓	✓		✓	✓	✓	
Routine drugs		✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓	✓	
Promotion of exclusive Breast-feeding	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓	✓	
Health Education	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓	✓	
Immunisation of the baby	✓	✓	✓	✓	✓	✓		✓			✓	✓	✓	✓		✓	✓	✓	
Cervical cancer screening		✓	✓	✓		✓	✓				✓	✓	✓	✓		✓	✓	✓	
FP counseling and services	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓		✓	✓	✓	
Referral	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

✓ Activity is done

N – Nurse

MO – Medical Officer

CO – Clinical Officer (Medical Assistant)

NA – Nursing Assistants (Nurse Aides)

LA – Laboratory Assistant/Technologist

MW – Midwife

OBS – Obstetrician

Table 7: Type of Service by Level and Cadre of Health workers

Service providers at each level of health care delivery system below will perform other SRH services:

Type of Service	**LEVELS AND CADRE**															
	Comm and HC II	**HC III**				**HC IV**					**District Hospital**			**Referral**		
	VHTs/ CHEW	**MW**	**CO**	**N**	**NA**	**MW**	**CO**	**MO**	**N**	**NA**	**MW**	**MO**	**OBS**	**MW**	**MO**	**OBS**
Preconception	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health education	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Immunisation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Family Planning	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Adolescent SRH services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Counselling		✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
STI/HIV/AIDS Management	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Referral	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

✓ Activity is done

CO – Clinical Officer (Medical Assistant)

MW – Midwife

N – Nurse

NA – Nursing Assistants (Nurse Aides)

OBS – Obstetrician

DRAFT

3.3.8 Prevention of Abortion and Post-abortion care

3.3.8.1 Definitions

Abortion: This is a medical term defining a condition when a pregnancy ends before 28 weeks and products of conception are completely or partially expelled. Abortion may be induced or spontaneous. Spontaneous abortion is commonly referred to as Miscarriage and Induced abortion commonly referred to as early termination of pregnancy.

Post Abortion care: This is health care given to a woman who has had an abortion of any cause. The care, to be provided on a 24-hour basis, is to be an integral part of SRHR services. The services are to be provided in all health facilities equipped to handle the service.

There are approximately 314,000 unsafe abortions in Uganda each year with at least 90,000 of them leading to severe health complications. Each year 1,500 girls and women die in Uganda from unsafe abortions contributing approximately 26% of all maternal deaths in the country. These could be prevented with adequate and accessible emergency obstetric care to manage complications and by counselling women and girls on prevention and dangers of inducing abortion. Access to information and services for complications of unsafe abortion are non-universal, judgmental and often incriminating and criminalized. Furthermore, there are no deliberate efforts to counsel females on how to avoid unintended pregnancy and prevention of abortion.

3.3.8.2 Types of abortion

a) *Threatened abortion*: a pregnancy complicated by bleeding before 20 weeks' gestation
b) *Complete abortion*: all products of conception have been passed without the need for surgical or medical intervention
c) *Incomplete abortion*: some, but not all, of the products of conception have been passed; retained products may be part of the fetus, placenta, or membranes
d) *Missed abortion*: a pregnancy in which there is a fetal demise (usually for a number of weeks) but no uterine activity to expel the products of conception
e) *Septic abortion*: a spontaneous or induced abortion that is complicated by intrauterine infection

DRAFT

When: Indication for early termination of pregnancy and post-abortion care :

3.3.8.3 Women carrying a risky pregnancy including the following conditions: Our aspiration is for every mother to carry pregnancy up to term. In the event where medical condition is out of control, the pregnancy may be terminated with the view of saving both the mother and baby. Such conditions include;

- Severe maternal illnesses threatening the health of a pregnant woman, the pregnancy would be terminated with the view of taking care of baby outside of womb e.g. severe cardiac disease, renal disease, severe pre-eclampsia and eclampsia;

In circumstances where the foetus cannot survive under any conditions, the intention is to save the life of the mother. Such conditions include;

- Severe foetal abnormalities which are not compatible with extra-uterine life e.g. molar pregnancy, anencephaly

Post-abortion care is indicated in emergency management of abortion and its complications.

3.3.8.4 Levels of prevention and management of post-abortion complications

a) **Primary prevention** → this is prevention of risky pregnancy and induced abortion **Secondary prevention**→this is management of risky pregnancy by ensuring safety of an abortion procedure that could not be avoided

b) **Tertiary prevention**→ this is management of life-threatening abortion complications, and complications of an unsafe abortion procedure that has taken place already, through high-quality post-abortion care

c) **Quaternary prevention**→is the prevention of repeated abortion by preventing risky pregnancies through post-abortion family planning counseling and contraception

The policy **objectives** of abortion prevention and Post Abortion Care (PAC) are:

- Create public awareness on the dangers of abortion and promote community involvement in the prevention of unprotected sex and abortion, especially among adolescents and young people.
- Reduce risk of death and disability of mother due to abortion- related complications.
- Manage and/or refer women and girls with abortion complications.
- Prevent repeated unintended pregnancies through the provision of immediate post-abortion counselling and family planning services.
- Counsel/investigate and treat clients with habitual abortions.

DRAFT

3.3.8.4 Target groups for prevention of abortion and Post-Abortion Care and services provided

The target will be all women who have had abortions and abortion complications and their partners/caretakers. Confidentiality is a principle.

Primary prevention targets:	*Secondary prevention targets:*
• Women with life threatening medical conditions during pregnancy • Adolescents and young people • Women with repeated abortions who need contraception • Women with repeated abortions who desire to have babies • Survivors of SGBV	• caretakers • partners • Service providers

Services and **information** to be provided as part of the abortion prevention and PAC package will include;

Level of prevention	Services	Information
Primary	- Life skills - Contraception including ECs - Management on SGBV survivor services - Management of alcohol and drug abuse - Provision of SRHR services in emergency settings - Screening and treatment for STIs	- Life skills - Dangers of unprotected and unsafe sex - Dangers of unintended pregnancy and examples and consequences of unsafe abortion - Availability of (where to obtain) services for prevention of pregnancies (e.g. Family Planning) - Livelihood skills - Dangers of alcohol and substance abuse
Secondary	- Early termination of pregnancy as referred to section 3.3.8.3) - Counselling about alternatives including fostering and adoption - Counselling on continuation of	- Availability of services - Medical indications for ending risky pregnancy - Services for fostering and adoption

	pregnancy and continuation of ANC services and where to obtain them - Screening and treatment for STIs	- Availability of preconception and counselling services
Tertiary	- Emergency management (PAC) - Availing other SRHR services including screening for HIV - Counselling and provision Post-abortion FP services, safe care and consequences - Post-abortion psychosocial support - Screening and treatment for STIs	- Outcomes of care - Availability of other SRHR services including FP, hope after rape, screening e.g. cancer of cervix and breast, HIV - Post-care expectations including resumption of sex and fertility (within 1 week) and avoidance of unintended pregnancy

DRAFT

Table 8: Post Abortion care and early termination of pregnancy services availability (who and where – level)

Type of service		Facility					
	Comm.	Outreach	HCII	HC III	HC IV	General hosp	Refer hosp
IEC	✓	✓	✓	✓	✓	✓	✓
Psychosocial support and counselling	✓	✓	✓	✓	✓	✓	✓
Abortion prevention information and counselling	✓	✓	✓	✓	✓	✓	✓
History taking	✓	✓	✓	✓	✓	✓	✓
Examination		✓	✓	✓	✓	✓	✓
HIV serology		✓	✓	✓	✓	✓	✓
High vaginal swab					✓	✓	✓
STI management		✓	✓	✓	✓	✓	✓
Anti-tetanus		✓	✓	✓	✓	✓	✓
Early termination of pregnancy (refer to Section 3.3.8.3)					✓	✓	✓
Misoprostol (management of incomplete abortion)		✓	✓	✓	✓	✓	✓
Injectable uterotonics		✓	✓	✓	✓	✓	✓
Resuscitation (shock/sepsis)			✓	✓	✓	✓	✓
Evacuation for incomplete abortion			✓	✓	✓	✓	✓
Preparation of tissue for histology					✓	✓	✓
Post-abortion family planning services including services	✓	✓	✓	✓	✓	✓	✓
Rehabilitation	✓	✓	✓	✓	✓	✓	✓
Referral to relevant SRHs	✓	✓	✓	✓	✓	✓	✓

Table 8: Post Abortion care and early termination of pregnancy service provision by Health Worker Categories

Type of service	**Cadre**									
	VHTs/ CHEWs	**Nurse Assistant**	**Midwife/ Nurse**	**Clinic-al officer**	**Medical officer**	**Gynae /Surgeon**	**Physiotherapist**	**Radiologist**	**Lab tech/ Cytologist**	**Social worker**
IEC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Psychosocial support and counselling	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Abortion prevention information and counselling	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
History taking	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Examination			✓	✓	✓	✓	✓	✓		
HIV serology			✓	✓	✓	✓			✓	
High vaginal swab					✓	✓			✓	
STI management			✓	✓	✓	✓				
Anti-tetanus		✓	✓	✓	✓	✓				
Early termination of pregnancy (Refer to Section 3.3.8.3)					✓	✓				
Early termination of pregnancy (Refer to Section 3.3.8.3) (Surgical induction e.g Molar pregnancy)						✓				
Resuscitation (shock/sepsis)			✓	✓	✓	✓				
Evacuation for incomplete abortion			✓	✓	✓	✓				
Preparation of tissue for histology			✓	✓	✓	✓			✓	
Post-abortion family planning services including information	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rehabilitation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Referral to relevant SRHs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

DRAFT

3.3.8.5 Post-abortion Family Planning services

It is very important to take note of the following:

- Fertility returns as soon as one week after an abortion in first trimester and after 1 month in subsequent trimesters
- Women should not leave a health facility after an abortion without a contraceptive method of their choice
- Even if a woman wants to have a child immediately, WHO guidelines recommend she waits at least 6 months after an abortion before getting pregnant again. This is intended to reduce incidence of maternal anaemia, premature rupture of membranes, low birth weight, and premature delivery in the subsequent pregnancy
- Post-abortion Family Planning (PAFP) reduces repeat abortions and unplanned pregnancy
- FP counselling and services must be provided at the same time and location where a woman receives PAC services
- Most modern contraceptive methods may be used following an abortion

DRAFT

3.4 Sub-theme 3: OBSTETRIC FISTULA

3.4.1 Definitions

Obstetric fistula is a condition in which a direct opening is created between the vagina and either the gastro-intestinal or urinary system or both leading to uncontrolled passage of urine or faeces or both through the vagina. These abnormal conditions are called Vesico Vaginal (VVF), Recto Vaginal (RVF), Urethro Vaginal Fistula (UVF) and Uretero Cervical Vaginal Fistula (UCVF). This is usually a result of prolonged obstructed labor when the foetal head gets stack in the pelvis and presses on the surrounding tissue. The result is necrosis of the tissues separating the vagina and bladder or rectum, which creates an opening and thus the passage of urine or faeces. The victims become outcasts in society due to the resulting smell.

3.4.2 Context and Rationale

The lives of women with an obstetric fistula are greatly altered. The baby usually dies during labor and the mother is left with chronic dribbling of urine and /or faeces leading to isolation from family and community life and being abandoned by the male partners. Without surgical repair, a woman's prospects for work or family support are greatly reduced and she is often left to rely on charity. Presence of this condition deprives the woman of her SRH rights. Nonetheless, up to 90% of cases the fistula can be surgically repaired. In 2011, 2 percent of Ugandan women have experienced fistula reducing from 3% in 2006. Of these, 62 percent sought treatment, 12 percent felt that it was an embarrassment and hence did not seek treatment, 9 percent did not know where to go for treatment, 7 percent did not know that a fistula could be fixed, and 3 percent said treatment is too expensive.

Some of the predisposing factors include;

- Increase in number of obstetric fistulae due to unsafe surgery practices
- Inadequate/poor quality maternity service in terms of service provision and treatment.
- Very few hospitals and specialists who offer services for the victims

Policy Statement

Obstetric fistula should be prevented at all time and when they do occur, should be treated appropriately by skilled health workers.

3.4.3 Policy goals

The goal is to address the underlying causes of obstetric fistula by strengthening emergency obstetric care and increasing society awareness of the consequences of poor management of labor and delivery, and improving services for prevention, treatment and management of

obstetric fistula in Uganda.

3.4 4 Specific objectives

- To use fistula as a catalyst to improve safe motherhood in general
- To increase community awareness on the causes and prevention of obstetric fistula
- Strengthen institutional capacity of health systems to address Prevention, treatment, care and re-integration of Obstetric Fistula clients
- To integrate prevention, treatment and care of obstetric fistula in the existing SRH including but not limited to ANC, EMOC, PNC, FP services
- To improve access to management and reintegration into the community of clients with obstetric fistula

3.4.5 Target audience

Primary	*Secondary*
• Adolescent girls and Young People • Women with obstetric fistula • Families of victims with obstetric fistula • Women in labour • Prime gravidas • Health workers especially doctors and midwives providing obstetric services	• Agencies and institutions involved in reproductive health • The girl child • Pregnant women • Patients with obstetric fistula • Health workers • Women and men of reproductive age • Communities and community health workers • Partners of clients • Schools • Social Workers • Village Health Teams

3.4.6 Implementation strategies

- Emphasis on prevention will be promoted through behavioral change communication on obstetric fistula
- Advocating for community participation and support for prevention, treatment and re-integration of fistula patients
- Pre and in-service training of service providers in counseling, referral, treatment and prevention of obstetric fistula clients more so the fistula treatment team of a

surgeon/obstetrician and gynaecologist, one theater nurse, one ward nurse and anaesthetist per regional referral hospital

- Institutionalize and support health facilities in particular Regional Referral Hospitals and General Hospitals with equipment, essential commodities and supplies for prevention and repair e.g. partographs
- Support treatment camps in areas with no or limited access to routine fistula repair services
- Inclusion of fistula treatment equipment, medicines and supplies on the medicines and equipment ordering forms for hospitals and regional referral hospitals
- Upgrading HMIS format to capture data on obstetric fistula both in the community/VHT i.e. (community based management information system , (CMIS) and HMIS
- Strengthen Operational research related to Obstetric fistula

3.4.7 Components of Obstetric Fistula Management

Prevention in the community	**Prevention at the facility**
• BCC/IEC on • importance of good nutrition for children and especially the girl child • Delay sexual debut and promote abstinence among adolescents • importance of formal education especially completion of secondary education • rights of the fistula clients • delay first pregnancy up after 18 years • attendance of ANC when pregnant • skilled attendance at birth; ○ effects of using traditional herbs during labour; ○ role of caesarean section; ○ negative cultural practices and taboos; ○ Importance of Family planning especially for prevention of adolescent pregnancy	• Pre conception care • Goal oriented antenatal care • Proper assessment and monitoring of labour using the partogram and timely action • Timely emergency obstetric care and new born care • Prompt referral of complicated cases/obstructed labour • Prompt intervention for management of prolonged/obstructed labour including timely caesarean section • Emphasis on Immediate Catheterization for obstructed labour after delivery

○ Importance of male involvement and birth preparedness ○ Importance of early referral ○ Availability of Obstetric fistula services ○ Myths and misconceptions associated with fistula	
Treatment and care of Obstetric Fistula	**RE-integration services**
• Pre-assessment before surgery • Repair of the client • Counselling of the fistula client and family members (i.e. Pre-operative, post-operative, discharge and follow-up) • Nursing care for the fistula clients pre-operatively, intra-operatively and post operatively	• Counselling with emphasis on couple counselling before and after repair • Support from immediate family members and the community • Physical rehabilitation • Family planning • Referral to social and health services and income generating support organizations

3.4.8 Service standards

Standard category	Services delivery level
Infrastructure and equipment	**Community level**: **HC II**: A counselling space that ensures privacy, two chairs and table **HC III**: **HC 1V**: **General Hospital**: All the above **Regional Referral Hospital**: All the above **National Referral hospital**: all the above
Management systems	
Infection control	**HC III and below**: All the above HC IV: all the above **General Hospital**: All the above
Information, Education and Communication	All levels: ▪ importance of good nutrition for children and especially the girl

DRAFT

	child; ▪ importance of formal education and completion of secondary education ▪ delay first pregnancy up after18 years; - attendance of ANC when pregnant ▪ skilled attendance at birth ▪ effects of using traditional herbs during labour; - role of caesarean section ▪ negative cultural practices and taboos ▪ Importance of Family planning especially for prevention of adolescent pregnancy - Importance of male involvement and birth preparedness ▪ Importance of early referral ▪ Availability of Obstetric fistula services
Clinical Services	HC II: • Goal oriented antenatal care • Proper assessment and monitoring of labour using the partograph **HC III**: All the above plus • Timely Emergency Obstetric care and new born care • Emphasis on Immediate Catheterization for obstructed labour after delivery • Prompt referral of complicated cases/obstructed labour **HC IV:** **All the above Plus** • Prompt intervention for management of prolonged/obstructed labour including timely caesarean section **General Hospital:** All the above **Regional Referral Hospital**: All the above plus • Pre-assessment before surgery • Repair of the client • Counselling of the fistula client and family members (i.e. Pre-operative, post-operative , discharge and follow-up) • Nursing care for the fistula clients pre-operatively, intra-

DRAFT

	operatively and post operatively • Legal support for survivors under treatment including legal framework for surgeons
Client Services	**Community Level:** Follow up by VHTs/CHWs, survivors and champions **HC II and above** • Counselling with emphasis on couple counselling before and after repair • Support from immediate family members and the community • Physical rehabilitation • Family planning • Referral to social and health services and income generating support organizations

Service providers at each level of health care delivery system (including the private sector) below will perform obstetric fistula activities:

DRAFT

Table 9: Provision of Obstetric Fistulae services by Level and Cadre of Health worker

Type of Service	LEVELS AND CADRE															
	Comm and HC II	HCIII				HC IV					General Hospital			Referral Hospital		
	VHTs/ CHEWs	MW	CO	N	NA	MW	CO	MO	N	NA	MW	MO	OBS/Surg/ Urologist	MW	MO	OBS/Surg/U rologist
History-taking	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Examination		✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
IEC/counselling	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Referral	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prevention	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Repairing								✓				✓	✓		✓	✓
Re-integration	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Operational research	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

✓ Activity is done

N – Nurse

VHT- Village Health Team

CO – Clinical Officer (Medical Assistant)

NA – Nursing Assistants (Nurse Aides)

MO – Medical Officer

MW – Midwife

OBS – Obstetrician

DRAFT

3.4.9 References

1. WHO, United Nations Population Fund, UNICEF.Pregnancy, childbirth, postpartum and newborn care. A guide for essential practice (3rd edition), 2015.
2. WHO, United Nations Population Fund, UNICEF, The World Bank. Managing complications in pregnancy and childbirth. A guide for midwives and doctors, 2003
3. World Health Organization. Standards for maternal and newborn health. Group 1: General standards of care for healthy pregnancy and childbirth
4. Ministry of Health. RMNCAH Investment Case and Sharpened Plan. 2016
5. Ministry of Health. Clinical Standards for Maternal and Newborn Care. 2016
6. Service Delivery Standards for the Health Sub-Sector. UNDP Supported Project on Oversight Monitoring. Draft Research Report

DRAFT

3.5 Sub theme 4: ADOLESCENT SEXUAL REPRODUCTIVE HEALTH AND RIGHTS

3.5.1 Definitions

Adolescence is a period of transition from childhood to adulthood. It is characterized by rapid physical, psychological, behavioral and biological changes. WHO defines an adolescent as a person aged 10-19 years and a young person aged 10-24 years. The UN, for statistical consistency across regions, defines youth, as those persons between the ages of 15 and 24 years.

For purposes of programming, these guidelines will target young people ages 10-24 years as stipulated in the National Adolescent Health Policy. This will be classified as follows:

Adolescents	Youth
a) 10-14 years → very young adolescent b) 15-19 years → older adolescents	a) 15 -24 years

3.5.2 Context and Rationale

Although declining, Uganda has one of the highest rates of adolescent pregnancy in Sub-Saharan Africa. Overall teenage birth rate or the proportion of birth per 1000 women aged 15-19 has decreased from 135 to 109 between 2011 and 2015 with 25% giving birth to their first child before turning 19. There is need to focus efforts on delaying sex debut and increasing contraceptive use among sexually active adolescents.

All adolescents are eligible for health services. The services will be provided in a youth-friendly environment and manner that meets their needs. In addition, all service providers and duty-bearers shall be oriented/ trained on a comprehensive SRH Package including the other issues that affect adolescent health. All health facilities shall provide comprehensive/responsive youth-friendly services. Adolescents shall participate in all stages of planning, implementation and evaluation of SRHR services.

Policy Statement

a) All health facilities shall provide age-appropriate quality information and services to all adolescents irrespective of their ability to pay, disability, marital status, school status, education level, location and ethnic origin.

b) All health facilities shall collect, analyse and use data on service utilization and quality of care, disaggregated by age, disability and sex to support quality improvement.

DRAFT

3.5.3 Policy goals

To ensure that every adolescent and young person attains the highest standards of sexual and reproductive health to have a healthy and productive life for development.

3.5.4 Specific objectives

- To promote an adolescent responsive health system that provides quality health services and information to all adolescents' boys and girls including the hard-to-reach, vulnerable and adolescents in humanitarian and fragile settings
- To prevent, protect adolescents from pregnancy and its consequences
- To prevent sexually transmitted infections including HIV and AIDS among adolescents and improve access to treatment services for the affected
- To prevent mental and neurological disorders including those caused by alcohol, substance and drug abuse
- To prevent harm and disability from unintentional and intentional injuries
- To prevent communicable and non-communicable diseases among adolescents and link them to appropriate specialists for care
- To prevent nutritional disorders among adolescents
- To provide adolescent friendly health facilities with appropriate infrastructure and competent workforce
- To facilitate school, community and health facility linkages

3.5.5 Target audience

Primary	Secondary
Adolescents aged 10-19 years and young people • Adolescents in and out of school • pregnant and lactating adolescents • sexually and not-sexually active adolescents • street adolescents • adolescents in key populations • adolescents with disabilities • orphans and vulnerable adolescents • adolescents in incarcerated areas • adolescents living with HIV and AIDS • violent adolescents • adolescents in emergency situations • Adolescents in employment likely to expose them to sexual and	• parents/guardians; • service providers including Community Based Distributors and Community Health Workers • school teachers, senior men and women teachers • sectoral extension workers • community leaders at all levels • cultural leaders • NGOs and development partners • religious bodies and leaders • legal practitioners in ASRH • high risk male groups e.g. boda-boda, taxi, brick layers, and truck drivers, fishing communities • "sugar mummies and daddies."

substance abuse • adolescents with substance abuse problems • Adolescents with abortion complications • Adolescents experiencing violence • Adolescents in poverty situation • Adolescent-headed households	

3.5.6 Implementation strategies

3.5.6.1 Adolescent Health Service Delivery Points and platforms

These will include:

Adolescent responsive health facilities which will provide services on a daily basis and timed to suit the adolescents and young people, such as:

- Institutions such as universities, schools, religious centres
- Youth/adolescent clubs in schools
- Local Council/youth council meeting places
- Quality Youth Friendly services shall be available by level of service provision
- Outreach sites in the community
- Mobile outreaches
- Home Based services
- Workplaces
- Recreational centers
- Electronic and Media platforms
- Key social gatherings

3.5.6.2 Components of the ASRH packages

The following services will be provided, depending on the level of health facility and resources available;

Services will include:

- Sexual and reproductive health age-appropriate information sharing and counselling
- Adolescent Growth and Development monitoring e.g. BMI(Body mass index)
- HPV vaccination for cervical cancer and Tetanus Toxoid for Tetanus
- Life skills education
- Counsel adolescents on unintended sex and unintended pregnancy
- Pregnancy prevention and timing
- Maternal health care such as ANC, post-natal care, Labour and delivery, eMTCT
- STI/HIV/AIDS including HCT

DRAFT

- Post abortion care
- Care of babies born to adolescents and young people
- Screening for pregnancy
- Breast examination
- Screening for breast cancer
- Gender Based Violence counseling and management
- Referral and follow up

Other areas for ASRHR integration

- Nutrition
- Drugs and substance abuse
- Information and advocacy on Harmful traditional practices
- Hygiene and Sanitation
- Injuries and accidents
- Anger and Stress management
- Mental Health
- Promoting physical activity

3.5.6.4 ASRHR information

ASRHR messaging will include components of adolescent sexual and reproductive health and other relevant areas to adolescent health:

- For younger adolescents aged 10-14years;
    - Key messages will focus on
        - Growth and development
        - Life skills
        - Proper nutrition and personal hygiene
        - Abstinence
        - Delay of sexual debut
        - Staying in school
- For older adolescents aged 15-19years, the above will be emphasized including;
    - Healthy relationships
    - Pregnancy prevention
    - Consequences of unintended pregnancies
    - Early and forced marriages
    - Sexual and gender-based violence
    - Care during pregnancy
    - Care of infants
    - Prevention, care and management of STI/HIV/AIDS
    - Harmful traditional practices
    - Risky sexual behaviour
    - Drug and substance abuse

DRAFT

- Special RH needs for adolescents with disabilities (blind, deaf, mentally challenged, physically challenged)
- Socio-economic consequences of adolescent ill health
    - Life skills
    - Centres providing adolescent-friendly health services
    - Causes of infertility

The messages should be clear, simple, accurate, gender and culturally sensitive, age-appropriate and observe the rights and responsibilities of adolescents and young people. They will be carried and relayed through drama, a variety of media and accessible formats e.g. print (brail, sign language, posters, charts, booklets, brochures, leaflets), radio, video, dialogues, TV and social media.

3.5.7 ASRH Service Standards (*applying to both private and public SDPs)*

Standard category	Services delivery level
Infrastructure and equipment	**HC II**: a youth corner that ensures privacy, two chairs and table **HC III**: As above **HC 1V**: As above **General Hospital**: All the above **Regional Referral Hospital**: All the above **National Referral hospital**: all the above

DRAFT

Information, Education and Communication	**Community and household level**: VHTs and CHEWS to provide a) Counselling b) Information and education on following topics • Pregnancy prevention and timing • Adolescent growth and development monitoring • SRHR information sharing • Information on Hepatitis B • Referral and follow up • SGBV **School:** • Information and education • Abstinence promotion • Referral • Life skills • Growth development and monitoring **Health Facility level:** All the above and clinical management of; • Complications of abortion • High risk pregnancies • SGBV • STI/HIV/AIDS • RH supplies and commodities • Obstetric emergencies • Information on prevention and management of complications of harmful traditional practices • Mental health problems

3.5.7.1 Youth-friendly Services (YFS) standards

- ***Positive attitude and competencies of the service providers:*** Welcoming, non-judgmental, empathetic, has time for the client, active listener
- ***Equitable services:*** All youth are served the health services they need without discrimination.
- ***Accessible services:*** Service provided at any time of the day or week
- ***Acceptable services:*** Services provided meet the expectations of youth, e.g. space for service provision caters for privacy, confidentiality, affordable, provided by a friendly provider.
- ***Appropriate services:*** Services offered are suitable for the age or stage of life of the young person.
- ***Effective services:*** The right services are provided to the young person in the right way and make a positive contribution to the young person's life.

- ***Gender equitable services:*** Services offered are safe, affordable, and accessible to young women and young men, and they are offered in a way that promotes the rights of the young person to make decisions and determine their life outcome.
- ***Youth participation:*** In determining the priority SRH needs that the YFS package should address, including the mode of delivery of the services and the means of communication in passing on information to the youth and adolescents and as much as possible, encourage youth to participate in implementation and giving feedback on the services offered.
- ***Comprehensive services:*** The facility offers a minimum package of services, e.g. information and counseling on sexuality, reproductive health, FP, STD diagnosis and management, HIV Counseling and Testing or referral for testing and care, pregnancy testing, ANC and Postnatal Care including contraception for birth spacing, screening and care for Sexual Gender-based violence (SGBV), Counseling and referral if needed for SGBV, PAC with counseling and contraception.

3.5.8 References

1. Global Standards for Quality Healthcare services for Adolescents. Volume 1: Standards and criteria. A Guide To Implement A Standards-Driven Approach To Improve The Quality Of Health-Care Services For Adolescents, 2015
2. Ministry of Health. Health Sector Development Plan, 2015 – 2020
3. Ministry of Health. Adolescent Health Policy, 2012
4. Ministry of Health. RMNCAH Investment Case and Sharpened Plan, 2016
5. WHO. 2017 Global Accelerated Action for the Health of Adolescents (AA-HA) Guidance

DRAFT

3.6 Sub-theme 5: INTEGRATING STI/HIV/AIDS AND SEXUAL AND REPRODUCTIVE HEALTH SERVICES

3.6.1 Definitions

Integration can be defined as an approach in which health care providers move beyond the initial reason for a health encounter to engage the client in addressing his/her broader health and social needs. Integration is the mind-set that allows for envisioning and planning more comprehensive services that better address clients‟ desires, needs and/or risks.

3.6.2 Context and Rationale

Sexual and Reproductive ill-health and HIV transmission share root causes such as poverty, limited access to SRH information, gender inequalities and stereotypes, harmful traditional/cultural practices and social marginalization. Sexually active individuals have a variety of social, reproductive and health related needs that are best addressed through a package of care. This calls for strengthening of linkages between HIV/AIDS and SRH policies, programs, and service delivery.

Prevention of HIV/AIDS and SRH ill-health targets can be more effectively and efficiently met when quality and equitable HIV/AIDS and SRH services are delivered in an integrated, comprehensive and sustainable manner. The separate delivery of SRH and HIV services is an important reason why the reproductive health needs of women living with HIV remain unmet, and there are missed opportunities to link women to HIV treatment and care programs.

Integration is also about people’s right to have the entire continuum of their needs and desires can be respected. If an integrated package of care is to be easily accessible by clients, it should ideally be offered at the same facility or at least with a strong referral system, and by providers that have been trained in both fields. This is beneficial to clients and more cost-effective for the health care system.

Policy Statement
Every STI/HIV service should include SRHR information and all SRHR services should include STI and HIV and AIDS information and provide services and /or linkages for services

3.6.3Policy goals

To improve the SRH/ HIV/STI services and related health systems through strengthening the linkages and integration of Policies, laws, programs, services and advocacy.

DRAFT

3.6.4 Specific objectives

- To Increase Access (Availability and affordability) to SRHR/HIV/STI information and messages at community and health facility levels
- To improve quality of care for SRHR/HIV/STI services at various units of care
- To increase utilization of SRHR/HIV/STI services

Key components to be addressed during integration should include:

- Infrastructure: There are 3 models of implementation, namely:
    - A one-stop centre
    - Multiple clinics within a health facility
    - Several health facilities with mechanisms for referral of clients for other services from one health facility to another
- Human resource skills and numbers
- Health commodities and supplies
- Funding
- Timing
- Tools
- Policies

3.6.5 Target audience

Primary Target	Secondary Target
• Community based peer groups • Adolescents and young people • Vulnerable (OVCs, armed forces, slum dwellers) • Key populations (Commercial sex workers, LGBT community) • Patients with chronic illnesses (eg TB, Hepatitis) • People living in Humanitarian setting • Infant and school-going children • Pregnant women and lactating mothers • PLWAs (Children, adolescents and adults)	• IEC and advocacy & program implementation • Program managers of SRH, ACP, Child Health, Development Partners and health workers • Clients attending SRH services and at "high risk" • Clients attending HIV Clinics

3.6.6 Implementation strategies

The following key principles represent strategies and the foundation and commitments upon which integration policy and programme is built:

DRAFT

1. ***Address structural determinants*:** Address the root causes of HIV and sexual and reproductive ill-health through action to reduce poverty, ensure equity of access to key health services and improve access to information and education opportunities.
2. ***Focus on human rights and gender*:** Sexual and reproductive rights of all people including women and men living with HIV need to be emphasized, as well as the rights of marginalized populations such as MSM, and SWs and eliminate gender-based violence.
3. ***Promotion of a coordinated and coherent response*:** Attention to SRH priorities within a coordinated and coherent response to HIV that builds upon the principles of one national HIV framework, one broad-based multi-sectoral HIV coordinating body, and one agreed country- level monitoring and evaluation system.
4. ***Meaningfully involve PLHIV***: Women and men living with HIV should be fully involved in designing, implementing and evaluating policies and programmes and research that affect their lives.
5. ***Foster community participation:*** Young people, key vulnerable populations, and the community at large are essential partners for an adequate response to the described challenges and for meeting the needs of affected people and communities.
6. ***Reduce stigma and discrimination:*** More vigorous legal and policy measures are to protect PWLHIV and vulnerable populations from discrimination.

In line with the MOH health policy including the SRHR and HIV Integration guidelines, the integration of SRH services into all existing health services will be achieved through:

- Setting the levels of integrated services including minimum standard for quality
- Articulating/tailor job functions for each cadre at every level of integrated service site consistent with the level of integration
- Increasing/expanding the range of equipment and commodities to sustain an integrated package of services
- Increase knowledge and skills of service providers in STI/HIV and SRH and increase awareness on need for integration
- Design and conduct integrated SRH and HIV/AIDS trainings
- Advocate for improvement of staffing levels and infrastructure to provide integrated services
- Mobilise and empower communities to create demand for integrated services.
- Strengthening supervision of integrated services (monitoring and evaluation)

HIV COUNSELING AND TESTING is the entry point to HIV/AIDS services, thus all clients seeking various sexual and reproductive health services including adolescents should be encouraged to take a test

3.6.7 References

1. WHO and UNFPA. Sexual and reproductive health of women living with HIV/AIDS. Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings, 2006.
2. Health Sector Development Plan, 2015 – 2020. 2016
3. Uganda National Strategy on SRHR and HIV/AIDS and Maternal Health service intergration Guidelines, 2015

DRAFT

3.7 Sub-theme 6: INFERTILITY

3.7.1 Definitions

Infertility is the failure of a couple to achieve a conception after one year of adequate unprotected sexual intercourse. Adequate sexual intercourse (coitus) refers to at least three times a week. For this *Policy*, sexual intercourse refers to penile penetration of the vagina.

Primary infertility applies to a woman in her reproductive age who has never conceived or a man in his reproductive age who has never made a woman pregnant.

Secondary infertility applies to a woman who has previously conceived or a man who previously made a woman pregnant.

3.7.2 Context and Rationale

Nearly 1 out of 3 couples in Uganda is infertile. Just like Obstetric Fistulae, infertility can contribute to the stigma of the woman, family breakup, depression, STI and HIV and AIDS and SGBV. Primary infertility can be caused by both male and female factors like sexually transmitted infections. Secondary infertility is often caused by abortion and infections during labour and puerperium.

Policy Statement
Infertility management should be integrated in all SRHR services at all service delivery points

3.7.3 Policy goals

The goal is to support individuals and couples with problems of infertility to attain their full fertility intentions.

3.7.4 Specific objectives

- Prevention of infertility by appropriate management of predisposing factors for instance post-abortion care, infections during labour and STI treatment
- Increase access to the management of infertility by integrating the management of infertility into existing SRHR services

3.7.5 Target audience

Primary targets	Secondary targets
• Men and women with proven infertility as per definition • Women with recurrent pregnancy wastage • Couples with repeat miscarriages	• Adolescents and young people • Men and women in reproductive age • The community in general, to dispel biases • Health providers at all SDPs

3.7.6 Implementation strategies

- IEC and Advocacy:
  - Developing, printing, distributing and disseminating IEC materials on infertility at the community level
  - Advocating for the removal of gender bias in the handling of infertility
- Service delivery:
  - Providing infertility management services at all levels of service delivery
  - Upgrading HMIS format (tools) to include data on infertility
  - Managing infertility according to the service standards and guidelines in this policy
- Capacity building:
  - Developing and printing of a training curriculum for infertility
  - Developing service guidelines for the management and prevention of infertility
  - Pre and in-service training of health providers to equip them with knowledge and skills for appropriate management and prevention of infertility
  - Providing appropriate equipment, technology, drugs and supplies

3.7.7 Information and services

The components of infertility management are prevention, treatment and adoption.

Prevention	Treatment	Adoption
Information: • Long term complications of STI and unsafe abortions • Danger of inappropriate treatment of STI, post abortion complications and puerperal sepsis • Risk factor of infertility for men e.g. mumps infection	This will depend on the cause and available options and the national guidelines on infertility and assisted pregnancies.	This will be guided by the National Adoption Policy framework

Services: • Provision of condoms to encourage protected sex • Early diagnosis and appropriate management of STIs • Management of puerperal sepsis • Proper management of post abortion complications		
IEC for Infertility management: This will include raising awareness about infertility. This will be achieved through provision of IEC content of information on; • Definition of infertility • Basic anatomy of the male and female reproductive systems • Risk factors for infertility • Causes of infertility (male and female) • Availability of management service/referral • Prevention of infertility • Community support for those affected and • Advocacy for couple investigations		

3.7.8 Service Standards

The following people will be **eligible** for infertility management services:

- All women in the reproductive age group who have failed to conceive
- Women with recurrent pregnancy wastage
- Men who have failed to 'father' a child
- Couples who have failed to have a baby as per definition

DRAFT

Table 10: Infertility Service standards

Standard category	Services delivery level
Infrastructure and equipment	**HC II and III**: A counselling space that ensures privacy, two chairs and table **HC 1V and above**: All the above
Information, Education and Communication	**Community Level:** • Information on infertility including causes, risk factors • Referral and case management services • Psychosocial support • Prevention of infertility
Client Services	**Community Level:** Follow up by VHTs/CHWs, survivors and champions **HC III and above:** • Counseling with emphasis on couple counseling before and after repair • Support from immediate family members and the community • Physical rehabilitation • Family planning • Referral to social and health services and income generating support organizations

DRAFT

Table 12: Availability of Services for Infertility

Type of service	Facility						
	Community	**Outreach**	**HCII**	**HC III**	**HCIV (HSD)**	**General Hospital**	**Referral Hospital/ specialised centres**
History-taking	✓	✓	✓		✓	✓	✓
Examination					✓	✓	✓
IEC/counseling	✓	✓	✓		✓	✓	✓
Referral	✓	✓	✓		✓	✓	
Investigation					✓	✓	✓
Prevention	✓	✓	✓		✓	✓	✓
Treatment			✓		✓	✓	✓
Specialised treatment (IVF, Surrogate)							✓
Rehabilitation	✓	✓	✓		✓	✓	✓

Integration of infertility services into SRHR services will be done within the existing SRHR services at various levels of health care depending on provider competence and availability of facilities.

3.7.9 References

1. WHO Manual for the Standardized Investigation, Diagnosis and Management of the Infertile Male. Published by Cambridge University Press

DRAFT

3.8 Sub-theme 7: REPRODUCTIVE TRACT CANCERS

3.8.1 Definitions

These are abnormal growths (malignant) that arise from and/or affect the organs of reproduction. These organs include the breasts as well as the male and female genital organs.

3.8.2 Context and Rationale

Reproductive organ cancers have become increasingly important over the years. Cancer of the cervix is the commonest malignant condition in women (43%) and cancer of the prostate gland in men (45%) according to the Uganda cancer registry (2007-2009). Cervical and prostate cancers top the list of cancer-related deaths from women and men respectively in Uganda. The other RH cancers include cancer of the breast, ovary, uterus, fallopian tube, testes, penis and choriacarcinoma.

Policy Statement

Increase awareness, prevention, early detection and quality management of cancers of the reproductive organs to reduce morbidity and mortality.

3.8.3 Policy goals

The policy goal is to establish and strengthen systems for screening, detection and management of RH cancers at SDPs and community level.

3.8.4 Specific objectives

- Increase early screening, detection and timely management of RH cancers
- Strengthen awareness of risk factors warning signs, symptoms and complications of Reproductive health cancers
- Increase awareness of the service delivery
- Provide refresher trainings and capacity building on new technologies for instance HPV DNA screening
- Strengthen delivery of services for cancers of the reproductive organs
- Integrate the services for screening, detection and management of cancers of the reproductive organs into existing SRHR services

DRAFT

3.8.5 Target audience

<table>
<tr><td colspan="2">Primary target
Everyone aged 10 and above is to be targeted. However, different groups will be prioritized for different cancers. All women and men should be target to screening.</td></tr>
<tr><td colspan="2">Targeting by vulnerability</td></tr>
<tr><td>Cervical cancer: There is increased risk of getting this cancer among women:
• Who are sexually active women
• Practicing unprotected sex
• With multiple sexual partners
• In polygamous relationships
• Who bore children with different husbands
• Who had first sexual intercourse before 18 years
• HIV-positive
• Smokers</td><td>Breast cancer: Screen Women such as:
• young women and girls in and out of school
• pregnant and lactating women (teach and promote self-breast examination)
▪ with a family history of breast cancer
▪ who had first pregnancy after 35 years
▪ who had menopause before 40 years;
▪ who did not breast feed
▪ who are nulliparous

Prostate cancer: Targeting:
• Men in RH services such as ANC/postnatal and other RH clinics
• Men over 50 years
• Men in polygamous marriages
• Male cancer survivors
• All men</td></tr>
</table>

3.8.6 Implementation strategies

All communities and clients receiving SRHR and HIV services will be given adequate information about cancers of the reproductive organs and the services available.

- **IEC and advocacy**:
  - Raising awareness in the community about cancers of the reproductive organs and the risk factors associated with these cancers
  - Promote healthy lifestyles
  - Assurance of confidentiality with regard to the findings
  - The benefits of screening and their effects on one's reproductive goals
  - The need for follow-up visits and/or referral

DRAFT

  - Mobilisation and advocacy for community support for those affected by the disease as well as increased resources for cancer services

- **Service provision**

3.8.6.1 Cervical cancer screening service provision

  - Primary prevention of cervical cancer, should be done through HPV vaccination, targeting young girls in and out of school that are not yet sexually active.
  - Secondary prevention of cervical cancer is by screening either using Visual inspection with Acetic Acid (VIA) or HPV-DNA testing with subsequent treatment of eligible precancerous lesions using cryotherapy or LEEP. Cervical cancer screening normally targets women aged 30 – 49 years of age. Can target women attending post-natal, gynaecological outpatient and STI clinics;
  - Tertiary management of cervical cancer is through surgical, radiotherapy, chemotherapy treatments and psychosocial support.

3.8.6.2 Service provision for other Reproductive Tract cancers

  - Primary prevention of cancers of the reproductive organs.
  - Secondary prevention of cancers of the reproductive organs such as treatment of precancerous disease
  - Management of cancers of the reproductive organs will be provided at every level of health care using appropriate technology and the type of service will depend on the level of health facility and availability of resources. Management will include screening, appropriate referral, treatment, rehabilitation and psychosocial support

- **Capacity building**:
  - The training of health workers in prevention and management of cancers of the reproductive organs will be both at pre- and in-service levels
  - Provision of appropriate equipment and supplies
  - Modelling of integrated cancer services within existing clinical services including provision of one stop services e.g. cervical cancer screening and breast examination in the same setting and same health workers (midwives/nurses and doctors)
  - The creation of a database within the existing HMIS system

3.8.7 Information and Service Standards for managing Reproductive Tract Cancers

As an integral part of SRH services, everyone aged 15-75 years and/or sexually active will receive information, education on risks, danger and complications of cervical, breast, prostate and testicle cancer. The IEC will be "geared at raising awareness, promoting early health seeking behaviour, clarifying public concerns and dispelling rumours and misconceptions.

Information, Education and Communication	• All channels of communication will be used to relay messages which are approved by the technical committee on SRHR at the national and district levels • Information on prevention topics for instance; - the importance of periodic screening and vaccination - risk factors - self-breast examination - harmful cultural practices in attempt to treat the cancer - warning symptoms and signs - monthly self-breast examination for women aged 20 and above biannual rectal examination for men aged 50 and over - the benefits of prolonged breast feeding - dispelling misconceptions and rumors on causes and symptoms - integrating cancer screening services at health units into the existing SRH services • Information on management of RH cancers • Referral according to need to those levels and facilities known to offer desired service.

DRAFT

Table 11: RH Cancer Services Availability

Type of service			Health facility						
	Comm.	Outreach	HC II	HC III	HC IV	General hospital	Referral hospital	CPHL	UCI
IEC/counseling	✓	✓	✓	✓	✓	✓	✓		✓
Psychosocial support	✓	✓	✓	✓	✓	✓	✓	✓	✓
Teaching Self Breast examination	✓	✓	✓	✓	✓	✓	✓		✓
Breast examination	✓	✓	✓	✓	✓	✓	✓		✓
Mammography						✓	✓		
Breast lump biopsy						✓	✓		
Pap smear		✓	✓	✓	✓	✓	✓		✓
Vaccinations			✓	✓	✓	✓	✓		✓ v
UVI		✓	✓	✓	✓	✓	✓		
VIA		✓	✓	✓	✓	✓	✓		✓
LEEP excision						✓	✓		
Coloposcopy					✓	✓	✓		
Ultrasound				✓	✓	✓	✓		✓
Cervical biopsy					✓	✓	✓		✓
Staging of cervical cancer						✓	✓		✓
Histopathology							✓		
Surgical treatment						✓	✓		
Cryotherapy		✓		✓	✓	✓	✓		
Radiotherapy							✓		✓
Prostate biopsy						✓	✓	✓	✓
Blood test for prostate cancer- PSA- Prostatic specific antigen test							✓	✓	✓
Chemotherapy for breast and prostate cancer							✓		✓
Rectal examination			✓	✓	✓	✓	✓		✓
Palliative/terminal care	✓	✓	✓	✓	✓	✓	✓		✓

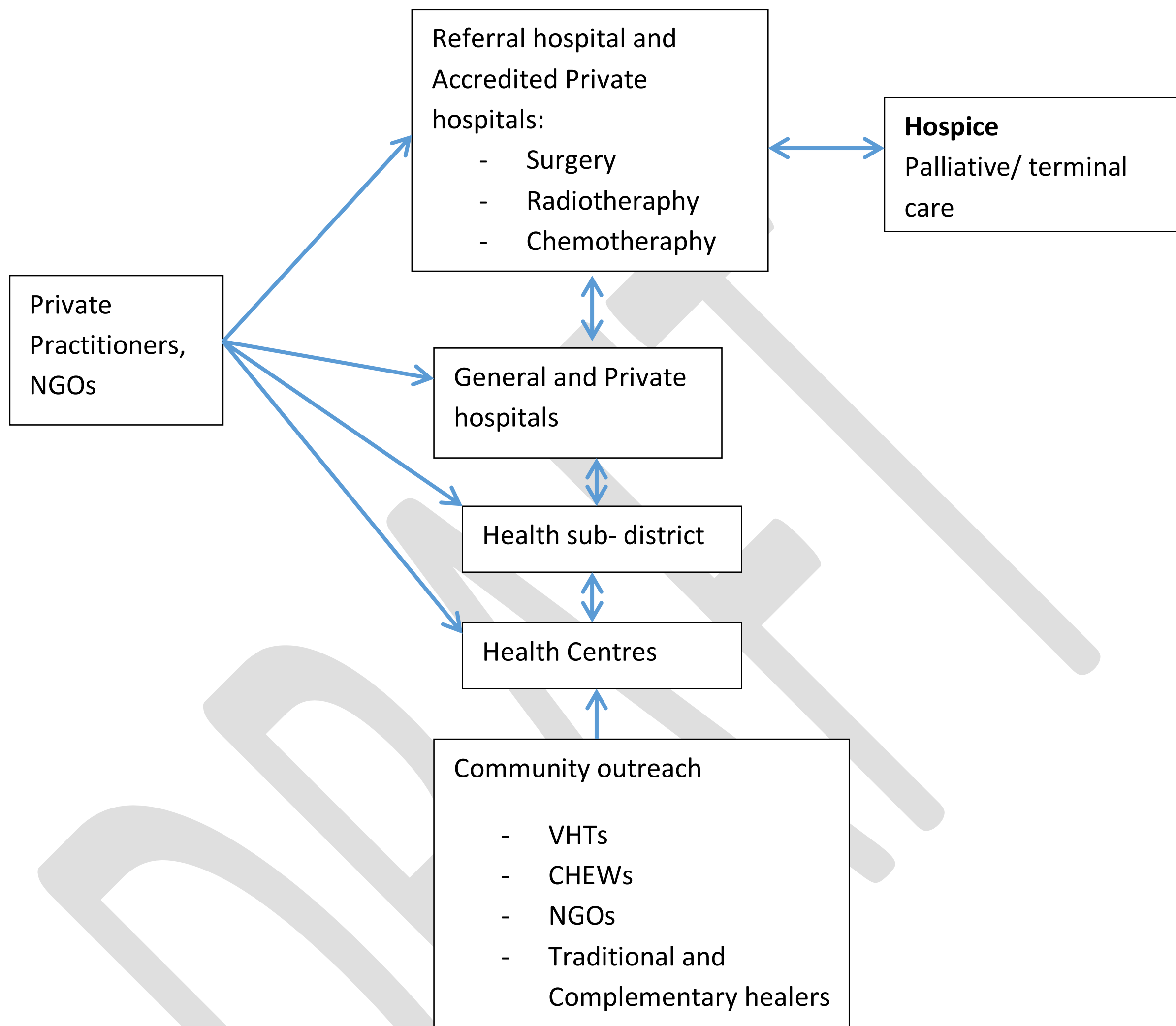
DRAFT

Table 12: Standards for RH Cancer service provision

Note: These apply to both public and private health facilities accordingly.

Type of service	Cadre									
	VHTs/CHEWs	**Nurse aide**	**Midwife/ nurse**	**Clinical officer**	**Medical officer**	**Gynaecologist /Surgeon**	**Physiotherapist**	**Radiogist**	**Cytologist**	**Social worker**
Referral	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
IEC/counseling	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Breast examination / teaching self breast examination	✓	✓	✓	✓	✓	✓	✓	✓		✓
Mammography								✓		
Breast lump biopsy					✓	✓		✓		
Pap smear			✓	✓	✓	✓			✓	
Vaccinations			✓	✓						
UVI			✓	✓	✓	✓				
VIA			✓	✓	✓	✓				
Ultrasound			✓	✓	✓	✓		✓		
Cervical biopsy					✓	✓				
Staging of cancers of the reproductive organs						✓				
LEEP Excision					✓	✓				
Histopathology									✓	
Cryotherapy			✓	✓	✓	✓				
Surgical treatment						✓				
Radiotherapy								✓		
Prostate biopsy					✓	✓				
Blood Test for cancer of the prostate(PSA-Prostatic specific antigen test)										
Chemotherapy for cancers of the reproductive organs					✓	✓				
Rectal examination			✓	✓	✓	✓				
Palliative/terminal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Figure 2: Schematic of Referral system for RH cancers



3.8.8 References

1. World Health Organisation. Comprehensive cervical cancer prevention and control: a healthier future for girls and women, 2013
2. Health Sector Development Plan, 2015 – 2020. 2016

3.9 Sub-Theme 8: MENOPAUSE AND ANDROPAUSE

3.9.1 Definitions

Menopause is the permanent cessation of menses, which marks the end of a woman's normal reproductive period. This usually occurs between the ages of 45 to 50yrs,though it may occur earlier or later.

Andropause is the effect of decreasing androgens in men; it is also referred to as male menopause or androgen deficiency in ageing men.

3.9.2 Context and Rationale

With increasing life expectancy in Uganda more men and women will be living in the age of menopause and andropause. The significant disorders associated with menopause and andropause become an increasing concern, the health care system needs to be adequately prepared to respond to the increasing health needs of the affect population.

Policy Statement
Every aging Ugandan male and female to fully enjoy their SRH needs and rights

3.9.3 Policy goals

The goal is to develop mechanisms and systems and ensure that every aging Ugandan male and female to fully enjoy their SRH needs and rights.

3.9.4 Specific objectives

- To integrate appropriate services for menopause/andropause into the existing sexual and reproductive health service delivery
- To create awareness and respond to concerns about symptoms and signs of menopause/andropause.
- To prepare and support women and men for Menopausal and andropausal changes
- To provide appropriate management of clients with bothersome Menopausal / andropausal symptoms;

3.9.5 Target audience

All women and men over 40 years will be targeted. While the priority will be:

- Women with peri/menopause symptoms and their spouses
- Men with andropausal symptoms and their spouses

- Women and men whose ovarian or testicular function has been or is to be terminated on medical grounds through surgery, radiotherapy or chemotherapy.

3.9.6 Implementation strategies

- Strengthen the availability of commodities
- Psychosocial support

3.9.7 Service Delivery Points

The following facility types will be the service delivery points for menopause/andropause information, care, treatment and management:

- health facilities at all levels
- health clubs
- specialised clinics
- community outreaches and gatherings
- religious institutions

DRAFT

3.10 Sub theme 9: SEXUAL AND GENDER-BASED VIOLENCE

3.10.1 Definitions

Sexual and gender based violence is a serious form of discrimination, particularly against women and children and as such contravenes the principle of non-discrimination. It is both a public health problem and a human rights issue.

Gender-based violence commonly manifests itself in the form of:

- Domestic violence such as wife battering, oppression and intimidation
- Sexual abuse e.g. rape, defilement and incest
- Sexual harassment and intimidation at work, institutions and schools
- Harmful cultural practices like female genital mutilation and widow inheritance
- Early marriage
- Coercion or arbitrary deprivation of liberty
- Belief in large families
- Dowry related violence
- Forced prostitution
- Violence perpetrated or condoned by the state
- Harmful religious practices/beliefs
- Child trafficking

3.10.2 Context and Rationale

Gender Based Violence affects a large proportion of women and children. According to WHO (2013) estimates, globally and in Africa, 35% and 45% of women, respectively, experienced intimate partner violence and/or non-partner sexual violence in their lifetime. Women in Uganda are more than twice as likely to experience sexual violence as men. More than 1 in 5 women age 15-49 (22 percent) report that they have experienced sexual violence at some point in time compared with fewer than 1 in 10 (8 percent) men. Thirteen percent of women and 4 percent of the men reported experiencing sexual violence in the 12 months preceding the survey (UBOS, 2016). Violence has serious consequences for women's physical, including sexual and reproductive health, and mental health. Globally, women who experience intimate partner violence are twice as likely to experience depression, 4.5 times more likely to attempt suicide and in some regions, are 1.5 times more likely to be infected with STIs including HIV. It also has adverse economic and social consequences for women, their children and families.

Policy Statement

All HFs should provide appropriate response and prevention services to survivors of SGBV without discrimination.

DRAFT

3.10.3 Policy goals

To improve response to SGBV and reduce the incidence of SGBV.

3.10.4 Specific objectives

- Create awareness about the magnitude, health implications and consequences of SGBV (such as STIs including HIV/AIDS, , unwanted pregnancy) in the community and amongst health workers
- Strengthen provision of accessible, appropriate, acceptable, affordable and quality medical, legal and psychosocial support services for survivors of SGBV
- Provide and increase availability and accessibility of appropriate, acceptable, affordable quality information and services to SGBV survivors, affected families/communities and perpetrators
- Promote awareness among adolescents, family and communities about existing SGBV response services
- Strengthen capacity of multiple stakeholders involved in prevention, response and management of SGBV
- Enhance capacity of law enforcers and health service providers on prevention, response and mitigation of SGBV
- Promote male involvement in combatting SGBV
- Support advocacy for implementation of legal instruments that protect the rights of women, girls, boys and men

3.10.5 Target audience

- Men, women and children
- Parents
- Teachers
- Health workers
- Justice and law enforcers
- Community, religious, cultural and political leaders
- stakeholders involved in the prevention, service provision and rehabilitation programmes
- Mass media practitioners

3.10.6 Implementation strategies

The strategies include:

- Appropriate and accurate documentation
- Data collection to accurately define the problem using standardized tools
- Improving knowledge, attitudes and skills of health workers

- Equipping health facilities for comprehensive SGBV case management
- Integrating services that respond to gender-based violence into SRHR programs and all other basic health services as may be found necessary
- Mobilizing communities for the prevention and early referral of the survivors affected and perpetrators
- Developing of appropriate IEC and BCC materials
- Inclusion of SGBV management including collection of forensic materials and legal procedures in pre and in-service training curricula
- Establishing and maintaining multisectoral team response amongst various service providers
- Strengthening the referral mechanism to create linkages between the health system, community, law enforcement and legal system
- Provision of guidelines to all health workers/responders and actors on SGBV management at all levels of SRHR service delivery
- Include key SGBV indicators in the HMIS for routine service data
- Re-orientation of health workers on forensic medicine and management of legal procedures relating to SGBV

3.10.7 SGBV service package

Service delivery points for SGBV may include;

- Health facilities at all levels(private and public)
- Schools and institutions
- NGOs and CSOs
- Local council and religious institutions

Information and services for SGBV management

a) Information

Critical information will be provided at each SRHR service delivery point including information on response to sexual and gender-based violence prevention and management. This should be integrated in the SRHR IEC, advocacy activities and behavioural change activities. Thus responders will provide information on;

- Active identification of survivors
- Preservation of evidence including amongst the dead
- Women and children's rights
- Legal procedures
- Health consequences of SGBV
- When and where to seek care from

Beyond SRHR service delivery points, this information will be provided via different information sharing, communication and education mechanisms and opportunities including; billboards, symposium, campaign events, radio and television/press conferences, public addresses and debates, testimonies of survivors and perpetrators, electronic and print media(websites), group discussions, music, dance and drama.

Services

SGBV services should include;

- Preservation of evidence and completion of relevant documentation
- Identify, manage and refer SGBV cases appropriately
- Provide psychosocial support services including counselling
- Complete records and referral procedure including police forms
- Management procedures (diagnosis and treatment)
- Provision of SRHR services including management of STIs, perineal tears etc;
- Provision of HIV prevention services including post exposure prophylaxis
- Provision of pregnancy prevention services (emergency contraception)

3.10.8 Service Standards

Table 13: SGBV Services Availability

Type of service	Facility							
	Comm.	**Outreach**	**HC II**	**HC III**	**HC IV**	**General hospital**	**Referral hospital**	**CPHL**
IEC	✓	✓	✓	✓	✓	✓	✓	
Psychosocial support and counseling	✓	✓	✓	✓	✓	✓	✓	
History taking	✓	✓	✓	✓	✓	✓	✓	
Examination	✓	✓	✓	✓	✓	✓	✓	
HIV serology		✓	✓	✓	✓	✓	✓	
High vaginal swab				✓	✓	✓	✓	
Semen examination					✓	✓	✓	
DNA testing and forensic investigation							✓	✓
PEP				✓	✓	✓	✓	
Emergency contraception	✓	✓	✓	✓	✓	✓	✓	
STI management		✓	✓	✓	✓	✓	✓	
Anti-tetanus toxoid		✓	✓	✓	✓	✓	✓	

Surgical interventions				✓	✓	✓	✓	
Rehabilitation	✓	✓	✓	✓	✓	✓	✓	
First Aid	✓	✓	✓	✓	✓	✓	✓	
Referral	✓	✓	✓	✓	✓	✓	✓	
Postmortem					✓	✓	✓	✓
Colonoscopy							✓	✓
Filling of police forms and forensic evidence collection				✓	✓	✓	✓	✓

Table 14: SGBV Service Provision by Cadre of Health workers

Type of service	Cadre									
	CRHW	Nurse aide	Mid-wife/ Nurse	Clinical officer	Medical officer	Gynae /Surg-eon	Physiot-herapist	Radiogi-st	Lab tech/ Cyto-	Social worker
IEC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Psychosocial support and counseling	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
History taking	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Examination			✓	✓	✓	✓	✓	✓	✓	
HIV serology		✓	✓	✓	✓	✓	✓	✓	✓	
High vaginal swab			✓	✓	✓	✓			✓	
Semen examination									✓	
DNA testing and forensic investigation									✓	
PEP			✓	✓	✓	✓				
Emergency contraception	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
STI management	✓	✓	✓	✓	✓	✓				
Anti-tetanus toxoid		✓	✓	✓	✓	✓				
Surgical interventions			✓	✓	✓	✓				
Rehabilitation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
First Aid	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Referral	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Postmortem					✓					
Colonoscopy					✓			✓		

3.10.9 References

1. Ministry of Health. Health Sector Development Plan, 2015 – 2020
2. UBOS 2016., Uganda Demographic and Health Survey, 2016; Key findings

DRAFT

4. CROSS CUTTING AREAS

4.1 Male sexual reproductive health and Involvement

4.1.1 Definition

Male sexual reproductive health and involvement refers to the fulfilment of males' roles and responsibilities in SRHR including HIV/AIDS prevention, care and support as well as parenting. Boys and men should take responsible decisions to realize their full potential in their Reproductive health and Rights; It also means men's full enjoyment of their realization of their Reproductive Health Goals and Rights in a responsible manner; Male Involvement requires that males participate effectively in their own health and well-being as well as respecting rights of their partners and Children.

4.1.2 Context and rationale

Men have sexual and reproductive health related problems which need to be addressed. Conditions of the male reproductive system include HIV/AIDS, fertility problems, midlife concerns, such as andropause and sexual dysfunction. Serious conditions include non-malignant genitor-urinary conditions and malignancies of prostate, testicles and genitor-urinary organs.

Vulnerability of males to SRH problems, their roles and responsibilities in prevention and care, including the prevention of gender based violence, are important aspects of a gendered approach to prevention interventions.

Empirical and anecdotal evidence indicates that often, cultural beliefs and expectations of manhood or masculinity encourage risky behaviour in men. Masculinity requires males to play brave by not seeking help or medical treatment if they are faced with ailments including HIV/AIDS.

Violence against women is more common and arises from the notion of masculinity based on sexual and physical domination over women. Therefore, there is need to strengthen and accelerate the active involvement and participation of males including adolescents and youth in sexual and reproductive health issues, HIV/AIDS and Sexual gender based violence. This should be aimed at;

1. Mainstreaming male friendly interventions into the RH including HIV/AIDS programs and services
2. Advocating for male friendly services at all levels of involvement

DRAFT

3. Promoting male involvement as a central tenet of reproductive health services
4. Increasing access to sexual and reproductive health services for males and young men and boys
5. Equipping health workers both at facility and community with knowledge and skills to provide male-friendly services
6. Engendering monitoring and evaluation to capture male specific data.

4.1.3 Service Interventions

To accelerate and strengthen male involvement, the package of services/interventions that should be available to motivate and promote male involvement in SRH and HIV/AIDS at the three levels (i.e. health facility level, community level and family level) includes:

Health facility

a) The Service Provider should be a skilled health worker offering the following services:
   - Counselling (FP, HIV, pre-conception, marriage and partner support, positive living, alcohol and drug abuse, sexual gender based violence, lifestyle diseases
   - Conditions of the male reproductive system include HIV/AIDS, fertility problems, midlife concerns, such as andropause and sexual dysfunction. Serious conditions include non-malignant genitor-urinary conditions and malignancies of prostate, testicles and genitor-urinary organs
   - Planning resources to support pregnancy and child care)
   - Testing (BP, blood sugar, cancer, nutrition assessment, fertility, blood grouping)
   - Family Planning
   - Testing for men on prostate cancer, STI screening and treatment
   - Health and nutrition education
   - Safe Male Circumcision (SMC)
   - Referral to other services such as IGAs, legal services, encouraging couple attendance, male corners, target men, run men access clinics, any form of invitation to men (letter, SMS, Cards, reminders, phone calls, word of mouth) etc

   The above should also be included in the outreach services.

b) Other service providers (VHTs, Expert Clients and Nursing Assistants) – support the skilled health workers in the above, accompany clients to other services within the health facility referral. Preferably, a male service provider should be part of the team.

DRAFT

- **Infrastructure:**

The layout of the facility should be male participatory friendly. It should have the following:

- Male corner
- A waiting area that is friendly to men
- Separate toilets and birth rooms for male and female
- IEC materials which encourage and engage men to participate in SRH service delivery

4.1.4 Service delivery points and platforms

Services should be male-friendly and non-discriminatory. Partner needs must be addressed in a more specific way to make services attractive to men. Implementing partners shall promote, advocate and ensure male involvement in all aspects of service delivery.

The SDPs include but not limited to;

- CHEWS/VHTs
- Religious and cultural leaders
- Politicians and legislators
- CBOs
- FBOs
- Local councils
- Community support groups
- Peer male groups

4.2 SRHR and Mental Health

4.2.1 Definition

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. The positive dimension of mental health is stressed in WHO's definition of health as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

4.2.2 Context and rationale

Although the international community has pledged to address mental health problems related to sexual and reproductive health, too many women and men still suffer their deleterious effects. These include perinatal depression and suicide; the mental and

psychological consequences of miscarriage, abortion or complications stemming from pregnancy and childbirth, lack of support following childbirth, gender-based violence (GBV) and HIV/AIDS. Perinatal mental health problems are associated with increased physical illness and higher mortality among women and children. There is a global increase in the number of mental health problems associated with sexual and reproductive health for example one in four women experience depression; 10-15 per cent or more women experience depression during pregnancy or after childbirth. In addition, one-third of rape victims suffer from post-traumatic stress disorder.

Mental health problems are associated with risky sexual behaviour and substance abuse, which can lead to unintended pregnancy, GBV and sexually transmitted infections (STIs) including HIV. In Uganda mental health is a major health problem contributing 13% to the national disease burden. Butabika hospital is the only national referral mental health institution.

Policy Statement
Mental health services should be integrated into Sexual and reproductive health services at all times

4.2.3 Policy goal

To ensure that all women, men and adolescents seeking sexual and reproductive health services receive mental health assessments and appropriate management at all SRH SDPs.

4.2.4 Target audience

- Women of reproductive age group
- Health care workers
- Community leaders
- Youth and adolescents
- Women in puerperium/postpartum women
- Victims of rape
- Victims of SGBV
- Post abortion women and girls
- Post-menopausal women
- Infertile women
- Persons affected by natural disasters
- Persons with disabilities
- Persons affected by conflict situations and
- Persons (women and girls) in refugee settings

DRAFT

4.2.5 Areas of focus

- Mental health issues of pregnancy, childbirth and the postpartum period.
- Psychological aspects of contraception and elective abortion
- Mental health consequences of miscarriage
- Menopause and depression
- Gynaecological morbidity and its impact on mental health
- Infertility and assisted reproduction
- Mental health and female genital mutilation
- Mental Health and GBV

4.2.6 Implementation strategies

- Ensure that each health facility has at least one health worker trained on assessment, detection and management of mental illness
- Include psychiatric examination and management in MCH services provision
    - Adapt mental health assessment forms in MCH registers
    - Collect and report service data on mental illnesses and management in MCH as part of the HMIS

4.2.7 Services and interventions

Screening can detect mental health problems. Medication and psychological interventions, most of them deliverable through primary health care services, can prevent these problems. Family, partner and peer support are effective; community involvement also plays an important role as does the social environment.

Level of care	Services
Community level	• Health education on mental disorders • Identification and referral of persons at risk of mental illnesses due to pregnancy and childbirth related causes • Mobilization and sensitization on rational drug use and drug and substance abuse • Capacity to handle mental drugs at community
Health facility level II, III and HC IV	• All the above, plus • Detect and refer basic mental problems • Review and follow-up patients with epilepsy • Follow up treatment for identified patients with mental health in the community • Health education and awareness raising on mental health in the community
District Hospital Mental health ward	• All the above, plus • Diagnosis and treatment of mental health patients • Regular mental health clinic (weekly)

	• Outreach services to the community

4.3 Community Health

4.3.1 Definition

Community health, often referred to as public **health**, is the science of protecting and improving the **health** of **communities** through education, promotion of **healthy** lifestyles, and research for disease and injury prevention[4].

4.3.2 Context and rationale

Community health workers have proven to be a reliable vehicle for delivery and improvement of community health. The use of community health workers to increase the reach of health services has been part of various health programs in both developed and developing countries since the 1970s. As more countries face critical health workforce shortages, increased involvement of community health workers as a strategy to address the human resource gaps became more apparent.

Uganda has adapted the CHEW strategy to establish and strengthen Community Health Extension Workers program as part of the national health system in order to bring services closer to the community and ensure equitable distribution of community and household-centered health care services. The CHEW program will improve the cost-effectiveness of health care system by reaching large numbers of previously underserved populations with high-impact basic services at low cost. In addition, the CHEW will act as a bridge between the community and the formal health services in all aspects of health development.

4.3.3 Community health services and interventions

According to the national CHEW strategy, the CHEW is expected to perform a wide range of functions, which include: home visits, environmental sanitation, safe water usage, first aid and treatment of simple and common ailments, health and nutrition education, disease surveillance, maternal and child health and family planning activities, communicable disease control, community development activities, referrals, record-keeping, and collection of data on vital events. This will be complemented by the voluntary actions of VHTs at household level. The functions of VHTs include[5]:

- Home visiting
- Mobilization of communities for utilization of health services
- Health Promotion and Education

---

[4]hes.lr.edu/**community-health**

[5] Ministry of Health, 2010. VHT Strategy and Operational Guidelines

DRAFT

- Community based case management of common ill health conditions
- Follow up of the mothers during pregnancy and afterbirth and the newborns for provision of advice, recognition of danger signs and referral
- Follow up of people who have been discharged from health facility and those on long term treatment
- Distribution of health commodities and
- Community information

Specifically for SRHR, the following functions/interventions will be undertaken by CHEWs[6];

- ❖ Provide basic nutrition information/education to the client
- ❖ Provide antenatal examination and information for a pregnant woman
- ❖ Promote delivery in a health facility in the hands of a skilled birth attendant
- ❖ Conduct home visit and refer a pregnant woman and their babies with risk factors
- ❖ Provide services for lactating mothers on infant care, nutrition and exclusive breast feeding
- ❖ Implement family and community practices that promote child survival, growth and development activities (Exclusive breast feeding, complementary feeding, Micronutrients ,hygiene, immunization, use of bed nets for malaria prevention, psychosocial development, homecare of illness, home treatment for infections, care seeking, compliance with advice and ANC)
- ❖ Educate the community on family planning options/methods and provide family planning service
- ❖ Promote adolescent and youth RH services

DRAFT

---

[6]Ministry of Health. Community Health Extension Workers Strategy in Uganda (2015-2020). Draft of September 2015

Annex 1: Types of Family Planning Methods to be Made Available

In order to increase the method mix and promote informed choice, all methods, both temporary and permanent, will be provided and made available in the country. The following methods are available in Uganda: hormonal, intra-uterine device, barrier, permanent, and fertility awareness based. Some of the methods require authorization for use by a qualified health worker. On the other hand, other methods can be offered by trained non-skilled personnel.

Family Planning clients have the right to be referred to another SDP if their preferred method of choice is not available at the health unit of call or the provider lacks the skills needed to provide such services safely. During the referral, appropriate counseling and alternative temporary contraception should be provided to prevent unwanted pregnancy.

Most family planning methods do not protect against STI/HIV. If there is a risk of STI/HIV the correct and consistent use of condoms is recommended either alone or with another contraceptive. Male/female latex condoms protect against STI/HIV and pregnancy. Dual protection with a condom and another FP method to protect HIV/AIDS and pregnancy is preferred.

a) Combined oral contraceptives (COC)

Who can use COC?

- all women of reproductive age who desire to use COCs;
- women with anemia, but the basic problem causing anaemia must be evaluated and treated;
- women with dysmenorrhoea;
- women with irregular cycles;
- women with history of ectopic pregnancies;
- diabetics lasting less than 20 years or without evidence of hypertension;
- women with BP less than 160/100 mmHg;
- women with trophoblastic disease (on treatment and follow-up);
- Varicose veins or superficial thromophlebitis;
- Benign ovarian tumours (including cysts)
- ovarian cancer awaiting definitive treatment
- Thyroid disease
- Benign breast disease
- Depressive disorders
- Undergoing treatment with the griseofulvin
- Undergoing treatment with ARVs (although effectiveness may be reduced)
- STIs, including HIV/AIDS

Who should not use COC?

The following contra-indicate administration of COC:

- Pregnancy (although there is known harm to the woman or the foetus if COCs are accidentally used during pregnancy);

- Complications or side effects that a service provider is not capable of handling;
- Breast feeding mothers less than 6 weeks post partum;
- Women due for major surgery within four weeks;
- History of current deep vein thrombosis;
- Vascular disease;
- Migraine with focal neurologic symptoms;
- Liver disease e.g. Hepatitis, cancer, cirrhosis;
- Jaundice;
- Active viral hepatitis.
- Undergoing treatment with drugs that affect the liver enzymes (rifampicin and certain anticonvulsants such as phenytoin, carbamazipine, barbiturates, primidone, topiramate, oxcarbazepine);
- History of all ischaemic heart disease;
- Stroke or history of stroke;
- Major surgery with prolonged immobilization;
- Hypertension greater than 160/100 mmhg;
- Known thrombogenic mutations (e.g. Factor v leiden: prothrombin mutation: protein s. Protein c and antithrombin deficiencies) due to higher risk of thrombosis;
- Women judged to be forgetful or mentally retarded;
- Diabetes with vascular complications or diabetes of more than 20 years duration;
- Smoking more than 15 cigarettes a day whatever the age
- Smoking when older than 35 years;

To date there is no concrete evidence that oral contraceptives have any effect on the transmission of HIV or the course of AIDS once a person is infected.

When can the client start taking COCs?

The client can start taking the COC:

- within the first five days after the start of her menstrual bleeding (no additional contraceptive protection needed);
- any other time if it is reasonably certain she is not pregnant: if it has been more than five days since menstrual bleeding started, she will need to abstain from sex or use condoms as a back-up method for the next seven days;
- three weeks after delivery, if not breast feeding;
- six months post partum if breast feeding;
- immediately following abortion.

b) Progesterone only pill (POP)

Who can use POP?

- Postpartum or postabortion (any time)
- breast feeding mothers;
- women in whom oestrogens are contra-indicated;
- women with BP more than 180/110 mmHg;
- women with sickle cell disease;
- diabetics without evidence of hypertension or history of a heart attack;
- women who have isolated history of pregnancy-induced hypertension;
- smokers;
- those due for major surgery;
- known thrombogenic mutations (e.g. factor V Leiden: prothrombin mutation, protein S. protein C and antithrombin deficiencies) due to higher risk of thrombosis.
- Headaches, including migraines
- Benign breast disease
- those with congenital heart disease;
- unexplained vaginal bleeding (although evaluation should be done as soon as possible to rule out underlying malignancy [pregnancy])
- Cervical, endometrial or ovarian cancer (awaiting definitive treatment)
- Depressive disorders
- Undergoing treatment with griseofulvin
- Undergoing treatment with ARVs although effectiveness may be reduced

Who should not use POP?

- pregnant mothers (although there is no harm to women or the foetus if POPs are accidentally used during pregnancy);

- women deemed forgetful or mentally retarded;
- women with current breast cancer or history of breast-cancer;
- women undertaking treatment for epilepsy with phenytoin or TB with Rifampicin.
- Current deep venous thrombosis
- Active viral hepatitis
- Severe cirrhosis or liver tumors
- Undergoing treatment with Rifampicin, anti-convulsants e.g. phenytoin

POPs are good method of choice for breastfeeding women. Women who are not breastfeeding and want to use oral contraceptives should consider using COCs rather than POPs because POPs are less effective in non breastfeeding women in typical use.

DRAFT

When can the client begin to use POP?

- any time provided pregnancy has been ruled out;
- Within the first 7 days of the menstrual cycle;
- immediate post-partum period if not breast feeding;
- immediately following an abortion;
- after 6 weeks post-partum if breast feeding.

For frequency and content of check-ups for COC and POP users, see the Procedure Manual.

The client should be encouraged to return to the facility any time in the event of problems, concerns, or new needs.

c) Injectable contraceptives- Depo- medroxyprogesterone acetate (DMPA)

Who can use injectable methods of contraception?

In general most women can use injectable contraceptive safely and effectively, especially by women who:

- Are any age including adolescents and over 40 years
- Smoke cigarettes
- Have just had an abortion
- women who do not want a long term method of family planning;
- women with sickle cell disease;
- women who are HIV-positive or suspected to be HIV-positive and want an effective contraception to protect themselves from pregnancy;
- breast feeding mothers after 6 weeks post-partum;
- anytime for non-breast feeding mothers;
- major surgery without prolonged immobilization;
- superficial thrombophlebitis;
- epilepsy;
- valvular heart disease;
- epilepsy;
- Endometriosis.
- PID
- STIs

Who should not use injectable method of contraception?

- as for POPs;
- women who want a pregnancy within less than two years after discontinuing the injection;
- women who cannot cope with possible disruptions in their menstrual cycle;
- breast feeding mothers before six weeks post-partum.

DRAFT

- Current breast cancer disease
- Women with a reported allergy to the constituents of the contraceptive preparation
- Women with unexplained vaginal bleeding

Diabetes mellitus is not an absolute contra-indication to injectables but in absence of facilities for medical consultation they should not be given.

When should the injectable family planning method be started?

- As for POPs.

d) Implants

There are several types of contraceptive implants approved for use in Uganda. The text below is applicable for all the progesterone-based implants, including Norplant®, Jadelle®, Implanon® and Zarin®

Who can use implants?

Implants can be used without restrictions or generally used by women with the following conditions which in the past were contraindications for implants use

- Nulliparous (have no children)
- Breastfeeding (more than six weeks postpartum)
- Post-abortion
- Obesity
- Multiple risk factors for cardiovascular disease
- Hypertension
- Headaches
- Irregular and/or heavy menstrual bleeding
- Cervical, endometrial, or ovarian cancer
- Benign breast disease
- Diabetes of any type and duration
- Sickle cell disease or other types of anaemia
- Depressive disorders
- Undergoing treatment with griseofulvin
- Undergoing treatment with ARVs
- Smoking

Note: There is no restriction on Implants use by adolescents or women over 45 years

DRAFT

Who should not use implants?

Implants are not generally recommended or are contraindicated for women with the following conditions:

- Pregnancy (although there is no known harm to the woman or the foetus if implants are accidentally used during pregnancy)
- Breastfeeding less than six weeks postpartum
- Current deep venous thrombosis
- Unexplained vaginal bleeding (before evaluation)
- Current breast cancer or history of breast cancer (with no active disease for five years)
- Diabetes with vascular complications or diabetes of more than 20 years duration
- Severe cirrhosis, active viral hepatitis, or liver tumours

3.10.5 Intra-uterine contraceptive devices (IUCD) The various types of IUCD include :

- CopperT *380A*
- Multi-load 375
- Mirena® hormonal IUCD (private sector)

Women who may want to consider an IUCD include:

- Women of reproductive age who prefer a nonhormonal, highly reliable method of contraception that does not require daily action
- Women and couples who have reached their desired family size and do not want to undergo sterilization
- Women who have trouble with correct and consistent use of other contraceptive methods (e.g., remembering to take pills on time, negotiating condom use with a partner)
- Women at low risk of STI
- Women who have a non-contraceptive indication for using Mirena®

Who can use an IUCD?

The IUCD can be used without restrictions or generally used by women of any age and parity who may also have the following conditions:

- Breastfeeding
- Current or history of cardiovascular disease or stroke
- Headaches, including migraine

The following category of people may use IUCD after evaluation of a trained health worker:

- Irregular, heavy, or prolonged menstrual bleeding patterns
- Severe dysmenorrhea

DRAFT

- Cervical ectopy
- Breast disease, including breast cancer
- History of pelvic inflammatory disease (PID)
- Increased risk of STI
- High risk of HIV or infection with HIV (no symptoms of AIDS)
- AIDS, and doing clinically well on ARV therapy

Who should not use the IUCD?

The IUCD is not generally recommended or is contraindicated for women with the following conditions:

- Pregnancy
- Distorted uterine cavity incompatible with IUCD insertion (including uterine fibroid)
- Unexplained vaginal bleeding (before evaluation)
- Trophoblastic disease
- Cervical, endometrial, or ovarian cancer
- Known pelvic tuberculosis
- Current PID
- High individual likelihood of exposure to gonorrhea and chlamydia [2]
- Current purulent cervicitis, gonorrhea, or chlamydia
- AIDS (without ARV treatment)

IUCD users who develop PID should be treated with the IUCD in place if they want to continue using it. If no improvement within 72 hours, remove it.

Timing of IUCD insertion:

- Any time provided pregnancy is ruled out
- The first seven days of the menstrual cycle
- Immediately following delivery or any time within 48 hours after childbirth
- Any time beyond four to six weeks after childbirth
- Immediately or within seven days after an uncomplicated abortion
- during caesarean section

Barrier Methods

Barrier methods must be used consistently and correctly in order to be effective.

e) Condoms (male and female)

Who can use condoms?

Condoms can be used by any man or woman regardless of his or her health status. People in particular need of condoms include:

DRAFT

- Men wishing to participate more actively in family planning
- Sexually active adolescents
- Couples who have sexual intercourse infrequently
- People in casual sexual relationships where pregnancy is not desired
- Couples needing a back-up method while waiting for another contraceptive method to become effective
- Couples who need a temporary method while waiting to receive another contraceptive method
- Those who are at increased risk of STIs, (e.g., when one or both partners have other partners)
- Couples where one or both partners are HIV positive

The effectiveness of condoms for both pregnancy and STI/HIV prevention depends greatly on clients‟ ability to use them consistently and correctly. Condoms, if used correctly and consistently, have been shown to provide a high degree of protection against STI/HIV transmission. In typical use, condoms are less effective; thus, it is important for providers to offer thorough counselling and instructions on use to encourage consistent condom use

Who should not use condoms?

Individuals allergic to latex (material of which male condoms are made) should consider other contraceptive options. However, for those at risk of STI/HIV, condom use is still appropriate as there are no other methods that offer STI/HIV protection.

f) Spermicides and diaphragms

Who should use spermicides or diaphragm?

- Women of any age and parity
- Women who are breastfeeding
- Women who want a female-controlled method of contraception
- Couples who have sexual intercourse infrequently
- Women whom hormonal contraception are contraindicated

Who should not use spermicides or diaphragm?

- Women who are at increased risk of HIV (e.g sero negative women in discordant relationships, CSWs), or are already HIV infected
- Women with AIDS
- Women allergic to latex or spermicides
- Women with some anatomical abnormalities that may interfere with appropriate diaphragm placement (e.g., uterine prolapse, vaginal stenosis)

Voluntary surgical contraception

Because male and female sterilization are permanent methods of contraception, thorough counselling procedures must be followed to ensure that the client fully understands his or her choice and to minimize chances of regret. Clients younger than 30 years old or with fewer than three children require particularly

DRAFT

careful counselling and exploration of other long-term method options.

g) Tubal ligation

Who can have tubal ligation?

In general, the majority of women who want tubal ligation can have a safe and effective procedure in a routine in a health facility equipped to provide the service, provided they have been counseled. They should also be able to give informed consent. Women who may consider tubal ligation include:

- Those who are certain that they have achieved their desired family size
- Women who want a highly effective permanent method of contraception
- Women for whom pregnancy presents unacceptable risk

Who should not have tubal ligation?
There are no medical conditions that would absolutely restrict a woman's eligibility for tubal ligation. Some conditions and circumstances indicate that the procedure should be delayed, or that certain precautions be taken.

Tubal ligation should be delayed in case of:

- Pregnancy
- Immediately/early postpartum if woman had severe pre-eclampsia/eclampsia, prolonged rupture of membranes (24 hours or more), sepsis, severe antepartum hemorrhage, or severe trauma to genital tract
- Complicated abortion (infection, haemorrhage)
- Current deep venous thrombosis
- Current ischemic heart disease
- Unexplained vaginal bleeding (before evaluation)
- Malignant trophoblastic disease
- Current PID or purulent cervicitis
- Current gall bladder disease
- Severe anaemia
- Acute respiratory disease
- Acute systemic infection or gastroenteritis
- Abdominal skin infection
- Evidence of peritonitis

Timing of the tubal ligation:

- Immediately after childbirth or within first seven days (if she made voluntary informed choice in advance)
- Six weeks or more after childbirth
- Immediately after abortion (if she made voluntary informed choice in advance)

DRAFT

- Any other time provided pregnancy is ruled out (but not between seven days and six weeks postpartum)
- During caesarean section

h) Vasectomy

Who can have vasectomy?

In general, the majority of men who want vasectomy can have a safe and effective procedure in a routine setting, provided they have been counselled. They should also be able to give informed/written consent. Men who may consider sterilization include:

- Those who are certain that they have achieved their desired family size
- Men who want a highly effective permanent contraceptive method
- Men whose wives face unacceptable risk in pregnancy

Who should not have vasectomy?

There are no medical conditions that would absolutely restrict a man�or"s eligibility for vasectomy. Some conditions and circumstances indicate that the procedure should be delayed, or that certain precautions be taken.

Vasectomy should be delayed in case of:

- Local infections (scrotal skin infection, balanitis, epididymitis, or orchitis)
- Current STI
- Systemic infection or gastroenteritis

Clients with following conditions will require a provider with extensive experience:

- Previous scrotal injury
- Cryptorchidism (undescended testes)
- Diabetes
- Inguinal hernia

Natural methods

i) Lactational amenorrhea method (LAM)

The effect of breastfeeding on reducing fertility is well known. However, LAM is a temporary (short-term) method of contraception. It is highly effective for the first six months postpartum, provided the woman breastfeeds fully and remains amenorrheic. When **all three criteria of LAM are met**, it is about 98% effective.

Who can use LAM?

- Women:
  - o who are fully breastfeeding **and**
  - o who are amenorrheic (no menses) **and** o whose baby is not older than six months

Fully breastfeeding means:

- **Breastfeeding whenever the baby desires (at least every four hours) Night-time feeding (at least every six hours)**
- **Not substituting other food or drink in place of breast milk**

Who cannot use LAM?

- Women whose menses have returned
- Women whose babies have turned six months old
- Women who have introduced supplementary feeding

Women with HIV should be counseled about infant feeding options to reduce risk of mother-to-child transmission, and be supported in their choice. Women without reliable access to safe alternative feeding options should be encouraged to breastfeed exclusively for six months.

j) Fertility awareness methods (FAM)

Fertility awareness methods of family planning involve identification of the fertile days of the menstrual cycle (when pregnancy is most likely to occur) and avoiding sexual intercourse (or using barrier methods) during these days. The fertile days of the menstrual cycle can be determined by one of the following methods:

- Basal body temperature (BBT)
- Cervical mucus
- Sympto-thermal (a combination of cervical mucus and BBT methods)
- Calendar (rhythm) or Standard Days Method, including cycle beads

A woman or couples who are planning to use Fertility awareness methods need special training from a trained counselor in family planning.

Who can use fertility awareness methods?

- Any woman or couple who is willing and motivated to observe, record, and interpret fertility signs daily
- Women who find other contraceptive methods unacceptable for various reasons, including religious beliefs
- Women who are unable to use some other methods for health reasons
- Couples who are willing to abstain from sexual intercourse (or use condoms) for more than one week during each cycle

Who should not use fertility awareness methods?

There are no medical conditions that are worsened with the use of fertility awareness methods. However, there are some conditions that make their use more difficult. If these conditions are present, the method can either be delayed or the provider should offer special counselling to ensure the correct use.These conditions include:

- Breastfeeding (especially until menses return)
- Less than three postpartum menses

DRAFT

- Irregular vaginal bleeding
- Abnormal vaginal discharge
- Disease that elevates body temperature

k) Emergency contraception (EC)

Emergency Contraception (EC) refers to methods of contraception used by women to prevent unintended pregnancy following unprotected sexual intercourse. It should not be used as a routine contraceptive method. EC is not a method for termination of pregnancy.

Emergency Contraceptive Pills (ECP):

Progesterone-only pills regimen (progesterone-only pills are the preferred ECPregimen as they aremore effective and have fewer side effects than combined oral contraceptive pills):

> ***Dedicated products like Postinor – 2*** **(LNG 750 mcg)–[also called Vikela]or** ***Levonelle-2 or NorLevo Plan B may be used:Regular progesterone-only pills such as Ovrette and microval can also be used in recommended doses:***

Combined oral contraceptive pills regimen *(*low-dose pills such as Lo-Femina,Microgynon, Nordette, or Pilplan) can be used in recommended doses.

Who can use ECPs?

- Any woman who has had unprotected sexual intercourse
- Women who have been raped
- Any woman whose contraceptive method has failed (e.g., condom broke or slipped)
- Any woman who has forgotten to take her combined oral contraceptive pills for more than two days or who has forgotten to take her progesterone only pill at the regular time.
- Any woman who has missed her contraceptive injection for more than two weeks

Women who need emergency contraception should be counseled about regular contraceptive options and encouraged to use regular methods consistently and correctly.

Referral:

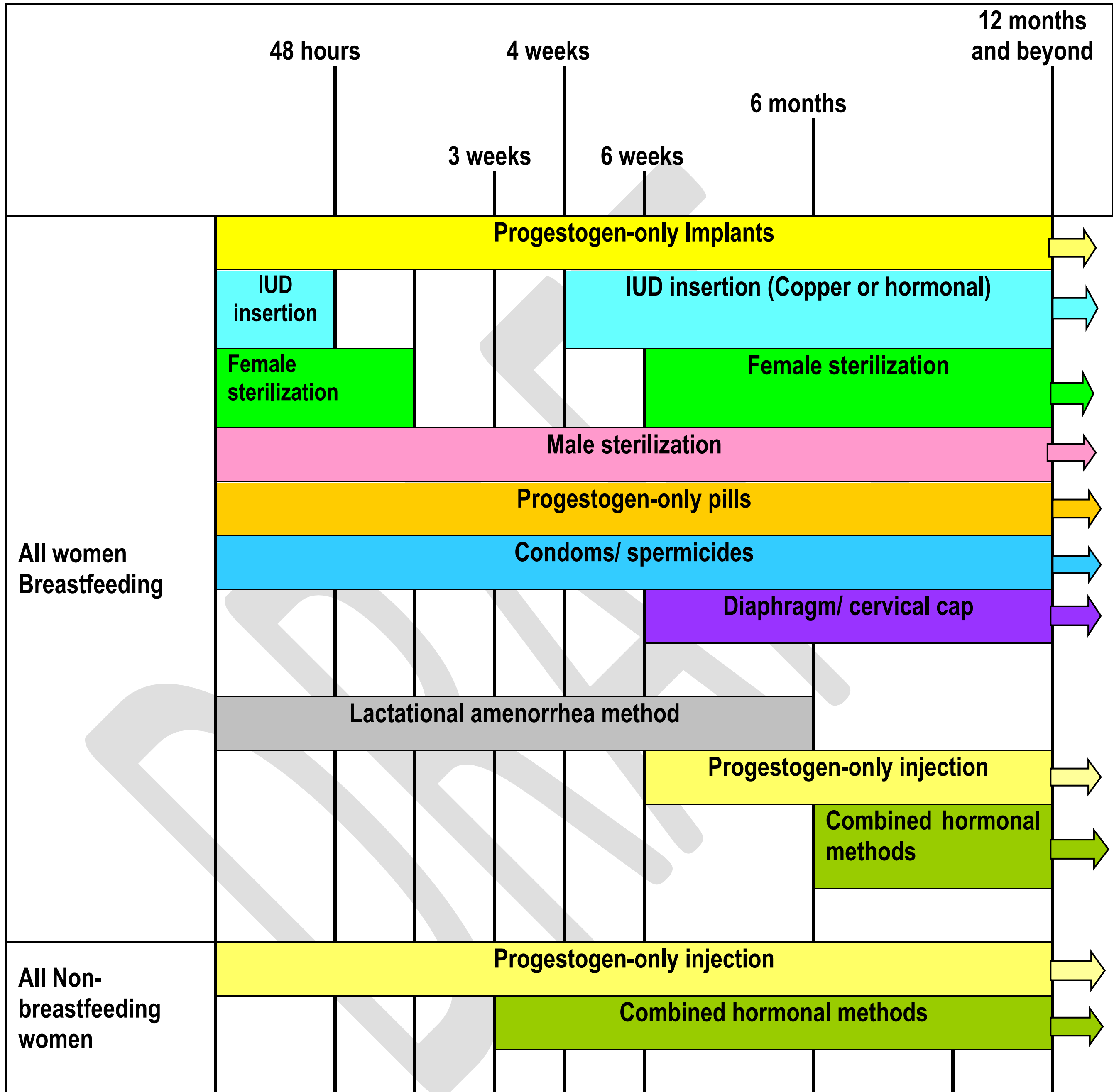
- Women should be referred for other relevant services such as HIV Counseling and Testing (HCT), Post-Exposure Prophylaxis (PEP) and treatment for STIs.
- Women should be referred to specialized services such as for sexual and gender-based violence.

Other types of ECs used:

An **intrauterine device (IUD)** can be inserted and used as an emergency contraceptive, and continued as a regular method.

IUD insertion for emergency contraception is not recommended for women at high risk for sexually transmitted infection at the time of insertion. Also it should not be used in women who may already be pregnant.

l) Contraceptive method eligibility for the first year postpartum



Annex 2: Goal Oriented Antenatal Care Protocol

Important: Goals are different depending on the timing of the visit. 4 visits are aimed for in an uncomplicated pregnancy. If a woman books later than in first trimester, preceding goals should be combined and attended to. At all visits address any identified problems, check the BP and measure the Symphysio-Fundal Height (SFH). All women must receive Hb, HIV testing and Syphilis testing (RPR) routinely.

VISIT	TIMING OF VISIT	GOALS	HISTORY TAKING	EXAMINATION	LABORATORY INVESTIGATIONS	HEALTH PROMOTION	ACTIONS
BOOKING VISIT	Any time before 14 weeks gestation	- Patient assessment - Plan for ANC - Identify and manage any illness - Develop birth and emergency plan - Give health education - Check foetal growth and maternal well-being - Start	- Medical - Surgical - Obstetric - LMP - Confirm period of gestation - Contraceptive use (type, duration) - STI - Family history - Access for SGBV - Social: smoking, alcohol/drugs	- General exam including evidence of trauma and mood , - Vital observations (BP, Pulse rate, respiratory rate) - SFH (symphysio-fundal height) - Abdominal	- Syphilis test (RPR) - HIV test - Urinalysis(Urine strip & microscopy) - If BP > 140/90, check urine for protein - Hb estimation - HBsAg testing - Blood grouping - If Mother has fever (Temp above 37.5°C do RDT/ BS - If RDT/BS	- Educate on ANC visits - Address any observed or volunteered problems and illnesses - Involve husband in ANC - Develop emergency plan - Teach danger signs during pregnancy - Discuss STI/HIV/AIDS prevention and	- Give TT1 - Give iron/folic acid - HIV counselling, testing and post-test counselling - If HIV+, begin eMTCT at 14 weeks gestation - Treat any illness - Counsel woman - Start IPTp with SP after 13 weeks gestation - Provide ITN (LLINs) - If low dietary calcium intake, provide daily calcium supplementation (1.5-

		preventive interventions	- Social support	exam Vulva exam (speculum if indicated	positive, follow guidelines - Check for hereditary conditions if suspected sickling test G6PD)	care - After HIV test, provide counselling. If HIV-positive, ask to come back 14 weeks to begin ARV for eMTCT - Discuss pregnancy discomforts, sexual relations - Counsel on ITN use - Discuss the danger of SGBV in pregnancy - Emphasise on hygiene, nutrition and adherence to treatment - Advise on common discomforts of pregnancy	2.0g oral elemental calcium)

DRAFT

SECOND VISIT	24-28 weeks	- Give TT - Exclude multiple pregnancy - Check for pregnancy-induced hypertension (PIH) - Determine foetal growth and movement - Exclude anaemia - Screen for GDM if the mother is at risk.	- Ask for any social problems and illnesses - Ask date of first foetal movements - Ask if there is/was any vaginal bleeding or discharge	- Measure BP and weight - Check for Oedema and Pallor - Measure SFH - Abdominal exam: rule out multiple pregnancy - Check foetal heartbeat - Access for SGBV	- If BP > 140/90, check urine for protein - Check Hb - Do OGGT - If Mother has fever (Temp above 37.5ºC do RDT/ BS - If RDT/BS positive, follow guidelines - Repeat HIV test - Viral load/CD4 for HIV positive mothers - For Rhesus Negative mothers, do anti body screening	- Address any observed or volunteered problems and illnesses - Update birth and emergency plan - Review danger signs in pregnancy - If HIV-positive, counsel on eMTCT - Counsel on ITN use - Advise on common discomforts of pregnancy - Discuss the danger of SGBV in pregnancy - Emphasise on hygiene, nutrition and adherence to	- Give TT2 - Refill iron/folic acid - Give IPTp-SP if 1 month has passed since previous dose - Give mebendazole - If HIV+, on eMTCT and refill of ARVs - Treat any illnesses problems - Counsel woman - Health educate on LLINs use, care and maintenance - If low dietary calcium intake, provide daily calciumsupplementation (1.5‑2.0g oral elemental calcium)

DRAFT

						treatment	
THIRD VISIT	30-32 weeks	- Determine foetal growth - Exclude anaemia - Check for PIH - Update birth and emergency plan	- Ask for any social problems and illnesses - Ask if there is/was any vaginal bleeding and discharge	- Measure BP - Check for pallor - Measure SFH - Abdominal exam - Check foetal heartbeat	- If BP > 140/90, check urine for protein - Check Hb - If Mother has fever (Temp above 37.5ºC do RDT/ BS - If RDT/BS positive, follow guidelines -	- Address any observed or volunteered problems and illnesses - Teach danger signs in pregnancy/labour - Discuss labour - Discuss and update birth and emergency plan - Discuss family planning - If HIV-positive, counsel on ePMTCT - Counsel ITN use - Teach about postpartum care - Teach care of the newborn: early exclusive breast-feeding thermal	- Refill iron/folic acid - Give IPTp-SP if 1 month has passed since previous dose - Treat any problems - If HIV+, eMTCT - Counsel to use dual protection for FP/HIV - Counsel woman - Health educate on LLINs use, care and maintenance - If low dietary calcium intake, provide daily calciumsupplementation (1.5‑2.0g oral elemental calcium)

						care, cord care, danger signs - Discuss the danger of SGBV in pregnancy - Emphasise on hygiene, nutrition and adherence to treatment -	
FOURTH VISIT	>36 weeks	- Determine foetal growth - Exclude anaemia - Check for PIH - Check for preeclampsia - Exclude cephalopelvic disproportion, abnormal presentation/lie - Explain symptoms of	- Ask for problems - Ask if any vaginal bleeding	- Measure BP - Measure SFH - Count foetal heart rate - Abdominal exam - Check lie - Check presentation	- If BP >140/90 check urine for protein - Check Hb - If Mother has fever (Temp above 37.5°C do RDT/ BS - If RDT/BS positive, follow guidelines -	- Address any observed or volunteered problems and illnesses - Discuss labour - update birth and emergency plan - Teach PMTCT in labour, birth, postpartum - Counsel on ITN use - Re-discuss FP and HIV	- Refill iron/folic acid - Give IPTp-SP if 1 month has passed since previous dose - Treat any problems - If HIV+, eMTCT - Counsel to use dual protection for FP/HIV prevention - Counsel woman - Health educate on LLINs use, care and maintenance - If low dietary calcium intake, provide daily

DRAFT

		labour - Update birth and emergency plan				prevention - Teach about postpartum care - Teach care of newborn: danger signs in newborn, early and exclusive breastfeeding, thermal care, cord care - Discuss the danger of SGBV in pregnancy - Emphasise on hygiene, nutrition and adherence to treatment	calciumsupplementation (1.5-2.0g oral elemental calcium)

DRAFT

Acknowledge the following persons and Organisations that participated in the revision.

a) Ministry of Health

1. Dr. Placid Mihayo (MoH)
2. Dr. Livingstone Makanga (MoH)
3. Dr. Andrew Chakura (MoH)
4. Dr. Nabakooza Jane (MoH)
5. Dr. Irene Mwenyango (MoH)
6. Ms. Agnes Baku Chandia (MoH)
7. Ms. Miriam Namugeere (MoH)
8. Mr. Wilberforce Mugwanya (MoH)
9. Ms. Kiconco Olivia (MoH)
10. Ms. Doreen Tukamushaba (MoH)
11. Vianney Owayezu (MoH)
12. Namanya Johnnie (MoH)
13. Carol Nalugya (MoH)

b) Development Partners:

1. Dr. Olive Sentumbwe (WHO)
2. Roseline Achola (UNFPA)
3. Dr. Malalay Ahmadzai (UNICEF)
4. Rosemary Kiryomunda (UNFPA)

c) Civil Society:

1. Patrick Aliganyira (SMF)
2. Dr. Mike Kagawa (Mulago Hospital)
3. Dr. Charles Kiggundu (Mulago Hospital)
4. Dr. Moses Muwonge (SMF)
5. Sarah Nakitto (UPMA)
6. Grace Ojirot (UPMA)
7. Prof. John Chrysostom Lule
8. Rajab Ssensalire
9. Dr. Carole Sekimpi (MSU)
10. Dr. Jennifer Wanyana (SMF)
11. Faith Kyateka (MSU)
12. Ann Sizomu (IPPF)
13. Robert Ocaya (IPPF)
14. Cornelia Asiimwe (SMF)
15. Rose Mahoro (MSU)
16. Joan Kilande (HEPS Uganda)
17. Lydia Mukombe Mukwani (RHU)
18. Richard Mugenyi (RHU)
19. Paul Kaduyu (Engender Health)
20. Lucy Asaba (Engender Health)