

**Clinical Practice Guidelines
for the Delivery of
Contraceptive Health
Services by Registered Nurses**

June 2011

Acknowledgments

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EXECUTIVE SUMMARY

Currently Manitoba has one of the highest teen pregnancy rates in Canada (64.4/1000) with 7 adolescents a day becoming pregnant. In 1995/96 Manitoba spent over \$71,000,000 to support teen parents. The impact of adolescent pregnancy has implications not only for the adolescent but for the family, community and society as a whole both socially and financially. We currently know that for every adolescent pregnancy delayed there is a cost saving of \$20,000/year, while every \$1 spent on prevention equals \$10 saved (abortions/income support). Access to culturally appropriate, evidence informed sexual health programs in all regions across Manitoba is essential in addressing the current realities of Manitoba's teen pregnancy rate. In order to make informed choices about sexuality, teens/young adults require information about their sexual health as well as access to appropriate reproductive health services, including contraception (Cherry and Dillon, 2001).

In the document *The Role of the Public Health Nurse within the Regional Health Authority* (Oct 1998), Manitoba Health identified the provision of reproductive health services as a core service provided by all of Manitoba's Regional Health Authorities. Under the Canada Health Act, provinces are obligated to ensure that all insured residents have universal access to services. This need challenges the system to insure that the appropriate provider is providing appropriate services at the appropriate time to the appropriate clients. Nurses working on in Public Health and Primary Care settings have a long history of providing sexual and reproductive health care to vulnerable populations. Current, evidence-informed, clinical practice guidelines are needed to provide standards for the delivery of this service, to encourage and enhance inter-disciplinary collaboration and to enable the registered nurse to work to the full scope of their practice. The Public Health Managers Network identified in 2007, the need for consistent, evidence-informed clinical practice guidelines to support sexual and reproductive health programs offered by nurses working in community and primary care settings throughout Manitoba. Nurses in community and primary care settings have been providing contraceptive services and supplies to their clients for many decades. The majority of services were "add-on" services that quietly evolved to meet the needs of youth and adults who were having difficulty

accessing services and supplies due to geographic isolation, lack of community options, privacy concerns or financial need. Services often relied on the expertise of key senior staff and lacked official program status. An Environmental Scan done in 2009 revealed that many programs did not have written clinical practice guidelines or generally referred to the Society of Obstetricians and Gynecologists of Canada's guidelines or were using an adaptation of the Provincial 2002 draft Reproductive Health Guidelines

The scan also revealed that many nurses were working in isolation without the support of an inter-disciplinary team. Approximately two-thirds of the scan respondents indicated that their programs had no or only limited access to physician support, even on a consultative basis. Also, two-thirds had no or only some access to clinical pharmacy support. Many respondents indicated that sexual and reproductive health care was only a small portion of their practice. The scan highlighted the need for evidence-informed clinical practice guidelines, particularly for nurses with independent practice that do not have easy access to an inter-disciplinary team for clinical support or who may not have an opportunity to draw on their knowledge of sexual and reproductive health issues on a frequent basis.

The scan also highlighted inconsistency across Manitoba with regards to basic elements of a comprehensive sexual and reproductive health program, specifically, access to emergency contraception and screening pregnancy testing. Approximately one-third of respondents were not able to offer Plan B[®] or pregnancy testing.

GOAL

The Clinical Practice Guidelines for Contraceptive Health Services by Registered Nurses are intended to assist nurses, working in Public Health, Community Health and Primary Care settings, throughout Manitoba. The goal is to provide current, evidence-informed clinical practice guidelines that can be implemented across all Regional Health Authorities or community agencies. They support nurses working to their full scope of practice, thereby improving access to contraceptive health services and supplies for vulnerable populations.

GUIDELINES

The Guidelines and accompanying Appendices provide a framework for care that supports:

- Client-centered model that offers nonjudgmental and respectful care
- Inter-disciplinary team collaboration, (both within and across programs)
- Registered nurses (nurses) working to full scope of practice
- Integration of web based resources and a comprehensive care model to address the complexities of sexual/contraceptive health, including:
 - Access to Contraceptive Supplies and Services
 - Healthy Relationships
 - Clinical Assessment
 - Informed Consent
 - Client Education
 - Hormonal and Non-hormonal Contraception
 - Contraception for Clients who are Postpartum or Breastfeeding
 - Young Men’s Sexual and Reproductive Health
 - Clinical Documentation
 - Persons Living with Intellectual Disability and Reproductive Health Services
 - Lesbian, Gay, Transgender, Transsexual, Two-spirited, Intersex, Queer and Questioning Community
 - Child Welfare Reporting

SUMMARY

The development of evidence–informed clinical practice guidelines offers a clinical resource and framework. Guidelines are an important step in building a comprehensive, sustainable program. They provide opportunity to support providers to work to their full scope of practice as part of an inter-disciplinary team, insure that programs are founded in current evidence and ultimately provide clients with quality health care. All new guidelines require an implementation plan which includes not only provider orientation but strategies to sustain ongoing quality care. Quality care is sustained by providing opportunities for continuous learning and a mechanism for

guideline updates, review and evaluation. These Clinical Practice Guidelines were developed at the request of the Health Programs and Services Executives' Network (HPSEN).

Although HPSEN identified a need to address contraceptive services across Manitoba and has endorsed these guidelines, it does not have the mandate to insure that they become the basis for contraceptive health services across Manitoba. This will require the commitment from all Regional Health Authorities and each agency/program that offers contraceptive health services. These guidelines are the starting point for individual programs to begin this discussion.

Clinical Practice Guidelines For The
Delivery of Contraceptive Health Services by Registered Nurses

INTRODUCTION

PURPOSE

To support the Registered Nurse in the provision of contraceptive health services with evidence-informed clinical practice guidelines.

GOAL

- To provide evidence-informed clinical practice guidelines to support the scope of practice of Registered Nurses providing contraceptive health services.
- To increase access to contraceptive health services for vulnerable populations through the effective and efficient use of resources. Resources include the inter-disciplinary team of health care providers, services and contraceptive supplies.

SCOPE

All references to nurses, assumes Registered Nurses (RNs) without prescribing privileges. It is also assumed that when a nurse is using the guidelines, their employer has endorsed and adopted them as the basis for care within their program.

For the purposes of the guidelines, contraceptive and reproductive health services are used interchangeably.

The guidelines support the nurse's role in providing comprehensive contraceptive health services within an inter-disciplinary team. The guidelines are intended for use by nurses working in Public Health, Community Health, and Primary Care settings throughout Manitoba where contraceptive health services are provided. Nurses working in hospital settings may also find the guidelines helpful.

The assessment and management of pregnancy, prenatal care, sexually transmitted infections and cervical screening are not covered of these guidelines. Refer to Manitoba Health's *Communicable Disease Management Protocols*, <http://www.gov.mb.ca/health/publichealth/cdc/protocol/>; and the Manitoba Cervical Cancer Screening Program's *Screening Guidelines*, http://www.cancercare.mb.ca/resource/File/MCCSP/HealthCareProfessional/MCCSP_Guideline_Chart_Jan10.pdf.

As new information and resources become available, please refer to the most current edition of the guidelines as posted on the Sexuality Education Resource Centre web page, <http://www.serc.mb.ca/>.

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BACKGROUND

People are sexual beings from conception. They need to develop attitudes, knowledge and skills to support their achievement of sexual and reproductive health (Marston & King, 2007).

Manitoba Health has identified reproductive health services as a core component of prevention and community health services. Reproductive health care for both women and men can benefit

not only the individual, but also partner(s) and family (Guttmacher Institute, 2002). Reproductive health services include a continuum of services based on harm reduction, health promotion and illness prevention. These services are not mutually exclusive. Providing care that is comprehensive and pro-active with an approachable, respectful, nonjudgmental and caring attitude will assist individuals to achieve improved sexual and reproductive health. (Black, Francoeur & Rowe, 2004).

Collaborative Practice

There is research and consultation in Canada to improve client care and safety within a complex healthcare system (Baker, 2004; Romanow, 2002). There is currently an evidence-based movement across the country toward inter-disciplinary teams of healthcare providers working collaboratively to provide client-centered care (Health Force Ontario, 2007). Inter-disciplinary collaborative client-centered care facilitates client goals, improves communication among healthcare providers, fosters respect for healthcare providers' contributions, and optimizes participation in clinical decision-making. Emerging evidence supports the contribution of collaborative client-centered practice to improve client health outcomes by facilitating access to healthcare, fostering the provision of quality care and quality improvement, enhancing client and healthcare provider satisfaction and improving client safety (Enhancing Interdisciplinary Collaboration in Primary Health Care, 2007). Inter-disciplinary collaborative client-centered practice requires healthcare providers practice to their full scope, to understand both the unique and shared competencies of all team members and to communicate effectively in decision-making to meet client goals and improve health outcomes (Canadian Nurses Association, 2006). Each work-place setting is unique and comprised of individuals from a variety of disciplines. Health care providers are encouraged to understand the role of each team member, including community resources such as pharmacists, physicians, social workers.

Scope of Nursing Practice

In Manitoba, the Registered Nurses Act legislated authority to the College of Registered Nurses of Manitoba (CRNM, 2009) to set standards of practice for RNs. Throughout this guideline, all references to nurses, implies Registered Nurses. It is the responsibility of all nurses in Manitoba to understand these standards and apply them to their own nursing practice, regardless of roles or practice settings. Refer to <http://www.crnmb.ca/>. The indicators for standards of practice for nurses providing reproductive health care include (but not limited to):

- Using critical thinking to assess client status and responding to actual or potential health problems or health promotion needs, and planning nursing interventions with a client-centered focus.
- Assisting clients to obtain appropriate information and services.
- Supporting clients to make informed decisions.

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- Using critical thinking to perform interventions safely and accurately, evaluating outcomes, and modifying interventions according to evaluations.
- Communicating and consulting with clients, the nursing team, and other members of the health care team for the delivery of safe, competent, and ethical care.

Currently in Manitoba, RNs cannot prescribe medication. The oral emergency contraceptive pill (Plan B[®], NorLevo[®]) does not require a prescription and is available over-the-counter at any retail outlet with a pharmacy. To provide oral emergency contraceptive is within the scope of practice of a nurse.

Urine pregnancy screening/testing is within the scope of practice of a nurse.

REQUIRED READING

The Society of Obstetricians and Gynaecologists of Canada (SOGC) clinical practice guidelines related to contraception, are key references. Nurses providing reproductive health services related to contraception must be aware of the SOGC guidelines, available at http://www.sogc.org/guidelines/index_e.asp.

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TITLE Access to Contraceptive Health Services	AUTHORIZED BY Public Health Managers Network and Health Programs and Services Executives' Network (HPSEN)	PAGE 11 of 101

GOAL

- Nurses will provide access to comprehensive, non-judgmental and confidential contraceptive health services and supplies, particularly for individuals and populations who face barriers in obtaining contraceptive health care e.g. individuals and/or communities who experience:
 - Power inequities or
 - Economic hardship/poverty or
 - Marginalized or stigmatized circumstances.
- Nurses will use consistent and sustainable eligibility criteria for no-cost/low-cost contraceptive health care supplies.

BACKGROUND

There are significant barriers to accessing contraceptive health services, including supplies. These barriers are influenced by a number of factors in programs, with service providers, clients, governments, and industry. Access to services are also influenced by social, cultural and economic environments (Fisher, Dunn & Lalonde, 2004).

DEFINITION

Formulary: refers to *The Manitoba Drug Benefits and Interchangeability Formulary* which lists medications that have been approved as eligible benefits under the Pharmacare drug benefit program (<http://www.gov.mb.ca/health/mdbif/index.html>). The Manitoba Formulary is the basis for most third party extended health benefit programs, including Employment and Income Assistance and Treaty/First Nations Inuit Health Branch.

RECOMMENDATIONS FOR SERVICES

- 1.0 The nurse should assess for barriers that can limit access to contraceptive health services and supplies, including economic, environmental, social and systemic barriers (Fisher, Dunn & Lalonde, 2004) e.g.:
 - Adolescents may be more reluctant to access health care services than older adults due to a number of factors such as their own developmental level/stage; difficulty acknowledging their sexuality and related activity; lack of knowledge about reproductive biology and health; and/or fear of medical procedures. Access can also be hindered by concerns related to being accepted by the health care provider in a confidential, respectful

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and non-judgmental manner. (Fleming, Morris, Pymar & Smith, 2004). (Refer to the Informed Consent Guideline re: personal health information privacy, informed consent, reporting obligations and exceptions to privacy).

- People with disabilities and their caregiver(s), may more frequently not anticipate, expect or plan sexual activity. Due to lack of knowledge about reproductive health and lack of access to appropriate contraceptive supplies (Fleming, Morris, Pymar & Smith, 2004). (See Appendix A for additional information).
- People of the Lesbian, Gay, Bisexual, Transgender, Transsexual, Two-spirited, Intersex, Queer and Questioning communities (LGBTTTIQ)) more frequently experience stigma; heterosexism and/or a tendency by health care providers to not anticipate their contraception needs (Gay and Lesbian Medical Association, 2006).
- Males are perceived to not want reproductive health services or contraceptive information beyond the prevention of sexually transmitted infections (Lindenberg, Sonfield & Gemmill, 2008).
- Youth who are street-involved more frequently experience lower access to services due to disparities in the determinants of health (Hathazi, Lankenau, Sanders & Bloom, 2009).
- Women may experience power inequities that can negatively impact their ability to access contraceptive health services (Health Canada, 1997).

2.0 The nurse should develop services that decrease barriers for the targeted population(s).

- 2.1. Make services available in accessible locations and during accessible times e.g. health clinics in schools; evening service hours (Fleming, Morris, Pymar & Smith, 2004).
- 2.2. Proactively communicate the purpose, availability and benefits of reproductive health services using tools/technology that reach targeted population(s).
- 2.3. Structure the environment of contraceptive health services to be proactive and welcoming of targeted populations by:
 - Providing gender neutral washrooms.
 - Displaying statements related to equal access for all people/genders/sexual orientations for staff and clients.
 - Displaying and having available educational resources for clients that support diversity in gender and/or sexual orientation.
 - Using inclusive language on forms (male, female & transgender; various options for relationship status and significant others).
- 2.4. Advocate for changing government and industry-related issues that decrease access to reproductive health supplies (Fisher, Dunn & Lalonde, 2004).

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3.0 The nurse should provide inclusive services.

3.1. Provide care as a collaborative partnership between practitioner and client (Fleming, Morris, Pymar & Smith, 2004).

3.2. Validate various types of relationships (Fisher, Dunn & Lalonde, 2004).

- Ask the client about relationships, who is important for her/him and how (s)he refers to her/his partner(s).
- Ask about sexual orientation, gender identity and sexual behaviours without heterosexual assumptions.
- Avoid assuming that sexual orientation is a health issue for the client.

4.0 The nurse should facilitate access to no-cost/low-cost contraceptive health supplies based on uniform eligibility criteria.

4.1. The nurse should facilitate access to contraceptive health supplies by:

- Discussing with client contraceptive options including client preference, prescription/non-prescription options, health risk-factors, options available in community, cost and ability of the client to obtain their contraceptive option.
- Asking the client if they purchase their own prescription medications. Having a cost-comparison list available for your local area to share with clients in order to facilitate discussion. If client pays for prescriptions, inform client to consider Pharmacare application.
- Determining eligibility for no-cost/low-cost contraceptive supplies based on client needs. There is no standard, reliable financial-means test to determine eligibility. Clients' that could be eligible include those who state they are unable to use a reliable method of contraception because they either lack third-party coverage, are unable to access third-party coverage due to confidentiality concerns, are unable to purchase supplies or are unable to access local retail outlets due to privacy concerns. No-cost/low-cost contraceptive supply programs are intended to assist individuals who are marginalized or vulnerable, may be learning how to budget and plan for their health needs, are experiencing economic hardship or power inequities that may make accessing contraception challenging.
- Ask client who pays for their prescription medications:
 - If the client indicates that their medications are paid for by Employment and Income Assistance or Treaty/First Nations Inuit Health Branch, then medications on the Manitoba Health Formulary are covered. Refer to <http://www.gov.mb.ca/health/mdbif/index.html> or community pharmacist for assistance related to prescription coverage.
 - If the client indicates that they may have extended health benefits, work with the client to contact the pharmacy to determine which contraceptives are

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eligible and how billing/payment to the pharmacy occurs. For the younger client, this may be the first time they are accessed health care services without their parents' or guardians' assistance and may be unaware of their extended health benefits. Asking about parental employment and potential third party coverage and their ability to ask their parent, may be useful in determining coverage by extended health benefits. Some employee benefit plans may require the employee's signature and thus present a barrier for youth who are unable to discuss their reproductive health needs with their parent or guardian.

- Discussing with client their future ability to budget for their contraceptive needs.
- Reassessing the client's need for no-cost/low-cost supplies at each client visit. This ongoing dialogue will help to build capacity with the client to budget for future contraceptive supplies. Document the client's eligibility status and plan.
- Although the SOGC Compassionate Contraceptive Assistance Program is available for prescribing physicians. It has limited contraceptive options available, offers limited quantities and has a significant turn around time for requests. For more information refer to http://www.sogc.org/projects/ccap_e.asp.

4.2. The program can facilitate access by:

- Having no-cost/low-cost contraceptive supplies available, in a range of options to best meet the needs of a variety of clients (who face barriers in obtaining reproductive health supplies) including:
 - Urine pregnancy testing kits.
 - Condoms.
 - Emergency contraceptives – oral formulation.
 - Combined hormonal contraceptive options - oral pills with a range of estrogen doses and progestin formulations, transdermal patch and intra-vaginal ring.
 - Progestin-only contraceptives - oral & injectable Depot-medroxyprogesterone acetate (DMPA).
 - Intrauterine Devices – copper and /or progesterone options. (See Appendix B).
- Purchasing lower cost hormonal contraceptive formulation whenever possible thereby maximizing access for the largest number of clients.
- Minimizing the number of formulations to streamline processes.
- Choosing a model for distribution of supplies. There is not a “best practice” model for no-cost/low-cost programs. For example, one agency and client base may suit a cost-recovery or donation model while another agency and client base may suit a no-cost model. Programs may choose to set a limit on the number of no-cost/low-cost supplies provided at one time. It is recommended that programs have flexibility to allow for individual client circumstances.

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- Developing a cost comparison list for contraceptive options in your local area to share with clients.

RECOMMENDED READING

Fisher, W., Dunn, S. and LaLonde, A. (2004). Contraceptive care and access. *Journal of Obstetrics and Gynaecology Canada*, 26(2), 148-153. Retrieved from www.sogc.org.

Fleming, N., Morris, M., Pymar, H., Smith, T. (2004). Contraception-Meeting special needs. *Journal of Obstetrics and Gynaecology Canada*, 143, 378-379. Retrieved from www.sogc.org.

Nova Scotia Rainbow Action Project (2006) *Halifax Rainbow Health Project: Assessment Tool Guidelines*. Retrieved from http://www.glhv.org.au/files/rainbow_audit_can.pdf.

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TITLE Healthy Relationships	AUTHORIZED BY Public Health Managers Network and Health Programs and Services Executives' Network (HPSEN)	PAGE 16 of 101

GOAL

- To support clients in the development of healthy relationship.
- To support the formation and maintenance of healthy relationships with family, friends or intimate partners. This is central to healthy sexuality and sexual wellness.

BACKGROUND

Healthy Relationships

In simplest terms, a healthy relationship is one that facilitates the individual to feel good about his/herself and partner. All relationships are different, but healthy ones tend to have the following qualities in common; summed up by the acronym SHARE:

Safety: In healthy relationships, one feels safe. One doesn't harm or worry about receiving physical or emotional harm. For example, an individual can try new things (e.g. taking a night class) or change one's mind (e.g. engaging in a sexual activity) without fearing a partner's reaction.

Honesty: An individual doesn't hide anything important from a partner. One can express thoughts without fear. Disagreements are resolved without lies.

Acceptance: Partners accept each other as is and appreciate each other's qualities without efforts to "fix" them.

Respect: Partners think highly of each other without feeling superior or inferior to each other in important ways. There is regard for different opinions and ideas. This does not mean tolerance of everything as setting limits is a sign of self-respect.

Enjoyment: A healthy relationship is satisfactory or enjoyable e.g. partners can play and laugh together (Sexuality Education Resource Centre, 2005).

Abuse

Partner abuse is a significant and widespread social problem. It can include physical, emotional, psychological, sexual, economic, financial or spiritual abuse (PHAC, 2002). Some forms of abusive behaviour, such as acts of physical assault and sexual assault, could result in charges under the Criminal Code of Canada (Department of Justice, 2006). Other behaviours, such as ridiculing or other verbal abuse, are harmful but not criminal offences (PHAC 2008). The demographics of people in abusive relationships cross all age, gender, sexual orientation, ethnic, educational or socio-economic strata (PHAC, 2002; PHAC, 2008).

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Canadian law requires that an individual consent to any type of sexual activity. Individuals have the right to set their own sexual limits. Consent is not given if a person says no, gives no reply, is too drunk or stoned to know what is happening or feels manipulated, pressured, threatened or forced into saying yes. Consent can not be assumed because of past acts of consensual sexual activity (Ontario Women's Directorate, 2009).

Age of Consent for Sex

The Canadian federal legislation related to age of consent for sex is addressed in the Tackling Violent Crime Act (Bill C-2),

http://www.parl.gc.ca/HousePublications/Publication.aspx?Doc=C-2_1&File=24&Language=E&Mode=1&Parl=39&Pub=Bill&Ses=2.

The Age of Consent for **Non-exploitative** Sexual Activity in Canada:

- Children under the age of 12 years are not able to consent to sex.
- The age of consent for non-exploitative sexual activity in Canada is 16 years.
- However there is a close-in-age exception whereby:
 - Children who are at least 12 years & less than 14 years may be able to consent to non-exploitative sexual activity with a peer who's within 2 yrs of age.
 - Children who are at least 14 years & less than 16 years may be able to consent to non-exploitative sexual activity with a peer who is within 5 yrs of age.
- Age of consent for non-exploitative anal sex is 18 years and older.

The Age of Consent for **Exploitative** Sexual Activity in Canada:

- People must be 18 years of age and older to consent to prostitution, pornography or sex within a relationship of trust, authority or dependency.

DEFINITIONS

Abuse: mistreatment, whether physical, sexual, mental, emotional, financial or a combination thereof, that is reasonably likely to cause death or that causes or is reasonably likely to cause serious physical or psychological harm to a vulnerable person, or significant loss to his or her property.

Economic or financial abuse: may include preventing a person from working, controlling their occupational choices, preventing them from achieving or maintaining financial independence, denying or controlling their access to financial resources, or exploiting them financially. Failing to provide the necessities of life to a spouse or dependent is against the law in Canada.

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Emotional or psychological abuse: includes insulting or swearing at, belittling or threatening a partner. It can also include destroying a partner's property or possessions and isolating him or her from friends and relatives. It can include isolating a person from their family and friends. Emotional abuse that is denigrating and employs intimidation is more likely to turn physically violent than other forms of emotional abuse.

LGBTTTIQ: lesbian, gay, bisexual, transgendered, transexual, two-spirited, intersex, queer and questioning community

Physical violence and abuse: occurs when one partner uses physical force to control the other. It includes a range of assaults, from pushing, shoving and grabbing to choking, burning and assaulting with a weapon. It may also include physical neglect through denial of food or medication, inappropriate personal or medical care, rough handling, or confinement. Each of these acts could result in charges under the Criminal Code. Physical violence is often characterized as moderate or severe. Moderate acts of violence are defined as acts for which the risk of permanent harm or injury is low.

Sexual health: a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships. As well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence (World Health Organization, 2006).

Sexual rights: embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence to:

- The highest attainable standard of sexual health, including, access to sexual and reproductive health care services.
- Seek, receive and impart information related to sexuality.
- Sexuality education.
- Respect of bodily integrity.
- Choose their partner.
- Decide to be sexually active or not.
- Consensual sexual relations.
- Consensual marriage.
- Decide whether or not, and when, to have children.
- Pursue a satisfying, safe and pleasurable sexual life (World Health Organization, 2006).

Sexual violence and abuse: includes sexual assault, unwanted sexual touching, sexual exploitation, or forcing a person to participate in any unwanted, unsafe, degrading, offensive

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sexual acts. It may include denying or ridiculing a person's sexuality or controlling her reproductive choices. Includes coercing a dating partner to engage in sexual activity, using force to attempt or to have sexual relations, and attempting or having intercourse with a person who is under the influence of drugs or alcohol and is unable to resist or give consent.

Spiritual abuse: preventing a person from participating in spiritual or religious practices, ridiculing their beliefs or using spiritual beliefs to justify controlling them (PHAC, 2002).

RECOMMENDATIONS FOR SERVICES

- 1.0 The nurse should create a welcoming, nonjudgmental, respectful, safe and private environment to foster open communication and support clients to discuss relationships by:
 - 1.1 Demonstrating self awareness of own beliefs and values.
 - 1.2 Respecting client's lifestyle choices and beliefs.
 - 1.3 Demonstrating awareness of sexual rights.
 - 1.4 Acknowledging the importance of building a therapeutic relationship between client and health care provider.
 - 1.5 Acknowledging barriers to disclosure of abuse e.g. client's sense of confidentiality, safety within the health care setting, client's relationship with provider, time for discussion, privacy during appointments and provider's skill set.
 - 1.6 Accepting/extending invitations to discuss relationships and/or abuse while acknowledging that discussions and disclosure are voluntary (Society of Obstetricians and Gynaecologists of Canada, 2005).
- 2.0 The nurse should assess client's relationship status (Refer to Assessment Guideline).
 - 2.1 Monitor for signs of relationship inequities and risk factors for abuse including:
 - Drastic changes in appearance, mood, behaviours, goals, school or work performance.
 - Change in attendance patterns, e.g. school, work or health care.
 - Deferring to a partner for decisions, permission.
 - Partner appearing to control client's activities, clothes, friendships including excessive monitoring or refusing to leave during health care visits.
 - Anger management issues for either person in the relationship.

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- Threats, jealousy, blaming, intimidation, bullying and hurtful teasing as common feature of either partner's communication style.
- Discounting of a partner's behaviour for any reason such as drinking, using substances, stress, unemployment etc.
- Increase in minor injuries, poorly explained bruising, burns, new onset of sleep problems, digestive problems, headaches, depression, and sexually transmitted infections or unintended pregnancy (Society of Obstetricians and Gynaecologists of Canada, 2005).

2.2 Screen for abuse and violence by asking direct and behavior-focused questions about abuse and violence. Normalize assessment by indicating that assessment is a standard aspect of care. Examples of occasions to screen include:

- New clients.
- On presentation of a risk factor/injury that is consistent with any indicator for violence/abuse.
- During routine health care services.
- During prenatal care.

2.3 Be aware that certain subsets may be particularly vulnerable to intimate partner violence:

- Women less than 25 years and over 65 years.
- Women with disabilities.
- Women who are Aboriginal, First Nations or Inuit, particularly if they live in isolated communities.
- Individuals experiencing life changes such as pregnancy, unemployment and addictions issues (Society of Obstetricians and Gynaecologists of Canada, 2005).

3.0 The nurse should counsel and promote healthy relationships. Be aware of issues related to specific populations:

3.1 Youth may have a greater tendency to be less aware of resources; be hesitant to seek help; be learning how to form relationships; lack positive role models for healthy relationships; lack confidence to speak-up in a relationship; still be learning communication and anger management skills; not recognize abuse due to belief that behaviours are signs of romantic love; feel pressured by peers to stay in a relationship; be reluctant to affect the dynamics in a group a friends; believe an unhealthy relationship is better than being single (PHAC, 2006; Price et al., 2000; Sexuality Education Resource Centre, 2005; Society of Obstetricians and Gynaecologists of Canada, 2005).

3.2 People who are LGBTTTIQ may experience:

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- Increased trend to minimize/discount abuse among LGBTTTIQ.
- Partner's use of homophobia and heterosexism to exert control.
- Partner's threat to 'out' an individual to friends, family, employers or a wider community (Society of Obstetricians and Gynaecologists of Canada, 2005; Davis, 2000). (Refer to Appendix C for additional information).

3.3 Women who are immigrant or refugee women may have:

- Varied understanding of what is abuse based on cultural background or past persecution.
- Limited English or French language and/or social isolation.
- Lack of privacy if family members provide translation.
- Fear that disclosure could result in deportation, breakdown of sponsorship agreements, loss of community status and respect, and loss of child custody.
- Familial or religious pressure to maintain sanctity of marriage and family integrity (Society of Obstetricians and Gynaecologists of Canada, 2005).

3.4 People with intellectual disabilities may experience a greater lack of knowledge, communication deficits, tendency to trust, isolation, struggle for acceptance, small peer groups and limited social support (Fleming, Morris, Pymar & Smith, 2004; Schor, 1987).

3.5 Individuals who are considering becoming sexually active with a partner have the opportunity to consider readiness and willingness beforehand. Considerations may include:

- Does having sex fit with my beliefs?
- Do I feel pressured?
- Do I have to 'prove' that I love my partner?
- Will having sex change the way I feel about myself?
- Do I think this will be a fun and pleasurable experience for me?
- Will sex change my relationship?
- Am I comfortable with my body and how it works?
- Can I talk about my feelings with my partner without feeling scared/embarrassed?
- Am I ready? (Think Again Committee, 2008).

4.0 The nurse should adapt counseling and teaching to the client's stage of change:

4.1 Precontemplative focus of interventions:

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- Raise individual's consciousness about dynamics of relationships and abuse.
- Affirm that nobody deserves to be abused.
- Offer information, and accept that individuals may refuse printed material.
- Encourage the individual to consider their safety and that of their family.
- Emphasize that there is no pressure on them to leave the situation.
- Recommend and offer a follow-up visit.

4.2 Contemplative focus of interventions:

- Discuss reasons they are considering for changing the relationship.
- Facilitate construction of a list of pros and cons about change.
- Review previous attempts to make change and outcomes of plans or attempts.
- Refer to community resources that can assist individual to gain support.

4.3 Preparation focus of interventions:

- Encourage and review planning including specific safety plans:
 - Think ahead about safety in any situation.
 - Consider double-dating the first few times when with a new person.
 - Before a date, know the exact plans for the evening.
 - Ensure a parent or friend knows the plans and when to expect you home.
 - Let your date know that you are expected to call when you get in.
 - Accept that drugs and alcohol affect judgment and ability to get help.
 - Use a buddy system with a friend, if drugs or alcohol are chosen/used.
 - Tell another person you are leaving and with whom, if you leave a party with someone you do not know well.
 - Ask a friend to call and make sure you arrived safely, when you leave.
 - Assert him/her; be firm and straightforward in relationships.
 - Trust his/her instincts. If a situation is uncomfortable, try to be calm and think of a way to remove oneself from the situation.
 - Try not to be alone with anyone or meet anyone in a secluded place, if you feel unsafe around your partner or anyone else.
 - Keep spare change or bus ticket for emergencies.
 - Think of a place she/he can go to 24/7 to be safe (PHAC, 2006).

4.4 Action focus of interventions:

- Offer support and monitor safety.
- Ongoing referral to appropriate resources.

4.5 Maintenance focus of interventions:

- Offer and provide a continuous support system.
- Make ongoing referrals.

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- Assess safety and reinforce safety plans as this is still a concern.

5.0 The nurse must follow program policies and legal responsibilities related to abuse reporting. The nurse should:

5.1 Be aware that you may be the first person they have spoken with about the abuse.

5.2 Utilize appropriate counseling and referral resources.

5.3 Listen, validate feelings, assess immediate risk, assist with safety planning, referral and follow-up. The nurse may assess client's readiness for change by asking:

- Have you thought of making any changes in your current situation within the next six-months?"
- Have you thought about making changes in the next 30 days? (SOGC, 2005)

6.0 The nurse must adhere to comprehensive documentation including assessment and action plan (see Documentation Guideline). This can include, but is not limited to:

6.1 Description of the client, including any abuse that may be noted (drawings may be useful to identify the area, size, and description of injuries related to physical abuse).

6.2 Observation the client's behaviour and interpersonal interactions during the clinical appointment.

6.3 Documentation of the client's statement of what happened to him/her, in his/her own words. The interview should be in the absence of the persons suspected of committing the abuse.

6.4 Addressing immediate risk, depression/suicide risk, safety plan and referral needs.

6.5 Consultation with other health care providers.

6.6 Name of agency and persons contacted.

RECOMMENDED READING

Halifax, Rainbow Health Project Inclusion Program Assessment Tool.

http://www.glhv.org.au/files/rainbow_audit_can.pdf

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Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients.

http://www.qahc.org.au/files/shared/docs/GLMA_guide.pdf

Lesbian Health Guidelines. SOGC Clinical Practice Guidelines.

<http://www.sogc.org/guidelines/public/87E-PS-March2000.pdf>

RECOMMENDED RESOURCES

Healthy Relationships. <http://www.serc.mb.ca/content/dload/>.

Sex – You Decide. www.thinkagain.ca.

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GOAL

- The nurse will complete a client assessment related to the provision of contraceptive health services.
- The nurse will consider absolute and relative contraindications for contraception options.
- Client assessments will be reviewed and updated at each clinical visit, as indicated.

RECOMMENDATIONS FOR SERVICES

- 1.0 The nurse works collaboratively with the client's inter-disciplinary health care team. The nurse should ensure that appropriate and effective communication occurs when aspects of the client's care is provided by others. The goal is to provide seamless care for the client, avoiding unnecessary duplication.
- 2.0 The nurse should provide client-centered care and be aware that seeking contraceptive health services may be challenging for some. It may take time to build rapport and trust with a client. The nurse should begin the clinical assessment during client's initial visit; however it may take several visits to complete. The health history and assessment should be reviewed as indicated. (Black, Francoeur & Rowe, 2004).
- 3.0 Provision of care must remain client-centered and as such the client may decline aspects of the assessment (e.g. pelvic exam). The nurse's role is to assess and provide the necessary information for the client to make an informed decision about her/his care options. Clients also have the right to request a chaperone or third party to be present during assessment/care.
 - Client assessments are indicated for all genders and include health history, systems review, lifestyle assessment, physical examination, discussion of contraceptive and harm reduction strategies.
 - The nurse should refer to appropriate health care practitioners for those portions of the physical examination that are not within the nurse's current scope of practice or skill set.
- 4.0 The nurse should be aware that it is the responsibility of the prescribing health care provider to decide what to prescribe and to be aware of contraindications. During the client assessment the nurse will review any medications for absolute and relative contraindications and bring identified contraindications or concerns to the attention of the prescribing health

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care provider. The World Health Organization (WHO) has developed a list of absolute and relative contraindications (WHO, 2001).

- For combined hormonal contraceptives, absolute contraindications include:
 - < 6 weeks postpartum if breastfeeding.
 - Smoker over the age of 35 (≥ 15 cigarettes per day).
 - Hypertension (systolic ≥ 160 mm Hg or diastolic ≥ 100 mm Hg).
 - Current or past history of venous thromboembolism.
 - Ischemic heart disease.
 - History of cerebrovascular accident.
 - Complicated valvular heart disease (pulmonary hypertension, atrial fibrillation history of subacute bacterial endocarditis).
 - Migraine headache with focal neurological symptoms.
 - Breast cancer (current).
 - Diabetes with retinopathy/nephropathy/neuropathy.
 - Severe cirrhosis.
 - Liver tumor (adenoma or hepatoma).

- For combined hormonal contraceptives, relative contraindications include:
 - Smoker over the age of 35 (< 15 cigarettes per day).
 - Adequately controlled hypertension.
 - Hypertension (systolic 140–159mm Hg, diastolic 90–99mm Hg).
 - Migraine headache over the age of 35.
 - Currently symptomatic gallbladder disease.
 - Mild cirrhosis.
 - History of combined oral contraceptive-related cholestasis.
 - Use of medications that may interfere with combined oral contraceptive metabolism.

- For progestin-only pills, absolute contraindications include:
 - Pregnancy.
 - Current breast cancer.

- For progestin-only pills, relative contraindications include:
 - Active viral hepatitis.
 - Liver tumors.

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- For Depot-medroxyprogesterone acetate (DMPA), absolute contraindications include:
 - Pregnancy (known or suspected).
 - Unexplained vaginal bleeding.
 - Current diagnosis of breast cancer.

- For Depot-medroxyprogesterone acetate (DMPA), relative contraindications include:
 - Severe cirrhosis.
 - Active viral hepatitis.
 - Benign hepatic adenoma.

- For intra-uterine devices or systems, absolute contraindications include:
 - Pregnancy.
 - Current, recurrent, or recent (within past 3 months) pelvic inflammatory disease or sexually transmitted infection.
 - Puerperal sepsis.
 - Immediate post-septic abortion.
 - Severely distorted uterine cavity.
 - Unexplained vaginal bleeding.
 - Cervical or endometrial cancer.
 - Malignant trophoblastic disease.
 - Copper allergy (for copper IUD).
 - Breast cancer (for LNG-IUS).

- For intrauterine devices or systems, relative contraindications include:
 - Risk factor for sexually transmitted infections.
 - Impaired response to infection in HIV-positive women and in women undergoing corticosteroid therapy.
 - From 48 hours to 4 weeks postpartum.
 - Ovarian cancer.
 - Benign gestational trophoblastic disease.

5.0 The nurse should be able to do a comprehensive health assessment related to the provision of contraceptive health services. A focused assessment is indicated when aspects of a comprehensive assessment have been done by other inter-disciplinary health team members. A comprehensive health assessment includes (Refer to Appendix D for sample forms that may assist to structure an assessment).

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Health History

- Allergies.
- Current Medications. For information on medications refer to e-Therapeutics+ Drug Interaction Program, <http://www.nurseone.ca/> .
- Review immunization history. Access Manitoba Immunization Monitoring System (MIMS) or EChart where available.
- Assess for immunization eligibility as per Manitoba Health Guidelines,. In particular, eligibility for: HPV, Hepatitis A, Hepatitis B, Tetanus, Diphtheria, Acellular Pertussis, Measles, Mumps and Rubella.
<http://www.gov.mb.ca/health/publichealth/cdc/vaccineeligibility.html>

Family History

- Cardiovascular disease, with attention to heart attack or stroke in premenopausal first degree relatives.
- Cancer: breast, uterine, ovarian, colo-rectal and others.
- Diabetes.
- Other chronic health issues.

Review of Systems (with attention to factors that may affect contraceptive options)

- Neurological e.g. migraine or vascular headaches. New or worsening headaches for clients on combination hormonal contraception must be investigated by prescribing health care provider. Combination hormonal contraceptive are contraindicated for women who have migraines headaches with focal neurological with symptoms (Hatcher, 2007).
- Endocrine e.g. Diabetes. Well controlled diabetes is not a contraindication to hormonal contraceptives. Clients with severe complications of their diabetes should be followed closing by their physician or nurse practitioner. Unintended pregnancy in women with poorly controlled diabetes is a health risk to mother and fetus.
- Cardiovascular e.g. hypertension, coronary artery disease, CVA (cerebral vascular accident), clotting disorder, thrombophlebitis.
- Gastrointestinal e.g. benign liver tumors, gallbladder disease. Association with low-dose combination hormonal contraceptives and benign liver tumors and risk of cholelithiasis and cholecystitis, has not been well established. There may be a increased risk of developing symptomatic gallbladder disease for women with pre-existing gallstones or sludge.
- Mental Health/Illness. There is no evidence that combination hormonal contraceptive options increase the risk of clinical depression. History of depression is not a

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contraindication for depo-provera use. Client education related to change in symptoms and medical follow-up are important.

- Reproductive:
 - Menstrual history: menarche, cycle pattern, amenorrhea, dysmenorrhea, undiagnosed intermenstrual vaginal bleeding.
 - LNMP (last normal menstrual period), pregnancy risk.
 - Previous contraception used (adherence and adverse effects).
 - Previous pregnancies, unplanned pregnancies, live births, spontaneous abortions, therapeutic abortions, still birth and molar pregnancies.
 - Reproductive cancers: breast, ovaries, cervix, vulva, endometrium.

Lifestyle Assessment

- Nutrition.
- Physical activity.
- Substance use: tobacco, marijuana, alcohol and other recreational drug use including sharing of injection/drug related equipment.
- Tattoo/body piercing, home-made.
- Family supports.
- Social supports.
- School/employment history.
- Sexual health assessment:
 - Are you sexually active? With males, females or both?
 - Are you in a sexual relationship? Do you currently have a partner? Are you happy in the relationship?
 - Age of first sexual experience (for e.g.; intimate genital touching, oral sex, vaginal or anal intercourse).
 - Number of sexual partners over lifetime.
 - History of abuse: childhood, bullying, intimate partner violence.
 - Refer to STI Risk Assessment Questionnaire, Canadian Guidelines on Sexually Transmitted Infections (Public Health Agency of Canada, 2006) . For additional assessment suggestions: <http://www.phac-aspc.gc.ca/std-mts/sti-its/guide-lignesdir-eng.php>

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Physical Assessment

- Urine pregnancy test based on assessment and pregnancy risk factors:
 - Consider possibility of pregnancy when an individual presents with any following complaints: irregular menses, missed period, unreliable menstrual history, unusual vaginal bleeding, amenorrhea, abdominal pain, breast enlargement/discomfort or fatigue.
 - Prior to testing, counsel the client regarding possible outcomes.
 - Testing: read product monograph, obtain urine sample and follow the instructions as per package insert.
 - Counsel following testing:
 - Discuss options related to pregnancy including abortion, adoption and parenting
 - Refer and/or facilitate client's access to care. (Refer to Appendix E, Guide to Referral Routes for Prochoice Services).

- Blood Pressure:
 - World Health Organization states that hypertension with systolic pressure > 160 mm Hg or diastolic pressure > 100 mm Hg is an absolute contraindications for combination hormonal contraceptive options. Hypertension with a systolic pressure of 140-159 mm Hg or diastolic pressure of 90-99 mm Hg is a relative contraindication. Well-controlled hypertension is a relative contraindication for combination hormonal contraceptive options (Black et al, 2004). Women with hypertension that is well controlled with medications and also using combination hormonal contraceptive options require frequent monitoring as their hypertension may become poorly controlled.
 - Ongoing blood pressure monitoring: It is not uncommon for women on low-dose combination hormonal contraceptive options to have a clinically insignificant increase in their blood pressure of 3-5 mm Hg in either systolic or diastolic blood pressure (Hatcher et al 2007). All combination hormonal contraceptive options that contain less than 50 mcg of estrogen are considered low-dose.

- Weight:
 - There is no evidence to support the benefit of weighing women at each visit. Accurate baseline weight and height are useful to have if the individual woman expresses concerns about weight related to her contraceptive choice.
 - Body weight is a relative contraindication and warrants additional counselling for individuals. There is also an increased risk for adverse pregnancy outcomes for women with obesity (Black, Francoeur & Rowe, 2004; Hatcher et al., 2007).

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- The effect of body weight on the efficacy of various contraceptive options is not well established. It is not correct that a woman with a Body Mass Index (BMI) > 30 or who weighed > 70 kg were at higher risk for contraceptive failure on low dose combination oral contraceptive pills.
- For the contraceptive patch, it is documented that there is increased risk of contraceptive failure for women weighing more than 90 kg.
- Randomized clinical trials have demonstrated that women do not experience weight gain on low-dose combination hormonal contraceptives. In some women, estrogen can cause hypertrophy of adipose cells in the breasts, hips or thighs even though weight does not change. Estrogen or progesterone can cause fluid retention for some. In theory, the androgen effect of some preparations could cause muscle mass increase (Black, Francoeur & Rowe, 2004; Hatcher et al., 2007).
- With regards to Depot-medroxyprogesterone acetate (DMPA), there is a misconception that all women will gain weight. Counselling for healthy eating and activity should be included with client education information (Black, Francoeur & Rowe, 2004).
- Pelvic Exam, assess need and discuss with client:
 - A pelvic exam is important for a comprehensive assessment however it is not a prerequisite for providing contraception or emergency contraception. It is important for clients to be aware of the reasons for a pelvic exam.
 - A pelvic examination should be negotiated with the client. Ask the client if they would like a chaperone or third party present. Document presence/absence of chaperone. A pelvic exam includes:
 - External genital assessment.
 - Speculum exam and assessment of vagina and cervix:
 - Vaginal swabs for vaginitis/vaginosis and sexually transmitted infections as indicated. Note that urine testing for gonorrhea and Chlamydia are similar in reliability to cervical swabs.
 - Pap test as per Manitoba Cervical Cancer Screening Guidelines. To request a pap test history phone 1-866-616-8805.
 - Bimanual exam to assess for cervical motion tenderness and adenexal tenderness.

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RECOMMENDED RESOURCES

Nurse One. *eTherapeutics*. Available from:

http://www.nurseone.ca/index.php?option=com_content&view=article&id=69&Itemid=53&lang=en.

RECOMMENDED READING

Black, A., Francoeur, D., Rowe, T. (2004). Canadian contraceptive consensus chapters 1-11. *Journal Obstetrics and Gynaecology Canada* 26(4) pp.143-387. Available from The Society of Obstetricians and Gynaecologists of Canada (SOGC) website:

http://www.sogc.org/guidelines/index_e.asp#Contraception.

Feldman & Goldberg (2006). *Transgender Primary Medical Care: Suggested Guidelines for Clinicians in British Columbia*. <http://transhealth.vch.ca/resources/library/tcpdocs/guidelines-primcare.pdf>.

Davis, V. (2000). *Lesbian Health Guidelines*. Available from The Society of Obstetricians and Gynaecologists of Canada (SOGC) website: <http://www.sogc.org/guidelines/>.

Hatcher, et al. *Contraceptive Technology* 19th Edition. Ardent Media. 2007.

Getiton website <http://www.getiton.ca/>.

	CLINICAL PRACTICE GUIDELINE FOR THE DELIVERY OF CONTRACEPTIVE HEALTH SERVICES BY REGISTERED NURSES	DATE June 20, 2011
TITLE Informed Consent	AUTHORIZED BY Public Health Managers Network and Health Programs and Services Executives' Network (HPSEN)	PAGE 33 of 101

GOAL

- To understand and apply informed consent process for the delivery of contraceptive health services

DEFINITIONS

Age for sexual consent: The age of consent for non-exploitative sexual activity in Canada is 16 years of age. Youth under 12 years of age cannot consent to sex (Refer to Healthy Relationship Guideline)

Decision-making capacity: includes the ability to understand:

- The information and to make a decision about the proposed course of action;
- The nature and the anticipated effect(s) of the proposed procedure, treatment or investigation; and
- The alternatives and risks, including the consequences of not proceeding with the proposed course of action.

Information: The necessary information provided to the client that a reasonable client would want to know, in order to make a decision about the proposed course of action, or, information that, if omitted, may result in a different decision. The information shall be provided in a manner that can be understood by the client or substitute decision-maker.

Informed consent: process involving dialogue, understanding and trust between client or substitute decision-maker and the responsible party or authorized designate. Informed Consent requires

- Client or substitute decision-maker to have Decision-Making Capacity;
- Disclosure of the information that is specific to the care provided;
- That it is specific to the act performed; and
- Consent to be given freely and voluntarily, without undue promise of favorable outcome, threat of penalty for non-compliance, or overt or covert coercion.

Minor: client under the age of 18 years. If the minor has decision-making capacity, the minor is to be regarded as having the capacity to provide informed consent, and the minor's informed consent is both necessary and sufficient for the proposed procedure(s), treatment(s) or investigations(s).

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RECOMMENDATIONS FOR SERVICES

- 1.0 The nurse must be aware of and inform clients, in particular adolescents, of the concepts of personal health information privacy, informed consent, reporting obligations and exceptions to privacy. For adolescents, this information includes:
- 1.1 Health care providers can supply contraception to a minor without parental/guardian consent as long as informed consent can be obtained from the individual.
 - 1.2 Health care providers are required under the Child & Family Services Act to report all cases of suspected or known child abuse. The Child and Family Services Act defines a “child in need of protection” when the life, health or emotional well-being of the child is endangered by an act or omission of a person. Health care providers are obligated to report this to a child protection agency such as Child & Family Services or the Police, or the child’s parent/guardian. When the concerns are related to the care provided by the parent or guardian, or the parent or guardian is unknown/unavailable, the report should be made directly to a child protection agency. Refer to your agency policy on reporting to Child Welfare. (Refer to Appendix F Child Welfare Reporting).
 - 1.3 Unmarried youth who become pregnant and will be delivering their baby prior to their 18th birthday, must be referred to a Child Welfare agency. Early referral provides more opportunity for the Child Welfare agency and youth to best plan for the child’s birth, however referral is not mandatory until a live newborn is delivered. Notice of Maternity form:
http://www.gov.mb.ca/fs/childfam/pubs/notice_of_maternity_fillable.pdf.
- 2.0 The nurse must provide information about the contraceptive health services.
- 2.1 Nurse should ask the client if there is a support person they wish to include in discussions related to their health care. When clients have authorized substitute decision-makers, they may need to be consulted regarding health care decisions.
 - 2.2 Contraceptive information should include:
 - Name of contraceptive
 - Contraceptive’s method of action and instructions for correct use
 - Expected benefits of the contraceptive(s) with perfect and typical use
 - Potential adverse effects and significant risks of the contraceptive(s)
 - Answers to any client or substitute decision-maker’s questions
- 3.0 The nurse must obtain informed consent from the client who has decision-making capacity before distribution of contraceptive supplies.

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3.1 The nurse must determine if a client has is able to comprehend the risk/benefits and consequences of the service.

3.2 In situations where the client has an authorized substitute decision-maker for health decisions, the nurse must obtain informed consent from the substitute decision-maker. Clarify if the substitute decision-maker is aware that the client is attending for care and facilitate discussion between client and substitute decision-maker.

3.2.1 The nurse must assess all clients regardless of age and intellectual ability for the capacity to make health decisions and provide informed consent. In most cases a designated substitute decision-maker will not authorize reproductive health care that is against what the client wishes.

4.0 The nurse should offer and use the services of a trained health interpreter when the service provider does not have excellent proficiency in a language that the client is proficient speaking.

RECOMMENDED READING

Manitoba Association for Rights and Liberties. *Under 18 Handbook*.
<http://marl.mb.ca/und18/under-18-handbook-online>.

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TITLE Client Education	AUTHORIZED BY Public Health Managers Network and Health Programs and Services Executives' Network (HPSEN)	PAGE 36 of 101

GOAL

- The target population will receive comprehensive and respectful contraception in order to achieve positive outcomes e.g. pregnancy prevention, informed reproductive choices, healthy sexuality.

BACKGROUND

The *Canadian Guidelines for Sexual Health Education* state:

All Canadians have a right to sexual health education that is relevant to their needs. Diverse populations such as sexual minorities, seniors, individuals with disabilities (physical/developmental) and socio-economically disadvantaged individuals such as street involved youth often lack access to information and education that meets their specific needs. Correspondingly, it is important that sexual health educators and service providers give particular attention to the kinds of programs and resources that support the sexual health and personal well being of these individuals across their lifespan (Public Health Agency of Can, 2006, p. 8).

RECOMMENDATIONS FOR SERVICES

1.0 The nurse should be aware that effective sexual health education:

- Varies in the amount of time it takes from client to client.
- Does not discriminate on the basis of age, race, ethnicity, gender identity, sexual orientation, socioeconomic background, physical/cognitive abilities or religious background.
- Is strength-focused and occurs across the lifespan
- Understands that sex and sexuality is a diverse, interactive process.
- Is provided within the context of the individual's age, race, ethnicity, gender identity, sexual orientation, socioeconomic background, physical/cognitive abilities, religious background and other such characteristics (Public Health Agency of Canada, 2006).

2.0 The nurse should assess the client related to their ability to use contraception, including:

2.1 Knowledge, motivation and ability to use contraception effectively.

2.2 Supports and barriers such as access to health care, financial considerations, ability to adhere to contraceptive choice(s) and partner attitudes/behaviors, (Lopez, Steiner, Grimes & Schulz, 2008).

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- 3.0 The nurse should provide client-centered education in plain language that focuses on strengths. Clients may be reluctant to voluntarily ask questions. The nurse should invite further discussion.
- 4.0 The nurse should encourage development of skills related to healthy sexuality and contraception, e.g. practicing negotiation skills for use of barrier methods with partners and/or condom application (Society of Obstetrics and Gynecologists Canada Contraception Guidelines, 2003).
- 5.0 The nurse should use motivational interviewing techniques to enhance client's success in using contraception, e.g.:
- On a scale of 1 to 10:
 - “How important is it to you to... take the pill as prescribed, each and every day?” or “... see to it that you and your partner always use condoms?”
 - “How confident are you to use birth control” ...
 - “Why did you say (score) and not lower/higher?” This paradoxical question encourages individuals to come up with personally convincing reasons why it is important to adhere to contraception or to practice safer sex.
 - “What would it take” or “What would have to happen for it to become more important to you to take the pill as prescribed, each and every day?” or “... see to it that you and your partner always use condoms.” The client can then be more able to know what it would take to make adherence or safer sex more important to them personally. (Lopez, Steiner, Grimes & Schulz, 2008).
- 6.0 The nurse should clarify knowledge deficits that the client may have related to contraceptive options, e.g.:
- 6.1 Reproductive anatomy and physiology.
- 6.2 Contraceptive(s) mechanisms of action efficacy, advantages and disadvantages, contraindications, risks/benefits.
- 6.3 How to use the selected contraceptive(s), troubleshooting, use of back-up contraception and prevention of sexually transmitted infections.
- 6.4 When to contact their health care provider. Follow-up health care recommendations (refer to Hormonal and Nonhormonal Contraception Guideline) (Society of Obstetrics and Gynecologists Canada Contraception Guidelines, 2003).

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RECOMMENDED READING

United Nations Population Fund (UNFPA) and International Planned Parenthood Federation (IPPF), 2007. Myths, Misperceptions and Fears: Addressing Condom Use Barriers.

<http://www.unfpa.org/publications/detail.cfm?ID=330> or

http://www.unfpa.org/upload/lib_pub_file/688_filename_myths_fears.pdf.

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GOAL

- To facilitate client access to all contraceptive methods and supplies.
- The nurse will maintain clinical knowledge related to contraceptive options. Clinical practice guidelines from The Society of Obstetricians and Gynaecologists of Canada (SOGC) are key references. All nurses providing contraceptive services must be aware of the SOGC guidelines, available at http://www.sogc.org/guidelines/index_e.asp. It is also recommended to check these guidelines regularly for updates.

DEFINITIONS

Barrier Methods: use of a mechanical or chemical barrier to obstruct the entry of sperm into the upper female genital tract. Available in a variety of forms (Black, Francoeur & Rowe, 2004).

Continuous Hormonal Contraception: Although no official definition exists, continuous use of hormonal contraception usually refers to uninterrupted use without hormone-free intervals (Guilbert & Boroditsky, 2007).

Depot-medroxyprogesterone acetate (DMPA): refers to an injectable form of progestin-only hormonal contraception (Black, Francoeur & Rowe, 2004).

Emergency Contraception (EC): any method of preventing conception/impregnation used after intercourse and before potential time of implantation. Not abortifacients as EC work prior to implantation. Methods are oral progesterone (e.g. Plan B[®] NorLevo[®]) or post-coital insertion of copper intrauterine device (Black, Francoeur & Rowe, 2004).

Extended Hormonal Contraception: extended use usually refers to use of combined hormonal contraception with planned hormone-free intervals (less often than every 21 or 24 days) (Guilbert & Boroditsky, 2007).

Formulary: refers to *The Manitoba Drug Benefits and Interchangeability Formulary* which lists medications that have been approved as eligible benefits under the Pharmacare drug benefit program (<http://www.gov.mb.ca/health/mdbif/index.html>). The Manitoba Formulary is the basis for most third party extended health benefit programs, including Employment and Income Assistance and Treaty/First Nations Inuit Health Branch.

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Hormonal Contraception: methods which prevent conception/impregnation by acting on a female's endocrine system to prevent pregnancy. There are two main types of hormonal contraceptives that are available in a variety of forms: combined hormonal contraception and progestin-only hormonal contraception (Black, Francoeur & Rowe, 2004).

Intrauterine Device (IUD): device used to prevent pregnancy that is inserted through the vagina into the uterus (Black, Francoeur & Rowe, 2004).

Intrauterine System (IUS): hormonal contraceptive device that is inserted through the vagina into the uterus (Black, Francoeur & Rowe, 2004).

Natural Family Planning: methods of controlling fertility that do not involve the use of contraceptive devices or chemicals (Black, Francoeur & Rowe, 2004).

Progestin-only Hormonal Contraception or Progestin-only Contraception: prevention of conception using methods with only progesterone or one of its synthetic analogues (progestins). Available in a variety of forms (Black, Francoeur & Rowe, 2004).

Quick-start: refers to a method of initiating hormonal contraception during a clinical visit rather than waiting for the next menstrual period (Association of Reproductive Health Professional, 2011; Lara-Torre, 2004).

RECOMMENDATIONS FOR SERVICES

- 1.0 The nurse should proactively offer contraceptive counseling (Black, Francoeur & Rowe, 2004). Contraceptive counseling:
 - 1.1 Is client-centered including lifestyle choices that may impact sexual and reproductive health, e.g. need for sexually transmitted infection protection, substance use, pre-conception folic acid.
 - 1.2 Assists the client to make a contraceptive plan.
 - 1.3 Provides appropriate client education related to the client's contraceptive plan. Although the hormonal contraception has conventionally been initiated in relation to the menstrual cycle, the Quick-Start method has demonstrated improved adherence (Refer to Appendix G Quick-Start Method).

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- 1.4 Provides clear, simple instructions, both written and oral, on missed hormonal contraception (Refer to Appendix H Missed Hormonal Contraceptives). The client may refer to Stay on Schedule (SOS) at <http://www.sexualityandu.ca/sos/> for information on hormonal contraception after a missed dose.
- 1.5 Addresses client questions related to hormonal contraception. Consults with prescribing practitioner when the client is seeking a change to dosing instructions (Refer to Appendix I Extended Use of Combined Hormonal Contraceptives).
- 1.6 Discusses harm reduction strategies related to pregnancy prevention, e.g. withdrawal has similar efficacy to male condoms and there's little evidence to support the belief that pre-ejaculate fluid contains sperm. (Black, Francoeur & Rowe, 2004, Association of Reproductive Health Professionals, 2011).
- 1.7 Provides information to all women and men about Emergency Contraception (EC). The client may refer to <http://sexualityandu.ca/adults/contraception-1.aspx>.
- 1.7.1 Informs clients how to obtain and indications for use.
 - 1.7.2 Informs all clients that the efficacy of hormonal EC may be higher when used within the first 24-72 hours post-coital however may still have benefit up to 5-days post-coital. EC should be started as soon as possible after an act of unprotected intercourse or failed contraception such as condom breakage or missed birth control pills.
 - 1.7.3 Inform the client that users of EC should be evaluated for pregnancy if menses have not begun within 21 days following EC treatment.
 - 1.7.4 The only absolute contraindications to the use of progestin-only EC is known pregnancy (making EC ineffective) or known allergy to one of the components of the product.
 - 1.7.5 Oral EC is available over the counter (OTC). Despite this, health care providers should consider having EC available in their facility to avoid barriers to obtaining oral EC (Katzman, D. and Taddeo, D., 2010). Oral emergency contraception does not require a prescription and is within the scope practice for nurses to provide.
- 1.8 Promotes the use of latex condoms in combination with other method of contraception (Black, Francoeur & Rowe, 2004).
- 1.9 Encourages females to have a pregnancy test if their period is more than one week late or different in volume from their usual menses.

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2.0 The nurse should discuss with the client (both women and men) their ability to access contraception:

2.1 Available for purchase with and without a prescription at local pharmacies or retail outlets.

2.2 Available with prescription and third-party coverage, e.g. First Nations and Inuit Health Branch (FNIHB), Employment and Income Assistance (EIA), Pharmacare or extended health benefits.

2.3 Available at no-cost or low-cost through specific clinics or programs (Public Health Nursing, Community Health Centre or Teen Clinic).

3.0 The nurse should facilitate the client in the acquisition of contraceptive supplies by referral to a prescribing provider for prescription contraception. The nurse must follow facility/program policy re: providing prescription contraception, as well as ensuring:

3.1 Valid prescription.

3.2 Medications/samples are provided in original packaging from the manufacturer.

3.3 Medication provided is only for use by the individual client.

3.4 Client is shown where the expiry date is on the package with reminder not to take expired medication.

3.5 Health care providers should inform clients who have third-party coverage that the Manitoba Formulary stipulates contraceptive options. Inform the client that generic substitutions will be made according to Manitoba Health's Drug Benefits & Interchangeability Formulary, <http://www.gov.mb.ca/health/mdbif/index.html> (Refer to Appendix J Generic Substitutions).

3.6 The nurse must refer clients to a pharmacy when a prescription states "no substitutions" and the specified contraceptive is not available within their facility/program.

4.0 The nurse should arrange follow-up care. Refer to the table below for frequency of follow-up. During follow-up care, assess and address the following:

- Appropriateness of method and satisfaction
- Presence and tolerance of adverse effects
- Client concerns
- Adherence with method (i.e. consistent and correct use)

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- Determine pregnancy status in the presence of amenorrhea and/or changes in menstrual flow
- Re-assess physical status, risk factors,
- Re-affirm condom use for STI prevention
- Facilitates referrals as indicated.

Method	Reasons	Timing for follow-up
Natural Family Planning including abstinence	Reassess contraceptive plan and adherence. Individualize concept of fertile days.	Per client request.
Barrier methods	Review contraceptive plan, satisfaction, adverse effects, method failure, adherence, STI prevention. Update personal and family history.	Per client request.
Diaphragm – note: not currently available in Canada	As per barrier methods.	
Hormonal methods, all types	Review contraceptive plan, satisfaction, adverse effects, method failure, adherence, STI prevention. Update personal and family history. Assess blood pressure, client perceived change in weight, other side effects, smoking, presence of migraines at each follow-up.	3 months after initial visit and for prescription renewals. If additional concerns, follow-up earlier or refer to prescribing practitioner. Note that, adolescents may require more frequent follow-up than above to address needs.

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Method	Reasons	Timing for follow-up
Depot medroxyprogesterone acetate (DMPA)	As per hormonal methods. Pregnancy status needs to be determined if an injection is not given within 13 weeks, before further injection with DMPA. Update personal and family history. (Refer to Appendix K DMPA)	Aim for every 12 weeks although contraceptive effectiveness is maintained with administration of repeat injection every 10 to 13 weeks. Urine pregnancy tests are not required for subsequent injections when given every 12 weeks and pregnancy was initially ruled out. When the interval between injections is greater than 14 weeks, see product insert. If menstrual cycle disturbance, follow-up sooner for reassessment and trouble-shooting.
Intra-uterine Device (also know as copper IUD) Intra-uterine System (also known as progesterone IUD, LNG-IUS)	Review contraceptive plan, satisfaction, adverse effects, method failure, adherence, STI prevention. Update personal and family history.	After first menses prior to 3 months after insertion. Follow-up as needed for signs of pelvic infection or severe cramping, unable to feel threads, able to feeling IUD/IUS or dyspareunia.

RECOMMENDED RESOURCES

Sexuality Education Resource Centre Manitoba www.serc.mb.ca.

The Society of Obstetricians and Gynaecologists of Canada www.sexualityandu.ca.

The Society of Obstetricians and Gynaecologists of Canada *Stay on Schedule*
<http://www.sexualityandu.ca/sos/>.

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RECOMMENDED READING

Guilbert, E., Black, A., Dunn, S., (2008). Missed Hormonal Contraception: New Recommendations. *Journal Obstetrics and Gynaecology Canada* 30(11) pp. 1050-1062. Available from http://www.sogc.org/guidelines/index_e.asp#Contraception.

Association of Reproductive Health Professional, Feb 2011. A Quick Reference Guide for Clinicians, Choosing a Birth Control Method. Available from <http://www.arhp.org/Topics>.

	CLINICAL PRACTICE GUIDELINE FOR THE DELIVERY OF CONTRACEPTIVE HEALTH SERVICES BY REGISTERED NURSES	DATE June 20, 2011
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GOAL

- To provide women who are postpartum or breastfeeding with evidence-informed, relevant, appropriate contraceptive health services that supports the continuation of breastfeeding.

BACKGROUND

After childbirth, many women resume sexual activity within several weeks of birth. Some individuals feel ready to resume sex within a few weeks of giving birth, while others need a few months - or even longer. Physical recovery, fatigue, role changes and other factors impact on an individual's readiness for sex. While there are various recommendations from four to six weeks when an individual can resume vaginal intercourse after birth, it is important for each individual to follow their own timeline according to physical and emotional readiness.

In addition, the duration of postpartum infertility is variable and unpredictable; on average the first ovulation will occur approximately 45 days post-partum.

Nurses can and should play a role in both family planning and promotion of breastfeeding as part of standard postpartum care.

Most methods of contraception are compatible with breastfeeding. Contraception is an important counseling issue for postpartum women, and counseling should also include the changes occurring in women, which may impact sexual feelings (Kennedy & Trussell, 2007).

DEFINITIONS

Almost exclusive breastfeeding: breastfeeding plus baby receives vitamins, minerals, water, juice, and any other foods infrequently (no more than 1-2 mouthfuls per day).

Exclusive breastfeeding: baby receives no liquids or solids other than the mother's milk.

Lactational Amenorrhea (LAM): family planning method; Provides more that 98% protection against pregnancy during the first six months after birth if the mother is exclusively or almost exclusively breastfeeding and menses has not yet returned.

RECOMMENDATIONS FOR SERVICES

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1.0 The nurse should begin to enquire about and provide counseling for postpartum contraception in the prenatal period. Many methods can be provided at the time of birth or shortly after (Kennedy & Trussell 2007).

1.1 With clients who are not seen in the prenatal period, the nurse should offer enquiries and counseling during the initial post partum period (Kennedy & Trussell 2007).

2.0 The nurse should provide assessment and counseling to clients who are postpartum or breastfeeding, the same as non-postpartum/breastfeeding clients, Additional consideration:

2.1 For LAM, include:

- LAM is effective (98%) for a breastfeeding women if:
 - No return of menses, and
 - Baby is under 6 months of age, and
 - Exclusive or almost exclusive breastfeeding (i.e. only additional intake by baby is infrequent water, juice or vitamins), and
 - Intervals between breastfeeding not over 4-hours during the day and 6-hours at night (Miller, 2004).
- Once baby begins sleeping more than 6-hours at night or goes longer than 4-hours without breastfeeding during the day or the mother increases supplements, note that the mother's hormonal balance may be altered sufficiently to permit ovulation to resume, thereby increasing the likelihood of a possible pregnancy without a supplementary method of contraception (Miller, 2004).
- Counsel on emergency contraception. There is high probability of failure with fertility awareness methods when not used consistently and correctly.
- LAM does not offer protection from sexually transmitted infections. Condoms are recommended for sexually transmitted infection protection (Miller, 2004).

2.2 For barrier methods and spermicides include:

- Lubrication is recommended with barrier methods, due to potential dryness caused by low estrogen levels during the early months of breastfeeding (Mohrbacher & Stock, 2003).
- Diaphragms/cervical caps and the accompanying spermicidal gels are no longer available in Canada. Diaphragms require a physical exam and need to be refitted whenever a woman's weight fluctuates by more than 10 pounds (4.5 kg) (Fleming, Morris, Pymar, & Smith, 2004).

2.3 For intra-uterine device/system include:

- Women who are breastfeeding may be good candidates for an intra-uterine device/system (Fleming, Morris, Pymar, & Smith, 2004).

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- The intra-uterine device/system can be inserted immediately postpartum; however, women who have insertion immediately after birth are at a higher risk of expulsion or uterine perforation. (Fleming, Morris, Pymar, & Smith, 2004).
- Women who wait until involution is complete, 4-6 weeks postpartum, to have lower expulsion and perforation rates (Fleming, Morris, Pymar, & Smith, 2004).

2.4 For progestin-only contraceptives (POC) include:

- Progestin-only methods should be considered as contraceptive options for postpartum women, regardless of breastfeeding status, and may be introduced immediately after birth (Fleming, Morris, Pymar, & Smith, 2004).
- There may or may not be an impact on milk production for women using progestin-only contraceptives. Research shows varied results with either no impact or a small decrease in milk production. The nurse should encourage the individual to monitor for sufficient milk supply (Fleming, Morris, Pymar, & Smith, 2004; Hale, 2008; Mohrbacher & Stock, 2003).
- Irregular bleeding, is common for the POC pill however, this does not normally occur during lactation (Mohrbacher & Stock, 2003).

2.5 Combined hormonal contraceptives include:

- Contraceptives containing estrogen can be used by women who are breastfeeding when the breastfeeding is well established. Past studies found that the use of combined hormonal contraception during the first few weeks after birth can decrease milk supply from 20-40% (Fleming, Morris, Pymar, & Smith, 2004). However, newer combined hormonal contraception with lower doses of estrogen appear to have less effect on both duration of breastfeeding and milk supply, particularly when they are started after breastfeeding has been established (Mohrbacher & Stock, 2003).
- It is suggested that the combined hormonal contraception should not be used until after lactation is well established, usually 6 weeks post-partum (Fleming, Morris, Pymar, & Smith, 2004).
- If a breastfeeding mother chooses a combined hormonal contraception, she can continue breastfeeding and watch for any signs of reduction in her milk supply (Fleming, Morris, Pymar, & Smith, 2004).
- If a woman is not breastfeeding, combined hormonal contraception may be introduced 3-4 weeks postpartum (Fleming, Morris, Pymar, & Smith, 2004). The risk of postpartum thrombophlebitis and thromboembolism is greatest just after birth, and delaying combined hormonal contraception for at least 3 weeks tends to bypass the period for peak risk for postpartum thrombotic complications (Kennedy & Trussell, 2007).

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- Clarification of myths and misconceptions, e.g. belief that use of combined hormonal contraception was not compatible with breastfeeding due to effects of estrogen on milk supply. However much of the earlier research was done on mothers taking the older, higher-dose oral contraceptives during early weeks after birth (Mohrbacher & Stock, 2003).

3.0 The nurse should address additional counseling issues for postpartum clients such as:

- 3.1 Women and men may experience reduced sexual feelings associated with bodily changes caused by pregnancy and birth.
- 3.2 Discussion of the bodily changes may help to reduce the couple's anxiety.
- 3.3 Tenderness in the perineum may make intercourse painful, especially if there has been an episiotomy.
- 3.4 Reduced postpartum estrogen secretion may result in diminished vaginal lubrication.
- 3.5 The lochia in the early postpartum period may be heavy and bloody, which may interfere with the women's sexual feeling.
- 3.6 Couples may find that exhaustion caused by the around-the clock responsibilities of being a parent temporarily decreases sexual drive.
- 3.7 Lactation may diminish the erotic significance of the breasts. Couples need to communicate feelings about whether sucking or touching the breasts is acceptable.
- 3.8 A birth (especially if planned) can be an exceedingly joyous experience that can enhance sexual intimacy. To some men and women, the shape or fullness of the lactating breast is particularly arousing (Kennedy & Trussell, 2007).

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RECOMMENDED RESOURCES

Motherrisk.ca. Available at <http://motherrisk.ca/hc3.asp>.

RECOMMENDED READING

Fleming, N., Morris, M., Pymar, H., Smith, T. (2004) Contraception-Meeting special needs. *Journal of Obstetrics and Gynaecology Canada*, 143, 378-379. Available from <http://www.sogc.org/guidelines/public/143E-CPG3-April2004.pdf>.

	CLINICAL PRACTICE GUIDELINE FOR THE DELIVERY OF CONTRACEPTIVE HEALTH SERVICES BY REGISTERED NURSES	DATE June 20, 2011
TITLE Young Men's Reproductive Health Services	AUTHORIZED BY Public Health Managers Network and Health Programs and Services Executives' Network (HPSEN)	PAGE 51 of 101

GOAL

- To provide accessible, relevant health care services that will improve reproductive health outcomes for young men.

BACKGROUND

Sexuality and human reproduction are an integral part of the health and well being of all humans. Acknowledging and being responsive to the sexual and reproductive health needs of young men is foundational to the promotion of healthy lifestyles, disease prevention and reduction of unplanned pregnancies for both men and women. Knowledge and skills are essential to empower men to become actively involved in the decision making around their own and partner's sexual and reproductive health.

To date although there are no national or international standards of care for reproductive and sexual health services for men, there is growing research and acknowledgement of need in this area. (Refer to Appendix L Young Men's Sexual and Reproductive Health Needs).

RECOMMENDATIONS FOR SERVICES

- 1.0 The nurse should assess for barriers that young men may experience in accessing contraceptive health services, including economic, environmental and social barriers:
 - Males are perceived to not want reproductive health services or contraception beyond the prevention and treatment of sexually transmitted infections (Kalmuss & Tatum, 2007; Region II Male Involvement Advisory Committee, 2005).
 - Young men who are sexually active may not be receiving adequate sexual and reproductive health care.
- 2.0 The nurse should develop and provide services that decrease barriers encountered by the male population:
 - Structure the clinical setting and services to better integrate care for men.
 - Create a clinical environment with a welcoming atmosphere, gender diversity in educational materials and inclusive services (Guttmacher Institute, 2002; Kalmuss & Tatum, 2007; Region II Male Involvement Advisory Committee, 2005).
- 3.0 The nurse should complete a health history and facilitate a physical assessment where indicated. (Refer to Assessment Guideline).

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4.0 The nurse should proactively provide information and counseling (Refer to Client Education Guideline, Health Relationships Guideline and to Appendix L Young Men's Sexual and Reproductive Health). This should include the following components:

- Sexual health and development.
- Psychosocial issues, e.g. promotion of positive self-concept; promotion of healthy relationships.
- Self-care, preventative health practices and harm reduction (Guttmacher Institute, 2002; Kalmuss & Tatum, 2007; Sonenstein, 2005).

RECOMMENDED READING

Engender Health (2003). *Men's Reproductive Health Curriculum*. Retrieved from Canadian Federation for Sexual Health website: <http://www.cfsh.ca/>.

Guttmacher Institute. *In Their Own Right: Assessing the Sexual & Reproductive Health Needs of American Men*. 2002. www.guttmacher.org/pubs/itor_intl.pdf.

	CLINICAL PRACTICE GUIDELINE FOR THE DELIVERY OF CONTRACEPTIVE HEALTH SERVICES BY REGISTERED NURSES	DATE June 20, 2011
TITLE Clinical Documentation	AUTHORIZED BY Public Health Managers Network and Health Programs and Services Executives' Network (HPSEN)	PAGE 53 of 101

GOAL

- To document client care efficiently and accurately to ensure continuity of care and the fulfillment of legal requirements.
- To communicate client information within an inter-disciplinary team.

RECOMMENDATIONS FOR SERVICES

- 1.0 The nurse must document client history, assessment, medication orders according to documentation standards of employer and profession (College of Registered Nurses of Manitoba, 2005). (Refer to Assessment Guideline).
- 2.0 The nurse who is providing prescription contraception should record the quantity provided and the amount remaining on the prescription. Refer to agency policy related to providing prescription medication, documentation requirements and quantity limits.
- 3.0 The nurse should be aware that telephone orders are discouraged as a practice by the Institute of Safe Medication Practices Canada (ISMP, 2005), due to the risk of error. If a nurse does receive a telephone order, the ISMP recommends that the nurse:
 - Ensure all telephone orders are complete, e.g. client name, product, dose, route, refills and specific instruction.
 - Record the order directly in client's chart as the order is received.
 - Read back all telephone orders, including spelling of drug name and dose confirmation in single digit format, e.g. 50 micrograms, read back "five, zero micrograms".
 - Verify indication for medication.
 - Ask questions as needed
 - Consider review by a second practitioner before filling order.
 - Call the practitioner with questions.
- 4.0 On request for information by a third-party, the nurse must collect and disclose information (including requests for transfer of file or prescription) as permitted by the policy of the Regional Health Authority/Facility, The Freedom of Information and Protection of Privacy Act (FIPPA) <http://www.gov.mb.ca/chc/fippa/index.html>, and The Personal Health Information Act (PHIA) <http://www.gov.mb.ca/health/phia/index.html>.

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TITLE Appendix A Clients With Intellectual Disability and Contraceptive Health Needs	AUTHORIZED BY Public Health Managers Network and Health Programs and Services Executives' Network (HPSEN)	PAGE 54 of 101

CLIENTS WITH INTELLECTUAL DISABILITY AND CONTRACEPTIVE HEALTH NEEDS

Intellectual disability (ID) refers to a disability that is characterized by significant limitations in cognitive functioning and adaptive behavior (conceptual, social and practical skills that originate (Wilkinson & Cerreto, 2008).

Individuals with an intellectual disability (ID), have the right to develop and express sexuality in an emotionally satisfying, socially and culturally appropriate manner. Their reproductive and contraceptive health needs parallels the general population. Sexuality is an intrinsic aspect of human development for all. People with an ID experience the same stages of human growth and development (including sexual and reproductive) as those in the general population. All individuals, regardless of ability, are sexual beings (Van Dyke, McBrien, & Sherbony, 1995). People with an ID often have limited access to appropriate, comprehensive reproductive health services (Waxman, 1994). This limitation is often due to the failure of health care providers to acknowledge the sexual and reproductive health needs of clients with ID compounded by the lack of knowledge, understanding and skills necessary to work effectively with this population (Wilkinson & Cerreto, 2008).

CARE CONSIDERATIONS

Vulnerabilities

- Intellectual, adaptive and independent functioning capacity of people with ID varies widely. An individualized approach to care and management is required.
- People with ID may have a tendency towards a traditional view of gender roles, sex for reproduction only, appropriateness of discussing personal concerns or “taboo” subjects with others.
- People with ID are at increased risk for unplanned pregnancy, sexually transmitted infection, sexual exploitation and maltreatment due to isolation, communication deficits, a generally small peer group and limited support services. In studies, 50% of mildly disabled individuals have had intercourse. Up to 90% of people with ID had been assaulted at least once in their life (15-25% assaulted by family members and 15% by friends of family) (Schlor, 1987; Schwab, 1992)
- People with ID may live on modest incomes and many live in poverty or less safe neighbourhoods.
- People with ID are often receiving health care that is incomplete, particularly related to preventative health services and routine screening. Health care providers may need to initiate discussions, ask specific assessment questions and take on an active advocacy role for clients with ID.

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Legal Status of the Client

- Competency is a legal issue. Vulnerable persons are presumed to have the capacity to make decisions affecting themselves, unless demonstrated otherwise. Parents for example cannot make health decisions for their adult child with ID unless designated as a decision-maker under the Vulnerable Persons Living with a Disability Act.
- Many clients with ID have social services workers, Public Trustee or family member who provides support. Health care providers need to clarify who they are mandated to share personal health information with, who is authorized to give consent for health care and when the client themselves must allow for the release of their personal health information.
- When clients have a substitute decision-maker, the health care provider must clarify the extent to which the substitute decision-maker wishes to be involved in routine health care and decision-making. This will vary depending on the capacity of the individual, the nature of the care required, the risk/benefit to the client and invasiveness of the proposed care.
- Refer to the Vulnerable Persons Living with a Disability Act, Manitoba Family Services and Consumer Affairs: http://www.gov.mb.ca/fs/pwd/what_is_vpa.html.

Functional Level of Client

- Care providers need to focus on abilities not disabilities of all clients.
- An individual may be able to make an informed decision in some situations but not in others.
- As for all clients, the ability to provide informed consent is an interactive process that must be individualized. The following needs to be considered:
 - Client's ability to receive, comprehend, retain and recall relevant information
 - A demonstrated ability to integrate the information received into one's situation
 - Ability to evaluate benefits and risks in terms of personal values
 - Ability to select an option and give reasons for the choice
 - Ability to communicate one's choices to others
 - Ability to act voluntarily and not under pressure from anyone
 - Ability to persevere with a choice until the decision is acted upon.

Routine Health Maintenance

- Clients with ID have the same need for routine screening, monitoring and access to health care as the general population. It is discriminating to assume that a particular treatment or care option is inappropriate only because the person has an ID.

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- Many clients with ID are able to take an active role in the decision-making for their personal health needs.
- The health care provider may need to initiate nonjudgmental discussions around sexual health and provide clear information tailored to the client's abilities.
- Due to the vulnerabilities of clients with ID, screening for neglect, physical, sexual, emotional or financial abuse should occur as indicated and annually.
- The health care provider, in discussion with the client and their substitute decision-maker, should individualize care based of the client's risk factors, symptoms and ability to cope with recommended interventions.
- Client with ID may require coaching regarding appropriate personal boundaries, behaviors related to lifestyle choices, how to access health services, how to talk to health care providers and how to recognize changes in their health.

Client Education

- Clients may not always be able to identify or request assistance related to perceived private matters such as family violence, intimate partner violence, unplanned pregnancy or sexual health concerns.
- Never assume knowledge and understanding. Determine level of understanding by promoting a dialogue with clients, rather than asking questions that can be answered with a yes/no. Clients with ID may have expressive language skills that suggest they have a higher level of knowledge and understanding than they actually do. Saying the words does not mean you understand them.
- As with all clients, use plain language that is clear and concise. Be specific in what you are describing or asking, speak directly and with respect.
- Complex information must be presented in a clear and simplified manner. Provide information one concept at a time. Provide opportunity for the first piece of information to be understood before proceeding to the next. Avoid the use of abstract questions or situations. Have clients describe in their own words what they know or have understood about the information shared with them, i.e. can you show me, can you tell me...
- Use terminology the client is most familiar with. Common or street language may need to be incorporate into education and discussions.
- People with ID often require more time to process and respond to questions and information.
- People with ID have varying degrees of abstract comprehension and are often kinesthetic learners. Immediate feedback, visual aids and opportunity to practice new skills will enhance learning.

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Contraceptive Management

- Clients with ID require the same comprehensive assessment and discussion related to contraceptive options as the general population. Ability to self-manage, adhere to a specific option, care-giver support, additional health concerns and medications must be given careful consideration.
- Therapy options related to therapeutic amenorrhea should consider the client's preference, personal challenges managing monthly menses, adherence concerns and risk/benefit.
- Condoms require a high level of personal initiative, negotiation skills and physical dexterity. This may present a significant challenge for some. Health care providers should assess the capacity of individuals to use condoms and discuss appropriately.
- Client with ID must be assessed for suitability of intrauterine devices. Some clients may have challenges identifying and reporting signs of complications such as severe abdominal pain.

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Refer to current pharmaceutical references for detailed medication information.

Be aware that contraceptive options, Pharmacare or third-party coverage is subject to change without notice. Refer to Manitoba Health Formulary <http://www.gov.mb.ca/health/mdbif/index.html>, the specific extended health benefits carrier or your community pharmacist with coverage questions.

Name	Dose	Type	Coverage
Alesse Aviane	Ethinyl estradiol 20 <i>ug</i> and Levonorgestrel 0.1 mg	OCEP, Monophasic, 21 (21/7 day off) or 28 (21/7) day	Pharmacare, most drug plans, FNIHB and FS-EIA
Brevicon 0.5/35 Ortho 0.5/35	Ethinyl estradiol 35 <i>ug</i> and Norethindrone 0.5 mg	OCEP, Monophasic, 21 or 28 day	Pharmacare, most drug plans, FNIHB and FSH-EIA
Brevicon 1/35 Ortho 1/35 Select 1/35	Ethinyl estradiol 35 <i>ug</i> and Norethindrone 1 mg	OCEP, Monophasic, 21 or 28 day	Pharmacare, most drug plans, FNIHB and FS-EIA
Copper IUDs Nova T Flexi T	Flexi T 300 for nulliparous women w uterine sound length < 7.5 cm or previous C-section. Flexi T +300 for women 40+ years old with uterine sound > 8 cm or > 2 deliveries. Flexi T +380 for women 23-40 years old with uterine sound > 8 cm or > 2 deliveries.	Intrauterine Device, 5 years Effective emergency contraception when inserted up to 7 days post-coital.	Nova T covered by Pharmacare, most drug plans, FNIHB and FS-EIA. Flexi T covered by FS-EIA.
Cyclen	Ethinyl estradiol 35 <i>ug</i> and Norgestimate 0.25 mg	OCEP, Monophasic, 21 or 28 day	Pharmacare, most drug plans, FNIHB and FS-EIA
Demulen	Ethinyl estradiol 30 <i>ug</i> and Ethinodiol diacetate 2 mg	OCEP, Monophasic, 21 or 28 day	Pharmacare, most drug plans, FNIHB and FS-EIA
Depot-Provera Medroxyprogesterone Acetate	Medroxyprogesterone acetate 150 mg every 12 weeks	Intramuscular injection every 12 weeks	Pharmacare, most drug plans, FNIHB and FS-EIA
Diane 35 Cyestra 35 Licensed as acne therapy. Off-label use for contraception.	Ethinyl estradiol 35 <i>ug</i> and Cyproterone acetate 2 mg	OCEP, Monophasic, 21 day	More costly than combination hormonal contraception. May be covered by Pharmacare, most drug plans, FNIHB and FS-EIA with Exceptional Drug Status application.
Evra	Ethinyl estradiol 600 <i>ug</i> and Norgestromin 6 mg weekly patch w daily release approx equal to Ethinyl estradiol 35 <i>ug</i> & Norelgestromin 200 mg	Transdermal Combined Estrogen & Progestin, Monophasic, weekly patch for 3 wks & no patch for 1 wk	May be covered by Pharmacare, most drug plans, FNIHB and FS-EIA with Exceptional Drug Status application.
Linessa	Ethinyl estradiol 25 <i>ug</i> and	OCEP, Triphasic, 21 or	Pharmacare, most drug plans,

OCEP = Oral – Combined Estrogen and Progestin
FNIHB = First Nations Inuit Health Branch
FS-EIA = Family Services – Employment and Income Assistance

Accurate as of June 13, 2011

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Name	Dose	Type	Coverage
	Desogestrel 0.1 mg/0.125 mg/0.15 mg	28 day	FNIHB and FS-EIA
Loestrin 1.5/30	Ethinyl estradiol 30 <i>ug</i> and Norethindrone acetate 1.5mg	OCEP, Monophasic, 21 or 28 day	Pharmacare, most drug plans, FNIHB and FS-EIA
Marvelon Ortho-cept Apri	Ethinyl estradiol 30 <i>ug</i> and Desogestrel 0.15 mg	OCEP, Monophasic, 21 or 28 day	Pharmacare, most drug plans, FNIHB and FS-EIA
Micronor	Norethindrone 0.35 mg	Oral Progestin-only Monophasic 28 day continuous	Pharmacare, most drug plans, FNIHB and FS-EIA
Minestrin 1/20	Ethinyl estradiol 20 <i>ug</i> and Norethindrone acetate 1 mg	OCEP, Monophasic 21 or 28 day	Pharmacare, most drug plans, FNIHB and FS-EIA
Min-ovral Portia	Ethinyl estradiol 30 <i>ug</i> and Levonorgestrel 0.15 mg	OCEP, Monophasic, 21 or 28 day	Pharmacare, most drug plans, FNIHB and FS-EIA
Mirena LNG-IUS	Levonorgestrel 52 mg with 20 <i>ug</i> daily release	Intrauterine System, Progestin-only, effective up to 5 yrs	May be covered by Pharmacare, most drug plans, FNIHB and FS-EIA with Exceptional Drug Status application.
Nuva	Ethinyl estradiol 15 <i>ug</i> and etonorgestrel 120 <i>ug</i> daily release	Vaginal Ring, combined estrogen and progestin, worn for 3 weeks & 1 week no ring	May be covered by some drug plans. Not covered by FNIHB, FS-EIA or Pharmacare.
Ortho 7/7/7	Ethinyl estradiol 35 <i>ug</i> and Norethindrone 0.5 mg/0.75 mg/1 mg	OCEP, Triphasic, 21 or 28 day	Pharmacare, most drug plans, FNIHB and FS-EIA
Plan B Norlevo	Levonorgestrel 0.75 mg x 2 tablets taken together.	Emergency Contraception, Progestin-only, most effective when taken as soon as possible/within 24-48 hrs post-coital. Of benefit up to 5 days post-coital	Non-prescription. Covered by FNIHB and FS-EIA with a prescription.
Seasonale	Ethinyl estradiol 30 <i>ug</i> and Levonorgestrel 0.15 mg	OCEP, Monophasic, 84/7 day	May be covered by some drug plans. Not covered by FNIHB, FS-EIA or Pharmacare.
Synphasic	Ethinyl estradiol 35 <i>ug</i> and Norethindrone 0.5 mg/1 mg/0.5 mg	OCEP, Triphasic, 21 or 28 day	Pharmacare, most drug plans, FNIHB and FS-EIA
Tri-cyclen	Ethinyl estradiol 35 <i>ug</i> and	OCEP, Triphasic,	Pharmacare, most drug plans,

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Name	Dose	Type	Coverage
	Norgestimate 0.18 mg/0.215 mg/0.25 mg	21 or 28 day	FNIHB and FS-EIA
Tri-cyclen Lo	Ethinyl estradiol 25 <i>ug</i> and Norgestimate 0.18 mg/0.215 mg/0.25 mg	OCEP, Triphasic, 21 or 28 day	Pharmacare, most drug plans, FNIHB and FS-EIA
Triquilar	Ethinyl estradiol 30 <i>ug</i> /40 <i>ug</i> /30 <i>ug</i> and Levonorgestrel 0.05 mg/0.075 mg/0.125 mg	OCEP, Triphasic, 21 or 28 day	Pharmacare, most drug plans, FNIHB and FSH-EIA
Yasmin	Ethinyl estradiol 30 <i>ug</i> and Drospirenone 3 mg	OCEP, Monophasic, 21 or 28 day	Pharmacare, most drug plans, FNIHB and FS-EIA
Yaz	Ethinyl estradiol 20 <i>ug</i> and Drospirenone 3 mg	OCEP, Monophasic, 24/4 day	Pharmacare, most drug plans, FNIHB and FS-EIA

The Canadian Nurses Association offers all RNs in Canada access to e-Therapeutics+. To access:

1. Go to Canadian Nurse Association http://www.cna-nurses.ca/cna/default_e.aspx
2. Select link to Nurse One <http://www.nurseone.ca/index.php?lang=en>
3. Nurses require their valid CRMN # to register with Nurse One
4. Create your personal password account
5. Go to the Library tab to access e-Therapeutics+.

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LESBIAN, GAY, BISEXUAL, TRANSGENDER, TRANSSEXUAL, TWO-SPIRITED, INTERSEX, QUEER AND QUESTIONING COMMUNITY

The lesbian, gay, bisexual, transgender, transsexual, Two-spirited, intersex, queer, and questioning community (LGBTTTIQ), represents a diverse community that often face significant barriers when trying to access health care (Gay and Lesbian Medical Association, 2009; Nova Scotia Rainbow Action Project, 2006).

While member of the LGBTTTIQ community have the same health concerns and needs as the general population, discrimination based on sexual orientation and gender identity produce health inequities for the LGBTTTIQ community. It has been well documented that members of the LGBTTTIQ community and in particular youth, have higher rates of suicide, depression, substance use, tobacco use, self-harm behaviors, and undiagnosed physical and mental health conditions. Members of the LGBTTTIQ community may also receive less preventative health care and screening or have unique risks for cancers, healthy body weight issues, sexually transmitted infections or fertility issues. Regardless if barriers are real or perceived, they interfere with an individual's ability to easily access care and ultimately lead to adverse health outcomes. Barriers can be rooted in societal attitudes, family attitudes, personal attitudes, lack of knowledge and awareness, and systemic discrimination (Gay and Lesbian Medical Association, 2009; Jackson, et al., 2006; Nova Scotia Rainbow Action Project, 2006).

Organizations committed to enhancing access and care for members of the LGBTTTIQ community can assess and modify their environment, services, policies, intake and assessment process/forms, and staffing, to create services that are more inclusive of people (Gay and Lesbian Medical Association, 2009; Nova Scotia Rainbow Action Project, 2006).

For example, does your service:

- Have and display positive statements related to equal access for all people/all genders/all orientations.
- Display educational resources, community newspapers or media items that support sexual/gender diversity.
- Use inclusive language on forms: male, female, transgender; various options for relationship status and significant others.
- Gender neutral washrooms.
- Audit service and identify opportunities to be more inclusive.

Health care providers tend to underestimate the proportion of LGBTTTIQ people in their practice. One of the reasons is that clients may be reluctant to disclose their sexual orientation to

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their health care provider. “Coming-out” is a process of personal and public disclosure that happens overtime as an individual gains insight, affirmation and comfort with themselves and a sense acceptance by others (Brotman & Ryan, 2002). Many LGBTTTIQ people are never fully “out” in all contexts or aspects of their lives. Youth in particular are just beginning this process and may not be comfortable discussing all aspects of their sexuality and issues related to gender identity or expression with their health care provider. The more self-affirmed an individual is about their sexual orientation and gender identity, the better one’s physical and psychological wellness (Brotman & Ryan, 2002).

The process of self-acceptance can begin with:

- Questioning your feelings
- Acknowledging your feelings
- Exploring your feelings
- Accepting your feelings
- Feeling good about your feelings
- Integrating your feelings (Brotman & Ryan, 2002).

Components of an inclusive or non-heterosexist approach by a health care provider include:

- Validation of all relationships. e.g. ask individuals who are important for them, how they refer to them
- Not making assumptions about sexual orientation or gender identity
- Not making assumptions about sexual behaviors or that particular sexual behaviors indicate sexual orientation
- Not making assumptions about monogamy
- Being inclusive of all youth
- Understanding that heterosexuality does not guarantee happiness; same-sex attraction does not guarantee sadness
- Awareness that sexual and gender expression happens along a continuum, one experience does not determine sexual orientation or gender identity
- Clarifying the real issue for the individual, do not assume the issue is sexual orientation
- Acknowledgement that intimate partner violence, sexual exploitation, sexually transmitted infections or sexual health concerns can happen for anyone
- Not minimizing the impact of homophobia and heterosexism
- Collaborating with the client as a partner in their health, (Brotman & Ryan, 2002).

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DEFINITIONS (adapted from Jackson, et al., 2006)

Bisexual: One who has sexual or romantic attractions to members of the same gender and/or sex as well as another gender and/or sex, or who identifies as a member of the bisexual community. Contrary to popular myths, people who are attracted to members of both genders or sexes (just like people who are attracted only to members of the same or other gender or sex) may be monogamous, polyfidelitous or non-monogamous.

Gay: One who has sexual or romantic attractions primarily to members of the same gender or sex, or who identifies as a member of the gay community. May be of any gender identity. Sometimes used as a synonym for gay male, lesgay, or LesBiGay. Lesbians and bisexuals often do not feel included by this term.

Gender Identity: The gender one identifies with, regardless of their biological sex.

Gender and Sexual Diversity: A term that captures the diversity of gender identities and sexualities such a lesbians, gays, bisexuals, transsexuals, transgendered, Two Spirit and intersex..

Heterosexism: A belief that heterosexuality is the norm and/or superior to all other forms of sexuality. Other sexualities may be considered abnormal, unnatural or not considered at all.

Homophobia: An irrational fear of people who are attracted to and intimate with members of the same sex.

Intersex: One whose external genitalia at birth do not match definitions of male or female (e.g. large clitoris, tiny penis), or one whose sex glands do not totally match the sex assigned at birth (e.g. male with ovarian tissue or female with testicular tissue), or one whose sexual development does not match the sex assigned at birth (e.g. development of penis or extensive facial hair in one assigned as female or the development of breasts in one assigned as male).

Lesbian: A girl or woman who has sexual or romantic attractions primarily to members of the same gender or sex, or who identifies as a member of the lesbian community. Bisexual women often do not feel included by this term.

Queer: Reclaimed derogatory slang for the sexual minority community. Not accepted by all the sexual minority community, especially older members. Sometimes the term is used for an even wider spectrum of marginalized or radicalized groups and individuals.

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Sexual Minorities: Communities that stand apart from the dominant heterosexual community based on their sexual desires and expression. This may be inclusive of lesbians, gays, bisexuals, transsexuals, transgendered and intersex people. This terminology is more commonly used in the USA and to some extent in Canada.

Sexual Orientation: Sexual attraction or activity that may involve the opposite sex (heterosexuality), the same sex (lesbian or gay) and/or both sexes (bisexuality). This may be fixed or fluid. This terminology is more commonly used in Canada and the USA.

Sexual Reassignment Surgery: A surgical procedure which changes one's primary sexual characteristics from those of one sex to those of another sex, to align them with one's gender identity (Hamilton 2000).

Sexuality: Sexual attraction or activity that may involve the opposite sex (heterosexuality), the same sex (lesbian or gay) and/or both sexes (bisexuality). This may be fixed or fluid. This terminology is more commonly used in the United Kingdom.

Transgendered: A transgendered person has no desire to be their "opposite sex", but rather takes on characteristics of their opposite gender, exhibiting stereotypical masculine or feminine modes of dress or behavior. A transgendered person may feel society is limiting his or her personal expression by maintaining only two distinct gender constructs. "Transgendered" is a term, which also serves as a banner, which covers all those who transgress society's notions of how biological sex and gender link together. Many transsexuals disagree with using the word this way, and do not choose to be lumped under this umbrella category.

Transsexual: One who changes one's sex to align with one's gender identity. Change of primary sex characteristics is accomplished by sexual reassignment surgery. Hormone therapy, electrolysis, additional surgery and other treatments that can change secondary sex characteristics. People who live as a different gender than their physical gender.

Two-Spirit: Refers to a person with both female and male spirits and/or characteristics. In some First Nations' communities, refers to people who do not fit traditional gender role associated with their physical sex. Depending on the community, they might fit a different gender role, sometimes as religious leaders, or they might simply choose to live in the gender role usually assigned to another physical sex. Traditionally, the Two-Spirit person was one who had received a gift from the Creator, that gift being the privilege to house both male and female spirits in their body.

REPRODUCTIVE HEALTH HISTORY

NAME _____	PHIN: _____	D.O.B. _____ (YY, MM, DD)
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PERSONAL HISTORY

- | | | | |
|-----------------------------------|-----------------------------|------------------------------|-------|
| Allergies | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| Medications | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| Heart or blood pressure problems | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| Thrombosis /DVT | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| CVA | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| Bleeding disorders | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| Diabetes | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| Migraines or headaches | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| Vaginal or bladder infections | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| Liver problems or hepatitis | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| Breast lumps | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| Ovarian cysts | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| Pelvic Inflammatory Disease (PID) | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| Skin problems or acne | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| Muscle or bone problems | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| Depression or anxiety | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| Other health condition | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |

IMMUNIZATION HISTORY

- | | | | |
|--------------------------|--|---------------------------------|--|
| | MIMS reviewed <input type="checkbox"/> | EChart <input type="checkbox"/> | |
| Rubella Immunization | Yes <input type="checkbox"/> | Date _____ | No <input type="checkbox"/> Recommended <input type="checkbox"/> Declined <input type="checkbox"/> |
| Hepatitis B Immunization | Yes <input type="checkbox"/> | Date _____ | No <input type="checkbox"/> Recommended <input type="checkbox"/> Declined <input type="checkbox"/> |
| HPV Immunization | Yes <input type="checkbox"/> | Date _____ | No <input type="checkbox"/> Recommended <input type="checkbox"/> Declined <input type="checkbox"/> |
| Tdap | Yes <input type="checkbox"/> | Date _____ | No <input type="checkbox"/> Recommended <input type="checkbox"/> Declined <input type="checkbox"/> |
| Other _____ | | | |

Appendix D Sample Forms

NAME _____	PHIN: _____	D.O.B. _____ (YY, MM, DD)
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FAMILY HISTORY

- Cancer of the breast, uterus or ovary Unknown No Yes _____
- Heart disease Unknown No Yes _____
- High blood pressure Unknown No Yes _____
- Thrombosis/CVA Unknown No Yes _____
- Diabetes Unknown No Yes _____
- Other Unknown No Yes _____

PSYCHOSOCIAL HISTORY

- Where are you living: _____
- Satisfaction with current living situation: _____
- Do you feel safe: _____
- Support people: _____
- Third-party coverage (record file number if known)
 - Employment Income Assistance _____
 - Treaty Status _____
 - Extended Health Benefits _____
- Barriers to accessing third-party: No Yes _____

LIFESTYLE HISTORY

- School _____ Employment _____
 - Do you have home-made (non-sterile): tattoo electrolysis body or skin piercing acupuncture
 - Tobacco use: No Yes Type _____ Amount/day or week _____
 - Alcohol use: No Yes How many drinks per week? _____
 - Other drugs/substances use: No Yes Frequency _____ Type _____
- _____

Appendix D Sample Forms

NAME _____ PHIN: _____ D.O.B. _____
(YY, MM, DD)

MENSTRUAL HISTORY

Age of first menses: _____ LNMP _____
Frequency of menses: every 28 days more than 28 days less than 28 days
Flow of menses: light medium heavy # days _____
Are your periods painful: No Yes _____
Abnormal vaginal bleeding: No Yes _____
Premenstrual Symptoms: No Yes _____

OBSTETRICAL HISTORY

Previous pregnancies: No Yes G: ____ P: ____ Ectopic: ____ SA: ____ TA: ____ Other: ____
Currently breastfeeding; No Yes _____

SEXUAL HEALTH HISTORY

Have you ever been sexually active: No Yes _____
Are your partners: males females both
Date of last sex: _____ Are you in a relationship? No Yes _____
Age of first intercourse: _____ # of sexual partners to-date: _____
Ever pressured to have sex: No Yes _____
Ever had sex for drugs or money: No Yes _____
Physical pain or bleeding during or after sex: No Yes _____
Ever thought you were pregnant: No Yes How often? _____ Previous pregnancy test: Yes No
Ever had a Sexually Transmitted Infection: No Yes _____
Pap Test: N/A No Yes Date of last test? _____ Abnormal No Yes _____
Past contraceptive methods: Pills Patch Ring Depot IUD Condoms Other _____
Use of Emergency Contraception: No Yes Number of times? _____

Date: _____ Name & Signature: _____
(YY, MM, DD)

Appendix D Sample Forms

Reproductive Health Record	
Client Name	Date of Birth
MHSC #:	PHIN:
Address:	Phone Number(s)
Initial Visit	
Health History Reason for visit _____ Discuss client/provider responsibility Yes <input type="checkbox"/> No <input type="checkbox"/> Discuss Confidentiality Yes <input type="checkbox"/> No <input type="checkbox"/> Parent aware of sexual activity/contraception: Yes <input type="checkbox"/> No <input type="checkbox"/> _____ Health History Form completed: Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindications to contraception: Yes <input type="checkbox"/> No <input type="checkbox"/> _____	Teaching Print resources given: Yes <input type="checkbox"/> No <input type="checkbox"/> Instructed how to use contraception Yes <input type="checkbox"/> No <input type="checkbox"/> Advised re: risks/warnings Yes <input type="checkbox"/> No <input type="checkbox"/> Reviewed potential adverse effects: Yes <input type="checkbox"/> No <input type="checkbox"/> Reviewed missed doses: Yes <input type="checkbox"/> No <input type="checkbox"/> Info re: emergency contraception Yes <input type="checkbox"/> No <input type="checkbox"/> STI Education Yes <input type="checkbox"/> No <input type="checkbox"/>
Sexual History Are you sexually active at present: No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Sexually Transmitted Infection Assessment STI risk factors: No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Blood-borne infection risk factors: No <input type="checkbox"/> Yes <input type="checkbox"/> _____	Contraceptive Option Prescribing Provider: _____ Name of Contraceptive: _____ Amount given: _____ Lot #: _____ Amount left on prescription _____ Condoms provided: Yes <input type="checkbox"/> No <input type="checkbox"/>
Physical Exam Blood pressure _____ Weight (as indicated) _____ Height _____ STI swabs/urine done: No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Pregnancy Test done: Pos <input type="checkbox"/> Neg <input type="checkbox"/> N/A <input type="checkbox"/> Request Pap Test history: Yes <input type="checkbox"/> Last Pap Test _____ Pap Test N/A <input type="checkbox"/> Pap Test recommended <input type="checkbox"/> Done <input type="checkbox"/>	Additional Notes Next Appointment:
Sign & Date	

Appendix D Sample Forms

Reproductive Health Record	
Client Name	Date of Birth
MHSC #:	PHIN:
Address:	Phone Number(s)
Follow-up	
DATE	
Health History Questions/Concerns: _____ Changes to Health History: No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Changes to menses since last visit: No <input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> lighter <input type="checkbox"/> heavier <input type="checkbox"/> shorter <input type="checkbox"/> longer <input type="checkbox"/> other: _____ Bleeding/spotting: No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Changes since last visit: <input type="checkbox"/> headaches _____ <input type="checkbox"/> breasts _____ <input type="checkbox"/> weight _____ <input type="checkbox"/> vision _____ <input type="checkbox"/> mood _____ <input type="checkbox"/> other: _____ Tobacco use: No <input type="checkbox"/> Yes <input type="checkbox"/> Amount: _____	Teaching Community resources discussed: No <input type="checkbox"/> Yes <input type="checkbox"/> Harm reduction discussed: No <input type="checkbox"/> Yes <input type="checkbox"/> Decision making/communication discussed: No <input type="checkbox"/> Yes <input type="checkbox"/> Relationships discussed (healthy vs. non-healthy): No <input type="checkbox"/> Yes <input type="checkbox"/> Comments:
Sexual History Are you sexually active at present?: No <input type="checkbox"/> Yes <input type="checkbox"/> _____ # of sexual partners since last visit? _____ Consistent and correct condom use: Yes <input type="checkbox"/> No <input type="checkbox"/> Cpmments: _____ Condoms ever slipped or broken: No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Physical pain or bleeding during or after sex: No <input type="checkbox"/> Yes <input type="checkbox"/> Comments: _____ Emergency Contraception since last visit: No <input type="checkbox"/> Yes <input type="checkbox"/> Date: _____ Comments: _____	Contraception Able to purchase contraception supplies: Yes <input type="checkbox"/> No <input type="checkbox"/> _____ Explore with client their ability to plan/budget for contraception: _____ Concerns with contraception: No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Name of Contraceptive: _____ Amount given: _____ Lot #: _____ Amount left on prescription _____ Condoms provided <input type="checkbox"/> yes <input type="checkbox"/> no
Physical Exam Blood pressure _____ Weight (as indicated) _____ STI swabs/urine/blood done: No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Pregnancy Test done: Pos <input type="checkbox"/> Neg <input type="checkbox"/> N/A <input type="checkbox"/> Pap Test N/A <input type="checkbox"/> Pap Test recommended <input type="checkbox"/> Done <input type="checkbox"/>	Additional Notes Next Appt
Sign & Date	

Appendix E: Guide to Referral Routes for Pro-Choice Services in Manitoba

GUIDE TO REFERRAL ROUTES FOR PRO-CHOICE SERVICES IN MANITOBA

The purpose of the document is to ensure Manitoba service providers have the necessary information to make timely pregnancy counselling and abortion referrals for their clients. The information is current as of the date printed on the document. If it has been some time since you have made a referral, contact the appropriate agency to insure that there have been no significant changes in their referral process.

There are several agencies which assist women with pregnancy counselling by providing accurate, non-judgmental information about all pregnancy options, abortion, adoption or parenting (See list at the end of this appendix). Women, who are certain of their decision to have an abortion, may be referred directly to appropriate abortion providers. Some providers accept self-referrals. Abortions are funded by Manitoba Health.

PREGNANCY COUNSELLING

The goal of decision-making counselling is to assist the woman to make the best choice for herself regarding her unintended pregnancy.

For many women, this initial counselling session may be the first time she has discussed her unintended pregnancy. Women may be fearful that they may not be able to access the services they wish. Some may be conflicted and/or undecided about their decisions. Others may know what they want and only require assistance accessing the necessary services.

Decision-making pregnancy counselling that supports all three-pregnancy choices must occur in a setting that is client centered. Respectful non-judgmental communication, informed decision-making and confidentiality are key elements of all client interactions. Research shows that women, who are appropriately counselled and supported throughout her entire unintended pregnancy experience, have no adverse adjustment issues post-abortion.

Community service providers may have the necessary training and skills to assist clients with the decision-making aspect of pregnancy counselling. If pregnancy counselling services are not available within your agency or community, clients can be referred to the following agencies for decision making counselling (See below for complete contact information):

Winnipeg Agencies

Health Action Centre

Klinik Community Health Centre

Mount Carmel Clinic

Nor' West Co-op Community Health Centre

Women's Health Clinic, Graham Avenue site

Health Sciences Centre Pregnancy Counselling Clinic, Women's Hospital

Brandon Agency

Sexual Health Program, Public Health Services

Appendix E: Guide to Referral Routes for Pro-Choice Services in Manitoba

ABORTION REFERRALS

Once a woman has made her decision to proceed with an abortion, the following section outlines the referral process. Currently in Manitoba, therapeutic abortions can be done up to 19 weeks 6 days gestation. Therapeutic abortions are safest when done prior to 16 weeks gestation. It is up to each individual abortion provider to decide their gestational limit. There are more provider options for first trimester and up to 16 weeks gestation services. Women under the age of 18 years of age may be able to get an abortion without parental consent. It is up to the discretion of each individual abortion provider to decide if they will require parental consent for youth under the age of 18 years or if a woman, regardless of age, is in fact able to give an informed consent for the procedure. Providers can not be mandated to provide service. Early referral is essential to insure a client's choice can be accommodated.

Although Women can self-refer for pregnancy counselling or abortion services to agencies listed at the end of this appendix, these agencies can not authorize travel warrants or grants. Women, who require financial assistance with travel costs, must contact their local health service agencies for assessment and referral. This process is the same for all referrals for health care services that are not available in one's home community.

Women without Manitoba Health coverage may need to pay for services upfront and then apply to any third party insurance carriers they may have. Women with health coverage from another Canadian province may be able to have their home province billed directly for the abortion procedure.

1. Options for Abortion Services

- **Health Science Centre Pregnancy Counselling Clinic** (phone 787-1980, fax 787-2876)
 - Pregnancy Counselling Clinic:
 - By appointment only, no walk-in services. Self-referral or provider-referral.
 - Intended for women who require decision-making counselling or who do not have access to a health care provider that can assist with decision-making counselling or “pre-op” assessment.
 - The initial appointment involves counselling with a nurse to discuss options for the client's unintended pregnancy.
 - For women opting for an abortion, the procedure is explained by the nurse, medical assessment including pelvic examination is arranged and the abortion scheduled.
 - Depending on gestational age, previous vaginal deliveries or provider preference, insertion of a cervical Laminaria Tent the day prior to the abortion procedure may be required. Some providers may opt to use Misoprostol to soften the cervix prior to the abortion procedure.
 - Although the abortion procedure itself takes less than 15 minutes, women can expect to be at the hospital approximately 3 - 4 hours.
 - Special scheduling arrangements can often be made for women from outside Winnipeg to minimize the number of days away from home. Discuss scheduling considerations when making the referral.
 - It is requested that health care providers/agencies fax all relevant lab and ultrasound results to the clinic before the appointment date.

Appendix E: Guide to Referral Routes for Pro-Choice Services in Manitoba

- Abortions performed up to 19 weeks 6 days gestation, dependent on abortion provider availability and assessment.
- Consent of one parent is usually required for women under 18 years of age. Some providers may perform an abortion without parental consent.
- International students with insurance coverage can have their abortion services billed directly to their insurance carriers. Women with coverage from another Canadian province can also have abortion services billed directly to home province.
- Mandatory social work referral required for all youth < 14 years of age at time of conception.

- **Fast Track:**
 - Women who received comprehensive pregnancy counselling with a “pre-op” assessment by their community health care provider can be referred directly for Laminaria Tent insertion and abortion procedure (refer to details in section “Initial Assessment” for “pre-op” requirements).

- **Private Physician**
 - There are several private physicians who will accept abortion referrals from health care providers. Please include all appropriate lab and ultrasound reports. Women are seen in the physician’s office for an initial assessment and given a follow-up appointment for the Laminaria Tent insertion (if required) and abortion procedure.
 - Some private physicians will accept “Fast Track” referrals or self-referrals.
 - Gestational limits for abortions and parental consent for youth under the age of 18 years, varies from provider to provider.
 - For security reasons, private physicians are not listed in this document. Please contact any agency listed below for assistance.

- **Women’s Health Clinic-Portage Site** (phone 477-1887, fax 477-1888)
 - The clinic provides abortions from 5.5 - 16 weeks gestation.
 - Parental consent is not required. All women regardless of age must be able to give an informed consent.
 - It is preferred that women self-refer by phone.
 - For security reasons, people without an appointment will not be allowed access into facility.
 - Women are often required to leave a message including their name, contact phone number, best time to reach them during regular working hours, date of positive pregnancy test (home pregnancy test accepted) and first day of last normal menstrual period. The intake clerk will call back. Due to confidentiality reasons, message will not be left unless the caller indicated permission to do so.
 - If there are barriers that hinder a woman’s ability to self-refer, a health care provider can refer on her behalf. Please fax all relevant assessments, labs and ultrasound reports to WHC-Portage at the time of referral.
 - WHC-Portage does not offer decision-making counselling. Women’s Health Clinic-Graham or the other agencies listed in below, offer decision-making counselling.

Appendix E: Guide to Referral Routes for Pro-Choice Services in Manitoba

- Intake assessment and education is done via phone.
- Women are booked for informed consent counselling and abortion procedure. This is usually done as one appointment however in some cases it may involve two separate appointments.
- When indicated, WHC-Portage uses Misoprostol to soften cervix (no Laminaria Tent used).
- WHC-Portage will take an Rh blood sample for all clients having an abortion.
- Cervical/vaginal swabs for Gonorrhea, Chlamydia and Bacterial Vaginosis will be taken at the time of the procedure. If indicated, a Pap smear can be done as well..
- The client can expect to be at the clinic for about 4 hours.
- Northern Health Travel Grant application forms are available from the clinic to assist women traveling from Northern Ontario.
- International students with insurance may need to pay up-front then submit insurance claim.
- Women with coverage from another Canadian province may need to pay up-front.
- Women with the following health concerns should be referred to HSC-PCC:
 - Gestation of > 16 weeks at time of the procedure
 - Chronic, severe respiratory illness, with or without supplemental oxygen (e.g. bronchiectasis)
 - Significant cardiac disease
 - Bleeding disorders
 - Anticoagulation with Warfarin or heparin
 - Sickle cell disease or sickle cell trait with Hemoglobin <100
 - Unstable chronic health conditions (e.g. unstable seizure disorder, uncontrolled/unstable hyperthyroidism)
 - Any medical or psychological condition that may require general anesthesia (e.g. vaginismus, severe anxiety)
 - Any condition that may require specialized medical equipment or that may result in client's inability to assume the standard position for procedure (may include BMI > 35).
 - Severe allergies/history of anaphylactic reaction to medications or medical devices used in the clinic (may include latex)
 - Heavy narcotic or recreational drug use
 - Gestation of > 14 weeks with more than two previous cesarean sections or cesarean section within the last 6 months.
- **Medical (Medication) Abortion**
 - Medical abortions are done using a combination of Methotrexate and Misoprostol. They are available up to 49 days from the first day of the last normal menstrual period. Gestational age (less than 7 weeks) must be confirmed by ultrasound.
 - Currently, accessibility to Medical Abortions is very limited. Accessibility is dependent on health care provider availability.
 - Medical abortion requires strict medical follow-up. Women must be willing and able to attend all appointments for repeat blood work and follow-up. They must have access to a phone, transportation and live within 30 minutes of an emergency department.
 - Medical abortion has a 5-10% failure rate. If a medical abortion is not successful, the woman must have a surgical abortion because the Methotrexate and Misoprostol medications used

Appendix E: Guide to Referral Routes for Pro-Choice Services in Manitoba

are teratogenic and will result in fetal death or severe anomalies.

- For additional information contact Mount Carmel Clinic in Winnipeg (See details below).

- **Gestation > 19 weeks 6 days**

- There are clinics in Canada that offer abortion services up to 23 weeks 6 days.
- There are clinics in the United States that may offer abortion services beyond 24 weeks.
- Fees vary depending on gestational age. Women, who exceed the gestational limit in Manitoba and need to go to another Canadian Province to access abortion services, may have some of their expenses reimbursed by Manitoba Health. Women usually need to pay directly for the abortion procedure, associated costs, travel and accommodations. Afterwards, they submit a claim to Manitoba Health for possible reimbursement.
- National Abortion Federation (NAF) Canada has information related to abortion services in Canada and the United States. NAF may be able to offer financial assistance to enable women to access abortion services. NAF Hotline at 1-800-772-9100 for general abortion information including funding assistance information. 1-877-257-0012 for information about abortion services. <http://www.prochoice.org/canada/index.html> .
- Agencies listed below can assist with referral information for these out-of-province clinics.

2. Initial Assessment

- **Health Sciences Centre**

- Confirmation of pregnancy with clinical pregnancy test and assessment of gestational age. First date of LNMP acceptable if certain.
- Ultrasound are required for procedures done at Health Sciences Centre (HSC) if:
 - Unsure dates
 - ≥ 13 weeks gestation at the time of abortion
 - All clients age <16 years
 - Women weighing >250 pounds
 - Previous ectopic pregnancy
 - Language barrier
- Required lab work for abortions done at HSC:
 - Rh (from current pregnancy)
 - Hemoglobin if history of anemia or > 14 weeks gestation at time of abortion
 - Cervical swabs for Gonorrhea and Chlamydia
- Women presenting with an unintended pregnancy may have other unaddressed health concerns. A pregnancy offers a health promotion opportunity to have a comprehensive sexual health assessment done. Based on health history and clinical assessment, referring health care providers may opt to do the following:
 - Vaginal swabs for Bacteria Vaginosis, Trichomonias
 - Pap test
 - Serology for sexually transmitted infections: Syphilis, HIV, Hepatitis B, Hepatitis C
 - Serology for immunity to Rubella, Varicella
 - If relevant to the management of care for an abortion, positive results, treatments or follow-up plans should be shared with the abortion provider.

Appendix E: Guide to Referral Routes for Pro-Choice Services in Manitoba

- For procedures done in hospital setting, “pre-op” assessment required (use WRHA Preop Assessment Patient Questionnaire form or generic pre-op health history and physical assessment). It expedites care when referring clinician able to assist with this assessment.
- Obtaining consent for abortion procedure is responsibility of the abortion provider/surgeon.
- **Women’s Health Clinic--Portage**
 - WHC-Portage prefers clients phone them directly. If there are barriers that make this challenging for individual clients, providers/agencies can refer on their behalf.
 - WHC-Portage does not require a “pre-op” assessment or lab work prior to booking an abortion. However, to facilitate client care and reduce duplication, it is helpful when referring providers forward relevant clinical assessments and lab results.

3. Post Abortion Follow-Up

- It is very important that women follow all aftercare instructions they have been given. As indicated, to address ongoing contraceptive or health needs, women should follow-up with their primary care provider or referring provider.

AGENCIES THAT PROVIDE PREGNANCY COUNSELLING AND ABORTION REFERRAL

Agencies may have specific intake or referral criteria and may not be open to all women. All agencies will assist with referral information.

Sexual Health Program

Public Health Services
Brandon Regional Health Authority
A5–800 Rosser Ave, Brandon, MB R7A 6N5
Phone: 1-204-578-2513 Fax: 1-204-578-2824

Health Action Centre

640 Main St, Wpg, MB R3B 0L8
Phone: 940-1626 Fax: 942-7828

Health Sciences Centre

Pregnancy Counselling Clinic Women’s Hospital
735 Notre Dame Ave, Wpg, MB R3E 0L8
Phone: 787-1980 Fax: 787-2876

Klinik Community Health Centre

870 Portage Ave, Wpg, MB R3G 0P1
Phone: 784-4051 Fax: 772-4013

Mount Carmel Clinic

886 Main Street, Wpg, MB R2W 5L4
Phone: 589-9460 Fax: 582-6006

Nor’ West Co-op Community Health

103-61 Tyndall Ave, Wpg, MB R2X 2W2
Phone: 940-2020 Fax: 632-4666

Women’s Health Clinic-Graham

3rd Floor 419 Graham Avenue, Wpg, MB R3C 0M3
Phone: 947-1517 Fax: 944-0223

Women’s Health Clinic-Portage

Address disclosed when necessary
Wpg, MB
Phone: 477-1887 Fax: 477-1888

	CLINICAL PRACTICE GUIDELINE FOR THE DELIVERY OF CONTRACEPTIVE HEALTH SERVICES BY REGISTERED NURSES	DATE June 20, 2011
TITLE Appendix F Child Welfare Reporting	AUTHORIZED BY Public Health Managers Network and Health Programs and Services Executives' Network (HPSEN)	PAGE 76 of 101

OBLIGATION TO INFORM CHILD WELFARE AGENCY

Health care providers **are required** under the Child & Family Services Act to report all cases of suspected or known child protection concerns. As per the Child and Family Services Act “child in need of protection” is defined as where the life, health or emotional well-being of the child is endangered by the act or omission of a person. Health care providers are obligated to report this to a child protection agency such as Child & Family Services or the Police, or the child’s parent/guardian. When the concerns are related to the care provided by the parent or guardian, or the parent or guardian is unknown/unavailable, the report should be made directly to a child protection agency.

Unmarried youth who become pregnant and will be delivering their baby prior to their 18th birthday, must be referred to a Child Welfare agency. Early referral provided more opportunity for the Child Welfare agency and youth to best plan for the birth of the child. Notice of Maternity form states that it is to be completed by a maternity institution or hospital upon admission of a minor single mother for care during pregnancy or labour and delivery:
http://www.gov.mb.ca/fs/childfam/pubs/notice_of_maternity_fillable.pdf

The legal age of sexual consent in Canada is 16 years and older. Youth who become pregnant prior to their 16th birthday require a referral to a Child Welfare agency for assessment.

Currently the Child & Family Services Act does not specifically mention any obligation on the part of service providers to notify a child welfare agency when a youth in their care has accessed services (assuming that there are no immediate concerns about protection, safety, abuse)..

Refer to agency/regional policy for reporting process.

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HEALTH ACTION CENTRE

Primary Care Clinic
640 Main Street
Winnipeg, MB R3B 0L8

Tel: 940-1626
Fax: 942-7828

Health and Social Services Near You



March 17, 2011

Claudia Ash-Ponce
Executive Director, Child Protection
201-114 Garry Street
Winnipeg, Manitoba
R3C 4V5

Dear Ms Ash-Ponce

The Teen Services Network will be holding their next meeting in early May and I would like to follow-up on an email I sent to you January 20th. The Network would very much appreciate clarification on the outlined issue.

I shared the document on "Obligation to Inform Child Welfare Agency" with our members. The membership is asking for clarification related to youth who become pregnant prior to their 16th birthday and decide to terminate the pregnancy, requiring a referral to a Child Welfare agency for assessment.

Considering the wording of Bill C-7, health care providers offering sexual and reproductive health care to youth under the age of 16 years would not mandatorily refer a sexually active youth to a Child Welfare agency unless there were indications of protection/abuse/neglect/sexual coercion concerns or the youth's sexual partner was significantly older than them. As outlined in Bill C-7, youth that are at least 12 years of age and less than 16 years of age are able to consent to sex in some circumstances. Youth that are at least 12 and less than 14 years of age can consent to sex if their partner is within 2 years of their age; youth that are at least 14 and less than 16 years of age can consent to sex if their partner is within 5 years of their age. This is assuming that the sex is consensual and the partner is not in a position of power, trust or authority over the youth.

Current practice at most teen clinics/primary care sites is that youth are encouraged to attend for health care, with or without their parent/legal guardians' permission. There is no defined age of consent for health care services. Care is given based on informed consent and the ability to understand care options, risks and benefits.

Youth are assessed and would receive care for primary care issues, contraception, sexually transmitted infections and pregnancy (including abortions) as appropriate. Youth 12 years of age or older, that seek

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care for sexual and reproductive health needs, would not mandatorily be referred to a Child Welfare agency unless there were additional indications suggesting protection/abuse/neglect/sexual coercion concerns or the male involved is discovered to be significantly older. The age of one's sexual partner(s) may not be relevant to the care needs of the youth and may not always be confirmed.

In keeping with the section of the Child Welfare Act that outlines the obligation to report unmarried, pregnant youth who are under the age of 18 years . . . "Where a hospital or other institution has received for care during pregnancy or accouchement an unmarried child or a child with respect to whose marriage there exists reasonable doubt, the person in charge of the hospital or other institution shall forthwith notify the director or an agency on a prescribed form and shall in like manner, on the birth of the child in the hospital or other institution, report the fact to the director forthwith", youth who choose to continue their pregnancy would be encouraged to consent to an early referral to a Child Welfare agency. If the youth refuses an early referral and there were no indications of protection/abuse/neglect/sexual coercion concerns, the referral may not happen until the youth delivers her baby. Early referral is ideal however alienating the youth from continuing with prenatal care is also not helpful.

The members are concerned that as youth less than 16 years of age, become aware that all pregnancies are referred to Child Welfare agencies, even when the youth decides to have an abortion (particularly when the youth is not telling their parent/guardian), youth may delay accessing care. Current practice is that youth who choose to terminate their pregnancy, are not referred to Child Welfare agencies unless there are indications of protection/abuse/neglect/sexual coercion concerns.

Your further clarification on this complex issue would be appreciated.

Sincerely

Teen Services Network, Co-Chair

Lea Smith, Health Action Centre
Access Downtown
640 Main Street
Winnipeg, Manitoba
R3B 0L8

Lisa Goss, Clinic Community Health Centre

Attachment: 1 document
CC: Teen Services Network Members

	CLINICAL PRACTICE GUIDELINE FOR THE DELIVERY OF CONTRACEPTIVE HEALTH SERVICES BY REGISTERED NURSES	DATE June 20, 2011
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Family Services and Housing

Child Protection
 Ste. 201 – 114 Garry Street, Winnipeg, Manitoba, Canada R3C 4V5
 T 204-945-6964 F 204-945-6717
 www.manitoba.ca

May 9, 2011

Ms. Lea Smith
 Teen Services Network Co-Chair
 Health Action Centre
 640 Main Street
 Winnipeg MB R3B 0L8

Dear Ms. Smith:

Re: Obligation to Inform Child Welfare Agency

I am writing in response to your letter, dated March 17, 2011, regarding the obligation of health care providers to inform child welfare agencies when providing health care to pregnant wards and other pregnant minors. We have sought further counsel to ensure that we are providing you advice that is accurate, particularly regarding your request for clarification related to youth who become pregnant prior to their 16th birthday and decide to terminate the pregnancy.

The intent of being informed of minors, particularly those under 16 years of age, who are pregnant and intend to deliver a child is to be able to offer supportive services to those young people. The Child Protection Branch receives numerous notifications of minors who have recently given birth or due to deliver a child in the next few weeks or months. Often a child welfare agency is already aware of these pregnancies, particularly those involving wards, and is able to provide services. In other cases, agencies are informed and able to offer services

We understand that a minor may decide to terminate the pregnancy and is entitled to a degree of autonomy in making this decision, as well as confidentiality. However, where you or other staff has information that leads you to reasonably believe that the pregnant child is or might be in need of protection, there remains an obligation to report those concerns to a child welfare agency or to a parent or guardian of the child, in accordance with section 18(1) of *The Child and Family Services Act*:

Reporting a child in need of protection

18(1) Subject to subsection (1.1), where a person has information that leads the person reasonably to believe that a child is or might be in need of protection as provided in section 17, the person shall forthwith report the information to an agency or to a parent or guardian of the child.

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While knowledge of a pregnancy or knowledge of a child's intent to terminate a pregnancy may not, in and of itself, raise protection concerns, it is possible co-existing circumstances would lead to such a reasonable belief. The obligation to report is underscored in *The Child and Family Services Act* at section 18(2):

Duty to report

18(2) Notwithstanding the provisions of any other Act, subsections (1) and (1.0.1) apply even where the person has acquired the information through the discharge of professional duties or within a confidential relationship, but nothing in this subsection abrogates any privilege that may exist because of the relationship between a solicitor and the solicitor's client.

In terms of reporting concerns to a child protection agency, *The Child and Family Services Act* sets out the circumstances when a report is to be made to an agency over a parent or guardian:

Reporting to agency only

18(1.1) Where a person under subsection (1)

- (a) does not know the identity of the parent or guardian of the child;
- (b) has information that leads the person reasonably to believe that the parent or guardian
 - (i) is responsible for causing the child to be in need of protection, or
 - (ii) is unable or unwilling to provide adequate protection to the child in the circumstances; or
- (c) has information that leads the person reasonably to believe that the child is or might be suffering abuse by a parent or guardian of the child or by a person having care, custody, control or charge of the child;

subsection (1) does not apply and the person shall forthwith report the information to an agency.

We hope this provides some clarification. We would welcome having a further discussion with your membership on this matter. Please let me know if you wish to schedule a meeting.

Sincerely,



Claudia Ash-Ponce
Executive Director

RD/ep

WPCRD/OBLIGATION TO INFORM CFS RE PREGNANCY OF MINORS MAY11
LOG NUMBER: FSCFE10-00503

	CLINICAL PRACTICE GUIDELINE FOR THE DELIVERY OF CONTRACEPTIVE HEALTH SERVICES BY REGISTERED NURSES	DATE June 20, 2011
TITLE Appendix G Quick-Start Method	AUTHORIZED BY Public Health Managers Network and Health Programs and Services Executives' Network (HPSEN)	PAGE 81 of 101

QUICK-START METHOD OF INITIATING HORMONAL CONTRACEPTION

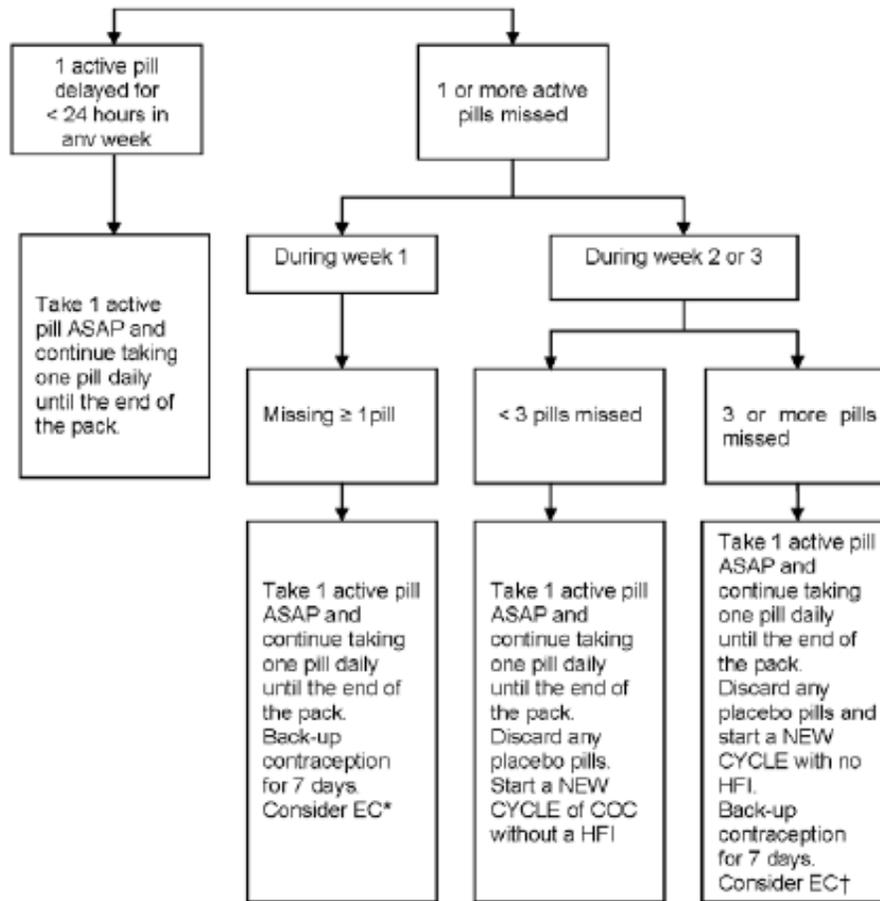
The Quick-Start method can be used for all hormonal contraceptives such as oral contraceptive pills, Patch, Ring, Injectable and LNG IUS (although Quick-Start LNG IUS is less common). Conventional initiation of hormonal contraception within 5 days of beginning the next menstrual cycle puts women at risk of unintended pregnancy for several additional weeks. Studies suggest up to 25% of women never begin OC pill when given a prescription (Association of Reproductive Health Professionals, 2011).

The Quick-Start method is appropriate for all clients and causes no significant difference in bleeding patterns or spotting than conventional start method (Association of Reproductive Health Professionals, 2011).

If last normal menstrual period (LNMP) has been within the last 5 days, initiate contraceptive method immediately.

If LNMP has been more than 5 days and urine pregnancy test is negative, assess the need for Emergency Contraception and provide as indicated. Start contraceptive method immediately. Advise the client to return for a urine pregnancy test in 3 weeks. Advise the client to use backup contraception for 7 days (Association of Reproductive Health Professionals, 2011; Lara-Torre, 2004).

Missed Combined Oral Hormonal Contraceptives

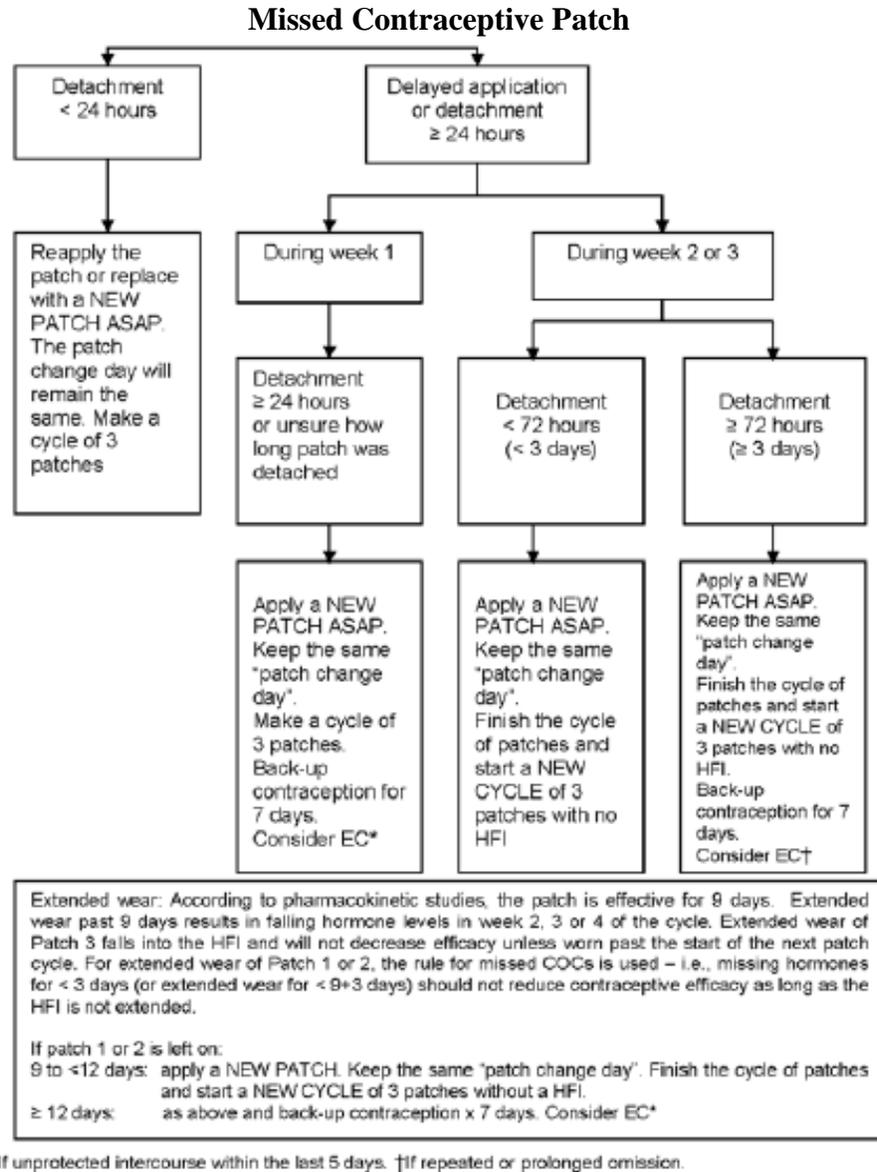


ASAP: As soon as possible. This may mean that 2 pills are taken on that day.
 *If unprotected intercourse within the last 5 days. †If repeated or prolonged omission.

Box 1. During the first week of use (week 1), delay in taking one pill ≥ 24 hours (i.e. missing one or more pills) increases the HFI and may allow ovulation during this week. Missing 1 active pill before ovulation is effectively inhibited (achieved after taking 1 active pill daily x 7 consecutive days) may also allow ovulation during this week. If intercourse occurred during the day of pill omission or in the 5 days prior, consider EC.

Box 2. Missing fewer than 3 pills in a row during week 2 or 3 is the same as having a short HFI after achieving effective inhibition of ovulation during the preceding week (1 pill daily x 7 consecutive days). Therefore, efficacy is not expected to be reduced, although breakthrough bleeding may occur. Eliminating the HFI may reduce the risk of unintended pregnancy when pills are missed in week 3. Eliminating the HFI when pills are missed in week 2 is proposed to simplify this algorithm.

Box 3. Missing 3 or more pills in a row during week 3 is likely to impair contraceptive effectiveness, because the HFI comes immediately after week 3. Eliminating the HFI and using a back-up method until 7 consecutive days of pills are taken should reduce the risk of unintended pregnancy. EC can be considered if unprotected intercourse has occurred during the interval of missed pills up until 7 consecutive pills have been taken. The same recommendation is proposed for week 2 to simplify the algorithm.

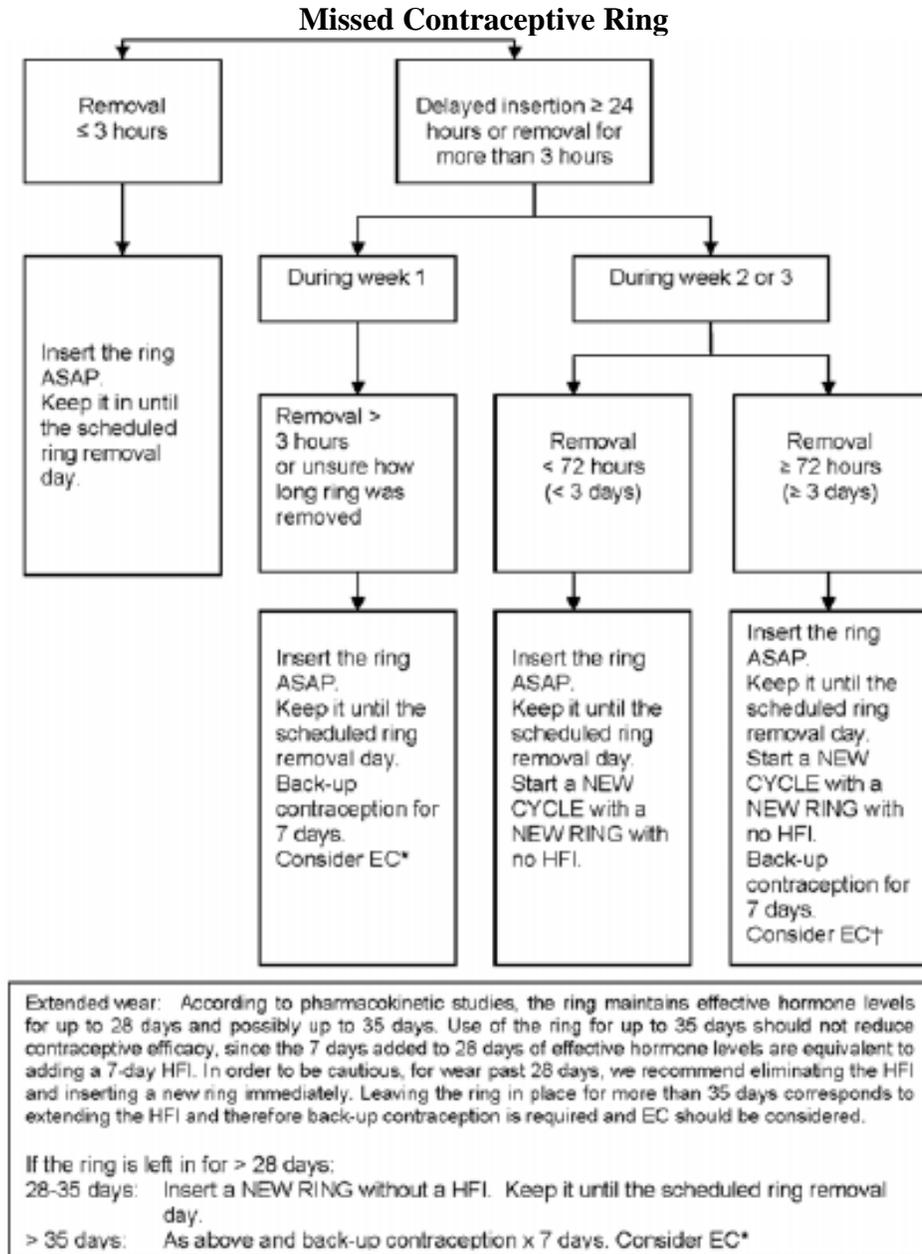


Box 1. Detachment ≥ 24 hours in week 1 is analogous to missing one combined oral contraceptive by 24 hours or more in week 1. When a woman is unsure how long the patch was detached in week 1, it is safer to consider it as a detachment of ≥ 24 hours.

Box 2. Detachment < 72 hours in week 2 or 3 is analogous to missing < 3 combined oral contraceptive. The suggestion to keep the same “patch change day” provides more simple patient advice than having changing the “patch change day” as recommended in the product monograph.

Box 3. Detachment ≥ 72 hours in week 2 or 3 is analogous to missing ≥ 3 combined oral contraceptive.

Appendix H: Missed Hormonal Contraceptives
<http://www.sogc.org/guidelines/documents/gui219ECO0811.pdf>



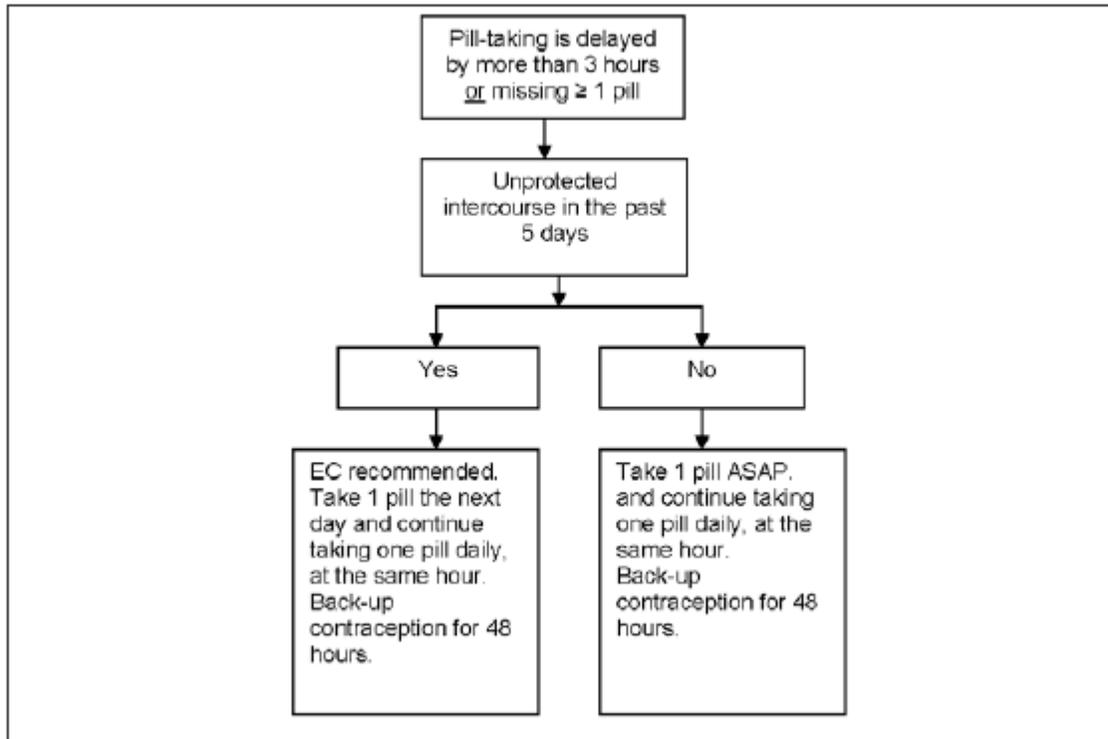
* If unprotected intercourse within the last 5 days. † If repeated or prolonged omission.

Box 1. Removal of the ring > 3 hours in week 1 is analogous to missing one active pill ≥ 24 hours in week 1. When a woman is unsure how long the ring was removed in week 1, it is safer to consider it as a removal > 3 hours. The scheduled ring removal day is day 21 after taking out the ring from the foil.

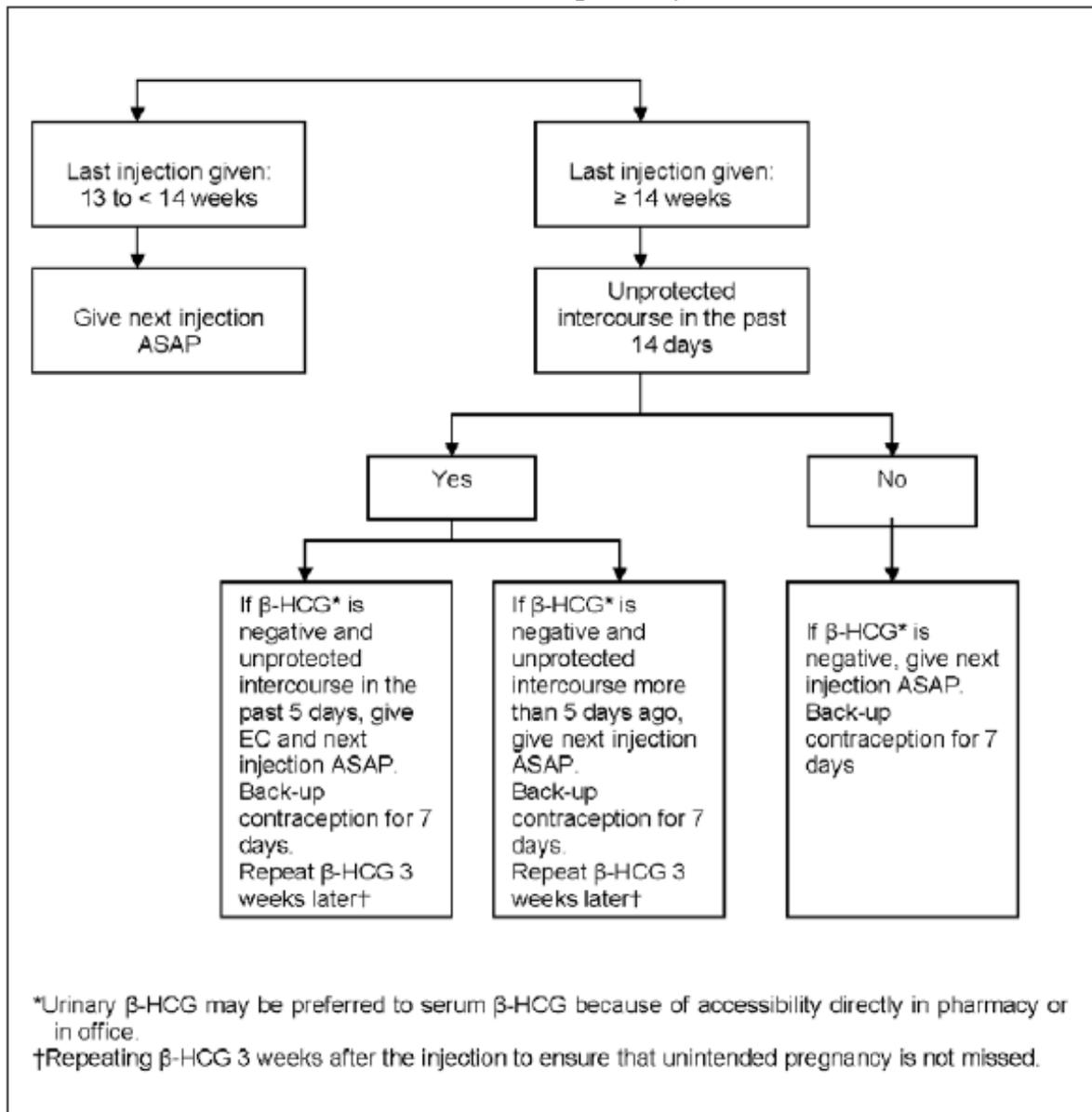
Box 2. Removal of the ring < 72 hours in week 2 or 3 is analogous to missing < 3 pills.

Box 3. Removal of the ring ≥ 72 hours in week 2 or 3 is analogous to missing ≥ 3 pills.

Missed Progestin Only Pills



Missed Contraceptive Injection



	CLINICAL PRACTICE GUIDELINE FOR THE DELIVERY OF CONTRACEPTIVE HEALTH SERVICES BY REGISTERED NURSES	DATE June 20, 2011
TITLE Appendix I Extended Use of Hormonal Contraceptives	AUTHORIZED BY Inter-Regional Public Health Managers Network and Health Programs and Services Executives' Network (HPSEN)	PAGE 87 of 101

EXTENDED USE OF HORMONAL CONTRACEPTIVES

A Registered Nurse cannot alter the dosing instruction on a prescription without consultation with the prescribing health care provider.

There is no biological need to have a monthly hormone induced withdrawal bleed while on hormonal contraceptives. The majority of annoying adverse effects of combined hormonal contraceptives is associated with the placebo week (headache, cramping, breast tenderness, bloating, swelling). The option of continuous or extended combined hormonal contraception can be made available to women for contraceptive, medical and/or personal reasons.

Various regimens are available. Most use multiples of 21 hormone days and 7 hormone free days. Often used regimen is 63 or 84 hormone days and 7 hormone free days. Some use no hormone free days. The length of continuous or extended combined hormonal contraceptive can be altered depending on the experience of side effects. All currently available low-dose combined hormonal contraceptive options can be used for continuous or extended use (monophasic, multiphasic, transdermal or vaginal) indication except for Seasonale (Guilbert & Boroditsky, 2007; Hatcher et al., 2007).

Counsel women that bleeding or spotting is common in the first three months of continuous or extended combined hormonal contraception options. If bleeding or spotting persists, rule-out other explanations (pregnancy, non-compliance, infections, smoking, mal-absorption issues or other medication use). If bleeding persists, after a minimum of 21 days, try 3-7 hormone free days, then resume daily hormone dose (Guilbert & Boroditsky, 2007).

Women who have been taking continuous or extended combined hormonal contraception for > 21 days have less likelihood of ovulation with missed doses. Women well established on continuous or extended combined hormonal contraception have a low risk of unintended pregnancy as long as they do not go > 7 days without taking hormone doses. Women who have had unprotected intercourse and have gone > 7 days without taking hormone, should be offered emergency contraception (Guilbert & Boroditsky, 2007).

Canadian Consensus Guideline on continuous and extended hormonal contraception, 2007.
http://www.sogc.org/guidelines/documents/gui195CPG0707_000.pdf

	CLINICAL PRACTICE GUIDELINE FOR THE DELIVERY OF CONTRACEPTIVE HEALTH SERVICES BY REGISTERED NURSES	DATE June 20, 2011
TITLE Appendix J Generic Contraceptives	AUTHORIZED BY Public Health Managers Network and Health Programs and Services Executives' Network (HPSEN)	PAGE 88 of 101

GENERTIC CONTRACEPTIVES

According to the Society of Obstetricians and Gynaecologists of Canada March 2008 statement, to qualify as bioequivalent to existing brand name formulations, new generic oral contraceptives are required to meet a standard of 80% to 125% blood equivalence. At this time, generic formulations have no Pearl Index rating, the accepted standard for evaluating the effectiveness of a contraceptive method http://www.sogc.org/guidelines/documents/gui205PS0803_000.pdf.

Drugs are listed as interchangeable on the Manitoba Formulary when determined by the Manitoba Drug Standards and Therapeutic Committee to be “therapeutically equivalent”. In general, determination is made that interchangeable products are said to provide the same therapeutic levels of active drug. These interchangeable products may however have different non-medical ingredients (dyes, fillers, etc). Often it is difficult to determine if differences in clinical response with interchangeable drug products is the result of patient variation or differences in non-medical agents.

The Formulary may be accessed on the Manitoba Health website at <http://www.gov.mb.ca/health/mdbif/>.

For example, when you look for the listing in the Formulary (<http://www.gov.mb.ca/health/mdbif/schedule.pdf>) for desogestrel-ethinyl estradiol as in the case of Marvelon you will find that Apri is listed as well so these are presently considered to be interchangeable in Manitoba.

If the prescribing health care practitioner wants a particular brand of drug product and does not want this brand to be substituted, they must write “No Substitution” on the prescription.

	CLINICAL PRACTICE GUIDELINE FOR THE DELIVERY OF CONTRACEPTIVE HEALTH SERVICES BY REGISTERED NURSES	DATE June 20, 2011
TITLE Appendix K Depot medroxyprogesterone acetate (DMPA)	AUTHORIZED BY Public Health Managers Network and Health Programs and Services Executives' Network (HPSEN)	PAGE 89 of 101

DEPOT MEDROXYPROGESTERONE ACCETATE

Conventionally, DMPA is given with the first 5 days of a normal menstrual period, to insure the woman is not pregnant. In this instance, no back-up contraceptive method is needed. The woman will have effective contraceptive protection within 24 hours of the. DMPA has a very low failure rate of 0.3 pregnancies/1,000 women/year on regular DMPA injections (Hatcher et al., 2007; Black, et al., 2004).

DMPA can be given at anytime during the menstrual cycle when a pregnancy has been ruled out. When DMPA is started > 5 days after LNMP, a back up method of contraception is needed for 7 days (Hatcher et al., 2007; Black, et al., 2004). When DMPA is given > 5 days after LNMP, a follow-up pregnancy test is recommended in 2-4 weeks to for early diagnose of pregnancies (Hatcher et al, 2007). There is no evidence that a fetus exposed to DMPA in-utero is at increased risk of congenital anomalies (Black et al, 2004).

If a woman is less than 14 weeks since her last injection, she can receive her DMPA injection (Black et al, 2004). Ovulation is unlikely for at least 14 weeks post DMPA injection (Hatcher et al, 2007).

If a woman is more than 14 weeks since her last injection and she has not had intercourse within the last 5 days and her urine pregnancy is negative, she can receive her injection. Back-up contraceptive methods are required for 7 days (Black et al, 2004). Repeat urine pregnancy test in 3 weeks. Serum pregnancy will be positive within 8 days post-conception (Black et al, 2004). Urine pregnancy tests that can detect 25 mIU of BHCG/ml will be positive as early as 10 days post-conception (Hatcher et al, 2007). Despite this difference, urine pregnancy tests provide immediate results in a clinic setting.

When switching from other hormonal contraceptive options to DMPA, no additional contraceptive coverage is required when DMPA is given within 5 days of the start of the hormone free interval (Black et al, 2004).

At each follow-up visit, review any questions and concerns the woman may have related to contraception, sexual health, bleeding patterns and adverse effects. There are no definitive recommendations for pregnancy tests prior to injections, when given every 12 weeks. Weight and blood pressure monitoring should be individualized based on client's health history.

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Progestins do not increase the risk of venous thromboembolism, myocardial infarction or stroke. Progestins may be an appropriate contraceptive choice for women who have cardiovascular risk factors or who have contraindications for estrogen (Black et al, 2004).

Although many women on DMPA do gain weight a significant number do not. In one study 44% either lost weight or maintained their baseline weight. Product monograph suggested that for women who do gain weight, ranges are 2.5 kg in first year, 3.7 kg after year 2 and 6.3 kg after the fourth year. Weight gain is thought to be associated with appetite stimulation and mild anabolic effect. Counselling for healthy eating and activity should be included with client education information on DMPA (Black, et al., 2004). There is no conclusive recommendation on the usefulness of weighting woman at each follow-up visit. A documented baseline weight would be helpful to have if an individual woman later becomes concerned about weight gain on DMPA.

The World Health Organization (WHO) and Society of Obstetricians and Gynaecologists of Canada (SOGC) do not place any restrictions on the duration of use of DMPA for women 18 to 45 years of age. The advantages of DMPA outweighs the concerns about bone health for adolescents and perimenopausal women. Women on DMPA should be counseled on bone health, the benefit of calcium and vitamin D supplementation, smoking cessation, weight-bearing exercise and reducing alcohol/caffeine consumption (Black, 2006).

	CLINICAL PRACTICE GUIDELINE FOR THE DELIVERY OF CONTRACEPTIVE HEALTH SERVICES BY REGISTERED NURSES	DATE June 20, 2011
TITLE Appendix L Young Men's Sexual and Reproductive Health	AUTHORIZED BY Public Health Managers Network and Health Programs and Services Executives' Network (HPSEN))	PAGE 91 of 101

YOUNG MEN'S SEXUAL AND REPRODUCTIVE HEALTH

Sexuality and human reproduction are an integral part of the health and well being for all individuals. Males like females are sexual beings from conception and have the same need for knowledge and skills to support them in active decision-making around reproduction and sexual health. Most services, resources and frameworks of care for sexual health have focused on women. This has created a gap in services, resources and evidence-informed practice when working with young men.

Addressing the sexual and reproductive health needs of young men is essential to the promotion of healthy lifestyles, disease prevention and reduction of unplanned pregnancies. Increases in sexually transmitted infections and unplanned pregnancy for young women and men across many cultures and societies makes sexual health for all young people a health promotion priority (Guttmacher Institute, 2002; Marston & King, 2007).

Recognition and acknowledgment of men's contribution to the formation of healthy relationships, the prevention of sexually transmitted infections (STI) and role in pregnancies, has highlighted the need for men to have access to care and services equal to that of women.

Work done by Kalmuss & Tatum (2007) identifies that young men who are sexually active are not receiving adequate sexual and reproductive health care and that the care they receive is neither comprehensive nor integrated. Recent studies have identified that although young males access clinical health services for a variety of reasons within the health care system, less than 30% received counseling and support related to their sexual and reproductive health needs (Lindenberg, Sonfield & Gemmill, 2008).

There are no national or internationally agreed upon standards of care for reproductive and sexual health services for adolescent and young males. There is a growing volume of research related to the need for comprehensive frameworks of care.

We have learned the following about the sexual and reproductive practices of this population:

- Adolescent males engage in a range of non coital sexual activities which include mutual masturbation, vaginal, oral and anal sex.

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- Overall rates of oral sex with a female partner among teen males are similar to rates of vaginal intercourse.
- 5% of teen males reported having oral or anal sex with a male partner.
- Young men report that they want more information about reproductive health issues than they receive (Guttmacher Institute, 2002; Lindenberg et al., 2008).

Although young males access the health care system for services, only a small percentage receive reproductive health services such as pregnancy counseling and STI prevention/testing (Raine, Marcell & Harper, 2003). Service is often brief and problem orientated. Identifying and addressing complex problems that may be related to high risk behaviors is low, resulting in missed opportunities for intervention. Research and best practice supports that reproductive health services for males, like females should aim to promote healthy sexual development, intimate relationships, responsible parenthood, prevention and control of STI and prevention of unintended pregnancy at each point of contact with the system (Sonenstein, 2000). Research and best practice has shown that when reproductive health counseling occurs with a medical professional, even for a short period of time, this will result in increased contraceptive knowledge and use among young men as well as an increase in discussion amongst both partners around contraception use (Raine et al., 2003). Involving men in reproductive health has been found to have a positive impact on the prevention and reduction of STI/HIV transmission as well as the continued use of effective contraception.

CARE CONSIDERATIONS

In order to reduce unintended pregnancies, interventions must address the physical and psychosocial needs of both men and women. By increasing gender-specific pregnancy prevention and involving young men in family planning, this approach to care supports improved health outcomes for all. There is a need to design services that supports young men and women to actively share in the decision-making around responsible lifestyle and reproductive health choices.

Health care providers need to seize every opportunity, as well as create new opportunities, to discuss sexual health issues. Services based on individual needs, stages of maturity and abilities are necessary to support young males in positive and responsible reproductive health decisions and practices. Increasing capacity within a female reproductive health model to serve males is feasible (Raine et al., 2003; Juszczak and Cooper 2002; Guttmacher Institute, 2002).

The following needs to be considered when developing a framework of care for young men's health:

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Sexual Health and Development

- Provision of age-appropriate information
- Basic sexuality and reproductive education
- Social and emotional development
- Components of a healthy lifestyle
- Genital health and hygiene

Male Sexuality

- sexual knowledge, attitudes and behavior
- sexual identity, self respect, male role identification
- promotion of self concept
- development of skills related to sexual and reproductive health issues and needs
- comprehensive contraception counseling
- gender issues

Promotion of Healthy Relationships

- communication (appropriate, clear lines)
- decision-making
- sexual expression
- healthy/appropriate relationships (sexual coercion, abusive relationship)

Psychosocial

- promotion of positive self-concept (strength-based, solution focused approach)
- interpersonal communication skills
- knowledge and skills in assessment and screening related to mental health

Beliefs and Values

- promotion of responsible fatherhood (developmentally appropriate)
- cultural appreciation

Aspects relations to Developmental Needs of Males

- peer pressure
- risk taking /harm reduction
- physical, cognitive and psychosocial characteristics of young males
- knowledge & skills in assessment of risk behavior (e.g. substance abuse screening)

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Physical

- essential components of physical exam
- diagnosis and treatment of disorders of the reproductive system
- testing for sexually transmitted infections and blood-borne pathogens
- genital health and hygiene

Preventative Health Care Services

- Comprehensive sexuality and reproductive health history
- components of a healthy lifestyle
- personal vulnerability to disease (prevention, intervention and treatment)
- knowledge of STI transmitted infections (prevention, transmission, detection treatment)
- harm reduction
- access to appropriate care

Considerations for Program Philosophy and Model

- Empowering of young males.
- Nurturing of positive values.
- Respectful of culture, age, setting, language, gender.
- Accessible to all young men
- Promoting necessary, appropriate information, skill development & positive self-esteem.
- Integrated services for males.
- Supportive of staff development needs (Boyer, 2000).
- Partnerships are essential.

Considerations for Direct Care Providers

- Honest, friendly and respectful, at all times.
- Knowledgeable and skilled at assessment (sexual health assessment, psychosocial assessment, contraceptive assessment, risk assessment).
- Knowledgeable and comfortable with all issues related to male sexuality and reproductive health (i.e. sexual orientation, risk behaviors of adolescence).
- Comfortable bringing up issues related to male sexual health.
- Skilled at using positive language that is non-judgmental and gender neutral when talking to and about males.
- Skilled at assessing the level of sexual responsibility of the individual in order to tailor care, services and resources to the individual.
- Skilled and knowledgeable enough to “seize on teachable opportunities” as they arise.

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- Knowledgeable and comfortable talking about Sexually Transmitted infections and HIV/AIDS in the broader context of reproductive health.
- Knowledgeable and comfortable talking about impotence and testicular self examination.
- Flexible and creative in the provision of services to allow for individually tailored approaches to care and service.
- Knowledgeable about and connected to appropriate referral resources and services for young men.

Consideration for Staff Training

- Counseling and communication skills.
- Knowledge and understanding around issues related to male sexuality.
- Facilitation of male/female sexual communication.
- Knowledge and understanding of current reproductive health issues.
- Knowledge and understanding of current STI.
- Knowledge and understanding of gender related issue.

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