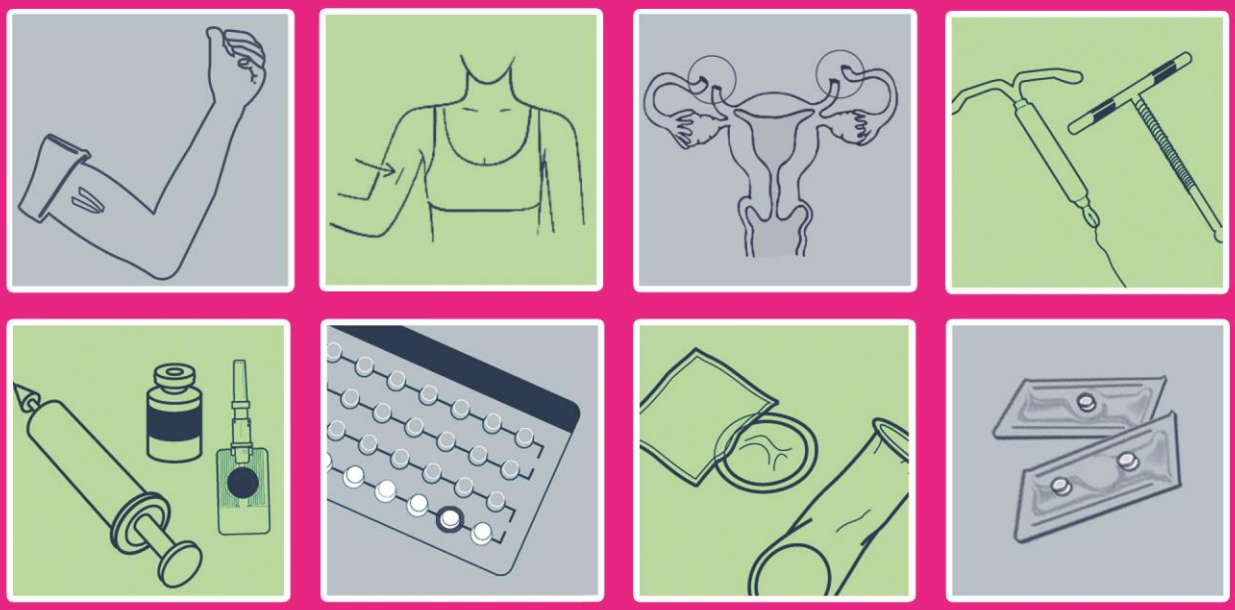
Family Planning Guideline

For Service Providers



Maternal and Reproductive Health Division
Ministry of Health and Sports

2018

UNFPA
World Health Organization Myanmar
FP FAMILY PLANNING 2020
psi Myanmar
MARIE STOPES MYANMAR
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ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ARV	Anti-Retro Viral
BBT	Basal Body Temperature
BCS+	Balance Counseling Strategy Plus
CIC	Combined Injectable Contraceptives
COC	Combined Oral Contraceptive
DMPA	Depot Medroxyprogesterone Acetate
DMPA-SC	Depot Medroxyprogesterone Acetate - Sub-Cutaneous
DVT	Deep vein thrombosis
ECPs	Emergency Contraceptive Pills
EPHS	Essential Package for Health Services
FP 2020	Family Planning 2020
HIV	Human Immunodeficiency Virus
HTSP	Healthy Timing and Spacing of Pregnancy
IUD	Intra Uterine Device
LAM	Lactational Amenorrhea
LMP	Last Menstrual Period
LARC	Long Acting Reversible Contraceptive
MRH	Maternal and Reproductive Health
MEC	Medical Eligibility Criteria
NET-EA	Norethisterone enanthate
NSAID	Non-steroidal anti-inflammatory drug
OC pills	Oral Contraceptive pills
PE	Pulmonary embolism
PID	Pelvic inflammatory disease
POP	Progestogen Only Pills
PSI	Population Services International
STIs	Sexually Transmitted Infections
WHO	World Health Organization
MMCWA	Myanmar Maternal and Child Welfare Association

UNITS

µg	microgram	mg	milligram

CHAPTER I. INTRODUCTION

Reproductive and sexual health and rights (SRHR) is a part of overall human health, and concepts related to this important aspect of health have been deliberated upon at many platforms, in particular at the International Conference of Population and Development (ICPD) at Cairo in 1994. In the global Reproductive Health Strategy of WHO[1], which Myanmar has adopted and included in the Five Years Reproductive Health Strategy (2014-2018), family planning is one of the components of reproductive health.

According to WHO, family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility[2]. The importance of family planning is well-established and well-known. If all women and girls in developing countries who want contraception have access to it, unintended pregnancies will drop by more than 70 percent, and each year nearly 100,000 mothers would not die from complications during pregnancy and childbirth, and more than half a million newborns would not die. Access to family planning information, services and supplies is equally critical for preventing HIV and other sexually transmitted infections. Women and couples who can decide on the number, spacing, and timing of their children are better able to increase their household income and invest in their existing children. Girls who are able to delay marriage and delay their first pregnancy are better able to gain the skills, confidence and assets they need to take up opportunities and improve their own lives.

Family planning is strongly linked to the third component of reproductive health (eliminating unsafe abortion). Unsafe abortion is a serious public health problem, and in Myanmar, and abortion related complications are the third leading cause of maternal deaths[3]. Primary prevention of unsafe abortion can only be achieved by preventing unwanted pregnancies where family planning plays a critical role.

Family planning services are included in Myanmar's basics essential package of health services (EPHS) under National Health Plan (2017-2021). Increase access to basic EPHS is integral to attaining Universal Health Coverage[4]. Along with other components to improve service delivery, it is important to guarantee quality of care of basic EPHS regardless of types of service providers. Moreover, in the delivery of family planning services ensuring quality is central not only to delivering positive health outcomes for the families but also to certifying that human rights are respected, protected and fulfilled.

Thus, the 'Family Planning Guideline for Service Providers 2018' has been developed to reduce the unmet need for contraception by increasing knowledge and services provided by the health service providers in Myanmar. With increase service delivery points in the community, the ultimate goal is to reduce untended pregnancies and maternal morbidity and mortality.

This guideline will serve as a reference guide[5] for health service providers at different levels of health system to provide quality and right-based family planning services to their clients. The guideline spells out the background of family planning in Myanmar and the details of processes and procedures relevant in directly delivering family planning services. These details are arranged in six chapters: human rights principles; counselling; quality of care; access to family planning services; and different contraceptive methods available in Myanmar; serving people with special needs, and job aids as annexes.

This guideline was developed in line with country's policy and context adapting from evidence based global guidelines. Guideline development was under taken through a highly consultative process consisting of:

- Setting up a core group for developing the guideline: including the Central Maternal and Reproductive Health Division, Professor and Head of Obstetrics and Gynaecology from four medical universities, representatives from WHO, UNFPA, Jhpiego and concerned partners.

- Review of the existing evidence based global guidelines on family planning: The Four Cornerstones of Family Planning (WHO)
    (1) Medical Eligibility Criteria for Contraceptive Use 2015 (MEC[6])
    (2) Selected Practice Recommendations for Contraceptive Use 2016 (SPR[7])
    (3) The Decision-Making Tool for Family Planning Clients and Providers 2005 (DMT[8])
    (4) Family Planning: A Global Handbook for Providers 2018[9]

- Organize discussions and working group meetings for drafting the guideline
- Conduct the finalization meeting and dissemination of the draft guideline to key stakeholders

Much of the information in this guideline have been adapted from WHO Family Planning: A Global Handbook for Providers 2018 and will be revised accordingly.

CHAPTER II. BACKGROUND OF FAMILY PLANNING IN MYANMAR

Myanmar has been endeavoring to reduce maternal morbidity and mortality aiming to achieve the Sustainable Development Goals, however, maternal mortality ratio (MMR) is currently the second highest among ASEAN countries.[10]As of 2014 Census, MMR in Myanmar amounts to 282 deaths per 100,000 live births.[11]

In this connection, reproductive, maternal, newborn, child and adolescent health (RMNCAH) care has been accorded as a priority issue in the action plan of National Health Plan (2017-2021). In addition, Myanmar has also committed to the ICPD goals, and United Nations Secretary General's Global Strategy for Women's, Children's and Adolescent's Health to improve women and children's health.

As Family planning is evidence-based intervention for improving the maternal and newborn health as well as cost-effective powerful tool for development, Myanmar demonstrated strong commitment by joining the Family Planning 2020; a global initiative to fulfilling the unmet need for family planning and reducing the maternal and newborn mortalities, in 2013.[12]

Myanmar has been endeavoring the quality family planning services to achieve the FP 2020 targets with the guidance of RH policy (2002), Five years Reproductive Health Strategic Plans (RHSP) and Costed Implementation Plan for FP 2020 through the coordination with the private sector, UN agencies, INGOs, NGOs and donor agencies.

Myanmar's family planning program started in 1991 as public sector's pilot in one township and then progressively extended to 164 out of 330 townships in 2014 with the support of UNFPA. Since 2012, the government of Myanmar has been increasing the health budget and investing more in family planning program. Myanmar became one of the 47 countries of UNFPA's Global Programme enhancing Reproductive Health Commodity Security (GPRHCS) in 2013 and received US$ 5.2 million worth of contraceptive commodities in 2014. UNFPA and John Snow Inc. supported Maternal and Reproductive Health Unit of MOHS in establishing a Reproductive Health Commodity Logistic System (RHCLS) to ensure that contraceptives supplies reach women at the last mile in the community level. It started in 2013 and has reached 115 townships in 2018.

In 2011, Government's investment in family planning started from US$ 20,000 and had increased annually up to US$ 3 million in 2016 whereby women including those in hard reach areas, ethnic

groups, migrants as well as young unmarried population have access to informed choice of variety of contraceptive methods including long acting reversible contraceptive methods (LARC) - promotion of which was part of FP 2020 commitment.

Collaboration between government, UNFPA, PSI, MSI, MMA, IPPF-MMCWA, Jhpiego and other partners the introduction of increased contraceptive methods including implants in public sectors since early 2016 serves as a good example of public-private-partnerships. Through advocacy, community awareness, capacity building of providers, and distribution of supplies and equipment, contraceptive prevalence has increased from 41% to 52.2% and is on track to reach the goal of 60% by 2020.[13,14]

Myanmar has come a long way to achieve greater impact as the DHS-2016 shows that unmet need for family planning has been reduced from 19% to 16%, towards the target of less than 10% in 2020.[13,14] However, there is much work to be done regarding rights based approach, quality of care and services regarding family planning and this National Guideline is timely and appropriate to empower health care providers in providing better choices of family planning information and services to reach all women and girls regardless of their age or marital status.

These good practices in family planning can be accelerated as the Government of Myanmar is highly committed to the health and welfare of women and had made sustainable investments in family planning programmes.

CHAPTER III: HUMAN RIGHTS PRINCIPLES GUIDING FAMILY PLANNING SERVICES

All people deserve the right to determine,[15] as best they can the course of their own lives. Whether and when to have children, how many and with whom are important parts of this right. Family planning service providers have the privilege and responsibility to help people to make and carry out these decisions.

High-quality family planning services and the people who deliver them respect, protect, and fulfill the human rights of all their clients. Everyone working at every level of the health system plays an important part. Family planning service providers express their commitment to human rights every day in every contact with every client.

As a family planning provider, you contribute to all of them. [15]

Principle 1 **Non-discrimination**
What you can do: Welcome all clients equally. Respect every client's needs and wishes. Set aside personal judgments and any negative opinions. Promise yourself to give every client the best care you can.

Principle 2 **Availability of contraceptive information and services**
What you can do: Know the family planning methods available and how to provide them. Help make sure that supplies stay in stock. Do not rule out any method for a client, and do not hold back information.

Principle 3 **Accessible information and services**
What you can do: Help make sure that everyone can use your facility, even if they have a physical disability. Participate in outreach, when possible. Do not ask clients, even young clients, to get someone else's permission to use family planning or a certain family planning method.

Principle 4 **Acceptable information and services** *What you can do:* Be friendly and welcoming and help make your facility that way. Put yourself in the client's shoes. Think what is important to the clients—what they want and how they want it provided.

Principle 5 **Quality**
What you can do: Keep your knowledge and skills up-to-date. Use good communication skills. Check that contraceptives you provide are not out-of-date.

Principle 6 **Informed decision-making**
What you can do: Explain family planning methods clearly, including how to use them, how effective they are, and what side effects they may have, if any. Help clients consider what is important to them in a family planning method.

Principle 7 **Privacy and confidentiality**
What you can do: Do not discuss your clients with others except with permission and as needed for their care. When talking with clients, find a place where others cannot hear. Do not tell others what your clients have said. Promptly put away clients' records.

Principle 8 **Participation**
What you can do: Ask clients what they think about family planning services. Act on what they say to improve care.

Principle 9 **Accountability**
What you can do: Hold yourself accountable for the care that you give clients and for their rights.

The fulfillment of human rights requires that health-care facilities, commodities and services be scientifically and medically appropriate and of good quality. Quality of care and human rights are therefore two intrinsically connected approaches. Realization of a rights-based approach without ensuring quality of care is not possible. Similarly, programs cannot achieve quality of care without guaranteeing human rights of clients.

As the schematic below highlights the high degree of overlap between the approaches, both are mutually dependent and reinforce each other.

Figure: 1. The relationship between quality of care and human right[16]

CHAPTER. IV: COUNSELLING IN FAMILY PLANNING

Good counseling helps clients choose and use family planning methods that suit them. Clients differ, their situations differ, and they need different kinds of help. The best counseling is tailored to the individual client.

Family planning counselling[17] is defined as a continuous process that you as the counselor provide to help clients and people in your village make and arrive at informed choice about the size of their family. (number of the children they wish to have).

Informed choice [17]is defined as a voluntary choice or decision, based on the knowledge of all available information relevant to the choice or decision. In order to allow people to make an informed choice about family planning, you must make them aware of all the available methods, and the advantages and disadvantages of each. They should know how to use the chosen method safely and effectively, as well as understanding possible side- effects. Counseling is an essential part of quality family planning services to assure that the clients make informed and voluntary decisions about their contraception use and family planning. Counselling using active listening and effective communication skills allows a woman feels in control of her choice of a contraceptive method and hence increases client satisfaction and encourages consistent use of the method chosen.

Well-informed clients are more likely to be satisfied with their method and to use it longer. Clients need to understand how that method works, how effective it is, how to make the method most effective, what are the most likely side effects, and what to do if such side effects occur.

Many different people can learn to inform and advise people about family planning and to provide family planning methods. When more types of health workers are authorized and trained to provide family planning methods, more people have access to them.

4.1: OVERVIEW OF THE STAGES OF COUNSELLING FOR FAMILY PLANNING

General counselling [17]

The first contact usually involves counselling on general issues to address the client's needs and concerns. You will also give general information about methods and clear up any mistaken beliefs or myths about specific family planning methods. During this session you would also give information on other sexual and reproductive health issues, like sexual transmitted infections, human immunodeficiency virus, acquired immunodeficiency syndrome and infertility.

In counselling, it is not possible or necessary to provide complete information about every method. Clients do, however benefit from key information especially, about the method that they want. The goal of counseling about method choice is to help client find a method that she or he can use successfully and with satisfaction.

Method specific counseling[17]

You give more information about chosen methods. You can explain

- Benefit of the method
- Risk of the method

- Alternatives of the method
- Inquiries about the method
- Decision to withdraw from using method
- Explanation of the method chosen
- Documentation of the session for you own report

You can explain the examination for fitness(screening) and instruct on how and when to use given method. (using MEC wheel- Figure.3)

Return/follow-up counselling [17]

Follow- up counselling should always be arranged. Main aim of follow-up counseling is to discuss and manage any problem and side effects related to given contraceptive methods.

4.2: STEPS IN FAMILY PLANNING COUNSELLING

When you counsel a new client in your village about family planning, you should follow step by step process. GATHER is an acronym that will help you remember the 6 basic steps for family planning counseling.

Family planning counselling – The GATHER approach[17]

G Greet the client respectfully
A Ask them about their family planning needs (reproductive goal)
T Tell them about different contraceptive options and methods
H Help them to make decisions about choices of methods
E Explain and demonstrate how to use the methods
R Return/refer, schedule and carry out a return visit and follow up.

Integration to information on Protection against HIV and sexually transmitted infections are very important. Condoms can also be used in conjunction with other methods of contraception – this is called “dual protection” to protect against pregnancy as well as STIs and HIV. [15]

Good counselling[9] helps clients choose and use family planning methods that suit them. Clients differ, their situation differ, and they need different kinds of help. The best counseling is tailored to the individual clients.

Clients Type	Usual counseling tasks
Returning clients with no problems	• Provide more supplies or routine follow-up • Ask a friendly question about how the client is doing with the method
Returning clients with problems	• Understand the problem and help resolve it- whether the problem is side effects, trouble using the method, an uncooperative partner, or another problem
New clients with method in mind	• Check that the client's understanding is accurate • Support the client's choice, if client is medically eligible • Discuss how to use method and how to cope with any side effects.
New clients with no method in mind	• Discuss the client's situation, plans, and what is important to her or him about a method. • Help the client consider methods that might suit her or him. If needed, help her or him reach a decision. • Support the client's choice, give instructions on use, and discuss how to cope with any side effects.

Give time to clients who need it. Many clients are returning with no problems and need little counseling. Returning clients with problems and new clients with no method in mind need the most time, but usually they are few.

Tips for successful counseling

- Show every client respect, and help each client feel at ease.
- Encourage the client to explain needs, express concerns, ask questions.
- Let the client's wishes and needs guide the discussion.
- Be alert to related needs such as protection from sexually transmitted infections including HIV, and support for condom use.
- Talk with the client in a private place, where no one else can hear.
- Assure the client of confidentiality— that you will not tell others about your conversation or the client's decisions.
- Listen carefully. Listening is as important as giving correct information.
- Give just key information and instructions. Use words the client knows.
- Respect and support the client's informed decisions.
- Bring up side effects, if any, and take the client's concerns seriously.
- Check the client's understanding
- Invite the client to come back any time for any reason.

Counseling has succeeded when:

- Clients feel they got the help they wanted
- Clients know what to do and feel confident that they can do it
- Clients feel respected and appreciated
- Clients come back when they need to
- And, most important, clients use their methods effectively and with satisfaction.

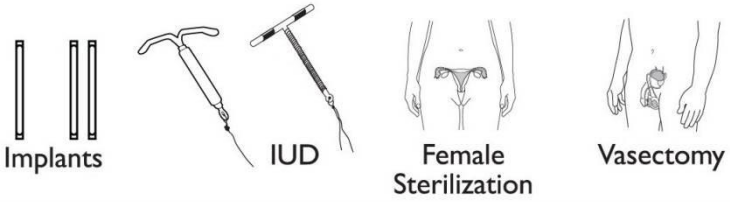
Counseling about Effectiveness

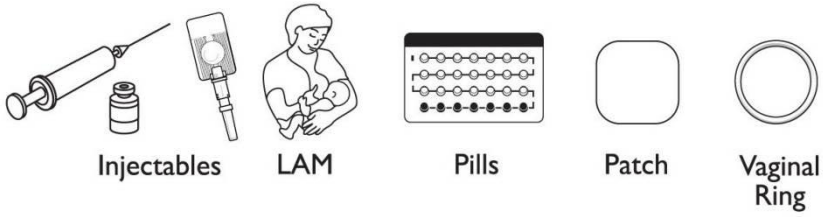
The effectiveness of a family planning method is very important to most clients. The effectiveness of family planning methods varies greatly. Describing and discussing effectiveness is an important part of counseling.

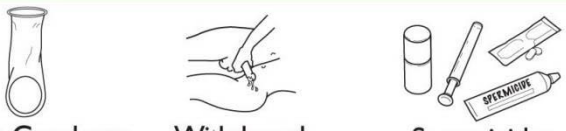
Describing effectiveness to clients takes thought and care. Instead of talking about pregnancy rates, which can be hard to understand, it may be more useful to compare the effectiveness of methods and to discuss whether the client feels able to use the method effectively. Following chart can help the contraceptive methods according to their effectiveness as commonly used. Also, it points out how the user can obtain the greatest possible effectiveness.

Comparing Effectiveness of Family Planning Methods

More effective
Less than 1 pregnancy per 100 women in one year







Less effective
About 20 pregnancies per 100 women in one year

How to make your method more effective

Implants, IUD, female sterilization: After procedure, little or nothing to do or remember

Vasectomy: Use another method for first 3 months

Injectables: Get repeat injections on time

Lactational Amenorrhea Method (for 6 months): Breastfeed often, day and night

Pills: Take a pill each day

Patch, ring: Keep in place, change on time

Male condoms, diaphragm: Use correctly every time you have sex

Fertility awareness methods: Abstain or use condoms on fertile days. Newer methods (Standard Days Method and TwoDay Method) may be easier to use.

Female condoms, withdrawal, spermicides: Use correctly every time you have sex

4.3: HEALTHY TIMING AND SPACING OF PREGNANCY (HTSP)

Multiple studies have shown that closely spaced pregnancies could lead to adverse maternal and perinatal outcomes. Adolescents are as twice likely to die from pregnancy and child birth-related causes as older counterparts; and the risk of their babies before age 1 is 50 percent higher than babies born to women in their twenties.[18,19] Health service providers could promote health timing and spacing of pregnancy since HTSP offers: *Reduced risks after a live birth*, *reduced risks after a miscarriage or post Abortion*, *reduced risks for adolescents.* [21]

What is HTSP?

Healthy Timing and Spacing of Pregnancy (HTSP)[18] is an intervention to help women and families delay or space their pregnancies, to achieve the healthiest outcomes for women, newborns, infants and children, within the context of free and informed choice**,** taking into account fertility intentions and desired family size. [20]

Recommendations regarding HTSP

- After a live birth, the recommended interval before attempting the next pregnancy should be at least 24 months (this is equivalent to 33 months birth-to-birth interval);
- After a miscarriage or induced abortion, the recommended minimum interval to next pregnancy should be at least six months; and
- To delay first pregnancy until at least 18 years of age

Ensuring No Missed Opportunity for Post-Partum Family Planning

Continuum of care throughout a woman's pregnancy, childbirth and postpartum provides opportunities to provide her family planning services. Health care system should integrate PPFP with maternal, newborn and child health interventions ensure no missed opportunity for PPFP. [21]Health care providers should be able to recognize opportunities throughout the continuum of health care contacts during antenatal care, Intrapartum care, postpartum care and well-child care including immunizations visits, growth monitoring, event days, and illness visits. [22]

Continuum of Health Care Contacts with Opportunities to Offer PPFP

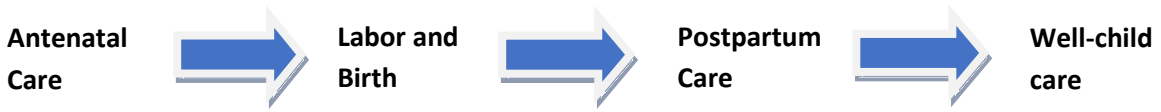
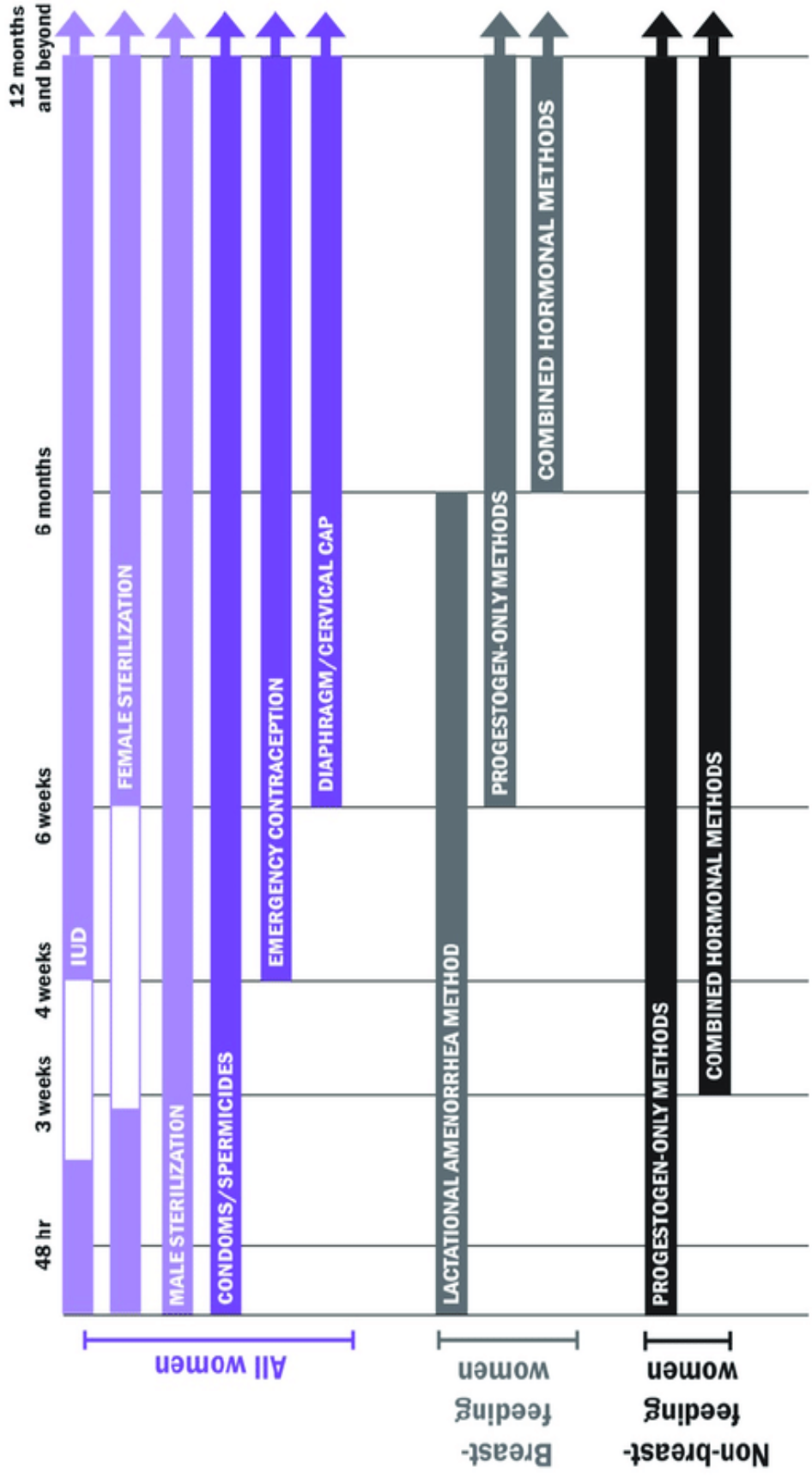


Figure.2. Postpartum contraceptive options (timing of method initiation and breastfeeding considerations)



CHAPTER V: QUALITY OF CARE

5.1: INFORMATION AND SERVICE

Service quality is equally important to promote consistent use of FP service. A minimum set of service delivery standards in the clinics like privacy and ensuring confidentiality can help create a comfortable and welcoming environment for clients seeking contraception advice. Precautions must be taken to ensure that client records are stored safely and confidentially to reflect respect to client rights in contraception and their methods choice. Special attention is required on privacy and confidentiality when providing contraceptive services to young and unmarried clients.

5.2: SAFETY

It is the one of the competencies of family planning service providers to assure safety. To provide safe and quality service the providers must be competent in screening the clients, performing safe medical procedures, and providing continuity of care for both counseling for informed choice and arranging follow-up visit for management of complications or consequences of choose method.

5.2.1: Screening the Clients

Before providing the method of choice, the provider must be reasonably sure that the client is not pregnant, and that the method chosen is safe for the client. The provider should use the checklist (see job aids:6) to rule out pregnancy.

The health care providers must properly screen clients for service eligibility, according to WHO Medical Eligibility Criteria (MEC). The MEC wheel, and quick reference chart for the WHO Medical Eligibility Criteria on Contraceptive Use presented in Figure 2 will help service provider easy reference for client screening. All providers should have access to the updated medical eligibility criteria information to screen their clients. Using Medical Eligibility Wheel will facilitate the screening process.

Figure.3.
2015 Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use – to initiate or continue use of combined oral contraceptives (COCs), depot-medroxyprogesterone acetate (DMPA), progestin-only implants, copper intrauterine device (Cu-IUD)

Condition	Sub-Condition	COC	DMPA	Inplant	Cu-IUD
Pregnancy		NA	NA	NA	
Breastfeeding	Less than 6 weeks postpartum				See i.
	6 weeks to < 6 months postpartum				
	6 months postpartum or more				
Postpartum and not breastfeeding VTE = venous thrombo-embolism	< 21 days				See i.
	<21 days with other risk factor for VTE*				
	≥ 21 to 42 days with other risk factors for VTE*				
	> 42 days				
Postpartum and breastfeeding or not breastfeeding	<48 hours or more than 4 weeks	See ii.	See ii.	See ii.	
	≥ 48 hours to less than 4 weeks				
	Puerperal sepsis				
Postabortion	Immediate post-septic				
Smoking	Age ≥ 35 years, < 15 cigarettes / day				
	Age ≥ 35 years, ≥ 15 cigarettes / day				
Multiple risk factors for cardiovascular disease					
Hypertension BP = blood pressure	History of (where BP cannot be evaluated)				
	BP is controlled and can be evaluated				
	Elevated BP (systolic 140 – 159 or diastolic 90-99)				
	Elevated BP (systolic ≥ 160 or diastolic ≥ 100)				
	Vascular disease				
Deep venous thrombosts (DVT) and pulmonary embolism (PE)	History of DVT/PE				
	Acute DVT/PE				
	DVT/PE, established on anticoagulant therapy				
	Major surgery with prolonged immobilization				
Known thrombogenic mutations					
Ischemic heart disease (current or history of) or stroke (history of)				I C	
Known hyperlipidemias					
Complicated valvular heart disease					
Systemic lupus erythemastosus	Positive or unknown antiphospholipid antibodies				
	Servere thrombocytopenia		I C		I C
	Immunosuppressive treatment				I C
Headaches	Non-migrainous (mild or servere)	I C			
	Migraine without aura (age < 35 years)	I C			
	Migraine without aura (age ≥ 35 years)	I C			
	Migraines with aura (at any age)		I C	I C	

	Category 1	There are no restrictions for use
	Category 2	Generally use; some follow-up may be needed
	Category 3	Usually not recommended; clinical judgment and continuing access to clinical services are required for use
	Category 4	The method should not be used.

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Condition	Sub-Condition	COC	DMPA	Inplant	Cu-IUD
Unexplained vaginal bleeding (prior to evaluation)					I C
Gestational trophoblastic disease	Regressing or undetectable β–hCG levels				
	Persistenty elevated β–hCG levels or malignant disease				
Cancers	Cervical (awaiting treatment)				I C
	Endometrial				I C
	Ovarian				I C
Breast disease	Undiagnosed mass	**	**	**	
	Current cancer				
	Past w / no evidence of current disease for 5 yrs				
Uterine distortion due to fibroids or anatomical abnormalities					
STIs / PID	Current purulent cervicitis, chlamydia, gonorrhea				I C
	Vaginitis				
	Current pelvic inflammatory disease (PID)				I C
	Other STIs (excluding HIV / hepatitis)				
	increased risk of STIs				
	Very high individual risk of exposure to STIs				I C
Pelvic tuberculosis					I C
Diabetes	Nephropathy / retinopathy / neuropathy				
	Diabetes for > 20 years				
Symptomatic gall bladder disease (current or medically treated)					
Cholestasis (hstory of)	Related to pregnancy				
	Related to oral contraceptives				
Hepatitis	Acute or flare	I C			
	Chronic or client is a carrier				
Cirrhosis	Mild				
	Severe				
Liver tumors (hepatocellular adenoma and malignant hepatoma)					
High risk of HIV or HIV-infected (Stage 1 or 2)					
AIDS (HIV-Infected Stage 3 or 4)	No antiretroviral therapy (ARV)	**See iii.**	**See iii.**	**See iii.**	I C
	Improved to Stage 1 or 2 on ARV therapy				
	Not improved on ARV therapy				I C
Drug Interactions	Rifampicin or rifabutin				
	Anticonvulsant therapy***				

This chart shows a complete list of all conditions classified by WHO as Category 3 and 4.
Source: Adapted from Medical Eligibility Criteria for Contraceptive Use, 5th Edition, Geneva: World Health Organization, 2015.
Available: http://www.who.int/reproductivehealth/publications/family_planning/en/inde.html

I/C Initiation/continuation: A woman may fall into either one category or another, depending on whether she is initiating or continuing to use a method.
NA Not Applicable: Women who are pregnant do not require contraception. If these methods are accidentally initiated, no harm will result.
i See condition "Postpartum and breastfeeding or not breastfeeding" instead.
ii See condition "Breastfeeding" or condition "Postpartum and not breastfeeding" instead.
iii Women who use methods other than IUDs can use them regardless of HIV stage or used of ART.
* Other risk factors for VTE include : previous VTE, thrombophilia, immobility, transfusion at deliver, BMI>30kg/m², postpartum hemorrhage, immediately post-caesarean delivery, pre-eclampsia, and smoking.
** Evaluation of an undiagnosed mass should be pursued as soon as possible.
*** Anticonvulsants include: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine, and lamotrigine.

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5.2.2: Safe Medical Procedure

Providers must follow appropriate infection prevention practices depending on the method they provide considering safety for the clients, providers and community. Infection Prevention practices such as hand washing, safe injection practices, instrument processing, using appropriate Personal Protective Equipment, housekeeping and proper waste management should be strictly followed. (Annex.1, Annex.4)

5.2.3: Assuring Continuity of Care

Continuity of care is also essential in ensuring client safety. Having rapport with clients helps assure continuity of care. To assure continuity of care, service providers should be able to

- Perform counseling on side effects, warning signs and when and where to seek health care as necessary
- Manage follow up cases accordingly

Establish a referral channel for provision of service as well as for management of certain complications (Management of side effects and complications of specific methods is discussed in Session)

5.2.4: Secure contraceptive commodities in public sector

Good-quality reproductive health care requires a continuous supply of contraceptives and other commodities. Family planning providers are the most important link in the contraceptive supply chain that moves commodities from the manufacturer to the clients.

Where contraceptive services are available in the public center, commodities may not be, leading most women to tend to the private center as an alternative source. If the contraceptives are not available to the users in time, unwanted pregnancies and sexually transmitted infectious diseases can occur. And it is important for unmet needs of women. So, the availability of commodities and consumables in the right quality at the public-sector delivery points is an integral component of good quality RH/BS service including forecasting, procurement and distribution. Successful use must include assess to a consistent supply of the product.

5.2.5: safe disposal and waste management of unwanted or unused

Good quality reproductive health care requires a continuous supply of contraceptives and other commodities.[23] Hormonal contraceptive waste is not disposed of in a proper manner, there are risks of environmental pollution. Family planning providers are the most important link in the contraceptive supply chain that moves commodities from manufacturer to the clients.
Accurate and timely reports and orders from providers help supply chain managers determine what products are needed, how much to buy, and where to distribute them.[9] Logistics responsibilities in the clinic in daily are track the number and types of contraceptives dispensed to clients using appropriate record forms, maintain proper storage conditions for all supplies, clean, dry storage, away from direct sunlight and protect from extreme heat. And then provide contraceptives to clients by ": first expiry, first out" management of the stock of supplies.
Disposal methods are land fill, waste immobilization, incineration, chemical decomposition, return to donor or manufacture for disposal.

Disposal of contraceptives will inevitably involve waste of these materials and environmental pollution at the same time.

The choice of disposal method within option will depend on the local circumstances (decision made by township level and above) as will the need for prior treatment of the condoms to minimize the risk of re- use. The availability of the above options will depend on the country in question.

CHAPTER VI. ACCESS TO FAMILY PLANNING SERVICES

To lower unmet needs for family planning, health systems should assure access to family planning services for all people, including adolescents, persons with disabilities, ethnic minorities, migrants, people living with HIV, internally displaced people and others.[11]Services are delivered through clinic, hospital, outreach and mobile.

To have a balanced method mix, the different components of the health system such as service delivery points with adequate commodities and supplies to meet the demand; trained health workforce; and quality services which are affordable will help to ensure equitable access to quality Family Planning services.[24] Therefore, there needs to develop and maintain a health system with a budget, supportive and clear policies and protocols that favors providing quality services, physical infrastructures including basics items needed for delivery of methods offered by the facility. As the provision of family planning services is client-right based and choice based, the providers are not subject to any targets or quotas.

6.1: Service delivery points

At any service delivery level, the availability of contraceptive methods/commodities and consumables in the right quantities at the facility is an integral part of quality health services. At the facility level, the facility manager should project commodities and supplies according to demand to avoid stock outs. Moreover, to maintain the efficacy of the drugs, the commodities must be stored in recommended way by the product manufacturer. In addition, there should be a clear mechanism for maintenance of infrastructure.

Organized health facility responsive to local needs are important to provide readily accessible services. Facilities should have comfortable waiting area and ensure minimum waiting time. It is good to consider operating facility with sufficient flexibility to make local-level changes based on client/community feedback.

In addition to improving access of FP services, it is important to make sure information being accessible and understandable to all individuals and ensuring that services are affordable.

6.2: Competent Service Providers for Family Planning

Providers competent in necessary skills to provide family planning services play a major role to increase service accessibility. Providers must be well trained, competent and confident in providing different methods to the range of clients as necessary.

Table 2: Range of services available

Method	Auxiliary Midwives	Midwives, Lady Health Visitor	medical doctor	Specialist (ob/Gyn)
Oral contraceptive pills	√	√	√	√
Condoms	√	√	√	√
Injectable IM		√	√	√
Injectable SC	√	√	√	√
IUD		√	√	√
Implants			√	√
Female sterilization			√	√
Male sterilization			Medical doctors who have adequate specific training	

All level of service providers could provide the information and counselling of all contraceptives. A proper referral system set up is necessary and the staff in the facility trained for provision of a range of contraceptives.

CHAPTER.VII: SPECIFIC CONTRACEPTIVE METHODS

In this session, the following contraceptive methods (common usage in Myanmar) will be discussed. The information mentioned in this session are referenced from WHO global handbook for providers 2018, WHO medical eligibility criteria (MEC) 2015 and 2015 quick reference chart for WHO MEC.

Program Method Mix

Short Term Contraceptive Methods	
1. Oral Contraceptive Pills	Combined Oral Contraceptive Pills (COCs)
	Progestin-Only Pills (POPs)
2. Injectables	Progestin-Only Injectable
	Monthly Injectable
3. Condoms	Male Condoms
	Female Condoms
Long Term Contraceptive Methods	
1. Implants	Jadelle
	Implanon NXT
	Levoplant (Sino-Implant 2)
2. Intrauterine Device (IUD)	Copper-Bearing Intrauterine Device
	Levonorgestrel Intrauterine Device (LNG-IUD)
Permanent Methods	
1. Sterilization	Female Sterilization
	Male Sterilization
Emergency Methods	
1. Emergency Contraceptive Pills (EPPs)	Ulipristal acetate (UPA),
	Progestin Only Pills with Evonorgestrel or Norgestrel
	Combined Oral Contraceptive with oestrogen and progesterone (COC)
2. Intrauterine Device (IUD)	Copper-Bearing Intrauterine Device
Natural Methods	
1. Fertility Awareness Methods	
2. Lactational Amenorrhea Method (LAM)	
3. Withdrawal	

There are other methods such as patch, vaginal ring, spermicide, diaphragm, cervical caps. These are not mentioned extensively in this guideline.

7.1: ORAL CONTRACEPTIVE PILLS

- Combine Oral Contraceptives (COC) Pill
- Progestin only pills

Blood pressure measurement is desirable before starting a hormonal method. However, where the risks of pregnancy are high, and few methods are available, a woman should not be denied a hormonal method simply because her blood pressure cannot be measured. If possible, she can have her blood pressure measured later at a time and place convenient for her (WHO, Global handbook 2018)

Key Points for all oral contraceptive pills:

- Take one pill every day. For greatest effectiveness a woman must take pills daily and start each new pack of pills on time.
- Bleeding changes are common but not harmful. Typically, irregular bleeding for the first few months and then lighter and more regular bleeding.
- Take any missed pill as soon as possible. Missing pills risks pregnancy and may make some side effects worse.
- Progestin-Only Pills (POP) is safe for breastfeeding women and their babies.
- Can be given to a woman at any time to start now or later.
- No delay in return to fertility after stop taking

7.1.1. Combine Oral Contraceptives (COC) Pill

- Contain low doses of 2 hormones—a progestin and an estrogen—like the natural hormones progesterone and estrogen in a woman's body.
- Works primarily by preventing the release of eggs from the ovaries (ovulation).

Health Benefits, and Health Risks

Known Health Benefits

Help protect against -

- Risks of pregnancy
- Endometrial and ovarian cancer
- Pelvic Inflammatory diseases (PID)

Reduce -

- Ovulation pain, menstrual cramps and menstrual bleeding problems
- Symptoms of endometriosis (pelvic pain, irregular bleeding)
- Polycystic ovarian syndrome (irregular bleeding, excess hair on face or body)
- Ovarian cysts
- Iron-deficiency anemia

Known health risks

- Very rare- blood clot in deep veins of legs or lungs (deep vein thrombosis or pulmonary embolism)
- Extremely rare: stroke and health attack

Who Can Use COC

Safe and Suitable for Nearly All Women

Nearly all women can use COCs safely and effectively, including women who:

- ❖ Have or have not had children
- ❖ Are not married
- ❖ Are of any age, including adolescents and women over 40 years old
- ❖ After childbirth and during breastfeeding, after a period of time
- ❖ Have just had an abortion or miscarriage or ectopic pregnancy
- ❖ Smoke cigarettes—if under 35 years old
- ❖ Have anemia now or had in the past
- ❖ Have varicose veins
- ❖ Are infected with HIV, whether or not on antiretroviral therapy

Women who can't use COC (see detail in Medical Eligibility Criteria: MEC)

- ❖ Breastfeeding a baby <6 months
- ❖ ≥35 years smoke any amount of cigarettes
- ❖ High Blood Pressure (>140/90 mmHg)
- ❖ Heart diseases, stroke and vascular disease. Deep venous thrombosis and pulmonary embolism
- ❖ Serious active liver disease, cirrhosis of liver, liver cancer and symptomatic gall bladder disease
- ❖ Diabetes for >20 year with complication
- ❖ Breast cancer
- ❖ migraine
- ❖ Taking rifampicin and anticonvulsant therapy
- ❖ Planning major surgery

When to start oral contraceptive pills (COC)

- A woman can **start using** oral contraceptives anytime she wants if it is reasonably certain she is not pregnant.
- If a woman is **fully breastfeeding**, she can take COC pills 6 month after delivery.
- If a woman starts taking COC more than 6 months after delivery and her monthly bleeding has not returned, she can start taking pills anytime if she is not pregnant. She will need a backup method for the first 7 days of taking COC.
- **If a woman is partially breastfeeding or no breastfeeding**, and if her monthly bleeding has not returned, she can start OC pills anytime it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking COC pills.
- If a woman is **switching from consistent correct use of hormonal method**, she can use OC pills without waiting for next menstrual bleeding and no need backup methods. If a woman's previous method was an injectable contraceptive, OC pills should be initiated when the repeat injection would have been given and no need for backup methods.
- If woman is **switching from non-hormonal method (other than IUD) or having within 5 days after her menstrual cycle**, she can take the pills immediately and no need for a backup method. If she takes more than 5 days after the start of her monthly bleeding, she can start OC pills anytime it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking COC pills.
- If woman is switching from an IUD, she can take the pills immediately if it is within 5 days after her menstrual cycle. There is no need for a backup method and IUD can be removed at that time. If she takes more than 5 days after the start of her monthly bleeding, she can start OC pills any time and it is reasonably certain she is not pregnant.
    - Sexually active in this menstrual cycle: it is recommended that IUD be removed at the time of her next menstrual period.
    - Not sexually active in this menstrual cycle: she will need to abstain from sex or use additional contraceptive protection for the first 7 days of taking COC pills. If that additional protection is to be provided by IUD she is using, it is recommended that this IUD be removed at the time of her next menstrual period.
- After **miscarriage or abortion**, start OC pills immediately. If she starts more than 7 days after miscarriage or abortion, use backup method for first 7 days of taking COC
- After taking emergency contraceptive pills (**ECPs**), she can start OC pills as soon as possible. All women need backup method for the first 7 days of taking OC pills.
- If a woman is **less than 4 weeks after delivery** and **not breastfeeding** she can take OC pills on days 21-28 without any backup method. If a woman is **more than 4 weeks after delivery** and **not breastfeeding** and no menstrual return yet, she can start COC pills anytime it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking COC pills.
- If a woman has **no monthly bleeding** (not related to childbirth or breastfeeding), she can start COC pills anytime it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking COC pills.

Side Effects

Changes in bleeding patterns including: – Lighter bleeding and fewer days of bleeding – Irregular bleeding – Infrequent bleeding – No monthly bleeding Headaches, dizziness, nausea, breast tenderness, weight changes, acne, increased blood pressure

Managing side effects for COC

Irregular Bleeding	Reassure. Become less or stop after the first few months. To reduce, urge her to take a pill each day and at the same time each day. She can try 800 mg ibuprofen 3 times daily after meals for 5 days or other nonsteroidal anti-inflammatory drug (NSAID), beginning when irregular bleeding starts.
No monthly bleeding	Reassure and exclude pregnancy and advice for any missed pills
Headache	Can give paracetamol (325–1000 mg), ibuprofen (200–400 mg), Aspirin (325-650 mg) or other pain reliever. Any headaches that get worse or occur more often during COC use should be evaluated
Nausea	Take COCs at bedtime or with food.
Breast tenderness	Wear supportive bra, try hot or cold compresses.
Weight changes	Review diet and counsel as needed
Mood changes	Provide appropriate support. Refer if major depression and other serious mood changes occurred.

7.1.2: Progestin-Only Pill (POP)

- Contains very low doses of a progestin like the natural hormone progesterone in a woman's body.
- Do not contain estrogen, and so can be used throughout breastfeeding and by women who cannot use methods with estrogen
- Work primarily by thickening cervical mucus (blocks sperm from meeting an egg) and disrupting the menstrual cycle, including preventing the release of eggs from the ovaries (ovulation).

Known Health Benefits (POP)

Help protect against

- Risks of pregnancy

Known health risks

- None

Who can **use POP**

Safe and Suitable for Nearly All Women

Nearly all women can use POPs safely and effectively, including women who:

- Are breastfeeding (she can start immediately after childbirth)
- Have or have not had children
- Are married or are not married
- Are of any age, including adolescents and women over 40 years old
- Have just had an abortion or miscarriage or ectopic pregnancy
- Smoke cigarettes—regardless of age and number of cigarettes smoked
- Have anemia now or had in the past
- Have varicose veins
- **Are infected with HIV, whether or not on antiretroviral therapy.**

Women who can't use POP (see detail in Medical Eligibility Criteria: MEC)

High Blood Pressure (≥160/100 mmHg)

- Ischemic heart disease, stroke and vascular disease
- Acute DVT/PE
- Cirrhosis, liver cancer
- Diabetes for >20 year with complication
- Had breast cancer but no recurrent for 5 years.
- Migraines with aura
- Unexplained vagina bleeding

When to start oral contraceptive pills (POP)

- A woman can **start using** oral contraceptives anytime she wants if it is reasonably certain she is not pregnant.
- If a woman is **fully breastfeeding,** POP immediately after delivery.
- If a woman starts taking POP more than 6 months after delivery and her monthly bleeding has not returned, she can start taking pills anytime if she is not pregnant. She will need a backup method for the first 2 days of taking POP.
- **If a woman is partially breastfeeding or no breastfeeding**, and if her monthly bleeding has not returned, she can start OC pills anytime it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking POP.
- If a woman is **switching from consistent correct use of hormonal method**, she can use OC pills without waiting for next menstrual bleeding and no need backup methods. If a woman's previous method was an injectable contraceptive, OC pills should be initiated when the repeat injection would have been given and no need for backup methods.
- If woman is **switching from non-hormonal method (other than IUD) or having within 5 days after her menstrual cycle**, she can take the pills immediately and no need for a backup method. If she takes more than 5 days after the start of her monthly bleeding, she can start OC pills anytime it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking POP.

- If woman is switching from an IUD, she can take the pills immediately if it is within 5 days after her menstrual cycle. There is no need for a backup method and IUD can be removed at that time. If she takes more than 5 days after the start of her monthly bleeding, she can start OC pills any time and it is reasonably certain she is not pregnant.
    - Sexually active in this menstrual cycle: it is recommended that IUD be removed at the time of her next menstrual period.
    - Not sexually active in this menstrual cycle: she will need to abstain from sex or use additional contraceptive protection for the first two days of taking POP. If that additional protection is to be provided by IUD she is using, it is recommended that this IUD be removed at the time of her next menstrual period.
- After **miscarriage or abortion**, start OC pills immediately. If she starts more than 7 days after miscarriage or abortion, use backup method for the first 2 days of taking POP if reasonably certain that she is not pregnant.
- After taking emergency contraceptive pills (**ECPs**), she can start OC pills as soon as possible. All women need backup method for the first 2 days of taking POP.
- If a woman is **less than 4 weeks after delivery** and **not breastfeeding** she can take POP pills at any time without any backup method. If a woman is **more than 4 weeks after delivery** and **not breastfeeding** and no menstrual return yet, she can start POP anytime it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking POP pills.
- If a woman has **no monthly bleeding** (not related to childbirth or breastfeeding), she can start POP pills anytime it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking POP.

Side Effects

Changes in bleeding patterns including:

- For breastfeeding women, longer delay in return of monthly bleeding
- Frequent, Infrequent, Irregular, Prolong bleeding or No monthly bleeding

Headaches, dizziness, nausea, breast tenderness, abdominal pain, mood changes

Managing side effects of POP

Irregular Bleeding	Reassure. Become less or stop after the first few months. To reduce, urge her to take a pill each day and at the same time. Teach her to make up for missed pills including after vomiting and diarrhea. She can try 800 mg ibuprofen 3 times daily after meals for 5 days or other nonsteroidal anti-inflammatory drug (NSAID), beginning when irregular bleeding starts.
No monthly bleeding	Reassure. It is not harmful.
Heavy/ Prolong bleeding	Reassure. Become less or stop after few months. To reduce, she can try Non-Steroidal Anti-inflammatory Drugs (NSAID), beginning when heavy bleeding starts.
Headache	Can give paracetamol (325–1000 mg), ibuprofen (200–400 mg), asprin (325-650 mg) or other pain reliever. Any headaches that get worse or occur more often during POP use should be evaluated
Nausea, dizziness	Take POPs at bedtime or with food.
Breast tenderness	Wear supportive bra, try hot or cold compresses. Check breast engorgement or other problems in the lactating women.
Severe lower abdomen pain	May be due to various problems such as enlarged ovarian follicles or cyst which need no treatment unless they grow abnormally large, twist or burst. However, exclude ectopic pregnancy although it is quite rare.
Mood changes	Provide appropriate support. Refer if major depression and other serious mood changes occurred.

7.1.3. Explain how to use the oral contraceptive pills

- Take one pill each day
- Take pills at the same time each day
- For 28 pills packs, when she finishes one pack, she should take the first pill from the next pack on the very next day. But for 21 pills pack, she needs to have 7 days break between packs.
- Provide backup method and explain use - Back up methods include abstinence, condoms, spermicides and withdrawal. (spermicides and withdrawal are the least effective methods)
- For women who choose POP, explain that the effectiveness decreases when breastfeeding stops. When she stops breastfeeding, she can either continue taking POP or change to another method.

7.1.4. Instructions on missed pill

- (See in job aids tool 7 for instruction on missed pill (COC))
- For POP, if the client late taking the pills 3 or more hours (late 12 hours or more for desogestreal 75 mg containing POP pills) or completely missed the pills, take a pill as soon as possible and continue a pill, once each day and consider ECP if she also had sex at that time. If a woman does not have regular monthly bleeding, she needs to use backup method for the next 2 days. If she had sex in the past 5 days, can consider taking ECP
- If she vomits within 2 hours after taking a pill, she should take another pill from her pack as soon as possible, and then keep taking pills as usual. If she has vomiting or diarrhea for more than 2 days, follow instructions for 3 or more missed pills, as above.

7.1.5. Managing any problems

1. Schedule a regular follow up annually or as necessary. This offers an opportunity to answer any questions, help with any problems, and check on correct use. Check the blood pressure annually.
2. For continuing users, provide any information or help that she needs.
3. For problems reported as side effects or related to the use of oral contraceptives, encourage the client to keep taking a pill every day. Many side effects will subside after a few months of use.
4. For new health problems that may require switching methods or if problems cannot be overcome, offer to help the client choose another method.
5. For minor problems, manage accordingly as described in the following table.
6. New problems that may require switching methods.
   If the woman developed the following symptoms, oral contraceptive pills usage should be stopped or switching to another method:
   - ❖ Unexplained vaginal bleeding (that suggests a medical condition not related to the method) or heavy or prolonged bleeding
   - ❖ Starting treatment with anticonvulsants, rifampicin, rifabutin or ritonavir– it can cause reducing effectiveness of pills.
   - ❖ Migraine headaches
   - ❖ Circumstances that will keep her from walking for one week or more
   - ❖ Certain serious health conditions (specify eg. suspected heart or serious liver diseases, high blood pressure, blood cloths in deep veins of legs or lungs, stroke, breast cancer, etc.
   - ❖ Suspected pregnancy

7.2: EMERGENCY CONTRACEPTIVE PILLS

Blood pressure measurement is desirable before starting a hormonal method. However, where the risks of pregnancy are high, and few methods are available, a woman should not be denied a hormonal method simply because her blood pressure cannot be measured. If possible, she can have her blood pressure measured later at a time and place convenient for her (WHO, Global handbook 2018)

Key Points

- Emergency contraceptive pills (ECPs) help a woman avoid pregnancy after she has sex without contraception.
- ECPs help to prevent pregnancy when taken up to 5 days after unprotected sex. The sooner they are taken, the better.
- Do not disrupt an existing pregnancy.
- Safe for all women—even women who cannot use ongoing hormonal contraceptive methods.
- Provide an opportunity for women to start using an ongoing family planning method.
- Many options can be used as emergency contraceptive pills. Dedicated products, progestin-only pills, and combined oral contraceptives all can act as emergency contraceptives.

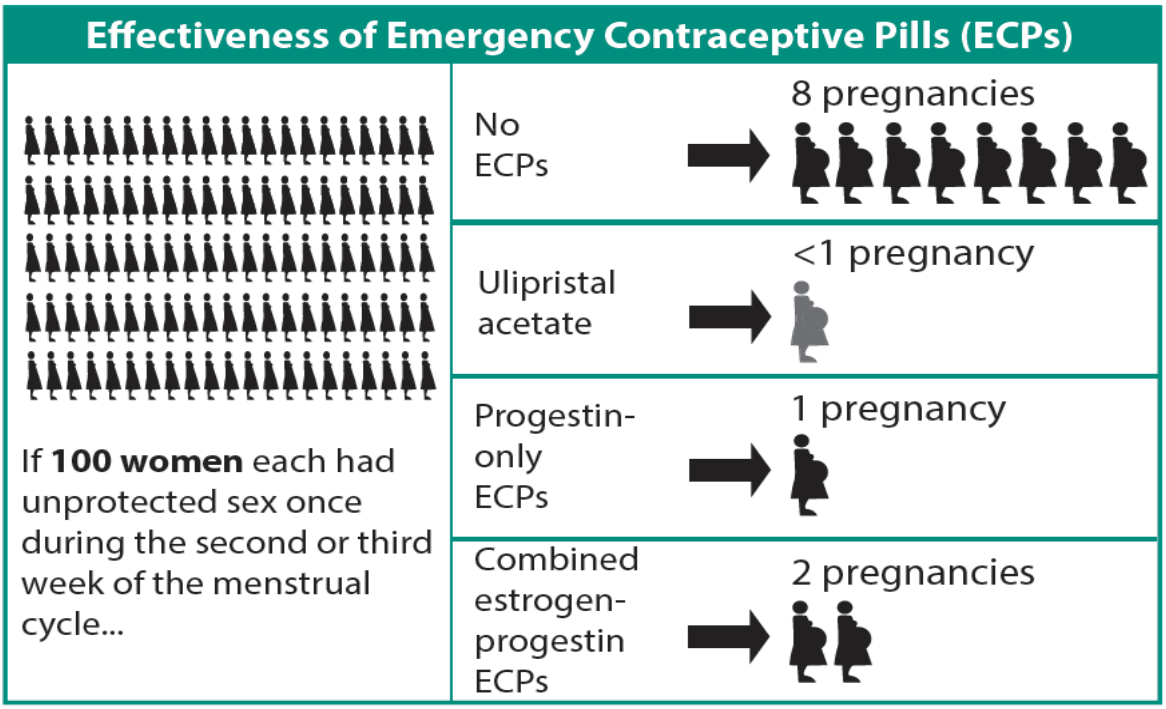
- Emergency contraceptive pills (ECPs) are sometimes called “morning after” pills or post-coital contraceptives.
- Work by preventing or delaying the release of eggs from the ovaries (ovulation). They do not work if a woman is already pregnant.
  (The copper – bearing IUD also can be used for emergency contraception.)

What Pills Can Be Used as Emergency Contraceptive Pills?

- A special ECP product with levonorgestrel only, or ulipristal acetate (UPA)
- Progestin-only pills with levonorgestrel or norgestrel
- Combined oral contraceptives with estrogen and a progestin— levonorgestrel, norgestrel, or norethindrone (also called norethisterone)

When to Take Them?

- As soon as possible after unprotected sex. The sooner ECPs are taken after unprotected sex, the better they prevent pregnancy.
- Can prevent pregnancy when taken any time up to 5 days after unprotected sex.



Pill Formulations and Dosing for Emergency Contraception

Pill Type and Hormone	Formulation	Pills to Take	
		At First	12 Hours Later
Dedicated ECP Products			
Progestin-only	1.5 mg LNG	1	0
	0.75 mg LNG	2	0
Ulipristal acetate	30 mg ulipristal acetate	1	0
Oral Contraceptive Pills Used for Emergency Contraception			
Combined (estrogen-progestin) oral contraceptives	0.02 mg EE + 0.1 mg LNG	5	5
	0.03 mg EE + 0.15 mg LNG	4	4
	0.03 mg EE + 0.15 mg LNG	4	4
	0.03 mg EE + 0.125 mg LNG	4	4
	0.05 mg EE + 0.25 mg LNG	2	2
	0.03 mg EE + 0.3 mg norgestrel	4	4

	0.05 mg EE + 0.5 mg norgestrel	2	2
Progestin-only pills	0.03 mg LNG	50*	0
	0.0375 mg LNG	40*	0
	0.075 mg norgestrel	40*	0

* Many pills, but safe.

LNG = levonorgestrel EE = ethinyl estradiol

For information on brands of ECPs and oral contraceptive pills, see: The Emergency Contraception Website (http:/ec.princeton.edu) and the International Consortium for Emergency Contraception (http: /www.cecinfo.org).

How to take Emergency Contraceptive Pills?

- Take two pills (0.75 mg) of levonogestrel containing ECP at once (1.5 mg in a single dose) -
- For combined Emergency Pills (0.1 mg ethinyl estradiol + 0.5 mg levonogestrel) take two doses 12 hours apart
- For combined Emergency Pills (0.1 mg ethinyl estradiol + 1 mg norgestrel) take two doses 12 hours apart
- For combined Emergency Pills (0.1 mg ethinyl estradiol + 2 mg norethindrone) take two doses 12 hours apart
- If she vomits within 2 hours after taking pills, she should repeat the dose. (She can use antiemetic medication with the repeat dose)

Side Effects, Health Benefits, and Health Risks

Known Health Benefits

Help protect against:

- Risks of pregnancy

Known Health Risks

- None

Who Can Use Emergency Contraceptive Pills

Safe and Suitable for All Women

Tests and examinations are not necessary for using ECPs. They may be appropriate for other reasons—especially if sex was forced (see Violence against Women)

When to Use

- Any time within 5 days after unprotected sex. The sooner after unprotected sex that ECPs are taken, the more effective they are.
- ECPs can be used any time a woman is worried that she might become pregnant. For example, after:
- Sexual assault, any unprotected sex, mistakes using contraception such as: Condom was used incorrectly, slipped, or broke.
- Couple incorrectly used a fertility awareness method (for example, failed to abstain or to use another method during the fertile days)
- Man failed to withdraw, as intended, before he ejaculated.
- Woman has missed 3 or more combined oral contraceptive pills or has started a new pack 3 or more day late
- IUD has come out of place
- Woman has had unprotected sex when she is more than 4 weeks late for her repeat injection of DMPA, more than 2 weeks late for her repeat injection of NET-EN or more than 7 days late for her repeat monthly injection

When to start or restart emergency contraceptive pills

A woman can start using ECPs any time within 5 days after unprotected sex**.** The sooner after unprotected sex that ECPs are taken, the more effective**.**

ECPs can be used any time a woman is worried that she might become pregnant after sexual assault, any unprotected sex and mistakes using contraception, such as condom was used incorrectly.

Hormonal methods

After taking progestin- only or combined ECPs: can start or restart any method immediately after she takes the ECPs. No need to wait for her next monthly bleeding.

- The continuing user of oral contraceptive pills who needed ECPs due to error can resume use as before. She does not need to start a new pack.

All women need to abstain from sex or use a backup for the first 7 days of using their methods.

If she does not start immediately, but instead returns for a method, she can start any method at any time if it is reasonably certain she is not pregnant.

If a woman after taking ulipristal acetate (UPA) ECPs, she can start or restart any method containing progestin on the 6th day after taking UPA-ECPs. No need to wait for nest menstrual bleeding. (if she starts a method containing progestin earlier, both the progestin and UPA could be less effective)

If woman wants to use oral contraceptive pills, give her a supply and tell her to start on the 6th day after taking UPA-ECPs. If woman wants to use injectables or implants, give her an appointment to return for the method on the 6th day after taking UPA- ECPs or as soon as possible after that. All women need to use a backup method from the time they take UPA- ECPs until they have been using a hormonal method for 7 days (or 2 days for progestin- only pills). If she does not start on the 6th day, but instead returns later for a method, she may start any method at any time if it is reasonably certain she is not pregnant.

Levonogestrel intrauterine device (LNG-IUD)

After taking progestin- only or combined ECPs: woman can have the LNG-IUD inserted at any time it can be determined woman is not pregnancy. Woman should use backup method* for the first 7 days after LNG-IUD insertion.

After taking UPA-ECPs: woman can have the LNG-IUD inserted on the 6th day after taking UPA-ECPs if it can be determined that she is not pregnancy. If she wants to use the LNG-IUD, give her an appointment to return to have it inserted on the 6th day after taking UPA-ECPs or as soon as possible after that.

She will need to use a backup method from the time she takes UPA-ECPs until 7 days after LNG-IUD is inserted.

If she does not have the LNG-IUD inserted on the 6th day, but instead returns later, she can have it inserted at any time if it can be determined she is not pregnant.

Copper bearing intrauterine device

After taking progestin- only, combined, or UPA- ECPs: If woman wants to use a copper- bearing IDU after taking ECPs, woman can have it inserted on the same day she takes the ECPs. No need for a backup method. If woman does not have it inserted immediately, she can have the copper- bearing IUD inserted any time if it can be determined that she is not pregnancy.

Female sterilization.

After taking progestin – only, combined, or UPA-ECPs: the sterilization procedure can be done within 7 days after the start of her next monthly bleeding or any other time if it is reasonably certain she is not pregnant. Give her a back method to use until she can have the procedure.

Male and female condoms

After taking progestin – only, combined or UPA-ECPs – woman can use immediately.

Fertility awareness methods

After taking progestin-only, combined, or UPA-ECPs, woman can use Standard Days Method with the start of her next monthly bleeding. She can use Symptoms-based methods once normal secretions have returned. Give woman a backup method to use until she can begin the method of her choice.

* Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.

Side Effects

Changes in bleeding patterns including:

- Slight irregular bleeding for 1–2 days after taking ECP
- Monthly bleeding that starts earlier or later than expected

In the week after taking ECPs:

- Nausea
- Abdominal pain
- Fatigue
- Headaches
- Breast tenderness
- Dizziness
- Vomiting

Managing problems

Slight irregular bleeding	• Irregular bleeding due to ECPs will stop without treatment. • Assure the woman that this is not a sign of illness or pregnancy.
Change in timing of next monthly bleeding or suspected pregnancy	• Monthly bleeding may start earlier or later than expected. This is not a sign of illness or pregnancy. • If her next monthly bleeding is more than one week later than expected after taking ECPs, assess for pregnancy. There are no known risks to a fetus conceived if ECPs fail to prevent pregnancy.

7.3: INJECTABLE CONTRACEPTIVES

- The progestin-only injectable contraceptives
    - Depot medroxyprogesterone acetate (DMPA)
    - Norethisterone enanthate(NET-EN)
- Combined injectable contraceptive (Monthly injectables)

Blood pressure measurement is desirable before starting a hormonal method. However, where the risks of pregnancy are high, and few methods are available, a woman should not be denied a hormonal method simply because her blood pressure cannot be measured. If possible, she can have her blood pressure measured later at a time and place convenient for her (WHO, Global handbook 2018)

Key Points

- ❖ Bleeding changes are common but not harmful. Typically, irregular bleeding for the first several months and then no monthly bleeding.
- ❖ Return for injections regularly and as scheduled. Coming back every 3 months (13 weeks) for DMPA or every 2 months for NET-EN and every 4 weeks for monthly injectables is important for greatest effectiveness.
- ❖ Injection can be provided up to 4 weeks late for DMPA 2 weeks late for NET-EN and 1 week late or early for monthly injectable. Client should come back even if later than scheduled date.
- ❖ Gradual weight gain is common.
- ❖ Return of fertility is often delayed. It takes several months longer on average to become pregnant after stopping progestin only injectables than after stopping other methods.

7.3.1. Progestin- only injectable contraceptives

The progestin-only injectable contraceptives; depot medroxyprogesterone acetate (DMPA) and norethisterone enanthate (NET-EN),

- each contain a progestin like the natural hormone progesterone in a woman's body. It does not contain estrogen, so it can be used throughout breastfeeding and by women who cannot use methods with estrogen. It can be given by (intramuscularly) and the hormone is then released slowly into the bloodstream.
- A different formulation of DMPA can be injected (subcutaneously). A new type of prefilled, single use syringe could be particularly useful to provide DMPA in the community (Sayana press – DMPA-SC). This formulation of DMPA is available in conventional prefilled auto-disable syringes and in the Uniject system, in which squeezing a bulb pushes the fluid through the needle.

Women can begin using injectable contraceptives:

- ❖ Without a pelvic examination
- ❖ Without any blood tests or other routine laboratory tests
- ❖ Without cervical cancer screening
- ❖ Without a breast examination

Even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant.

Health Benefits, and Health Risks of Progestin-only injection

DMPA

Known Health Benefits

Helps protect against:

- Risk of pregnancy
- Endometrial cancer
- Uterine fibroid

May help protect against:

- Symptomatic pelvic inflammatory (PID) disease
- Iron-deficiency anemia

Reduces:

- Sickle cell crises among women with sickle cell anemia
- Symptoms of endometriosis (pelvic pain, irregular bleeding)

NET-EN

Helps protect against:

- Risks of pregnancy
- Iron-deficiency anemia

Known Health Risks

None – DMPA/ NET-EN

Who Can Use Injection Contraceptives (DPMA)

Safe and Suitable for Nearly All Women

Nearly all women can use injectables safely and effectively, including women who:

- ❖ **Are breastfeeding (as soon as 6 weeks after birth)**
- ❖ Have or have not had children

- Are not married
- Are of any age, including adolescents and women over 40 years old
- Have just had an abortion or miscarriage
- Smoke cigarettes—**regardless of age and number of cigarettes smoked**
- Are infected with HIV, whether or not on antiretroviral therapy.

Women who can't use DPMA Injectable Contraceptives (see detail in MEC)

- Fully breasting a baby <6weeks
- High Blood Pressure ≥160/100 mmHg
- Ischemic heart diseases, stroke and vascular disease
- Acute DVT/PE
- Cirrhosis of liver and liver cancer
- Diabetes for >20 years with complication
- Breast cancer
- unexplained vaginal bleeding

When to start projestin- only injectables

- A woman can **start using** contraceptive injections anytime she wants if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection if the injection is given after 7th day of menstrual cycle.
- If a woman is **fully breastfeeding**, she can take injection contraceptive 6 week after delivery.
- If a woman starts taking injectable contraceptives **more than 6 months after delivery and her monthly bleeding has not returned**, she can start taking injection anytime if she is not pregnant. She will need a backup method for the first 7 days after the injection.
- If a woman is **< 6 weeks after delivery and partially breastfeeding** delay injection until at least 6 weeks after delivery. If a woman is **not breastfeeding**, she can start injection anytime on days 21-28 after delivery without backup method.
- If a woman is **> 6 weeks after delivery and partially breastfeeding** or if a woman is **> 4 weeks after delivery without breastfeeding**, and if her monthly bleeding has not returned, she can start injection anytime it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after injection.
- If a woman is **switching from consistent correct use of hormonal method**, she can use injection without backup methods. If a woman is **switching from another injectable**, she can have new injection when the repeat injection would have been given.

- If a woman is **switching from non-hormonal method (other than IUD) or having within 7 days after her menstrual cycle**, she can take the injection immediately and no need for a backup method. If she takes more than 7 days after the start of her monthly bleeding, she can start injection anytime it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.
- If woman is switching from an IUD, she can take the injection immediately if it is within 7 days after her menstrual cycle. There is no need for a backup method and IUD can be removed at that time. If she takes more than 7 days after the start of her monthly bleeding, she can start injection any time and it is reasonably certain she is not pregnant.
    - Sexually active in this menstrual cycle and more than 7 days since the start of menstrual bleeding: it is recommended that IUD be removed at the time of her next menstrual period.
    - Not sexually active in this menstrual cycle and more than 7 days since the start of menstrual bleeding: she will need to abstain from sex or use additional contraceptive protection for the next 7 days. If that additional protection is to be provided by IUD she is using, it is recommended that this IUD be removed at the time of her next menstrual period.
- If a woman is after **miscarriage or abortion**, start injection immediately. If she starts more than 7 days after miscarriage or abortion, use backup method for first 7 days after the injection.
- If a woman is after taking emergency contraceptive pills (**ECPs**), she can take injectable on the same day as the ECPs. She will need a backup method for the first 7 days after the injection.
- If a woman has no monthly bleeding (not related to childbirth or breastfeeding), she can start injection anytime it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.

Side Effects

Changes in bleeding pa**tterns including,**

For DMPA users:

First 3 months: Irregular/Prolong bleeding

At one year: No monthly bleeding, Infrequent/Irregular bleeding

For NET-EN users:

They have fewer days of bleeding in the first 6 months and are less likely to have no monthly bleeding after one year than DMPA users

Weight gain, headaches, dizziness, abdominal bloating and discomfort, mood changes, less sex drive, loss of bone density

Management of side effects of DPMA/NET-EN

No monthly bleeding	Reassure. If no monthly bleeding bothers her, she may want to switch to monthly injectable, if available.
Irregular Bleeding/ Heavy/ Prolong bleeding (twice as much as usual or longer than 8 days)	Reassure. Become less or stop after the first few months. For modest short-term relief, she can take 500 mg mefenamic acid 2 times daily after meals for 5 days or 40 mg of valdecoxib daily for 5 days, beginning when irregular bleeding starts. If bleeding is heavy or prolong, she can try 50ug of ethinyl estradiol daily for 21 days, beginning when heavy bleeding starts Iron supplement and diet If irregular or heavy bleeding persists for several months, consider underlying conditions.
Weight changes	Review diet and counsel as needed
Abdominal bloating and discomfort	Locally available remedies
Headache	Can give paracetamol (325–1000 mg), ibuprofen (200–400 mg), aspirin (325-650 mg) or other pain reliever. Any headaches that get worse or occur more often during injectable use should be evaluated
Dizziness	Consider locally available remedies
Mood changes or changes in sex drive	Provide appropriate support. Refer if major depression and other serious mood changes occurred.

7.3.2. Combined injectable contraceptives contain 2 hormones; a progestin and an estrogen and also known as monthly injectables

Key Points
Bleeding changes are common but not harmful. Typically, lighter monthly bleeding, fewer days of bleeding, or irregular or infrequent bleeding. Return on time. Coming back every 4 weeks is important for greatest effectiveness. Injection can be as much as 7 days early or late.

All injectable contraceptives provide the contraceptive effect primarily by preventing the ovulation.

Health Benefits, and Health Risks of CIC

Known Health Benefits (CIC)

(similar with COC, might difference in the effects on the liver)

Help protect against

- Risks of pregnancy
- Endometrial and ovarian cancer
- PID

May reduce

- Ovarian cysts
- Iron-deficiency anemia

Reduce

- Ovulation pain, menstrual cramps and bleeding problems
- Reduce symptoms of endometriosis

Known Health Risks (CIC)

Very rare

- (Deep vein thrombosis or pulmonary embolism)

Extremely rare

- Stroke
- Heart Attack

Who Can Use Combined injectable contraceptives (CIC)

Safe and Suitable for Nearly All Women

Nearly all women can use injectable safely and effectively, including women who:

- ❖ Breast feeding women at ≥6 months after birth
- ❖ Have or have not had children

- Are not married
- Are of any age, including adolescents and women over 40 years old
- Have just had an abortion or miscarriage
- Have anemia now or had anemia in the past
- Have varicose veins
- Are infected with HIV, whether or not on antiretroviral therapy

Women who can't use CIC Injectable Contraceptives (see detail in MEC)

- Fully Breastfeeding a baby <6 months
- ≥35 year and Smoke any number of cigarettes a day(>15 cigarette a day)
- High Blood Pressure (>140/90 mmHg)
- Heart diseases, stroke and vascular disease
- Deep venous thrombosis and pulmonary embolism
- Serious active liver disease, cirrhosis of liver and liver cancer
- Symptomatic gall bladder disease
- Diabetes for >20 years with complication
- Had breast cancer but no recurrent for 5 years.
- Migraine
- Taking rifampicin or rifabutin and anticonvulsant therapy

When to start (Combined injectable contraceptive)

- A woman can **start using** contraceptive injections anytime she wants if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection if the injection is given after 7th day of menstrual cycle.
- If a woman is **fully breastfeeding**, she can take injection contraceptive 6 months after delivery.
- If a woman starts taking injectable contraceptives **more than 6 months after delivery and her monthly bleeding has not returned**, she can start taking injection anytime if she is not pregnant. She will need a backup method for the first 7 days after the injection.
- If a woman is **< 6 week after delivery and partially breastfeeding**, delay injection until at least 6 weeks after delivery. If a woman is **not breastfeeding**, she can start injection at any time on days 21-28 after delivery.
- If a woman is **> 6 weeks after delivery and partially breastfeeding** or if a woman **is > 4 weeks after delivery without breastfeeding** , and if her monthly bleeding has not returned, she can start injection anytime it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after injection.

- If a woman is **switching from consistent correct use of hormonal method**, she can use injection without backup methods. If a woman is **switching from another injectable**, she can have new injection when the repeat injection would have been given.
- If a woman is **switching from non-hormonal method (other than IUD) or having within 7 days after her menstrual cycle**, she can take the injection immediately and no need for a backup method. If she takes more than 7 days after the start of her monthly bleeding, she can start injection anytime it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.
- If woman is switching from an IUD, she can take the injection immediately if it is within 7 days after her menstrual cycle. There is no need for a backup method and IUD can be removed at that time. If she takes more than 7 days after the start of her monthly bleeding, she can start injection any time and it is reasonably certain she is not pregnant.
    - Sexually active in this menstrual cycle and more than 7 days since the start of menstrual bleeding: it is recommended that IUD be removed at the time of her next menstrual period.
    - Not sexually active in this menstrual cycle and more than 7 days since the start of menstrual bleeding: she will need to abstain from sex or use additional contraceptive protection for the next 7 days. If that additional protection is to be provided by IUD she is using, it is recommended that this IUD be removed at the time of her next menstrual period.
- If a woman is after **miscarriage or abortion**, start injection immediately. If she starts more than 7 days after miscarriage or abortion, use backup method for first 7 days after the injection.
- If a woman is after taking emergency contraceptive pills (**ECPs**), she can take injectable on the same day as the ECPs. She will need a backup method for the first 7 days after the injection.
- If a woman has no monthly bleeding (not related to childbirth or breastfeeding), she can start injection anytime it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.

Side Effects (Combined Injectable Contraceptive)

- Changes in bleeding patterns including,
- Lighter bleeding and fewer days of bleeding
- Irregular bleeding
- Infrequent bleeding
- Prolonged bleeding
- No monthly bleeding

Weight gain, headaches, dizziness, breast tenderness

Managing any problems

1. For minor problems, manage accordingly as described in the following table
2. If problems can't be overcome, offer to help the client choose another method.

No monthly bleeding	Reassure that is not harmful. It is similar to not having monthly bleeding during pregnancy. Blood is not building up inside her.
Irregular Bleeding/ Heavy/ Prolong bleeding	Reassure. Become less or stop after the first few months. For modest short-term relief, she can try 800 mg ibuprofen 3 times daily after meals for 5 days or other NSAIDs, beginning when irregular bleeding starts. If bleeding persists for several months, consider underlying conditions. Consider iron supplement and diet.
Weight changes	Review diet and counsel as needed
Headache	Can give paracetamol (325–1000 mg), ibuprofen (200–400 mg), Aspirin (325-650 mg) or other pain reliever. Any headaches that get worse or occur more often during CIC use should be evaluated
Breast tenderness	Wear a supportive bra Try hot or cold compresses
Dizziness	Consider locally available remedies

If the woman developed the following symptoms, injectable contraceptive usage should be stopped:

- ❖ Unexplained vaginal bleeding (that suggests a medical condition that is not related to the method) or heavy or prolonged bleeding to make diagnosis easier.
- ❖ Starting treatment with anticonvulsants, rifampicin, rifabutin or ritonavir (Progestin-Only Injectables) and starting treatment with lamotrigine or ritonavir (CIC)

- ❖ Migraine headaches
- ❖ Certain serious health conditions
- ❖ Suspected pregnancy

7.3.3. Giving the Injection

- ❖ DMPA- 150 mg IM injection. NET-EN – 200 mg IM injection. DMPA-SC – 104 mg SC injection.
- ❖ The provider must follow the standard operating procedures for provision of a safe injection procedures including hand washing, using sterile needle and syringe, gently shake the vial if DMPA and MPA/estradiol cypionate, prepare vial into a normal temperature, and proper disposal of used needles.
- ❖ Instruct the client not to massage the injection site.
- ❖ Tell the client the name of the injection and agree on a date for her next injection. Give appointment according to the type of progestin-only injectable (3 months for DMPA, 2 months for NET-EN and 1 month for monthly injectable).
- ❖ Ask the client to come back on time. However, with DMPA, she may come up to 4 weeks late, with NET-EN, she may come up to 2 weeks late and with CIC, she may come up to 1 week late and still get an injection. With either DMPA or NET-EN, she can come up to 2 weeks early and 1 week early for CIC monthly injectable.
- ❖ She should come back no matter how late she is for her next injection. If she is late for injection, a woman should use a backup method until she can get an injection. If she has had sex without using any contraceptive methods, she can consider ECP.
- ❖ A woman can receive her next injection, if a woman is >4 weeks late for DMPA or > 2 weeks late for NET-EN, or > 1 week late for CIC exclude if she has had sex since 2 weeks after she should have had her last injection, or confirm if she is fully or nearly fully breastfeeding and she gave birth < 6 months, uses other backup methods or has taken ECPs. She would need a backup method for the first 7 days after the injection. Discuss how to remember the date, perhaps tying it to a holiday or other event.

7.4: MALE AND FEMALE CONDOMS

Key Points

- ❖ Male and female condoms help protect against sexually transmitted infections (STI), including HIV. Condoms are the only contraceptive method that can protect against both pregnancy and STI.
- ❖ Require correct use with every act of sex for greatest effectiveness.
- ❖ A male condom require both male and female partner's cooperation.
- ❖ A woman can initiate female condom use, but the method requires her partner's cooperation
- ❖ May dull the sensation of sex for some men (Male condom).
- ❖ May require some practice. Inserting and removing the female condom from the vagina becomes easier with experience

- Male Condoms are mostly made of thin latex rubber; and they are sheaths or coverings that fit over a man's erect penis.
- Female Condoms are sheaths or lining that fit loosely inside a woman's vagina. They have flexible rings at both ends. One ring at the closed end helps to insert the condom whereas the open-end ring holds outside the vagina.
- Work by forming a barrier that keeps sperm out of the vagina and preventing pregnancy. Also keep infections in semen, on the penis, or in the vagina from infecting the other partner.

Health Benefits, and Health Risks

Known Health benefits

Help protect against:

- Risks of pregnancy
- STIs, including HIV

May help protect against (conditions caused by STIs):

- Recurring pelvic inflammatory disease and chronic pelvic pain
- Cervical cancer

Known Health Risks

Extremely rare:

- Severe allergic reaction (among people with latex allergy)

Who Can and Cannot Use Male Condoms

- ❖ All men and women can safely use condoms except those with severe allergic reaction to latex rubber

When to Start

- ❖ Anytime the client wants

Correcting misunderstanding, Female condoms:

- Cannot get lost in the woman's body
- Are not difficult to use, but correct use needs to be learned
- Do not have holes that HIV can pass through
- Are used by married couples. They are not only for use outside marriage
    - Do not cause illness in a woman because they prevent semen or sperm from entering her body

Side Effects

None

Managing Any Problems

- ❖ Problems with condoms affect clients' satisfaction and use of the method. Offer to help the client choose another method, unless condoms are needed for protection from STIs, including HIV.
- ❖ ECPs can help prevent pregnancy if condom breaks or slips off.
- ❖ If the client has signs or symptoms of STIs after, condom breaks or slips off, assess the client for treatment or refer.
- ❖ If the client has difficulty putting on the condoms, demonstrates by using a model or other item and correct any errors.
- ❖ Discuss ways to talk about condoms with partners and dual protection rationales to encourage the difficulty persuading partner.

- ❖ If the inner ring of female condom become uncomfortable or painful, suggest that she reinsert or reposition the condom so that the inner ring is tucked back behind the pubic bone and out of the way. If the condom squeaks or make noises, use more lubricants.
- ❖ For minor irritation, suggest putting lubricant to reduce rubbing or trying another brand of condoms. If the symptoms persist, assess and treat possible vaginal infection or STI as appropriate or refer.
- ❖ If the woman has the following conditions, male partner should stop using latex condom Female partner is using miconazole or econazole, for treatment of vaginal infection, which can damage latex.
- ❖ Severe allergic reaction to condom

How to use male/female condoms

Detail steps of using male/female condoms are illustrated in the table 3 and 4

Table .3:Explaining How to Use Male Condom

Explaining How to Use

IMPORTANT: Whenever possible, show clients how to put on a condom. Use a model of a penis, if available, or other item, like a banana, to demonstrate.

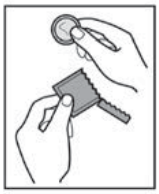
Explain the 5 Basic Steps of Using a Male Condom		
Basic Steps	**Important Details**	
1. Use a new condom for each act of sex	• Check the condom package. Do not use if torn or damaged. Avoid using a condom past the expiration date. Do so only if a newer condom is not available. • Tear open the package carefully. Do not use fingernails, teeth, or anything that can damage the condom.	
2. Before any physical contact, place the condom on the tip of the erect penis with the rolled side out	• For the most protection, put the condom on before the penis makes any genital, oral, or anal contact.	
3. Unroll the ondom all the way to the base of the erect penis	• The condom should unroll easily. Forcing it on could cause it to break during use. • If the condom does not unroll easily, it may be on backwards, damaged, or too old. Throw it away and use a new condom. • If the condom is on backwards and another one is not available, turn it over and unroll it onto the penis.	
4. Immediately after ejaculation, hold the rim of the condom in place and withdraw the penis while it is still erect	• Withdraw the penis. • Slide the condom off, avoiding spilling semen. • If having sex again or switching from one sex act to another, use a new condom.	
5. Dispose of the used condom safely	• Wrap the condom in its package and put it in the rubbish bin or latrine. Do not put the condom into a flush toilet, as • it can cause problems with plumbing	

Table .4:Explaining How to Use Female Condom

When to Start

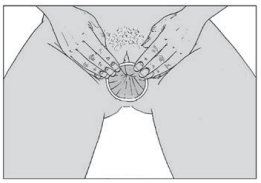
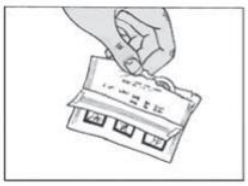
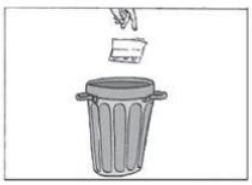
Any time, whenever a woman or a couple wants protection from pregnancy or STIs.

Explaining How to Use

IMPORTANT: Whenever possible, show the client how to insert the female condom. Use a model or picture, if available, or your hands to demonstrate. You can create an opening similar to a vagina with one hand and show how to insert the female condom with the other hand.

Explain the 5 Basic Steps of Using a Female Condom

Basic Steps	Important Details
1. Use a new female condom for each act of sex	• Check the condom package. Do not use if torn or damaged. Avoid using a condom past its expiration date. Do so only if newer condoms are not available. • If possible, wash your hands with mild soap and clean water before inserting the condom
2. Before any physical contact, insert the condom into the vagina  	• For the most protection, insert the condom before the penis comes in contact with the vagina. Can be inserted up to 8 hours before sex • Choose a position that is comfortable for insertion—squat, raise one leg, • sit, or lie down. • Rub the sides of the female condom together to spread the lubricant evenly. • Grasp the ring at the closed end, and squeeze it so it becomes long and narrow. • With the other hand, separate the outer lips (labia) and locate the opening of the vagina. • Gently push the inner ring into the vagina as far up as it will go. Insert a finger into the condom to push it into place. About 2 to 3 centimeters of the condom and the outer ring remain outside the vagina.

Basic Steps	Important Details
3. Ensure that the penis enters the condom and stays inside the condom	• The man or woman should carefully guide the tip of his penis inside the condom—not between the condom and the wall of the vagina. If his penis goes outside the condom, withdraw and try again. • If the condom is accidentally pulled out of the vagina or the outer ring is pushed into it during sex, put the condom back in place. 
4. After the man withdraws his penis, hold the outer ring of the condom, twist to seal in fluids, and gently pull it out of the vagina	The female condom does not need to be removed immediately after sex. • Remove the condom before standing up, to avoid spilling semen. • If the couple has sex again, they should use a new condom. • Reuse of female condoms is not recommended 
5. Dispose of the used condom safely	• Wrap the condom in its package and put it in the rubbish bin or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing  

What Condom Users Should Follow

- ❖ Avoid practices that can increase the risk of the condom break do not unroll the condom first and then try to put it on the penis
- ❖ Do not use lubricants with an oil base because they damage latex.
- ❖ Do not use a condom if the color is uneven or changed.
- ❖ Do not use a condom that feels brittle, dried out, or very sticky
- ❖ Do not reuse condoms.
- ❖ Do not have dry sex.
- ❖ Do not use the same condom when switching between different penetrative sex acts, such as from anal to vaginal sex. This can transfer bacteria that can cause infection.

Why some women say they like female condoms:

- Women can initiate their use
- Have a soft, moist texture that feels more natural than male latex condoms during sex
- Help protect against both pregnancy and STIs including HIV
- Outer ring provides added sexual stimulation for some women
- Can be used without seeing a health care provider

Why some men say they like female condoms:

- Can be inserted ahead of time so do not interrupt sex
- Are not tight or constricting like male condoms
- Do not dull the sensation of sex like male condoms
- Do not have to be removed immediately after ejaculation

7.5. LONG ACTING REVERSIBLE CONTRACEPTION (LARC) – IMPLANTS

Blood pressure measurement is desirable before starting a hormonal method. However, where the risks of pregnancy are high and few methods are available, a woman should not be denied a hormonal method simply because her blood pressure cannot be measured. If possible, she can have her blood pressure measured later at a time and place convenient for her (WHO, Global handbook 2018)

Key Points

- **Implants are small flexible rods or capsules** that are placed just under the skin of the upper arm.
- **Provide long-term pregnancy protection.** Very effective for 3-5 years, depending on the type of implant, immediately reversible.
- **Require specifically trained provider to insert and remove.**
- **Little required of the client once implants are in place. Avoids user errors and problems with resupply.**
- **Bleeding changes are common but not harmful.** Typically, prolonged irregular bleeding over the first year, and then lighter, more regular bleeding or infrequent bleeding.

- Small plastic rods or capsules, each about the size of a matchstick, that release a progestin like the natural hormone progesterone in a woman's body.
- Do not contain estrogen, and so can be used throughout breastfeeding and by women who cannot use methods with estrogen.
- Types of Impants:
  - Jadelle – 2 rods, effective for 5 years;
  - Implanon NXT (Nexplanon)– 1 rod containing etonogestrel, labeled for up to 3 years of use. Replace implanon: Implanon NXT can be seen on X ray and has an improved insertion device ,effective for 3 years .
  - Levoplant (Sino-Implant (II)), 2 rods containing levonorgestrel. Labeled for up to 4 years of use.
- Work primarily by thickening cervical mucus (this blocks sperm from meeting an egg) and disrupting the menstrual cycle, including preventing (ovulation).

Health Benefits, Health Risks, and Complications

Known Health Benefits

Help protect against:

- Risks of pregnancy
- Symptomatic PID

May help protect against:

- Iron-deficiency anaemia

Known Health Risks

- None

Complications

Uncommon:

- Infection at insertion site (most infections occur within the first 2 months after insertion)
- Difficult removal (rare if properly inserted and the provider is skilled at removal)

Rare:

Expulsion of implant (expulsions most often occur within the first 4 months after insertion)

Who Can Use LARC – Implants

Safe and Suitable for Nearly All Women

Nearly all women can use implants safely and effectively, including women who:

- Are breastfeeding
- Have or have not had children
- Are married or not married
- Are of any age, including adolescents and women over 40 years old
- Have just had an abortion or miscarriage or ectopic pregnancy
- Smoke cigarette – **regardless of age and number of cigarette smoked**.
- Have anemia now or in the past
- Have varicose veins
- Are infected with HIV, whether or not on antiretroviral therapy.

Women can begin using implants:

- Without a pelvic examination
- Without any blood tests or other routine laboratory tests
- Without cervical cancer screening
- Without a breast examination
- Even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant

Women who can't use Implants

- Cirrhosis of liver and liver cancer
- Acute blood clot in deep veins of legs or lungs
- Unexplained vaginal bleeding
- Had breast cancer but no recurrent for 5 years
- Positive or unknown antiphospholipid antibiotics
- Systemic lupus erythematosus with positive (or unknown) antiphospholipid antibodies, and not on immunosuppressive therapy

When to start providing implants

- A woman can **start using** implants anytime she wants if it is reasonably certain she is not pregnant.
- If a woman is **fully breastfeeding**, she can receive implant insertion. No need to waits until 6 weeks after delivery (category 2 - WHO MEC 2015).
- If a woman has insertion of implants 6 months after delivery and her monthly bleeding has not returned, she can receive implants insertions anytime if she is not pregnant. She will need a backup method for the first 7 days after the implant insertion.
- **If a woman is partially breastfeeding or no breastfeeding**, and if her monthly bleeding has not returned, she can receive implant insertion anytime it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after implant insertion.
- If a woman is **switching from consistent correct use of hormonal method**, she can receive implant insertion without backup methods and no need to wait for next monthly bleeding. If the previous method was an injectable contraceptive the implant should be inserted when the repeat injection would have been given and no need for backup methods.
- If a woman is **switching from non-hormonal method (other than IUD) or having within 7 days after her menstrual cycle**, she can receive implant insertion immediately and no need for a

backup method. If more than 7 days after the start of her monthly bleeding, she will need a backup method for the first 7 days after the implant insertion.

- If woman is switching from an IUD, an implant can be inserted if it is within 7 days after the start of menstrual bleeding. There is no need for a backup method and IUD can be removed at that time. If she takes more than 7 days after the start of her monthly bleeding, the implant can be inserted if it is reasonably certain she is not pregnant.
    - Sexually active in this menstrual cycle and more than 7 days since the start of menstrual bleeding: it is recommended that IUD be removed at the time of her next menstrual period.
    - Not sexually active in this menstrual cycle and more than 7 days since the start of menstrual bleeding: she will need to abstain from sex or use additional contraceptive protection for the next 7 days. If that additional protection is to be provided by IUD she is using, it is recommended that this IUD be removed at the time of her next menstrual period.
- **After taking ulipristal acetate ECPs:** Implants can be inserted on the 6th day after taking UPA-ECPs. No need to wait for her next monthly bleeding. Implants and UPA interact. If an implant is inserted sooner, and thus both are present in the body, one or both may be less effective.
- If a woman has no monthly bleeding (not related to childbirth or breastfeeding) she can receive implant insertion anytime it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the implant insertion.

Inserting procedure of Implants

A woman who has chosen implants needs to know what will happen during insertion. Learning to insert and remove implants requires training and practice under direct supervision. The following description is a summary and help explain the procedure to her.

1. The provider uses proper infection- prevention procedure.
2. The provider marks the skin where the implant will be inserted on the inner's side of the women upper arm (usually the arm she uses less often)
3. The woman receives an injection of local anesthetics under the skin of her arm to prevent pain while the implant is being inserted. This injection may be sting, but she should not feel any pain when the implant is inserted. She stays fully awake throughout the procedure.
4. The provider uses a specially designed applicator to make an incision and insert the implant under the skin.
5. After the implant is inserted, the provider closes the incision with surgical tape and an adhesive bandage. Stitches are not needed. The incision is covered with dry piece of gauze (a pressure dressing) and the arm is wrapped snugly with gauze.

Removing procedure

A woman need to know what will happen during removal. The following description can help explain the procedure to her.

1. The provider uses proper infection prevention procedures.
2. The provider marks the location of implant.
3. The woman receives an injection of local anesthesia under the skin of her arm at the incision site to prevent pain during implant removal. This injection may sting. She stays fully awake throughout the procedure.
4. The health care provider makes a small incision in the skin near the site of insertion.
5. With the fingers, the provider pushes the implant toward the incision and then uses forceps to pull out the implant. A woman may feel tugging, slight pain, or soreness during the procedure and for a few days after.
6. The provider closes the incision with an adhesive bandage. Stitches are not needed. An elastic bandage may be placed over the adhesive bandage to apply gentle pressure for 24 hours and keep down swelling.

The provider should ask whether the woman wants to continue preventing pregnancy and discuss her option. If she wants new implants, they are placed above or below the site of implants or in the other arm.

Provide client the following specific information:

a. To keep arm dry for 4 days. She can take off the elastic bandage or gauze after 24 hours and adhesive bandage after 5 days.
b. Expect soreness after anesthetic wears off, bruising at the insertion site. Will resolve after a few days without treatment.
c. Length of pregnancy protection, type of implant inserted, date of insertion, month and year when to remove or replace implants
d. Where to go if she has problems or question about her implants
e. Return for removal or replacement before the implant start losing effectiveness

Side Effects

- **Changes in bleeding patterns including:**

First several months:

- Lighter bleeding and fewer days of bleeding
- Prolong bleeding
- Irregular bleeding
- Infrequent bleeding
- No monthly bleeding

After about one year:

- Lighter bleeding and fewer days of bleeding
- Irregular bleeding
- Infrequent bleeding

Implanon NXT users are more likely to have infrequent or no monthly bleeding than irregular bleeding. Users of Implanon and Implanon NXT are more likely to have infrequent bleeding, prolonged bleeding or no monthly bleeding than irregular bleeding.

- Headaches
- Abdominal pain
- Acne (can improve or worsen)
- Weight change
- Breast tenderness
- Dizziness
- Mood changes
- Nausea

Other possible physical changes (Enlarged ovarian follicles)

Managing any problems

1. Schedule a regular follow up annually or as necessary. This offers an opportunity to answer any questions and help with any problems.
2. For new health problems that may require switching methods or if problems cannot be overcome, offer to help the client choose another method.
3. For minor problems, manage accordingly as described in the following table

Managing side effects of Implants

Irregular Bleeding	Reassure. Become less or stop after the first year of use For modest short-term relief, she can take 800 mg ibuprofen or 500 mg mefenamic acid 3 times daily after meals for 5 days, beginning when irregular bleeding starts. If these drugs do not help her, she can try one of the following, beginning when irregular bleeding starts: Combined oral contraceptives with the progestin levonorgestrel. Ask her to take one pill daily for 21 days or 50 µg ethinyl estradiol daily for 21 days. If the bleeding persists, consider underlying conditions.
No Bleeding	Reassure.
Heavy/ prolong bleeding (twice as much as usual or longer than 8 days)	Reassure. For modest short-term relief, she can try any of the treatments for irregular bleeding, above, beginning when heavy bleeding starts. Combined oral contraceptives with 50 µg of ethinyl estradiol may work better than low-dose pills. Iron supplement and diet.
Headache	Can give paracetamol (325–1000 mg), ibuprofen (200–400 mg), asprin (325-650 mg) or other pain reliever. Any headaches that get worse or occur more often during use of implants should be evaluated
Mild abdominal pain	Suggest paracetamol (325–1000 mg), ibuprofen (200–400 mg), asprin (325-650 mg) or other pain reliever.
Acne, Nausea or dizziness	Local remedies.
Weight changes	Review diet and counsel as needed
Breast tenderness	Wear supportive bra, try hot or cold compresses.
Mood changes or sex drive	Provide appropriate support. Refer if major depression and other serious mood changes occurred.
Pain after insertion/ removal	For pain after insertion, check that the bandage or gauze on her arm is not too tight. Put a new bandage on the arm and advise her to avoid pressing on the site for a few days. Give her aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.
Infection at the insertion site	Do not remove the implants. Clean the infected area with soup and water or antiseptic. Give oral antibiotics for 7-10 days. Ask the client to return after the antibiotic course. If the infection has not cleared, remove the implants or refer for removal. Expulsion or partial expulsion often follow infection. Ask the client to return if she notices an implant coming out.

Abscess	Clean the area with antiseptic. Cut open (incise) and drain the abscess, treat the wound, give oral antibiotic for 7-10 days. Ask the client to return after the antibiotic course. If the infection has not cleared, remove the implants or refer for removal.
Expulsion	Rare. Usually occurs within a few months of insertion or with infection. If no infection is present, replace the expelled rod through a new incision near the rods, or refer for replacement.
Severe Abdominal pain	Rule out the ectopic pregnancy and other serious health conditions, and refer as necessary

4. If the woman developed the following symptoms, Implants should be removed:
   - ❖ Unexplained vaginal bleeding (that suggests a medical condition not related to the method) or heavy or prolonged bleeding
   - ❖ Migraine headaches
   - ❖ Certain serious health conditions
   - ❖ Heart disease or stroke
   - ❖ Suspected pregnancy

7.6 LONG ACTING REVERSIBLE CONTRACEPTION – INTRAUTERINE DEVICE (IUD)

Key Points

- **Long-term pregnancy protection.** Shown to be very effective for 12 years (Copper-bearing IUD) and 5 years (Levonorgestrel IUD), immediately reversible.
- **Inserted into the uterus by a specifically trained provider.**
- **Little required of the client once the IUD is in place**
- **Bleeding changes are common.** Typically, longer and heavier bleeding and more cramps or pain during monthly bleeding, especially in the first 3 to 6 months of inserting copper-bearing IUD and lighter and fewer days of bleeding or irregular bleeding with levonorgestrel IUD.

7.6.1. The copper-bearing intrauterine device (IUD) is:

- a small, flexible plastic frame with copper sleeves or wire around it.
- Almost all types of IUDs have one or two strings or threads, tied to them. The strings hang through the cervix into the vagina

- Works primarily by causing a chemical change that damages sperm and ovum (Copper-bearing IUD).

Known Health Benefits (Copper IUD) health Benefits, and Health Risks and Complications – copper- bearing IUD

Help protect against

Risk of pregnancy

Endometrial cancer

Cervical cancer

Reduce risk of ectopic pregnancy

Known Health Risks (Copper IUD)

Uncommon

May contribute to anaemia if IUD causes heavier monthly bleeding.

Rare

- PID may occur if the woman has chlamydia or gonorrhea at the time or IUD insertion

Who Can Use IUD (copper- bearing)

Safe and Suitable for Nearly All Women

Nearly all women can use IUD safely and effectively, including women who:

- ❖ Have or have not had children
- ❖ Are not married
- ❖ Are of any age, including adolescents and women over 40 years old
- ❖ Have just had an abortion or miscarriage (no evidence of infection)
- ❖ Are breastfeeding
- ❖ Do hard physical work
- ❖ Have had ectopic pregnancy
- ❖ Have had PID
- ❖ Have vaginal infection
- ❖ Have anemia
- ❖ Are infected with HIV or on antiretroviral therapy and doing well

Women who can't use IUD (see detail in MEC – (ANNEX :1)

- A woman who delivered more than 48 hours to less than 4 weeks.
- Immediate post-abortion
- Puerperal sepsis
- Gestational trophoblast disease
- Uterine distortion
- Unexplained vaginal bleeding
- Cervical, endometrial and ovarian cancer
- Very high risk of STIs
- Currently with purulent cervicitis, gonorrhea, chlamydia, PID, pelvic tuberculosis
- AIDS patient who is not clinically well/ not on ART
- Systemic lupus erythematous with severe thrombocytopenia

When to start providing IUD (Copper bearing IUD)

- A woman can **start using** IUD anytime she wants if it is reasonably certain she is not pregnant.
- If a woman is **fully breastfeeding**, she can receive IUD insertion between 4 weeks to 6 months after the delivery. No need for a backup method.
- **If a woman is partially breastfeeding or no breastfeeding and** > **4 weeks after delivery** and if her monthly bleeding has not returned, she can receive IUD insertion anytime it is reasonably certain she is not pregnant.
- If a woman is **switching from consistent correct use of another method**, she can receive any type of IUD without backup methods if it is reasonably certain she is not pregnant. No need to wait for next monthly bleeding. No need for a backup method.
- If a woman is switching from injectables, she can have any IUD inserted at schedule for repeat injection. No need for a backup method.
- If a woman is **having menstrual cycles - if within 12 days for Copper bearing IUD/ after the start of her menstrual cycle**, she can insert IUD and no need for a backup method. If it is more than 12 days after the start of her monthly bleeding, she can have the IUD inserted anytime it is reasonably certain she is not pregnant. No need backup method for Copper IUD.
- **If a woman is soon after childbirth** – Copper-bearing IUD can be inserted anytime within 48 hours of giving birth including by caesarean delivery. If it is more than 48 hours after birth, delay until 4 weeks or more after giving birth.

- ❖ If a woman is after **miscarriage or abortion**, insert implants immediately or within 12 days (Copper-bearing IUD). If she starts more than 12 days after miscarriage or abortion and no infection, she can start anytime and no need for backup method.
- ❖ If IUD insertion **after second trimester abortion or miscarriage** requires specific training. If not specifically trained, delay insertion until at least 4 weeks after miscarriage or abortion.
- ❖ After taking emergency contraceptive pills (**ECPs**), she can insert IUD on the same day and no need for a backup method.

IUD can be used as **emergency contraception** within 5 days after unprotected sex. When the time of ovulation can be estimated, she can have an IUD inserted up to 5 days after ovulation. Sometimes this may be more than 5 days after unprotected sex. **Side Effects**

Changes in bleeding patterns (especially in the first 3 to 6 months) including:

- Prolonged and heavy monthly bleeding
- Irregular bleeding

More cramps and pain during monthly bleeding

Managing any problems

1. Schedule a regular follow up or as necessary. This offers an opportunity to answer any questions and help with any problems.
2. For new health problems that may require switching methods or if problems cannot be overcome, offer to help the client choose another method.
3. For minor problems, manage accordingly as described in the following table

Managing side effects of IUD (Copper-bearing IUD)

Heavy/ prolong bleeding (twice as much as usual or more than 8 days)	Reassure. For modest short-term relief, she can try any of the treatments for irregular bleeding. Tranexamic acid (1500 mg) 3 times daily for 3 days, then 1000 mg once daily for 2 days OR NSAID (except aspirin)2 times daily after meals for 5 days, beginning when heavy bleeding starts. Iron supplement and diet.
Irregular Bleeding	Reassure. Become less or stop after the first year of use For modest short- term relief, she can take 400 mg ibuprofen or 25 mg indomethacin 2 times daily after meals for 5 days, beginning when irregular bleeding starts. If the bleeding persists, consider underlying conditions.
Cramping abdominal pain	She can expect cramping and pain for the first day or two after IUD insertion. Explain that it is common in the first 3-6 months of IUD use, particularly during monthly bleeding, generally not harmful and usually decreases over time. Suggest paracetamol (325–1000 mg), ibuprofen (200–400 mg), asprin (325-650 mg) or other pain reliever. If cramping became severe and can't find other cause, discuss removing IUD.
Possible Anemia	Due to heavier monthly bleeding. Iron supplement and dietary advice.
Partner can feel IUD strings during sex	Explain that this happens when strings are cut too short. Options: strings can be cut shorter so that they are not coming out from cervical canal. Yet, the woman will no longer able to check the IUD strings.

Severe lower abdominal pain	Pelvic Inflammatory Diseases or other abdominal conditions such as ectopic pregnancy. Rule of ectopic pregnancy and do abdominal and pelvic examination. Treat PID or immediately refer. If ectopic pregnancy is suspected, refer.
Suspected uterine perforation	If perforation is suspected at the time of insertion or sounding of the uterus, stop procedure immediately (and remove the IUD if inserted). Note vital signs 5-10 minutely up to 1 hour. If she remains stable after 1 hour, do other investigations (to rule our intra-abdominal bleeding). Observe for more hours, if she has no signs and symptoms, she can be sent home and tell her to avoid sex for 2 weeks. If her vital signs are not stable, refer immediately to higher level of care. If the uterine perforation is suspected within 6 weeks after insertion or later and causing symptoms, refer patients for removal of IUD.
Partial Expulsion	Remove the IUD and counsel the client for another IUD or a different method.
Complete Expulsion	If the patient reports that IUD came out, discuss the client for another IUD or a different method. If complete expulsion is expected and the client does not know whether IUD came out, refer for X-ray or Ultrasound to assess whether the IUD might have moved to the abdominal cavity. Give her a backup method.
Missing strings	Ask the client: – Whether and when she saw the IUD come out – When she last felt the strings – When she had her last monthly bleeding – If she has any symptoms of pregnancy – If she has used a backup method since she noticed the strings were missing. Always start with minor and safe procedures and be gentle. Check for the strings in the folds of the cervical canal with forceps. About half of missing IUD strings can be found in the cervical canal. If strings cannot be located in the cervical canal, either they have gone up into the uterus or the IUD has been expelled unnoticed. Rule out pregnancy before attempting more invasive procedures. Refer for evaluation. Give her a backup method to use in the meantime, in case the IUD came out.

4. If the woman developed the following symptoms, IUD should be removed:
    - ❖ Unexplained vaginal bleeding (that suggests a medical condition not related to the method) or heavy or prolonged bleeding
    - ❖ Suspected pregnancy

7.6.2. The levonorgestrel intrauterine device (LNG-IUD) is:

Blood pressure measurement is desirable before starting a hormonal method. However, where the risks of pregnancy are high and few methods are available, a woman should not be denied a hormonal method simply because her blood pressure cannot be measured. If possible, she can have her blood pressure measured later at a time and place convenient for her (WHO, Global handbook 2018)

- T-shaped plastic device that steadily releases small amounts of levonorgestrel each day. (Levonorgestrel is a progestin widely used in implants and oral contraceptive pills.) Also called the levonorgestrel-releasing intrauterine system, LNG-IUS or hormonal IUD
- A specifically trained health care provider inserts it into the uterus through the cervix.
- Works by preventing sperm from fertilizing an egg

Health Benefits, and Health Risks and Complications – (LNG-IUD)

Known Health Benefits

Help protect against -

Risks of pregnancy

Iron- deficiency anemia

PID

Reduces -

Menstrual cramps

Symptoms of endometriosis

Known Health Risks

None

Who can use (LNG- IUD)

Safe for all women**.**

Who can't use (LNG- IUD)

- Cirrhosis of liver and liver cancer
- Acute DVT or Pulmonary Embolism
- Unexplained vaginal bleeding
- Had breast cancer but no recurrence for 5 years
- Positive or unknown antiphospholipid antibiotics

When to start providing IUD (LNG- IUD)

- A woman can **start using** IUD anytime she wants if it is reasonably certain she is not pregnant.
- If a woman is **fully breastfeeding**, she can receive IUD insertion between 4 weeks to 6 months after the delivery. No need for a backup method.
- If a woman wants insertion of IUD 6 months after delivery and her monthly bleeding has not returned, she can receive IUD insertion anytime if she is not pregnant. She will need a backup method for the first 7 days after insertion.
- **If a woman is partially breastfeeding or no breastfeeding**, and if her monthly bleeding has not returned, she can receive IUD insertion anytime it is reasonably certain she is not pregnant.
- If a woman is **switching from consistent correct use of another method**, she can receive any type of IUD without backup methods if it is reasonably certain she is not pregnant. No need to wait for next monthly bleeding. No need for a backup method.
- If a woman is switching from injectables, she can have any IUD inserted at schedule for repeat injection. She will need a backup method for the first 7 days after insertion.
- If a woman is **having menstrual cycles - if within 7 days for LNG – IUD after the start of her menstrual cycle**, she can insert IUD and no need for a backup method. If it is more than 7 days after the start of her monthly bleeding, she can have the IUD inserted anytime it is reasonably certain she is not pregnant. But need a backup method for the first 7 days after insertion.
- **If a woman is soon after childbirth** – (regardless of breast feeding status) LNG-IUD can be inserted anytime within 48 hours of giving birth including by caesarean delivery. If it is more than 48 hours after birth, delay until 4 weeks or more after giving birth.
- If a woman is after **miscarriage or abortion**, insert implants immediately or within 7 days (LNG-IUD). If she starts more than 7 days after miscarriage or abortion and no infection, she can start anytime and no need for backup method.
- If IUD insertion **after second trimester abortion or miscarriage** requires specific training. If not specifically trained, delay insertion until at least 4 weeks after miscarriage or abortion.
- After taking emergency contraceptive pills (**ECPs**), she can insert IUD on the same day and no need for a backup method.

Side effects

Changes in bleeding patterns including:

- Lighter, Infrequent, Irregular, no monthly bleeding or prolong bleeding or
- Acne, headaches, nausea, dizziness, mood changes, weight gain, breast tenderness or pain and ovarian cysts
- Perforation of the uterus by the IUD or an instrument used for insertion
- Miscarriage, preterm birth or infection if the woman becomes pregnant with the IUD in place.

Managing any problem

1. Schedule a regular follow up or as necessary. This offers an opportunity to answer any questions and help with any problems.
2. For new health problems that may require switching methods or if problems cannot be overcome, offer to help the client choose another method.
3. For minor problems, manage accordingly as described in the following table

Managing side effects of IUD

Heavy/ prolong bleeding (twice as much as usual or more than 8 days)	Reassure. For modest short-term relief, she can try any of the treatments for irregular bleeding. Tranexamic acid (1500 mg) 3 times daily for 3 days, then 1000 mg once daily for 2 days OR NSAID (except aspirin)2 times daily after meals for 5 days, beginning when heavy bleeding starts. Iron supplement and diet.
Irregular Bleeding	Reassure. Become less or stop after the first year of use For modest short-term relief, she can take 400 mg ibuprofen or 25 mg indomethacin 2 times daily after meals for 5 days, beginning when irregular bleeding starts. If the bleeding persists, consider underlying conditions.
Cramping abdominal pain	She can expect cramping and pain for the first day or two after IUD insertion. Explain that it is common in the first 3-6 months of IUD use, particularly during monthly bleeding, generally not harmful and usually decreases over time. Suggest paracetamol (325–1000 mg), ibuprofen (200–400 mg), asprin (325-650 mg) or other pain reliever. If cramping became severe and can't find other cause, discuss removing IUD.
Possible Anemia	Due to heavier monthly bleeding. Iron supplement and dietary advice.
Partner can feel IUD strings during sex	Explain that this happens when strings are cut too short. Options: strings can be cut shorter so that they are not coming out from cervical canal. Yet, the woman will no longer able to check the IUD strings.

Severe lower abdominal pain	Pelvic Inflammatory Diseases or other abdominal conditions such as ectopic pregnancy. Rule of ectopic pregnancy and do abdominal and pelvic examination. Treat PID or immediately refer. If ectopic pregnancy is suspected, refer.
Suspected uterine perforation	If perforation is suspected at the time of insertion or sounding of the uterus, stop procedure immediately (and remove the IUD if inserted). Note vital signs 5-10 minutely up to 1 hour. If she remains stable after 1 hour, do other investigations (to rule our intra-abdominal bleeding). Observe for more hours, if she has no signs and symptoms, she can be sent home and tell her to avoid sex for 2 weeks. If her vital signs are not stable, refer immediately to higher level of care. If the uterine perforation is suspected within 6 weeks after insertion or later and causing symptoms, refer patients for removal of IUD.
Partial Expulsion	Remove the IUD and counsel the client for another IUD or a different method.
Complete Expulsion	If the patient reports that IUD came out, discuss the client for another IUD or a different method. If complete expulsion is expected and the client does not know whether IUD came out, refer for X-ray or Ultrasound to assess whether the IUD might have moved to the abdominal cavity. Give her a backup method.
Missing strings	Ask the client: – Whether and when she saw the IUD come out – When she last felt the strings – When she had her last monthly bleeding – If she has any symptoms of pregnancy – If she has used a backup method since she noticed the strings were missing. Always start with minor and safe procedures and be gentle. Check for the strings in the folds of the cervical canal with forceps. About half of missing IUD strings can be found in the cervical canal. If strings cannot be located in the cervical canal, either they have gone up into the uterus or the IUD has been expelled unnoticed. Rule out pregnancy before attempting more invasive procedures. Refer for evaluation. Give her a backup method to use in the meantime, in case the IUD came out.

4. If the woman developed the following symptoms, IUD should be removed:
    - ❖ Unexplained vaginal bleeding (that suggests a medical condition not related to the method) or heavy or prolonged bleeding
    - ❖ Suspected pregnancy

* In cases of uterine perforation or if removal is not so easy (for example, when IUD string are missing), refer the woman to an experienced clinician who can use an appropriate removal technique.

7.6.4. Intrauterine Devices for Women with HIV

- ❖ Women living with HIV can safely have an IUD inserted if they have mild or no clinical disease, whether or not they are on antiretroviral therapy.
- ❖ Women who have HIV infection with advanced or severe clinical disease should *not* have an IUD inserted. If a woman becomes infected with HIV while she has an IUD in place, it does not need to be removed.
- ❖ An IUD user living with HIV who develops advanced or severe clinical disease can keep the IUD but should be closely monitored for pelvic inflammatory disease.
- ❖ Urge women who have HIV or are at risk for HIV to use condoms along with the IUD. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.
- ❖ Women who are at risk of HIV but not infected with HIV can have an IUD inserted. The IUD does not increase the risk of becoming infected with HIV.

7.6.5 Assessing Women for Risk of Sexually Transmitted Infections

A woman who has gonorrhea or chlamydia now should not have an IUD inserted. Having these sexually transmitted infections (STIs) at the time of insertion may increase the risk of pelvic inflammatory disease.

If this risk for the *individual* client is very high, she generally should not have an IUD inserted.

Possibly risky situations include:

- A sexual partner has STI symptoms such as pus coming from his penis, pain or burning during urination, or an open sore in the genital area
- She or a sexual partner was diagnosed with an STI recently
- She has had more than one sexual partner recently
- She has a sexual partner who has had other partners recently

In contrast, if a *current* IUD user's situation changes and she finds herself at very high individual risk for gonorrhea or chlamydia, she can keep using her IUD.

7.6.3. Insertion procedure of IUD (Annex:3)

A pelvic examination and STI risk assessment are essential before insertion.

Giving Specific instruction

Expect cramping and pain	• Woman can expect some cramping and pain for a few days after insertion. • Suggest ibuprofen (200- 400mg) paracetamol(325-1000mg) • Also, she can expect some bleeding or spotting immediately after insertion. Irregular spotting can continue during the first month after insertion.
Length of pregnancy protection	Discuss how to remember the date to return for removal or replacement. Give each woman the following information (reminder card) • Type of IUD • Date of IUD insertion • Moth and year when IUD will need to be removed or replaced • Where to go if woman has problems or questions about her IUD
Follow-up visit	• A follow- up visit after her first monthly bleeding or 3 to 6 weeks after IUD insertion is recommended. No woman should be denied an IUD, however, because follow-up would be difficult or not possible.

Come Back Any Time; Reasons to return

- If the IUD was expelled or she thinks it may have been expelled from her uterus.
- She has symptoms of pelvic inflammatory disease (increasing or severe pain in the lower abdomen, pain during sex, unusual vaginal discharge, fever, chills, nausea, and or vomiting), especially in the first 20 days after insertion.
- Woman think she might be pregnant
- Woman wants the IUD removed, for whatever reason.

7.7: PERMANENT METHOD – STERILIZATION

Key Points

- Permanent. Intended to provide life-long, permanent, and very effective protection against pregnancy. Reversal is usually not possible.
- Involves a physical examination and surgery. The procedure is done by a specifically trained provider.
- No long-term side effects.
- Male sterilization (vasectomy) is not routinely allowed in Myanmar. It can be done only when the women has serious medical problems and does not suitable for any types of contraception (Myanmar Penal Code).

Female Sterilization

Permanent surgical contraception for women who will not want more children

The two surgical approaches most often used: 1) minilaparotomy involves making a small incision in the abdomen. The fallopian tubes are brought to the incision to be cut or blocked 2) Laparoscopy involves inserting ta long, thin tube containing lenses into the abdomen through a small incision this laparoscope enables the doctor to reach and block or cut the fallopian tubes in the abdomen

Works because the fallopian tubes are blocked or cut. Eggs released from the ovaries cannot move down the tubes, and so they do not meet sperm.

Also called tubal sterilization, tubal ligation, voluntary surgical contraception, tubectomy, bi-tubal ligation, tying the tubes, minilaparotomy and the operation. (2018 Global Handbook)

Side Effects, Health Benefits, Health Risks and Complications

Side Effects

None

Known health benefits

Helps protect against**:**

- Risks of pregnancy
- Pelvic inflammatory disease (PID)

May help protect against**:**

- Ovarian cancer
- Reduces risk of ectopic pregnancy

Known health risks

Uncommon to extremely rare:

Complications of surgery and anaesthesis

Criteria for sterilization

1) Pregnant woman with 2 LSCS scars
2) Previous one classical scar
3) Grandmultip irrespective of age
4) Multipara with 35 completed years of age with 3 alive children
5) Multipara with 38 completed years of age with 2 alive children
6) 40 completed years old with one alive child
7) Previous child with genetic and chromosomal disorders that have a high risk of recurrence
8) Any medical disorder endorsed by respective specialty (at least consultant level) that contraindicate future can harm maternal health
9) Gynaecological diseases that can harm
10) Obstetric emergencies that can endanger the future pregnancy

Informed consent must be obtained prior to procedure. The following 7 points should be included while counselling for informed consent.

Counseling must cover all 7 points of informed consent. In some programs, the client and the counselor also sign an informed consent form. To give informed consent to sterilization, the client must understand the following points:

1. Temporary contraceptives also are available to the client, including long-acting reversible contraceptives.
2. Voluntary sterilization is a surgical procedure.
3. There are certain risks of the procedure as well as benefits. (Both risks and benefits must be explained in a way that the client can understand.)
4. If successful, the procedure will prevent the client from ever having any more children.
5. The procedure is considered permanent and probably cannot be reversed.
6. The client can decide against the procedure at any time before it takes place (without losing rights to other medical, health, or other services or benefits)
7. The procedure does not protect against sexually transmitted infections, including HIV

When to perform Female Sterilzation

Performing the Sterilization Procedure

Explaining the Procedure

A woman who has chosen female sterilization needs to know what will happen during the procedure. The following description can help explain the procedure to her. Learning to perform female sterilization takes training and practice under direct supervision. Therefore, this description is a summary and not detailed instruction.

(The description below is for procedures done more than 6 weeks after childbirth. The procedure used up to 7 days after childbirth is slightly different.)

The Mini-laparotomy Procedure

1. The provider uses proper infection-prevention procedures at all times.
2. The provider performs a physical examination and a pelvic examination. The pelvic examination is to assess the condition and mobility of the uterus.
3. Spinal/Local anesthesia was given.
4. The provider makes a small horizontal incision (2–5 centimeters) in the anesthetized area. This usually causes little pain. (For women who have just given birth, the incision is made horizontally at the lower edge of the navel.)
5. The provider inserts a special instrument (uterine elevator) into the vagina, through the cervix, and into the uterus to raise each of the 2 fallopian tubes so they are closer to the incision. This may cause discomfort.
6. Each tube is tied and cut or else closed with a clip or ring.
7. The provider closes the incision with stitches and covers it with an adhesive bandage.
8. The woman receives instructions on what to do after she leaves the clinic or hospital.

The Laparoscopy Procedure

1. The provider uses proper infection-prevention procedures at all times.
2. The provider performs a physical examination and a pelvic examination. The pelvic examination is to assess condition and mobility of the uterus.
3. Spinal anesthesia was given for anesthetic effect.
4. The provider places a special needle into the woman's abdomen and, through the needle, inflates (insufflates) the abdomen with gas or air. This raises the wall of the abdomen away from the pelvic organs.
5. The provider makes a small incision (about one centimeter) in the anesthetized area and inserts a laparoscope. A laparoscope is a long, thin tube containing lenses. Through the lenses the provider can see inside the body and find the 2 fallopian tubes.
6. The provider inserts an instrument through the laparoscope (or, sometimes, through a second incision) to close off the fallopian tubes.
7. Each tube is closed with a clip or a ring, or by electric current applied to block the tube (electrocoagulation).
8. The provider then removes the instrument and laparoscope. The gas or air is let out of the woman's abdomen. The provider closes the incision with stitches and covers it with an adhesive bandage.
9. The woman receives instructions on what to do after she leaves the clinic or hospital.

Managing Any Problems

1. If the client reports complications of female sterilization, listen to her concerns, give advice and support, and, if appropriate, treat. Make sure she understands the advice and agrees.
2. **Infection at the incision site** (redness, heat, pain, pus) – Clean the infected area with soap and water or antiseptic. Give oral antibiotics for 7 to 10 days. Ask the client to return after taking all antibiotics if the infection has not cleared.
3. **Abscess** (a pocket of pus under the skin caused by infection) – Clean the area with antiseptic. Cut open (incise) and drain the abscess. Treat the wound. Give oral antibiotics for 7 to 10 days. Ask the client to return after taking all antibiotics if she has heat, redness, pain, or drainage of the wound.
4. **Severe pain in lower abdomen** (if suspect ectopic pregnancy, manage accordingly)
5. **Failed sterilization such as suspected pregnancy**

Table:9: Shows explaining Self-Care for Female Sterilization

Before the procedure the woman should	• Use another contraceptive until the procedure. • Not to eat anything for 8 hours before surgery. She can drink clear liquids until 2 hours before surgery • Not to take any medication for 24 hours before the surgery • Wear clean, loose – fitting clothing to the health facility possible. • Not to wear nail polish or jewelry • If possible, bring her partner, a friend, or a relative to help her go home afterwards
After the procedure the women should	• Rest for 2 days and avoid vigorous work and heavy lifting for a week • Keep the incision clean and dry for 1 to 2 days • Avoid rubbing the incision for 1 week. • Nor have sex for at least I week and then only when she feels comfortable having sex.
What to do about the most common problems	• She may have some abdominal pain and swelling after the procedure. It usually goes away within a few days. Suggests Ibuprofen (200- 400 mg), paracetamol (325- 1000mg) , or other pain reliever. She should not take aspirin which slows blood clotting. If she had laparoscopy, she may have shoulder pain or feel bloated for a few days.
Plan the follow- up visit	Following up within 7 days or at least within 2 weeks is strongly recommended. No woman should be denied sterilization, however, because follow-up would be difficult or not possible. A health care provider checks the site of the incision, looks for any signs of infection, and remove any stitches. This can be done in the clinic, in the client's home. (by a specifically trained paramedical worker, for example), or at any other health center.

7.8: FERTILITY AWARENESS METHODS

Key Points

- ❖ Fertility awareness methods require partners' cooperation. Couple must be committed to abstaining or using another method on fertile days
- ❖ Must stay aware of body changes or keep track of days, according to rules of the specific method.
- ❖ No side effects or health risks.

- "Fertility awareness" means that a woman knows how to tell when the fertile time of her menstrual cycle starts and ends.
- Sometimes called periodic abstinence or natural family planning
- A woman can use several ways, alone or in combination, to tell when her fertile time begins and ends
- *Calendar-based methods* involve keeping track of days of the menstrual cycle to identify the start and end of the fertile time.
  - Examples: Standard Days Method, which avoids unprotected vaginal sex on days 8 through 19 of the menstrual cycle, and calendar rhythm method.
- *Symptoms-based methods* depend on observing signs of fertility.
  - Cervical secretions: When a woman sees or feels cervical secretions, she may be fertile. She may feel just a little vaginal wetness.
  - Basal Body Temperature (BBT): A woman's resting body temperature goes up slightly after the release of an egg (ovulation). Her temperature stays until the beginning of the next monthly bleeding.
  - Examples: Two Day method, BBT method, ovulation method and symptothermal method
- Work primarily by helping a woman know when she could become pregnant. The couple prevents pregnancy by avoiding unprotected vaginal sex during these fertile days—usually by abstaining or by using condoms. Some couples use spermicides or withdrawal, but these are among the least effective methods.
- No side effects and health risks.
- Women who are infected with HIV, have AIDS, or are on antiretroviral (ARV) therapy can safely use fertility awareness methods.
- Urge these women to use condoms along with fertility awareness methods. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.

Who Can Use and Who Cannot Use Fertility Awareness Methods

All women can use calendar-based methods. No medical conditions prevent the use of these methods, but some conditions can make them harder to use effectively.

Caution means that additional or special counseling may be needed to ensure correct use of the method.

Delay means that use of a particular fertility awareness method should be delayed until the condition is evaluated or corrected. Give the client another method to sue until she can start the symptoms-based method.

Calendar-based Methods	Symptoms-based Methods
<u>Use caution in the following situations:</u> • Menstrual cycles have just started or have become less frequent or stopped due to older age (Menstrual cycle irregularities are common in young women in the first several years after their first monthly bleeding and in older women who are approaching menopause. Identifying the fertile time may be difficult.)	<u>Use caution in the following situations:</u> • Recently had an abortion or miscarriage • Menstrual cycles have just started or have become less frequent or stopped due to older age • A chronic condition that raises her body temperature (for basal body temperature and symptothermal methods)
<u>Delay starting in the following situations:</u> • Recently gave birth or is breastfeeding (Delay until she has had at least 3 menstrual cycles and her cycles are regular again. For several months after regular cycles have returned, use with caution.) • Recently had an abortion or miscarriage (Delay until the start of her next monthly bleeding.) • Irregular vaginal bleeding	<u>Delay starting in the following situations:</u> • Recently gave birth or is breastfeeding (Delay until normal secretions have returned—usually at least 6 months after childbirth for breastfeeding women and at least 4 weeks after childbirth for women who are not breastfeeding. For several months after regular cycles have returned, use with caution.) • An acute condition that raises her body temperature (for basal body temperature and symptothermal methods) • Irregular vaginal bleeding • Abnormal vaginal discharge

Delay or use caution in the following situations: • Taking any mood-altering drugs such as anti-anxiety therapies (except benzodiazepines), antidepressants (selective serotonin reuptake inhibitors [SSRIs], tricyclic, or tetracyclic), long-term use of certain antibiotics, or long-term use of any NSAID (such as aspirin, ibuprofen, or paracetamol). These drugs may delay ovulation.	Delay or use caution in the following situations: • Taking any mood-altering drugs such as anti-anxiety therapies (except benzodiazepines), antidepressants (selective serotonin reuptake inhibitors [SSRIs], tricyclic, or tetracyclic), anti-psychotics (including chlorpromazine, thioridazine, haloperidol, risperdone, clozapine, or lithium), long-term use of certain antibiotics, any NSAID (such as aspirin, ibuprofen, or paracetamol), or antihistamines. These drugs may affect cervical secretions, raise body temperature, or delay ovulation.

When to start Fertility Awareness Methods

- A woman can start fertility awareness methods at any time, once she is trained how to use.
- If a woman has regular menstrual cycles, she can start anytime of the month and there is no need to wait until the start of the next monthly bleeding.
- If a woman has no monthly bleeding, she needs to delay the use of fertility awareness methods until monthly bleeding returns.
- After childbirth (whether or not breastfeeding):
  - Delay the Standard Days Method until she has had 3 menstrual cycles and the last one was 26–32 days long.
  - She can start symptoms-based methods once normal secretions have returned.
  - Regular cycles and normal secretions will return later in breastfeeding women than in women who are not breastfeeding.
- After **miscarriage or abortion**:
  - Delay the Standard Days Method until the start of her next monthly bleeding, when she can start if she has no bleeding due to injury to the genital tract.
  - She can start symptoms-based methods immediately with special counseling and support, if she has no infection-related secretions or bleeding due to injury to the genital tract.

- If a woman is **switching from consistent correct use of hormonal method**:
  - Delay starting the Standard Days Method until the start of her next monthly bleeding.
  - If she is switching from injectables, delay the Standard Days Method at least until her repeat injection would have been given, and then start it at the beginning of her next monthly bleeding.
  - She can start symptoms-based methods in the next menstrual cycle after stopping a hormonal method.
- If a woman is after taking emergency contraceptive pills (ECPs):
  - Delay the Standard Days Method until the start of her next monthly bleeding.
  - She can start symptoms-based methods once normal secretions have returned.

Explaining how to use Fertility Awareness Methods

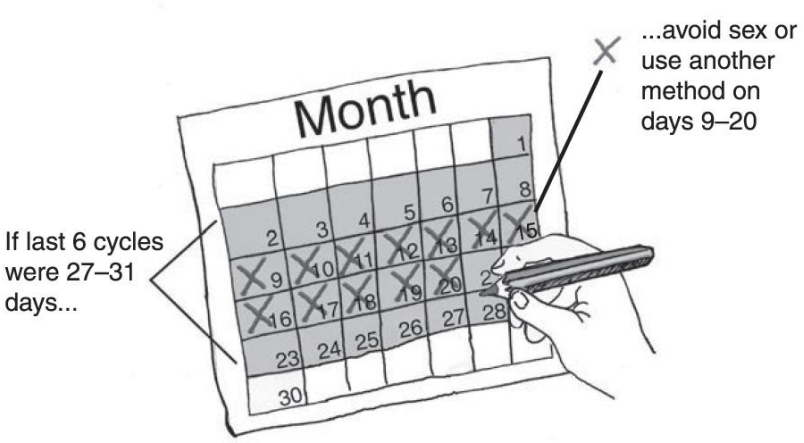
Standard Days Method

IMPORTANT: A woman can use the Standard Days Method if most of her menstrual cycles are 26 to 32 days long. If she has more than 2 longer or shorter cycles within a year, the Standard Days Method will be less effective and she may want to choose another method.

Keep track of the days of the menstrual cycle	• A woman keeps track of the days of her menstrual cycle, counting the first day of monthly bleeding as day 1.
Avoid unprotected sex on days 8–19	• Days 8 through 19 of every cycle are considered fertile days for all users of the Standard Days Method. • The couple avoids vaginal sex or uses condoms or a diaphragm during days 8 through 19. They can also use withdrawal or spermicides, but these are less effective. • The couple can have unprotected sex on all the other days of the cycle—days 1 through 7 at the beginning of the cycle and from day 20 until her next monthly bleeding begins.

Calendar Rhythm Method

Keep track of the days of the menstrual cycle	• Before relying on this method, a woman records the number of days in each menstrual cycle for at least 6 months. The first day of monthly bleeding is always counted as day I.
Estimate the fertile time	• The woman subtracts 18 from the length of her shortest recorded cycle. This tells her the estimated first day of fertile time. Then she subtracts II days form the length of her longest recorded cycle. This tells her the estimated last day of her fertile time
Avoid unprotected sex during fertile time	• The couple avoids vaginal sex, or uses condoms or a diaphragm, during the fertile time. They can also use withdrawal or spermicides, but these are less effective.
Update calculations monthly	• She updates these calculations such month always using the 6 most recent cycles. Example: - If the shortest of her last 6 cycles was 27 days, 27-18=9. She starts avoiding unprotected sex on day 9. - If the longest of her last 6 cycles was 31 days 31-11=20. She can have unprotected sex again on day 21. - Thus, she must avoid unprotected sex from day 9 through day 20 of her cycle.

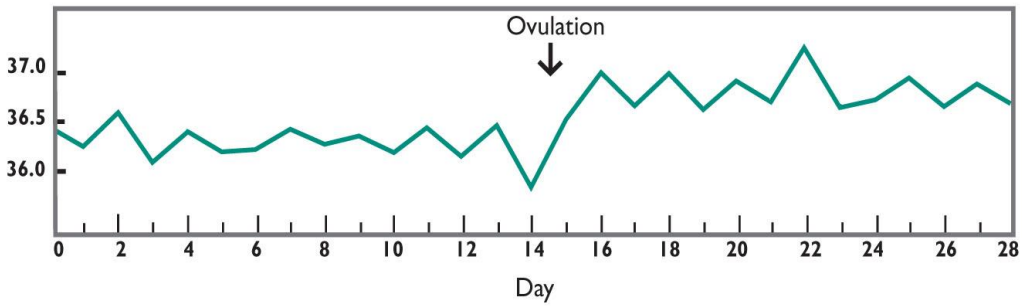


Two Day Method

IMPORTANT: If a woman has a vaginal infection or another condition that changes cervical mucus, the TwoDay Method will be difficult to use.	
Check for secretions	The woman checks for cervical secretions every afternoon and/or evening, on fingers, underwear, or tissue paper or by sensation in or around the vagina. • As soon as she notices any secretions of any type, color, or consistency, she considers herself fertile that day and the following day.
Avoid sex or use another method on fertile days	• The couple avoids vaginal sex or uses condoms or a diaphragm on each day with secretions and on each day following a day with secretions. They can also use withdrawal or spermicides, but these are less effective.
Resume unprotected sex after 2 dry days	• The couple can have unprotected sex again after the woman has had 2 dry days (days without secretions of any type) in a row.

Basal Body Temperature (BBT) Method

IMPORTANT: If a woman has a fever or other changes in body temperature, the BBT method will be difficult to use.	
Take body temperature daily	• The woman takes her body temperature at the same time each morning before she gets out of bed and before she eats anything. She records her temperature on a special graph. • She watches for her temperature to rise slightly—0.2° to 0.5°C (0.4° to 1.0°F)— just after ovulation (usually about midway through the menstrual cycle).
Avoid sex or use another method until 3 days after the temperature rise	• The couple avoids vaginal sex or uses condoms or a diaphragm from the first day of monthly bleeding until 3 days after the woman's temperature has risen above her regular temperature. They can also use withdrawal or spermicides, but these are less effective.
Resume unprotected sex until next monthly bleeding begins	• When the woman's temperature has risen above her regular temperature and stayed higher for 3 full days, ovulation has occurred, and the fertile period has passed. • The couple can have unprotected sex on the 4th day and until her next monthly bleeding begins.



Ovulation Method

IMPORTANT: If a woman has a vaginal infection or another condition that changes cervical mucus, this method may be difficult to use.

Check cervical secretions daily	• The woman checks every day for any cervical secretions on fingers, underwear, or tissue paper or by sensation in or around the vagina.
Avoid unprotected sex on days of heavy monthly bleeding	• Ovulation might occur early in the cycle, during the last days of monthly bleeding, and heavy bleeding could make mucus difficult to observe.
Resume unprotected sex until secretions begin	• Between the end of monthly bleeding and the start of secretions, the couple can have unprotected sex, but not on 2 days in a row. (Avoiding sex on the second day allows time for semen to disappear and for cervical mucus to be observed.) • It is recommended that they have sex in the evenings, after the woman has been in an upright position for at least a few hours and has been able to check for cervical mucus.
Avoid unprotected sex when secretions begin and until 4 days after "peak day"	• As soon as she notices any secretions, she considers herself fertile and avoids unprotected sex. • She continues to check her cervical secretions each day. The secretions have a "peak day"—the last day that they are clear, slippery, stretchy, and wet. She will know this has passed when, on the next day, her secretions are sticky or dry, or she has no secretions at all. She continues to consider herself fertile for 3 days after that peak day and avoids unprotected sex. 
Resume unprotected sex	• The couple can have unprotected sex on the 4th day after her peak day and until her next monthly bleeding begins.

Symptothermal Method (basal body temperature+ cervical secretions + other fertility signs)

Avoid unprotected sex on fertile days	• Users identify fertile and nonfertile days by combining BBT and ovulation method instructions. • Women may also identify the fertile time by other signs such as breast tenderness and ovulatory pain (lower abdominal pain or cramping around the time of ovulation). • The couple avoids unprotected sex between the first day of monthly bleeding and either the fourth day after peak cervical secretions or the third full day after the rise in temperature (BBT), whichever happens later. • Some women who use this method have unprotected sex between the end of monthly bleeding and the beginning of secretions, but not on 2 days in a row.

Managing any problems

- For a woman unable to abstain from sex during fertile time, suggest using a barrier method or sexual contact without vaginal sex. If she has had unprotected sex in the past 5 days she can use ECPs.
- If a woman has 2 or more cycle outside the 26-32-day range within any 12 months, suggest her to use calendar rhythm method or a symptoms-based method.
- If a woman's menstrual cycle is very irregular, suggest her using symptoms-based method.
- If a woman is difficult to recognize the different types of secretions for the ovulation method, counsel and provide her additional guidance for how to interpret cervical secretions or suggest her to use TwoDay Method which does not require the user to tell the difference among types of secretions.
- If a woman is difficult to recognize the presence of secretions for the ovulation method or the TwoDay Method, counsel and provide her additional guidance for how to recognize cervical secretions or suggest her to use calendar-based method.

7.9: LACTATIONAL AMENORRHEA METHOD

Key Points

- ❖ A family planning method based on breastfeeding. Provides contraception for the mother and best feeding for the baby.
- ❖ Can be effective for up to 6 months after childbirth, as long as monthly bleeding has not returned and the woman is fully or nearly fully breastfeeding.
- ❖ Requires breastfeeding often, day and night. Almost all of the baby's feedings should be breast milk.
- ❖ Provides an opportunity to offer a woman an ongoing method that she can continue to use after 6 months.

- A temporary family planning method based on the natural effect of breastfeeding on fertility.
- The lactational amenorrhea method (LAM) requires 3 conditions. All 3 must be met:
  1. The mother's monthly bleeding has not returned
  2. The baby is fully or nearly fully breastfed and is fed often, day and night
  3. The baby is less than 6 months old

- "Fully breastfeeding" includes both exclusive breastfeeding (the infant receives no other liquid or food, not even water, in addition to breast milk) and almost-exclusive breastfeeding (the infant receives vitamins, water, juice, or other nutrients once in a while in addition to breast milk).
- "Nearly fully breastfeeding" means that the infant receives some liquid or food in addition to breast milk, but the majority of feedings (more than three-fourths of all feeds) are breast milk.
- **Can be effective for up to 6 months after childbirth,** as long as monthly bleeding has not returned and the woman is fully or nearly fully breastfeeding.
- Works primarily by preventing the release of eggs from the ovaries (ovulation). Frequent breastfeeding temporarily prevents the release of the natural hormones that cause ovulation.

Side Effects, Health Benefits, and Health Risks

Side Effects: None. Any problems are the same as for other breastfeeding women.
Helps protect against:
risks of pregnancy
Encourages that is the best breast-feeding patterns and there are health benefits for both mother and baby.

Who can and cannot use LAM
All breastfeeding women can safely use LAM, but a woman in the following circumstances may want to consider other contraceptive methods:

- ❖ Has HIV infection including AIDS
- ❖ Is using certain medications during breastfeeding (including mood altering drugs, reserpine, ergotamine, anti-metabolites, cyclosporine, high doses of corticosteroids, bromocriptine, radioactive drugs, lithium, and certain anticoagulants)
- ❖ The newborn has a condition that makes it difficult to breastfeed (including being small-for-date or premature and needing intensive neonatal care, unable to digest food normally, or having deformities of the mouth, jaw, or palate)

Women who are infected with HIV or who have AIDS can use LAM.

Breastfeeding will not make their condition worse. There is a chance, however, that mothers with HIV will transmit HIV to their infants through breastfeeding. Without any antiretroviral (ARV) therapy, if infants of HIV-infected mothers are mixed-fed (breast milk and other foods) for 2 years, between 10 and 20 of every 100 will become infected with HIV through breast milk, in addition to those already infected during pregnancy and delivery. Exclusive breastfeeding reduces this risk of HIV infection through breastfeeding by about half.

Reducing the length of time of breastfeeding also greatly reduces the risk. For example, breastfeeding for 12 months reduces transmission by 50% compared with breastfeeding for 24 months. HIV transmission through breast milk is more likely among mothers with advanced disease or who are newly infected.

Women taking ARV therapy can use LAM. In fact, giving ARV therapy to an HIV-infected mother or an HIV-exposed infant very significantly reduces the risk of HIV transmission through breastfeeding. At 6 months—or earlier if her monthly bleeding has returned or she stops exclusive breastfeeding—a woman should begin to use another contraceptive method in place of LAM and continue to use condoms. Urge women with HIV to use condoms along with LAM.

Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.

When to start

- Start breastfeeding immediately (within one hour) or as soon as possible after the baby is born. In the first few days after childbirth, the yellowish fluid produced by the mother's breasts (colostrum) contains substances very important to the baby's health.
- Any time if she has been fully or nearly breastfeeding her baby since birth and her monthly bleeding has not returned.
- An ideal pattern is feeding on demand (that is, whenever the baby wants to be fed) and at least10 to 12 times a day in the first few weeks after childbirth and thereafter 8 to 10 times a day, including at least once at night in the first months.
- Daytime feedings should be no more than 4 hours apart, and night-time feedings no more than 6 hours apart.
- Some babies may not want to breastfeed 8 to 10 times a day and may want to sleep through the night. These babies may need gentle encouragement to breastfeed more often. She should start giving other foods in addition to breast milk when the baby is 6 months old.

Managing Any Breastfeeding Problems

If a client reports any of these common problems, listen to her concerns and give advice and support. Make sure she understands the advice and agrees.

Baby is not getting enough milk

- Reassure the woman that most women can produce enough breast milk to feed their babies.
- If the newborn is gaining more than 500 grams a month, weighs more than birth weight at 2 weeks, or urinates at least 6 times a day, reassure her that her baby is getting enough breast milk.
- Tell her to breastfeed her newborn about every 2 hours to increase milk supply.
- Recommend that she reduce any supplemental foods and/or liquids if the baby is less than 6 months of age.

Sore breasts

- If her breasts are full, tight, and painful, then she may have engorged breasts. If one breast has tender lumps, then she may have blocked ducts. Engorged breasts or blocked ducts may progress to red and tender infected breasts. Treat breast infection with antibiotics according to clinic guidelines. To aid healing, advise her to:
  - Continue to breastfeed often
  - Massage her breasts before and during breastfeeding
  - Apply heat or a warm compress to breasts
  - Try different breastfeeding positions
  - Ensure that the infant attaches properly to the breast
  - Express some milk before breastfeeding

Sore or cracked nipples

- If her nipples are cracked, she can continue breastfeeding. Assure her that they will heal with time.
- To aid healing, advise her to:
  - Apply drops of breast milk to the nipples after breastfeeding and allow to air-dry.
  - After feeding, use a finger to break suction first before removing the baby from the breast.
  - Do not wait until the breast is full to breastfeed. If full, express some milk first.
- Teach her about proper attachment and how to check for signs that the baby is not attaching properly.
- Tell her to clean her nipples with only water only once a day and to avoid soaps and alcohol-based solutions.
- Examine her nipples and the baby's mouth and buttocks for signs of fungal infection (thrush).

7.10: WITHDRAWAL

Key Points

- ❖ One of the least effective contraceptive methods:
- ❖ Always available in every situation.
- ❖ Promotes male involvement and couple communication.

What is withdrawal?

- The man withdraws his penis from his partner's vagina and ejaculates outside the vagina, keeping his semen away from her external genitalia. Also known as coitus interrupts and "pulling out."
- Works by keeping sperm out of the woman's body.

Side Effects, Health Benefits, and Health Risks

None

Who can and cannot use Withdrawal

All men can use withdrawal. No medical conditions prevent its use.

Explaining how to use –

- Before sex he should urinate and wipe the tip of his penis to remove any sperm remaining if man has ejaculated recently.
- When the man feels close to ejaculation, he should withdraw his penis from the woman's vagina and ejaculate outside the vagina, keeping his semen away from her external genitalia.
- Suggest the couple also use another method until the man feels that he can use withdrawal correctly with every act of sex.
- Some men may have difficulty using withdrawal because he cannot sense consistently when ejaculation is about to occur, or he ejaculate prematurely. Explain ECP use in case a man ejaculates before withdrawing.

CHAPTER VIII: SERVING THE PEOPLE WITH SPECIAL NEEDS

8.1. ADOLESCENTS AND YOUTHS

Adolescents are the young people between the age of 15 to 24 years.

Pregnancy among adolescents is associated with several potential medical problems, including: high health risk, unsafe abortion, inadequate or lack of antenatal care and sexually transmitted disease from unprotected sex. Adolescent pregnancy also has social consequences, such as loss of educational and employment opportunities as well as emotional and financial unpreparedness for raising a child.

Reproductive Health counseling and services must be made accessible, available, affordable, and acceptable for adolescents and youths, in a supportive and non-judgmental environment. Just like any client, young individuals must be assured of confidentiality and privacy and must not be subjected to unnecessary procedures before they can avail of the appropriate contraceptive method.

Provide Services with Care and Respect:

Young people deserve nonjudgmental and respectful care no matter how young they are. Criticism or unwelcoming attitudes will keep young people away from the care they need.

To make services friendly to youths:

- Show young people that you enjoy working with them.
- Counsel in private areas where you cannot be seen or overheard. Ensure confidentiality and assure the client of confidentiality.
- Listen carefully and ask open-ended questions such as “How can I help you?” and “What questions do you have?”
- Use simple language and avoid medical terms.
- Use terms that suit young people. Avoid such terms as “family planning,” which may seem irrelevant to those who are not married.
- Welcome partners and include them in counseling, if the client desires.
- Try to make sure that a young woman’s choices are her own and are not pressured by her partner or her family. In particular, if she is being pressured to have sex, help a young woman think about what she can say and do to resist and reduce that pressure. Practice skills to negotiate condom use.

- Speak without expressing judgment (for example, say “You can” rather than “You should”). Do not criticize even if you do not approve of what the young person is saying or doing. Help young clients make decisions that are in their best interest.
- Take time to fully address questions, fears, and misinformation about sex, sexually transmitted infections (STIs), and contraceptives. Many young people want reassurance that the changes in their bodies and their feelings are normal. Be prepared to answer common questions about puberty, monthly bleeding, masturbation, night-time ejaculation, and genital hygiene.

Recommended Contraceptive Methods for Adolescents and Youths

All contraceptives are safe for young people. Unmarried and married youth may have different sexual and reproductive health needs.

Young women are often less tolerant of side effects than older women. With counseling, however, they will know what to expect and may be less likely to stop using their methods. Unmarried young people may have more sex partners than older people and so may face a greater risk of STIs. Considering STI risk and how to reduce it is an important part of counseling.

For young people, there are specific considerations for some contraceptive methods.

- Hormonal contraceptives (oral contraceptives, injectables, and implants): Injectables can be used without others knowing. Some young women find regular pill-taking particularly difficult.
- Emergency contraceptive pills (ECPs): Young women may have less control than older women over having sex and using contraception. They may need ECPs more often. Provide young women with ECPs in advance, for use when needed. ECPs can be used whenever she has any unprotected sex, including sex against her will, or a contraceptive mistake has occurred.
- Female sterilization: Provide with great caution. Young people and people with few or no children are among those most likely to regret sterilization.
- Male and female condoms: Protect against both STIs and pregnancy, which many young people need. Readily available, and they are affordable and convenient for occasional sex. Young men may be less successful than older men at using condoms correctly. They may need practice putting condoms on.
- Intrauterine device: IUDs are more likely to come out among women who have not given birth because their uteruses are small.
- Fertility awareness methods: Until a young woman has regular menstrual cycles, fertility awareness methods should be used with caution. Need a backup method or ECPs on hand in case abstinence fails.

- Withdrawal: Requires the man to know when he is about to ejaculate so he can withdraw in time. This may be difficult for some young men. One of the least effective methods of pregnancy prevention, but it may be the only method available—and always available—for some young people.

8.2: CLIENTS WITH STIS, HIV AND AIDS

Clients with STIs, HIV, AIDS, or on antiretroviral (ARV) therapy can start and continue to use most contraceptive methods safely. In general, contraceptives and ARV medications do not interfere with each other. However, dual protection is critical in reducing transmission of STIs and HIV. Using dual method helps clients with STIs, HIV and AIDS to prevent transmission to an uninfected partner. There are a few special family planning considerations for clients with SITs, HIV, AIDS or on antiretroviral therapy as table below.

Method	Client with STIs	Client with HIV or AIDS	Client on Anti-retroviral Therapy
Intrauterine device	Do not insert an IUD in a woman who is at very high individual risk for gonorrhea and chlamydia, or who currently has gonorrhea, chlamydia, purulent cervicitis, or PID. (A current IUD user who becomes infected with gonorrhea or chlamydia or develops PID can safely continue using an IUD during and after treatment.)	A woman with HIV can have an IUD inserted. A woman with AIDS should not have an IUD inserted unless she is clinically well on ARV therapy. (A woman who develops AIDS while using an IUD can safely continue using the IUD.)	Do not insert an IUD if client is not clinically well.
Female Sterilization	If client has gonorrhea, chlamydia, purulent cervicitis, or PID, delay sterilization until the condition is treated and cured.	Women who are infected with HIV, have AIDS, or are on antiretroviral therapy can safely undergo female sterilization. Special arrangements are needed to perform female sterilization on a woman with AIDS. Delay the procedure if she is currently ill with AIDS-related illness.	

Method	Client with STIs	Client with HIV or AIDS	Client on Anti-retroviral Therapy
Combined oral contraceptives, combined injectables	Can safely use combined hormonal methods.	Can safely use combined hormonal methods.	A woman can use combined hormonal Methods while taking ARVs
Progestin only pills	Can safely use progestin-only pills	Can safely use progestin-only pills.	A woman can use progestin only pills while taking ARVs.
Progestin-only injectables and implants	No special considerations. Can safely use progestin-only injectables or implants.		

* If woman with ARV wants to use hormonal contraception, check with MEC wheel.

8.3: CLIENTS WITH DISABILITY

Health care providers should treat people with disabilities in the same way that they should treat people without disabilities: with respect. People with disabilities have the same sexual and reproductive health needs and rights as people without disabilities, but often they are not given information about reproductive and sexual health or adequate care. The ability to make an informed choice may be compromised in persons with disability, including mental disability. The ability of the person with disability to use a contraceptive method in a timely way should also be considered. In view of these: Counseling and informed decision should involve parents, or next of kin, or guardians, depending on the degree of the mental disability. In the absence of these caretakers, the provider may decide, in the best interests of the client with serious mental disability, on a method choice. Some drugs that are used to treat mental disorders affect the bioavailability and efficacy of hormonal contraceptives. Hence, alternative methods of contraception should be considered. As much as possible, contraceptive methods that do not seriously demand user compliance (e.g. IUD, implants, surgical methods) should be encouraged, to ensure efficacy.

8.4: SURVIVORS OF SEXUAL VIOLENCE

Key points for violence against women
❖ Violence is not the woman's fault. It is very common. All health care providers can do something to help. ❖ Women experiencing violence have special health needs, many of them sexual and reproductive health needs and providers consider to support physical needs as well as psychological support.

Sexual violence is a public health problem and is associated with several physical, psychological, and emotional consequences. Healthcare providers are expected to provide counseling and social support to the survivors of sexual violence to promote quick recovery. Unwanted pregnancy is one of the complications of sexual violence. Hence, emergency contraception should be provided for all victims of sexual violence and rape, who are at risk of pregnancy.

Emergency contraceptive pills and the IUD are the two recommended types of emergency contraception.

There are two Emergency Contraceptive Pill regimens that can be used:

1) The levonorgestrel-only regimen: 1.5 mg of levonorgestrel in a single dose (this is the recommended regimen; it is more effective and has fewer side-effects), or
2) The combined estrogen-progestogen regime: two doses of 100 micrograms ethinylestradiol plus 0.5 mg of levonorgestrel taken 12 hours apart.
3) Ulipristal acetate (UPA) regimen: 30 mg ulipristal acetate single dose

Treatment with either regimen should be started as soon as possible after the rape since efficacy declines with time. Both regimens are effective when used up to 72 hours after the rape, and continue to be moderately effective if started between 72 hours and 120 hours (5 days) after.

The levonorgestrel regimen has been shown to cause significantly less nausea and vomiting than the Yuzpe regimen. If vomiting occurs within 2 hours of taking a dose, repeat the dose. In cases of severe vomiting, ECPs can be administered vaginally.

ECPs will not be effective in the case of a confirmed pregnancy. ECPs may be given when the pregnancy status is unclear and pregnancy testing is not available, since there is no evidence to suggest that the pills can harm the woman or an existing pregnancy. There are no other medical contraindications to use of ECPs.

Whenever prepackaged ECPs are not available, oral contraceptives can be substituted. Considering these facts, ECPs should be provided for all survivors of rape who are at risk of pregnancy and who present within five days of the assault.

The Copper Bearing IUD can be used as emergency contraception if the survivor presents within five days after the rape (and if there was no earlier unprotected sexual act in this menstrual cycle). It will prevent more than 99% of expected subsequent pregnancies. Women should be offered counseling on this service so as to reach an informed decision. A skilled provider should counsel the patient and insert the IUD. If an IUD is inserted, make sure to give full STI treatment. The IUD may be removed at the time of the woman's next menstrual period or left in place for future contraception.

8.5: WOMEN NEAR MENOPAUSE

Menopause usually occurs between the age of 45 to 55, a woman has reached menopause when her ovaries stop releasing eggs. (Ovulating) Because bleeding does not come every month as menopause approaches, a woman is considered no longer fertile once she has gone 12 months in a row without having any bleeding.

To prevent pregnancy until it is clear that she is no longer fertile, an older woman can use any method, if she has no medical condition that limits its use. By itself, age does not restrict a woman from using any contraceptive method.

When helping woman near menopause choose the methods consider：

Combined hormonal methods (combined oral contraceptive (CoC) and mothly injectable)

- Women age 35 and older who smoke—regardless of how much—should not use COCs.
- Women age 35 and older who smoke 15 or more cigarette a day should not use monthly injectables.
- Women age 35 or older should not use COCs, monthly injectables if they have migraine headaches (whether with migraine aura or not)

Progestin only methods (progestin only pills, progestin only injectables, implants)

- A good choice for women who cannot use methods with estrogen.
- During use, DMPA decreases bone mineral density slightly. This may increase the risk of developing osteoporosis and possibly having bone fracture later, after menopause. WHO has conducted that this decrease in bone mineral density does not place age or time limits on use of DMPA.

Emergency contraceptive pills

- Can be used by women of any age, including those who cannot use hormonal methods on a continuing basis.

Female sterilization and vasectomy

- May be a good choice for older women and their partners who know they will not want more children.
- Older women are more likely to have conditions that require delay, referral, or caution for female sterilization.

Male and female condoms, spermicides, cervical caps and withdrawal

- Protect older women well because of women's reduced fertility in the years before menopause.
- Affordable and convenient for women who may not have sex often

Intrauterine device

- Expulsion rates fall as women grow older and are lowest in women over 40 years of age.
- Insertion may be more difficult due to tightening of the cervical canal.

Fertility awareness method

- Lack of regular cycles before menopause makes it more difficult to use these methods reliably.

When a Woman Can Stop Using Family Planning

- Because bleeding does not come every month in the time before menopause, it is difficult for a woman whose bleeding seems to have stopped to know when to stop using contraception. Thus, it is recommended to continue using contraception. Thus, it is recommended to continue using a family planning method until 12 months with no bleeding have passed.
- Hormonal methods affect bleeding, and so it may be difficult to know if a woman using them has reached menopause. She can switch to a nonhormonal method. She no longer needs contraception once she has had no bleeding for 12 months in a row.
- Copper- bearing IUDs can be left in place until after menopause. The IUD should be removed 12 months after woman's last monthly bleeding.

Relieving Symptoms of Menopause

- Women experience physical effects before, during, and after menopause: hot flushes, excess sweating, difficult holding urine, vaginal dryness that can have sex painful, and difficult sleeping.
- Providers can suggest ways to reduce some of these symptoms：
- Deep breathing from the diaphragm may make a hot flush go away faster. A woman can also try eating foods containing soy or taking 800 international units per day of vitamin E.
- Eat foods rich in calcium (such as dairy products, beans, fish) and engage in moderate physical activity to help slow the loss of bone density that comes with menopause.
- Vaginal lubricants or moisturizers can be used if vaginal dryness persists and causes irritation. During sex, use a commercially available vaginal lubricants, water, or saliva as a lubricant if vaginal dryness is a problem.

8.6: INFERTILITY

Key points for Infertility
❖ Infertility often can be prevented. Avoiding sexually transmitted infections and receiving prompt treatment for these and other reproductive tract infections can reduce a client's risk of infertility.

Involuntary infertility is a disease of the reproductive system: the inability to become pregnant when desired children, whether due to inability to achieve pregnancy or due to stillbirth or miscarriage. Infertility is defined by "failure to establish a clinical pregnancy after 12 months of regular unprotected sexual intercourse "between a man and a woman. (on average, 85% of women would be pregnant by then)

There are differences among regions. In some countries or communities, infertility or childlessness can have drastic consequences, especially for women but also with significant impact on men. These consequences can include economic deprivation, divorce, stigma and discrimination, isolation, intimate partner violence, murder, mental health disorders, and suicide.

Causes of Involuntary fertility

- Counsel clients about STI prevention including HIV, encourage clients to seek treatment as soon as they think they might have an STI or might have been exposed.
- Treat or refer clients with signs and symptoms of STI and clinical PID, treating these infections can help to prevent infertility.
- Avoid causing infection by following proper infection-prevention practices when performing medical procedures that pass instruments from the vagina into the uterus, such as IUD insertion.
- Treat or refer clients with signs or symptoms of infection postpartum or post abortion.
- Help clients with fertility problems become aware of risks to fertility not only infection but also lifestyle and environmental factors.
- Counsel clients about available options for their future childbearing—that is, fertility preservation techniques such as sperm freezing for men and in vitro fertilization for freezing eggs- if they are being treated or are having surgery for cancer or other diseases that may affect reproductive tissue or organs.

Contraceptives do not cause infertility

- With most modern contraceptive methods, there is no significant delay in the time to desired pregnancy after contraception is stopped. On average, pregnancy occurs after 3 to 6 months of unprotected sex. There is great variation around this average, however, related to the age and the health status of the individuals in the couple. When counseling couples who stop contraception, and want to have child, aging and other factors affecting the fertility of the woman and the man to be considered.
- The return of fertility after injectable contraceptives are stopped usually takes longer than with most other methods. In time, however, a woman is as fertile as before using the method, taking aging into account.
- Among woman with current gonorrhea or chlamydia, IUD insertion slightly increases the risk of pelvic inflammatory disease in the first 20 days after insertion. However, research has not found that former IUD users are more likely to be infertile than other women.

Counseling clients with infertility problem

- Counsel both partners together, if possible. A man may blame his partner for infertility when he himself may be responsible for the inability of the woman to become pregnant or to maintain a pregnancy.

- Explain that a man is just as likely to have fertility problems as a woman. In more than 40% of couples with fertility problems, it is because of semen or sperm abnormalities, or other health problems of the male partners. In 20% of couples with fertility problems, both male and female factors reduce fertility. Sometimes it is not possible to find the cause of the problem.
- Recommend that the couple attempt pregnancy with unprotected sex for at least 12 months before they suspect infertility. Provide educational materials and guidance on risks to fertility.
- The most fertile time of woman's cycle is several days before and at the time of ovulation. Fertility awareness methods can help couples identify the most fertile time of each cycle. Provide educational material about these methods and/or refer the couple to fertility care provider or specialist.
- If, after one year, following the suggestion above has not resulted in a pregnancy or live birth, refer both partners to a qualified fertility care provider for evaluation and assessment, if available. Referral to fertility care provider or specialist may be particularly helpful in the following situation: the couple is affected by HIV or suspected genital TB; woman is age 35 or older, she has polycystic ovary syndrome or has been diagnosed with endometriosis; the woman or the man suspects they had an STI and it was not treated; either had been treated for a cancer or had surgery that may have affected the reproductive tissue or organs.
- The couple also may want to consider adoption or other alternatives to having children or more children of their own, such as taking in nieces and nephews.

8.7: FAMILY PLANNING IN POST ABORTION CARE

Key points for providers and clients
• Post abortive care • Fertility returns quickly within 8 days, after abortion or miscarriage. Women need to start using a family planning method almost immediately to avoid unplanned pregnancy. (post abortive family planning)

Women who have just been treated for post abortion complications need easy and immediate access to family planning services, health care providers can offer these women family planning services, including those who provide post abortive care. When such services are integrated with post abortive care, are offered immediately post abortion, or nearby, women are more likely to use contraception when they face the risk of unintended pregnancy.

Help women obtain family planning

Counsel with compassion

A woman who has had post abortion complications needs support. A woman who has faced the double risk of pregnancy and unsafe induced abortion especially needs help and support. Good counseling gives support to the woman who has just treated for post abortion complications. In particulars:

- Try to understand what she has been through
- Treat her with respect and avoid judgement and critism
- Ensure privacy and confidentially
- Ask if she wants someone she trust to be present during counseling

Provide important information

A woman has important choices to make after receiving post abortion care. To make decisions about her health and fertility, she needs to know:

Fertility returns quickly—within 8 days after a first-trimester abortion or miscarriage. Therefore, she needs protection from pregnancy almost immediately.

She can choose among many different family planning methods that she can start at once. Methods that women should not use immediately after giving birth pose no special risks after treatment for abortion complications.

- She can wait before choosing a contraceptive for ongoing use, but she should consider using backup methods (abstinence, withdrawal, male or female condoms, spermicides) in the meantime if she has sex. If a woman decides not to use contraceptives at this time, providers can offer information on available methods and where to obtain them. Also, providers can offer condoms, contraceptive pills for women to take home and use later.

- To avoid infection, she should not have sex until bleeding stops—about 5 to 7 days. If being treated for infection or vaginal or cervical injury, she should wait to have sex again until she has fully healed.

- If she wants to become pregnant again soon, encourage her to wait. Waiting at least 6 months may reduce the chances to low birth weight, premature birth, and maternal anemia.

A woman receiving post abortive care may need other reproductive health services. In particular, a provider can help her consider if she might have been exposed to sexually transmitted infections.

When to start contraceptives

- Combined oral contraceptives, progestin-only pills, progestin-only injectables, monthly injectables, implants, male condoms, female condoms, and withdrawal can be started immediately in every case, even if the woman has injury to the genital tract or has a possible or confirmed infection.

- IUDs, female sterilization, and fertility awareness methods can be started once infection is ruled out or resolved.

- IUDs, female sterilization, and fertility awareness methods can be started once any injury to the genital tract has healed.

Special consideration

IUD insertion immediately after a second-trimester abortion requires a specially trained provider.

Female sterilization must be decided upon in advance, and not while a woman is sedated, under stress, or in pain. Counsel carefully and be sure to mention available reversible methods.

Fertility awareness methods: A woman can start symptoms-based methods once she has no infection- related secretions or bleeding due to injury to the genital tract. She can start calendar-based methods with her next monthly bleeding, if she is not having bleeding due to injury to the genital tract. (Difficult to use)

8.8: MOBILE groups including migrants and internally displaced persons(IDPs)

Key points for migrants, IDP and mobile communities
Due to the mobile nature of these clients they have specific vulnerability and needs regarding sexual and reproductive health including family planning. These groups might have access to family planning.

- Mobile groups often face health inequities, human rights violations, stigmatization, marginalization and discriminatory policies. During transit and upon arrival, such vulnerability is influenced by legal status, poverty, stigma/discrimination, insecure living conditions, fear of authorities and cultural and linguistic differences. For instance, migrant women often work in unregulated and often poorly paid informal sector, e.g. trade, domestic work, agriculture, etc., are exposed to conditions that increase their health risks as well as their vulnerability to gender-based violence. They have reduced access to sexual and reproductive health services, including where how to access services. Thus, they often experience higher incidences of SRH negative outcomes.

- In humanitarian settings, child bearing risks are compounded for women, due to increased exposure to forced sex, increased risk taking and reduced availability of and sensitivity to sexual and reproductive health services, including adolescent sexual and reproductive health.

When counseling mobile clients keep in mind their barriers and address where possible. Also, in recommending family planning methods, be aware of their mobile status.

JOB AID AND TOOL

JOB AID AND TOOL: 1. COMPARING COMBINED METHODS

Characteristic	Combined Oral Contraceptives	Monthly Injectables
How it is used	Pill taken orally.	Intramuscular injection.
Frequency of use	Daily.	Monthly: Injection every 4 weeks.
Effective- ness	Depends on user's ability to take a pill every day.	Least dependent on the user. User must obtain injection every 4 weeks (plus or minus 7 days)
Bleeding patterns	Typically, irregular bleeding for the first few months and then lighter and more regular bleeding.	Irregular bleeding or no monthly bleeding is more common than with COCs. Also, some have prolonged bleeding in the first few months.
Privacy	No physical signs of use but others may find the pills.	No physical signs of use.

JOB AID AND TOOL: 2. COMPARING INJECTABLES

Characteristic	DMPA	NET-EN	Monthly Injectables
Time between injections	3 months.	2 months.	1 month.
How early or late a client can have the next injection	2 weeks before or 4 weeks after scheduled injection date.	2 weeks before or after scheduled injection date.	7 days before or after scheduled injection date.
Injection technique	Deep intramuscular (IM) injection into the hip, upper arm, or buttock. Subcutaneous injection into back of upper arm, abdomen, or front of thigh.	Deep intramuscular injection into the hip, upper arm, or buttock. May be slightly more painful than DMPA-IM.	Deep intramuscular injection into the hip, upper arm, buttock, or outer thigh.
Typical bleeding patterns in first year	Irregular and prolonged bleeding at first, then no bleeding or infrequent bleeding. About 40% of users have no monthly bleeding after 1 year.	Irregular or prolonged bleeding in first 6 months but shorter bleeding episodes than with DMPA. After 6 months bleeding patterns are similar to those with DMPA. 30% of users have no monthly bleeding after 1 year.	Irregular, frequent, or prolonged bleeding in first 3 months. Mostly regular bleeding patterns by 1 year. About 2% of users have no monthly bleeding after 1 year.
Average weight gain	1–2 kg per year.	1–2 kg per year.	1 kg per year.
Pregnancy rate, as commonly	About 4 pregnancies per 100 women in the first year.	Assumed to be similar to DMPA.	About 3 pregnancies per100 women in the first year.
Average delay in time to pregnancy after stopping injections	4 months longer than for women who used other methods.	1 month longer than for women who used other methods.	1 month longer than for women who used other methods.

JOB AID AND TOOL. 3: COMPARING IMPLANTS

Characteristic	Jadelle	Implanon NXT	Levoplant
Type of progestin	Levonorgestrel	Etonogestrel	Levonorgestrel
Number	2 rods	1 rod	2 rods
Approved lifespan	5 years	3 years	4 years

JOB AID AND TOOL. 4: COMPARING CONDOMS

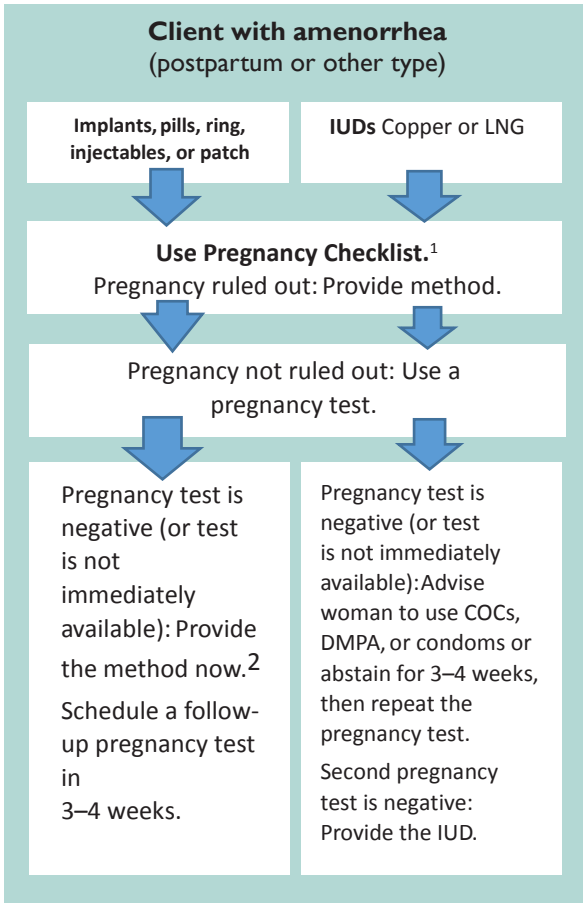
Characteristic	Male Condoms	Female Condoms
How to wear	Rolled onto man's penis. Fits the penis tightly.	Inserted into the woman's vagina. Loosely lines the vagina and does not constrict the penis.
When to put on	Put on erect penis right before sex.	Can be inserted up to 8 hours before sex.
Material	Most made of latex; some of synthetic materials or animal membranes.	Most made of a thin, synthetic film; a few are latex.
How they feel during sex	Change feeling of sex.	Fewer complaints of changed feeling of sex than with male condoms.
Noise during sex	May make a rubbing noise during sex.	May rustle or squeak during sex.
Lubricants to use	Users can add lubricants: • Water-based or silicone-based only. • Applied to outside of condom.	Users can add lubricants: • Water-based, silicone- based, or oil-based (but not with latex condoms). • Before insertion, applied to outside of condom. • After insertion, applied to inside of condom or to the penis.

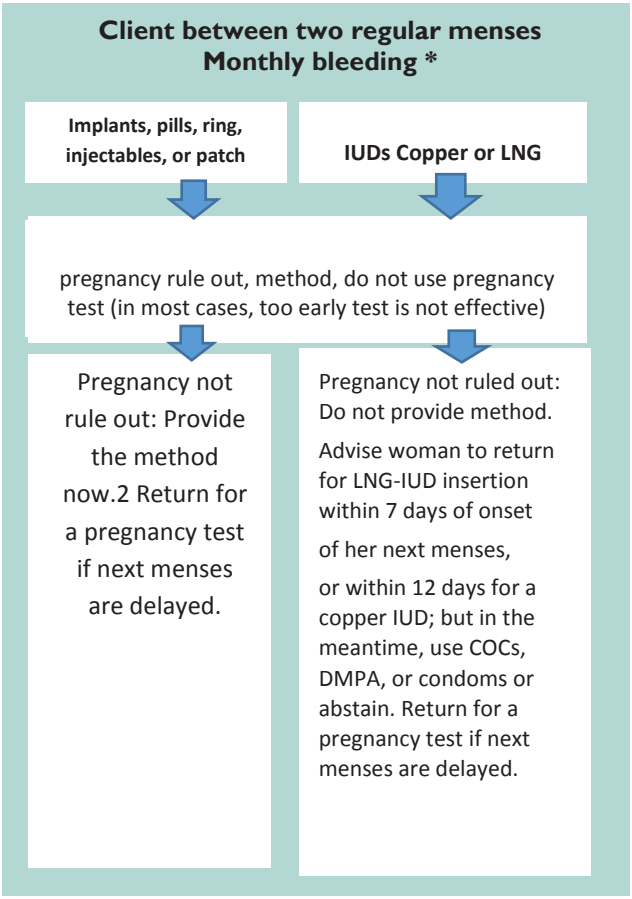
Breakage or slippage	Tend to break more often than female condoms.	Tend to slip more often than male condoms.
When to remove	Require withdrawing from the vagina before the erection softens.	Can remain in vagina after erection softens. Requires removal before woman stands.
What they protect	Cover and protect most of the penis, protect the woman's internal genitalia.	Cover both the woman's internal and external genitalia and the base of the penis.
How to store	Store away from heat, light, and dampness.	Plastic condoms are not harmed by heat, light or dampness.
Reuse	Cannot be reused.	Reuse not recommended (see Female Condoms, Question 5, p. 270).
Cost and availability	Generally low cost and widely available.	Usually more expensive and less widely available than male condoms.

JOB AID AND TOOL. 5: COMPARING IUDs

Characteristic	Copper-Bearing IUD	Levonorgestrel IUD
Effectiveness	Nearly equal. Both are among the most effective methods.	
Length of use	Approved for 10 years.	Approved for 3 to 5 years.
Bleeding patterns	Longer and heavier monthly bleeding, irregular bleeding, and more cramping or pain during monthly bleeding.	More irregular bleeding and spotting in the first few months. After 1 year no monthly bleeding is more common. Causes less bleeding than copper-bearing IUDs over time.
Anemia	May contribute to iron-deficiency anemia if a woman already has low iron blood stores before insertion.	May help prevent iron- deficiency anemia.
Main reasons for discontinuation	Increased bleeding and pain.	No monthly bleeding and hormonal side effects.
Noncontraceptive benefits	May help protect against endometrial cancer.	Effective treatment for long and heavy monthly bleeding (alternative to hysterectomy). May also help treat painful monthly bleeding. Can be used to provide the progestin in hormone replacement therapy.
Postpartum use	Can be inserted up to 48 hours postpartum. After 48 hours, delay until 4 weeks or more.	
Use as emergency contraception	Can be used within 5 days after unprotected sex.	Not recommended.
Insertion	Requires specific training.	
Cost	Less expensive.	More expensive.

JOB AID AND TOOL. 6.A: HOW AND WHEN TO USE PREGNANCY CHECKLIST AND PREGNANCY TEST





1 See inside back cover for Pregnancy Checklist.

2 For implants, counsel about the need to remove the implant if pregnancy is confirmed and she wishes to continue the pregnancy.

In cases where pregnancy cannot be ruled out, offer emergency contraception if the woman had unprotected sex within the last 5 days.

Counsel all women to come back any time they have a reason to suspect pregnancy (for example, she misses a period).

*** If the client presents with a late/missed menses, use a pregnancy test to rule out pregnancy. If using a highly sensitive pregnancy test** (for example, 25 mIU/ml) and it is negative, provide her desired method.

If using a test with lower sensitivity (for example,50 mIU/ml) and it is negative during the time of her missed period, wait until at least 10 days after expected date of menses and repeat the test. Advise the woman to use condoms or abstain in the meantime. If the test is still negative, provide her desired method.

If test sensitivity is not specified, assume lower sensitivity.

JOB AID AND TOOL. 6.B: PREGNANCY CHECKLIST

Ask the client questions 1–6. As soon as the client answers" yes" to any question, stop and follow the instruction below.

NO		YES
	1 Did your last monthly bleeding start within the past 7 days?*	
	2 Have you abstained from sexual intercourse since your last monthly bleeding, delivery, abortion, or miscarriage?	
	3 Have you been using a reliable contraceptive method consistently and correctly since your last monthly bleeding, delivery, abortion, or miscarriage?	
	4 Have you had a baby in the last 4 weeks?	
	5 Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no monthly bleeding since then?	
	6 Have you had a miscarriage or abortion in the past 7 days?*	

* If the client is planning to use a copper-bearing IUD, the 7-day window is expanded to 12 days.

If the client answered NO to all of the questions, pregnancy cannot be ruled out using the checklist. Rule out pregnancy by other means.

If the client answered YES to *at least one of the questions*, you can be reasonably sure she is not pregnant.

JOB AID AND TOOL. 7: MANAGING MISS PILLS (COC)

If You Miss Pills

Always take a pill as soon as you remember, and continue taking pills, one each day.

Also...

If you miss pills 3 days or more in a row, or if you start a pack 3 days or more late:

Use condoms or avoid sex for the next 7 days

If you miss those 3 or more pills in a row in week 3:

Use condoms or avoid sex for the next 7 days

Also, skip the nonhormonal pills (or skip the pill-free week) and start taking pills at once from the next pack

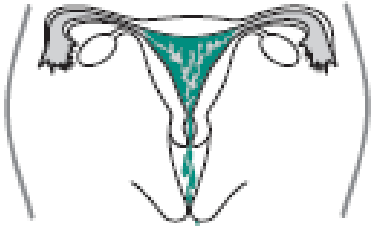
If you miss any nonhormonal pills (last 7 pills in 28-pill packs only):

Discard the missed pills and continue taking pills, one each day

JOB AID AND TOOL. 8: THE MENSTRUAL CYCLE

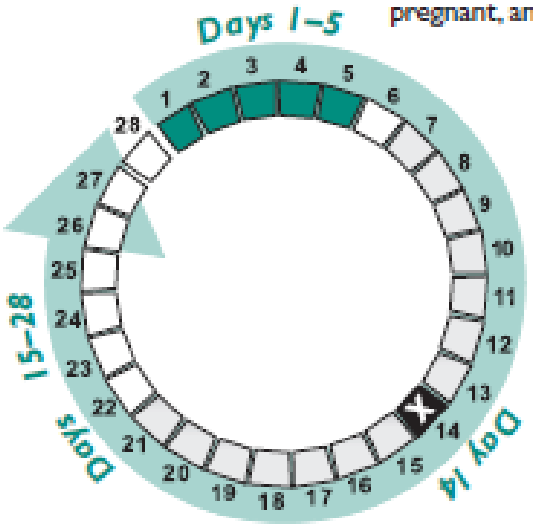
The Menstrual Cycle

1 Days 1–5: Monthly bleeding

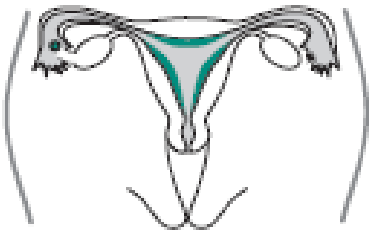


Usually lasts from 2–7 days, often about 5 days

If there is no pregnancy, the thickened lining of the womb is shed. It leaves the body through the vagina. This monthly bleeding is also called menstruation. Contractions of the womb at this time can cause cramps. Some women bleed for a short time (for example, 2 days), while others bleed for up to 8 days. Bleeding can be heavy or light. If the egg is fertilized by a man's sperm, the woman may become pregnant, and monthly bleeding stops.



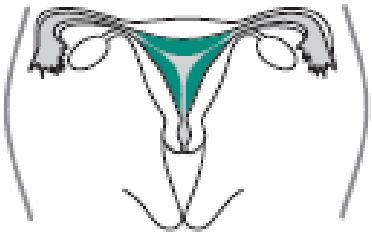
2 Day 14: Release of egg



Usually occurs between days 7 and 21 of the cycle, often around day 14

Usually, one of the ovaries releases one egg in each cycle (usually once a month). The egg travels through a fallopian tube towards the womb. It may be fertilized in the tube at this time by a sperm cell that has travelled from the vagina.

3 Days 15–28: Thickening of the womb lining



Usually about 14 days long, after ovulation

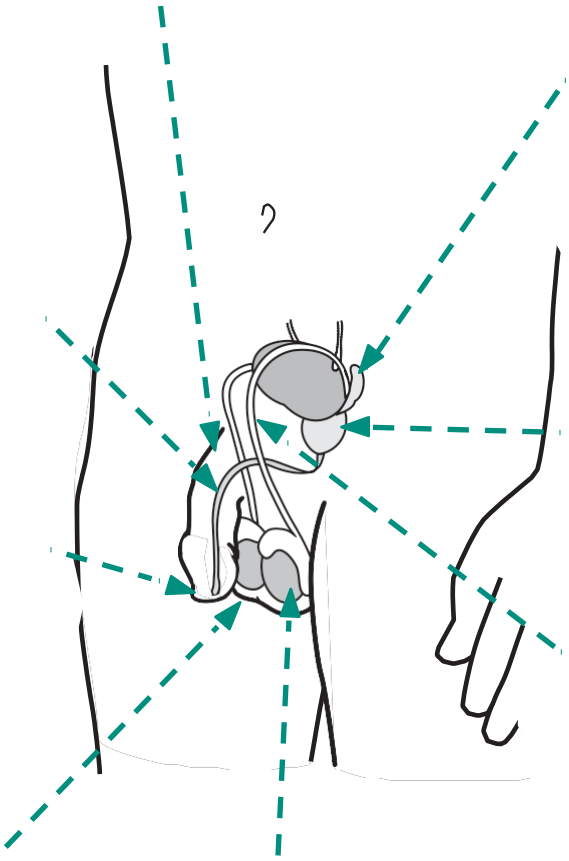
The lining of the uterus (endometrium) becomes thicker during this time to prepare for a fertilized egg. Usually there is no pregnancy, and the unfertilized egg cell dissolves in the reproductive tract.

JOB AID AND TOOL. 9.A: MALE ANATOMY

Male Anatomy

Penis
Male sex organ made of spongy tissue. When a man becomes sexually excited, it grows larger and stiffens. Semen, containing sperm, is released from the penis (ejaculation) at the height of sexual excitement (orgasm).
A *male condom* covers the erect penis, preventing sperm from entering the woman's vagina.

Urethra
Tube through which semen is released from the body. Liquid waste (urine) is released through



Seminal vesicles
Where sperm is mixed with semen.

Prostate
Organ that produces some of the fluid in semen.

Foreskin
Hood of
Skin covering the end of the penis.
Circumcision removes the foreskin..

Vas deferens
Each of the 2 thin tubes that carry sperm from the testicles to the seminal vesicles.
Vasectomy involves cutting or blocking these tubes so that no sperm enters the

Scrotum
Sack of thin loose skin containing the testicles.

Testicles
Organs that produce sperm.

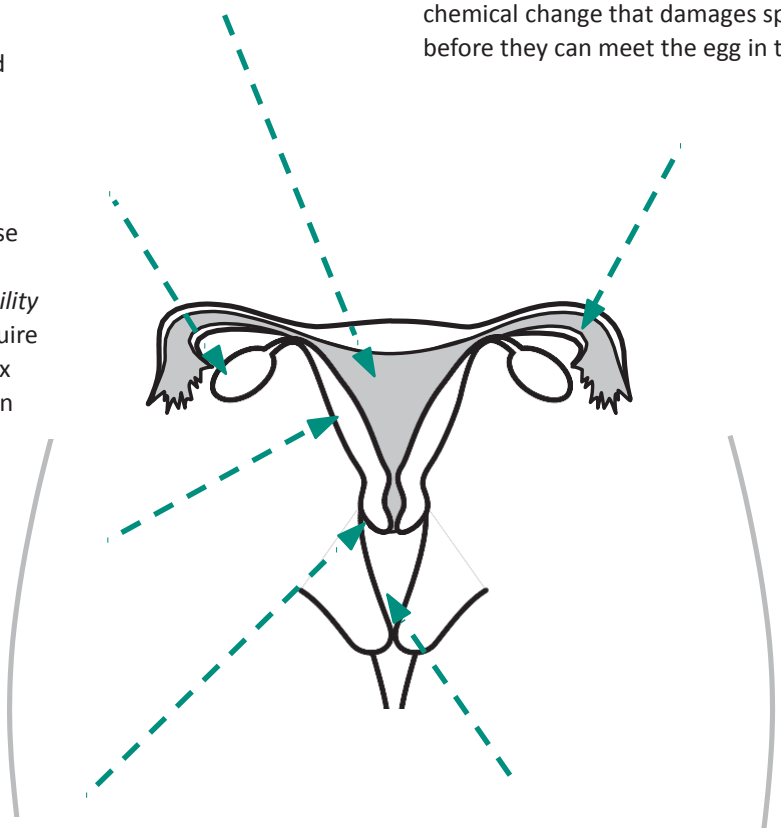
JOB AID AND TOOL. 9.B: FEMALE INTERNAL ANATOMY

Internal Anatomy

Womb (uterus)
Where a fertilized egg grows and develops into a fetus. *IUDs* are placed in the uterus, but they prevent fertilization in the fallopian tubes. *Copper-bearing IUDs* also kill sperm as they move into the uterus

Fallopian tube
An egg travels along one of these tubes once a month, starting from the ovary. Fertilization of the egg (awhen sperm meets the egg) occurs in these tubes. *Female sterilization* involves cutting or clipping the fallopian tubes. This prevents sperm and egg from meeting. *IUDs* cause a chemical change that damages sperm before they can meet the egg in the

Ovary
Where eggs develop and one is released each month. The *lactational amenorrhea method (LAM)* and *hormonal methods*, especially those with estrogen, prevent the release of eggs. *Fertility awareness methods* require avoiding unprotected sex around the time when an



Uterine lining
(endometrium)
Lining of the uterus, which gradually thickens and then is shed during monthly bleeding.

Cervix
The lower portion of the uterus, which extends into the upper vagina. It produces mucus. *Hormonal methods* thicken this mucus, which helps prevent sperm from passing through the cervix. Some *fertility awareness methods* require monitoring cervical mucus. The *diaphragm*, *cervical cap*, and *sponge*

Vagina
Joins the outer sexual organs with the uterus. The *combined ring* and the *progesterone-releasing vaginal ring* are placed in the vagina, where they release hormones that pass through the vaginal walls. The *female condom* is placed in the vagina, creating a barrier to sperm. *Spermicides* inserted into the vagina kill sperm.

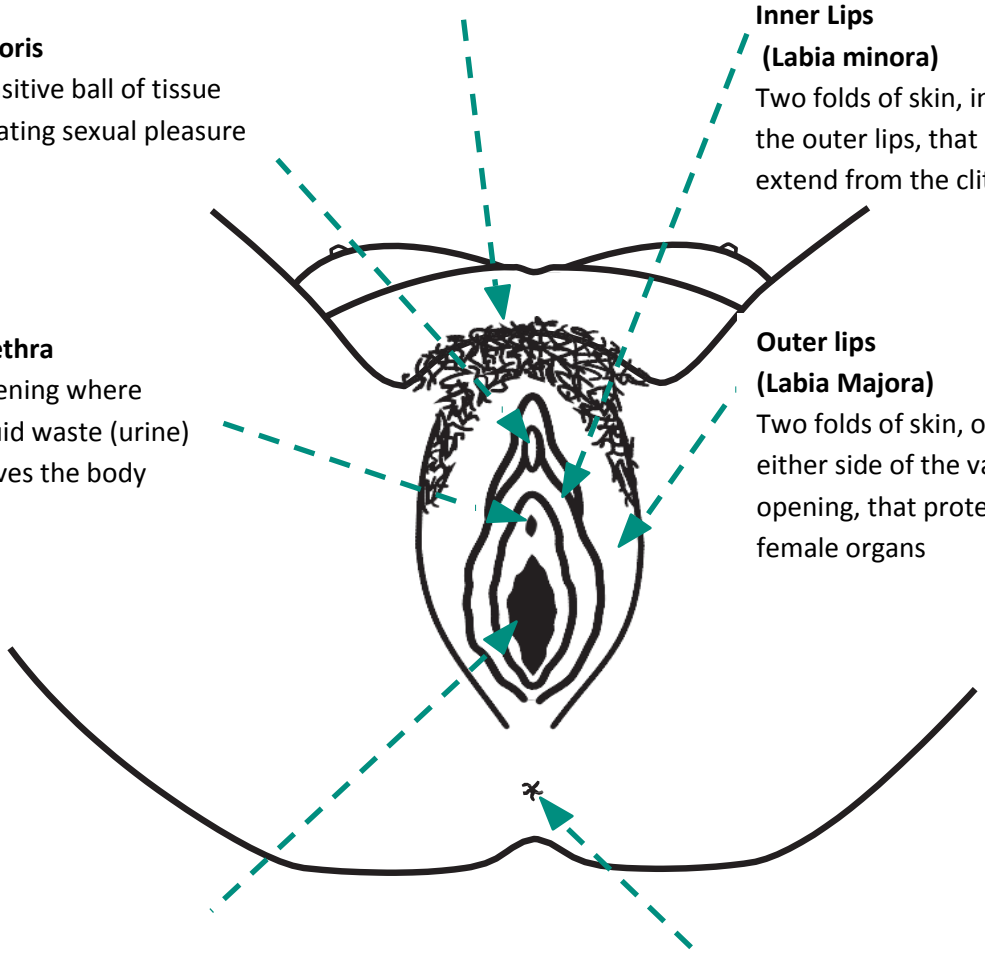
JOB AID AND TOOL. 9.C: FEMALE EXTERNAL ANATOMY

External Anatomy

Pubic hair
Hair that grows during puberty and surrounds the female organs

Clitoris
Sensitive ball of tissue creating sexual pleasure

Inner Lips
(Labia minora)
Two folds of skin, inside the outer lips, that extend from the clitoris



Urethra
Opening where liquid waste (urine) leaves the body

Outer lips
(Labia Majora)
Two folds of skin, one on either side of the vaginal opening, that protect the female organs

Vaginal opening
The man's penis is inserted here during sexual intercourse. Blood flows from here during monthly bleeding

Anus
Opening where solid waste (feces) leaves the body

ANNEX

ANNEX. 1: BASIC RULES OF INFECTION PREVENTION

These rules apply the universal precautions for infection prevention to the family planning clinic.

Wash Hands

- Hand washing may be the single most important infection-prevention procedure.
- Wash hands before and after examining or treating each client. (Hand washing is not necessary if clients do not require an examination or treatment.)
- Use clean water and plain soap, and rub hands for at least 10 to 15 seconds. Be sure to clean between the fingers and under fingernails. Wash hands after handling soiled instruments and other items or touching mucous membranes, blood, or other body fluids. Wash hands before putting on gloves, after taking off gloves, and whenever hands get dirty.
- Wash hands when you arrive at work, after you use the toilet or latrine, and when you leave work. Dry hands with a paper towel or a clean, dry cloth towel If clean water and soap are not available, a hand sanitizer containing at least 60% alcohol can reduce the number of germs on the hands. Sanitizers do not eliminate all types of germs and might not remove harmful chemicals.

Process instruments that will be reused

- High-level disinfect or sterilize instruments that touch intact mucous membranes or broken skin
- Sterilize instruments that touch tissue beneath the skin.

Wear Glass

- Wear gloves for any procedure that risks touching blood, other body fluids, mucous membranes, broken skin, soiled items, dirty surfaces, or waste. Wear surgical gloves for surgical procedures such as insertion of implants. Wear single-use examination gloves for procedures that touch intact mucous membranes or generally to avoid exposure to body fluids. Gloves are not necessary for giving injections.
- Change gloves between procedures on the same client and between clients.
- Do not touch clean equipment or surfaces with dirty gloves or bare hands.
- Wash hands before putting on gloves. Do not wash gloved hands instead of changing gloves. Gloves are not a substitute for hand washing.
- Wear clean utility gloves when cleaning soiled instruments and equipment, handling waste, and cleaning blood or body fluid spills.

Do pelvic examinations only when needed

- Pelvic examinations are not needed for most family planning methods—only for female sterilization, the IUD, diaphragm, and cervical cap. Pelvic examinations should be done only when there is a reason—such as suspicion of sexually transmitted infections, when the examination could help with diagnosis or treatment.

For injections, use new autodisable syringes and needles

- Auto-disable syringes and needles are safer and more reliable than standard single-use disposable syringes and needles, and any disposable syringes and needles are safer than sterilizing reusable syringes and needles. Sterilizing and reusing syringes and needles should be avoided. It might be considered only when single-use injection equipment is not available, and the program can document the quality of sterilization.
- Cleaning the client's skin before the injection is not needed unless the skin is dirty. If it is, wash with soap and water and dry with a clean towel. Wiping with an antiseptic has no added benefit.

Wipe surfaces with chlorine solution

- Wipe examination tables, bench tops, and other surfaces that come in contact with unbroken skin with 0.5% chlorine solution after each client.

Dispose of single use equipment and supplies properly and safely

- Use personal protective equipment—goggles, mask, apron, and closed protective shoes—when handling wastes.
- Needles and syringes meant for single use must not be reused. Do not take apart the needle and syringe. Used needles should not be broken, bent, or recapped. Put used needles and syringes immediately into a puncture-proof container for disposal. (If needles and syringes will not be incinerated, they should be decontaminated by flushing with 0.5% chlorine solution before they are put into the puncture-proof container.) The puncture-proof sharps container should be sealed and either burned, incinerated, or deeply buried when three-fourths full.
- Dressings and other soiled solid waste should be collected in plastic bags and, within 2 days, burned and buried in a deep pit. Liquid wastes should be poured down a utility sink drain or a flushable toilet or poured into a deep pit and buried.
- Clean waste containers with detergent and rinse with water.
- Remove utility gloves and clean them whenever they are dirty and at least once every day.
- Wash hands before and after disposing of soiled equipment and waste.

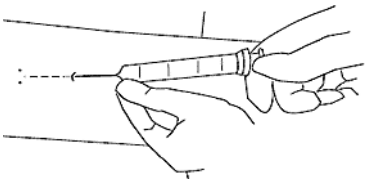
Wash linens

- Wash linens (for example, bedding, caps, gowns, and surgical drapes) by hand or machine and line-dry or machine-dry. When handling soiled linens, wear gloves, hold linens away from your body, and do not shake them.

ANNEX. 2: INSERTION AND REMOVAL OF IMPLANTS

Insertion of Jadelle

- A woman who has chosen implants needs to know what will happen during insertion. Inserting implants usually takes only a few minutes, but can sometimes take longer.
- Implant is inserted with a specially made applicator similar to a syringe. It does not require an incision.
- Learning to insert and remove implants requires training and practice under direct supervision.



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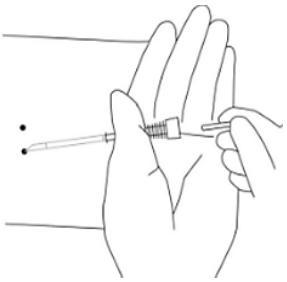

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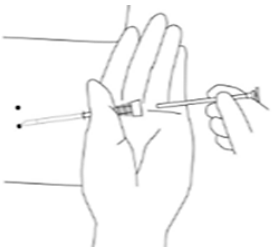

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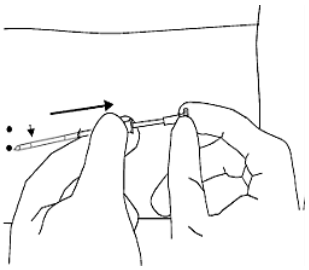

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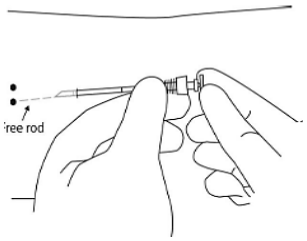

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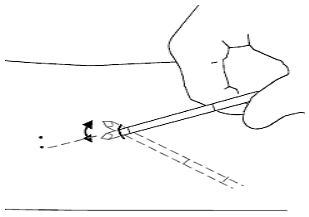

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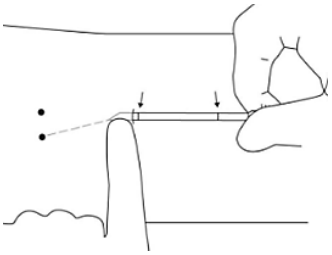

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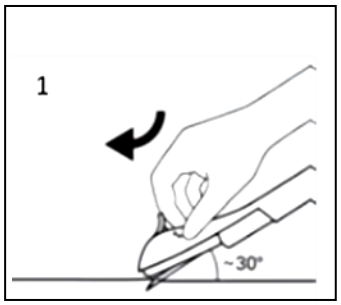
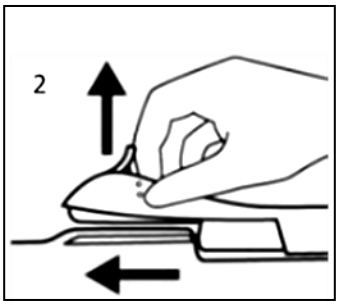
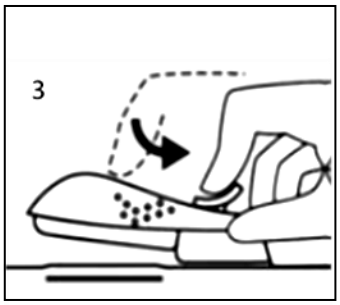
1. Position the client's arm and determine the optimal insertion site (8 cm above the elbow fold) and mark the insertion points. Insert under aseptic condition.
2. Provide 0.5 – 2 ml of 0.5% local anesthesia (lignocaine) to prevent pain during insertion.
3. Make an incision and Insert disposable trocar and attached plunger, with the bevel on tip facing upward, directly through the skin to the superficial subdermal layer at 20□-30□ angle from the skin. Tilt the trocar upward while tenting the skin. The trocar will move easily if it is in a proper, shallow plane. Advance the trocar and plunger slowly and smoothly until the outer marks near the hub.
4. Remove the plunger once the trocar has been advanced to the mark nearest the hub. Load the first rod into the trocar with forceps. Slide the rod into the top of the trocar and reinsert the plunger. Use the plunger to gently advance the rod toward the tip of trocar until encounter resistance.
5. Keeping the plunger steady and stabilize the rod, withdraw the trocar back out until the first ring mark (nearest to the tip) and the hub touches the handle of the plunger. The rod is now free from the trocar and be lying beneath the skin.
6. Fix the first rod with forefinger of the free hand over the end of first rod, redirect the trocar about 15□ and slowly advance the trocar following a "V" shape toward the mark nearest the hub.
7. Load the second rod into the trocar and using the same technique (repeat steps 4-8).
8. Palpate the rob to be sure the rods are placed correctly with the end of the rods 5 cm away from the insertion point and two rods close to each other forming the tips of "V" shape. Reassure the client, the rods are in place through her palpation.
9. Carefully withdraw the trocar and apply pressure on the insertion point with gauze for a minute or so to stop bleeding. Apply surgical tape longitudinally and wrap Band-Aid over it. Clean the area around with alcohol or boiled-cooled water.
10. Disposed the disposable trocar and plunger into sharp container for waste disposal.

Insertion of Implanon- NXT

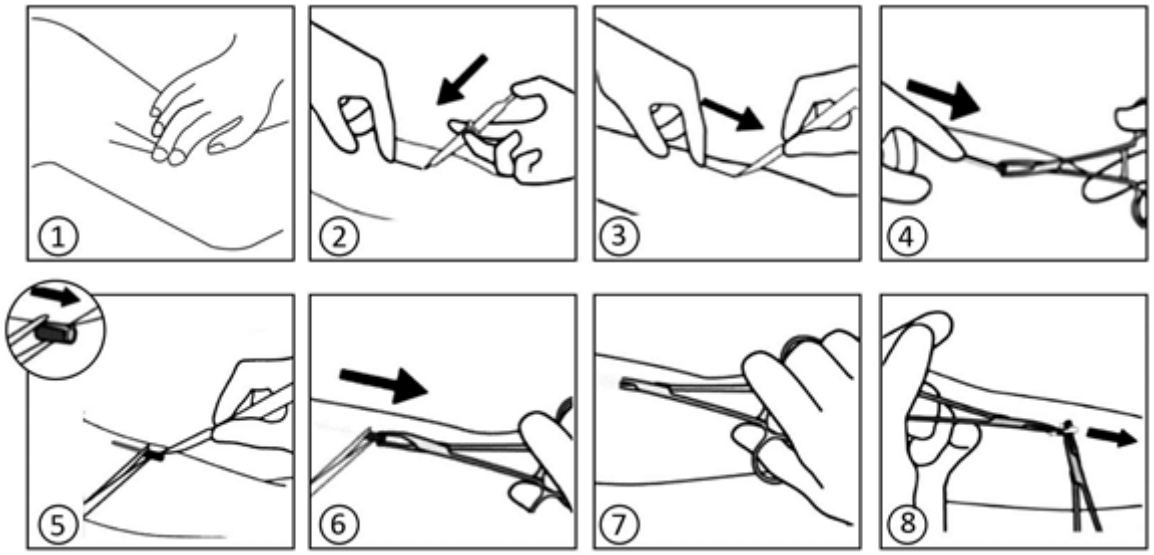






1. Same steps 1-2 as Jedelle insertion
2. Check the implanon-NXT is pre-loaded inside the applicator
3. Puncture the skin with the tip of the needle angle about 30 degrees. (Figure 1)
4. Lower the applicator to a horizontal position while tending the skin with the tip of the needle (Figure 2) to insert the rod superficially and sub-dermally. Advance the needle to its full length until a resistance is felt.
5. Stabilize the applicator in the same position and unlock the purple slider by pushing it slightly down, move the slider fully back until it stops. The implant is now remained sub-dermally and the needle is locked inside the body of the applicator. Remove the applicator (Figure 3).
6. Verify the presence of the implant in woman's arm immediately after insertion by palpation.
7. Ask the client to palpate and reassure the implant is in place.
8. Cover the insertion site.
9. Disposed the applicator into the sharp container for waste disposal.

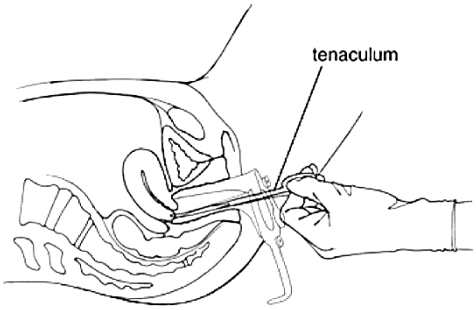
Removal of Implants



1. The provider must not refuse if woman desire to remove the implant for any reasons. All providers must understand that client must not be pressured to continue implant.
2. Explain a woman what will happen during removal.
3. Determine the location of implant by palpation. Mark the tip(s) of the rod(s) to guide the incision point (Figure 1).
4. Remove under aseptic and anaesthetize condition. (Inject 0.5 ml of 0.5% local anesthesia (lignocaine) at the tip of incision under the implant to make it superficial (Figure 2).
5. Push down the proximal end of the implant to stabilize it and form a bulge showing the distal end of the implant. Make a 2 mm long longitudinal incision toward the elbow and deep enough to expose the rod (Figure 3).
6. Gently push the implant toward the incision until the tip is visible. Grasp the implant with a curved mosquito forceps and gently remove the implant (Figure 4).
7. If the implant is encapsulated, use the forceps to gently grasp and stabilize the encapsulated rod, then make a small incision into the tissue sheath to expose the rod. With another curved mosquito forceps, grasp and gently remove the implant after releasing the first stabilized forceps (Figure 5).
8. If the tip of the implant does not become visible in the incision, gently insert a forceps tip into the incision. Flip the forceps over into your other hand, with a second pair of forceps, carefully dissect the tissue around the implant and grasp the implant and remove it (Figure 6-7).
9. Confirm that the entire implant, which is about 4.0/4.3 cm long, has been removed by measuring its length. If removing two-rod implants, repeat the procedure for the second rod.
10. If the client desires to continue contraception with implant, reinsert implant as insertion procedure.
11. If not, covering the incision as do after insertion.
12. Dispose the implant as to surgical waste and decontaminate the instrument ready for next use.

ANNEX. 3: INSERTION PROCEDURE OF IUD

A pelvic examination and STI risk assessment are essential.



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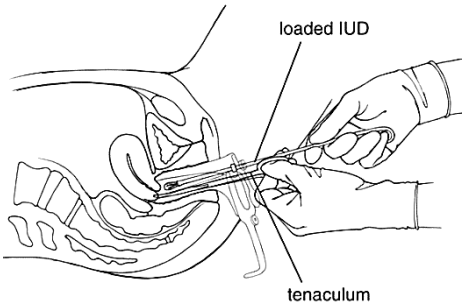

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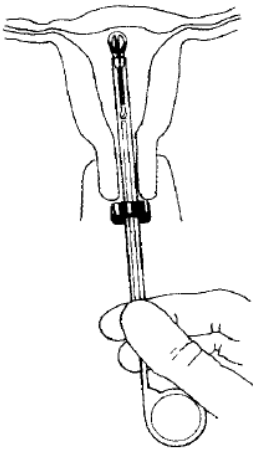

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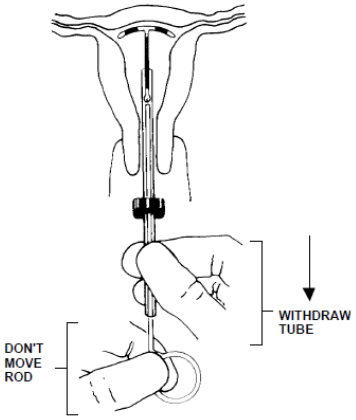

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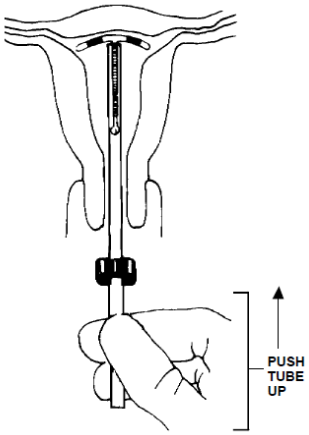

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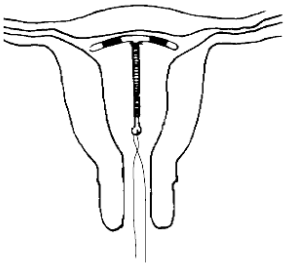

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1. The provider uses proper infection prevention procedure
2. The provider conducts a pelvic examination to determine the position of uterus and assess eligibility. The provider first does the bimanual examination and then inserts a speculum into the vagina to inspect the cervix.
3. The provider cleans the cervix and vagina with appropriate antiseptic.
4. The provider slowly inserts the tenaculum through speculum and closes the tenaculum just enough to gently hold the cervix and uterus steady.
5. The provider slowly and gently passes the uterine sound through the cervix to measure the depth and position of the uterus
6. The provider loads the IUD into the inserter while both are still in the unopened sterile package.
7. The provider slowly and gently inserts the IUD into the uterus and remove the inserter.
8. The provider cuts the strings on the IUD, leaving about 3 centimeters hanging out of the cervix.
9. After the insertion, the woman rests. She remains on the examination table until she feels ready to get dressed.

*Use high-level disinfected or sterile instruments. Ensure high-level disinfection is done by boiling, steaming, or soaking them in disinfectant chemicals. Use a new, pre-sterilized IUD that is package with its inserter.

After insertion, teach the client how she can check the strings on her own, at specific times, to confirm that her IUD is still in place.

Give each woman the reminder card and explain: the type of IUD she has, date of IUD insertion, month and year when IUD will need to be removed or replaced, where to go if she has problems or questions with her IUD.

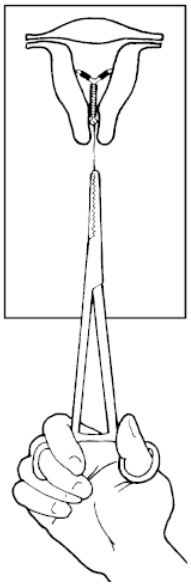
A follow-up visit after her first monthly bleeding or 3 to 6 weeks after IUD insertion is recommended. No woman should be denied an IUD, however, because follow-up visit would be difficult or not possible.

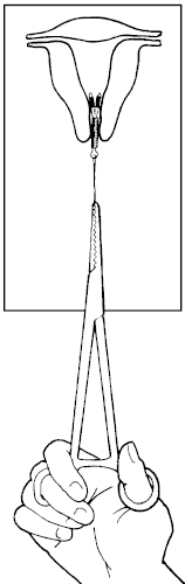
Removing the IUD

If a woman is finding side effects difficult to tolerate, first discuss the problems she is having. Removing an IUD is usually simple. It can be done any time of the month. Removal may be easier during monthly bleeding, when the cervix is naturally softened.

In case of uterine perforation or if removal is not easy (For example, when IUD strings are missing) refer the woman to an experienced clinician who can use an appropriate removal technique.

Removal procedure





- Explain the client before the procedure. The provider inserts a speculum to see the cervix and IUD strings and carefully cleans the cervix and vagina with an antiseptic solution, such as iodine.
- The provider asks the woman to take slow, deep breaths and to relax. The woman should say if she feels pain during the procedure.
- Using narrow forceps, the provider pulls the IUD strings slowly and gently until the IUD comes completely out of the cervix.

ANNEX. 4: WASTE DISPOSAL

Disposal of contraceptives waste	
Methods/primary ingredients	Disposal Method
Male condom (with primary packaging)	
Latex	Land fill Incineration
Female condom (with primary packaging)	
Polyurethane Latex	Incineration • Same as for male latex condoms
Oral pill (with Primary packaging)	
Estrogen and Progesterone	Land fill Incineration Encapsultion Inertization (only the pills after separating them from the blisters. Blister material can be incinerated if it is of aluminium or placed in a landfill
Hormonal Patch (with primary packaging)	
Estrogen and progesterone	Land fill incineration (plastic other than PVC blister)
Hormonal ring (with primary packaging)	
Estrogen and progesterone the ring is made of plastic, so question is same as above.	Incineration (plastic other than PVC blister)
Hormoral IUD (with primary packaging)	
progesterone	Incineration (plastic other than PVC blister)
Implants (with primary covering)	
Progesterone hormone in silastic rods	Incineration
Injectable contraceptives	
Progesterone Glass vials/ampule	Land fill Crush the vials/ ampule and then dispose through landfill
Copper IUD (with primary covering)	
Copper and plastics	Copper containing IUDs can be disposed of by incineration after removing from primary packing
Packing materials and other related waste	
Paper, cardboard (Bio-degradable materials)	Recycle, if possible Landfill Incineration

FORM

COMSUMPTION REPORT FORM OF CONTRACEPTION

Hospital / Township .... Report period ....

State / Region .... Date ....

No	Facility Name/ Hospital Name	Age	Methods (Quantity)														Consumption (√)			Remark
			Condom (C) (pcs)		Emergency contraceptive pill (ECP) (Strip)		Oral contraceptive pill (OCP) (Strip)		Contraceptive Injection (IM-D)		Contraceptive Injection (SC-D)		Intra-uterine device (IUD)	Implant			First time user**	Client who is using contraceptive method continousely ***	Clinet who is switching from another contraceptive method ****	
			Health Care Provider	Auxiliary	Health Care Provider	Axullary	Health Care Provider	Auxiliary	Health Care Provider	Auxiliary	Health Care Provider	Auxiliary		3 year	4 year	5 year				
		15 - 19 years																		
		20 - 24 years																		
		25 years and above																		
		15 - 19 years																		
		20 - 24 years																		
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		20 - 24 years																		
		25 years and above																		
Total		15 - 19 years																		
		20 - 24 years																		
		25 years and above																		

Remark *Summit this report form to State/Region in every quaterly from township after compiling from RHC/SC/MCH Center. Township summit to central sixmonthly.

** Client who use the model contraceptive method for the first time

*** Client who is contiously using the current contraceptive method

**** Switching = Client who is switching the model contraceptive method from current method to another method (Please mention sepcifily of used method OCP ၊ IM-D ၊ SC-D ၊ C ၊ IUD ၊ Jad/NXT etc,...)

Sign ....

Name ....

Title ....

CLIENT REPORT FORM OF CONTRACEPTION

Facility Name..... Report Period ..... Date .....

Village.....Township..... District ..... State/Region.....

No	Date	Name	Age	Address	Methods (Quantity)*									Follow up	Consumption (√)			Remark
					Condom	ECP	Pills	IM Inj	SC Inj	IUD	Implant				Newly user	Old use	Switching methd	
											3 year	4 year	5 year					
Total																		

*Methods - fill the providing amonut

** Client who use the model contraceptive method for the first time

*** Client who is contiously using the current contraceptive method

**** Switching = Client who is switching the model contraceptive method from current method to another method (Please mention sepcifily of used method OCP ၊ IM-D ၊ SC-D ၊ C ၊ IUD)

Signature .....

Name .....

Designation .....

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REFERENCES

1. Adopted by the 57th World Health Assembly in May 2004
2. WHO Family Planning Factsheet. 2018
3. Department of Health, Ministry of Health, Maternal Death Review Report.2013.
4. MOHS, 2017. Myanmar national Health Plan 2017-2021. The Ministry of Health and Sport, The Republic of the Union of Myanmar, 2016
5. WHO and UNFPA, 2015. Ensuring human right within contraceptive service delivery: Implementation Guide
6. WHO. Medical Eligibility Criteria for Contraceptive use. Fifth Edition .2015
7. WHO. Selected Practice Recommendations for Contraceptive use. Third Edition.2016
8. WHO. Decision making Tool for Family Planning Clients and providers.2005
9. WHO. Family Planning: A Global Handbook for Service Provider.2018 xl
10. Global Health Observatory Data Repository. Maternal Mortality Ratio. 2015
11. Department of Population. Myanmar population and Housing census.2014
12. MoHS. Country Statement of Myanmar' s commitment towards Family Planning 2020 at the Press Brief of International Conference on Family Planning 2013, Addis Ababa, Ethiopia. 2013
13. MOHS. Fertility and Reproductive Health Survey
14. MOHS. Myanmar Demographic and Health Survey (2015-2016).2017
15. WHO Guidance and Recommendation for ensuring human rights in the provision of contraceptive information and service
16. Quality of care in contraceptive information and services based on human right standard: a checklist for health care providers, WHO, 2017
17. Family Planning Module: 3 (www.open.edu/openlearncreat/mod/oucontent/view.php?id=138@printable=1)
18. USAID, ESD.HTSP 101: Everything You Want to Know about Healthy Timing and Spacing of Pregnancy
19. WHO, 2006. Married Adolescents: No place for safety. WHO and UN Population Fund 2006
20. Shane Barbara, 1997. Cited in *State of the World's Mothers 2006: Saving the Lives of Mothers and Newborns.* Save the Children, 2006.
21. WHO,2006. A report of Technical Consultation Meeting on Birth Spacing (WHO,2006)

22. WHO, 2013.Program Strategies for Post-Partum Family Planning

23. Safe Disposal and Management of unused, unwanted contraceptives, UNFPA,2013

24. MOH and UNFPA, 2014. Costed Implementation Plan to meet FP2020 commitments Myanmar 2014. Department of Public health, Ministry of Health, 2015