Part 2
Sexual and Reproductive Healthcare

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Chapter 2:

Facility requirements and client history/examination

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1. Introduction

This chapter provides guidance on the requirements for comprehensive sexual and reproductive healthcare facilities (including design and infrastructure) and how to take a client's medical history and conduct physical examinations. It intersects with several chapters, including *Chapter 3: Counselling*, *Chapter 8: Gynaecology and other reproductive healthcare*, and *Chapter 11: Sexual and reproductive healthcare delivery in humanitarian settings*.

What are the facility requirements and clinical guidance for sexual and reproductive healthcare in humanitarian settings?

For detailed guidance, programme managers and frontline healthcare providers should refer to *Chapter 11: Sexual and reproductive healthcare delivery in humanitarian settings* and various guidance tools:

- Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crisis Situations [1]
- Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings [2]
- Inter-Agency Reproductive Health Kits [3]
- Adolescent Sexual and Reproductive Health (ASRH) Toolkit for Humanitarian Settings [4]
- MISP process evalation tools [5]
- Reproductive health kits calculator [6]

2. Facility requirements for comprehensive sexual and reproductive healthcare

To ensure the sustainability, quality, and uptake of healthcare, programme/clinic managers should implement standard requirements for sexual and reproductive healthcare facilities for the following: clinic infrastructure (*Section 2.1*); supply chain management (*Section 2.2*); health facility finance (*Section 2.3*); health workforce competency (*Section 2.4*); infection prevention and control (*Section 2.5*), quality improvement mechanisms (*Section 2.6*); and referrals, community partnerships, and linkages (*Section 2.7*). As a general recommendation, facility requirements should follow international standards that consider accessibility, to ensure that disability inclusion is considered standard quality criteria [7,8]. Furthermore, issues related to infrastructure should also follow accessibility criteria to ensure inclusion of people with disabilities, although national regulations and frameworks may differ. All clients benefit from accessible infrastructure.

2.1 Clinic infrastructure

It is essential to consider infrastructure and design when setting up a static sexual and reproductive health clinic or integrating sexual and reproductive healthcare into existing facilities. The space required will depend on the healthcare being provided, the client population, and plans for scaling up or introducing additional services in the future.

2.1.1 Sexual and reproductive healthcare

Comprehensive sexual and reproductive healthcare delivery includes sexual and reproductive health and rights counselling, abortion care, maternal and newborn health, contraception, sexual and gender-based violence prevention and response services, screening and treatment for sexually transmitted infections (STIs) including HIV, cervical cancer screening and treatment, laboratory testing, and general gynaecological care for all population groups. However, the level of sexual and reproductive healthcare may vary and will depend on the designated facility level. The minimum standard for most sexual and reproductive healthcare, including basic emergency obstetric and newborn care (BEmONC) can generally be provided in primary health clinics with space between 700 and 1,500 ft^2 (65–139 m^2), whereas healthcare for permanent contraceptive methods, abortion care at or after 13 weeks, and comprehensive emergency obstetric and newborn care (CEmONC) can be provided with clinic space between 1,500 and 2,000 ft^2 (139–186 m^2). A summary of comprehensive sexual and reproductive health facility requirements is provided in *Appendix 1*.

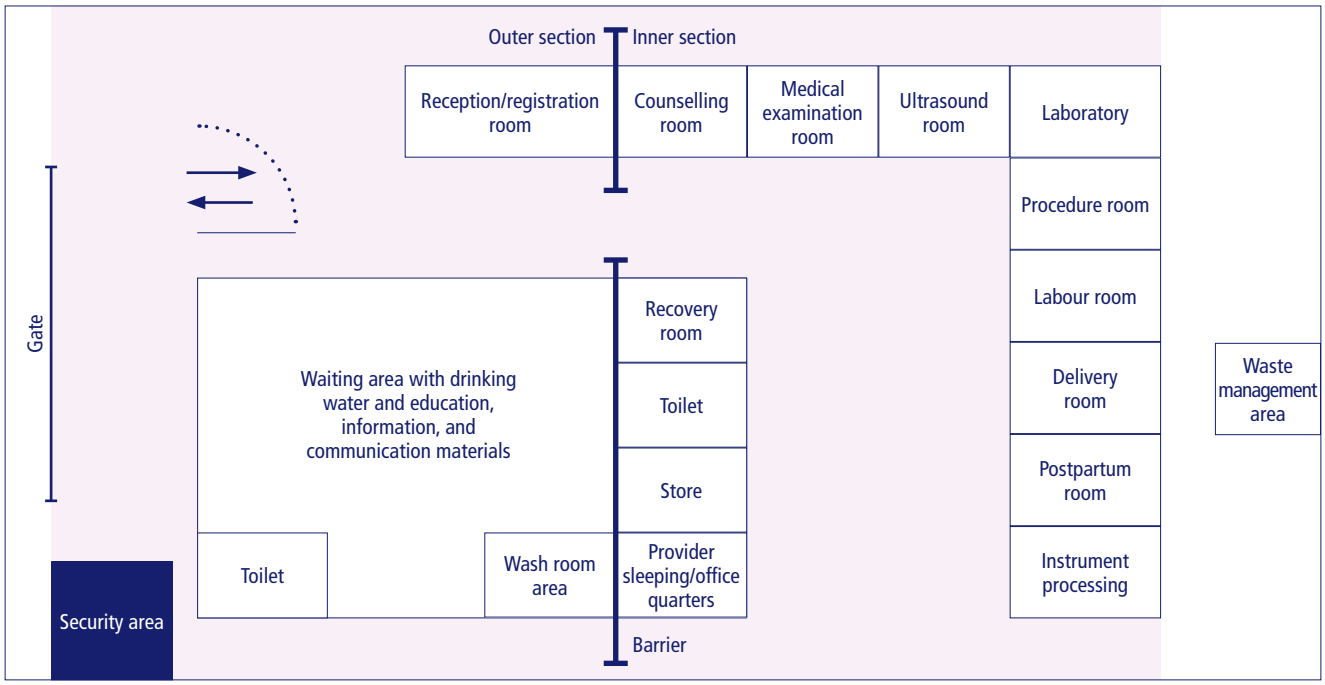
2.1.2 Location

When selecting a location, the clinic should be easily accessible, safe from environmental factors such as heavy air/water pollution and natural disaster-prone areas, and within distance of referral sites. The clinic should be close to public transport, preferably less than a 20-minute walk from the nearest bus stop, train station, or other public transport. Clinic opening hours should be convenient for everyone – especially those traveling long distances and marginalized groups, such as people with disabilities – with specialized clinic hours. The clinic should be secure and safe for both clients and healthcare providers during clinic hours and security measures should be in place to prevent unwanted people from entering the clinic and for clients' easy and safe passage into and out of the clinic.

2.1.3 Infrastructure and design

Clinic infrastructure and design must reflect the provision of current and future healthcare and the needs and safety of clients. The clinic infrastructure should have access to reliable water and electricity supplies and be accessible for all clients, including people with different impairments or physical disabilities (see *Box 1*: *Accessibility of clinic infrastructure and information* – next page). The clinic should be designed to include an outer and inner section to help ensure safety, privacy, confidentiality, and prevention of infection. Client flow should be one way to avoid clients going back to the waiting area, except to exit the clinic. A separate exit is preferable if the clinic provides abortion care and/or healthcare for young and marginalized people. It is preferable that separate procedure and recovery rooms are provided for pregnant and labouring clients, abortion clients, survivors of sexual and gender-based violence, and clients seeking permanent sterilization. The design of the facility outlined in *Figure 1* should be adapted based on the designated level of the facility and intention to scale up integrated sexual and reproductive healthcare. *Figure 1* illustrates the two main sections of static sexual and reproductive healthcare facilities. The *outer section* includes the reception/registration, waiting areas, toilets, and handwashing station. The *inner section* includes counselling, examination, laboratory, ultrasound, and procedure rooms, recovery room, and toilet for clients. The barrier/wall between the outer and inner sections of the facility is the permanent partition that ensures audiovisual privacy and prevents non-essential movement into the inner section of the clinic (see *Appendix 1*).

FIGURE 1. Example of an ideal setup for a sexual and reproductive healthcare facility



BOX 1: Accessibility of clinic infrastructure and information

Entrances/doors

- Paved street
- Signage in accessible format
- Tactile markings
- Adequate door width at the gate for pedestrians
- Dedicated parking spaces for people with disabilities

Facility areas

- Adequate facility area
- Cemented pathway
- No obstacles to impede movement through facility areas
- Orientation signs
- Tactile markings on the floor to orient people with visual impairments
- Drainage system
- Ramps follow international standards
- Stairs follow international standards
- Handles, grips, and handrails for support on the stairs and ramps
- Tactile markings at the bottom and top of stairs and ramps
- Furniture arrangement does not obstruct movement
- Reception counter is an appropriate height
- Floor of the stairs is not slippery

Outpatient department rooms

- Secure cupboards with doors that close
- Space for wheelchair users to move freely
- Adequate door width
- No difference in level to enter rooms or ramps available
- Up-to-date and adjustable equipment (e.g. examination and delivery beds)
- Accessible beds
- Accessibility of information
- Good ventilation
- Bathroom and toilets
- Cemented pathways leading to toilets
- Dedicated toilet for people with disabilities
- Toilet seats available
- Handles and handrails are sufficient and in the right position to enable people with mobility impairments and wheelchair users to use the toilet
- Sink inside the toilet room

Visible and accessible signage

- Signs and information in accessible formats
- Good lighting

Communication

- A focal person trained in sign language

2.2 Supply chain management

Sexual and reproductive healthcare delivery requires supplies, equipment, and infrastructure. Supply chain management focuses on people having access to a consistent supply of essential medicines and consumables. A functional supply chain requires the availability of the right medicine in the right quantity for the right client at the right time and the right condition (quality), and for the right price (in the most efficient, safest, and least costly way possible). As a result, essential supply chain management functions consist of product selection, forecasting/quantification, procurement, storage, inventory management, transportation, resupply, and serving beneficiaries. A key indicator is to ensure adequate stock, preferably a 3-month supply of essential equipment, commodities, and medicines for all sexual and reproductive healthcare provided at the facility. To ensure quality medicines and equipment are procured, dispensed, and utilized, health facility managers should select based on their country's essential drug and equipment lists and/or the international prequalification standards set by the World Health Organization (WHO)/UNFPA [9]. These instruments and medications must be routinely included in the planning, budget procurement, distribution, and management systems. *Appendix 2* outlines the essential drugs, equipment, and supplies required for the sexual and reproductive healthcare described. See *Section 5.1: Resources* for guidance tools related to supply chain management.

2.3 Health facility finance

Health facility budgets must include sufficient funds for the following types of costs: administration costs and equipment, drugs, and supplies required to provide sexual and reproductive healthcare and infection prevention and control; personal protective equipment; budget lines for reasonable adjustments for people with disabilities; staff time; community and stakeholder outreach activities, training programmes, and supervisions; infrastructure upgrades; record-keeping; and monitoring and evaluation. Health facility managers should develop yearly budget projections and conduct quarterly health facility assessments and analyses to inform any necessary budget amendments.

2.4 Health workforce competency

Within the health system, a health workforce consists of support staff, healthcare providers of all cadres, and community health workers. Where possible, the health workforce should reflect the diversity of the local population, including under-represented groups such as people with disabilities. All staff working in a health facility should be trained on the facility's clinical standard operating procedures and healthcare delivery guidelines. Healthcare providers must be trained, technically competent, and use appropriate clinical technologies to provide high-quality sexual and reproductive healthcare. Community health workers must be trained and demonstrate competency to provide evidence-based information, basic healthcare (dependent on legal context), and referrals along the sexual and reproductive health and maternal, neonatal, child, and adolescent health continuum of care. Support staff within the health facility must be trained to provide a welcoming and safe environment, even when conducting administrative tasks, infection prevention and control, security measures, finance, and supply chain management. Where there are gaps in competence, the health workforce should receive staff development training to ensure that competencies in skills, knowledge, and attitudes essential for providing quality sexual and reproductive healthcare are maintained. Regardless, clinic managers should ensure that the health workforce receive periodic updates of their skills.

2.5 Infection prevention and control

All staff, clinical and non-clinical, must be trained to apply universal precautions for infection prevention and control. These efforts must be performed in every situation and reinforced further in public health outbreaks and pandemics where healthcare providers are in contact with blood, body fluids, non-intact skin, and mucous membranes. Infection prevention precautions must be taken, regardless of the infection status or diagnosis of the client, to reduce the risk of disease transmission for clients and healthcare providers in the facility. Infection prevention and control protocols and information, education, and communication materials should be available, displayed, and implemented. If staff are exposed to any bodily fluid, the procedure for occupational exposures as indicated in facility standard operating procedures should be followed. The essential elements of infection prevention and control include handwashing, personal protective barriers, utilization of aseptic technique, facility cleanliness and waste management of infectious waste, and proper handling and processing of sharp instruments and materials. See *Section 5.1: Resources* for guidance tools related to infection prevention and control.

2.6 Quality improvement mechanisms

Programme and clinic managers should ensure the effectiveness, equity, efficiency, and quality of their health system by implementing systematic quality improvement mechanisms at both individual and organizational levels of healthcare delivery. The core objective of quality improvement is to improve care and client safety through non-punitive learning. All quality improvement activities must be systematically planned and integrated into facility operations by utilizing simple indicators, performed ethically, and be participatory and transparent for staff, clients, and community stakeholders. Regular data collection and analysis of client health records, collected manually or electronically through a clinic management information system, and healthcare statistics are needed to improve or maintain quality standards for healthcare delivery. This may include institutionalizing a data reporting

system for data entry on all sexual and reproductive healthcare, equipment, drugs, and supplies; supportive supervision and mentoring; review and analysis of all sexual and reproductive healthcare statistics and policies through logbook reviews; client management information system checklist; self-assessment tools; observations using checklists, clinic audit tools, case reviews, serious adverse events and near-miss audits; client exit interviews; feedback from staff and inclusive of all members of the community (including youth and people with disabilities); and outreach healthcare assessment tools. Collected data should allow for disaggregation by marginalized groups (e.g. age, disability status, immigration status). The International Planned Parenthood Federation's (IPPF) quality of care framework provides detailed guidance on sexual and reproductive health quality improvement frameworks and indicators [10]. See *Section 5.1: Resources* for other relevant information on quality of care.

2.7 Referrals, community partnerships, and linkages

Facility–community partnerships across sectors enhance the quality of healthcare delivery, including referrals and the sexual and reproductive health-seeking behaviours of individuals in the community. The location of referral points (e.g. higher-level facilities, rehabilitation centres), as well as referral pathway protocols must be prearranged, established, and clearly displayed and communicated to all staff and community health workers. Health facility staff play an important role as local leaders in their communities and community health workers play an important role in building linkages between community members, their local facilities, civil society organizations (e.g. women's groups, youth groups), and social services. Together these partnerships help empower individuals to access sexual and reproductive healthcare and help people recognize signs and symptoms to access care in a timely manner. See *Chapter 3: Counselling* for guidance on creating an enabling environment along the continuum of care.

3. Medical history

In addition to counselling clients, taking a detailed medical history is an important component of the client–healthcare provider relationship. Topics discussed during counselling may be relevant when taking a medical history. The core rights-based principles and guidance provided in *Chapter 3: Counselling* apply to all healthcare providers taking a client's medical history.

3.1 What to include in a medical history

After welcoming a client to the facility and introducing the provider(s), taking a medical history is the next step in the client–healthcare provider relationship and underpins the reasons behind subsequent physical examinations and decisions about diagnostic testing and sexual and reproductive healthcare options. *Table 1* (next page) outlines what to include when taking a medical history to help identify and assess risk factors. See *Chapter 3: Counselling* for details on client-centred counselling and informed consent, including maintenance of confidentiality and privacy. Clients should only answer questions that they feel comfortable addressing.

3.2 Communication techniques for obtaining sexual history

Healthcare providers should maintain positive and non-judgemental communication when setting the stage for questions about a client's sexual history. The healthcare provider–client interaction is a two-way communication process and this section provides step-by-step communication techniques for healthcare providers enquiring about a client's sexual history. If the client has an accompanying person with them in the examination room, the healthcare provider must ensure that the client consents for that person to remain in the room when discussing issues related to sexual and reproductive health.

1. **Set the stage for sexual history questions.** Before asking questions about sexual history, the healthcare provider should make the client aware that questions surrounding sexual history are asked of all clients as part of routine care. Questions are only asked

TABLE 1: What to include in a medical history

Category	Information to document
Personal data	• Name, age, gender identity, race, religion, language, occupation, education level, and contact information, if clients feel comfortable to share
Social history	• Partner status (married, single) • Family environment • Violence or coercion • History and current use of alcohol and illegal drugs • Assessment of functioning [11] • Other social issues that could impact care
Medications and allergies	• Daily medications, e.g. prenatal vitamins, non-steroidal anti-inflammatory drugs, anti-tuberculosis, anti-epilepsy, antiretroviral drugs • Use of herbal remedies and details of their use (dose, route, timing) • Any known allergies to medications
Medical history	• Communicable diseases e.g. tuberculosis, malaria, Zika virus disease, Ebola virus disease • Non-communicable/chronic diseases: diabetes mellitus, hypertension, heart disease, blood-clotting disorders, liver disease • Cancers: breast cancer, cervical cancer, prostate cancer • Neuropsychology issues: anxiety, depression, eating disorders, sleep disorders, substance abuse (alcohol and drugs) • Tobacco history, including number of cigarettes smoked per day • Urinary, gastrointestinal, musculoskeletal, endocrine, skin issues • Details of past hospitalizations (reason why, date, location)
Surgical history	• Type, date, location of surgery
Gynaecological history	• First date of last menstrual period and menstrual cycle pattern, bleeding pattern, discharge • Number of live births, stillbirths, miscarriages, and abortions • Contraceptive history and current use • Current symptoms and previous diagnosis of STIs including HIV • Pelvic tuberculosis • Eligibility for particular screening or treatment
Sexual history	• Relationship status and concurrent sexual partnerships • Individual risk for STIs including HIV, human papillomavirus (HPV)

when relevant to the client's healthcare, to enable an accurate diagnosis and ensure provision of the most effective treatment. This may begin with a statement such as: "I would like to talk with you about your sexual health. I talk to all my clients about sexual health because it is a very important part of overall health. Everything you tell me is confidential. Do you have any questions before we start?"

2. **Respond to the client's questions.** The client may be hesitant and unsure of why these questions are important for their health. Healthcare providers should reassure the client that their information will remain confidential and begin the process of destigmatizing sexuality and sexual health matters. Providers should also understand that the client may decline to complete a sexual history and should not be forced to answer any questions. At this point the healthcare provider can ask if the client would prefer to speak to someone of the same gender. Statements to destigmatize the conversation may include:

   - "We ask everyone these questions because it is common for sexual behaviours and partners to change over time."
   - "Some clients have concerns about their sexual health, so I want to make sure I understand what your questions or concerns might be and provide whatever information you might need."
   - "As you may know, sexual activity without protection (such as condoms) can lead to STIs. These kinds of infections are very common and often there is no way to know if you have them without testing. If we do not find and treat these infections, you may be at risk for longer-term problems."
   - "This is a conversation about ways to protect yourself against the risk of unintended pregnancy, STIs including HIV, or other things that may concern you. This is also an opportunity to talk about problems with, or changes in, your sexual desire and functioning."

3. **Ask an initial screening question about sexual activity and follow the screening procedure outlined in *Figure 2*** (next page)**.** Screening for a client's sexual behaviours and nature of their relationships helps inform if a further risk assessment should be conducted and the type of referrals for general health, mental health, and social services that may be needed. For guidance on conducting further risk assessments see *Chapter 6: Sexually transmitted infections* and *Chapter 10: Sexual and gender-based violence*.

4. Physical examination

Physical examination of the client is guided by their history and should begin with a general routine clinical examination. Components of a physical examination may include general examination (*Section 4.1*), abdominal examination (*Section 4.2*), gynaecological examination (*Section 4.3*), breast examination (*Section 4.4*), and examination of male genitalia (*Section 4.5*).

Key overarching points to integrate into a physical examination include:

- Obtain consent from the client before proceeding with any part of the examination. Refer to *Chapter 3: Counselling* for informed consent/assent guidelines.
- Summarize all examination procedures in terms that the client will understand and utilize pictorial job aids as appropriate. Ensure that the client has enough time to understand and ask questions.
- Ensure infection prevention and control protocols for physical examinations are followed, including hand washing at the start and end of each examination.
- Inform the client that the examination(s) can stop at any point, reinforcing that the client is in control of their healthcare.
- Position the client correctly, or instruct them to position themselves, for each exam. Ask people with disabilities if they need assistance with positioning and adopt examination procedures to accommodate, if needed.

FIGURE 2: Essential sexual health questions to ask adults and adolescents

Adults

ASK AT LEAST ANNUALLY

Have you been sexually active in the last year?

NO → **Have you ever been sexually active?**

YES → **What types of sex do you have (oral, vaginal, anal, other)?**

With men, women, both, or another gender identity?

YES → **What types of sex do you have (oral, vaginal, anal, other)?**

With men, women, both, or another gender identity?

NO → **Continue with medical history**

Ask Older Adults

Has sex changed for you? If so, how?

Conversational Tips

- **Ensure confidentiality and emphasize this is routine for all patients**
- **Ask open-ended questions, for example, "Are there any sexual concerns or questions you'd like to discuss?"**
- **Be non-judgmental (verbal and non-verbal)**

Ask at least once and update as needed. Gender identity and sexual orientation can be fluid

1. What do you consider yourself to be?
   - A. Lesbian or gay
   - B. Straight or heterosexual
   - C. Bisexual
   - D. Another (please specify)
   - E. Don't know
2. What is your current gender identity?
   - A. Male
   - B. Female
   - C. Transgender man
   - D. Transgender woman
   - E. Neither exclusively male nor female (e.g. non-binary or nonconforming)
   - F. Another (please specify)
   - G. Decline to answer
3. What sex were you assigned at birth?
   - A. Male
   - B. Female
   - C. Decline to answer

Adolescents

Ask at least annually

1. What questions do you have about your body and/or sex?
2. Your body changes a lot during adolescence, and although this is normal, it can also be confusing. Some of my patients feel as though they're more of a boy or a girl, or even something else, while their body changes in another way. How has this been for you?
3. Some patients your age are exploring new relationships. Who do you find yourself attracted to? (Or, you could ask, "How would you describe your sexual orientation?")
4. Have you ever had sex with someone? By "sex," I mean vaginal, oral, or anal sex. (If sexual activity has already been established, ask about sex in the past year.)

If the adolescent has had sex, ask about

- ✔ Number of lifetime partners
- ✔ Number of partners in the past year
- ✔ Gender of those partners (men, women, both, or another gender identity)
- ✔ Types of sex (vaginal, oral, anal, other)
- ✔ Use of protection (condoms and contraception)
- ✔ Coercion or rape

Prepare for the sexual history interview

- ✔ Explain to a parent or caregiver that you spend a portion of each visit alone with the adolescent.
- ✔ Put your patient at ease. Ensure confidentiality except if the adolescent intends to inflict harm or reports being abused. Know your state's laws that affect minor consent and patient confidentiality.
- ✔ Incorporate the four essential sexual health questions into a broader psychosocial history.
- ✔ Start with less threatening topics, such as school or activities, before progressing to more sensitive topics, such as drugs and sexuality.
- ✔ Use open-ended questions, rather than closed-ended, to better facilitate conversation.
- ✔ Listen for strengths and positive behaviors and for opportunities to give praise where praise is due.

Source: Reuse with permission from The National Coalition for Sexual Health. Essential Sexual Health Questions to Ask Adults and Adolescents. Altarum Institute. 2022. See the same link for details of recommended preventive sexual healthcare for adults and adolescents.

- Explain each step of an examination (e.g. "I'm going to place the speculum outside your vagina, and you will feel it. Let me know how you feel. I am now going to insert the speculum into your vagina."
- Only expose the relevant parts of the body to maintain the client's dignity as much as possible.
- Thank the client at the end of the examination and help them back into a comfortable position.
- Give the client some privacy to dress again before discussing the findings of the examination.
- Based on findings from the medical history and physical examination, and with the client's informed consent, provide the appropriate referrals. Ask the client to sign a release of information form.

4.1 General examination

A general health examination includes:

- Vital signs including pulse and blood pressure, body weight, height, body mass index, temperature, and, if clinically indicated, heart sounds, respiratory rate, and breath sounds.
- General condition such as build, gait, posture, speech pattern.
- Signs of physical or sensory disability.
- Signs of weakness, lethargy, anaemia, or malnourishments.
- Signs or marks of physical violence.
- Presence of pallor, jaundice, leg varicosities, ankle oedema, abnormal skin pigmentation and markings.
- Presence of enlargement or tenderness of the liver, spleen, or kidneys, and any other abdominal mass (e.g. gravid uterus).
- Exclude the possibility of thyroid enlargement; palpate the cervical and supraclavicular lymph nodes; check presence of inguinal lymph nodes.

4.2 Abdominal examination

The four steps for abdominal examination are outlined below. Ask the client to lie flat on their back with their legs uncrossed and arms by their side and begin the evaluation by:

1. Inspecting

Check for presence of abdominal scars, specifically for midline laparotomy, Pfannenstiel incision scar (gynaecological/obstetric procedure), appendectomy (right iliac fossa). Check for abdominal distension or masses and their possible causes – the five F's: fluid, fat, fetus, flatus, faeces. Check for abnormal distribution of body hair.

2. Palpating

Palpate for any mass or enlarged uterus, noting the size, shape, and whether any tenderness is present. Observe the client's face for signs of pain and tenderness and ask if they experience pain when palpating (deep and light palpations) each abdominal quadrant and the left and right groin for signs of lymphadenopathy.

3. Percussing

Percuss the liver and spleen limits to exclude enlargement and, where suspected, assess the level of free fluid in the abdominal cavity.

4. Auscultation

For abdominal distension and suspected bowel obstruction, listen (auscultate) for 'tinkling' or absence of bowel sounds.

4.3 Gynaecological examination

A gynaecological examination includes gynaecologic history and gynaecologic examination of a client's reproductive organs. The gynaecological examination includes examining the external genitalia, speculum examination, bimanual pelvic examination, and assessment of ovarian masses. Not all components of a gynaecological examination need to be conducted, only those indicated depending on the client's history, symptoms and signs, and general examination findings. *Box 2* provides information on examining clients with physical disabilities.

4.3.1 Examination of external genitalia

This includes inspection of the labia, prepuce, clitoris, urethral opening, perineum, and anal opening. Inspect the vulva for scars from previous surgery (e.g. episiotomy, female genital mutilation); STIs such as genital herpes, HPV (warts), etc; abnormal discharge/bleeding; atrophy (post-menopausal); masses (e.g. Bartholin's cyst); varicosities (varicose veins); and abnormal hair distribution. Palpate the vulva for tenderness and/or masses, particularly around the Bartholin's glands. If there is a history of pelvic organ prolapse or urinary stress incontinence, ask the client to cough with a full bladder to observe whether cystocele, rectocele, or urine leakage is present. The client can also change posture to standing for further evaluation of prolapse.

4.3.2 Speculum examination

Speculum examination helps healthcare providers observe the vaginal walls and cervix. Providers should use a speculum of the appropriate size, such as a larger speculum for a multiparous client with lax vaginal walls and a narrow speculum for a nulliparous client. The most commonly used instruments are the bivalve Cusco or Graves speculum, or the Sims speculum. If a speculum examination is clinically indicated for a client who has never been sexually active, a small-size speculum is required, and the client should be informed that the hymen will likely be damaged. Water or a water-soluble lubricant should be used to assist insertion of the speculum. Inspect the cervix and vaginal canal for foreign bodies, rugae, discharge (noting colour, amount, consistency, and odour), and protruding masses. Examine the cervix for the presence of ectropion, ulceration, growths, blood, polyps, cancer, or contact bleeding. If indicated (e.g. in a client with suspected pelvic inflammatory disease, STI or at high risk of STIs), take an endocervical swab to use for diagnosis.

BOX 2: Examining clients with physical disabilities

- If the clinic does not provide accessible beds or the client is more comfortable lying on the floor, examine them on the floor after ensuring the area is clean and they are comfortable. To examine a person on the floor, place a folded cloth under the client's hips to raise them slightly, and turn the speculum handle up (or it will be difficult to open).
- Clients with spinal cord injuries or cerebral palsy may have stiff muscles during an exam. This can happen if they are in an uncomfortable position, or if a speculum or any other instrument is inserted without due care. Adjust the position and be gentle when placing.
- Proceed slowly during the exam and ask the client to communicate if they have a spasm or if the exam is painful.
- Do not massage or rub the spastic muscles as it may result in tightening.
- To help the client relax, ask them to practice pushing down into their bottom. Deep breathing at each push can help the client relax.
- Autonomic dysreflexia is a medical emergency and is common in people with spinal cord injuries. A sudden hypertensive peak is caused by a reaction to a possible pain that could not be felt because of neurological damage. To prevent dysreflexia, be careful to avoid hard or cold examination surfaces, cold temperature in the exam room, and strong pressures on the perineum during the exam, especially while using the speculum.

4.3.3 Bimanual pelvic examination

A bimanual examination helps inform the healthcare provider about the client's pain and comfort levels, pregnancy status, gestational age, presence of infection, anatomical abnormalities, and uterine position. Except for post-partum clients, bimanual pelvic examination must be performed for all clients before any procedure in which instruments are placed inside the uterus. Therefore, any client requesting an intrauterine device, diaphragm, surgical sterilization, or surgical abortion should undergo bimanual examination by the healthcare provider performing the procedure. Furthermore, bimanual pelvic examination should always be performed in the presence of pelvic symptoms such as abnormal vaginal bleeding, urinary symptoms, abdominal swelling, lower abdominal pain or discomfort, or pain during sex (see *Chapter 8: Gynaecology and other reproductive healthcare, Section 3*). Healthcare providers should document the various characteristics of the uterus, specifically size (approximately pear-sized in a healthy client), shape (may be distorted by masses such as fibroids), position (anteverted versus retroverted), surface characteristics (smooth versus nodular), and tenderness during palpation or cervical motion tenderness (if any).

4.3.4 Assessment of ovarian masses

Differentiating between benign and malignant ovarian masses on clinical examination alone is difficult. Palpate each lateral fornix for abnormal masses or tenderness and assess any masses detected for size, consistency, position, and mobility. Suspicion of advanced cancer can be raised in the presence of other symptoms and signs such as dyspepsia, bloating and abdominal distention, or weight loss, especially in a post-menopausal client. In these cases, the adnexa may be difficult to palpate by vaginal examination due to the volume of peritoneal fluid. Perform or refer the client for an ultrasound if ovarian pathology is suspected.

A rectovaginal examination is not routinely carried out but may be indicated if the client has symptoms and/or signs of pelvic tumour, advanced cervical cancer, or endometriosis. With the index finger in the vagina and the middle finger of the same hand in the rectum, palpate the uterosacral ligaments and rectovaginal septum for nodularity and other lesions.

4.4 Clinical breast examination

Clinical breast examinations are a low-cost method for detecting an abnormality suggestive of breast cancer. Clinical breast examinations should be conducted once a year and when a client presents with breast symptoms or concerns from 25 years of age. Healthcare providers should proceed with the examination by comparing both breasts visually and then palpating each breast in turn, using the three steps described below.

1. Inspection

Ask the client to lie supine or to sit leaning back at a 45° angle. Visually inspect both breasts at the same time (see *Table 2* – next page).

2. Palpation

Palpation includes examination of each breast and the axillary and supraclavicular lymph nodes. The full area of each breast for the examination should be understood as the rectangular area bordered by the clavicle (top), sternum (centre), bra-strap line (bottom), and the mid-axillary line (left and right) with a 'tail' extending into the axilla, which must also be examined. The axillary lymph nodes fall in a triangular area, with the apex at the narrow gap between the first rib and the axillary vessels.

TABLE 2: What to observe on visual inspection

Size and shape of breasts	The size and shape of the breasts vary in healthy clients, and it is common for one breast to be larger than the other. Document any marked asymmetry in the size or contour of the breasts
Colour changes	May be a sign of imminent ulceration
Skin changes	Lumps and associated skin changes (e.g. inflammation, ulceration, and skin retraction) may indicate severe pathology such as cancer
Visible dimpling	An 'orange peel' appearance is a sign of skin oedema caused by obstruction of lymphatics, which can be caused by tumour cells, infection, or radiotherapy
Nipples and areolae	Nipple or areolar changes not associated with congenital features, such as inverted or retracted nipples; abnormal discharge (milky or greenish-yellow colour or thick/sticky, grey and green tint); nipple lumps and bumps (blisters, abscess, ductal carcinoma in situ); changes in skin texture and colour (not associated with pregnancy); pain (not associated with pregnancy or menstrual cycle)
Tethering	Use movements to accentuate subtle masses in the breast. Asking the client to raise their arms above their head makes skin tethering more apparent. If the client presses their hands against their hips to tense the pectoral muscles, this will accentuate the presence of tethering to the chest wall. Demonstrate and ask the client to copy

Tips for performing a breast exam

For clients with large or pendulous breasts, use the following positions to aid examination:

- To examine the right lateral breast, the client can roll onto their left hip keeping their shoulders flat on the couch and with their right hand on their forehead; in this way, the lateral part of the breast is flattened and easier to examine. Do the same on the other side to examine the left lateral breast
- To examine the right medial breast, the client can lie supine and move their right elbow up until it is level with their shoulder. Do the same with the left elbow to examine the left medial breast

a. Breast examination steps:

- Positioning the client: Ask the client to lie supine or to sit leaning back at a 45° angle. Ask the client to put their right hand behind their head to examine the right breast and vice versa for the left breast.
- Use the three-finger technique to palpate the breast using the pads of the middle three fingers (not the fingertips); two hands can be used in clients with larger breasts. The healthcare provider should select one of the three palpation methods described below that they feel most confident with and ensure that they have thoroughly examined all important areas:
  - *Vertical stripe pattern:* Start palpation at one corner of the breast area for each breast, moving vertically upwards and downwards between the clavicle and the bra-strap line, moving across the whole area until all breast tissue has been palpated, including the axillary tail. The small circular movement pressure can be varied in three grades: light for the superficial layer, moderate for the middle layer, and firm for deep layers.
  - *Concentric circles pattern*: Palpate in a spiral, moving outwards from the nipple.
  - *Radial spokes pattern*: Palpate in lines moving outwards from the nipple, as if along the hands of a clock face or the spokes of a bicycle.

b. Axillary and supraclavicular lymph node examination steps:

- Ensure that the client's pectoral muscles are relaxed to feel the lymph nodes. The provider can either hold the client's elbow (right elbow held in provider's right hand when examining the right breast, and vice versa for the left breast) to take the weight off their arm while palpating with the other hand or the client can rest their hand on the provider's shoulder.
- The provider should place their hand into the axilla and palpate as for the breast (using the three-finger technique, in small circles), moving upwards from the base of the axilla palpating along the lateral chest wall.
- Ensure that the entire area of the axilla is covered and push the fingertips upwards and inwards to palpate at the apex of the axilla.
- The provider can examine the supraclavicular fossae from in front of the client by placing their fingers into them (first one side, then the other), moving in small circles to try and identify any enlarged lymph nodes.

3. Documentation

Utilizing the clock system, document the location of any concern and abnormality, the distance from the areola, and size of the mass.

Breast self-examination

Encourage clients of reproductive age to conduct breast self-examination at least once a month to become familiar with how their breasts feel and look to detect any changes, and when to visit a healthcare provider. Provide a breast self-exam information, education, and communication handout and describe the self-examination instructions. Ask the client if they have any questions. See *Chapter 8: Gynaecology and other reproductive healthcare, Appendix 5* for steps on how to perform breast self-examination

4.5 Examination of clients with male genitalia

Male reproductive organs consist of the penis, testes, spermatic cord, epididymis, scrotum and perineum, and the prostate. Physical examination involves visual inspection and palpitation of these organs and the anus when indicated from the medical history and general examination. Physical examinations should be normalized as an essential part of staying healthy for adolescents and adults, and clients should be taught to self-examine their reproductive organs.

General examination includes vital signs and overall appearance that is focused on the client's weight, signs of anaemia or other illnesses, and the health of the skin, specifically skin lesions and keloids on and around the penis, testes, scrotum, and perineum. Before starting a physical examination, healthcare providers should wash their hands and ensure that they are warm, as the testicles may react to cold by retracting.

When and how to perform a digital rectal examination

Digital rectal examination of the prostate is indicated when a client complains of problems with:

- urination (frequency, urgency, terminal dribbling, or overactive bladder)
- blood in the urine or ejaculate, bone pain/lower back pain, and/or erectile dysfunction possibly combined with weight loss and/or lethargy

Steps for performing digital rectal examination:

1. Wear gloves.
2. Ask the client to lie on their left side with their knees up to the chest.
3. Place the index finger anteriorly, putting pressure on the midline of the anus, and insert the finger into the anus.
4. Sweep the finger clockwise and anti-clockwise and make a systematic assessment of any masses and impacted faeces.

5. The prostate lies anteriorly – check its size, smoothness, and midline groove.

6. Check glove for blood.

The healthcare provider should ask the client to cough to examine for hernia and tumour. For hernias, check for weakness in the abdominal wall between the scrotum and the intestines. For tumours, the provider should check for growths throughout the body and the testicles.

Medical concerns and/or abnormalities detected during physical and general examinations and medical history should be documented and, when appropriate, clients should be treated or referred to specialized care.

When should healthcare providers consider conducting diagnostic tests?

The following tests may be performed based on individual risk factors identified during the counselling session and from the client's history, findings on physical examination, and available resources:

- Pregnancy test if pregnancy is unconfirmed
- Diagnostic ultrasound, if indicated, to confirm pregnancy dating or the location of the pregnancy
- Haemoglobin or haematocrit for suspected anaemia
- Rhesus (Rh)-testing, where Rh-immunoglobulin is available for Rh-negative clients
- HIV testing/counselling
- STI screening (usually performed during the pelvic examination)
- Cervical cancer screening (performed during the pelvic examination)
- Semen analysis for non-scalpel vasectomy procedure
- Other laboratory tests as indicated by the medical history (e.g. kidney or liver function tests)

Note: Routine laboratory testing and ultrasound are not prerequisites for abortion care

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Supply chain management

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Outer service area	Size*	Fixtures and furniture	Equipment	Supplies
Reception, client registration, and waiting areas	120–240 ft²	• Spacious, well-ventilated, and covered waiting area – 60 per cent covered • Chairs or benches to seat at least 10 clients at a time • Reception desk with chair • Filing cabinet	• Display screen and equipment for audiovisual IEC materials • Display shelves or racks for paper and IEC materials • Computer • Printer	• Registration materials • Drinking water • Newspapers and magazines • Posters and pamphlets for IEC materials • Direction boards • Clinic map
Toilets	60–90 ft²	• Toilet fixtures • Sink with tap	N/A	• Washing soap • Detergent • Toilet paper • Sanitary towels • Waste buckets for general and medical waste
Wash area	60 ft²	• Sink with tap	N/A	• Washing soap
Inner service area	**Size***	**Fixtures and furniture**	**Equipment**	**Supplies**
Counselling/ consultation room	60–120 ft²	• Small desk with three chairs • Small storage cabinet or cupboard	• Contraceptive models e.g uterus • Contraceptive samples • MVA sample	• Contraceptives (condoms and pills, including emergency contraception) • Posters, flip charts on different sexual and reproductive health topics • Tissues

Appendices

Appendix 1: Summary of clinic requirements for comprehensive sexual and reproductive healthcare

This table complements *Figure 1* and provides a brief overview of each type of room, including requirements for size, general facility fixtures, equipment, and supplies.

Inner service area	Size*	Fixtures and furniture	Equipment	Supplies
Examination and injection room (Physical exams and screenings)	60–150 ft²	• Small desk with three chairs • Examination table • Sink with running water (washing hands)	• Blood pressure machine • Stethoscope, thermometer • Focus light • Examination instruments • Surgical drum • Trolly	• Disposable surgical gloves • Sterile cotton wool and gauze • Alcohol hand rub • Antiseptics • Contraceptives • Medical abortion pills • NSAIDs
Procedure room for minor procedures (LARC, MVA, VIA, etc)	120–200 ft²	• Procedure table • Stool for healthcare provider • Foot stool for client • Job aids displayed on the walls	• Focus light • Two instrument trolleys: one for procedure instruments, the other for surgical drums containing extra sterile instruments and the emergency tray • 1–3 surgical drums • MVA and cannula set and products of conception examination equipment (see Appendix 2) • Implant insertion and removal equipment set (see Appendix 2) • IUD insertion and removal equipment set (see Appendix 2) • Emergency equipment (see Appendix 2) • Buckets and waste bins	• Disposable surgical gloves • Sterile cotton wool and gauze • Alcohol hand rub • Antiseptics • Emergency drugs (see Appendix 2) • Sterile instruments
Recovery room (medical abortion, MVA clients)	120–300 ft²	• Sufficient beds or recliners to allow adequate recovery time for each client • Screen dividers for privacy • Small table and two chairs	• Blood pressure machine • Stethoscope • Thermometer	• Drinking water • IEC materials

Inner service area	Size*	Fixtures and furniture	Equipment	Supplies
Labour and delivery rooms	180–250 ft²	• Bed, table, foot stool for primary healthcare provider, focus light, job aids displayed on the walls	• Thermometer • Autoclave • Vital signs instruments • Doppler • Delivery set (see Appendix 2)	• Drinking water • IEC materials • Clean pads • Clean towel • See Appendix 2
Recovery room for labour and delivery clients	120–300 ft²	• Sufficient beds or recliners to allow adequate recovery time for each client • Screen dividers for privacy • Small table and two chairs	• Blood pressure machine • Stethoscope • Thermometer	• Drinking water • IEC materials
Minor operating theatre (if required for tubal ligation and/or non-scalpel vasectomy	180–250 ft²	• Operating table • Foot stool for primary healthcare provider • Focus light • Job aids displayed on the walls	• Blood pressure machine • Two instrument trolleys (same as procedure room) • 1–2 surgical drums • Tubal ligation and non-scalpel vasectomy equipment and instruments (see Appendix 2) • Emergency equipment (same as procedure room)	• Drinking water • IEC materials
Recovery room (permanent methods)	120–300 ft²	• Sufficient beds or recliners to allow adequate recovery time for each client • Screen dividers for privacy • Small table and two chairs	• Blood pressure machine • Stethoscope • Thermometer	• Drinking water • IEC materials
Instrument processing room/ area	60–120 ft²	• Two tables • Two cabinets for storing clean and sterile instruments • Running water	• Autoclave • Surgical drums • Buckets for cleaning • Equipment for drying instruments and linen	• Detergent • Disinfectants: bleaching powder/solution • Scrubbing brushes

CHAPTER 2 CONTENTS
MAIN CONTENTS

Inner service area	Size*	Fixtures and furniture	Equipment	Supplies
Storage (well ventilated)	80–200 ft²	• Shelves • Cabinet with lock	N/A	• Medical supplies • Contraceptives • Spare equipment • Non-clinical supplies
Client toilets (easily accessible to those in recovery)	60–90 ft²	• Toilet fixtures • Sink with tap	N/A	• Washing soap • Detergents • Toilet paper • Sanitary towels • Waste buckets for general and medical waste
Corridors	20–80 ft²	• Sexual and reproductive health and rights IEC materials displayed on the walls	N/A	N/A
Staff room	80–150 ft²	• 4–6 chairs • One small table • Two beds • Locker	N/A	• Clinical protocols, healthcare delivery and referral guidelines • Training manuals and educational tools
Admin/clinic support room	100–150 ft²	• Desk • Three chairs • One filing cabinet	• Computer and printer	• Clinical protocols, healthcare delivery and referral guidelines • Training manuals and educational tools

Abbreviations: IEC: information, education, and communication; MVA, manual vacuum aspiration; NSAIDs, non-steroidal anti-inflammatory drugs; LARC, long-acting reversible contraceptives; VIA, visual inspection with acetic acid.

* 1 square foot = 0.0929 square meters.

Appendix 2: Essential drugs, equipment, and supplies required for sexual and reproductive healthcare

Comprehensive abortion care

These tables provide clinic managers and trained abortion healthcare providers with a comprehensive list of the essential drugs, equipment, and supplies for quality abortion care before and after 13 weeks of gestation.

Facility	Equipment/supplies/drugs	Medications
• Private area for counselling (ideally both visual and auditory privacy) • Restrooms with toilets should be easily accessible for all clients receiving abortion-related care • Handwashing stations* • Potable water for drinking/cups • Emergency transport/referral capability • Procedure room (MVA only) • Recovery area (MVA only) • Safe box for sharps* • Coloured bins for waste segregation • Stool for exam/procedure room • Lockable cupboards for medications • Emergency transport/referral capability • Service delivery logbook • Consent forms for abortion care and contraception • Referral forms • Pamphlets, educational materials (for adult and younger clients) • Job aids for comprehensive abortion care: MA regimen card, instrument processing wallchart*, MA/MVA supply guidance, MA wheel, etc. • Job aids for postabortion contraception counselling, contraceptive efficacy chart, MEC wheel, etc. • Clinical service delivery guidelines and protocol and referral pathways	• Available contraceptive methods, including IUD/IUS, implants • Blood pressure cuff • Thermometer • Stethoscope • Sanitary pads • Disinfectants* • Instrument trolley, instrument tray, drums/containers for storage of autoclaved MVA packs*, kidney dishes (large and medium), gulli pot • Pelvic exam table • Lamp for pelvic exams • Cover/drape to cover client's legs **Laboratory supplies** • (optional) Ultrasound and its accessories • (optional) Urine ß-hCG tests and urine cups • (country-dependent) Rh testing and anti-D immunoglobulin • Not required for abortion care but optional if other preventative health testing is provided: cervical cancer screening, STI testing, HIV testing, anaemia screening, immunizations	• Mifepristone, depending on availability, or combipack • Misoprostol • Antibiotics (prophylaxis and treatment dosing) • Side-effect medications (e.g. anti-nausea medicine) • Pain medication • NSAIDs • Narcotic/anxiolytics and reversal agents

* Items with an asterisk are required for infection prevention.

continued

continued

Surgical	Complication Management	Instrument Processing

MVA
• Atraumatic tenaculum or vulsellum forceps
• Sponge/ring forceps (Foerster)
• Gauze
• Betadine (povidone-iodine) and cup*
• Ipas MVA Plus aspirator
• Ipas EasyGrip cannulae
• Self-retaining speculums of varying sizes
• Denniston or Pratt dilators
• Container for POC, lamp, clear basin, sieve
• Bucket with soaking fluid*
• Paracervical block supplies and local anesthetic
• 10-20 ml syringe, 21-23 gauge needle at least 3 cm (1 in) Lidocaine 1.0 per cent
 	
D&E
• Non-perforated stainless steel instrument tray
• Stainless-steel instrument tray without cover
• Vaginal speculum – Klopfer
• Atraumatic angled tenaculum
• Ipas EasyGrip cannulae
• Set of Pratt and Ipas Denniston dilators
• Sponge-holding forceps
• Bierer forceps 13" size small and large slightly curved
• Sopher uterine evacuation forceps 11" size small and large, slightly curved
• Sopher Ovum Forceps
• PCB, local anaesthetic, needle, syringe
• Ipas MVA Plus aspirator
• Antiseptic
• 60 cc foley catheter
• Cheshire medical vacuum curette straight,14 mm
• Supplies needed:
  ◦ Alcohol or povidone-iodine
  ◦ Gloves (sterile or clean)
  ◦ Two 5 ml syringes
  ◦ 22-gauge spinal needle and needle holder
  ◦ Digoxin 1.0-1.5 mg
• 4x4 gauze
• Small dressing or adhesive bandage (optional)
	Emergency
	• Blood glucose monitor with test strips
	• Blanket
	• Instruments for assessment/ vital signs as listed under Clinical Assessment
	• IV cannulation equipment - a range of large bore cannula (sizes 16-22), syringes, saline flush, tape, cannula fixing dressing, tourniquet, sharps box
	• Oxygen cylinder size D/E with non-rebreathe mask (with oxygen reservoir) or portable oxygen kit
	• Pocket mask
	• Portable pulse oximeter
	• IV infusion sets
	• Syringes (2, 5, 10 ml)
	• Needles – 21 G
	• Clean and sterile gloves – different sizes*
	• Sterile gauze pack
	• Urine catheter (Foley) and bag (adult size catheter)
	• Large scissors
	• Crepe bandage
	• IV fluids – normal saline (0.9%), ringer lactate solution
	• Sterile water for injection/IV flush
	• Inj. hypertonic glucose solution, 25%, 50%,
	• Inj. adrenaline, 1:1000
	• Inj. atropine, 1 mg/ml
	• Salbutamol inhaler
	• Inj. chlorpheniramine
	• Inj. oxytocin
	• Inj. antibiotics (IV/IM)
	• Inj. tetanus toxoid/tetanus antitoxin
	• Aspirin tablets (81 mg)
		• Personal protective barriers (for instrument processing: heavy duty gloves, boot/ shoe covers, face protection, gown/apron; for procedure/exam: clean and sterile gloves, gown/ apron, boot/ shoe covers, eye protection)*
		• Sterile forceps (optional)
		• 3 buckets (soak, HLD/sterilizer, rinse)*
		• Small brush*
		• Tap water, sterile or boiled water, detergent, HLD (0.5 per cent chlorine) or sterilizer (glutaraldehyde)*
		• If HLD with boiling water, large metal pot and heat source
		• If sterilizing with autoclave, paper or linen, autoclave
		• Covered containers to store instruments*

* Items with an asterisk are required for infection prevention.

Abbreviations: MVA, manual vacuum aspiration; MA, medical abortion; MEC, medical eligibility criteria; IUD, intrauterine device; IUS, intrauterine system; STI, sexually transmitted infection; POC, products of conception; D&E, dilatation and evacuation; IV, intravenous; IM, intramuscular; HLD, high-level disinfection.

Source: Adapted from Ipas. Woman-Centered, Comprehensive Abortion Care Reference Manual. Chapel Hill, NC: Ipas; 2013; Edelman A, Kapp N. Dilatation & Evacuation (D&E) Reference Guide: Induced abortion and postabortion care at or after 13 weeks' gestation ('second trimester'). Chapel Hill, NC: Ipas; 2018; International Planned Parenthood Federation. Comprehensive abortion care: Guidelines and tools. London: IPPF; 2021. Available at: https://ippfmaforum.org/2021/10/06/abortion-care-guidelines/. Accessed 22 April 2022.

Cervical cancer prevention, screening, and treatment

This table provides clinic managers and trained sexual and reproductive healthcare providers with a comprehensive list of the essential drugs, equipment, and supplies for cervical cancer prevention, screening, and treatment procedures for primary health facilities.

Procedure	Medical devices category	Equipment	Accessories/hardware/software/ consumables/single use devices
HPV vaccine	Personal protective equipment		• Gloves, examination, non-sterile, single use (various sizes)
	Single use devices/ disposables/medical supplies		• Safety box for used syringes/needles; cotton wool, 500 g roll; non-sterile syringes, auto-disable (various capacities)
Gynaecological examination and procedures†	Medical equipment	• Bright light source • Gynaecological examination/ treatment table	
	Instruments	• Forceps tissue-long • Cheron forceps • Long needle holders • Cervical punch biopsy forceps • Ring forceps • Vaginal sidewall retractors • Vaginal speculum, reusable	• Compress, gauze, sterile and non-sterile, single use • Specimen container • Absorbent tipped applicator/large • Tongue depressor, single use (wooden or plastic spatula) • Examination table paper cover
	Personal protective equipment and clothing	---	• Gloves, examination, non-sterile, single use (various sizes)
	Solutions and reagents	---	• Formalin 10 per cent, or tissue fixation reagents, phosphate buffered • Lubricating jelly • Monsel's paste • Saline solution • Lugol iodine, bottle/acetic acid solution 3–5 per cent • 0.5 per cent chlorine solution for decontaminating instruments
	Other	---	• Container for warm water • Bag for contaminated disposable supplies

continued

† The devices listed in this procedure should be considered in addition to the equipment enlisted for the following procedures: colposcopy, cryotherapy, visual inspection with acetic acid, endocervical curettage, and Pap smear.

continued

Procedure	Medical devices category	Equipment	Accessories/hardware/software/ consumables/single use devices
Colposcopy	Medical equipment	Colposcope	---
Cryotherapy	Medical equipment	• Cryosurgery unit with all parts and accessories listed • Colposcope	• Probe, trigger, handle grip, yoke, inlet of gas cylinder, tightening knob, pressure gauge showing cylinder pressure, silencer outlet, gas-conveying tube probe tip
Papanicolaou test (Pap smear)	Instruments	Vaginal speculum, reusable	• Local anaesthetic, syringes
	Personal protective equipment and clothing	---	• Gloves, examination, non-sterile, single use (various sizes)
	Single use devices/ disposables/medical supplies	---	• Microscope slides frosted or liquid-based container (tube containing a special preservative solution) • Tongue depressor, single use (wooden or plastic spatula) • Cervical cytology brush or cervical cytology scraper (optional) • Examination table paper cover
	Solutions and reagents	---	• 0.5 per cent chlorine solution for decontaminating instruments • Fixative spray or solution for Pap smear (if slides are used)
	Other	---	• Container for warm water • Bags for contaminated disposable supplies

continued

continued

Procedure	Medical devices category	Equipment	Accessories/hardware/software/ consumables/single use devices
Visual inspection with acetic acid (VIA)	Instruments	Vaginal speculum, reusable	---
	Single use devices/ disposables/medical supplies	---	• Examination table paper cover • Absorbent tipped applicator/large
	Personal protective equipment and clothing	---	• Gloves, examination, non-sterile, single use (various sizes)
	Solutions and reagents	---	• Lugol iodine, bottle/acetic acid solution 3–5 per cent • 0.5 per cent chlorine solution for decontaminating instruments
	Other	---	• Container for warm water • Bags for contaminated disposable supplies

Source: Adapted from World Health Organization. WHO list of priority medical devices for cancer management. Geneva: WHO; 2017. Licence: CC BY-NC-SA 3.0 IGO. Available at: https://apps.who.int/iris/handle/10665/255262. Accessed 10 September 2021.

Clinical management of rape

This table informs clinic and programme managers and trained healthcare providers on the important infrastructure required to set up safe and quality healthcare for rape survivors at primary health and tertiary centres.

Furniture/setting	Supplies

• Clean, quiet, child-friendly, accessible consultation room with direct access to a toilet or latrine, and with a door, curtain, or screen for visual privacy
• Examination table
• Light, preferably fixed (a torch may be threatening for children)
• Magnifying glass (or colposcope). Access to an autoclave to sterilize equipment
• Access to laboratory facilities/microscope with a trained technician
• Weighing scales and a height chart for children
	• Available speculums†† (only adult sizes)
	• Tape measure for measuring the size of bruises, lacerations, etc.††
	• Syringes/needles†† (butterfly type for children) and tubes for collecting blood
	• Supplies for universal precautions (gloves, box for safe disposal of contaminated and sharp materials, soap)††
	• Resuscitation equipment††
	• Sterile medical instruments (kit) for repair of tears, and suture material††
	• Tongue depressor (for inspection of oral frenulum and injury)
	• Cover (gown, cloth, sheet) to cover the survivor during the examination††
	• Spare items of clothing to replace those that are torn or taken for evidence
	• Sanitary supplies (disposable or cloth pads)††
	• Pregnancy tests
	• Pregnancy calculator disk to determine the age of a pregnancy
	• Additional supplies that may be needed for forensic evidence collection/documentation:
	  ◦ Comb for collecting foreign matter in pubic hair
	  ◦ Cotton-tipped swabs/applicators/gauze compresses for collecting samples
	  ◦ Glass slides for preparing wet and/or dry mounts (for sperm)
	  ◦ Laboratory containers for transporting swabs, paper sheet for collecting debris as the survivor undresses
	  ◦ Paper bags for collection of evidence
	  ◦ Paper tape for sealing and labelling containers/bags

†† Indicates the minimum requirements for examination and treatment of a rape survivor.

continued

continued

Medications with age-appropriate dosages	Administrative supplies
• For treatment of sexually transmitted infections (STIs) as per country protocol[††] • For post-exposure prophylaxis (PEP) at HIV transmission[††] • Emergency contraceptive pills[††] and/or intrauterine device (IUD) • Tetanus toxoid tetanus immunoglobulin[††] • Hepatitis B vaccine[††] • Pain relief[††] (e.g. paracetamol) • Anxiolytic (e.g. diazepam) • Sedative for children (e.g. diazepam) • Local anaesthetic for use when suturing[††] • Antibiotics for wound care[††]	• Available medical history and examination form including chart with pictograms[††] • Medical certificate/medico-legal forms • Referral directory • Job aids in the language of the provider (e.g. care/treatment algorithm, referral flow chart) • Consent forms[††] • Information pamphlets for post-rape care (for the survivor) • Safe and locked filing space to keep records confidential, or password-protected computer for electronic files[††]

[††]Indicates the minimum requirements for examination and treatment of a rape survivor.

Source: World Health Organization. Clinical management of rape and intimate partner violence survivors: Developing protocols for use in humanitarian settings. Geneva: WHO; 2020. Licence: CC BY-NC-SA 3.0 IGO. Available at: https://apps.who.int/iris/handle/10665/331535. Accessed 9 June 2022.

Contraceptives

These tables provide lists of the essential drugs, equipment, and supply information to set up facilities for short-acting methods, long-acting reversible methods, and sterilization methods.

1. Short-acting methods

Basic furniture, equipment, and supplies	Commodities	Supplies
• Examination couch • Stepping stool • Blood pressure machine • Stethoscope • Weighing scale • Chairs • Table • Storage cupboard/cabinet • Waste disposal bins **Administrative items** • Log book • Information, education, communication materials • Job aids • Consent forms • Clinical protocols/standard operating procedures • Client face sheet • Instrument processing chart	• Male condoms • Female condoms • Emergency contraception • Oral contraceptive pills (COC, POC) • DMPA vials (POI) • DMPLA POI (NET-EN) • Combined injectible (CIC)	For DMPA • Cotton • Syringe • DMPA vials containing sterile aqueous suspension: 150 mg per ml • Needles or with 22-gauge x 1.5-inch long or 3.5 cm SafetyGlide™ needles • 5 ml syringe

2. Implant

Basic furniture and equipment	Equipment (no. in brackets = quantity)	Supplies
• Examination couch • Stepping stool • Blood pressure machine • Stethoscope • Weighing scale • Chairs • Table • Storage cupboard/cabinet • Waste disposal bins **Administrative items** • Log book • Information, education, communication materials • Job aids • Consent forms • Clinical protocols/standard operating procedures • Client face sheet • Instrument processing chart	**Insertion** • (1) Cup/bowl/gallipot • Optional: (1) Forceps, sponge-holding, straight, 5.5 inches (14 cm) for cleaning **Removal** • (1) Cup/bowl/gallipot • (1) Scalpel with corresponding handle or a disposable scalpel with handle • (1) Forceps, mosquito, straight, 5 inches (12.7 cm) • (1) Forceps, mosquito, curved, 5 inches (12.7 cm) **Additional instruments for difficult implant removal:** This is deeply inserted implants and non-palpable implants using modified U technique • (1) Kidney dish • (1) Standard artery forceps 5.5 inches (14 cm) • (1) Modified vasectomy straight blunt • 12.5 cm forceps (also known as "U clamp", NSV ringed clamp or "Norgrasp" with a diameter of 2.2 mm)	• Alcohol-based hand rub AND soap and water or antiseptic soap and water (for hand hygiene) • Small towel (for hand drying if soap and water were used) • Sterile gloves (powder-free) • Exam gloves only required for Nexplanon and Implanon • Povidone iodine (preferred as an antiseptic) • Sterile gauze sponges • Local anaesthetic such as lidocaine (without epinephrine, 1 per cent or 2 per cent) • Distilled water to dilute lidocaine (if 2 per cent lidocaine is used) • 5 ml syringe with 1.5 inch and 21-gauge needle • Scalpel blade #11 with handle or disposable scalpel #11 with handle) • Adhesive tape • Arm bandage (to apply pressure to the incision) • Sterile small drape (to rest the client's arm on) (24 inches square) • Sterile fenestrated drape (24 inches square) • Material for packing instruments (drapes or disposable material) • Safety box

Source: EngenderHealth. Basic furniture, equipment, instruments, and expendable supplies needed to provide long-acting reversible and permanent methods of contraception. 2017. Available at: https://toolkits.knowledgesuccess.org/sites/default/files/larc-pm_equipment_instruments_and_supplies_list_-_12212017.pdf. Accessed 21 April 2022.

3. Intrauterine device

Basic furniture and equipment	Equipment (no. in brackets = quantity)	Supplies
• Examination couch (Gynae—with stirrups and Macintosh or rubber sheet) • Stepping stool • Light source • Auxiliary table • Chairs • Table • Storage cupboard/cabinet • Waste disposal bins **Administrative items** • Log book • Information, education, communication materials • Job aids • Consent forms • Clinical protocols/standard operating procedures • Client face sheet • Instrument processing chart	**Interval insertion** • (1) Cup/bowl/gallipot • (1) Forceps, Schroeder-Braun uterine tenaculum, 9.75 inches (24.8 cm) • (1) Sound, uterine, Sims, 13 inches (33 cm) • (1) Scissors, suture, Mayo-Clinic OR Littauer, curved, 6.75 inches (17.1 cm) • (1) Speculum (Graves or any self-retaining speculum), vaginal, Graves, medium (1.38 inches [3.5 cm] x 4 inches [10.2 cm]) **Postpartum insertion** • (1) Forceps ringed 9.5 inches (24.1 cms) • (1) Forceps Kelly placental 12 inches (30 cm) • (1) Speculum (Graves or any self-retaining speculum) Sims or any vaginal **Removal** • (1) Cup/bowl/gallipot • (1) Forceps, sponge, Foerster, straight, 9.5 inches (24.1 cm) • (1) Speculum, vaginal, Graves, medium (1.38 inches [3.5 cm] x 4 inches [10.2 cm]) • (1) Forceps, Bozeman uterine dressing, straight, 10.5 inches (26.7 cm) • (1) IUD removal forceps, alligator jaw, 8 inches • (1) IUD string retriever	• Cup/bowl/gallipot • The IUD (TCu 380A or Multiload or LNG-IUS) • Alcohol-based handrub AND soap and water or antiseptic soap and water (for hand hygiene) • Small towel (for hand drying if soap and water were used) • Exam gloves • Povidone iodine (preferred as an antiseptic) • Sterile gauze sponges • Drapes (to cover client's thighs, pubic area, and to put underneath their buttocks) • Drapes (for packing instruments) • Sanitary pad

Source: EngenderHealth. Basic furniture, equipment, instruments, and expendable supplies needed to provide long-acting reversible and permanent methods of contraception. 2017. Available at: https://toolkits.knowledgesuccess.org/sites/default/files/larc-pm_equipment_instruments_and_supplies_list_-_12212017.pdf. Accessed 21 April 2022.

4.Tubal ligation (female sterilization)

Equipment and basic furniture	Instruments no. in brackets = quantity)	Supplies
Preprocedure room • Examination couch • Light source • Auxiliary table • Blood pressure machine • Stethoscope • Weighing scale • Thermometer • Table and chairs • Storage cupboard/cabinet • Waste disposal bins • Procedure area/operating theater • Operating table (with reclining capabilities) • Stepping stool • Source of light (theater lamp) • Auxiliary table (anaesthesia) • Instrument trolleys • Blood pressure machine • Stethoscope • Emergency tray • IV stand • Waste disposal bin **Adminsitrative items** • Log book • Information, education, communication materials • Job aids • Consent forms • Clinical Protocols/standard opearting procedures • Client face sheet • Instrument processing chart	**Abdominal instruments** • (1) Cup/bowl/gallipot • (1) Forceps, sponge, Foerster, straight, 9.5 inches (24.1 cm) • (1) Forceps, dressing, standard pattern, 5 inches (12.7 cm) • (1) Forceps, tissue, delicate pattern, 5.5 inches (14 cm) • (2) Forceps, artery, Kelly, straight, 5.5 inches (14 cm) • (2) Forceps, intestinal, Allis, delicate, (5x6 teeth) 6 inches (15.2 cm) • (2) Forceps, intestinal, baby Babcock, 5.5 inches (14 cm) • (1) Needle holder, Mayo Hegar, 7 inches (17.8 cm) • (2) Richardson-Eastman retractor, small or (1 set- 2 pieces) Army-Navy retractor, double-ended • (1) Scissors, tonsil, Metzenbaum, 7 inches (17.8 cm) • (1) Scissors, operating, Mayo, curved, 6.75 inches (17.1 cm) • (1) Scalpel, handle, #3, graduated in cm • (1) Hook, tubal, Ramathibodi **Vaginal instruments** • (1) Cup/bowl/gallipot • (1) Forceps, sponge, Foerster, curved, 9.5 inches (24.1 cm) • (1) Speculum, vaginal, Graves, medium (1.38 inches [3.5 cm] x 4 inches [10.2 cm]) or (1) Jackson vaginal retractor (deep blade) 1.5 inches (3.8 cm) x 3 inches (7.6 cm) • (1) Forceps, Schroeder-Braun uterine tenaculum, 9.75 inches (24.8 cm) • (1) Elevator, uterine, Ramathibodi **Emergency equipment and supplies**[¶]	**Pain management supplies** • Local anaesthetic such as lidocaine, (without epinephrine, 1 per cent or 2 per cent) • Distilled water to dilute lidocaine (if 2 per cent is used) • 10–20 ml syringe with a 1.5 inch and 21-gauge needle • Pain management drugs • Sedatives such as diazepam or midazolam or promethazine • Analgesics such as diclofenac or ibuprofen • Narcotic analgesics such as fentanyl or pentazocine or meperidine (pethidine) or nalbuphine **Surgical procedure supplies** • Scalpel blade • Absorbable suture (on an atraumatic needle) **Infection prevention supplies** • Soap and water and alcohol-based hand rub OR antiseptic soap and water • Small sterile towel • Sterile gloves • Iodine • Sterile gauze sponges • Surgical adhesive tape • Sterile surgical drapes (4 drapes or one fenestrated drape to cover client) • Sterile gowns for surgeon and surgeon's assistant • Cap and face mask • Client's gown • Drape to cover surgical cushion table • Drapes (for packing instruments) • Safety box

[¶] For a list of emergency supplies and equipment for tubal ligation, see table on tubal ligation.

Source: EngenderHealth. Basic furniture, equipment, instruments, and expendable supplies needed to provide long-acting reversible and permanent methods of contraception. 2017. Available at: https://toolkits.knowledgesuccess.org/sites/default/files/larc-pm_equipment_instruments_and_supplies_list_-_12212017.pdf. Accessed 21 April 2022.

5. Non-scalpel vasectomy (male sterilization)

Basic furniture and equipment	Instruments (no. in brackets = quantity)	Supplies
• Examination couch • Auxiliary table • Blood pressure machine • Stethoscope • Thermometer • Weighing scale • Stepping stool • Light source • Chairs • Table • Storage cupboard • Waste disposal bin • Emergency tray • IV stand **Adminstrative items** • Log book • Information, education, communication materials • Job aids • Consent forms • Clinical protocols/standard operating procedures • Client face sheet • Instrument processing chart	• (1) Cup/bowl/gallipot • (1) Forceps, sponge-holding, straight, 5.5 inches (14 cm) • (1) Scissors, suture, Mayo Clinic OR Littauer straight, 5.5 inches (14 cm) • (1) NSV ringed clamp (forceps), 4 mm • (1) NSV dissecting forceps **Emergency equipment and supplies**[¶]	• Ordinary soap (or antiseptic soap) • Sterile hand towels • Running water • Alcohol-based hand rub • Antiseptic solution (iodine) • Examination gloves • Sterile gloves • Sterile gauze • Sterile surgical drapes • One fenestrated drape • Sterile surgeon's gown • Cap • Face mask • Boots • Client's gown • Chromic cat gut or non-absorbable silk or cotton • Lidocaine solution (2 per cent strength) • Syringe 5 ml or 10 ml with needle (21 G) • Waste disposal lining • Safety box • Analgesics • Adhesive tape • Basic emergency drugs

[¶] For a list of emergency equipment, drugs, and supplies for vasectomy, see table on vasectomy.

Source: EngenderHealth. Basic furniture, equipment, instruments, and expendable supplies needed to provide long-acting reversible and permanent methods of contraception. 2017. Available at: https://toolkits.knowledgesuccess.org/sites/default/files/larc-pm_equipment_instruments_and_supplies_list_-_12212017.pdf. Accessed 21 April 2022.

Safe delivery equipment, medicines, and supplies list for BEmONC and CEmONC

A. Primary healthcare BEmONC level

General supplies and equipment	Supplies in the delivery room	Medications/injections/drips
• Power supply • Clean water • Soap and alcohol hand rub • Disinfectant • Autoclave • Clean gloves • Stethoscope • Thermometer • Blood pressure instrument • Partograph • Fetoscope/Doppler • Consent and referral forms • Job aids • Information, education, communication materials • Standard operating procedures/ clinical protocols • Safety box	• Suction machine • Mucus extractor • Neonatal bag and mask • Oxygen cylinder/concentrator • Baby scale • Needle/syringe • Urine dip sticks • Sterilized blade scissor • Cord tie/clamp • Clean pads for mother • Clean towel • Vaccum extractor, Bird, manual, complete set • Intrauterine device • Delivery set: plastic bags, sheets, towels, sterile gloves, scissors, cord clamps x2, PPE (mask and personal cover) • Perineal repair set	• Bag of intravenous fluids • Injectable oxytocin • Injectable magnesium sulfate • Antibiotics for mother • Anitbiotics for infant • Antihypertensives • Misoprostol for post-abortion care

Source: Adapted from World Health Organization. WHO safe childbirth checklist implementation guide: improving the quality of facility-based delivery for mothers and newborns. Geneva: WHO; 2015. License: CC BY-NC-SA 3.0 IGO. Available at: https://apps.who.int/iris/handle/10665/199177. Accessed 10 September 2021; Inter-Agency Working Group on Reproductive Health in Crises. Inter-Agency Reproductive Health Kits 6th Edition – Manual. Available at: https://iawg.net/resources/inter-agency-reproductive-health-kits-6th-edition-manual. Accessed 1 October 2021.

B. Tertiary centre/hospital CEmONC performing caesarean delivery and blood transfusion

Requires all the essential supplies and medications mentioned above and the following:

- Blood transfusion kit
- Caesarean delivery kit
- Embryotomy set

Sexually transmitted infections including HIV

These tables provide clinic managers and trained clinical healthcare providers with a comprehensive list of the essential drugs, equipment, and supplies to screen for sexually transmitted infections (STIs), and syndromic and prophylactic management of STI/HIV healthcare delivery at primary health centres.

Equipment: Outpatient clinic	Equipment: Pharmacy	Equipment and tests: Laboratory	Guidelines and IEC materials
• Examining beds • Chairs for patients • Tables for doctors • X-ray reading machine • Scale/weighing machine • Scale to measure height • Tape measure to measure head circumference • Thermometer • Stethoscope • Torch • Medical scissors • Ear/nose/throat equipment set • Opthalmoscope • Tendon hammer • Medical record storage cupboard • Specialized test request forms/records • Ambu bag for ventilation	• Pill-counting trays • Lockable cabinet • Dispensing trays • Dispensing containers, envelopes, bags • Refrigerator and temperature chart • Air conditioning/and or fans • White coats • Gloves, face masks	• Phlebotomy chair • Dedicated toilet for stool and urine collection • Space for sputum selection • Rapid HIV antibody test • Full blood count • Liver function test • Hepatitis B and C serology • Renal function and electrolytes • Sputum smear microscopy • Pregnancy test • CD4 counts • STI tests (syphilis, urethral, cervical, and vaginal infection) • PEP kit for staff and clients	• National MoH HIV care and treatment guidelines • SOPs, patient flow charts, and job aids for HIV management, adherence counselling and assisted reproductive care available for adults and paediatric clients • Paediatric files include growth monitoring charts • Dosing charts for paediatric patients (OI drugs and assisted reproductive care drugs) are available • Infection control SOPs • Daily and monthly dispensing records and stock report templates • Procedure manual for safe specimen collection (blood, sputum, vaginal and urethral swab, body fluid, urine, and stool) available in specimen reception area • STI/HIV IEC materials for all age groups, genders, etc. • Counselling materials

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General medicines and OI drugs	Dispensing of pharmaceutical supplies (ARV and OI drugs)	Emergency drugs
• Acyclovir 200 mg • Ceftriaxone 1 g • Azithromycin 500 mg • Doxycycline 100 mg • Cephalexin 500 mg • Amoxicillin 250, 500 mg • Penicillin, Benzathine 2.4. MU • Co-trimoxazole syrup • Co-trimoxazole 480 mg and 960 mg tablets • Ciprofloxacin 500 mg • Dapsone 100 mg • Metronidazole 250 mg • Erythromycin 500 mg • Itraconazole 200 mg tablets • Mebendazole 100 mg • Fluconazole 150 mg tablets • Fluconazole syrup 2 mg/ml-100 ml • Primperan 10 mg tablets • Primperan 10 mg/2ml injection • Promethazine • Folic acid • Miconazole gel • Benzyl benzoate lotion	• Diclofenac 50 mg • Cimetidine 300 mg • Paracetamol 500 mg/codeine 30 mg • Oral morphine • Paracetamol 120 mg/5ml 60ml • Loratadine • Clotrimazole 1 per cent • Hydrocortisone 1 per cent • Vitamin B6 250 mg • Multivitamin tablet and syrup • Loperamide • Ibuprofen 200 mg tablets **First-line ARV drugs for adults and paediatric clients if applicable** • Zidovudine • Lamivudine • Stavudine • Nevirapine • Efavirenz **Second-line ARV drugs for adults and paediatric clients if applicable** • Abacavir • Didanosine • Tenofovir • Nelfinavir • Kaletra	• Adrenalin • Antihistamines • Hydrocortisone • Oxygen

Abbreviations: IEC, information, education, and communication; STI, sexually transmitted infection; PEP, post-exposure prophylaxis; MoH, Ministry of Health; SOPs, standard operating procedures; OI, opportunistic infection; ARV, antiretroviral.

Source: Adapted from FHI 360. HIV Clinical Care and Treatment (Outpatient) Facility QA/QI checklist. Available at: https://www.fhi360.org/sites/default/files/media/documents/HIV%20Clinical%20Care%20and%20Treatment%20%28Outpatient%29%20Facility%20QAQI%20Checklist.pdf. Accessed 21 April 2022.

Tubal ligation (female sterilization): Emergency supplies and equipment

Basic drugs and indication	Administration and dosages
Epinephrine (adrenaline) Indicated for: • Low blood pressure • Acute asthma • Anaphylaxis • Heart arrhythmias (ventricular fibrillation; pulseless ventricular tachycardia; asystole; pulseless electrical activity)	**Low blood pressure:** 2–16 μg IV; then 0.05–0.3 μg/kg/min (mix 4 mg in 500 ml; 1 ml = 8 μg/ml) **Acute asthma and anaphylaxis:** 0.3–0.5 mg (0.3–0.5 ml of a 1:1000 solution) SQ every 10–20 minutes, as needed **Heart arrhythmias:** 1 mg IV bolus (10 ml of 1:10,000 solution) followed by 20 ml saline flush q 3–5 minutes. (If only 1:1000 is available, dilute 1 ml of adrenaline into 10 ml of normal saline) **WARNING—1:1000** solution should never be used for IV administration. (Ensure 1:10,000 dilution)
Aminophylline (when albuterol and terbutaline are not available) Indicated for: • Acute asthma • Anaphylaxis with inadequate breathing	5–6 mg/kg IV over 20 minutes; then 0.5–0.7 mg/kg/hour
Atropine Indicated for: • Vasovagal reaction • Asystole • Pulseless electrical activity	**Vasovagal reaction:** 0.4–0.6 mg IV **Asystole and pulseless electrical activity:** 1.0 mg IV bolus; repeat as needed every 3–5 minutes, to a maximum of 0.04 mg/kg
Diazepam Indicated for: • Seizure activity	5–10 mg (0.15–0.25 mg/kg) IV at rate of 5 mg per 5 min; may repeat at 10–15 minute intervals, with careful monitoring to maximum dose of 30 mg. May repeat in 2–4 hours. Do not overdose **Note:** If IV cannot be started, give 10–20 mg per rectum, using a syringe
Diphenhydramine Indicated for: • Anaphylaxis	50 mg IV or IM every 6–8 hours (if severe anaphylaxis, give 100 mg IV initially)
Ephedrine (when spinal/epidural anaesthesia is used) Indicated for: • Low blood pressure after spinal/epidural	10–15 mg IV or 25–50 mg IM

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Basic drugs and indication	Administration and dosages
Hydrocortisone Indicated for: • Acute asthma • Anaphylaxis	250 mg IV; repeat every 4–6 hours as needed. Higher dosages may be needed for management of shock
Physostigmine (when flumazenil is not available) Indicated for: • Respiratory depression from benzodiazepines (Diazepam) when flumazenil is not available • Overdose of atropine • Ketamine response	0.5–2.0 mg IV or IM given in 0.5 mg increments to a total dose of 3–4 mg. Repeat in 1–2 hours, as needed
Promethazine • Nausea and vomiting • Tranquilizer for premedication • Antihistaminic	25 mg or 50 mg, deep IM preoperatively or postoperatively Adds to the sedative effect of narcotics. If given with meperidine, reduce dose by 25–50 per cent
Additional drugs (drugs that are desirable to provide additional safety)	
Albuterol (or terbutaline) Indicated for: • Acute asthma • Anaphylaxis with inadequate breathing.	Deliver 3 ml via aerosol (nebulized 0.83 mg/ml; 3 ml/ampule) every 20 minutes for 3–6 doses, then every 4–6 hours, as needed
Flumazenil (preferred over physostigmine) Indicated for: • Respiratory depression from benzodiazepines (diazepam)	0.2 mg (2 ml) IV mg over 30 seconds; repeat at 1 minute intervals to a total dose of 3 mg (15 ml) **Note:** If this treatment does not reverse the respiratory depression, then benzodiazepine (diazepam) overdose is unlikely to be the cause of the depression. If there is a partial response, give additional doses in 0.5 mg amounts, to a maximum dose of 5 mg

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Emergency equipment

Basic equipment

- Demand resuscitator **OR** manual resuscitator (Ambu bag)
- Face mask
- Oxygen tank with pressure-reducing valve, flow meter tubing, oxygen nipple, and tubing
- Suction machine with tubing and two traps
- Non-flexible (size Fr 18) catheters
- Flexible suction catheter
- Oral airways (sizes 90 mm and 100 mm)
- Nasopharyngeal airways (sizes 28 and 30)
- Tourniquet
- Foley bladder catheter (size 16 or 18) and drainage bag
- Blood pressure apparatus (stethoscope, sphygmomanometer)
- Torch (flashlight)
- Emesis basin
- Blanket

Basic supplies

- Oxygen
- IV fluids (normal saline and 5per cent dextrose in water)
- Infusion sets with large-calibre needles (14–16 gauge) and tubing
- Adhesive tape
- Gauze sponges
- Antiseptics to clean the skin
- Lubricant for nasopharyngeal intubation
- Syringes and needles (hypodermic)

Source: Training Resource Package for Family Planning [website]. Tubal Ligation Handout #17: Emergency Supplies and Equipment. Available at: https://www.fptraining.org/training/19/downloads. Accessed 9 June 2022.

Vasectomy (male sterilization): Emergency supplies and equipment

Drugs list

Basic drugs and indication	Administration and dosages
Epinephrine (adrenaline) Indicated for: • Low blood pressure • Acute asthma • Anaphylaxis • Heart arrhythmias (ventricular fibrillation; pulseless ventricular tachycardia; asystole; pulseless electrical activity)	**Low blood pressure:** 2–16 μg IV; then 0.05–0.3 μg/kg/min (mix 4 mg in 500 ml; 1 ml = 8 μg/ml) **Acute asthma and anaphylaxis:** 0.3–0.5 mg (0.3–0.5 ml of a 1:1000 solution) SQ every 10–20 minutes, as needed **Heart arrhythmias:** 1 mg IV bolus (10 ml of 1:10,000 solution) followed by 20 ml saline flush q 3–5 minutes (if only 1:1000 is available, dilute 1 ml of adrenaline into 10 ml of normal saline) **WARNING—1:1,000** solution should never be used for IV administration (ensure 1:10,000 dilution)
Aminophylline (when albuterol and terbutaline are not available) Indicated for: • Acute asthma • Anaphylaxis with inadequate breathing	5–6 mg/kg IV over 20 minutes; then 0.5–0.7 mg/kg/hour
Atropine Indicated for: • Vasovagal reaction • Asystole • Pulseless electrical activity	**Vasovagal reaction:** 0.4–0.6 mg IV **Asystole and pulseless electrical activity:** 1.0 mg IV bolus; repeat as needed every 3–5 minutes, to a maximum of 0.04 mg/kg
Diazepam Indicated for: • Seizure activity	5–10 mg (0.15–0.25 mg/kg) IV at rate of 5 mg per 5 min; may repeat at 10–15 minute intervals, with careful monitoring to maximum dose of 30 mg. May repeat in 2–4 hours. Do not overdose. **Note:** If IV cannot be started, give 10–20 mg per rectum, using a syringe
Diphenhydramine Indicated for: • Anaphylaxis	50 mg IV or IM every 6–8 hours (if severe anaphylaxis, give 100 mg IV initially)

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Basic drugs and indication	Administration and dosages
Hydrocortisone Indicated for: Acute asthma Anaphylaxis	250 mg IV; repeat every 4–6 hours as needed. Higher dosages may be needed for management of shock
Physostigmine (when flumazenil is not available) Indicated for: Respiratory depression from benzodiazepines (diazepam) when flumazenil is not available Overdose of atropine Ketamine response	0.5–2.0 mg IV or IM given in 0.5 mg increments to a total dose of 3–4 mg. Repeat in 1–2 hours, as needed
Promethazine Nausea and vomiting Tranquilizer for premedication Antihistaminic	25 mg or 50 mg, deep IM pre- or postoperatively **Note:** Adds to the sedative effect of narcotics. If given with meperidine, reduce dose by 25–50 per cent
Additional drugs (drugs that are desirable to provide additional safety)	
Albuterol (or terbutaline) Indicated for: Acute asthma Anaphylaxis with inadequate breathing	Deliver 3 ml via aerosol (nebulized 0.83 mg/ml; 3 ml/ampule) every 20 minutes for 3–6 doses, then every 4–6 hours, as needed
Flumazenil (preferred over physostigmine) Indicated for: Respiratory depression from benzodiazepines (diazepam)	0.2 mg (2 ml) IV mg over 30 seconds; repeat at 1 minute intervals to a total dose of 3 mg (15 ml). **Note:** Benzodiazepine overdose is unlikely if there is no response to such treatment. If there is a partial response, give additional doses in 0.5 mg amounts, to a maximum dose of 5 mg

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Basic supplies

- Ambu bag
- Oxygen
- IV fluids (normal saline and 5 per cent dextrose in water)
- Infusion sets with large-calibre needles (14–16 gauge) and tubing/tourniquet
- Adhesive tape
- Gauze sponges
- Antiseptics to clean the skin
- Syringes and needles (hypodermic)

Emergency equipment

Basic equipment

- Demand resuscitator **OR** manual resuscitator (Ambu bag)
- Face mask
- Oxygen tank with pressure-reducing valve, flow meter tubing, oxygen nipple, and tubing
- Suction machine with tubing and two traps
- Non-flexible (size Fr 18) catheters
- Flexible suction catheter
- Oral airways (sizes 90 mm and 100 mm)
- Nasopharyngeal airways (sizes 28 and 30)
- Tourniquet
- Foley bladder catheter (size 16 or 18) and drainage bag
- Blood pressure apparatus (stethoscope, sphygmomanometer)
- Torch (flashlight)
- Emesis basin
- Blanket

Optional equipment

(if personnel trained in its use are available)

- Laryngoscope, with spare bulb and spare battery
- Endotracheal tubes
- Pulse oximeter
- Electrocardiogram (ECG) machine with leads
- Defibrillator
- General inhalation anaesthesia machine

Source: Training Resource Package for Family Planning [website]. Vasectomy Handout #16: List of Emergency Equipment, Drugs, and Supplies. Available at: https://www.fptraining.org/training/6/downloads. Accessed 9 June 2022.