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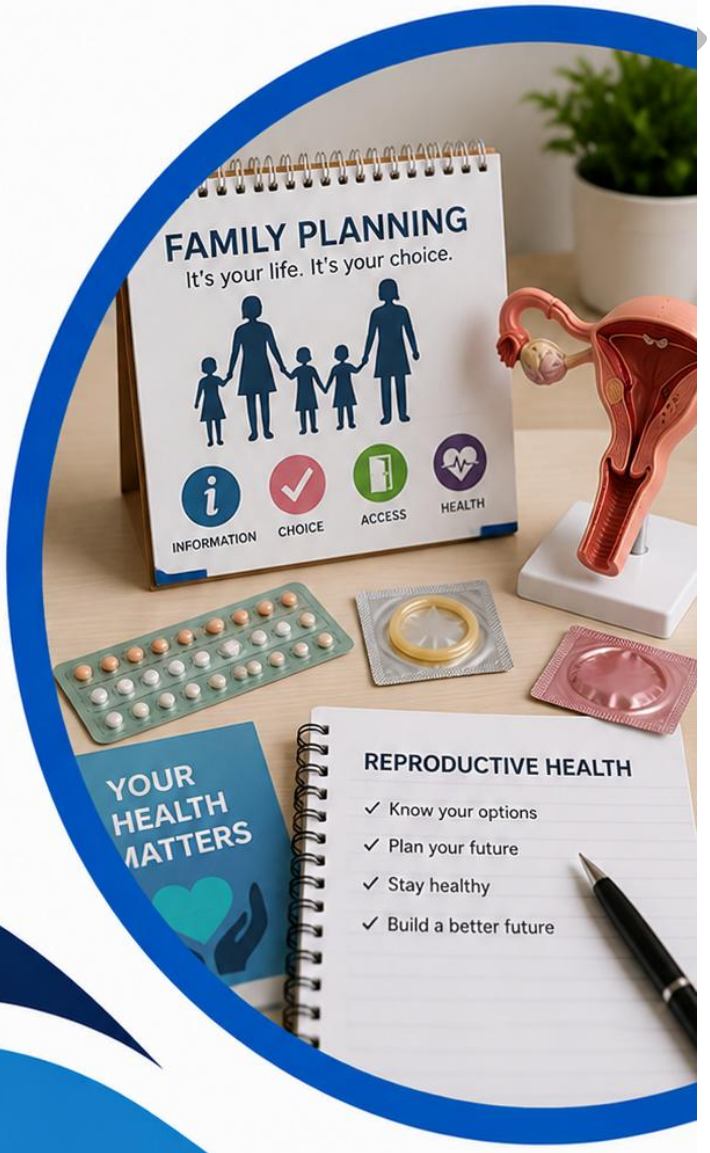
OBG 502

REPRODUCTIVE HEALTH AND FAMILY PLANNING



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Course code: OBG 502

Course title: Reproductive Health and Family Planning

Course credit load: 2 Units

Series 1: Foundations of Reproductive Health

- **Part 1.1: Concept and Components of Reproductive Health**
    - Sub Part 1.1.1: Definition and concept of reproductive health
    - Sub Part 1.1.2: Components of reproductive health
    - Sub Part 1.1.3: Reproductive rights and reproductive health
- **Part 1.2: Family Planning: General Considerations**
    - Sub Part 1.2.1: Definition and goals of family planning
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- **Part 1.3: Communication and Counselling in Family Planning**
    - Sub Part 1.3.1: Principles of effective communication in family planning
    - Sub Part 1.3.2: Counselling techniques in family planning
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- **Part 1.4: Population Dynamics and Reproductive Health Indicators**
    - Sub Part 1.4.1: Basic concepts in population dynamics
    - Sub Part 1.4.2: Population growth and reproductive health
    - Sub Part 1.4.3: Reproductive health indicators

Introduction

Picture a young couple sitting across from a health worker, uncertain about their options for planning their family, surrounded by conflicting advice from friends, family, and things they have heard but never quite verified. Helping them navigate that uncertainty, confidently and compassionately, begins with a solid grasp of what reproductive health actually means, how family planning fits within it, and how to communicate about it effectively. This Series lays that essential foundation for the whole of this course, before we turn in later Series to the specific pelvic infections, contraceptive methods, and services that build upon it.

The aim of this Series is to equip you with a thorough understanding of the concept and components of reproductive health, the goals and benefits of family planning, effective communication and counselling technique, and basic population dynamics.

We shall commence this Series by examining the concept and components of reproductive health. Next, we will consider family planning, its definition, goals, benefits, and the unmet need that persists in many settings. Following that, our attention turns to communication and counselling in family planning, including how to address common myths and rumours. Finally, we will conclude by examining population dynamics and the key indicators used to monitor reproductive health at a population level.

Series Learning Outcomes

Upon completing this Series, you should be able to:

- **SLO 1.1:** define reproductive health,
- **SLO 1.2:** identify and describe each component of reproductive health,
- **SLO 1.3:** describe the definition, goals, and benefits of family planning,
- **SLO 1.4:** describe the unmet need for family planning,
- **SLO 1.5:** describe the principles of effective communication and counselling in family planning,
- **SLO 1.6:** describe common myths and rumours in family planning and how to address them, and
- **SLO 1.7:** describe basic population dynamics and reproductive health indicators.

1.1 Concept and Components of Reproductive Health

1.1.1 Definition and concept of reproductive health

Reproductive health is defined by the World Health Organization as a state of complete physical, mental, and social wellbeing in all matters relating to the reproductive system, its functions, and its processes, and not merely the absence of disease or infirmity, a definition that deliberately extends far beyond the narrow, purely clinical management of disease to encompass the broader physical, emotional, and social dimensions of a person's reproductive life.

Implicit within this definition is the principle that people should be 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, established at the landmark 1994 International Conference on Population and Development in Cairo, a conference widely regarded as marking a genuine shift in global

thinking, moving away from earlier population-control-focused approaches towards a rights-based, individually centred conception of reproductive health and reproductive choice.

Fill in the blank: Reproductive health is defined as complete physical, mental, and social _____ in all matters relating to the reproductive system. The rights-based conception of reproductive health was established at the 1994 International Conference on Population and Development in _____.

1.1.2 Components of reproductive health

Reproductive health is a genuinely broad field encompassing several distinct but closely interconnected components, including safe motherhood (antenatal, intrapartum, and postnatal care), family planning and contraception, prevention and management of sexually transmitted infections including HIV, prevention and safe management of unsafe abortion, and management of infertility, each representing a substantial area of clinical practice in its own right while together forming a genuinely coherent, integrated whole.

Further components include adolescent reproductive health (recognising the distinct needs of young people navigating puberty, sexuality, and reproductive decision-making for the first time), prevention and management of gynaecological cancers, and, increasingly recognised as integral to the field, the prevention and management of gender-based violence, together reflecting the genuinely comprehensive scope that modern reproductive health programming, education, and clinical practice must address to be considered genuinely complete.

Fill in the blank: Reproductive health includes safe motherhood, family planning, and prevention and management of sexually transmitted _____. Adolescent reproductive health recognises the distinct needs of young people navigating puberty and reproductive _____.

1.1.3 Reproductive rights and reproductive health

Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children, and to have the information and means to do so, alongside the right to attain the highest standard of sexual and reproductive health, principles formally recognised in numerous international human rights instruments and reaffirmed at successive global conferences on population and development.

In practice translating these rights into genuine, lived reality for individuals requires not only appropriate national law and policy, but also accessible, affordable, high-quality reproductive health services, comprehensive reproductive health education, and a broader social and cultural environment that genuinely respects individual reproductive autonomy, meaning that reproductive rights, while formally recognised in principle almost universally, remain considerably more fully realised in some settings and for some populations than others, including within Nigeria itself.

Fill in the blank: Reproductive rights rest on the recognition of the right of all couples and individuals to decide freely the number, spacing, and _____ of their children. Translating

reproductive rights into lived reality requires appropriate law, accessible services, and reproductive health _____.

Component	Key Details
Safe Motherhood	Ensuring antenatal care, skilled birth attendance, and emergency obstetric services to reduce maternal mortality.
Family Planning	Providing contraceptive options to prevent unintended pregnancies and promote healthy birth spacing.
STI/HIV Prevention	Education, testing, and treatment to reduce transmission and improve sexual health outcomes.
Safe Abortion Care	Access to safe abortion services and post-abortion care to prevent complications from unsafe procedures.
Infertility Management	Evaluation and treatment of couples with difficulty conceiving, including counselling and assisted reproduction.
Adolescent Reproductive Health	Education and services tailored to young people to promote safe practices and prevent early pregnancy.
Gynaecological Cancer	Screening, early detection, and treatment of cancers such as cervical and ovarian cancer.
Gender-Based Violence	Prevention, protection, and support services for survivors of sexual and domestic violence.

Box 1.1: Components of reproductive health.

Pilot questions 1.1

1. Define reproductive health according to the World Health Organization. (Linked to SLO 1.1)
2. Explain the significance of the 1994 International Conference on Population and Development in Cairo. (Linked to SLO 1.1)
3. List and describe the components of reproductive health. (Linked to SLO 1.2)
4. Describe the principle underlying reproductive rights. (Linked to SLO 1.2)
5. Explain what is required to translate reproductive rights into lived reality for individuals. (Linked to SLO 1.2)

1.2 Family Planning: General Considerations

1.2.1 Definition and goals of family planning

Family planning refers to the practices that help individuals and couples achieve their desired number of children and determine the spacing and timing of pregnancies, achieved through the use of contraceptive methods, alongside the treatment of infertility for those wishing to achieve a pregnancy, reflecting that family planning as a concept encompasses both the prevention and the achievement of pregnancy according to an individual or couple's own reproductive intentions.

The overarching goals of family planning programming include enabling individuals and couples to achieve their desired family size, promoting healthy timing and spacing of pregnancies to improve maternal and child health outcomes, preventing unintended pregnancy and its associated risks, including unsafe abortion, and supporting broader social and economic development through the empowerment that genuine reproductive choice and control affords to women in particular.

Fill in the blank: Family planning refers to practices that help individuals and couples achieve their desired number of children and determine the spacing and _____ of pregnancies. A key goal of family planning is preventing unintended pregnancy and its associated risks, including unsafe _____.

1.2.2 Benefits of family planning

The health benefits of family planning are substantial and well established, including reduced maternal mortality and morbidity (by preventing unintended and closely spaced pregnancies, both recognised risk factors for adverse maternal outcomes), reduced infant and child mortality (through improved birth spacing, allowing adequate time for maternal recovery and infant care between successive pregnancies), and reduced rates of unsafe abortion, itself a major contributor to maternal mortality in Nigeria.

Beyond these direct health benefits family planning confers substantial social and economic benefits, including improved educational and economic opportunities for women (particularly when unintended adolescent pregnancy is prevented), broader household economic wellbeing through more manageable family size relative to available resources, and, at a population level, more sustainable demographic growth relative to available social infrastructure and economic development, together representing a genuinely powerful, cost-effective public health and development intervention.

Fill in the blank: Family planning reduces maternal mortality by preventing unintended and closely _____ pregnancies. Family planning confers social and economic benefits including improved educational and economic _____ for women.

1.2.3 The unmet need for family planning

Unmet need for family planning describes the proportion of women who wish to delay or avoid pregnancy but are not currently using any method of contraception, reflecting a genuine gap between reproductive intention and actual contraceptive practice that carries direct implications for rates of unintended pregnancy, unsafe abortion, and, ultimately, maternal mortality in the population concerned.

Unmet need in Nigeria remains substantial, reflecting a combination of factors including limited access to contraceptive services, particularly in rural areas, cost barriers, inadequate contraceptive counselling and choice, persistent myths and misconceptions about contraceptive methods, and, in some communities, cultural or religious objections to contraceptive use, together representing a genuinely important, multifaceted target for family planning programming and policy attention across the country.

Fill in the blank: Unmet need for family planning describes women who wish to delay or avoid pregnancy but are not currently using any _____ of contraception. Unmet need in Nigeria reflects limited access, cost barriers, inadequate counselling, and persistent _____ about contraceptive methods.

Category	Examples
Health Benefits	Reduces maternal mortality by preventing high-risk pregnancies; lowers infant mortality through birth spacing; improves overall reproductive health.
Social Benefits	Empowers women to pursue education and careers; enhances family stability; promotes gender equality and informed reproductive choices.
Economic Benefits	Reduces healthcare costs from unintended pregnancies; increases household financial security; contributes to national economic growth by improving workforce participation.

Table 1.2: Health, social, and economic benefits of family planning.

Pilot questions 1.2

1. Define family planning and describe its goals. (Linked to SLO 1.3)
2. Describe the maternal and child health benefits of family planning. (Linked to SLO 1.3)
3. Describe the social and economic benefits of family planning. (Linked to SLO 1.3)
4. Define unmet need for family planning. (Linked to SLO 1.4)
5. Describe the factors contributing to unmet need for family planning in Nigeria. (Linked to SLO 1.4)

1.3 Communication and Counselling in Family Planning

1.3.1 Principles of effective communication in family planning

Effective communication in family planning requires clear, accurate, non-judgemental information delivered in language the client can genuinely understand, tailored to her or his

individual circumstances, literacy level, and cultural context, alongside active listening and genuine responsiveness to the client's own questions, concerns, and preferences, rather than a standardised, generic script delivered identically to every client regardless of their specific situation.

Respecting client autonomy throughout family planning communication, including the right to decline any or all methods discussed, and avoiding any form of coercion, whether subtle or overt, is a fundamental ethical principle underpinning genuinely client-centred family planning practice, reflecting the recognition that the ultimate decision about contraceptive use belongs entirely to the individual or couple concerned, not to the provider offering counselling and information.

Fill in the blank: Effective communication in family planning requires clear, accurate, and _____ information tailored to the client's individual circumstances. Respecting client autonomy includes the right to _____ any or all methods discussed without coercion.

1.3.2 Counselling techniques in family planning

Structured counselling frameworks (such as the widely used GATHER approach: greet, ask, tell, help, explain, and return) provide a systematic, memorable structure for family planning counselling, ensuring that key elements, including establishing rapport, understanding the client's needs and circumstances, providing balanced information about available methods, and supporting an informed, voluntary decision, are consistently addressed in every counselling encounter.

Effective counselling also requires genuine attention to method-specific information relevant to the client's particular choice, including how the method works, its effectiveness, correct use, possible side effects, and what to do if problems arise, alongside a clear, mutually understood plan for follow-up, given that the quality of counselling received has been consistently shown to directly influence both correct, continued method use and overall client satisfaction with the family planning service received.

Fill in the blank: The GATHER approach to counselling stands for greet, ask, tell, help, explain, and _____. The quality of counselling received directly influences correct, continued method use and overall client _____.

1.3.3 Myths and rumours in family planning

Myths and rumours about contraception are widespread and represent a genuinely significant barrier to family planning uptake and continuation in many settings, including Nigeria, encompassing a range of unfounded beliefs such as claims that hormonal contraception causes infertility, that intrauterine devices can migrate to other parts of the body, or that contraceptive use is inherently contrary to religious or cultural values, each requiring specific, patient, and genuinely respectful correction during counselling.

Addressing myths and rumours effectively requires acknowledging the client's specific concern respectfully rather than dismissing it outright, providing clear, accurate, evidence-based information to directly address the specific misconception raised, and, where relevant and appropriate, involving trusted community or religious leaders in broader efforts to address these misconceptions at a community level, recognising that individual counselling alone, however skilfully delivered, cannot fully address myths that are often deeply embedded within broader community and social networks.

Fill in the blank: Myths about contraception include unfounded claims that hormonal contraception causes _____. Addressing myths effectively requires acknowledging the client's concern _____ rather than dismissing it outright.

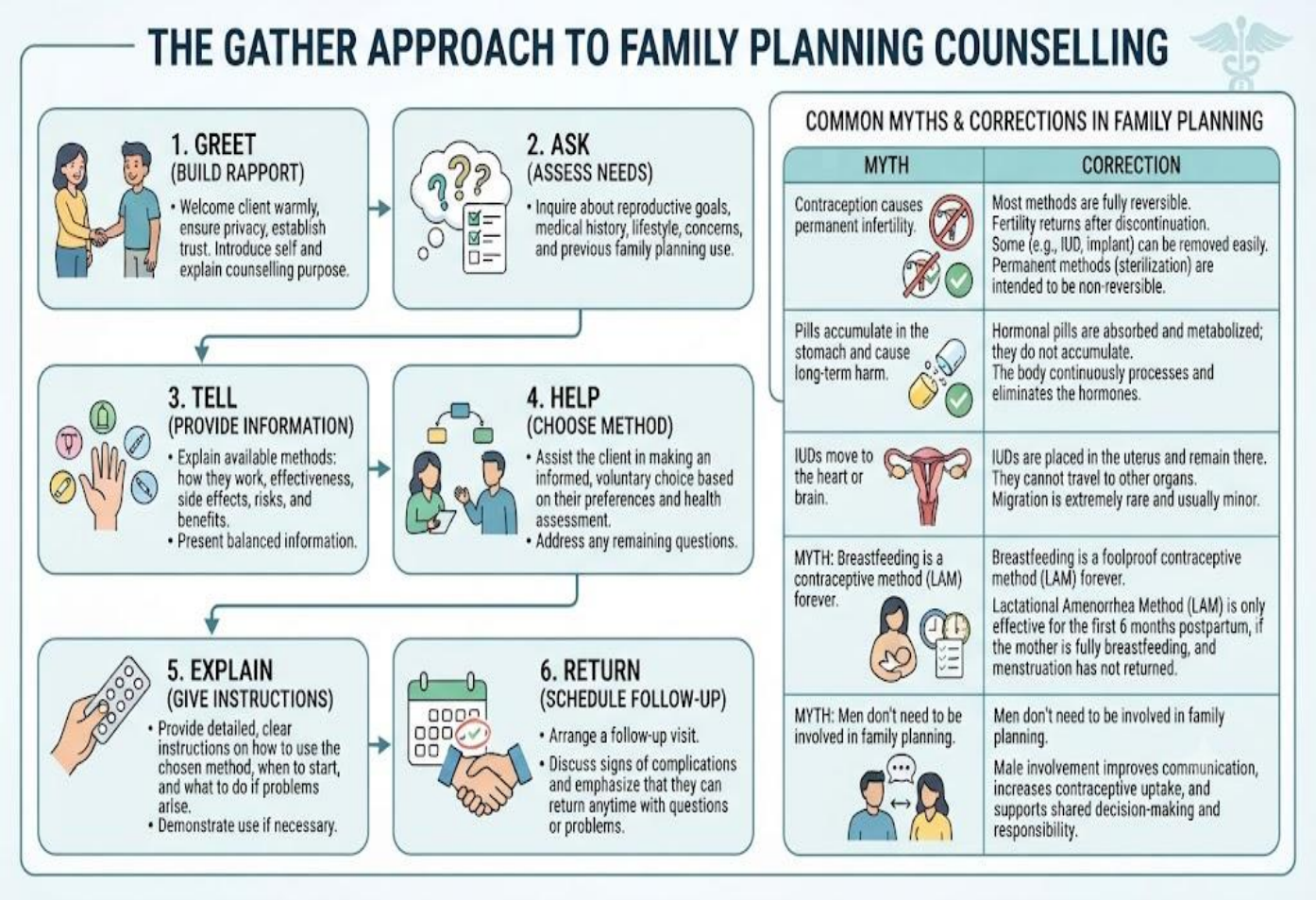

Figure 1.3: The GATHER approach to family planning counselling and common myths with corrections.

Pilot questions 1.3

1. Describe the principles of effective communication in family planning. (Linked to SLO 1.5)
2. Explain why respecting client autonomy is fundamental to family planning counselling. (Linked to SLO 1.5)

3. Describe the GATHER approach to family planning counselling. (Linked to SLO 1.5)
4. Describe common myths and rumours about contraception encountered in Nigerian practice. (Linked to SLO 1.6)
5. Describe an effective approach to addressing myths and rumours during counselling. (Linked to SLO 1.6)

1.4 Population Dynamics and Reproductive Health Indicators

1.4.1 Basic concepts in population dynamics

Population dynamics describes the study of how populations change over time in size, structure, and distribution, influenced by the interrelated factors of fertility (the rate of childbearing), mortality (the rate of death), and migration (movement of people into and out of a given population), together determining the overall rate and pattern of population growth or decline in any given country or region.

The total fertility rate (the average number of children a woman would have over her reproductive lifetime, based on current age-specific fertility rates) and the population growth rate are key summary measures used to characterise a population's demographic trajectory, with Nigeria's total fertility rate remaining relatively high by global standards, contributing to a rapidly growing population with substantial implications for social infrastructure, healthcare capacity, and economic development.

Fill in the blank: Population dynamics is influenced by the interrelated factors of fertility, mortality, and _____. The total fertility rate is the average number of children a woman would have over her reproductive _____.

1.4.2 Population growth and reproductive health

Rapid population growth places substantial pressure on health systems, educational infrastructure, and broader economic development, a relationship that runs genuinely in both directions, as improved reproductive health, particularly expanded access to family planning, itself contributes meaningfully to more sustainable, manageable population growth, reflecting the close, bidirectional relationship between reproductive health programming and broader national demographic and development trajectories.

The demographic dividend (the potential economic growth benefit that can arise when a population's working-age proportion grows relative to its dependent, non-working-age proportion, typically following a sustained decline in fertility rate) represents a genuinely significant potential opportunity for Nigeria and similar countries, though realising this potential benefit requires substantial, coordinated investment in education, employment creation, and health services, including family planning, to accompany any demographic shift towards a larger working-age population.

Fill in the blank: The demographic dividend is the potential economic growth benefit when a population's working-age proportion grows relative to its _____ proportion. Realising the demographic dividend requires substantial, coordinated investment in education, employment, and health services including family _____.

1.4.3 Reproductive health indicators

Reproductive health indicators used to monitor and evaluate progress at a population level include the contraceptive prevalence rate (the proportion of women of reproductive age currently using a method of contraception), the maternal mortality ratio, the adolescent birth rate, and the unmet need for family planning, each providing a specific, quantifiable measure of reproductive health status and progress that can be tracked over time and compared across regions or countries.

These indicators collectively inform national and international reproductive health policy and programming priorities, allowing genuinely evidence-based allocation of limited health resources towards the areas of greatest need, and providing an important, objective mechanism for holding health systems and governments accountable for progress, or the lack of it, towards agreed national and international reproductive health targets and goals over time.

Fill in the blank: The contraceptive prevalence rate is the proportion of women of reproductive age currently using a _____ of contraception. Reproductive health indicators allow evidence-based resource allocation and provide accountability for progress towards agreed _____.

Indicator	Definition
Contraceptive Prevalence Rate	Percentage of women of reproductive age using (or whose partner is using) a contraceptive method at a given time.
Maternal Mortality Ratio	Number of maternal deaths per 100,000 live births, reflecting risk associated with pregnancy and childbirth.
Adolescent Birth Rate	Number of births per 1,000 women aged 15–19 years, indicating teenage pregnancy levels.
Unmet Need for Family Planning	Percentage of women who want to delay or stop childbearing but are not using any contraceptive method.
Total Fertility Rate	Average number of children a woman would have over her lifetime if current fertility patterns persist.

Table 1.4: Key reproductive health indicators and their definitions.

Pilot questions 1.4

1. Describe the basic concepts and factors influencing population dynamics. (Linked to SLO 1.7)
2. Define the total fertility rate and describe Nigeria's demographic trajectory. (Linked to SLO 1.7)

3. Explain the bidirectional relationship between population growth and reproductive health. (Linked to SLO 1.7)
4. Describe the demographic dividend and what is required to realise it. (Linked to SLO 1.7)
5. List and describe key reproductive health indicators used at a population level. (Linked to SLO 1.7)

Series Summary

This Series has covered the concept and components of reproductive health, followed by family planning, its definition, goals, benefits, and unmet need. It went on to examine communication and counselling in family planning, including common myths and rumours, before concluding with population dynamics and the key indicators used to monitor reproductive health at a population level.

You should now be able to define reproductive health and describe its components, describe the definition, goals, and benefits of family planning, describe the unmet need for family planning, describe effective communication and counselling, describe common myths and rumours, and describe basic population dynamics and reproductive health indicators (Linked to SLOs 1.1 to 1.7).

Glossary of Terms

- **Contraceptive prevalence rate:** the proportion of women of reproductive age currently using a method of contraception.
- **Demographic dividend:** the potential economic growth benefit when a population's working-age proportion grows relative to its dependent proportion.
- **Family planning:** practices that help individuals and couples achieve their desired number of children and determine pregnancy spacing and timing.
- **GATHER approach:** a structured counselling framework: greet, ask, tell, help, explain, and return.
- **Population dynamics:** the study of how populations change over time in size, structure, and distribution.

- **Reproductive health:** a state of complete physical, mental, and social wellbeing in all matters relating to the reproductive system.
- **Reproductive rights:** the recognition of the right of all couples and individuals to decide freely the number, spacing, and timing of their children.
- **Total fertility rate:** the average number of children a woman would have over her reproductive lifetime, based on current age-specific fertility rates.
- **Unmet need for family planning:** the proportion of women who wish to delay or avoid pregnancy but are not currently using any method of contraception.
- **Adolescent birth rate:** the number of births per 1,000 women aged 15 to 19 years, a key reproductive health indicator.
- **Client-centred counselling:** a counselling approach that respects and prioritises the individual client's autonomy, needs, and preferences.
- **International Conference on Population and Development (ICPD):** the 1994 Cairo conference that established a rights-based, individually centred approach to reproductive health.

Concept Check Questions [Series 1]

Objective questions

1. The rights-based conception of reproductive health was established at the 1994 International Conference on Population and Development in _____.
2. A key goal of family planning is preventing unintended pregnancy and its associated risks, including unsafe _____.
3. Unmet need for family planning describes women who wish to delay or avoid pregnancy but are not currently using any _____ of contraception.
4. The GATHER approach to counselling stands for greet, ask, tell, help, explain, and _____.
5. The contraceptive prevalence rate is the proportion of women of reproductive age currently using a _____ of contraception.

Short-answer questions

6. List and describe the components of reproductive health. (Linked to SLO 1.2)
7. Describe the social and economic benefits of family planning. (Linked to SLO 1.3)

8. Describe the factors contributing to unmet need for family planning in Nigeria. (Linked to SLO 1.4)
9. Describe an effective approach to addressing myths and rumours during counselling. (Linked to SLO 1.6)
10. Describe the demographic dividend and what is required to realise it. (Linked to SLO 1.7)

Long-answer questions

11. Define reproductive health and describe its components. (Linked to SLO 1.1, SLO 1.2)
12. Describe the definition, goals, benefits, and unmet need of family planning. (Linked to SLO 1.3, SLO 1.4)
13. Describe the principles of effective communication and counselling in family planning. (Linked to SLO 1.5)
14. Describe common myths and rumours in family planning and how to address them. (Linked to SLO 1.6)
15. Describe basic population dynamics and the key indicators used to monitor reproductive health. (Linked to SLO 1.7)

Answers to Concept Check Questions [Series 1]

Objective questions

1. Cairo.
2. Abortion.
3. Method.
4. Return.
5. Method.

Short-answer questions

6. Safe motherhood, family planning, STI/HIV prevention, safe abortion care, infertility management, adolescent reproductive health, gynaecological cancer, and gender-based violence.

7. Improved educational and economic opportunities for women, more manageable household economic wellbeing, and more sustainable population growth.
8. Limited access particularly in rural areas, cost barriers, inadequate counselling and choice, and persistent myths and misconceptions.
9. Acknowledging the client's concern respectfully, providing clear evidence-based information, and involving trusted community leaders where relevant.
10. The economic growth benefit from a growing working-age population, requiring coordinated investment in education, employment, and health services.

Long-answer questions

11. **Basic response:** Reproductive health is complete physical, mental, and social wellbeing in matters relating to the reproductive system, comprising components from safe motherhood to gender-based violence prevention.

Value-added response: Reproductive rights, established at the 1994 Cairo conference, underpin this definition, requiring accessible services and education to be genuinely realised.

12. **Basic response:** Family planning helps individuals achieve desired family size and spacing, offering substantial health, social, and economic benefits, though unmet need remains significant in Nigeria.

Value-added response: Unmet need reflects access, cost, counselling quality, and persistent myths, representing a genuinely multifaceted target for programming attention.

13. **Basic response:** Effective family planning communication is client-centred and non-judgemental, structured using frameworks such as GATHER, and requires actively addressing myths and rumours.

Answers to Pilot Questions [Series 1]

Part 1.1

1. Complete physical, mental, and social wellbeing in all matters relating to the reproductive system, not merely the absence of disease.
2. It established a rights-based, individually centred approach to reproductive health, shifting away from earlier population-control-focused approaches.

3. Safe motherhood, family planning, STI/HIV prevention, safe abortion care, infertility management, adolescent health, gynaecological cancer, and gender-based violence.
4. The right of all couples and individuals to decide freely the number, spacing, and timing of their children.
5. Appropriate law and policy, accessible services, comprehensive education, and a social environment respecting reproductive autonomy.

Part 1.2

1. Practices helping individuals achieve desired family size, spacing, and timing, including contraception and infertility treatment.
2. Reduced maternal, infant, and child mortality through prevention of unintended and closely spaced pregnancies.
3. Improved educational and economic opportunities for women and more sustainable population growth relative to resources.
4. The proportion of women wishing to delay or avoid pregnancy but not currently using contraception.
5. Limited access, cost barriers, inadequate counselling, and persistent myths and misconceptions.

Part 1.3

1. Clear, accurate, non-judgemental information tailored to the client, with active listening and genuine responsiveness.
2. The ultimate decision about contraceptive use belongs entirely to the individual or couple, not the provider.
3. Greet, ask, tell, help, explain, and return, a systematic structure ensuring key counselling elements are addressed.
4. Claims that contraception causes infertility, that IUDs can migrate, or that use is contrary to religious values.
5. Acknowledging the concern respectfully, providing accurate information, and involving trusted community leaders where appropriate.

Part 1.4

1. Fertility, mortality, and migration together determine population size, structure, and distribution over time.
2. The average number of children per woman over her reproductive lifetime; Nigeria's rate remains relatively high.
3. Improved reproductive health and family planning access itself contributes to more sustainable population growth.
4. The economic benefit from a growing working-age population, requiring investment in education, employment, and health services.
5. Contraceptive prevalence rate, maternal mortality ratio, adolescent birth rate, and unmet need for family planning.

References and Attributions [Series 1]

Textual References

- Hoffman, B. L., Schorge, J. O., Halvorson, L. M. et al. (2020). Williams Gynecology (4th ed.). McGraw Hill.
- World Health Organization (2021). Reproductive Health Strategy to Accelerate Progress Towards the Attainment of International Development Goals and Targets. WHO Press.
- United Nations (1995). Report of the International Conference on Population and Development, Cairo, 1994. United Nations.
- National Population Commission and ICF (2019). Nigeria Demographic and Health Survey 2018. NPC and ICF.

Figures, Plates, Tables, and Boxes

- Box 1.1: Components of reproductive health. AI-generated using the prompt: "Create a simple single-column reference box with an outside border titled Components of Reproductive Health, listing each component with a one-line description. Clinical reference box style."
- Table 1.2: Health, social, and economic benefits of family planning. AI-generated using the prompt: "Create a clean reference table titled Benefits of Family Planning, listing health, social, and economic benefit categories with examples. Simple clinical reference table style with outside border."
- Figure 1.3: The GATHER approach to family planning counselling and common myths with corrections. AI-generated using the prompt: "Create a professional medical diagram titled The

GATHER Approach to Family Planning Counselling, showing the six steps with a panel of common myths and corrections. Clean clinical educational diagram style."

- Table 1.4: Key reproductive health indicators and their definitions. AI-generated using the prompt: "Create a clean reference table titled Key Reproductive Health Indicators, listing indicators with brief definitions. Simple clinical reference table style with outside border."

Course code: OBG 502

Course title: Reproductive Health and Family Planning

Course credit load: 2 Units

Series 2: Pelvic Infections and Abortion Care

- **Part 2.1: Sexually Transmitted and Other Pelvic Infections**
  - Sub Part 2.1.1: Common sexually transmitted infections
  - Sub Part 2.1.2: Other pelvic infections
  - Sub Part 2.1.3: Prevention and screening for STIs
- **Part 2.2: Pelvic Inflammatory Disease**
  - Sub Part 2.2.1: Acute pelvic inflammatory disease
  - Sub Part 2.2.2: Chronic pelvic inflammatory disease
  - Sub Part 2.2.3: Management and complications of PID
- **Part 2.3: Spontaneous and Induced Abortion**
  - Sub Part 2.3.1: Spontaneous abortion (miscarriage)
  - Sub Part 2.3.2: Induced abortion: legal and illegal
  - Sub Part 2.3.3: Complications of unsafe abortion
- **Part 2.4: Post-Abortal Care**
  - Sub Part 2.4.1: Principles of post-abortal care
  - Sub Part 2.4.2: Post-abortion contraception
  - Sub Part 2.4.3: Post-abortal counselling and follow-up

Introduction

In the last Series, we explored the foundations of reproductive health and family planning. We now turn to two areas that bring women to gynaecological care as often in emergency as in routine outpatient settings: pelvic infections, from common sexually transmitted infections through to pelvic inflammatory disease, and abortion, both spontaneous and induced, together

with the essential principle of comprehensive, non-judgemental post-abortal care regardless of the circumstances that led to it.

The aim of this Series is to equip you with the knowledge to recognise and manage sexually transmitted and pelvic infections, pelvic inflammatory disease, spontaneous and induced abortion, and to provide comprehensive post-abortal care.

We shall commence this Series by examining sexually transmitted infections and other pelvic infections, together with their prevention and screening. Next, we will consider acute and chronic pelvic inflammatory disease, its management and complications. Following that, our attention turns to spontaneous and induced abortion, including the complications of unsafe abortion. Finally, we will conclude by examining post-abortal care, including contraception and counselling.

Series Learning Outcomes

Upon completing this Series, you should be able to:

- **SLO 2.1:** describe common sexually transmitted infections and other pelvic infections,
- **SLO 2.2:** describe the prevention and screening of sexually transmitted infections,
- **SLO 2.3:** describe acute and chronic pelvic inflammatory disease,
- **SLO 2.4:** describe the management and complications of pelvic inflammatory disease,
- **SLO 2.5:** describe spontaneous abortion and its classification,
- **SLO 2.6:** discuss induced abortion, legal and illegal, and the complications of unsafe abortion, and
- **SLO 2.7:** describe the principles of post-abortal care, including contraception and counselling.

2.1 Sexually Transmitted and Other Pelvic Infections

2.1.1 Common sexually transmitted infections

Chlamydia trachomatis and Neisseria gonorrhoeae are among the most common bacterial sexually transmitted infections, frequently asymptomatic, particularly chlamydial infection, but capable of ascending to cause pelvic inflammatory disease and subsequent tubal factor infertility if left undiagnosed and untreated, while Trichomonas vaginalis, a protozoal infection, and syphilis, caused by the spirochaete Treponema pallidum, represent further important sexually

transmitted infections encountered in Nigerian clinical practice, each with distinct clinical features and diagnostic tests.

HIV infection remains a critically important sexually transmitted infection given its substantial morbidity and mortality if untreated, its potential for vertical transmission during pregnancy and breastfeeding, and its close epidemiological relationship with other sexually transmitted infections, which independently increase both susceptibility to and transmissibility of HIV, meaning that comprehensive sexually transmitted infection care should always include HIV testing and counselling as an integral, routine component rather than a separate, optional addition.

Fill in the blank: Chlamydial infection is frequently _____, but capable of ascending to cause pelvic inflammatory disease if untreated. Other sexually transmitted infections independently increase both susceptibility to and _____ of HIV.

2.1.2 Other pelvic infections

Bacterial vaginosis (an imbalance of normal vaginal flora, with reduction of protective lactobacilli and overgrowth of anaerobic organisms, rather than a classic sexually transmitted infection) is a common cause of abnormal vaginal discharge, associated with an increased risk of preterm birth in pregnancy and, when present, an increased susceptibility to acquiring genuine sexually transmitted infections including HIV, making its recognition and appropriate treatment clinically important beyond the immediate discomfort of the discharge itself.

Vulvovaginal candidiasis (a fungal infection, most commonly caused by Candida albicans) presents with thick, curd-like discharge and vulval itching, common and generally not sexually transmitted, though it can be more frequent or severe in women with diabetes, immunosuppression, or recent antibiotic use, and, unlike bacterial vaginosis and true sexually transmitted infections, does not require partner treatment in the majority of straightforward cases.

Fill in the blank: Bacterial vaginosis reflects an imbalance of normal vaginal flora rather than a classic _____ infection. Vulvovaginal candidiasis does not require _____ treatment in the majority of straightforward cases.

2.1.3 Prevention and screening for STIs

Prevention of sexually transmitted infection relies on a combination of consistent, correct condom use, reduction in the number of sexual partners, prompt diagnosis and treatment of both index cases and their sexual partners to interrupt ongoing transmission, and, where available, specific vaccination such as against human papillomavirus, together forming a genuinely comprehensive prevention strategy rather than reliance on any single intervention alone.

Screening for sexually transmitted infection should be considered in any sexually active individual with risk factors, including multiple partners, a new partner, or a partner with a known infection, and is a routine, standard component of antenatal care given the significant maternal and neonatal risks of untreated infection during pregnancy, with nucleic acid amplification

testing now the preferred, highly sensitive method for chlamydia and gonorrhoea detection in most modern clinical settings.

Fill in the blank: Prevention of sexually transmitted infection relies on condom use, partner reduction, and prompt treatment of index cases and their _____. Screening for STIs is a routine, standard component of _____ care given the risks of untreated infection in pregnancy.

Condition	Causative Organism	Key Clinical Feature
Chlamydia	*Chlamydia trachomatis*	Often asymptomatic; may cause cervicitis, urethritis, pelvic inflammatory disease.
Gonorrhoea	*Neisseria gonorrhoeae*	Purulent discharge, dysuria, pelvic pain; can lead to infertility.
Trichomoniasis	*Trichomonas vaginalis*	Frothy, greenish vaginal discharge with itching and "strawberry cervix."
Syphilis	*Treponema pallidum*	Painless chancre (primary), rash on palms/soles (secondary), systemic complications if untreated.
HIV	Human immunodeficiency virus	Progressive immunodeficiency, opportunistic infections, chronic systemic illness.
Bacterial Vaginosis	Polymicrobial imbalance (esp. *Gardnerella vaginalis*)	Thin, grey-white discharge with fishy odour; clue cells on microscopy.
Candidiasis	*Candida albicans*	Thick, curdy white discharge with intense vulval itching and erythema.

Table 2.1: Common sexually transmitted and pelvic infections, causative organisms, and key features.

Pilot questions 2.1

- Describe chlamydia and gonorrhoea and their potential complications if untreated. (Linked to SLO 2.1)
- Explain the relationship between other sexually transmitted infections and HIV transmission risk. (Linked to SLO 2.1)
- Describe bacterial vaginosis and its associated risks. (Linked to SLO 2.1)
- Describe vulvovaginal candidiasis and distinguish it from a true sexually transmitted infection. (Linked to SLO 2.1)
- Describe the strategies used to prevent and screen for sexually transmitted infections. (Linked to SLO 2.2)

2.2 Pelvic Inflammatory Disease

2.2.1 Acute pelvic inflammatory disease

Acute pelvic inflammatory disease (PID) is infection and inflammation of the upper female genital tract, most commonly ascending from a lower genital tract sexually transmitted infection, particularly Chlamydia trachomatis and Neisseria gonorrhoeae, presenting with lower abdominal pain, abnormal vaginal discharge, and, on examination, cervical excitation and adnexal tenderness, with fever and systemic upset present in more severe cases.

Risk factors for acute PID include young age, multiple sexual partners, a new sexual partner, previous PID, and recent instrumentation of the uterine cavity, such as intrauterine device insertion or endometrial sampling, without adequate prior screening or treatment of any existing lower genital tract infection, with prompt clinical suspicion and low threshold for empirical treatment essential given the significant reproductive consequences of delayed or inadequate diagnosis.

Fill in the blank: Acute PID most commonly ascends from a lower genital tract infection, particularly Chlamydia trachomatis and Neisseria _____. A low threshold for empirical _____ is essential given the significant reproductive consequences of delayed diagnosis.

2.2.2 Chronic pelvic inflammatory disease

Chronic pelvic inflammatory disease results from inadequately treated or recurrent acute PID, causing persistent low-grade inflammation, adhesion formation, and structural damage to the fallopian tubes and surrounding pelvic structures, presenting with chronic pelvic pain, deep dyspareunia, and menstrual irregularity, often considerably more difficult to diagnose and manage than the acute presentation given its more insidious, less clearly demarcated onset.

Hydrosalpinx (a fluid-filled, distended, and typically non-functional fallopian tube, resulting from chronic tubal damage and occlusion) is a recognised long-term consequence of chronic PID, itself associated with reduced fertility and, when present, reduced success rates of in vitro fertilisation unless surgically addressed beforehand, illustrating the genuinely far-reaching reproductive consequences that chronic, inadequately treated pelvic infection can have long after the original acute episode has resolved.

Fill in the blank: Chronic PID results from inadequately treated or _____ acute PID, causing persistent inflammation and adhesion formation. A fluid-filled, distended, non-functional fallopian tube resulting from chronic tubal damage is called a _____.

2.2.3 Management and complications of PID

Management of PID is with broad-spectrum antibiotics covering the likely causative organisms, including chlamydial and gonococcal cover, commenced empirically without waiting for

microbiological confirmation given the risk of delayed treatment to future fertility, alongside partner notification and treatment, and screening for other sexually transmitted infections, with hospital admission and intravenous antibiotics reserved for more severe presentations or where oral treatment has failed or is not tolerated.

Complications of PID include tubo-ovarian abscess (a severe complication requiring more intensive management, sometimes including surgical drainage), chronic pelvic pain, tubal factor infertility from resulting tubal scarring and occlusion, and a markedly increased risk of subsequent ectopic pregnancy, together representing a genuinely substantial, largely preventable burden of long-term reproductive morbidity that underscores why prompt recognition and treatment of PID matters so greatly for a woman's future reproductive health.

Fill in the blank: Treatment of PID is commenced empirically with broad-spectrum antibiotics without waiting for microbiological _____. Complications of PID include tubal factor infertility and a markedly increased risk of subsequent _____ pregnancy.

Category	Key Details
Risk Factors	Multiple sexual partners, unprotected intercourse, prior STIs (especially chlamydia/gonorrhoea), young age, intrauterine device insertion, and poor genital hygiene.
Clinical Features	Lower abdominal pain, fever, abnormal vaginal discharge, dyspareunia, irregular bleeding, adnexal tenderness, and cervical motion tenderness.
Long-Term Complications	Infertility due to tubal damage, chronic pelvic pain, ectopic pregnancy, and recurrent PID episodes.

Box 2.2: Risk factors, clinical features, and complications of pelvic inflammatory disease.

Pilot questions 2.2

1. Describe the presentation and risk factors for acute pelvic inflammatory disease. (Linked to SLO 2.3)
2. Describe chronic pelvic inflammatory disease and its presentation. (Linked to SLO 2.3)
3. Describe hydrosalpinx and its reproductive consequences. (Linked to SLO 2.3)
4. Describe the management of pelvic inflammatory disease. (Linked to SLO 2.4)
5. List the complications of pelvic inflammatory disease. (Linked to SLO 2.4)

2.3 Spontaneous and Induced Abortion

2.3.1 Spontaneous abortion (miscarriage)

Spontaneous abortion (miscarriage) is the spontaneous loss of a pregnancy before viability, generally before 24 weeks of gestation, most commonly resulting from chromosomal abnormality in the early embryo, particularly in the first trimester, though other causes including uterine structural abnormality, maternal endocrine or autoimmune conditions, and infection contribute to a proportion of cases, particularly recurrent miscarriage.

Clinical classification of miscarriage as threatened, inevitable, incomplete, complete, or missed, based on clinical and ultrasound findings, directly guides management, ranging from reassurance and monitoring for a threatened miscarriage with a viable pregnancy, to active management, whether expectant, medical, or surgical, for confirmed pregnancy loss, with the woman's own preference, where clinically appropriate, playing a genuinely important role in this specific management decision.

Fill in the blank: Spontaneous abortion most commonly results from _____ abnormality in the early embryo, particularly in the first trimester. Clinical classification of miscarriage directly guides management, ranging from reassurance to active _____ management.

2.3.2 Induced abortion: legal and illegal

Induced abortion is the deliberate termination of a pregnancy, distinguished as legal (permitted under the specific circumstances and conditions defined by national law) or illegal (performed outside this legal framework), with Nigerian law restricting abortion to circumstances where it is performed to preserve the life of the pregnant woman, a considerably more restrictive legal framework than in many other countries.

This restrictive legal framework results in a substantial burden of illegal, frequently unsafe abortion performed outside appropriate medical settings, a major and largely preventable contributor to maternal morbidity and mortality across Nigeria, with healthcare providers holding a professional obligation to provide appropriate, non-judgemental care to any woman presenting with a complication of abortion, whether spontaneous or induced, safe or unsafe, entirely separately from the legal circumstances surrounding it.

Fill in the blank: Nigerian law restricts legal abortion to circumstances where it is performed to preserve the _____ of the pregnant woman. Healthcare providers hold a professional obligation to provide non-judgemental care regardless of the _____ circumstances of an abortion.

2.3.3 Complications of unsafe abortion

Unsafe abortion carries substantial risk of serious complications, including incomplete evacuation with retained products of conception, haemorrhage, sepsis (sometimes progressing to severe septic shock), uterine perforation, and, particularly with unskilled instrumentation, injury

to adjacent structures such as the bowel or bladder, together representing a major, largely preventable contributor to maternal death in Nigeria and a significant burden on emergency gynaecological services.

Management of complications follows standard emergency principles: resuscitation, broad-spectrum antibiotics where sepsis is suspected, evacuation of any retained products, and surgical repair of any identified visceral injury, with prompt recognition and aggressive early management critical to reducing the mortality associated with the more severe presentations of unsafe abortion complications, echoing the septic abortion management principles established elsewhere in this broader curriculum.

Fill in the blank: Unsafe abortion carries risk of serious complications including haemorrhage, _____, and uterine perforation. Management of complicated unsafe abortion follows standard emergency principles including resuscitation and broad-spectrum _____.

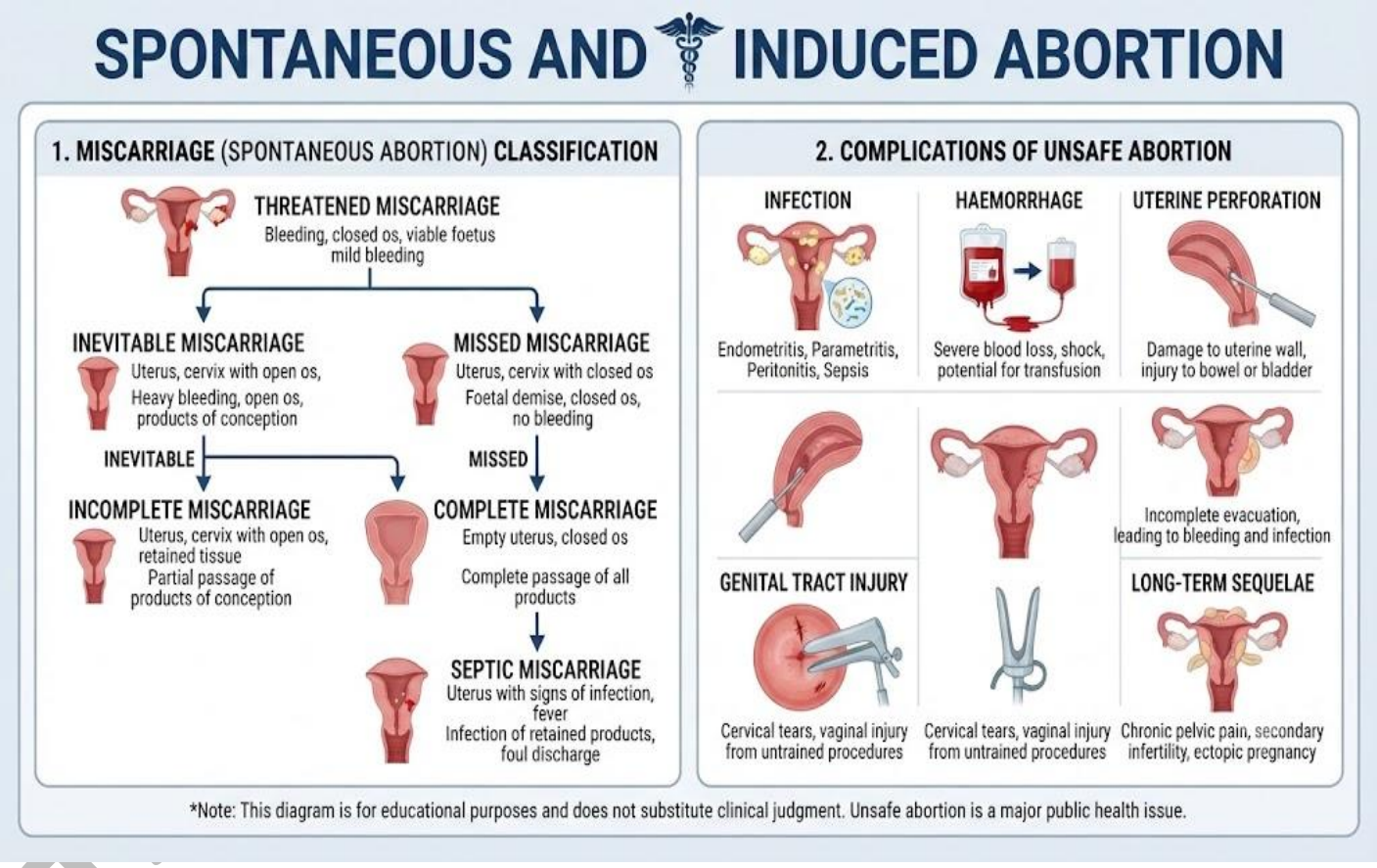

Figure 2.3: Classification of miscarriage and complications of unsafe abortion.

Pilot questions 2.3

1. Define spontaneous abortion and describe its common causes. (Linked to SLO 2.5)
2. Describe the clinical classification of miscarriage. (Linked to SLO 2.5)

3. Describe the legal framework governing induced abortion in Nigeria. (Linked to SLO 2.6)
4. Explain the ethical obligation of healthcare providers when caring for a woman with a complication of abortion. (Linked to SLO 2.6)
5. Describe the complications of unsafe abortion and their emergency management. (Linked to SLO 2.6)

2.4 Post-Abortal Care

2.4.1 Principles of post-abortal care

Post-abortal care is a recognised standard of care applicable regardless of the legal circumstances of the abortion, whether spontaneous or induced, safe or unsafe, encompassing prompt treatment of any medical complications, provision of contraceptive counselling to prevent future unwanted pregnancy, and, where appropriate and desired by the patient, referral for further psychological or social support, reflecting a harm-reduction, genuinely compassionate approach to a clinical reality that healthcare providers must engage with without judgement.

The core components of comprehensive post-abortal care, sometimes summarised within a broader post-abortion care model, include emergency treatment of complications, family planning counselling and service provision, and linkage to other reproductive health services and, where needed, community support, delivered together as an integrated package rather than a series of disconnected, isolated interventions offered only if specifically requested by the woman herself.

Fill in the blank: Post-abortal care is a recognised standard of care applicable regardless of the _____ circumstances of the abortion. Comprehensive post-abortal care is delivered as an integrated _____ rather than disconnected interventions.

2.4.2 Post-abortion contraception

Fertility can return remarkably soon after abortion, in some cases within as little as two weeks, meaning that contraceptive counselling and, where desired, immediate provision of a chosen method should be offered before the woman leaves the facility, rather than deferred to a later follow-up visit that a proportion of women will not, in practice, actually attend, resulting in a missed opportunity to prevent a subsequent unintended pregnancy.

The great majority of contraceptive methods can be initiated immediately following an uncomplicated abortion, including the intrauterine device, which can generally be inserted immediately after surgical evacuation, and hormonal methods, which can generally be started on

the same day, with the specific choice of method guided by the same individualised counselling principles applied to any other contraceptive decision, respecting the woman's own informed preference throughout this specific and often emotionally significant encounter.

Fill in the blank: Fertility can return remarkably soon after abortion, in some cases within as little as _____ weeks. The great majority of contraceptive methods can be initiated _____ following an uncomplicated abortion.

2.4.3 Post-abortal counselling and follow-up

Post-abortal counselling should be delivered sensitively and without judgement, acknowledging the potentially wide range of emotional responses a woman may experience following abortion, from relief to grief or a complex combination of both, and should never assume a particular emotional response on the woman's behalf, instead allowing her own genuine feelings and reactions to guide the specific content and tone of the counselling conversation that follows.

A clear follow-up plan should be agreed before the woman leaves the facility, including specific advice on when to seek urgent medical attention (such as heavy bleeding, fever, or severe pain), a scheduled follow-up appointment where indicated, and contact information for accessing further support, whether medical, contraceptive, or psychological, should the need for any of these arise after she has returned home.

Fill in the blank: Post-abortal counselling should never assume a particular _____ response on the woman's behalf. A clear follow-up plan should include specific advice on when to seek _____ medical attention.

Component	Key Details
Emergency Treatment	Immediate management of haemorrhage, sepsis, or injury to stabilise the patient.
Contraceptive Counselling	Guidance on family planning methods to prevent unintended future pregnancies.
Psychological Support	Emotional counselling and support to address grief, trauma, or stigma.
Follow-Up Planning	Scheduled visits for monitoring recovery, managing complications, and reinforcing reproductive health education.

Box 2.4: Core components of comprehensive post-abortal care.

Pilot questions 2.4

1. Describe the principles of post-abortal care. (Linked to SLO 2.7)
2. Describe the core components of comprehensive post-abortal care. (Linked to SLO 2.7)
3. Explain why contraceptive counselling should be offered immediately after abortion rather than deferred. (Linked to SLO 2.7)
4. Describe the contraceptive methods that can be initiated immediately following an uncomplicated abortion. (Linked to SLO 2.7)
5. Describe the principles of sensitive post-abortal counselling and follow-up planning. (Linked to SLO 2.7)

Series Summary

This Series has covered sexually transmitted infections and other pelvic infections, together with their prevention and screening, followed by acute and chronic pelvic inflammatory disease, its management and complications. It went on to examine spontaneous and induced abortion, including the complications of unsafe abortion, before concluding with post-abortal care, including contraception and counselling.

You should now be able to describe sexually transmitted and pelvic infections and their prevention, describe acute and chronic pelvic inflammatory disease and its management, describe spontaneous abortion, discuss induced abortion and the complications of unsafe abortion, and describe the principles of post-abortal care (Linked to SLOs 2.1 to 2.7).

Glossary of Terms

1. **Bacterial vaginosis:** an imbalance of normal vaginal flora, with reduction of protective lactobacilli and overgrowth of anaerobic organisms.
2. **Chronic pelvic inflammatory disease:** persistent low-grade inflammation and structural damage resulting from inadequately treated or recurrent acute PID.
3. **Hydrosalpinx:** a fluid-filled, distended, and typically non-functional fallopian tube, resulting from chronic tubal damage.

4. **Incomplete miscarriage:** miscarriage in which some but not all pregnancy tissue has been passed.
5. **Induced abortion:** the deliberate termination of a pregnancy, classified as legal or illegal according to national law.
6. **Pelvic inflammatory disease (PID):** infection and inflammation of the upper female genital tract.
7. **Post-abortal care:** a standard of care encompassing treatment of complications, contraceptive counselling, and psychological support after any abortion.
8. **Spontaneous abortion (miscarriage):** the spontaneous loss of a pregnancy before viability, generally before 24 weeks of gestation.
9. **Tubal factor infertility:** infertility resulting from tubal scarring and occlusion, a long-term complication of untreated PID.
10. **Tubo-ovarian abscess:** a walled-off collection of pus involving the fallopian tube and ovary, a severe complication of PID.
11. **Nucleic acid amplification test (NAAT):** a highly sensitive molecular test used to detect chlamydia and gonorrhoea.
12. **Vulvovaginal candidiasis:** a fungal infection, most commonly caused by Candida albicans, presenting with discharge and itching.

Concept Check Questions [Series 2]

Objective questions

- Chlamydial infection is frequently _____, but capable of ascending to cause pelvic inflammatory disease if untreated.
- Acute PID most commonly ascends from a lower genital tract infection, particularly Chlamydia trachomatis and Neisseria _____.
- A fluid-filled, distended, non-functional fallopian tube resulting from chronic tubal damage is called a _____.
- Nigerian law restricts legal abortion to circumstances where it is performed to preserve the _____ of the pregnant woman.
- Fertility can return remarkably soon after abortion, in some cases within as little as _____ weeks.

Short-answer questions

1. Explain the relationship between other sexually transmitted infections and HIV transmission risk. (Linked to SLO 2.1)
2. Describe hydrosalpinx and its reproductive consequences. (Linked to SLO 2.3)
3. List the complications of pelvic inflammatory disease. (Linked to SLO 2.4)
4. Explain the ethical obligation of healthcare providers when caring for a woman with a complication of abortion. (Linked to SLO 2.6)
5. Explain why contraceptive counselling should be offered immediately after abortion rather than deferred. (Linked to SLO 2.7)

Long-answer questions

6. Describe common sexually transmitted and pelvic infections and their prevention. (Linked to SLO 2.1, SLO 2.2)
7. Describe acute and chronic pelvic inflammatory disease, its management, and its complications. (Linked to SLO 2.3, SLO 2.4)
8. Describe spontaneous abortion and its clinical classification. (Linked to SLO 2.5)
9. Discuss induced abortion in Nigeria and the complications of unsafe abortion. (Linked to SLO 2.6)
10. Describe the principles and core components of comprehensive post-abortal care. (Linked to SLO 2.7)

Answers to Concept Check Questions [Series 2]

Objective questions

11. Asymptomatic.
12. Gonorrhoeae.
13. Hydrosalpinx.

14. Life.
15. Two.

Short-answer questions

16. Other sexually transmitted infections independently increase both susceptibility to and transmissibility of HIV.
17. A fluid-filled, non-functional tube from chronic damage, associated with reduced fertility and lower IVF success unless surgically addressed.
18. Tubo-ovarian abscess, chronic pelvic pain, tubal factor infertility, and increased risk of ectopic pregnancy.
19. The ethical duty to treat and the legal restriction on performing the procedure are separate considerations that should never be conflated.
20. A proportion of women will not attend a later follow-up visit, resulting in a missed opportunity to prevent unintended pregnancy.

Long-answer questions

21. **Basic response:** Common infections include chlamydia, gonorrhoea, and HIV, alongside bacterial vaginosis and candidiasis, prevented through condom use and prompt partner treatment.

Value-added response: Screening is a routine part of antenatal care, given the maternal and neonatal risks of untreated infection during pregnancy.

22. **Basic response:** Acute PID presents with pain, discharge, and cervical excitation, managed with empirical antibiotics; chronic PID causes persistent pain and structural damage.

Value-added response: Complications including tubo-ovarian abscess and tubal infertility underscore why prompt PID treatment matters for future reproductive health.

23. **Basic response:** Spontaneous abortion is classified by clinical findings to guide management, while induced abortion in Nigeria is legally restricted, contributing to unsafe abortion.

Answers to Pilot Questions [Series 2]

Part 2.1

1. Both frequently asymptomatic, particularly chlamydia, but can ascend to cause PID and tubal infertility if untreated.
2. Other STIs independently increase both susceptibility to and transmissibility of HIV.
3. An imbalance of vaginal flora associated with preterm birth risk and increased susceptibility to other infections including HIV.
4. A fungal infection causing thick discharge and itching, generally not sexually transmitted and not requiring partner treatment.
5. Condom use, partner reduction, prompt treatment of index cases and partners, vaccination where available, and routine screening.

Part 2.2

6. Lower abdominal pain, discharge, and cervical excitation and adnexal tenderness on examination, with fever in severe cases.
7. Persistent pelvic pain, deep dyspareunia, and menstrual irregularity from prior inadequately treated or recurrent acute PID.
8. A fluid-filled, non-functional tube from chronic damage, associated with reduced fertility and lower IVF success.
9. Empirical broad-spectrum antibiotics, partner notification and treatment, and screening for other STIs.
10. Tubo-ovarian abscess, chronic pelvic pain, tubal factor infertility, and increased ectopic pregnancy risk.

Part 2.3

11. Spontaneous pregnancy loss before viability, most commonly from chromosomal abnormality in the early embryo.

12. Threatened, inevitable, incomplete, complete, and missed, based on clinical and ultrasound findings.
13. Restricted to preserving the life of the pregnant woman, a more restrictive framework than many other countries.
14. The ethical duty to treat and the legal restriction on performing the procedure are separate considerations.
15. Haemorrhage, sepsis, uterine perforation, and visceral injury, managed with resuscitation, antibiotics, and evacuation or repair.

Part 2.4

1. A standard of care applicable regardless of legal circumstances, encompassing treatment, contraception, and support.
2. Emergency treatment of complications, family planning counselling and provision, and linkage to other services and support.
3. Fertility can return within as little as two weeks, and a proportion of women will not attend a later follow-up visit.
4. The intrauterine device immediately after evacuation, and hormonal methods generally starting the same day.
5. Sensitive, non-judgemental counselling without assuming a particular emotional response, and a clear follow-up plan agreed before discharge.

References and Attributions [Series 2]

Textual References

1. Hoffman, B. L., Schorge, J. O., Halvorson, L. M. et al. (2020). Williams Gynecology (4th ed.). McGraw Hill.
2. World Health Organization (2018). Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors (2nd ed.). WHO Press.

3. British Association for Sexual Health and HIV (2018). UK National Guideline for the Management of Pelvic Inflammatory Disease. BASHH.
4. World Health Organization (2014). Clinical Practice Handbook for Safe Abortion. WHO Press.

Figures, Plates, Tables, and Boxes

1. Table 2.1: Common sexually transmitted and pelvic infections, causative organisms, and key features. AI-generated using the prompt: "Create a clean reference table titled Sexually Transmitted and Pelvic Infections, listing organisms and key clinical features. Simple clinical reference table style with outside border."
2. Box 2.2: Risk factors, clinical features, and complications of pelvic inflammatory disease. AI-generated using the prompt: "Create a simple single-column reference box with an outside border titled Pelvic Inflammatory Disease Summary, listing risk factors, features, and complications. Clinical reference box style."
3. Figure 2.3: Classification of miscarriage and complications of unsafe abortion. AI-generated using the prompt: "Create a professional medical diagram titled Spontaneous and Induced Abortion, showing miscarriage classification and complications of unsafe abortion. Clean clinical educational diagram style."
4. Box 2.4: Core components of comprehensive post-abortal care. AI-generated using the prompt: "Create a simple single-column reference box with an outside border titled Post-Abortal Care: Core Components, listing key components of comprehensive care. Clinical reference box style."

Course code: OBG 502

Course title: Reproductive Health and Family Planning

Course credit load: 2 Units

Series 3: Contraceptive Methods and Eligibility

- **Part 3.1: Hormonal Contraception: Oral and Injectable Methods**
  - Sub Part 3.1.1: Combined oral contraceptive pill
  - Sub Part 3.1.2: Progestogen-only pill
  - Sub Part 3.1.3: Injectable contraceptives
- **Part 3.2: Long-Acting Hormonal Contraceptive Methods**
  - Sub Part 3.2.1: Contraceptive implants
  - Sub Part 3.2.2: Hormonal intrauterine system
  - Sub Part 3.2.3: Indications and contraindications of hormonal methods
- **Part 3.3: WHO Medical Eligibility Criteria and Prescribing**
  - Sub Part 3.3.1: The WHO Medical Eligibility Criteria framework
  - Sub Part 3.3.2: Applying MEC to select a suitable method for the patient
  - Sub Part 3.3.3: Prescribing hormonal contraceptives in practice
- **Part 3.4: Non-Hormonal Contraceptive Methods**
  - Sub Part 3.4.1: Copper intrauterine device
  - Sub Part 3.4.2: Barrier methods and surgical contraception
  - Sub Part 3.4.3: Natural and periodic abstinence methods

Introduction

In the last Series, we explored pelvic infections and abortion care. We now arrive at the very heart of this course: the contraceptive methods that allow individuals and couples to plan their

families safely and confidently, and the structured framework that guides you in matching each method to the individual woman in front of you. From the combined pill to the copper intrauterine device, and from the WHO Medical Eligibility Criteria to the practical art of counselling, this Series equips you with the knowledge to prescribe contraception thoughtfully and safely.

The aim of this Series is to equip you with a thorough understanding of hormonal and non-hormonal contraceptive methods, the WHO Medical Eligibility Criteria, and the practical skills of selecting, prescribing, and counselling on contraception.

We shall commence this Series by examining oral and injectable hormonal contraception. Next, we will consider long-acting hormonal contraceptive methods, including the implant and hormonal intrauterine system. Following that, our attention turns to the WHO Medical Eligibility Criteria and the practical process of prescribing hormonal contraceptives. Finally, we will conclude by examining non-hormonal contraceptive methods.

Series Learning Outcomes

Upon completing this Series, you should be able to:

- **SLO 3.1:** list types of hormonal contraception,
- **SLO 3.2:** describe the various hormonal contraceptives and their indications and contraindications,
- **SLO 3.3:** describe long-acting hormonal contraceptive methods,
- **SLO 3.4:** enumerate the WHO medical eligibility criteria for hormonal contraceptives,
- **SLO 3.5:** explain which hormonal contraceptive is suitable for a particular patient,
- **SLO 3.6:** prescribe appropriate hormonal contraceptives for a patient,
- **SLO 3.7:** illustrate counselling on hormonal contraceptives, and
- **SLO 3.8:** list non-hormonal contraceptives and their indications and contraindications.

3.1 Hormonal Contraception: Oral and Injectable Methods

3.1.1 Combined oral contraceptive pill

The combined oral contraceptive pill contains synthetic oestrogen and progestogen, working principally by suppressing ovulation, with additional contraceptive effects from thickening cervical mucus and thinning the endometrium, offering high effectiveness with correct,

consistent use, alongside recognised non-contraceptive benefits including lighter, more regular, less painful periods and a reduced long-term risk of ovarian and endometrial cancer.

Correct use requires taking one pill daily, generally with a seven-day hormone-free or placebo interval, or, increasingly, using an extended or continuous regimen that reduces or eliminates this interval, and effectiveness can be reduced by missed pills, vomiting or severe diarrhoea, and interaction with certain enzyme-inducing medications, making clear, specific counselling on correct use and management of missed pills a genuinely essential component of prescribing this particular method.

Fill in the blank: The combined oral contraceptive pill works principally by suppressing _____. Effectiveness of the combined pill can be reduced by missed pills, vomiting, and certain enzyme-_____ medications.

3.1.2 Progestogen-only pill

The progestogen-only pill contains progestogen alone, working principally by thickening cervical mucus to impair sperm penetration, with some, but not all, formulations also suppressing ovulation, offering a suitable alternative for women in whom oestrogen is contraindicated or undesirable, including breastfeeding women and those with specific cardiovascular risk factors.

Correct use of traditional progestogen-only pill formulations requires strict timing, generally within a narrow three-hour window each day, considerably less forgiving than the combined pill, though newer desogestrel-containing formulations offer a somewhat wider twelve-hour window, with clear counselling on this specific timing requirement, and what to do if a pill is taken late or missed, essential to maintaining reliable contraceptive effectiveness with this method.

Fill in the blank: The progestogen-only pill works principally by thickening cervical _____ to impair sperm penetration. Traditional progestogen-only pill formulations require strict timing within a narrow _____-hour window each day.

3.1.3 Injectable contraceptives

Injectable progestogen-only contraceptives (such as depot medroxyprogesterone acetate, administered every twelve weeks) offer highly effective, convenient contraception not dependent on daily user action, working principally by suppressing ovulation, with a recognised, generally reversible effect on bleeding pattern, most commonly progressing towards amenorrhoea with continued use, alongside a delayed return of fertility, sometimes taking several months, following discontinuation.

Counselling before initiating injectable contraception should specifically address the expected bleeding pattern changes, the delayed return of fertility after stopping, and, with prolonged use, a recognised, generally reversible reduction in bone mineral density, information that should be discussed proactively rather than only in response to a woman's own specific concerns, given how commonly bleeding pattern change in particular leads to method discontinuation when it has not been adequately anticipated and explained in advance.

Fill in the blank: Depot medroxyprogesterone acetate is typically administered every _____ weeks. Prolonged use of injectable contraception is associated with a generally reversible reduction in bone mineral _____.

Method	Mechanism	Correct Use Timing	Key Counselling Points
Combined Oral Contraceptive Pill	Inhibits ovulation via suppression of FSH/LH; thickens cervical mucus.	Start within first 5 days of cycle; daily use at same time.	Risk of thromboembolism; not recommended if breastfeeding <6 months; may regulate cycles and reduce dysmenorrhoea.
Progestogen-Only Pill	Thickens cervical mucus; inhibits ovulation variably.	Start within first 5 days of cycle; must be taken at same time daily.	Safe in breastfeeding; strict adherence needed (3-hour window for traditional POP, 12-hour for desogestrel POP).
Injectable Contraceptive	Sustained release of progestogen suppresses ovulation and thickens cervical mucus.	Given intramuscularly every 8–12 weeks depending on preparation.	Safe in breastfeeding; may cause menstrual irregularities and delayed return to fertility; convenient for those preferring non-daily method.

Table 3.1: Comparison of the combined pill, progestogen-only pill, and injectable contraceptive.

Pilot questions 3.1

- Describe the mechanism of action and correct use of the combined oral contraceptive pill. (Linked to SLO 3.1)
- Describe the non-contraceptive benefits of the combined oral contraceptive pill. (Linked to SLO 3.2)
- Describe the mechanism and correct use of the progestogen-only pill. (Linked to SLO 3.2)
- Describe the mechanism and administration schedule of injectable contraception. (Linked to SLO 3.2)
- Describe the key counselling points before initiating injectable contraception. (Linked to SLO 3.2)

3.2 Long-Acting Hormonal Contraceptive Methods

3.2.1 Contraceptive implants

The subdermal contraceptive implant (a small, flexible rod inserted beneath the skin of the upper arm, releasing progestogen continuously) offers highly effective contraception for three to five years depending on the specific product, working principally by suppressing ovulation and thickening cervical mucus, with the considerable practical advantage of not requiring ongoing daily or periodic user action once correctly inserted.

Insertion and removal require specific training given the risk of deep insertion or, at removal, difficulty locating a deeply placed or migrated implant, with correct technique, including accurate identification of anatomical landmarks in the upper arm, essential to minimise the risk of neurovascular injury, and bleeding pattern disturbance, similar to that seen with injectable contraception, remains the most common reason for early discontinuation, again underscoring the importance of thorough pre-insertion counselling.

Fill in the blank: The subdermal contraceptive implant offers highly effective contraception for _____ to five years depending on the product. Correct insertion technique is essential to minimise the risk of _____ injury.

3.2.2 Hormonal intrauterine system

The hormonal intrauterine system (a small, T-shaped device inserted into the uterine cavity, releasing progestogen locally) offers highly effective, long-acting contraception for three to eight years depending on the specific product, working principally through a local effect on the endometrium and cervical mucus, with markedly reduced menstrual blood loss, and, in many women, amenorrhoea, a genuinely valuable additional benefit for women with heavy menstrual bleeding alongside its primary contraceptive effect.

Insertion technique requires assessment of uterine size and position, appropriate infection screening beforehand where clinically indicated, and gentle, careful technique to minimise the risk of uterine perforation, with correct positioning subsequently confirmed by checking the visible threads at follow-up, and any woman with threads that are missing, appear shortened, or lengthened requiring further assessment, typically by ultrasound, to confirm the device's location.

Fill in the blank: The hormonal intrauterine system offers long-acting contraception for three to _____ years depending on the product. It causes markedly reduced menstrual blood loss through a local effect on the _____.

3.2.3 Indications and contraindications of hormonal methods

Indications for hormonal contraception are broadly shared across methods, centring on a woman's desire for effective, reversible contraception, with the specific method selected guided by her individual preference, medical history, and desired duration of effect, while additional,

method-specific indications include heavy menstrual bleeding (favouring the hormonal intrauterine system) or a strong preference for a method not requiring any ongoing daily or user action at all (favouring implant, injectable, or intrauterine methods).

Contraindications vary meaningfully by method, with oestrogen-containing methods specifically contraindicated in women with a history of venous thromboembolism, certain migraine subtypes, or significant cardiovascular risk factors, while progestogen-only methods carry a more limited, generally more permissive range of absolute contraindications, reflecting their notably more favourable safety profile in women with these specific, more complex medical risk factors.

Fill in the blank: Heavy menstrual bleeding is a method-specific indication favouring the hormonal _____ system. Oestrogen-containing methods are specifically contraindicated in women with a history of venous _____.

Category	Key Details
Contraceptive Implant	**Duration**: Effective for 3–5 years. **Mechanism**: Continuous release of progestogen suppresses ovulation and thickens cervical mucus. **Counselling Points**: Safe in breastfeeding, may cause irregular bleeding, fertility returns quickly after removal.
Hormonal IUS	**Duration**: Effective for 3–5 years depending on type. **Mechanism**: Local release of levonorgestrel thickens cervical mucus, thins endometrium, and may suppress ovulation. **Counselling Points**: Highly effective, reduces menstrual bleeding and pain, safe in breastfeeding, fertility returns after removal.
Indications	Desire for long-term reversible contraception, safe postpartum use, suitability for women who prefer non-daily methods.
Contraindications	Current breast cancer, unexplained vaginal bleeding, severe liver disease, distorted uterine cavity (for IUS).

Box 3.2: Long-acting hormonal methods and general indications and contraindications.

Pilot questions 3.2

1. Describe the mechanism and duration of the subdermal contraceptive implant. (Linked to SLO 3.3)
2. Describe the technical considerations for implant insertion and removal. (Linked to SLO 3.3)
3. Describe the mechanism and benefits of the hormonal intrauterine system. (Linked to SLO 3.3)

4. Describe the general indications for hormonal contraception. (Linked to SLO 3.2)
5. Compare the contraindications of oestrogen-containing and progestogen-only methods. (Linked to SLO 3.2)

3.3 WHO Medical Eligibility Criteria and Prescribing

3.3.1 The WHO Medical Eligibility Criteria framework

The WHO Medical Eligibility Criteria (MEC) for contraceptive use provides a structured, evidence-based framework classifying the safety of each contraceptive method for a woman with a specific medical condition or characteristic into one of four categories: category 1 (no restriction on use), category 2 (advantages generally outweigh theoretical or proven risks), category 3 (theoretical or proven risks generally outweigh advantages, requiring careful clinical judgement and, often, specialist input), and category 4 (unacceptable health risk, the method should not be used).

This structured framework allows a clinician to systematically assess the safety of a given method for an individual woman based on her specific medical history, replacing potentially inconsistent, purely individual clinical judgement with a genuinely standardised, evidence-based approach, and is regularly updated by the World Health Organization as new evidence on contraceptive safety in specific medical conditions continues to emerge over time.

Fill in the blank: MEC category 3 indicates that theoretical or proven risks generally outweigh advantages, requiring careful clinical _____. MEC category 4 indicates an unacceptable health _____, meaning the method should not be used.

3.3.2 Applying MEC to select a suitable method for the patient

Applying the MEC framework in practice requires first eliciting a thorough medical history, specifically screening for the conditions and characteristics included within the MEC framework, such as hypertension, migraine with aura, smoking status and age, history of venous thromboembolism, and breastfeeding status, before cross-referencing the woman's specific profile against the MEC category for each contraceptive method she is considering.

Where a woman has multiple relevant medical conditions simultaneously, the most restrictive applicable MEC category across all relevant conditions should generally guide the final prescribing decision, and where genuine clinical uncertainty remains despite careful application of the MEC framework, specialist referral or discussion is appropriate, reflecting that the MEC framework, while an extremely valuable and structured decision-making tool, does not entirely replace individual clinical judgement in every single, more complex clinical scenario encountered in practice.

Fill in the blank: Where a woman has multiple relevant medical conditions, the most _____ applicable MEC category should generally guide the prescribing decision. The MEC framework does not entirely replace individual clinical _____ in complex scenarios.

3.3.3 Prescribing hormonal contraceptives in practice

Prescribing a hormonal contraceptive in practice combines the structured MEC assessment with genuine consideration of the woman's own preferences, including her desired duration of effect, tolerance for a particular bleeding pattern change, and any practical considerations such as ability to attend for follow-up injections or ability to remember a daily pill, recognising that the theoretically most suitable method by MEC category alone will not achieve good outcomes if it does not genuinely match the individual woman's practical circumstances and preferences.

Follow-up after initiating hormonal contraception should be planned to review effectiveness, tolerability, and any side effects experienced, with a genuine, ongoing willingness to switch methods if the woman's initial choice proves unsuitable in practice, reflecting the recognition that contraceptive prescribing is rarely a single, final decision, but rather an ongoing, collaborative, and often genuinely iterative process between the woman and her healthcare provider over time.

Fill in the blank: Prescribing a hormonal contraceptive combines the structured MEC assessment with genuine consideration of the woman's own _____. Contraceptive prescribing is rarely a single, final decision, but an ongoing, _____ process over time.

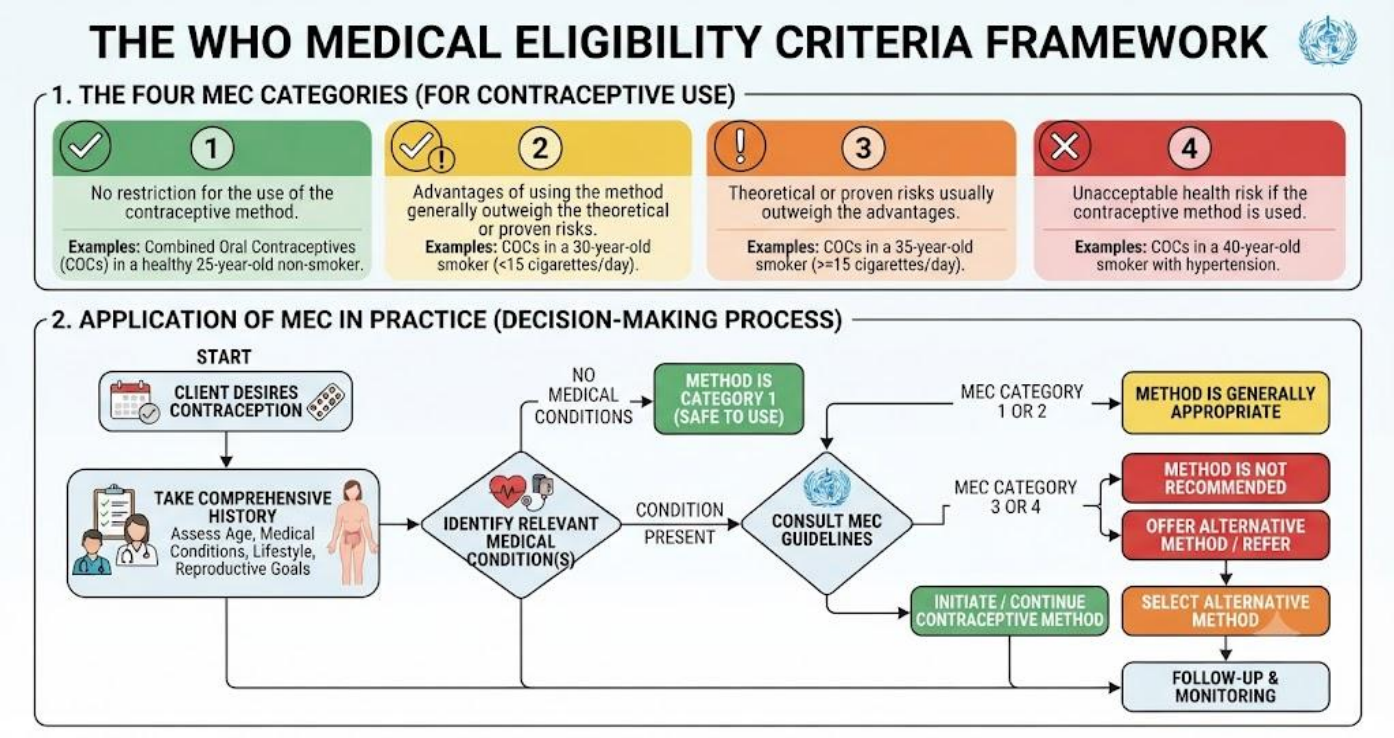

Figure 3.3: The WHO Medical Eligibility Criteria categories and the process of applying MEC in practice.

Pilot questions 3.3

1. Describe the four categories of the WHO Medical Eligibility Criteria. (Linked to SLO 3.4)
2. Explain the value of the MEC framework in contraceptive prescribing. (Linked to SLO 3.4)
3. Describe the process of applying MEC to select a suitable method for a patient. (Linked to SLO 3.5)
4. Explain how multiple relevant medical conditions should be handled when applying MEC. (Linked to SLO 3.5)
5. Describe the practical considerations that should guide prescribing a hormonal contraceptive. (Linked to SLO 3.6)

3.4 Non-Hormonal Contraceptive Methods

3.4.1 Copper intrauterine device

The copper intrauterine device offers highly effective, long-acting, non-hormonal contraception for five to ten years depending on the specific device, working principally through a local inflammatory and spermicidal effect within the uterine cavity, making it a valuable option for women who prefer or require a non-hormonal method, including as a specific method of emergency contraception when inserted within five days of unprotected intercourse.

Recognised side effects of the copper intrauterine device include heavier, sometimes more painful periods, particularly in the first few months following insertion, in contrast to the reduced bleeding typically seen with the hormonal intrauterine system, an important, specific counselling point for any woman choosing between these two intrauterine options, alongside the shared general risks of intrauterine device insertion including perforation and expulsion.

Fill in the blank: The copper intrauterine device offers non-hormonal contraception for five to _____ years depending on the device. The copper device can also be used as a specific method of emergency contraception when inserted within _____ days.

3.4.2 Barrier methods and surgical contraception

Barrier methods (male and female condoms, and, less commonly used, the diaphragm) offer contraception with the considerable additional benefit of protection against sexually transmitted infection, a genuinely important advantage not shared by any other contraceptive method, though with somewhat lower typical-use effectiveness than most hormonal or intrauterine methods,

reflecting the genuine, well-documented difference between perfect and typical use for user-dependent methods of this kind.

Surgical contraception (female tubal ligation or male vasectomy) offers permanent contraception, generally reserved for individuals or couples who have genuinely completed their family and are certain in this decision, with vasectomy offering a simpler, lower-risk procedure than tubal ligation, and both methods requiring thorough, unhurried preoperative counselling given their intended permanence, though vasectomy in particular offers the reassurance of a somewhat greater, though not absolute, potential for surgical reversal if circumstances were to genuinely change.

Fill in the blank: Barrier methods offer the additional benefit of protection against sexually transmitted _____, not shared by other contraceptive methods. Vasectomy offers a simpler, lower-risk procedure than _____ ligation.

3.4.3 Natural and periodic abstinence methods

Natural family planning methods (including the calendar or rhythm method, basal body temperature monitoring, and cervical mucus assessment) rely on identifying the fertile window within the menstrual cycle and avoiding unprotected intercourse during this period, requiring genuine commitment, careful daily tracking, and, importantly, a reasonably regular menstrual cycle to achieve reliable effectiveness, with typical-use effectiveness generally considerably lower than most other contraceptive methods discussed within this Series.

The lactational amenorrhoea method (relying on the contraceptive effect of exclusive, frequent breastfeeding) can provide effective contraception for up to six months postpartum, but only when three specific criteria are all genuinely met together: exclusive or near-exclusive breastfeeding, amenorrhoea, and less than six months postpartum, with effectiveness declining rapidly once any one of these three specific conditions is no longer reliably satisfied.

Fill in the blank: Natural family planning methods rely on identifying the fertile _____ within the menstrual cycle. The lactational amenorrhoea method requires exclusive breastfeeding, amenorrhoea, and being less than _____ months postpartum.

Method	Mechanism	Typical-Use Effectiveness	Key Counselling Points
Copper IUD	Copper ions create a hostile uterine environment, impairing sperm motility and viability.	>99% effective.	Long-term (up to 10 years), reversible, may increase menstrual bleeding and cramps.
Barrier Methods	Physical prevention of sperm entry (condoms, diaphragms, cervical caps).	79–88% effective depending on consistency.	Protect against STIs (condoms), require correct and consistent use, may be combined with spermicides.

Method	Mechanism	Typical-Use Effectiveness	Key Counselling Points
Surgical Contraception	Permanent interruption of reproductive tract (tubal ligation, vasectomy).	>99% effective.	Irreversible, requires informed consent, no effect on sexual function.
Natural Methods	Fertility awareness, withdrawal, lactational amenorrhoea method (LAM).	75–88% effective depending on adherence.	Requires motivation and accurate cycle tracking; LAM effective only up to 6 months postpartum with exclusive breastfeeding.

Table 3.4: Non-hormonal contraceptive methods, mechanism, and counselling points.

Pilot questions 3.4

1. Describe the mechanism and use of the copper intrauterine device, including as emergency contraception. (Linked to SLO 3.8)
2. Compare the copper intrauterine device and hormonal intrauterine system in terms of bleeding pattern. (Linked to SLO 3.8)
3. Describe the advantages and limitations of barrier methods. (Linked to SLO 3.8)
4. Describe surgical contraception and its key counselling considerations. (Linked to SLO 3.8)
5. Describe natural family planning methods and the lactational amenorrhoea method. (Linked to SLO 3.8)

Series Summary

This Series has covered oral and injectable hormonal contraception, followed by long-acting hormonal methods, including the implant and hormonal intrauterine system. It went on to examine the WHO Medical Eligibility Criteria and the practical process of prescribing hormonal contraceptives, before concluding with non-hormonal contraceptive methods.

You should now be able to list types of hormonal contraception, describe their indications and contraindications, describe long-acting methods, enumerate the WHO Medical Eligibility Criteria, explain which method suits a particular patient, prescribe appropriate contraception, illustrate counselling, and list non-hormonal methods (Linked to SLOs 3.1 to 3.8).

Glossary of Terms

1. **Combined oral contraceptive pill:** a pill containing synthetic oestrogen and progestogen, working principally by suppressing ovulation.
2. **Contraceptive implant:** a small, flexible progestogen-releasing rod inserted beneath the skin, offering three to five years of contraception.
3. **Copper intrauterine device:** a non-hormonal intrauterine device working through a local inflammatory and spermicidal effect.
4. **Depot medroxyprogesterone acetate:** an injectable progestogen-only contraceptive administered every twelve weeks.
5. **Hormonal intrauterine system:** a progestogen-releasing intrauterine device offering long-acting contraception and reduced menstrual bleeding.
6. **Lactational amenorrhoea method:** a contraceptive method relying on the effect of exclusive, frequent breastfeeding.
7. **Medical Eligibility Criteria (MEC):** a WHO framework classifying the safety of contraceptive methods for women with specific medical conditions into four categories.
8. **Progestogen-only pill:** a pill containing progestogen alone, working principally by thickening cervical mucus.
9. **Typical-use effectiveness:** the effectiveness of a contraceptive method as used in real-world practice, accounting for imperfect or inconsistent use.
10. **Vasectomy:** male surgical sterilisation, offering a simpler, lower-risk procedure than female tubal ligation.
11. **Emergency contraception:** contraception used after unprotected intercourse to prevent pregnancy, including the copper intrauterine device.
12. **Fertile window:** the days within the menstrual cycle during which pregnancy can occur, targeted by natural family planning methods.

Concept Check Questions [Series 3]

Objective questions

- The combined oral contraceptive pill works principally by suppressing _____.
- Depot medroxyprogesterone acetate is typically administered every _____ weeks.
- MEC category 4 indicates an unacceptable health _____, meaning the method should not be used.
- The copper intrauterine device can be used as emergency contraception when inserted within _____ days.
- Barrier methods offer the additional benefit of protection against sexually transmitted _____.

Short-answer questions

1. Describe the key counselling points before initiating injectable contraception. (Linked to SLO 3.2)
2. Describe the mechanism and benefits of the hormonal intrauterine system. (Linked to SLO 3.3)
3. Explain how multiple relevant medical conditions should be handled when applying MEC. (Linked to SLO 3.5)
4. Describe the practical considerations that should guide prescribing a hormonal contraceptive. (Linked to SLO 3.6)
5. Compare the copper intrauterine device and hormonal intrauterine system in terms of bleeding pattern. (Linked to SLO 3.8)

Long-answer questions

6. Describe the types, mechanisms, and indications and contraindications of hormonal contraception. (Linked to SLO 3.1, SLO 3.2)
7. Describe long-acting hormonal contraceptive methods, including the implant and hormonal intrauterine system. (Linked to SLO 3.3)

8. Describe the WHO Medical Eligibility Criteria and how it is applied to select a suitable contraceptive method. (Linked to SLO 3.4, SLO 3.5)
9. Describe the practical process of prescribing and counselling on hormonal contraception. (Linked to SLO 3.6, SLO 3.7)
10. Describe non-hormonal contraceptive methods and their indications and contraindications. (Linked to SLO 3.8)

Answers to Concept Check Questions [Series 3]

Objective questions

11. Ovulation.
12. Twelve.
13. Risk.
14. Five.
15. Infection.

Short-answer questions

16. Expected bleeding pattern changes, delayed return of fertility, and, with prolonged use, reversible reduction in bone mineral density.
17. A local effect on the endometrium and cervical mucus causing markedly reduced menstrual blood loss and, in many, amenorrhoea.
18. The most restrictive applicable MEC category across all relevant conditions should generally guide the final prescribing decision.
19. Desired duration of effect, tolerance for bleeding pattern change, and practical considerations such as ability to attend follow-up.
20. The copper device typically causes heavier periods, while the hormonal system typically causes reduced bleeding.

Long-answer questions

21. **Basic response:** Hormonal contraception includes oral, injectable, implant, and intrauterine methods, each with a distinct mechanism, indications, and contraindications.

Value-added response: Oestrogen-containing methods are contraindicated in women with thromboembolism risk, while progestogen-only methods offer a more permissive safety profile.

22. **Basic response:** The MEC framework classifies contraceptive safety into four categories, guiding selection of a suitable method based on the woman's medical history.

Value-added response: Prescribing combines MEC assessment with the woman's own preferences and practical circumstances, with an ongoing willingness to switch methods if needed.

23. **Basic response:** Non-hormonal methods include the copper IUD, barrier methods, surgical contraception, and natural methods, each with distinct effectiveness and counselling needs.

Answers to Pilot Questions [Series 3]

Part 3.1

1. Suppresses ovulation, with additional effects on cervical mucus and endometrium; taken daily with a hormone-free interval.
2. Lighter, more regular, less painful periods, and reduced long-term risk of ovarian and endometrial cancer.
3. Thickens cervical mucus, with some formulations also suppressing ovulation; requires strict, narrow daily timing.
4. Suppresses ovulation, administered every twelve weeks.
5. Expected bleeding pattern changes, delayed return of fertility, and reversible bone mineral density reduction with prolonged use.

Part 3.2

6. Suppresses ovulation and thickens cervical mucus, offering three to five years of contraception depending on the product.
7. Requires accurate identification of anatomical landmarks to avoid neurovascular injury during insertion and removal.
8. Local effect on endometrium and cervical mucus, offering three to eight years of contraception and reduced menstrual bleeding.
9. A woman's desire for effective, reversible contraception, guided by preference, history, and desired duration of effect.
10. Oestrogen-containing methods are contraindicated in thromboembolism risk; progestogen-only methods have fewer absolute contraindications.

Part 3.3

11. Category 1 (no restriction), category 2 (advantages outweigh risks), category 3 (risks generally outweigh advantages), category 4 (unacceptable risk).
12. It provides a standardised, evidence-based approach to assessing method safety for an individual woman's medical profile.
13. Eliciting a thorough medical history and cross-referencing the woman's profile against the MEC category for each method.
14. The most restrictive applicable category across all relevant conditions should generally guide the prescribing decision.
15. Desired duration of effect, tolerance for bleeding changes, and practical considerations such as ability to attend follow-up.

Part 3.4

1. A local inflammatory and spermicidal effect, offering five to ten years of contraception, or emergency contraception within five days.
2. The copper device typically causes heavier periods, while the hormonal system typically causes reduced bleeding.

3. Protection against sexually transmitted infection, though with somewhat lower typical-use effectiveness than other methods.
4. Permanent contraception requiring thorough preoperative counselling, with vasectomy simpler and lower-risk than tubal ligation.
5. Rely on identifying the fertile window; the lactational amenorrhoea method requires exclusive breastfeeding, amenorrhoea, and under six months postpartum.

References and Attributions [Series 3]

Textual References

1. World Health Organization (2015). Medical Eligibility Criteria for Contraceptive Use (5th ed.). WHO Press.
2. Hoffman, B. L., Schorge, J. O., Halvorson, L. M. et al. (2020). Williams Gynecology (4th ed.). McGraw Hill.
3. Faculty of Sexual and Reproductive Healthcare (2019). UK Medical Eligibility Criteria for Contraceptive Use. FSRH.
4. World Health Organization (2018). Family Planning: A Global Handbook for Providers (3rd ed.). WHO Press.

Figures, Plates, Tables, and Boxes

1. Table 3.1: Comparison of the combined pill, progestogen-only pill, and injectable contraceptive. AI-generated using the prompt: "Create a clean reference table titled Oral and Injectable Hormonal Contraception, comparing mechanism, timing, and counselling points. Simple clinical reference table style with outside border."
2. Box 3.2: Long-acting hormonal methods and general indications and contraindications. AI-generated using the prompt: "Create a simple single-column reference box with an outside border titled Long-Acting Hormonal Contraception, comparing implant and IUS, with indications and contraindications. Clinical reference box style."

3. Figure 3.3: The WHO Medical Eligibility Criteria categories and the process of applying MEC in practice. AI-generated using the prompt: "Create a professional medical diagram titled The WHO Medical Eligibility Criteria Framework, showing the four MEC categories and the process of applying them in practice. Clean clinical educational diagram style."
4. Table 3.4: Non-hormonal contraceptive methods, mechanism, and counselling points. AI-generated using the prompt: "Create a clean reference table titled Non-Hormonal Contraceptive Methods, listing mechanism, effectiveness, and counselling points. Simple clinical reference table style with outside border."

Course code: OBG 502

Course title: Reproductive Health and Family Planning

Course credit load: 2 Units

Series 4: Family Planning Services and Special Needs

- **Part 4.1: Family Planning Service Delivery Systems**
  - Sub Part 4.1.1: Management information systems in family planning
  - Sub Part 4.1.2: Integrating family planning with other reproductive health services
  - Sub Part 4.1.3: Quality of care in family planning service delivery
- **Part 4.2: Contraception in Special Needs**
  - Sub Part 4.2.1: Contraception in women with chronic medical conditions
  - Sub Part 4.2.2: Contraception in women with disability
  - Sub Part 4.2.3: Contraception in women living with HIV
- **Part 4.3: Family Planning in Adolescents**
  - Sub Part 4.3.1: Adolescent sexual and reproductive health needs
  - Sub Part 4.3.2: Contraceptive counselling and method choice in adolescents
  - Sub Part 4.3.3: Legal and ethical considerations in adolescent family planning
- **Part 4.4: Addressing Unmet Need in Contraception**
  - Sub Part 4.4.1: Understanding and measuring unmet need
  - Sub Part 4.4.2: Barriers contributing to unmet need
  - Sub Part 4.4.3: Strategies to address unmet need

Introduction

In the last Series, we explored contraceptive methods and the WHO Medical Eligibility Criteria that guide their safe selection. We now turn to how family planning services are actually

delivered, monitored, and made accessible to everyone who needs them, including populations with particular needs: women with chronic medical conditions or disability, women living with HIV, and adolescents. We close by confronting the persistent, substantial unmet need for family planning that remains across Nigeria, and the strategies available to address it.

The aim of this Series is to equip you with the knowledge of family planning service delivery systems, contraception for special needs populations, family planning in adolescents, and strategies to address unmet need.

We shall commence this Series by examining family planning service delivery systems, including management information systems and integration with other reproductive health services. Next, we will consider contraception for women with special needs, including chronic medical conditions, disability, and HIV. Following that, our attention turns to family planning in adolescents. Finally, we will conclude by examining the barriers to and strategies for addressing unmet need in contraception.

Series Learning Outcomes

Upon completing this Series, you should be able to:

- **SLO 4.1:** describe management information systems in family planning,
- **SLO 4.2:** describe the integration of family planning with other reproductive health services and quality of care,
- **SLO 4.3:** describe contraception for women with chronic medical conditions and disability,
- **SLO 4.4:** describe contraception in women living with HIV,
- **SLO 4.5:** describe family planning needs and method choice for adolescents,
- **SLO 4.6:** describe the legal and ethical considerations in adolescent family planning, and
- **SLO 4.7:** describe the barriers to and strategies for addressing unmet need in contraception.

4.1 Family Planning Service Delivery Systems

4.1.1 Management information systems in family planning

A management information system (MIS) in family planning refers to the structured collection, analysis, and use of routine service data, including client numbers, method mix,

discontinuation rates, and stock levels of contraceptive commodities, providing the essential evidence base that programme managers and policymakers require to plan, monitor, and continuously improve family planning service delivery at facility, regional, and national level.

Accurate, timely data allows early identification of genuine service gaps, such as a specific facility experiencing frequent contraceptive stockouts or unusually high discontinuation rates for a particular method, enabling a genuinely targeted, evidence-based response rather than a generic, one-size-fits-all intervention applied uniformly across an entire programme regardless of the actual, specific pattern of need or difficulty in each particular location.

Fill in the blank: A management information system collects routine service data including client numbers, method mix, and _____ levels of contraceptive commodities. Accurate, timely data allows early identification of genuine service _____ requiring a targeted response.

4.1.2 Integrating family planning with other reproductive health services

Integration of family planning with other reproductive health services, including antenatal and postnatal care, HIV testing and treatment services, and post-abortal care, offers genuine efficiency benefits by reducing the number of separate visits a woman must make, and, importantly, reaches women at moments when they are already engaging with the health system and may be genuinely receptive to family planning counselling and service provision that might otherwise be missed if offered only through a separate, standalone family planning clinic.

Successful integration requires adequately trained staff capable of confidently offering family planning counselling and services alongside their existing primary clinical role, sufficient supply of contraceptive commodities at the point of integrated service delivery, and genuinely supportive policy and health system structures, given that integration attempted without these essential supporting elements in place frequently proves considerably less effective in practice than intended.

Fill in the blank: Integration of family planning with other services reaches women at moments when they are already _____ with the health system. Successful integration requires adequately trained staff and sufficient _____ of contraceptive commodities.

4.1.3 Quality of care in family planning service delivery

Quality of care in family planning service delivery encompasses genuine choice among a reasonable range of contraceptive methods, accurate information provided during counselling, technical competence of the provider delivering the chosen method, good interpersonal relations between provider and client, appropriate follow-up and continuity of care, and a service delivery environment that respects client privacy, dignity, and confidentiality throughout every stage of the encounter.

Poor quality of care in any of these dimensions, whether limited method choice, inadequate counselling, technically incompetent service delivery, or a disrespectful provider manner,

directly contributes to reduced contraceptive uptake, higher discontinuation rates, and, ultimately, persistent unmet need for family planning, meaning that investment in genuine service quality, not merely service availability or coverage, represents an essential, evidence-based priority for family planning programming.

Fill in the blank: Quality of care in family planning includes genuine method choice, accurate counselling, and appropriate follow-up and _____ of care. Poor quality of care in any dimension directly contributes to higher _____ rates and persistent unmet need.

Dimension	Key Details
Method Choice	Clients should have access to a wide range of contraceptive options to suit individual needs.
Information	Clear, accurate counselling on benefits, risks, and correct use of each method.
Technical Competence	Providers must be skilled in safe, effective service delivery and procedure performance.
Interpersonal Relations	Respectful, supportive, and non-judgmental communication between provider and client.
Follow-Up	Ongoing support to manage side effects, switch methods, and ensure continued satisfaction.
Privacy	Confidentiality and dignity must be maintained during counselling and service provision.

Box 4.1: Dimensions of quality of care in family planning service delivery.

Pilot questions 4.1

- Describe the purpose and components of a management information system in family planning. (Linked to SLO 4.1)
- Explain how accurate data supports targeted family planning programming. (Linked to SLO 4.1)
- Describe the benefits of integrating family planning with other reproductive health services. (Linked to SLO 4.2)
- Describe the requirements for successful integration of family planning services. (Linked to SLO 4.2)
- Describe the dimensions of quality of care in family planning service delivery. (Linked to SLO 4.2)

4.2 Contraception in Special Needs

4.2.1 Contraception in women with chronic medical conditions

Women with chronic medical conditions such as diabetes, hypertension, epilepsy, or cardiac disease require particularly careful, individualised contraceptive counselling, applying the WHO Medical Eligibility Criteria framework established earlier in this course to identify safe, suitable options, given that certain conditions substantially restrict or entirely contraindicate specific methods, most notably oestrogen-containing methods in women with significant cardiovascular risk factors.

Certain anticonvulsant medications used in epilepsy management are enzyme-inducing, reducing the effectiveness of hormonal contraceptive methods metabolised through the same hepatic pathway, meaning that women with epilepsy require specific counselling about drug interactions and, frequently, preferential selection of non-hormonal or non-orally administered methods less affected by this specific, clinically important interaction.

Fill in the blank: Certain anticonvulsant medications are enzyme-_____, reducing the effectiveness of hormonal contraceptive methods. Women with significant cardiovascular risk factors are generally advised against _____-containing contraceptive methods.

4.2.2 Contraception in women with disability

Women with physical or intellectual disability have the same fundamental right to autonomous reproductive decision-making and access to appropriate contraceptive services as any other woman, though practical adaptations, including accessible physical facilities, appropriate communication support, and, where relevant, careful, genuinely respectful consideration of capacity and consent for those with significant intellectual disability, are frequently required to ensure genuinely equitable access to family planning services.

Assumptions about sexual activity or reproductive desires should never be made on the basis of disability alone, and any decision regarding contraceptive method choice, including any decision around long-term or permanent methods, must be made with the fullest possible involvement of the woman herself, applying the same fundamental principles of informed consent and reproductive autonomy that apply to any other woman, adapted as genuinely necessary but never abandoned or diminished on account of her disability.

Fill in the blank: Practical adaptations for women with disability may include accessible facilities and appropriate _____ support. Assumptions about sexual activity or reproductive desires should never be made on the basis of _____ alone.

4.2.3 Contraception in women living with HIV

Women living with HIV can safely use the great majority of contraceptive methods, with the WHO Medical Eligibility Criteria framework specifically addressing HIV status and antiretroviral therapy regimen as relevant factors, given that certain antiretroviral medications, similarly to certain anticonvulsants, can interact with hormonal contraceptive metabolism, requiring specific consideration of this interaction when selecting and prescribing a suitable method.

Dual protection (simultaneous use of a highly effective contraceptive method alongside consistent condom use) is specifically recommended for women living with HIV, both to prevent unintended pregnancy and to reduce the risk of onward HIV transmission to a partner or, in the specific context of pregnancy, vertical transmission to a future child, reflecting the genuinely dual reproductive health objectives relevant to contraceptive counselling in this specific population.

Fill in the blank: Certain antiretroviral medications can interact with hormonal contraceptive _____, requiring specific consideration when prescribing. Dual protection combines a highly effective contraceptive method with consistent _____ use.

Population	Key Considerations
Chronic Medical Conditions	Choice depends on condition: avoid oestrogen-containing methods in hypertension, diabetes with vascular disease, or thromboembolic disorders; progestogen-only and non-hormonal methods often preferred.
Disability	Focus on ease of use and autonomy; long-acting reversible contraception (LARC) may be suitable; ensure informed consent and respect for reproductive rights.
HIV	Barrier methods essential for dual protection (contraception + STI prevention); hormonal methods generally safe but check for drug interactions with antiretroviral therapy; IUDs can be used if no active pelvic infection.

Table 4.2: Contraceptive considerations for special populations.

Pilot questions 4.2

1. Describe the contraceptive considerations for women with chronic medical conditions. (Linked to SLO 4.3)
2. Explain the drug interaction relevant to contraception in women with epilepsy. (Linked to SLO 4.3)
3. Describe the practical adaptations required to ensure equitable contraceptive access for women with disability. (Linked to SLO 4.3)
4. Describe the contraceptive considerations relevant to women living with HIV. (Linked to SLO 4.4)

5. Explain the concept and rationale for dual protection in women living with HIV. (Linked to SLO 4.4)

4.3 Family Planning in Adolescents

4.3.1 Adolescent sexual and reproductive health needs

Adolescents have distinct sexual and reproductive health needs, reflecting their specific developmental stage, evolving autonomy, and, frequently, limited prior exposure to accurate, comprehensive reproductive health information, meaning that family planning services genuinely tailored to this specific age group must address not only contraceptive method provision but also broader sexuality education, negotiation skills, and awareness of both the risks and normal aspects of adolescent sexual development.

Barriers specific to adolescent access to family planning services include fear of judgement or breach of confidentiality, limited awareness of available services, cost, and, in some communities, genuine social or cultural stigma attached to unmarried or young people seeking contraceptive services, together contributing to the disproportionately high burden of unintended adolescent pregnancy and its associated risks discussed elsewhere in this broader curriculum.

Fill in the blank: Barriers specific to adolescent access to family planning include fear of judgement or breach of _____. Adolescent family planning services must address not only contraceptive provision but also broader _____ education.

4.3.2 Contraceptive counselling and method choice in adolescents

Contraceptive counselling for adolescents requires an adapted approach, using genuinely age-appropriate, non-judgemental language, offering, wherever appropriate and safe, an opportunity to speak with the provider alone for at least part of the consultation, and being explicit and honest about the specific limits of confidentiality, particularly where there are safeguarding concerns that would need to be escalated regardless of the adolescent's own preference for information to remain confidential.

Long-acting reversible contraceptive methods (implant and intrauterine methods) are now increasingly recommended as first-line options for adolescents given their high effectiveness independent of ongoing daily user action, though method choice should ultimately be genuinely individualised according to the adolescent's own preferences, medical eligibility, and specific practical circumstances, rather than a single method being universally imposed on every adolescent client regardless of her own informed choice.

Fill in the blank: Contraceptive counselling for adolescents should be explicit and honest about the specific limits of _____. Long-acting reversible contraceptive methods are increasingly recommended as first-_____ options for adolescents.

4.3.3 Legal and ethical considerations in adolescent family planning

The legal and ethical framework governing adolescent access to contraceptive services varies across jurisdictions and is often genuinely complex, generally guided by an assessment of the individual adolescent's maturity and capacity to understand the information and implications relevant to the specific decision being made, sometimes formalised through the concept of evolving capacity, rather than a rigid, fixed age threshold applied identically and inflexibly to every adolescent regardless of her individual circumstances.

Providers must balance genuine respect for adolescent autonomy and confidentiality against relevant safeguarding responsibilities, particularly where there is concern about coercion, exploitation, or a significant age or power differential between the adolescent and a sexual partner, requiring careful, case-by-case clinical and, at times, genuinely difficult ethical judgement rather than a simple, universally applicable rule capable of resolving every individual situation encountered in practice.

Fill in the blank: The legal and ethical framework for adolescent contraceptive access is generally guided by an assessment of individual _____ and capacity to understand the decision. Providers must balance respect for adolescent autonomy against relevant _____ responsibilities.

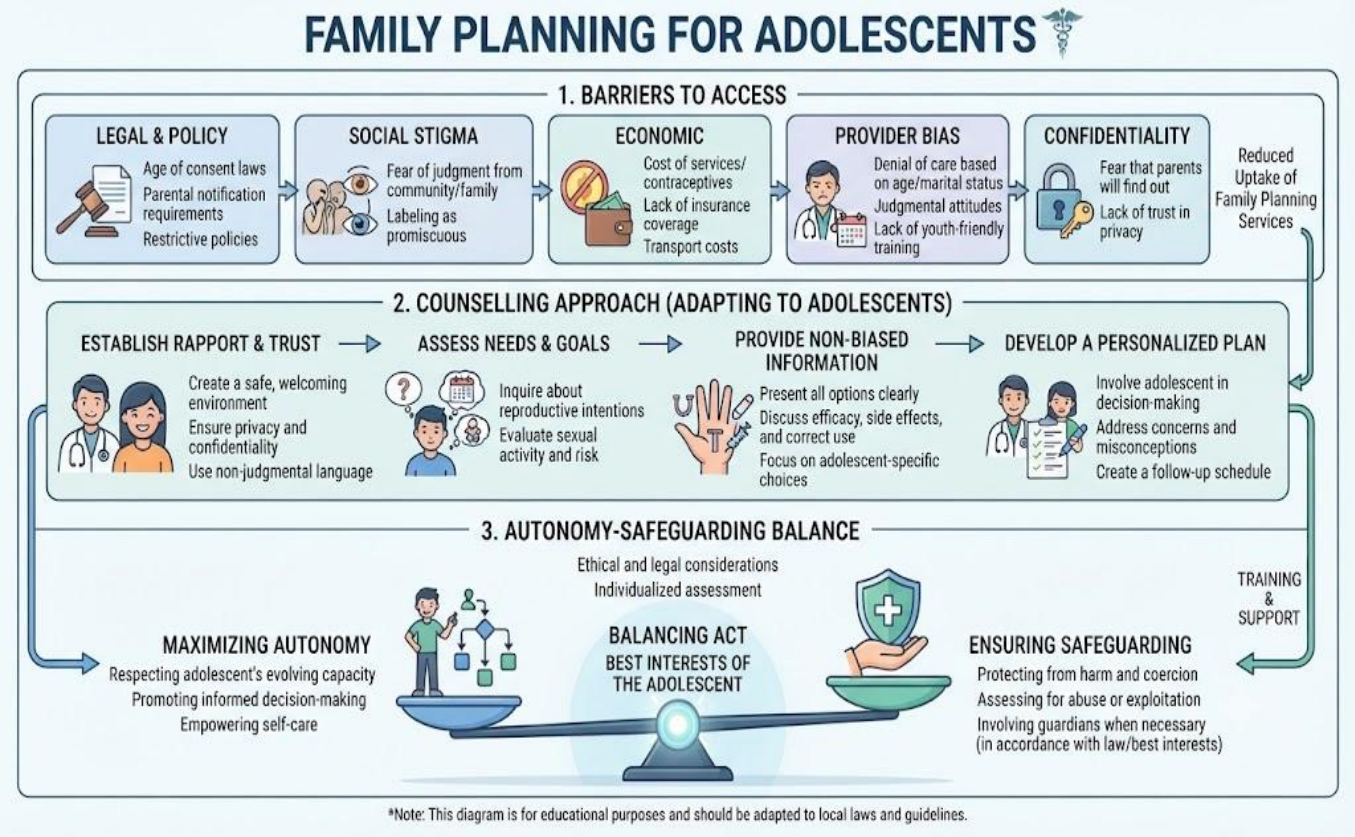

Figure 4.3: Barriers, counselling approach, and the autonomy-safeguarding balance in adolescent family planning.

Pilot questions 4.3

1. Describe the distinct sexual and reproductive health needs of adolescents. (Linked to SLO 4.5)
2. Describe the barriers specific to adolescent access to family planning services. (Linked to SLO 4.5)
3. Describe the adapted approach to contraceptive counselling for adolescents. (Linked to SLO 4.5)
4. Explain why long-acting reversible methods are increasingly recommended for adolescents. (Linked to SLO 4.5)
5. Describe the legal and ethical considerations relevant to adolescent family planning. (Linked to SLO 4.6)

4.4 Addressing Unmet Need in Contraception

4.4.1 Understanding and measuring unmet need

Unmet need for family planning is formally measured as the proportion of women who are fecund and sexually active, wish to postpone their next pregnancy or stop childbearing altogether, but are not currently using any method of contraception, distinguished from met need (women with the same reproductive intentions who are currently using contraception), together allowing calculation of the total demand for family planning and the proportion of that demand currently being satisfied within a given population.

Nigeria's demographic and health surveys have consistently documented substantial unmet need for family planning across the country, with meaningful variation by region, education level, and socioeconomic status, providing an important, quantifiable target against which the success of national family planning programming and investment can be genuinely and objectively measured over successive survey rounds.

Fill in the blank: Unmet need is measured as the proportion of fecund, sexually active women who wish to postpone or stop childbearing but are not currently using any _____. Nigeria's demographic and health surveys have consistently documented substantial _____ need across the country.

4.4.2 Barriers contributing to unmet need

Barriers contributing to unmet need span multiple levels, including individual-level factors (limited knowledge, fear of side effects, and persistent myths and rumours discussed earlier in this course), service-level factors (limited method choice, inadequate counselling, provider bias, and contraceptive stockouts), and broader structural factors (cost, geographical access, and restrictive social, cultural, or religious norms around contraceptive use), together forming a genuinely complex, multilayered barrier requiring a correspondingly multifaceted response.

Partner or family opposition to contraceptive use represents a further, specific and genuinely significant barrier in many settings, including parts of Nigeria, reflecting broader gender power dynamics within relationships and households, and requiring specific, sensitive programmatic attention, including engagement of male partners and other family members in family planning education and counselling wherever this is genuinely feasible and appropriate to the specific situation.

Fill in the blank: Barriers contributing to unmet need span individual, service, and broader _____ levels. Partner or family opposition to contraceptive use reflects broader gender power dynamics within _____ and households.

4.4.3 Strategies to address unmet need

Strategies to address unmet need for family planning include expanding genuine method choice and ensuring reliable contraceptive commodity supply, improving the quality and accessibility of counselling, reducing cost barriers through subsidised or free provision, community-based distribution to overcome geographical access barriers, and sustained, community-level myth-busting and awareness campaigns addressing the specific misconceptions most prevalent in a given community.

Task-shifting (expanding the range of appropriately trained health workers authorised to provide specific family planning methods, including community health extension workers) has been shown to meaningfully improve access, particularly in rural and underserved areas of Nigeria, and, alongside integration of family planning with other reproductive health services discussed earlier in this Series, represents one of the most genuinely evidence-based, cost-effective strategies available for addressing this persistent, multifaceted public health challenge.

Fill in the blank: Strategies to address unmet need include expanding method choice, improving counselling, and reducing _____ barriers. Task-shifting expands the range of appropriately trained _____ workers authorised to provide specific family planning methods.

Barriers	Evidence-Based Strategies
Limited Access	Expand service delivery points, strengthen supply chains, and integrate family planning into primary health care.
Cultural and Religious Beliefs	Engage community leaders, provide culturally sensitive counselling, and promote awareness campaigns.
Fear of Side Effects	Offer clear information, manage side effects proactively, and provide alternative method options.
Gender Inequality	Empower women through education, involve men in counselling, and promote shared decision-making.
Adolescent Barriers	Provide youth-friendly services, confidential counselling, and targeted education programs.
Weak Follow-Up Systems	Strengthen continuity of care, establish reminder systems, and improve provider-client communication.

Box 4.4: Barriers to and strategies for addressing unmet need in family planning.

Pilot questions 4.4

1. Define unmet need for family planning and distinguish it from met need. (Linked to SLO 4.7)
2. Describe the individual-level barriers contributing to unmet need. (Linked to SLO 4.7)

3. Describe the service-level and structural barriers contributing to unmet need. (Linked to SLO 4.7)
4. Describe the strategies used to address unmet need for family planning. (Linked to SLO 4.7)
5. Explain the role of task-shifting in addressing unmet need in Nigeria. (Linked to SLO 4.7)

Series Summary

This Series has covered family planning service delivery systems, including management information systems and integration with other reproductive health services, followed by contraception for women with special needs, including chronic medical conditions, disability, and HIV. It went on to examine family planning in adolescents, including its legal and ethical considerations, before concluding with the barriers to and strategies for addressing unmet need in contraception.

You should now be able to describe family planning service delivery and quality of care, describe contraception for special needs populations, describe adolescent family planning needs and legal and ethical considerations, and describe strategies to address unmet need for contraception (Linked to SLOs 4.1 to 4.7).

Glossary of Terms

1. **Dual protection:** simultaneous use of a highly effective contraceptive method alongside consistent condom use.
2. **Enzyme-inducing medication:** a medication that increases hepatic metabolism, potentially reducing the effectiveness of hormonal contraception.
3. **Evolving capacity:** the concept that an adolescent's capacity to make autonomous decisions develops progressively with maturity.
4. **Management information system (MIS):** the structured collection, analysis, and use of routine service data to inform programme planning and monitoring.

5. **Met need:** women with reproductive intentions to postpone or stop childbearing who are currently using contraception.
6. **Quality of care:** the dimensions of family planning service delivery including method choice, information, competence, and respect for the client.
7. **Task-shifting:** expanding the range of appropriately trained health workers authorised to provide specific health services.
8. **Unmet need for family planning:** the proportion of fecund, sexually active women who wish to postpone or stop childbearing but are not using contraception.
9. **Long-acting reversible contraception (LARC):** highly effective contraceptive methods, including implants and intrauterine methods, not dependent on ongoing user action.
10. **Integration of family planning:** the incorporation of family planning counselling and services into other reproductive health service delivery points.
11. **Safeguarding:** measures taken to protect a vulnerable individual, such as a child or adolescent, from harm.
12. **Vertical transmission:** transmission of an infection, such as HIV, from mother to child during pregnancy, delivery, or breastfeeding.

Concept Check Questions [Series 4]

Objective questions

- A management information system collects routine service data including client numbers, method mix, and _____ levels.
- Certain anticonvulsant medications are enzyme-_____, reducing the effectiveness of hormonal contraceptive methods.
- Dual protection combines a highly effective contraceptive method with consistent _____ use.
- Long-acting reversible contraceptive methods are increasingly recommended as first-_____ options for adolescents.
- Unmet need is measured as the proportion of fecund, sexually active women not currently using any _____ of contraception.

Short-answer questions

1. Describe the requirements for successful integration of family planning services. (Linked to SLO 4.2)
2. Explain the drug interaction relevant to contraception in women with epilepsy. (Linked to SLO 4.3)
3. Explain the concept and rationale for dual protection in women living with HIV. (Linked to SLO 4.4)
4. Describe the barriers specific to adolescent access to family planning services. (Linked to SLO 4.5)
5. Describe the individual-level barriers contributing to unmet need. (Linked to SLO 4.7)

Long-answer questions

6. Describe family planning service delivery systems, including management information systems and integration. (Linked to SLO 4.1, SLO 4.2)
7. Describe contraceptive considerations for women with chronic medical conditions, disability, and HIV. (Linked to SLO 4.3, SLO 4.4)
8. Describe the sexual and reproductive health needs of adolescents and the adapted approach to counselling. (Linked to SLO 4.5)
9. Describe the legal and ethical considerations in adolescent family planning. (Linked to SLO 4.6)
10. Describe the barriers to and strategies for addressing unmet need for family planning. (Linked to SLO 4.7)

Answers to Concept Check Questions [Series 4]

Objective questions

11. Stock.
12. Inducing.
13. Condom.

14. Line.
15. Method.

Short-answer questions

16. Adequately trained staff, sufficient commodity supply, and genuinely supportive policy and health system structures.
17. Anticonvulsants can be enzyme-inducing, reducing hormonal contraceptive effectiveness through the same hepatic metabolic pathway.
18. It prevents unintended pregnancy and reduces the risk of onward HIV transmission to a partner or child.
19. Fear of judgement or confidentiality breach, limited awareness, cost, and social or cultural stigma.
20. Limited knowledge, fear of side effects, and persistent myths and rumours about contraception.

Long-answer questions

21. **Basic response:** Family planning service delivery relies on management information systems and integration with other reproductive health services to improve efficiency and reach.

Value-added response: Quality of care, including method choice and respectful provider manner, directly influences uptake, continuation, and persistent unmet need.

22. **Basic response:** Women with chronic conditions, disability, and HIV require individualised contraceptive counselling applying the MEC framework and addressing specific drug interactions.

Value-added response: Assumptions should never be made about sexual activity based on disability, and dual protection is specifically recommended for women living with HIV.

23. **Basic response:** Adolescents have distinct reproductive health needs and barriers, requiring adapted, confidential counselling and often benefiting from long-acting reversible methods.

Answers to Pilot Questions [Series 4]

Part 4.1

1. Structured collection, analysis, and use of routine service data to inform planning, monitoring, and improvement.
2. It allows early identification of specific service gaps, enabling a targeted rather than generic response.
3. Reduces the number of separate visits and reaches women already engaging with the health system.
4. Adequately trained staff, sufficient commodity supply, and supportive policy and health system structures.
5. Method choice, accurate information, technical competence, interpersonal relations, follow-up, and respect for privacy and dignity.

Part 4.2

6. Applying the MEC framework to identify safe options, given that certain conditions restrict specific methods.
7. Enzyme-inducing anticonvulsants reduce hormonal contraceptive effectiveness through shared hepatic metabolism.
8. Accessible facilities, appropriate communication support, and respectful consideration of capacity and consent.
9. The MEC framework addresses HIV status and antiretroviral regimen, given potential drug interactions with hormonal methods.
10. Combining a highly effective contraceptive method with consistent condom use, preventing pregnancy and reducing transmission risk.

Part 4.3

11. Distinct needs reflecting developmental stage, evolving autonomy, and limited prior exposure to reproductive health information.
12. Fear of judgement or confidentiality breach, limited awareness, cost, and social or cultural stigma.
13. Age-appropriate, non-judgemental language, an opportunity to speak alone, and explicit honesty about confidentiality limits.
14. They offer high effectiveness independent of ongoing daily user action, well suited to adolescent circumstances.
15. Guided by assessment of individual maturity and capacity, balancing autonomy against relevant safeguarding responsibilities.

Part 4.4

1. Unmet need describes women with reproductive intentions to delay or stop childbearing who are not using contraception; met need describes those who are.
2. Limited knowledge, fear of side effects, and persistent myths and rumours about contraception.
3. Limited method choice, inadequate counselling, provider bias, stockouts, cost, and restrictive social norms.
4. Expanding method choice, improving counselling quality, reducing cost, community-based distribution, and myth-busting campaigns.
5. It expands the range of trained health workers authorised to provide methods, improving access in rural and underserved areas.

References and Attributions [Series 4]

Textual References

1. World Health Organization (2018). Family Planning: A Global Handbook for Providers (3rd ed.). WHO Press.

2. World Health Organization (2015). Medical Eligibility Criteria for Contraceptive Use (5th ed.). WHO Press.
3. National Population Commission and ICF (2019). Nigeria Demographic and Health Survey 2018. NPC and ICF.
4. World Health Organization (2018). WHO Consolidated Guideline on Self-Care Interventions for Health: Sexual and Reproductive Health and Rights. WHO Press.

Figures, Plates, Tables, and Boxes

1. Box 4.1: Dimensions of quality of care in family planning service delivery. AI-generated using the prompt: "Create a simple single-column reference box with an outside border titled Quality of Care in Family Planning, listing each dimension with a one-line description. Clinical reference box style."
2. Table 4.2: Contraceptive considerations for special populations. AI-generated using the prompt: "Create a clean reference table titled Contraception in Special Populations, listing chronic conditions, disability, and HIV with key considerations. Simple clinical reference table style with outside border."
3. Figure 4.3: Barriers, counselling approach, and the autonomy-safeguarding balance in adolescent family planning. AI-generated using the prompt: "Create a professional medical diagram titled Family Planning for Adolescents, showing barriers to access, counselling approach, and the autonomy-safeguarding balance. Clean clinical educational diagram style."
4. Box 4.4: Barriers to and strategies for addressing unmet need in family planning. AI-generated using the prompt: "Create a simple single-column reference box with an outside border titled Unmet Need: Barriers and Strategies, listing barriers and evidence-based strategies. Clinical reference box style."

Course code: OBG 502

Course title: Reproductive Health and Family Planning

Course credit load: 2 Units

Series 5: Population Dynamics and Gender Issues

- **Part 5.1: Population Dynamics and Demographic Transition**
  - Sub Part 5.1.1: Demographic transition theory
  - Sub Part 5.1.2: Nigeria's population structure and trends
  - Sub Part 5.1.3: Family planning and demographic transition
- **Part 5.2: Gender and Reproductive Health**
  - Sub Part 5.2.1: Gender roles and reproductive health decision-making
  - Sub Part 5.2.2: Gender inequality and its impact on reproductive health outcomes
  - Sub Part 5.2.3: Male involvement in family planning
- **Part 5.3: Gender-Based Violence: Recognition**
  - Sub Part 5.3.1: Definition, forms, and epidemiology of gender-based violence
  - Sub Part 5.3.2: Health consequences of gender-based violence
  - Sub Part 5.3.3: Clinical recognition of gender-based violence
- **Part 5.4: Responding to and Preventing Gender-Based Violence**
  - Sub Part 5.4.1: Clinical response and documentation
  - Sub Part 5.4.2: Referral pathways and support services
  - Sub Part 5.4.3: Prevention of gender-based violence and course synthesis

Introduction

In the last Series, we explored family planning services and the special populations who require particular, thoughtful attention. We conclude this course, and this entire journey through

Reproductive Health and Family Planning, by stepping back to consider the broader forces that shape reproductive health at a population level, demographic transition and population dynamics, and the gender dynamics, both everyday and, at their most serious, violent, that so profoundly influence every individual woman's reproductive choices and outcomes. This final Series asks you to see reproductive health not only as a clinical discipline but as a genuinely social and structural one.

The aim of this Series is to equip you with an understanding of population dynamics and demographic transition, the influence of gender on reproductive health, and the recognition, response to, and prevention of gender-based violence.

We shall commence this Series by examining population dynamics and demographic transition theory, including Nigeria's own population trends. Next, we will consider gender and reproductive health, including gender roles, inequality, and male involvement in family planning. Following that, our attention turns to the recognition of gender-based violence, its forms, epidemiology, and health consequences. Finally, we will conclude by examining the clinical response to and prevention of gender-based violence, bringing this course to a close.

Series Learning Outcomes

Upon completing this Series, you should be able to:

- **SLO 5.1:** describe demographic transition theory and Nigeria's population trends,
- **SLO 5.2:** describe the relationship between family planning and demographic transition,
- **SLO 5.3:** discuss the influence of gender roles and inequality on reproductive health outcomes,
- **SLO 5.4:** describe the role of male involvement in family planning,
- **SLO 5.5:** define gender-based violence and describe its forms, epidemiology, and health consequences,
- **SLO 5.6:** describe the clinical recognition and response to gender-based violence, and
- **SLO 5.7:** describe referral pathways and prevention strategies for gender-based violence.

5.1 Population Dynamics and Demographic Transition

5.1.1 Demographic transition theory

Demographic transition theory describes the characteristic pattern through which a population moves from high birth and death rates (stage one, historically typical of pre-industrial societies) through a period of declining death rates with initially sustained high birth rates, producing rapid population growth (stage two), to eventually declining birth rates (stage three) and, finally, low, roughly stable birth and death rates (stage four), a pattern observed with considerable consistency across many countries undergoing sustained economic and social development.

Nigeria is generally considered to remain within stage two of this demographic transition, characterised by declining mortality, particularly infant and child mortality, alongside a birth rate that, while showing some signs of gradual decline in certain regions, remains relatively high overall, producing the sustained, rapid population growth that continues to characterise the country's current demographic trajectory.

Fill in the blank: Demographic transition theory describes a population moving from stage one (high birth and death rates) through stage two (declining death rates with sustained _____ birth rates) to stage four. Nigeria is generally considered to remain within stage _____ of this demographic transition.

5.1.2 Nigeria's population structure and trends

Nigeria's population is characterised by a notably youthful age structure, with a substantial proportion of the population under the age of 15, reflecting the country's sustained high fertility rate, a structure that carries direct implications for future population growth momentum, as this large cohort of young people will themselves enter reproductive age over the coming decades, continuing to drive population growth even were fertility rates to decline more rapidly in the interim.

Understanding this population structure is genuinely essential for effective health system and broader development planning, as a youthful population structure creates substantial, sustained demand for maternal and child health services, education, and, eventually, employment opportunities, meaning that reproductive health and family planning programming cannot be considered in isolation from these genuinely broader, interconnected demographic and development planning considerations.

Fill in the blank: Nigeria's population has a notably _____ age structure, with a substantial proportion under the age of 15. This youthful structure creates substantial, sustained _____ for maternal and child health services, education, and employment.

5.1.3 Family planning and demographic transition

Access to family planning is widely recognised as a genuinely critical accelerator of the demographic transition, particularly the shift from stage two to stage three, enabling couples to align their actual fertility with their genuinely desired family size, which, in most settings undergoing sustained development, tends to decline over time as child mortality falls, female education expands, and the broader economic and social benefits of smaller families become increasingly apparent to individual couples themselves.

This relationship between family planning access and demographic transition operates in both directions, as declining fertility itself, once established as a broader social norm, further reinforces continued contraceptive use and smaller family size preferences within a community, illustrating why sustained, long-term investment in family planning access and broader female education together represent such a genuinely powerful, mutually reinforcing combination for accelerating Nigeria's own demographic transition.

Fill in the blank: Access to family planning enables couples to align their actual fertility with their genuinely desired family _____. The relationship between family planning access and demographic transition operates in both _____.

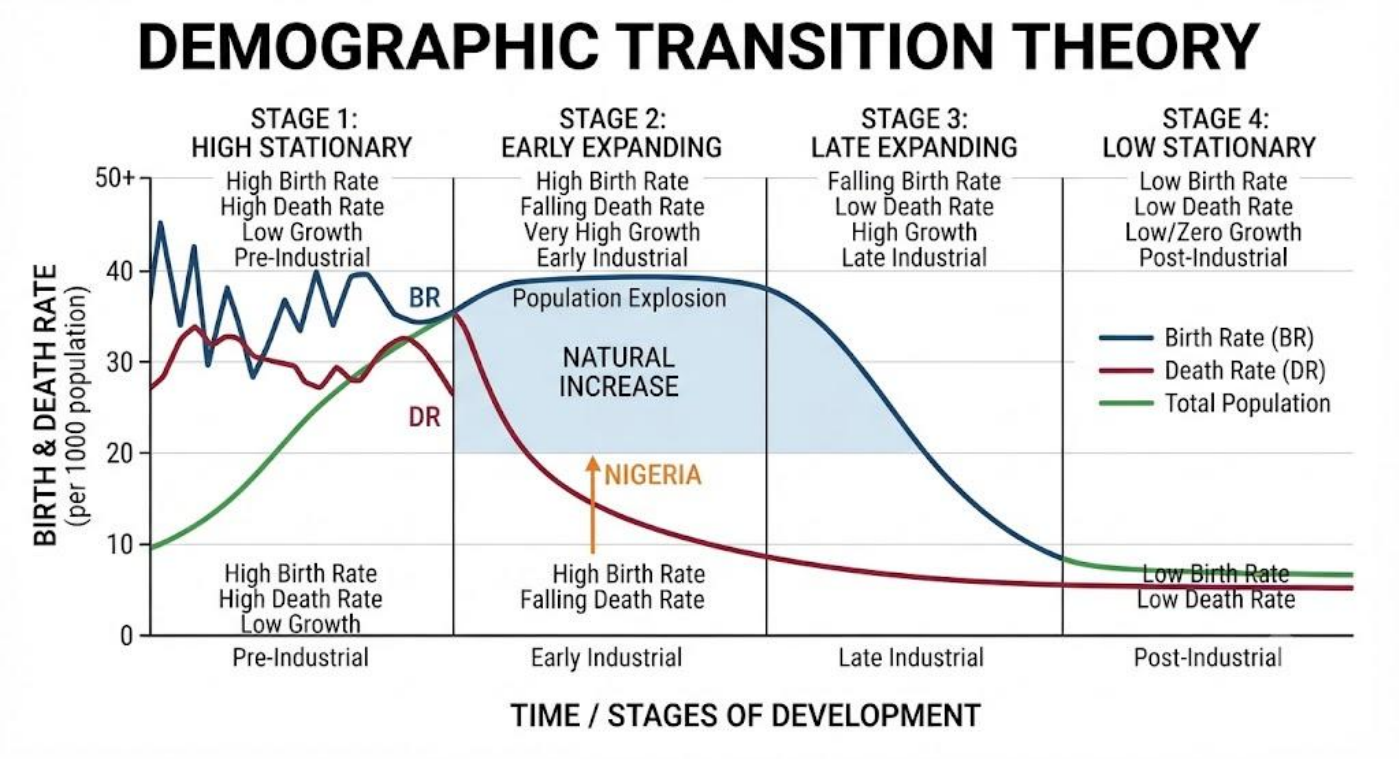

Figure 5.1: The four stages of demographic transition theory, with Nigeria's approximate current position.

Pilot questions 5.1

- Describe the four stages of demographic transition theory. (Linked to SLO 5.1)
- Describe Nigeria's current position within the demographic transition. (Linked to SLO 5.1)
- Describe Nigeria's population age structure and its implications. (Linked to SLO 5.1)

- Explain why family planning access is considered a critical accelerator of demographic transition. (Linked to SLO 5.2)
- Explain the bidirectional relationship between family planning access and demographic transition. (Linked to SLO 5.2)

5.2 Gender and Reproductive Health

5.2.1 Gender roles and reproductive health decision-making

Gender roles within a household or community substantially influence reproductive health decision-making, including whether and which contraceptive method is used, who attends antenatal care and when, and who ultimately makes decisions about family size, with women in many settings, including parts of Nigeria, having genuinely limited independent decision-making authority over these matters relative to their male partners or, in some family structures, senior female relatives.

Understanding these gender dynamics is essential for effective reproductive health programming, as counselling and service delivery approaches that fail to account for the genuine, lived decision-making context within a particular household or community risk being considerably less effective than those that are genuinely sensitive to, and appropriately work within or around, these existing gender-based power dynamics wherever they cannot be immediately and directly changed.

Fill in the blank: Gender roles substantially influence reproductive health decision-making, including who ultimately makes decisions about _____ size. Reproductive health programming must be genuinely sensitive to existing gender-based power _____ within a household or community.

5.2.2 Gender inequality and its impact on reproductive health outcomes

Gender inequality (including limited female education, restricted economic independence, and limited decision-making authority within relationships) is consistently and strongly associated with poorer reproductive health outcomes, including higher fertility rates, higher unmet need for family planning, and higher maternal mortality, reflecting how broader social and economic disempowerment translates directly into reduced ability to exercise genuine reproductive choice and access appropriate, timely healthcare.

Addressing gender inequality therefore represents a genuinely essential, though admittedly longer-term and more structurally challenging, component of comprehensive reproductive health strategy, extending well beyond the direct provision of clinical reproductive health services alone to encompass broader investment in female education, economic empowerment, and legal and

policy reform addressing discriminatory practices that continue to constrain women's genuine reproductive autonomy in many settings.

Fill in the blank: Gender inequality is consistently associated with poorer reproductive health outcomes, including higher fertility rates and higher maternal _____. Addressing gender inequality requires broader investment in female education, economic empowerment, and legal and _____ reform.

5.2.3 Male involvement in family planning

Male involvement in family planning, whether as a supportive partner in a woman's own contraceptive decision-making, or as a direct user of male-specific methods such as condoms or vasectomy, is consistently associated with improved contraceptive uptake and continuation, reflecting the genuine, practical reality that reproductive decisions in most relationships and households are rarely made by a woman in complete isolation from her partner's own views and level of support.

Programmatic strategies to increase male involvement include specifically targeted male-focused reproductive health education and outreach, actively inviting and welcoming male partners into family planning consultations wherever the woman herself desires this, and broader community engagement approaches that specifically and deliberately work to shift prevailing social norms around men's role and genuine responsibility in family planning decision-making, moving beyond a historically women-only framing of this shared reproductive responsibility.

Fill in the blank: Male involvement in family planning is consistently associated with improved contraceptive _____ and continuation. Programmatic strategies to increase male involvement include shifting prevailing social _____ around men's role in family planning.

Aspect	Key Details
Impact of Gender Roles	Traditional norms often place reproductive responsibility solely on women, limiting autonomy and access to care.
Inequality in Decision-Making	Male-dominated household decisions can restrict women’s ability to use contraception or seek health services.
Health Outcomes	Inequality contributes to higher maternal mortality, unmet need for family planning, and poor reproductive health indicators.
Strategies for Male Involvement	Promote couple counselling, community education, workplace programs, and policies encouraging shared responsibility in reproductive health.

Box 5.2: Gender, reproductive health outcomes, and strategies for male involvement.

Pilot questions 5.2

1. Describe how gender roles influence reproductive health decision-making. (Linked to SLO 5.3)
2. Describe the impact of gender inequality on reproductive health outcomes. (Linked to SLO 5.3)
3. Describe the broader strategies required to address gender inequality in reproductive health. (Linked to SLO 5.3)
4. Explain why male involvement in family planning is associated with improved contraceptive outcomes. (Linked to SLO 5.4)
5. Describe strategies used to increase male involvement in family planning. (Linked to SLO 5.4)

5.3 Gender-Based Violence: Recognition

5.3.1 Definition, forms, and epidemiology of gender-based violence

Gender-based violence is defined as any harmful act perpetrated against a person's will, based on socially ascribed gender differences, encompassing physical, sexual, psychological, and economic abuse, and occurring in multiple forms including intimate partner violence, sexual assault, harmful traditional practices such as female genital mutilation, and human trafficking, affecting individuals across all social, economic, and educational backgrounds, though certain populations face disproportionately elevated risk.

Gender-based violence remains substantially under-reported in most settings, including Nigeria, reflecting genuine fear of retaliation, social stigma, limited trust in the justice or health system's likely response, and, in some cases, direct economic or social dependence on the perpetrator, meaning that documented prevalence figures, however concerning in their own right, likely still substantially underestimate the true scale of this genuinely widespread public health and human rights problem.

Fill in the blank: Gender-based violence encompasses physical, sexual, psychological, and _____ abuse. Gender-based violence remains substantially _____-reported in most settings, meaning documented figures likely underestimate the true scale.

5.3.2 Health consequences of gender-based violence

The health consequences of gender-based violence are genuinely extensive, including direct physical injury, chronic pain syndromes, mental health conditions such as depression, anxiety, and post-traumatic stress disorder, adverse pregnancy outcomes when violence occurs during

pregnancy, sexually transmitted infection including HIV, and substantially increased use of healthcare services overall, reflecting the genuinely far-reaching, long-term physical and psychological toll that violence exacts on survivors well beyond any immediate, acute injury sustained.

Gender-based violence and reproductive health outcomes are closely, bidirectionally interconnected, with violence itself a recognised risk factor for unintended pregnancy (through coerced or non-consensual intercourse, or through direct interference with a partner's contraceptive use) and unsafe abortion, while, conversely, an unintended or unwanted pregnancy can itself, in some relationships, precipitate or worsen existing intimate partner violence, illustrating the genuinely complex, mutually reinforcing relationship between these two areas of reproductive health practice.

Fill in the blank: Gender-based violence is associated with health consequences including chronic pain, mental health conditions, and adverse _____ outcomes. Violence is a recognised risk factor for unintended pregnancy through coerced intercourse or interference with a partner's _____ use.

5.3.3 Clinical recognition of gender-based violence

Clinical recognition of gender-based violence requires genuine, sustained vigilance, as survivors frequently present with non-specific symptoms, such as chronic pain, recurrent attendance with vague complaints, or mental health symptoms, rather than directly disclosing violence, meaning routine, sensitive enquiry, in an appropriately private setting and delivered without judgement, should be considered as part of comprehensive reproductive health assessment more broadly, not reserved only for situations where violence is already strongly suspected on other clinical grounds.

Specific clinical signs that should raise suspicion include injuries inconsistent with the explanation given, injuries at different stages of healing suggesting repeated episodes, a partner reluctant to leave the consultation or who repeatedly answers questions on the woman's behalf, and delayed presentation for treatment of an injury, each warranting further, sensitive exploration during the clinical encounter rather than being dismissed or overlooked as clinically insignificant or unrelated to the woman's presenting reproductive health concern.

Fill in the blank: Survivors of gender-based violence frequently present with non-specific symptoms rather than directly _____ violence. Injuries at different stages of _____ suggest repeated episodes of violence.

Form	Key Health Consequences	Clinical Warning Signs
Physical Abuse	Injuries, chronic pain, disability, increased risk of maternal complications.	Unexplained bruises, fractures, repeated injuries, delay in seeking care.

Form	Key Health Consequences	Clinical Warning Signs
Sexual Abuse	STIs including HIV, unwanted pregnancy, genital trauma, psychological distress.	Genital injuries, recurrent STIs, fearfulness during examination, avoidance of sexual health services.
Psychological Abuse	Depression, anxiety, PTSD, substance misuse, suicidal ideation.	Flat affect, hypervigilance, inconsistent history, unexplained somatic complaints.
Economic Abuse	Poor access to healthcare, malnutrition, dependency, increased vulnerability to exploitation.	Missed appointments, inability to afford medications, reliance on partner for financial decisions.

Table 5.3: Forms, health consequences, and clinical warning signs of gender-based violence.

Pilot questions 5.3

1. Define gender-based violence and describe its various forms. (Linked to SLO 5.5)
2. Explain why gender-based violence remains substantially under-reported. (Linked to SLO 5.5)
3. Describe the health consequences of gender-based violence. (Linked to SLO 5.5)
4. Describe the bidirectional relationship between gender-based violence and reproductive health outcomes. (Linked to SLO 5.5)
5. Describe the clinical signs that should raise suspicion of gender-based violence. (Linked to SLO 5.6)

5.4 Responding to and Preventing Gender-Based Violence

5.4.1 Clinical response and documentation

Clinical response to a disclosure or suspicion of gender-based violence should be calm, non-judgemental, and genuinely centred on the woman's own safety and autonomy, offering appropriate treatment for any injury or health consequence identified, and careful, objective documentation, recording the woman's own words in quotation marks wherever possible, a detailed and precise description of any injuries, and the clinician's own objective observations, explicitly separated from any interpretation or conclusion.

This documentation may later serve an important role in legal or protective proceedings, and safety assessment, including specific, sensitive enquiry about escalating risk factors such as previous strangulation, threats to kill, or access to weapons, should be undertaken wherever gender-based violence is disclosed or genuinely suspected, directly informing subsequent, urgent safety planning discussions with the woman herself.

Fill in the blank: Clinical documentation should record the patient's own words in _____ wherever possible, separated from any interpretation. Safety assessment includes enquiry about escalating risk factors such as previous strangulation or access to _____.

5.4.2 Referral pathways and support services

Effective response to gender-based violence requires clear, well-understood referral pathways to specialist support services, including counselling and psychological support, legal aid and advocacy, shelter and safe accommodation where genuinely needed, and, where children are involved or the risk is judged serious, appropriate child safeguarding referral, always respecting the woman's own autonomy to make informed decisions about accepting or declining each specific referral offered.

Multisectoral coordination between health, justice, social welfare, and community-based organisations meaningfully improves the overall response to gender-based violence, as no single sector can adequately address every dimension of a survivor's genuinely complex, multifaceted needs alone, reinforcing why healthcare providers should be genuinely familiar with local referral pathways and resources available within their own specific practice setting.

Fill in the blank: Effective response requires clear referral pathways to counselling, legal aid, and shelter, always respecting the woman's own _____ to accept or decline each referral. Multisectoral _____ between health, justice, and social welfare improves the overall response.

5.4.3 Prevention of gender-based violence and course synthesis

Prevention of gender-based violence requires genuinely sustained, long-term investment addressing its deeply rooted social and structural drivers, including gender inequality, harmful social norms around masculinity and violence, and broader economic disempowerment of women, with community-level education programmes, engagement of men and boys as genuine partners in prevention efforts, and supportive legal and policy frameworks together forming a comprehensive, evidence-based prevention strategy operating well beyond the clinical encounter alone.

As we conclude this course on Reproductive Health and Family Planning, it is worth recognising how closely gender-based violence, addressed in this final Series, connects back to every topic explored throughout: the reproductive rights established in our very first Series, the contraceptive autonomy at the heart of Series 3, and the family planning access explored in Series 4, together illustrating that reproductive health can never be genuinely and fully achieved

without also addressing the broader gender equity within which every individual reproductive health decision and encounter ultimately takes place.

Fill in the blank: Prevention of gender-based violence requires addressing deeply rooted social and structural drivers, including gender _____ and harmful social norms. Reproductive health can never be genuinely achieved without also addressing broader gender _____.

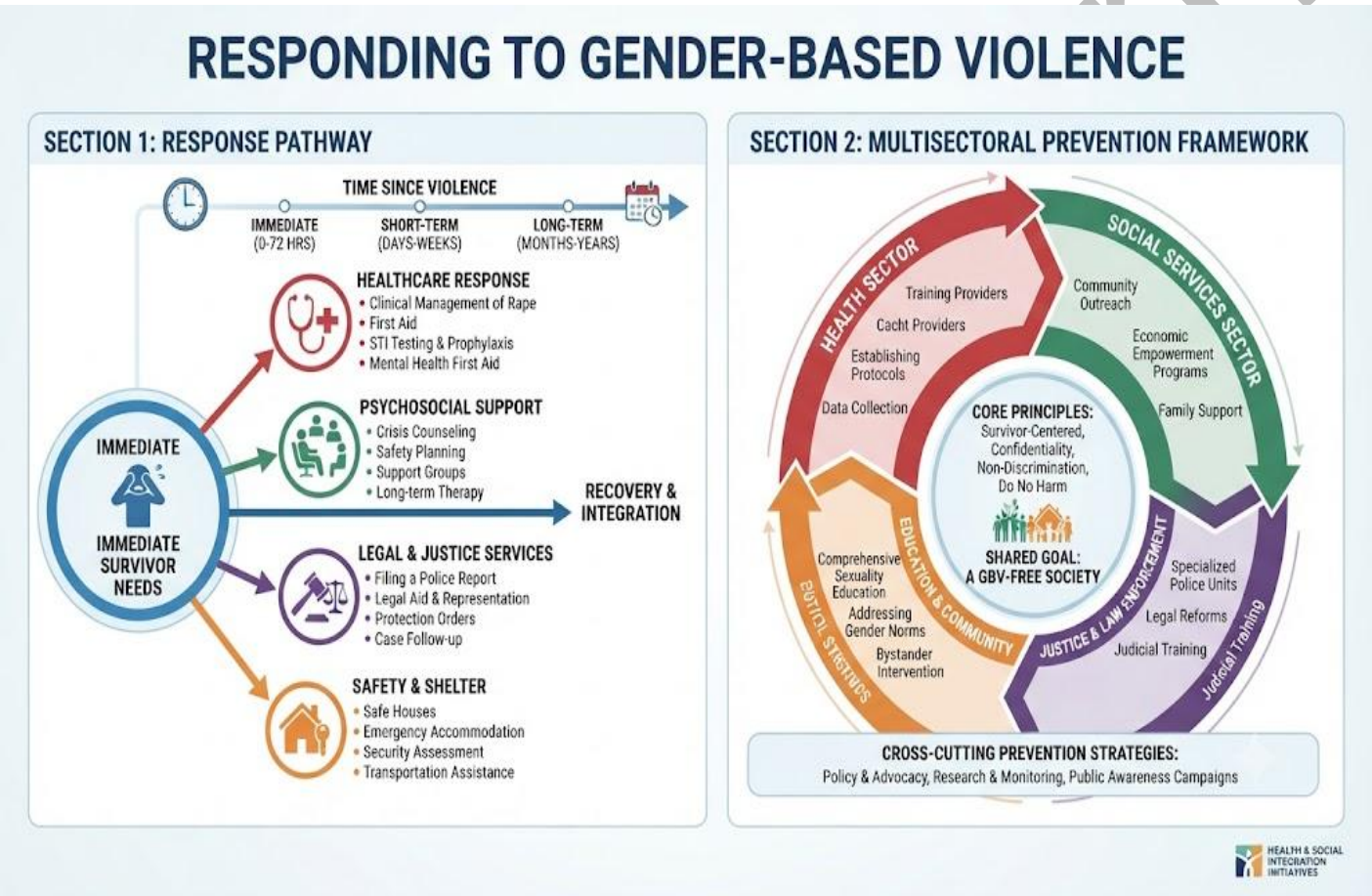

Figure 5.4: Clinical response pathway and the multisectoral prevention framework for gender-based violence.

Pilot questions 5.4

1. Describe the principles of clinical response and documentation for gender-based violence. (Linked to SLO 5.6)
2. Describe the components of safety assessment following disclosure of gender-based violence. (Linked to SLO 5.6)
3. Describe the referral pathways relevant to gender-based violence. (Linked to SLO 5.7)

4. Explain the value of multisectoral coordination in responding to gender-based violence. (Linked to SLO 5.7)
5. Describe the strategies required to prevent gender-based violence at a population level. (Linked to SLO 5.7)

Series Summary

This Series has covered population dynamics and demographic transition theory, including Nigeria's own population trends, followed by gender and reproductive health, including gender roles, inequality, and male involvement in family planning. It went on to examine the recognition of gender-based violence, its forms, epidemiology, and health consequences, before concluding with the clinical response to and prevention of gender-based violence, bringing this course on Reproductive Health and Family Planning to a close.

You should now be able to describe demographic transition theory and Nigeria's population trends, describe the relationship between family planning and demographic transition, discuss the influence of gender on reproductive health, define gender-based violence and describe its consequences, and describe the clinical response, referral, and prevention of gender-based violence (Linked to SLOs 5.1 to 5.7).

Glossary of Terms

1. **Demographic dividend:** the potential economic growth benefit when a population's working-age proportion grows relative to its dependent proportion.
2. **Demographic transition theory:** a theory describing the characteristic pattern of population change from high to low birth and death rates.
3. **Gender-based violence:** any harmful act perpetrated against a person's will, based on socially ascribed gender differences.
4. **Gender inequality:** unequal social, economic, or decision-making status between genders, associated with poorer reproductive health outcomes.
5. **Intimate partner violence:** a form of gender-based violence occurring between individuals in a current or former intimate relationship.

6. **Male involvement:** the participation of men as supportive partners or direct users in family planning decision-making and practice.
7. **Multisectoral coordination:** collaboration between health, justice, social welfare, and community organisations in responding to a complex problem.
8. **Population structure:** the age and sex composition of a population at a given point in time.
9. **Safety assessment:** structured enquiry about risk factors for escalating violence, informing safety planning.
10. **Total fertility rate:** the average number of children a woman would have over her reproductive lifetime, based on current age-specific fertility rates.
11. **Female genital mutilation:** a harmful traditional practice involving partial or total removal of external female genitalia, a recognised form of gender-based violence.
12. **Youthful age structure:** a population age distribution with a high proportion of young people, typical of a country in early demographic transition.

Concept Check Questions [Series 5]

Objective questions

- Nigeria is generally considered to remain within stage _____ of the demographic transition.
- Nigeria's population has a notably _____ age structure, with a substantial proportion under the age of 15.
- Gender inequality is consistently associated with poorer reproductive health outcomes, including higher maternal _____.
- Gender-based violence encompasses physical, sexual, psychological, and _____ abuse.
- Clinical documentation should record the patient's own words in _____ wherever possible.

Short-answer questions

1. Explain why family planning access is considered a critical accelerator of demographic transition. (Linked to SLO 5.2)
2. Describe the impact of gender inequality on reproductive health outcomes. (Linked to SLO 5.3)
3. Explain why gender-based violence remains substantially under-reported. (Linked to SLO 5.5)
4. Describe the bidirectional relationship between gender-based violence and reproductive health outcomes. (Linked to SLO 5.5)
5. Describe the components of safety assessment following disclosure of gender-based violence. (Linked to SLO 5.6)

Long-answer questions

6. Describe demographic transition theory and the relationship between family planning and demographic transition. (Linked to SLO 5.1, SLO 5.2)
7. Discuss the influence of gender roles, inequality, and male involvement on reproductive health outcomes. (Linked to SLO 5.3, SLO 5.4)
8. Define gender-based violence and describe its forms, epidemiology, and health consequences. (Linked to SLO 5.5)
9. Describe the clinical recognition and response to gender-based violence. (Linked to SLO 5.6)
10. Describe referral pathways and prevention strategies for gender-based violence. (Linked to SLO 5.7)

Answers to Concept Check Questions [Series 5]

Objective questions

11. Two.
12. Youthful.
13. Mortality.

14. Economic.
15. Quotation marks.

Short-answer questions

16. It enables couples to align actual fertility with desired family size, which tends to decline with development.
17. Higher fertility rates, higher unmet need for family planning, and higher maternal mortality.
18. Fear of retaliation, social stigma, limited trust in system response, and economic or social dependence on the perpetrator.
19. Violence is a risk factor for unintended pregnancy and unsafe abortion, while unwanted pregnancy can itself precipitate violence.
20. Enquiry about escalating risk factors such as previous strangulation, threats to kill, or access to weapons.

Long-answer questions

21. **Basic response:** Demographic transition theory describes population change through four stages, with family planning access accelerating the shift towards lower fertility.

Value-added response: Nigeria remains in stage two, with a youthful population structure carrying substantial implications for future health and development planning.

22. **Basic response:** Gender roles and inequality substantially influence reproductive health decision-making and outcomes, while male involvement improves contraceptive uptake.

Value-added response: Addressing gender inequality requires broader investment in education and economic empowerment, not clinical services alone.

23. **Basic response:** Gender-based violence encompasses multiple forms with extensive health consequences, requiring vigilant clinical recognition and a sensitive, structured response.

Answers to Pilot Questions [Series 5]

Part 5.1

1. Stage one (high birth and death rates), stage two (declining death rates, high birth rates), stage three (declining birth rates), stage four (low, stable rates).
2. Nigeria remains within stage two, with declining mortality and a birth rate remaining relatively high overall.
3. A notably youthful structure with a substantial proportion under 15, carrying implications for future growth and service demand.
4. It enables couples to align actual fertility with desired family size, which tends to decline with development.
5. Declining fertility itself reinforces continued contraceptive use and smaller family size preferences within a community.

Part 5.2

6. Gender roles influence method use, antenatal attendance, and who ultimately makes decisions about family size.
7. Higher fertility rates, higher unmet need for family planning, and higher maternal mortality.
8. Investment in female education, economic empowerment, and legal and policy reform addressing discriminatory practices.
9. Reproductive decisions are rarely made by a woman in complete isolation from her partner's views and support.
10. Male-focused education and outreach, inviting partners into consultations, and shifting social norms around men's role.

Part 5.3

11. Any harmful act based on socially ascribed gender differences, including physical, sexual, psychological, and economic abuse.

12. Fear of retaliation, social stigma, limited trust in system response, and economic or social dependence on the perpetrator.
13. Physical injury, chronic pain, mental health conditions, adverse pregnancy outcomes, and sexually transmitted infection.
14. Violence is a risk factor for unintended pregnancy and unsafe abortion, while unwanted pregnancy can itself precipitate violence.
15. Inconsistent injury explanations, injuries at different healing stages, a reluctant or overly present partner, and delayed presentation.

Part 5.4

1. Calm, non-judgemental response, treatment of health consequences, and careful, objective documentation.
2. Enquiry about escalating risk factors such as previous strangulation, threats to kill, or access to weapons.
3. Counselling, legal aid, shelter, and safeguarding referral, respecting the woman's autonomy to accept or decline each.
4. No single sector can address every dimension of a survivor's complex needs alone, so coordinated response improves outcomes.
5. Community education, engagement of men and boys, and supportive legal and policy frameworks addressing root causes.

References and Attributions [Series 5]

Textual References

1. National Population Commission and ICF (2019). Nigeria Demographic and Health Survey 2018. NPC and ICF.
2. World Health Organization (2013). Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines. WHO Press.
3. United Nations Population Fund (2020). State of World Population 2020. UNFPA.

4. World Health Organization (2018). Family Planning: A Global Handbook for Providers (3rd ed.). WHO Press.

Figures, Plates, Tables, and Boxes

1. Figure 5.1: The four stages of demographic transition theory, with Nigeria's approximate current position. AI-generated using the prompt: "Create a professional diagram titled Demographic Transition Theory, showing birth and death rate curves across four stages with Nigeria's position marked. Clean clinical educational diagram style."
2. Box 5.2: Gender, reproductive health outcomes, and strategies for male involvement. AI-generated using the prompt: "Create a simple single-column reference box with an outside border titled Gender and Reproductive Health, listing key impacts and male involvement strategies. Clinical reference box style."
3. Table 5.3: Forms, health consequences, and clinical warning signs of gender-based violence. AI-generated using the prompt: "Create a clean reference table titled Gender-Based Violence: Forms, Consequences, and Warning Signs, listing key details for each category. Simple clinical reference table style with outside border."
4. Figure 5.4: Clinical response pathway and the multisectoral prevention framework for gender-based violence. AI-generated using the prompt: "Create a professional medical diagram titled Responding to Gender-Based Violence, showing the response pathway and a multisectoral prevention framework. Clean clinical educational diagram style."