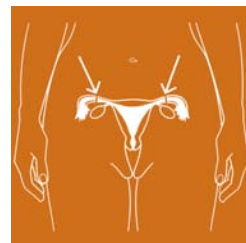
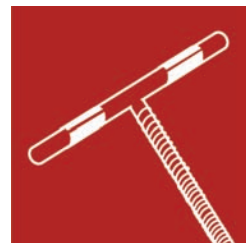
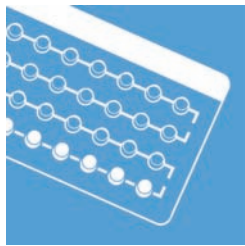




Republic of Malawi  
Ministry of Health

# Preservice Education Family Planning Reference Guide



# Preservice Education Family Planning Reference Guide

September 2010

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<http://info.k4health.org/globalhandbook/> Major sections of the following units are reprinted from the Global Handbook:

Unit 7: Contraceptive Implants

Unit 8: Intrauterine Contraceptive Devices

Unit 9: Vasectomy

Unit 10: Female Sterilisation

Unit 11: Combined Oral Contraceptives

Unit 12: Progestin-Only Injectables

Unit 13: Progestin-Only Pills

Unit 14: Emergency Contraceptive Pills

Unit 15: Lactational Amenorrhea Method

Unit 16: Fertility Awareness Methods

Unit 17: Barrier Methods (Male and Female Condoms)

Unit 18: Withdrawal

Unit 19: Postpartum and Postabortion Family Planning

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# Acronyms

<b>AFASS</b>	Affordable, feasible, acceptable, sustainable, and safe	<b>IUCD</b>	Intrauterine Contraceptive Device
<b>ARV</b>	Antiretroviral	<b>IUD</b>	Intrauterine Device (same as IUCD)
<b>BBT</b>	Basal body temperature	<b>LAM</b>	Lactational amenorrhoea method
<b>BCS+</b>	Balanced Counselling Strategy Plus	<b>LH</b>	Luteinizing hormone
<b>BP</b>	Blood pressure	<b>LMIS</b>	Logistics management information system
<b>C&amp;T</b>	Counselling and testing	<b>LMP</b>	Last menstrual period
<b>CBD</b>	Community-based distribution (of contraceptives)	<b>LTPM</b>	Long-term and permanent methods
<b>CCP</b>	[Johns Hopkins Bloomberg School of Public Health] Center for Communications Programs	<b>MEC</b>	Medical eligibility criteria
<b>CIC</b>	Combined injectable contraceptive	<b>MICS</b>	Multiple Indicator Cluster Survey
<b>COC</b>	Combined oral contraceptives	<b>NSAID</b>	Nonsteroidal anti-inflammatory drug
<b>CPR</b>	Contraceptive prevalence rate	<b>NSV</b>	No-scalpel vasectomy
<b>DHS</b>	Demographic and Health Surveys	<b>PEP</b>	Post-exposure prophylaxis
<b>DMPA</b>	Depot medroxy progesterone acetate (Depo-Provera)	<b>PID</b>	Pelvic inflammatory disease
<b>DVT</b>	Deep vein thrombosis	<b>PMTCT</b>	Prevention of mother-to-child transmission
<b>EC</b>	Emergency contraception	<b>POP</b>	Progestin-only pill
<b>ECP</b>	Emergency contraceptive pills	<b>PRB</b>	Population Reference Bureau
<b>FAM</b>	Fertility awareness methods	<b>RH</b>	Reproductive health
<b>FEFO</b>	First-to-expire, first-out	<b>RHR</b>	WHO Dept of Reproductive Health and Research
<b>FSH</b>	Follicle stimulating hormone	<b>SDM</b>	Standard Days Method®
<b>GBV</b>	Gender-based violence	<b>SSRI</b>	Selective serotonin reuptake inhibitor
<b>GnRH</b>	Gonadotropin-releasing hormone	<b>STI</b>	Sexually transmitted infection
<b>HBV</b>	Hepatitis B	<b>TFR</b>	Total fertility rate
<b>HLD</b>	High-level disinfected	<b>TDM</b>	TwoDay Method®
<b>HPV</b>	Human papillomavirus	<b>TB</b>	Tuberculosis
<b>HSA</b>	Health surveillance assistant	<b>USAID</b>	United States Agency for International Development
<b>HTSP</b>	Healthy Timing and Spacing of Pregnancy	<b>WHO</b>	World Health Organization
<b>ICPD</b>	International Conference on Population and Development		



# PRESERVICE EDUCATION FAMILY PLANNING REFERENCE GUIDE: INTRODUCTION

The Preservice Education Family Planning Reference Guide has been developed to assist preservice health institutions in Malawi in creating, updating, or adapting the family planning content of their curricula and individual courses. Included in this document are materials that institutions and individual tutors can use to develop technically accurate and pedagogically sound lessons on family planning. This document includes:

- Up-to-date information about the provision of family planning services and the family planning methods currently available or expected to be available in Malawi in coming years
- Training activities, such as role plays and case studies, to aid tutors in making their classes more participatory, thereby enhancing the learning process
- Assessment tools, such as quizzes to assess knowledge gained, and learning guides and checklists to support learner practice and assess mastery of skills.

## The Reference Guide's Development Process

The Reference Guide was developed through a participatory process, led by IntraHealth International under USAID's Southern Africa Human Capacity Development project (SAHCD), in close collaboration with the Malawi Ministry of Health. A variety of Malawi stakeholders were engaged in the development, including preservice tutors and lecturers from many institutions across the country, family planning providers from a selection of facilities, and representatives from regulatory bodies and international nongovernmental organizations. The process consisted of a series of stakeholder meetings during which the attendees developed the list of the topics needed and the pertinent content to be included, and then reviewed subsequent drafts of the manuscript. Key global and national resource documents were used to create the content, ensuring that it is evidence-based, up-to-date, and in accordance with international standards and Malawi Ministry of Health policies and protocols.

## How to Use this Document

The Reference Guide provides broad information and training activities on family planning topics. Its purpose is to ensure that the information needed to teach family planning in preservice institutions can be easily found in a single document. It is assumed that no one institution will use all of the information included but that each institution will select content appropriate for its specific needs.

Suggested uses for this guide include:

- Selecting content and activities to create a customized course or section of a course, according to defined learning objectives and the time allotted
- Developing a family planning curriculum for the institution and/or associated family planning teaching documents such as separate tutor manuals and student handbooks
- Updating existing courses in family planning

- Making the guide available in libraries and elsewhere as a resource document for students and tutors.

The Reference Guide is divided into units, each of which contains technical content as well as a variety of student handouts, activities, and assessment tools. There is a unit for each family planning method available in Malawi as well as units on related topics such as *Gender and Family Planning* and *Family Planning Counselling*. In addition, there are units on cross-cutting topics such as *Postpartum and Postabortion Family Planning* and *Family Planning and Sexually Transmitted Infections, including HIV*. Further, references provided at the end of each unit can be used to locate additional information and activities, as needed.

Note that this guide is available both in hard copy as well as on CD-ROM. The CD-ROM version can be used for printing technical content, activities, and assessment tools. This is especially recommended for printing charts and other handouts in colour. If printing from the CD-ROM is not possible, pages can be photocopied as needed.

## Instructions For Using the Training Activities

Learning activities and assessment tools such as those included here can be selected to enhance course content according to the defined needs of the institution. The following are general instructions for the use of case studies, role plays, quizzes, and learning guides/checklists. For more detailed information on how and why to use these and other participatory learning activities and assessment tools, see the Effective Teaching Appendix at the end of the Reference Guide.

### Case Studies

Case studies are brief scenarios that focus on specific issues related to the lesson's learning objectives. The case studies require students to determine the best course of action to be taken in a given situation.

#### Instructions for teacher

- Select all or some of the case studies provided in the unit to be included in your curriculum/course. Make sure that the content of each case selected is covered during class or in assigned readings.
- Print or photocopy the selected case studies to be distributed to each small group.
- Divide the class into small groups of 3-5 students each.
- Tell each group to select a recorder and reporter.
- Hand out the case studies.
- Tell each group to read the assigned case studies and record their answers. Let them know how long they have to complete this assignment. When done, each group should be prepared to share their answers with the larger class.
- After the time allotted, bring the class together again.
- Have each group present their answers and lead a class discussion of the information covered. Use the case study answer key, if provided, to guide the discussion.
- Summarise key points and ask students to share their perspectives on what they learned.
- Address any questions raised by the students.

## Role Plays

A role play is a learning activity in which students play out roles in simulated situations that relate to one or more of the lesson's learning objectives.

### Instructions for teacher

- Select all or some of the role plays provided in the unit to be included in your curriculum/course. Make sure that the content of each role play selected is covered during class or in assigned readings.
- Print or photocopy the selected role plays to be distributed to each small group.
- Divide the class into small groups of 3-4 students each, depending on how many roles are to be depicted. Involve every student in the role play exercise, either as a player or as an observer.
- Hand out the role play descriptions. Most role plays will require 1 provider, 1-2 clients, and an observer.
- Observers will watch the role play and note elements that were performed well or that were omitted or need improvement. They may use a checklist to guide and record these observations in a systematic and objective manner. An example of such a checklist can be found in the Effective Teaching Appendix at the end of the Reference Guide.
- Tell each group to read the assigned role play. Let them know how long they have to complete this assignment. Provide them with a few minutes to read the background information and prepare for the exercise.
- The groups can perform their role plays simultaneously while the tutor circulates to monitor them, or each group can perform one at a time in front of the class, with their classmates serving as observers.
- After the time allotted, bring the class together again.
- Lead a discussion highlighting the strengths and points on which there could be improvement. Sample discussion points include:
  - Ask someone who played the part of the provider to describe the client visit, including what information and/or services he/she provided to the client(s).
  - Ask others who played the role of the same provider if they discovered any additional information about their client(s) that led them to provide different treatment or advice. Discuss any differences or deficiencies in the treatment provided.
  - Ask observers about any areas of particular strength or weakness that the providers demonstrated. Ask them to suggest ways providers could improve their counselling and service delivery skills.
- Summarize key points and ask students to share their perspectives on what they learned.
- Address any questions raised by the students.

## Quizzes

A quiz is a tool to assess the knowledge related to the lesson's learning objectives that the students gained during the class sessions and assigned readings.

### Instructions for teacher

- Select all or some of the quiz questions provided in the unit to be included in your curriculum/course. Make sure that the content of each question selected is covered during class or in assigned readings.



- Print or photocopy the selected questions to be distributed to the students.
- Hand out the quizzes.
- Advise the students how long they will have to complete the quiz questions. After the time allotted, collect the quizzes from each student.
- Use the quiz answer key to correct the students' work.
- Use the quiz answers to determine the students' level of knowledge. If a large number of them answered specific questions incorrectly, review this information with the class to ensure that they now understand it.

### **Learning Guides/Checklists**

Learning guides and checklists provide lists of the steps needed to perform specific skills correctly, and in the correct sequence. By directly observing students performing the required tasks, the observer can assess the students' level of skill and identify areas which need improvement.

Usually, learning guides are used by pairs of students, with one practicing the skill in question and the other watching and noting their observations on the form. Checklists are usually used for assessment purposes, with a teacher or preceptor observing the student performing the skill in question and noting whether it is being performed to an acceptable standard.

#### **Instructions for teacher**

- Select the learning guides and checklists provided in the unit to be included in your curriculum/course. Make sure that the content of each is covered during class or in assigned readings.
- Print or photocopy the selected learning guide and/or checklist that corresponds to the skill to be observed.
- For learning guides:
  - Divide the class into pairs.
  - Hand out the appropriate learning guide and/or checklist to each pair.
  - Tell each pair that one of them will perform the selected skill while the other follows along and notes which steps on the learning guide are completed competently and which need further practice. Advise the students how long they have to complete this assignment.
- After the allotted time, bring the class together again.
- Lead a class discussion of how well the students performed and the steps for which more practice might be needed.
- Summarise key points and ask students to share their perspectives on what they learned.
- Address any questions raised by the students.

#### **For checklists:**

- Have each student perform the selected skill individually while the teacher/preceptor observes and uses the checklist to determine if mastery of this skill has been obtained.
- If the student performs well, he/she can be considered "trained to competency." If not, further instruction and practice is needed.

# Unit 1

## INTRODUCTION TO FAMILY PLANNING IN MALAWI

### Learning Objectives

By the end of this unit, learners will be able to:

- ❖ Describe what family planning is
- ❖ List international declarations that recognize the importance of access to family planning as a basic human right
- ❖ Explain health benefits of family planning to women, families, communities, and societies
- ❖ Describe the historical and current usage of family planning in Malawi
- ❖ State the unmet need for contraception in Malawi
- ❖ List the key types of contraceptive methods available in Malawi
- ❖ Describe the concept of healthy timing and spacing of pregnancy (HTSP)
- ❖ Describe the concept of long-term and permanent methods (LTPM).

### Teaching Resources in this Unit

#### Learning Activities

Handout: Comparing Effectiveness of Family Planning Methods 15

#### Unit Assessment

Quiz Questions 16

Quiz Questions Answer Key 17

## Unit 1: Introduction to Family Planning in Malawi

### Key Points

- ❖ **International declarations recognize the importance of access to reproductive health, including family planning, as a basic human right.**
- ❖ **Family planning benefits women, families, communities, and societies.**
- ❖ **Although family planning use in Malawi has notably increased in recent decades, a significant unmet need for contraception remains.**
- ❖ **The most common reasons for non-use of family planning by women in Malawi are misconceptions about their risk of pregnancy and health concerns about side effects.**
- ❖ **A variety of contraceptive methods are available, each with its own unique characteristics, effectiveness rates, and methods of use.**
- ❖ **Family planning is used to achieve Healthy Timing and Spacing of Pregnancy (HTSP), an approach to timing first pregnancies and spacing subsequent ones that results in improved health outcomes for mothers, newborns, and infants.**
- ❖ **Long-term and permanent methods (LTPM) are highly effective but underused in Malawi and elsewhere.**

### 1.1 Defining Family Planning

Family planning is a program that allows individuals and couples to determine the number of children to have, when to have them, and at what intervals. This is achieved through the voluntary use of various devices, sexual practices, chemicals, drugs, or surgical procedures that interfere with the normal process of ovulation, fertilization, and implantation.

The goal of family planning programs in Malawi is to reduce unmet need for family planning through the provision of voluntary comprehensive family planning services at all levels of care to all men, women, and young people of reproductive age, thereby promoting good health and socioeconomic development.

### 1.2 Family Planning: The Policy Framework

A number of international rights declarations and other documents recognize the importance of access to reproductive health, including family planning, as basic human rights. Three international agreements, to which Malawi is a signatory, are of particular importance to family planning.

One is the Programme of Action from the International Conference on Population and Development (ICPD) held in Cairo, Egypt in 1994. At this meeting, 179 countries agreed that empowering women and meeting people's needs for education and health, including reproductive health, are necessary for both individual advancement and balanced development. This Programme of Action included advancing gender equality, eliminating violence against women, and ensuring women's ability to control their own fertility as cornerstones of population and development policies.

Actions recommended to help couples and individuals meet their reproductive goals included preventing unwanted pregnancies and reducing the incidence of high-risk pregnancies and morbidity and mortality; making quality family planning services affordable, acceptable, and accessible to all who need and want them; improving the quality of family planning advice, information, education, communication, counselling, and services; increasing the participation and sharing of responsibility of men in the actual practice of family planning; and promoting breastfeeding to enhance birth spacing.

The following year, 1995, the United Nations Fourth World Conference on Women took place in Beijing, China. The Platform of Action from this meeting included the following:

*Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this condition are the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice. Reproductive rights ... rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.*

(Division for the Advancement of Women, Department of Economic and Social Affairs. September 1995.)

In addition, Malawi is also a signatory to the 2006 African Union Maputo Plan of Action on Sexual and Reproductive Health and Rights. The goal of this plan is to make universal access to comprehensive sexual and reproductive health and rights a reality in Africa by 2015. The plan's main focus is the integration of sexual and reproductive health services into primary health care, including repositioning family planning as a key development strategy.

## 1.3 Family Planning Is Important to Women, Families, and Societies

In addition to this rights framework, family planning is important on both individual and family levels as well as being a key contributor of socioeconomic development for communities and nations.

Family planning services help avert maternal morbidity and mortality that result when pregnancies are too early, too many, too late, and too frequent. Complications related to pregnancy and childbirth are among the leading causes of mortality and morbidity of women of reproductive age in many parts of the developing world. Most of these deaths, health problems, and injuries are preventable through improved access to adequate health care services, including safe and effective family planning methods. The lifetime probability of maternal death in this country is 1 in 7. This compares to 1 in 54 in Namibia, 1 in 120 in South Africa, and 1 in 2,500 in the United States. Family planning also helps avert infant and child morbidity and mortality, significant problems in Malawi. Preventing unintended pregnancies could significantly improve these figures, saving lives and preserving the well-being of families.

Furthermore, more than one-third of pregnancies in developing countries—about 76 million each year—are unintended. About half of these end in induced abortions, most of which are either illegal or unsafe. The remaining half (16% of all pregnancies) result in unwanted or

mistimed births. Two-thirds of these unintended pregnancies occur among women who were not using any method of contraception. If these pregnancies could be avoided, the following could be averted:

- 90% of abortion-related mortality and morbidity
- 20% of obstetric-related mortality and morbidity
- 150,000 maternal deaths annually.

According to the 2006 Multiple Indicator Cluster Survey (MICS), Malawi's total fertility rate (TFR), or the number of children the typical woman will have over her childbearing years, is estimated to be 6.3 per woman, ranging from 6.6 in the rural areas to 4.5 in urban areas. If this number could be lowered, many lives would be saved. In addition, the MICS also revealed a maternal mortality ratio (the annual number of deaths of women from pregnancy-related causes) of 807/100,000 live births, and an infant mortality rate (the number of infant deaths in a given year divided by the number of live births in the same year) of 76/1,000 live births. These statistics show the need for comprehensive sexual reproductive health services delivered by well-trained and competent service providers.

In addition to saving women's and children's lives, family planning helps:

- Preserve women's health by preventing untimely and unintended pregnancies and reducing their exposure to the health risks of childbirth and abortion
- Prevent HIV/AIDS, including preventing mother-to-child-transmission, by preventing unintended pregnancies
- Provide social, educational, and economic benefits for women, increasing their rights and self-determination and giving them more time to care for their children and themselves
- Improve the socioeconomic status of families, for instance, by leading to healthier individuals with higher literacy rates and improved nutrition
- Stabilize societies and accelerate the socioeconomic status of nations
- Reduce population pressures on the natural environment.

## 1.4 Family Planning Use in Malawi: Historical Trends and Currently

Although much work remains to be done, Malawi has made tremendous progress in recent years in its efforts to increase contraceptive use and reduce fertility. Malawi's move to a multi-party democracy in 1994 greatly enhanced family planning policy and programmatic activities nationwide. In the 1990's, a number of new policies were enacted that helped increase the use of family planning in Malawi including the development of the first national family planning policy. In addition, new curricula were developed to train health care workers as family planning providers as well as for use in preservice institutions.

Malawi's contraceptive prevalence rate (CPR) for married women of reproductive age using modern methods in 1992 was 7.4%. This means that only 7.4% of married women, ages 15-49, used a modern contraceptive method at that time. This rate increased to 28% in 2004 (Malawi Demographic and Health Survey 2004) and to 39% by 2009 (Population Reference Bureau 2009). Although this number is still quite low, it reflects a remarkably rapid increase in family planning use. Malawi's CPR compares favorably to the CPRs in some neighboring countries: 12% in Mozambique, 32% in Kenya, and 33% in Zambia. South Africa, on the other hand, has a contraceptive prevalence rate of 60%.

Currently, family planning services are provided in approximately 60% of the health facilities in Malawi. This includes in the public and private sectors, and through non-governmental organisations (NGOs) like Banja La Mtsogolo (BLM) and the Christian Health Association of Malawi (CHAM). In addition, outreach and community-based services have been introduced. Community-based distribution agents began working in Malawi in the late 1980s and have been a key contributor to the success of family planning in the country. While traditionally these workers provided pills and condoms, current projects are now permitting them to also provide injectable contraception.

Most Malawians are aware of family planning: 97% of both women and men can name at least 1 method. Of the contraceptive methods currently used in Malawi, the most popular are:

- Injectables: 33.9%
- Combined oral contraceptives (COCs): 9.7%
- Male condoms: 8.6%

In general, the highest rates of family planning use in Malawi, as in most other countries, are in women:

- Living in urban areas: 34.7% (vs. 26.9% rural)
- With higher levels of education:
  - The rate of family planning use for those with secondary or greater education is 41%.
  - The rate of family planning use for those with no education is 23.1%.
- With greater wealth:
  - The rate of family planning use in the 20% with the highest incomes (the highest quintile) is 37.6%.
  - The rate of family planning use in the 20% with the lowest incomes is 21.8%.

## 1.5 Unmet Need for Family Planning

Women who say either that they do not want any more children or that they want to wait 2 or more years before having another child, but are not using contraception, are considered to have an unmet need for family planning. Women are said to have an unmet need for contraception if they:

- Are sexually active
- Are able to conceive
- Do not want to have a child soon or at all
- Are not using any contraceptive method.

By one estimate, satisfying the unmet need for contraceptive services in developing countries would avert 52 million unintended pregnancies a year, thereby saving 1.5 million lives and preventing 505,000 children from losing their mothers (Singh et al., 2003).

Fifteen percent of married women aged 15-49 in developing countries have an unmet need for contraception. This figure rises to 24% in sub-Saharan Africa and 28% in Malawi (Westhoff, 2006). This compares favorably to the rate of unmet need in Rwanda (38%) but is higher than that in Kenya (25%) and Mozambique (18%). While Malawi's rate of unmet need is still unacceptably high, it is improving. In 1992, the rate of unmet need was 36%, and in 2000 it was 30%.

## Reasons for nonuse of family planning

In spite of all of the reasons for using family planning, married women cite a number of reasons why they do not always use a method. These include:

- Misconceptions about pregnancy risk (don't think they will get pregnant)
- Health concerns about side effects
- Lack of knowledge
- Lack of access and high cost
- Lack of empowerment for women to participate in decision-making related to family planning use
- Opposition to family planning (religious or other).

Of these reasons, misconceptions about pregnancy risk (41.0%) and health concerns about side effects (37%) are the most common in Malawi. In order to dispel these misconceptions, there is clearly a need for more education about family planning in Malawi.

## 1.6 Types of Contraceptive Methods

A variety of contraceptive methods are available. They each have different characteristics, such as effectiveness rates, method of use, advantages, disadvantages, side effects, etc. Family planning clients should select the method that is best for them by making a fully informed, voluntary choice. Offering the client a variety of methods from which to choose increases the likelihood that she or he will initiate and continue use of a method.

The contraceptive methods available in Malawi can be divided into several categories:

### Permanent methods

- Female sterilisation (tubal ligation)
- Male sterilisation (vasectomy)

### Long-term methods

- Contraceptive implants (such as Jadelle ) containing the hormone progestin
- Intrauterine contraceptive devices (IUCDs)

### Other hormonal methods

- Injectable contraceptives (such as DMPA/Depo Provera) containing the hormone progestin
- Oral contraceptives (pills): can be either combined estrogen/progestin oral contraceptives (COCs) or progestin-only pills (POPs)
- Emergency contraceptive pills (ECPs): can be either combined estrogen/progestin oral contraceptives (COCs) or progestin-only pills (POPs)

### Other nonhormonal methods

- Barrier methods such as male and female condoms
- Lactational Amenorrhea Method (LAM) for breastfeeding women
- Fertility Awareness Methods (FAM) such as the Standard Days Method® and the Two-Day Method®
- Withdrawal

## 1.7 Emerging Concepts Regarding Family Planning

### Healthy Timing and Spacing of Pregnancy (HTSP)

HTSP is an approach to family planning that underscores the importance of contraception as a health intervention that is associated with the best health outcomes for newborns, infants, and mothers. It recommends the use of effective family planning methods of choice to achieve the healthiest pregnancy outcomes, specifically concerning the timing of first pregnancies and spacing of subsequent ones (following a live birth or after a miscarriage or abortion).

This approach is based on data that show that when a woman becomes pregnant too soon after a birth or too soon after a miscarriage/abortion, both she and the newborn face higher risks of complications or even death. Further, research shows that when women younger than 18 years of age become pregnant, there are increased risks of complications for both the mother and the newborn, compared to women 20 to 24 years old.

For these reasons, the World Health Organization (WHO) has developed the following HTSP recommendations:

#### For spacing after a live birth

- After a live birth, the recommended interval before attempting the next pregnancy is at **least 24 months**.

#### For spacing after an abortion

- After a miscarriage or induced abortion, the recommended minimum interval before attempting the next pregnancy is **at least 6 months**.

In addition, USAID includes a third message:

#### For adolescents

- The recommended age for a first pregnancy is at least 18 years.

Additional details on HTSP can be found in Unit 6: Healthy Timing and Spacing of Pregnancy.

### Long-term and permanent methods

#### (Also known as long-acting and permanent methods or LAPM)

Long-term and permanent methods (LTPM) are by far the most effective (99% or greater) types of contraception. They are also very safe, convenient, and cost-effective in the long-run. Four contraceptive methods are categorized as LTPM: IUCDs, implants, female sterilisation, and vasectomy.

IUCDs and implants are long-acting temporary methods: when removed, the woman can become pregnant very quickly. Copper IUCDs, the type available in Malawi, are effective for at least 12 years, although they are labeled for 10 years. Implants, such as Norplant or Jadelle, last for 5 to 7 years. Female sterilisation (tubal ligation) and vasectomy are permanent methods.

Experience in countries where LTPM are available shows that they are highly popular:

- Female sterilisation is the most widely used method of contraception worldwide, accounting for approximately 20% of all contraceptive use.
- The second most popular method in the world is the IUCD, used by 150 million women.
- Vasectomy is the fourth most popular method, after oral contraceptive pills. The surgery required for vasectomy is simpler and safer than that for female sterilisation.



One reason these methods are so popular is that they are highly effective; another is that they do not require daily action on the part of the user or repeated visits to obtain resupply. They are also cost-effective for both the client and the family planning programs/clinics. Although there is a higher up-front cost to obtain these methods, they are much less expensive than other methods if used for at least 2-3 years. This is for reasons ranging from fewer clinic visits required to fewer unintended pregnancies. For these and other reasons, LTPM have higher continuation rates than for other family planning methods.

Despite these advantages, LTPMs tend to be under-used in some places, including in Malawi. The most recent data available (DHS, 2004) show that the use of these family planning methods in Malawi is very low. Usage figures are as follows:

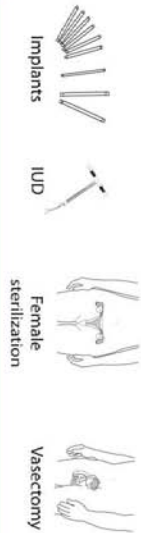
- IUCD: 0.1%
- Implants: 0.4%
- Female sterilisation: 4.8%
- The rate of men in Malawi using vasectomy is similarly low: 0.8%.

***Additional details on LTPM can be found in the individual units on Contraceptive Implants (Unit 7), IUCDs (Unit 8), Vasectomy (Unit 9) and Female Sterilisation (Unit 10).***

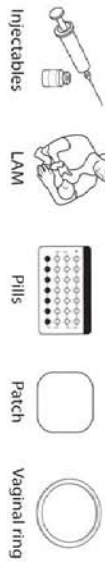
## Comparing Effectiveness of Family Planning Methods

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

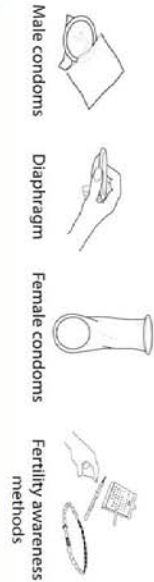
**How to make your method more effective**



**Implants, IUD, female sterilization:** After procedure, little or nothing to do or remember  
**Vasectomy:** Use another method for first 3 months

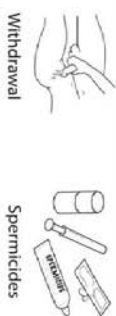


**Injectables:** Get repeat injections on time  
**Lactational amenorrhea method, LAM (for 6 months):** Breastfeed often, day and night  
**Pills:** Take a pill each day  
**Patch, ring:** Keep in place; change on time



**Condoms, diaphragm:** Use correctly every time you have sex  
**Fertility awareness methods:** Abstain or use condoms on fertile days; Newest methods (Standard Days Method and TwoDay Method) may be easier to use.

**Less effective**  
About 30 pregnancies per 100 women in 1 year



**Withdrawal, spermicides:** Use correctly every time you have sex



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2007

## Introduction to Family Planning Quiz Questions

1. What is the meaning of the term “unmet need for family planning”?
  - a. When a woman has no need for family planning
  - b. When couples do not want to use contraceptives but the healthcare worker insists that they need them
  - c. Nonuse of contraception among women who are sexually active, able to conceive, but do not want a child soon or at all
  - d. When women understand that they need to use a birth spacing method, but their partners do not agree, so they use it without their partners’ knowledge
2. The following contraceptive methods are considered to be “long-term”:
  - a. IUCDs
  - b. Implants
  - c. Injectables
  - d. “a” and “b” above
  - e. All of the above
3. Which of the following are true about LTPM (*tick all that apply*):
  - a. Are safe for long-term use
  - b. Are not as effective as combined contraceptive pills (COCs) in preventing pregnancy
  - c. Have low continuation rates
  - d. Are cost-effective if used for at least 2 years
4. The most common reason(s) married women give for not using contraception is/are:
  - a. Lack of knowledge about contraception
  - b. Lack of access to methods, including high cost
  - c. Opposition to contraception due to religious and/or cultural beliefs
  - d. Health concerns about side effects
  - e. Misconceptions about pregnancy risk (don’t think they will get pregnant)
  - f. “b” and “e”
  - g. “d” and “e”
5. The most common contraceptive method currently used in Malawi is the:
  - a. Injectable (DMPA)
  - b. Combined oral contraceptive (COC)
  - c. Male condom
  - d. Female sterilisation

**Questions 6–8:** Indicate whether the following statements about are **true** or **false** by writing a **“T”** for true or an **“F”** for false in the space provided before each statement.

- \_\_\_ 6. According to healthy timing and spacing of pregnancy (HTSP) recommendations, a woman should wait at least 1 year (12 months) before getting pregnant following a live birth.
- \_\_\_ 7. Averting unplanned pregnancies could reduce the number of maternal deaths in Malawi.
- \_\_\_ 8. The Platform for Action from the 1995 United Nations Fourth World Conference on Women in Beijing recognizes the “basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children.”

# Introduction to Family Planning Quiz Questions Answer Key

1. What is the meaning of the term “unmet need for family planning”?
  - c. Nonuse of contraception among women who are sexually active, able to conceive, but do not want a child soon or at all.**
2. The following contraceptive methods are considered to be “long term”:
  - d. “a” and “b” above**
3. Which of the following are true about LTPM (tick all that apply):
  - a. Are safe for long-term use**
  - d. Are cost-effective if used for at least 2 years**
4. The most common reason(s) married women give for not using contraception is/are:
  - g. “d” and “e”**
5. The most common contraceptive method currently used in Malawi is the:
  - a. Injectable (DMPA)**
- E** \_\_ 6. According to healthy timing and spacing of pregnancy (HTSP) recommendations, a woman should wait at least 1 year (12 months) before getting pregnant following a live birth.
- I** \_\_ 7. Averting unplanned pregnancies could reduce the number of maternal deaths in Malawi.
- I** \_\_ 8. The Platform for Action from the 1995 United Nations Fourth World Conference on Women in Beijing recognizes the “basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children.”

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## Unit 2

# GENDER-SENSITIVE FAMILY PLANNING SERVICES

### Learning Objectives

By the end of this unit, learners will be able to:

- ❖ Explain how gender affects family planning service provision
- ❖ Explain the Malawian gender norms and stereotypes that can affect family planning acceptability and use
- ❖ Identify potential gender-related fears and concerns that women and men may have about family planning use
- ❖ Describe effective approaches to partner negotiation regarding family planning
- ❖ Describe how providers' personal beliefs and values regarding gender may affect family planning provision
- ❖ Identify male behaviours that have a positive impact on family planning use and those that have a negative impact on family planning use
- ❖ List signs associated with gender-based violence
- ❖ Explain how gender-based violence can influence family planning acceptance, use, and continuation
- ❖ Identify how providers can help clients who experience gender-based violence.

### Teaching Resources in this Unit

#### Handout

Gender in Our Daily Lives 27

#### Learning Activities

Individual Activity: Gender in Our Lives 28

Group Activity: Vote with Your Feet 29

#### Unit Assessment

Gender and Family Planning Quiz Questions 31

Gender and Family Planning Quiz Questions Answer Key 33

## Unit 2: Gender-Sensitive Family Planning Services

### Key Points

- ❖ Gender norms and differences can affect the acceptance, use, and continuation of family planning.
- ❖ Gender norms and values evolve over time, vary from place to place, and are subject to change.
- ❖ Decision-making power and access to resources affect women's ability to obtain and continue using family planning.
- ❖ Providers can help change the negative effects of certain gender norms and stereotypes by empowering women to make life choices and encouraging constructive male participation in family planning.
- ❖ Family planning providers' attitudes and behaviours, including those about gender, can affect their ability to counsel and support their clients.
- ❖ Partner involvement may be an important factor for some clients when making family planning choices.
- ❖ Fear of violence can influence a victim's choice of family planning methods and her ability to use them.

### 2.1 The Importance of Gender for Family Planning Services

Each culture has its own way of interpreting what it is to be a man or a woman. While “sex” refers to the biological differences between males and females, “gender” refers to the different social, cultural, economic, and political opportunities and constraints associated with being male or female.

Both gender norms and gender inequalities (differences that systematically empower one group more than the other) can affect the acceptance, use, and continuation of family planning. For example:

- A man who does not allow his wife to use family planning because his parents believe he should have many sons to assure the family's lineage
- A woman who does not want her husband to have a vasectomy because she thinks it will lead to promiscuity.

Fortunately, gender norms and values are not fixed. They evolve over time, vary from place to place, and are subject to change. Providers can offer gender-sensitive family planning services and promote societal change with a view to eliminating gender as a barrier to family planning.

#### **Gender norms and stereotypes that might affect family planning**

Gender norms and stereotypes influence peoples' behaviours and actions—what they do, how they do it, and how they spend their time. Gender influences who (men/women, boys/girls) has access to:

- Knowledge and information
- Resources (natural resources, information, income, education, health care services, etc.)

- Power (decision-making, control over one’s body, control over resources, control over the household, political power, etc.).

In Malawi, as elsewhere, gender norms and stereotypes exist that can affect how well family planning is accepted and to what extent it is used. These can include:

- A higher value is placed on having boys; hence women are under pressure to produce male babies.
- The advice given to women is to persevere even when forced to have many children.
- The illiteracy rate among women is high because education for girls is not valued; hence women are poorly informed and have fewer choices.

### Access to resources and decision-making power

Decision-making power and access to resources affect women’s ability to obtain and continue using family planning. As in other countries, the following is often true in Malawi:

- Men decide on the number of children in his family; hence men may not approve of family planning use if they feel the family is not large enough.
- Women are generally not economically independent; hence their access to family planning services is limited.
- Illiterate women in particular may lack information on family planning issues and thus cannot make fully informed choices regarding them.

### Gender-related fears and concerns women and men may have about family planning use

Women’s fears/concerns	Men’s fears/concerns
<ul style="list-style-type: none"> <li>• Family planning discussion/use possibly inciting violence (e.g., wife beatings)</li> <li>• Husband engaging in extramarital affairs</li> <li>• Stigma and discrimination for not producing children</li> <li>• Loss of intimacy and affection, fear of divorce</li> <li>• Cost of contraception (Negotiate with partner? Pay by herself?)</li> <li>• Loss of status: women recognized by their number of children</li> <li>• Economic insecurity</li> <li>• Conflict with extended family/ancestors</li> </ul>	<ul style="list-style-type: none"> <li>• Women refusing to fulfill their reproductive and sexual obligations</li> <li>• Wife engaging in extramarital affairs</li> <li>• Stigma/discrimination for not producing children</li> <li>• Loss of control over their wives</li> <li>• Loss of man’s ability to have another child in a new marriage (vasectomy)</li> <li>• Harm his image as a “real man”</li> <li>• Others possibly thinking that he is impotent</li> <li>• Conflict with family/ancestors</li> </ul>

## 2.2 Provider Response to Gender Issues

Providers can help change the negative effects of certain gender norms and stereotypes by:

- Acknowledging the role of gender in their own decision-making and behaviour
- Empowering women to make family planning decisions for themselves
- Encouraging men’s constructive participation in family planning, either through the use of a method or by supporting their partners’ use of a method.



## Provider self-awareness

A provider who is aware of his/her personal gender beliefs, attitudes, and biases enhances her/his ability to offer high quality services to clients, be they women, men, adolescent boys, and girls or couples. For example, a provider who has a bias against men may make them feel uncomfortable or unwelcome thus reinforcing men's distrust of family planning services, as well as men's resistance to their partner accessing these services.

## Empowering women to make life choices

Providers should do the following to help empower women to make their own life choices:

- Sensitively elicit information about a client's power to make decisions and obtain family planning methods, and any gender-related fears and anxieties the clients may have related to family planning use
- Demonstrate respect for the client's right to privacy and confidentiality about use of family planning
- Offer clients information related to their reproductive rights relative to family planning (see Introduction to Family Planning in Malawi, Unit 1)
- Offer clients complete information about family planning methods, including the costs, the visibility of their use and of any side effects, and potential need for partner support or involvement
- Encourage clients to make their own life, sexual and reproductive health choices
- Consult with clients on how to negotiate with their partners and when or if to bring partners into family planning counselling.

## Men's constructive participation in family planning

Male norms and men's behaviours can have either positive or negative impacts on family planning acceptance, use, and continuation. Including men in constructive ways (as clients, or supportive influences in the lives of women) can reduce the negative effects of gender norms.

Positive impact	Negative impact
<p>Men can give their partners:</p> <ul style="list-style-type: none"><li>• Financial support (helping pay for the method)</li><li>• Emotional support (discussing and supporting her choice, accompanying her to the clinic)</li><li>• Help with the method if they desire (i.e., helping insert the female condom, reminding her when to take her pill)</li><li>• Support in using a male method such as vasectomy or male condoms</li></ul>	<ul style="list-style-type: none"><li>• Forbidding use of family planning, possibly resulting in clandestine use by his partner</li><li>• Not allowing the woman the time to use a method, such as a female condom, before sex</li><li>• Complaining or criticizing her for the use of her method</li><li>• Pressuring her to use a method that may be harmful to her specific health condition(s)</li><li>• Pressuring her to have sex during her fertile period (if she is using a fertility awareness method)</li></ul>

(Adapted from EngenderHealth 2003)

Strategies for promoting constructive participation of men in family planning include:

- Community sensitization targeting local leaders
- Distribution of informational materials to men where they work and where they congregate
- Improving the attitudes of health workers towards men in health facilities
- Building men’s awareness of human rights (including client, sexual, and reproductive rights).

### Partner involvement in family planning

Certain family planning methods (male condoms, fertility awareness methods, withdrawal) require partner involvement or knowledge. Others—intrauterine contraceptive devices (IUCDs), pills, injectables, female sterilisation and vasectomy—do not. Partner involvement may be an important factor for some clients when making family planning choices.

Table 2.1: Advantages and Disadvantages of Partner Involvement or No Partner Involvement in Family Planning

	Partner involvement	No partner involvement
<b>Advantages</b>	<ul style="list-style-type: none"> <li>• Mutual understanding</li> <li>• Gender-based violence may be reduced because of mutual understanding, increased trust</li> <li>• Support in all aspects (e.g., financial, psychological, physical)</li> </ul>	<ul style="list-style-type: none"> <li>• No need for consent</li> <li>• Full control of the methods</li> <li>• Method may be initiated when needed</li> </ul>
<b>Disadvantages</b>	<ul style="list-style-type: none"> <li>• May delay initiation of method</li> <li>• Requires negotiation with partner</li> <li>• May prompt conflict or violence (if partner is not willing to negotiate)</li> </ul>	<ul style="list-style-type: none"> <li>• Potential for violence if secret is disclosed</li> <li>• Sustainability of the method may be affected (hiding, financial constraints)</li> </ul>

Providers can suggest the following approaches to the client for discussing family planning concerns with their partners:

- Identify areas of family life or relationships that the partners *do* talk about. Determine if these topics could serve as an entry point for a discussion about life choices or family planning.
- Start a conversation by saying that this is something that the client heard about in a talk at the health care facility and wonders if their partner knows anything about it.
- Identify family members (of either partner) who might be supportive, and ask them to help him or her communicate with the partner.

Provider tips:

- Use role playing with the client to allow her or him to practice negotiation.

- Be nonjudgmental of the partner as well as of the client. Criticizing the partner might threaten the client’s sense of well-being and interfere with the counselling relationship.
- Respect the client’s willingness and ability to negotiate with the partner. If a client says that he or she cannot discuss this with their partner, explore other options.

*(Adapted with permission from EngenderHealth 2003.)*

Couples counselling (conducting counselling with both partners at once) can encourage shared decision-making, gender equity, effective use of family planning and agreement about desired family size. Nevertheless, shared communication can sometimes lead to risks of violence or loss of decision-making power for one partner, especially the female partner. Couples counselling is not recommended when providers have not been adequately trained in the additional skills it requires.

## 2.3 The Effects of Gender-Based Violence on Family Planning Use

According to the Malawi National Reproductive Health Service Delivery Guidelines (2007), gender-based violence is “...any unlawful act perpetrated by a person against another person on the basis of their sex that causes suffering on the part of the victim and results in, among others, physical, psychological and emotional harm and economic deprivation.”

Acts of gender-based violence are perpetrated to gain power and control. In a couple, this can include power over reproduction, including the use of family planning.

Examples of gender-based violence within a couple, also called intimate partner violence (IPV), include:

- **Physical:** slapping, kicking, burning, strangling
- **Sexual:** rape, sexual coercion of any kind, being forced to do degrading/humiliating sex acts, preventing use of protection from sexually transmitted infections (STIs), including HIV or from pregnancy
- **Emotional:** threats of harm, physical and social isolation, extreme jealousy and possessiveness, degradation and humiliation, constant criticism and insults
- **Economic:** withholding funds, preventing access to health care or employment, etc.

In many settings, society justifies, tolerates, or ignores violence against women because of traditional gender norms and beliefs.

Emotional and economic ties exist between perpetrators and victims of gender-based violence that have major implications for a woman’s ability to protect herself as well as to make life choices. Fear of violence can influence a victim’s choice of family planning methods and her ability to use them. Factors that may increase the risk of violence in relation to family planning use are:

- Lack of trust—the fear that a woman might have multiple sexual partners because she uses family planning
- A man’s sense of loss of control over his wife and his family
- Abuse by extended family who are in opposition to family planning or to the wife making decisions
- Hiding family planning method from spouse, if the secret is found out.

## 2.4 Gender-Based Violence in Malawi

Several studies have been conducted on gender-based violence in Malawi (Bisika T. 2008; Chakwana C.D. 2004; Mathiassen 2007), and the issue is gaining more attention by the government. One of the main underlying causes of violence against women in Malawi has been women’s lack of rights. As a response, the government has ratified a number of international and regional women’s rights and gender equality documents and has also developed a National Strategy to Combat Gender-Based Violence (2000-2006).

A traditional culture where men have dominance over women, especially their wives, is found throughout Malawi. Collecting information about gender-based violence is difficult because many view it as a personal family issue, and researchers have found that it is difficult to obtain honest answers from women, especially if the perpetrator of the violence is present, since answering the questions might lead to further violence.

The most common form of violence practiced against women is physical violence. Many women believe there are situations that justify a husband beating his wife. The acceptance level of this violence is lower in wealthier households and where women have higher levels of education. Other types of abuse that are recognized include use of abusive language, men not providing some necessities, and women being overworked by their husbands.

Some cultural practices and beliefs encourage men to abuse women. These include “chiongo” dowry, polygamy and “the notion of the household head;” initiation ceremonies where women are told to persevere and satisfy the man; acceptance of extramarital sex for males; and “chikamwini” or “chitengwa” where the woman is asked to live with the man’s relatives or in his family’s village.

Jealousy is a big factor in the perpetuation of violence, and one way men choose to deal with this is restricting their wives’ social access by demanding to know where she is at all times, restricting her access to family and friends, and by controlling her financial means.

### Fatal outcomes of gender-based violence

- Femicide (murder of a female victim)
- Suicide (of the female victim)
- Homicide (murder of the perpetrator)
- AIDS-related mortality
- Maternal mortality
- Foetal death

Table 2.2: Non-Fatal Health Consequences of Gender-Based Violence

Physical	Sexual and Reproductive	Psychological and Behavioural
<ul style="list-style-type: none"> <li>● Fractures and lacerations</li> <li>● Chronic pain syndromes</li> <li>● Fibromyalgia</li> <li>● Permanent disability</li> <li>● Gastro-intestinal disorders</li> </ul>	<ul style="list-style-type: none"> <li>● STIs, including HIV</li> <li>● Unwanted pregnancy</li> <li>● Pregnancy complications</li> <li>● Traumatic gynecologic fistula</li> <li>● Unsafe abortion</li> </ul>	<ul style="list-style-type: none"> <li>● Depression and anxiety</li> <li>● Eating and sleep disorders</li> <li>● Drug and alcohol abuse</li> <li>● Poor self-esteem</li> <li>● Post-traumatic stress disorder</li> <li>● Self-harm</li> </ul>

## 2.5 Provider Response to Gender-Based Violence

The signs that a family planning provider may see that could indicate gender-based violence include:

- Chronic, vague complaints that have no obvious physical cause
- Injuries that do not match the explanation of how they occur
- A male partner who is overly attentive, controlling or unwilling to leave the woman's side
- Vaginal itching or bleeding
- Abdominal or pelvic pain, sometimes chronic
- Painful defecation or painful urination, urinary tract infection, chronic irritable bowel syndrome
- Sexual problems, lack of pleasure
- Vaginismus (spasms of the muscles around the opening of the vagina)
- Anxiety, depression, self-destructive behaviour
- Difficulty with or avoiding pelvic exams

### **How providers can help clients who experience gender-based violence**

Many survivors of gender-based violence have difficulty seeking help because of stigma and shame, judgmental attitudes of service providers, fear of consequences for self and family, and lack of access to services. They frequently report feeling humiliated or degraded by service providers.

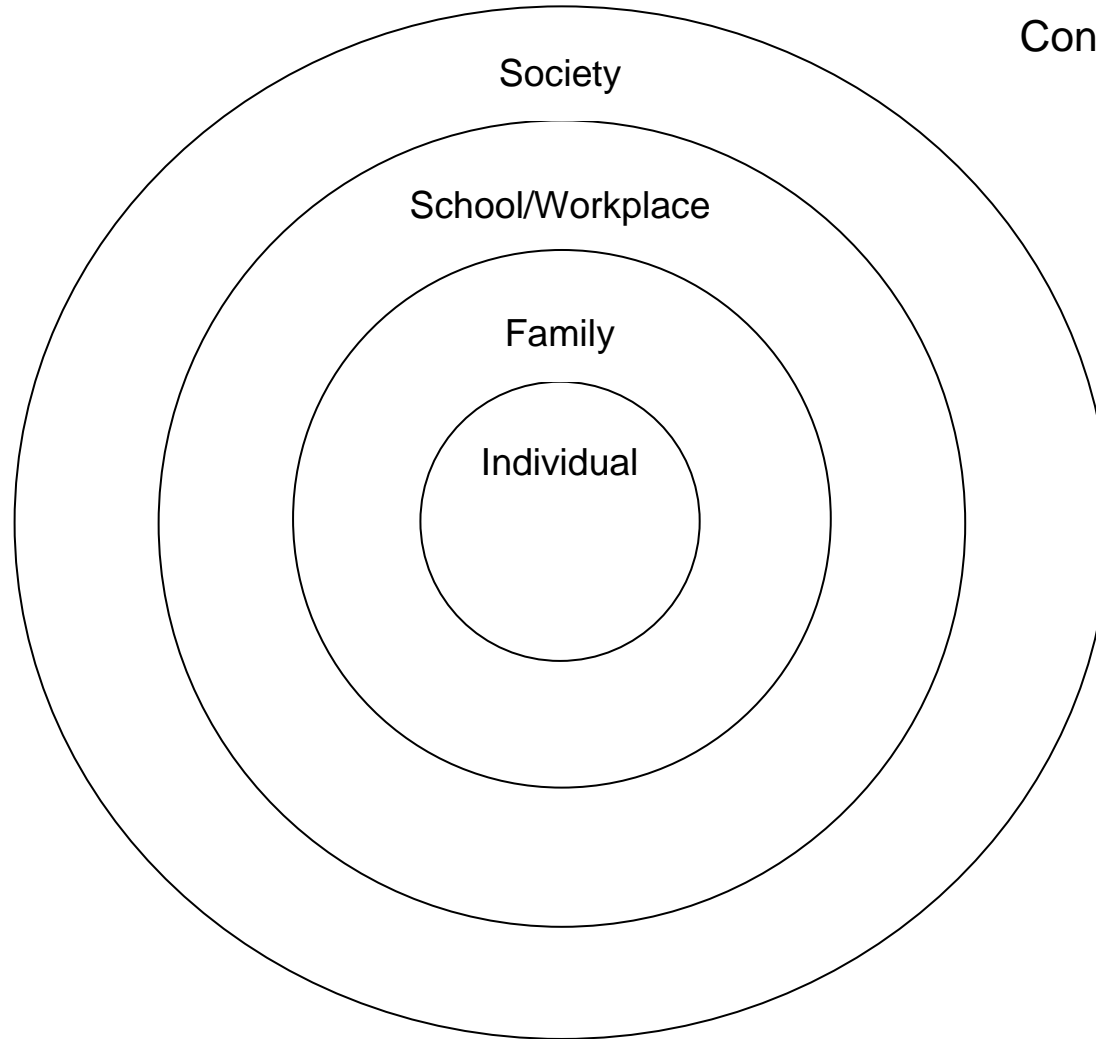
Service providers can help these survivors by doing the following:

- Provide privacy and confidentiality: The client may be at risk if you speak about the violence in the presence of anyone else.
- Screen clients for gender-based violence: Studies suggest that victims want to be asked about violence, even if they cannot admit to the violence at first.
- Validate the client's experience with gender-based violence: Give a compassionate response.
  - Be kind. Avoid superior attitudes.
  - Let her tell you what is happening and how you can help her.
  - Never pressure or press her to talk about it if she does not want to.
  - Don't ever tell her it's her fault.
- Document the client's condition and provide appropriate care. Refer to Malawi STI, post-exposure prophylaxis, and emergency contraception guidelines for more information.
- Find out whether the woman feels that she or her children are in immediate danger. If so, help her consider various courses of action.
- Provide information about the health consequences of abuse and the rights of victims .
- Respect the client's decisions.
- Help the client develop a safety plan, and refer her to available community resources.

# Gender in Our Daily Lives

Opportunities?

Constraints?



## Individual Activity: Gender in Our Lives

### Activity objectives

At the end of the activity, students will be able to:

- Identify gender constraints and opportunities in their lives
- Cite ways in which gender changes over time and what this can mean for family planning provision
- **Time:** 55 minutes

### Preparation

#### Part I:

- Prepare flipchart with concentric circles graphic “Gender in our daily lives” with “Constraints” and “Opportunities” written to the left and right of the outer circle (see handout on previous page).
- Blank flip chart to list opportunities and constraints
- Concentric circles handout “Gender in Our Daily Lives”

#### Part II:

- Flip charts with questions for participants

### Instructions

#### Part I: Gender constraints and opportunities (30 min)

**Step 1:** (5 min) As an introduction, remind students that gender roles and responsibilities influence our everyday lives—the way we perceive ourselves, the way we act within our family, the way we interact in the classroom, and as members of a society. Explain to the students that they are going to participate in an individual exercise that will get them thinking about gender in their daily lives.

**Step 2.** (5 min) Distribute the “Gender in Our Daily Lives” handout and refer to same graphic on the flip chart. Tell students to think about the gender norms and stereotypes in their own lives, those that might govern their self-concept, their family role, etc. Ask them to think of several times in their lives when a gender norm or a prescribed role has *constrained* them in some way. Ask them to write the constraint into the appropriate level(s) of their graphic handout. As the second part of the exercise, students should think of a time when gender has provided them with a unique *opportunity*. Because they were born a man or woman, did their gender open a particular door for them? Make note of these occasions as well on the graphic handout.

**Step 3.** (15 min) Allow 5 minutes for students to complete their individual handouts and then ask for volunteers to share their experiences. Take a few examples of constraints, beginning at the self-concept/individual level and moving outward to “society,” noting them on the other flip chart. Repeat process for “opportunities.”

**Step 4:** (5 min) Debrief the activity by thanking students for sharing, and reminding them that it is often helpful to remember that gender roles affect each of us as well as our future clients every day.

## **Part II: Gender Can Change over Time: (25–30 min)**

**Step 1.** (5 min) Remind students that social roles, responsibilities, constraints, and opportunities change over time within and across cultures. Ask students to think about the changes that have occurred in their own lifetimes. Write responses on a flip chart. Sample questions to ask the students include:

- (For female students) How is being a woman different for you than it was for your mother?
- (For male students) How is being a man different for you than it was for your father?
- Which of these do you perceive as advances? As losses?
- When you consider your childhood, how is being a girl or boy different for your children (nieces/nephews) now than it was for you?

**Step 2.** (15 min) Ask students to identify ways in which social roles, responsibilities, constraints, or opportunities have changed for their mothers, themselves, and their daughters; and for their fathers, themselves and their sons. Record (on flip chart) the ways gender roles, responsibilities, constraints have changed for men and women since their mother's/father's time.

**Step 3.** Thank the students for sharing, and say the following:

- As we think of empowering women to use family planning and of encouraging men's constructive participation in family planning, keep in mind that gender roles, constraints, and opportunities are not written in stone. They do change over time and can change through health service provider interventions as well as larger social forces.
- Facilitate a discussion and answer any questions.

## **Group Activity: Vote with Your Feet**

(Adapted from a training session developed by the USAID Interagency Gender Working Group)

### **Objectives**

At the end of the activity, students will be able to:

- Identify personal experiences and beliefs regarding gender and how they may affect family planning provision.

**Time:** 30–40 minutes

### **Preparation**

- Review the instructions and Vote with Your Feet statements.
- Arrange the area so that there is adequate space for students to move from one side of the room to the other.
- Post flip chart paper on opposite ends of the room, the one on the right saying "Agree" and the one on the left saying "Disagree."

### **Instructions**

**Step 1.** Ask the group to stand in the centre of the room. Explain that you are going to read a statement aloud (see below). Tell the students to vote with their feet "yes" or "no" by moving



to one side of the room if they **agree** with the statement or to the other if they **disagree**. Students cannot stand in the middle.

**Step 2.** Read the first statement. Repeat it to ensure everyone heard it. Allow students to “vote with their feet.” Remind them that they cannot stand in the middle.

**Step 3.** After everyone chooses whether they agree or not, ask 2 or 3 students from each side to explain why they voted the way they did. Facilitate a brief discussion on their reasons. Explain the rules of the discussion:

- Be honest—don’t succumb to peer pressure
- Respect others’ values
- No debates.

**Step 4.** Read up to 5 statements (below) and follow the same process.

**Step 5.** Debrief the activity by explaining/asking the following:

- Even though we may be familiar with gender and the importance of gender-sensitive service delivery, some questions are still difficult for us to work with.
- When speaking of gender, people tend to have positions or strong convictions. This should be taken into account when providing family planning services.
- Our own experiences with and beliefs on gender can have an impact on how we view and understand our services or programs.
- Ask “How do you think providers’ values and attitudes might affect their interactions with couples, male clients, or women seeking family planning?”
- Facilitate a discussion and answer any questions.

### **“Vote with your feet” statements**

- Even if you offer free and convenient family planning services with a range of methods to men, they will have little interest in utilizing the services.
- It is a service provider’s duty to address a suspected case of domestic violence if a client shows signs of having been beaten.
- It is a woman’s right to choose the number, timing, and spacing of her children.
- Men sometimes have a good reason to use violence against their partners.
- Promoting gender equality in couples is a valid goal of a family planning program.
- Involving men in family planning counselling sessions will only further increase men’s power over decisions that affect women’s fertility and health.
- It is okay for a man to have sex outside of marriage if his wife does not know about it.
- It is okay for a woman to have sex outside of marriage if her husband does not know about it.
- Men will feel threatened if too many women start making decisions for themselves.
- A woman should not refuse sex to her husband.
- It is wrong to give a family planning method to a woman who wants to conceal it from her husband.

## Gender-Sensitive Family Planning Services Quiz

**Questions 1-11.** Indicate whether the following statements about gender and family planning are **true** or **false** by writing a **“T”** for true or an **“F”** for false in the space provided before each statement.

- \_\_\_ 1. “Gender” refers to the biological differences between males and females.
  - \_\_\_ 2. Decision-making power and access to resources affect women’s ability to obtain and continue using family planning.
  - \_\_\_ 3. A woman may fear economic insecurity if she uses family planning.
  - \_\_\_ 4. A man may be concerned about losing control over his wife if he allows her to use family planning.
  - \_\_\_ 5. The use of family planning may incite violence between partners.
  - \_\_\_ 6. Providers can help female clients who have little decision-making power by choosing appropriate family planning methods for them.
  - \_\_\_ 7. Involving a partner may increase the continuation of a method.
  - \_\_\_ 8. Restricting a woman’s access to her family and friends is a form of gender-based violence.
  - \_\_\_ 9. The signs of gender-based violence are almost always easily visible.
  - \_\_\_ 10. Providers should tell a client’s family members if he/she suspects that the client is experiencing violence.
11. List 2 gender norms or stereotypes in Malawi that can affect how well family planning is accepted and to what extent it is used:

12. Give an example of how gender differences or gender inequalities in Malawi can affect the acceptance, use, and continuation of family planning:

13. Describe one approach a client can use to discuss family planning concerns with their partners:

14. List some things a man can do that will have a positive impact on family planning acceptance, use, and continuation:
  
  
  
  
  
  
  
  
  
  
15. Name a man's behaviour that can have a negative impact on family planning acceptance, use, and continuation:
  
  
  
  
  
  
  
  
  
  
16. List 2 factors that may increase the risk of violence in relation to family planning use:

# Gender Sensitive Family Planning Services Quiz Answer Key

- F \_\_ 1. “Gender” refers to the biological differences between males and females. False: “Gender” refers to the different social, cultural, economic, and political opportunities and constraints associated with being male or female.
- T \_\_ 2. Decision-making power and access to resources affect women’s ability to obtain and continue using family planning.
- T \_\_ 3. A woman may fear economic insecurity if she uses family planning.
- T \_\_ 4. A man may be concerned about losing control over his wife if he allows her to use family planning.
- T \_\_ 5. The use of family planning may incite violence between partners.
- F \_\_ 6. Providers can help female clients who have little decision-making power by choosing appropriate family planning methods for them. **False: Providers can help by empowering women to make their own sexual and reproductive health choices.**
- T \_\_ 7. Involving a partner may increase the continuation of a method. True: It may result in increased financial, psychological, physical support.
- T \_\_ 8. Restricting a woman’s access to her family and friends is a form of gender-based violence.
- F \_\_ 9. The signs of gender-based violence are almost always easily visible. False: Often the signs are not visible such as chronic, vague complaints that have no obvious physical cause.
- F \_\_ 10. Providers should tell a client’s family members if he/she suspects that the client is experiencing violence. **False: The client is at risk if you speak about family violence in the presence of anyone else.**
11. List 2 gender norms or stereotypes in Malawi that can affect how well family planning is accepted and to what extent it is used:
- Answers include two of the following:**
- **A higher value is placed on having boys; hence women are under pressure to produce male babies.**
  - **The advice given to women is to persevere even when forced to have many children.**
  - **The illiteracy rate among women is high because education for girls is not valued; hence women are poorly informed and have fewer choices.**
12. Give an example of how gender differences or gender inequalities in Malawi can affect the acceptance, use, and continuation of family planning:
- Possible answers include:**
- **A man might not allow his wife to use family planning because his parents believe he should have many sons to assure the family’s lineage.**

- **A woman does not want her husband to have a vasectomy because she thinks it will lead to socially accepted promiscuity.**
13. Describe one approach a client can use to discuss family planning concerns with their partners:
- One of the following:**
- **Identify areas of family life or relationships that the partners do talk about. Determine if these topics could serve as an entry point for a discussion about life choices or family planning.**
  - **Start a conversation by saying that this is something that the client heard about in a talk at the health care facility and wonders if their partner knows anything about it.**
  - **Identify family members (of either partner) who might be supportive, and ask them to help him or her communicate with the partner.**
14. List some things a man can do that will have a positive impact on family planning acceptance, use, and continuation:
- Answers include:**
- **Give financial support**
  - **Give emotional support**
  - **Help with the use of the method**
  - **Use a male method (vasectomy, male condoms).**
15. Name a man's behaviour that can have a negative impact on family planning acceptance, use, and continuation:
- Any of the following:**
- **Forbidding use of family planning (thus making the partner use it secretly, if she chooses)**
  - **Not allowing the woman the time to use the method before sex**
  - **Complaining or criticising the woman for the use of her method**
  - **Pressuring the woman to use a method that may be harmful to her specific health condition(s)**
  - **Pressuring her to have sex during her fertile period (if she is using a fertility awareness method).**
16. List 2 factors that may increase the risk of violence in relation to family planning use:
- Any 2 of the following:**
- **Lack of trust—the fear that a woman might have multiple sexual partners because she uses family planning**
  - **A man's sense of loss of control over his wife and his family**
  - **Abuse by extended family who are in opposition to family planning or to the wife making decisions**
  - **Hiding family planning method from spouse, if the secret is found out.**

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# Unit 3

## REPRODUCTIVE SYSTEMS AND THE MENSTRUAL CYCLE

### Learning Objectives

By the end of this unit, the learner should be able to:

- ❖ Explain the importance of understanding the male and female reproductive systems
- ❖ Define the ovarian cycle, the menstrual (uterine) cycle and menstruation, the female reproductive cycle, and hormones
- ❖ Describe the anatomy and physiology of female and male reproductive systems
- ❖ Describe the phases of the menstrual cycle and what occurs in each phase
- ❖ Explain how fertilization and implantation occur and when during the menstrual cycle a woman can become pregnant.

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## Unit 3: Reproductive Systems and the Menstrual Cycle

### Key Points

- ❖ Understanding the female reproductive cycle is essential for understanding how pregnancy occurs and how family planning methods work to prevent it.
- ❖ The female reproductive cycle involves both the development of an egg in the ovaries (oogenesis) and the preparation of the uterus to receive a fertilized ovum.
- ❖ Sperm can usually live up to 48 hours in the woman's body.
- ❖ A woman is most likely to become pregnant if she has unprotected sex from 2 days before ovulation to the day after ovulation.

### 3.1 Importance of Understanding Human Reproductive Systems

It is essential that family planning providers understand the female and male reproductive systems and female reproductive cycles in order to provide high quality family planning services. To be able to help their clients make informed decisions about family planning methods, instruct clients about how to use their chosen methods, and advise clients about managing side effects, service providers need to understand how pregnancy occurs, when a woman can become pregnant (her fertile time), and how contraceptive methods work. Another benefit of understanding the reproductive cycles is a greater understanding of their roles in female fertility problems and bleeding disorders.

### 3.2 Overview and Definitions

*(Note: This section was adapted from Principles of Anatomy and Physiology, 7<sup>th</sup> edition, by Gerard J Tortora and Sandra Reynolds Grabowski. Copyright 1993, HarperCollins College. Reprinted with permission of John Wiley & Sons, Inc.)*

During their reproductive years, non-pregnant females normally experience a cyclical series of changes in the ovaries and uterus. Each cycle takes about a month and involves both oogenesis (development of an ovum) and preparation of the uterus to receive a fertilized ovum. Hormones control the events in these cycles.

**The ovarian cycle** is a series of events that are involved in the maturation of an ovum, or egg.

**The menstrual (uterine) cycle** is a series of changes in the endometrium (lining) of the uterus. Each month, the endometrium is prepared for the potential arrival of a fertilized ovum that will develop in the uterus. If an ovum is not fertilized, the outer portion of the endometrium sheds off.

**Menstruation** is the shedding of the endometrium accompanied by bleeding. Menstruation starts during puberty (at menarche) and stops permanently at menopause. It is also known as “monthly bleeding,” a “period,” and menses.

The term **female reproductive cycle** refers to the ovarian and uterine cycles, the hormonal changes that regulate them, and cyclical changes in the breasts and cervix.

**Male and female reproductive systems** include all of the structures and organs involved in fertilization and implantation.

**Hormones** are chemicals produced by glands and structures in the body. Hormones act as chemical messengers to another body structure or gland. Hormones control the events in the menstrual and ovarian cycles.

This unit focuses on the phases of the menstrual cycle, and includes events in the ovarian cycle in the menstrual (uterine) cycle description.

### 3.3 The Female Reproductive System

(**Note:** To save space, illustrations of female and male anatomy are not included here but are reprinted in the Handouts section at the end of this unit.)

#### External female reproductive anatomy

Structures of external female reproductive anatomy include:

- **Pubic hair:** Surrounds the female reproductive organs
- **Clitoris:** Sensitive ball of tissue creating sexual pleasure
- **Labia majora (outer lips):** Two folds of skin, 1 on either side of the vaginal opening, that protect the female organs
- **Labia minora (inner lips):** Two folds of skin, inside the labia majora, that extend from the clitoris
- **Urethra:** Opening where urine leaves the body
- **Vaginal opening:** Where a man's penis is inserted during sex, and where blood flows out during menstruation
- **Anus:** Where solid waste leaves the body.

#### Internal female reproductive anatomy

Primary structures and organs include:

- **Uterus (womb):** Reproductive organ where a fertilized ovum, or egg, grows and develops into a foetus
- **Fallopian tube:** Each of the two tubes that link the ovaries to the uterus. An ovum travels along one of these tubes once a month. Fertilization occurs in this tube.
- **Ovary:** Two reproductive glands where ova (eggs) develop and 1 is released each month
- **Ovarian follicle:** A hollow ball of cells that contains an immature ovum. Located in each ovary
- **Endometrium:** The lining of the uterus, which gradually thickens and then is shed during menstruation
- **Cervix:** Lower portion of the uterus that extends into the upper vagina. It produces mucus.
- **Vagina:** Joins the outer sexual organs with the uterus.

### 3.4 The Male Reproductive System

The primary structures and organs of the male reproductive system include:

- **Penis:** Male sex organ made of spongy tissue

- **Urethra:** Tube through which semen is released from the body. Urine is released through the same tube.
- **Seminal vesicles:** Where sperm is mixed with semen
- **Foreskin:** Hood of skin covering the end of the penis
- **Prostate:** Organ that produces some of the fluid in semen
- **Testicles:** Organs that produce sperm
- **Scrotum:** Sack of thin, loose skin containing the testicles
- **Vas deferens:** Each of the 2 thin tubes that carry sperm from the testicles to the seminal vesicles.

### 3.5 Phases of the Menstrual and Ovarian Cycles

By definition, the menstrual (or uterine) cycle begins with the first day of bleeding, which is counted as day 1. The cycle ends just before the next menstrual period. Menstrual cycles normally range from about 25 to 36 days. The description of the phases of the menstrual cycle below assumes a cycle length of 28 days. However, only 10% to 15% of women have cycles that are exactly 28 days.

The menstrual and ovarian cycles each have 3 phases:

#### **Menstrual cycle**

##### **Days 1-5: Menstrual phase**

- This phase is from first day of the menses to last day of bleeding (usually lasts from 3–5 days, up to 7 days).
- Bleeding occurs when there is no fertilization.
- Low levels of both progesterone and oestrogen make the blood vessels of the endometrium constrict, cutting off blood flow to the uterine lining.
- The cells of the uterine lining start to die, and the lining sloughs off and causes bleeding.
- Two-thirds of the endometrial lining sheds during menses.
- During this time the ovaries are beginning the follicular stage (see below).

##### **Days 6-14: Proliferative phase**

- This phase is from cessation of menses to ovulation.
- Endometrial lining thickens in preparation for implantation of a fertilized ovum. Its thickness doubles to about 4–6 mm.
- Uterine secreting glands increase in size and produce mucus.
- Uterine blood vessels begin to grow.
- Ovulation occurs in the ovaries at the end of this stage, usually around day 14, triggered by a surge in luteinizing hormone (LH) from the anterior pituitary gland.

##### **Days 15-28: Secretory phase**

- This phase is from ovulation to the start of the next menses.
- Endometrial glands secrete mucus, which prepares the uterus to receive a fertilized ovum.
- The corpus luteum produces oestrogen, while the cells of the ovaries produce progesterone.

- Endometrium continues to thicken.

### **Ovarian cycle:**

While the uterus is proceeding through the 3 phases above, the ovaries pass through the following phases:

- **Follicular phase:** (about 14 days): Between 3-30 follicles, each containing 1 ovum (egg), begin to grow, with usually 1 reaching maturity while the others break down.
- **Ovulatory phase** (about 16-32 hours): The ovum is released from the follicle and enters the Fallopian tube.
- **Luteal phase** (about 14 days): The ruptured follicle forms a structure called the corpus luteum. The corpus luteum produces progesterone, which helps prepare the endometrium for a fertilized egg.

## **3.6 Fertilization and Implantation**

Once the egg is released from the ovary (ovulation), it can live for about 24 hours. Once sperm move up the female reproductive tract (through the cervix and into the uterus) after ejaculation, they can usually live for about 48 hours. Fertilization, when the egg joins with the sperm and forms the oocyte, usually happens within 24 hours of intercourse. The fertilized oocyte then implants into the endometrium by 5-7 days after fertilization.

Following implantation:

- The developing placental tissues secrete chorionic gonadotropine, a hormone that helps maintain pregnancy, which maintains the corpus luteum.
- The corpus luteum of pregnancy, as this is now called, produces the oestrogens and progesterone required to maintain the pregnancy until the placenta takes over this function.

If the ovum is not fertilized by a sperm, the corpus luteum regresses, levels of oestrogens and progesterone drop off, the endometrium begins to slough off and pass through the vagina, and menstruation begins the reproductive cycle again.

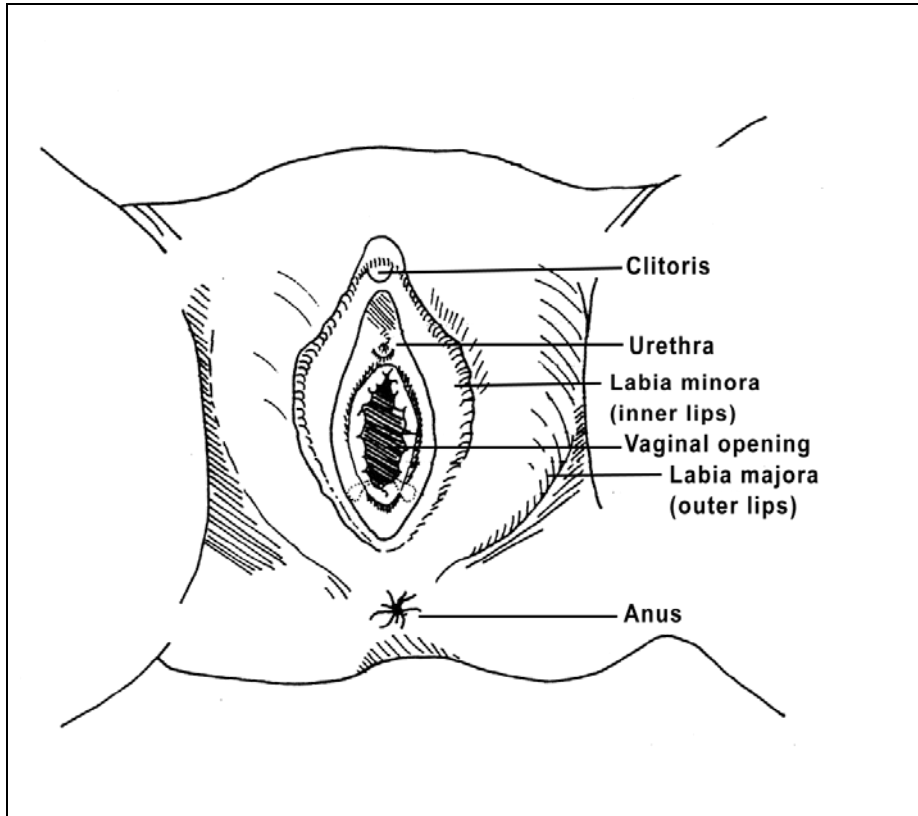
## **3.7 Fertile Days of the Menstrual Cycle**

A woman's fertile days depend on ovulation as well as the life span of the egg and the sperm. The egg and sperm are most likely to join, and pregnancy is most likely to occur, when unprotected sexual intercourse takes place during the 2 days before ovulation or on the day of ovulation. It is also possible a day or 2 after ovulation—although this is less likely.

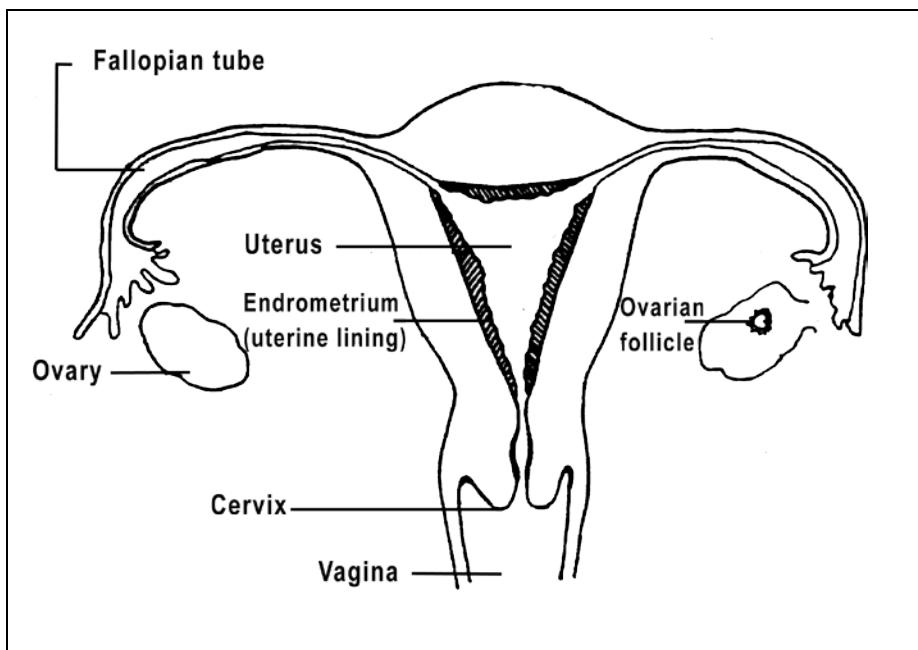
Most women ovulate between 11 and 18 days after the first day of their last period. This is the time when women are most fertile and most likely to get pregnant. But the time of ovulation can be different from month to month and different between different women. Therefore, a woman could potentially become pregnant if she has unprotected sex on most days of her menstrual cycle.

Handouts

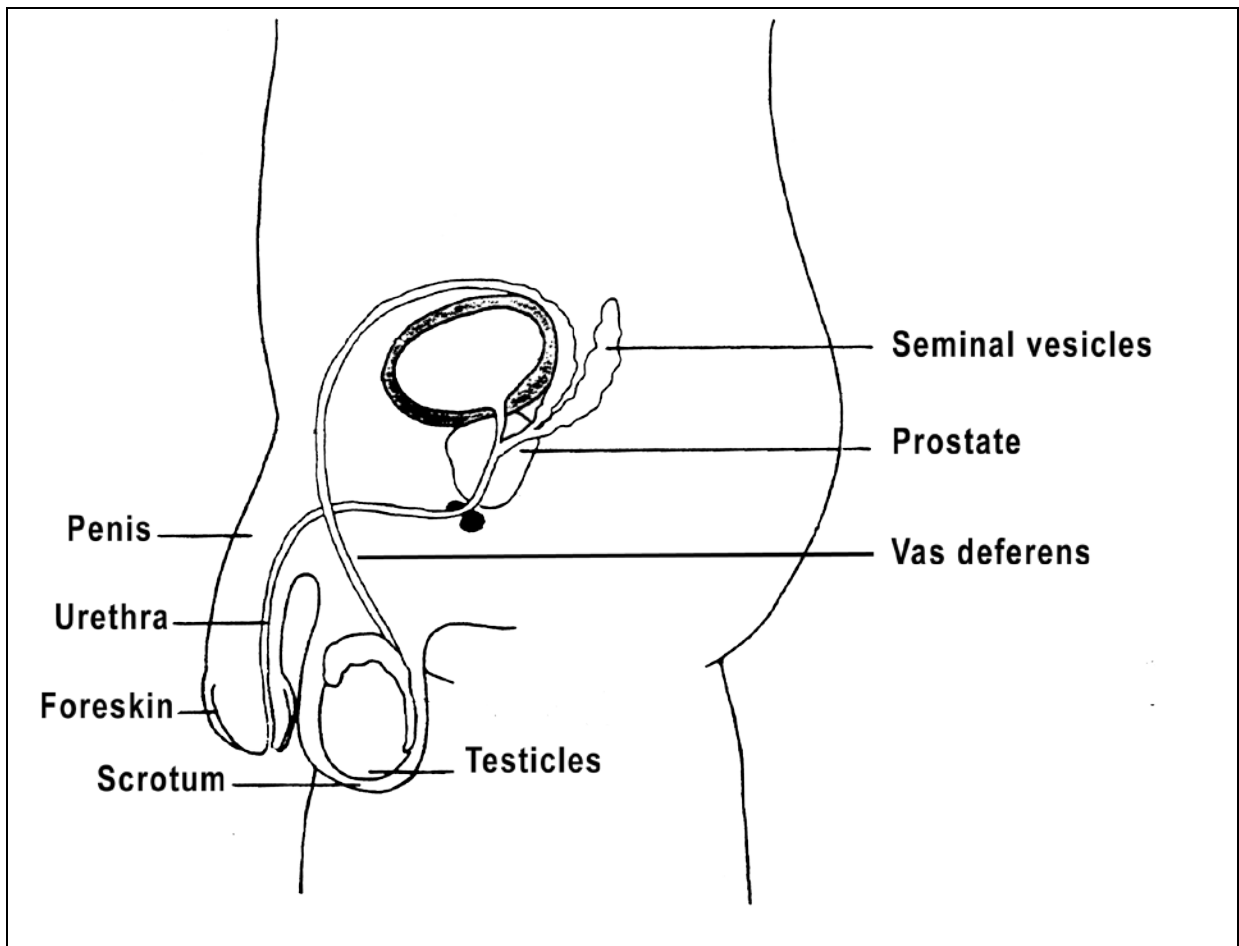
**External Female Reproductive Anatomy**



**Internal Female Reproductive Anatomy**



## Male Reproductive Anatomy



## Reproductive Systems Quiz Questions

**Questions 1–9 :** Indicate whether the following statements about the reproductive systems are true or false by writing a “T” for true or an “F” for false in the space provided before each statement.

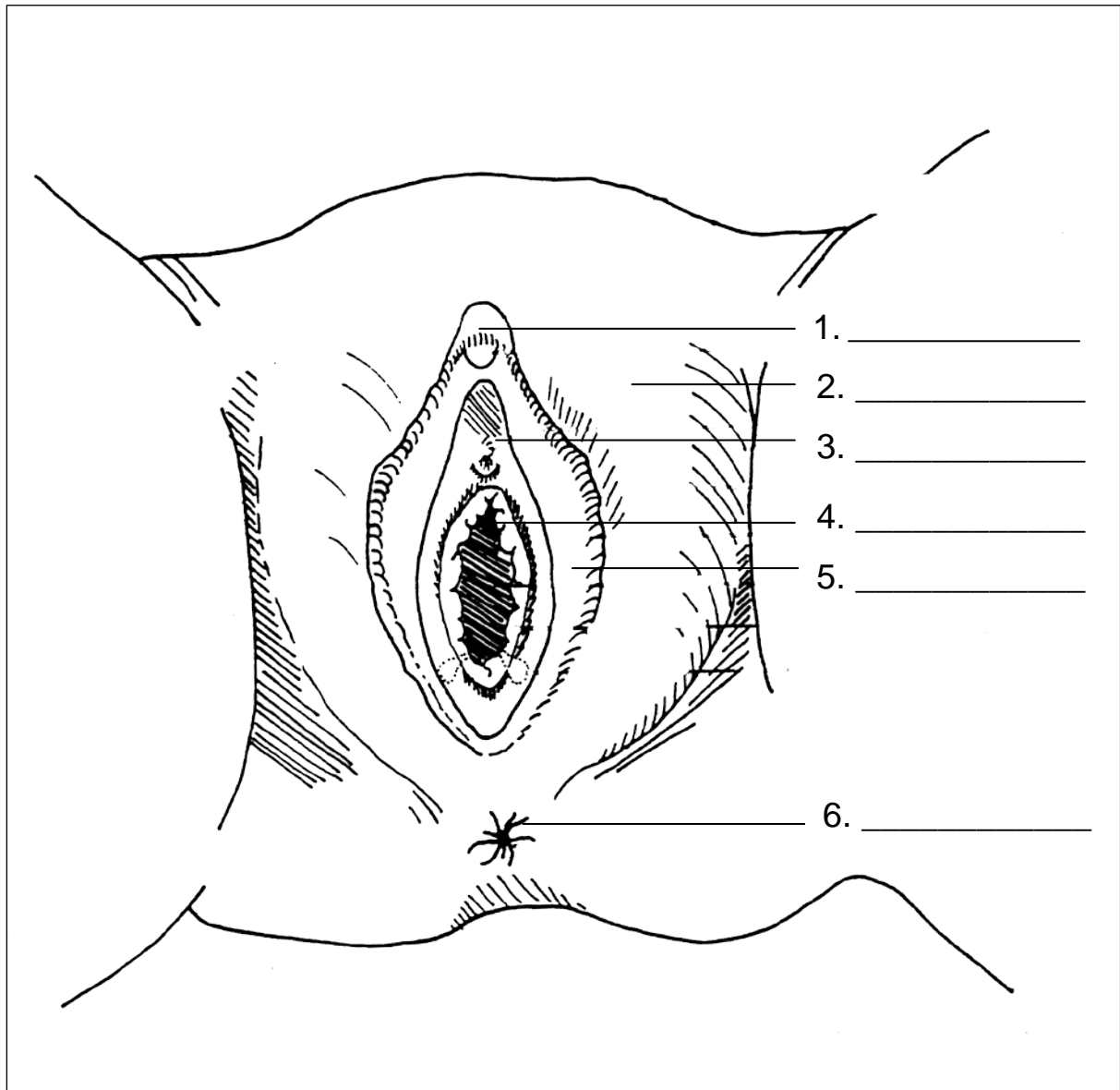
- \_\_\_ 1. Proteins control the changes in the ovaries and uterus associated with the reproductive cycle.
- \_\_\_ 2. The urethra is a tube through which semen is released from the body.
- \_\_\_ 3. The vas deferens are 2 thin tubes that carry sperm from the seminal vesicles to the testicles.
- \_\_\_ 4. Fertilization occurs in the uterus.
- \_\_\_ 5. The menstrual cycle begins with the first day of bleeding.
- \_\_\_ 6. The majority of women have menstrual cycles that last 28 days.
- \_\_\_ 7. Blood pools in the uterus during the month and is released during the menstrual phase of the menstrual cycle.
- \_\_\_ 8. During the proliferative phase of the menstrual cycle, endometrial glands secrete mucus, which prepares the uterus to receive a fertilized ovum.
- \_\_\_ 9. Fertilization is most likely to occur when unprotected sexual intercourse happens during the 2 days before ovulation or on the day of ovulation.

**Questions 10–15 :** Please fill in the blank spaces to complete the following sentences.

- 10. After ovulation, the ovum normally lives for \_\_\_\_\_ (length of time) in the reproductive tract.
- 11. After ejaculation, sperm normally survive \_\_\_\_\_ (length of time) in the female reproductive tract.
- 12. If an ovum is fertilized, it continues to travel down the \_\_\_\_\_ toward the \_\_\_\_\_.
- 13. A fertilized ovum implants into the \_\_\_\_\_ about \_\_\_\_\_ days after fertilization.
- 14. At the end of the proliferative phase, \_\_\_\_\_ occurs in the ovaries.
- 15. The phases of the menstrual cycle, in the order in which they occur, are \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

## External Female Reproductive Anatomy Assessment

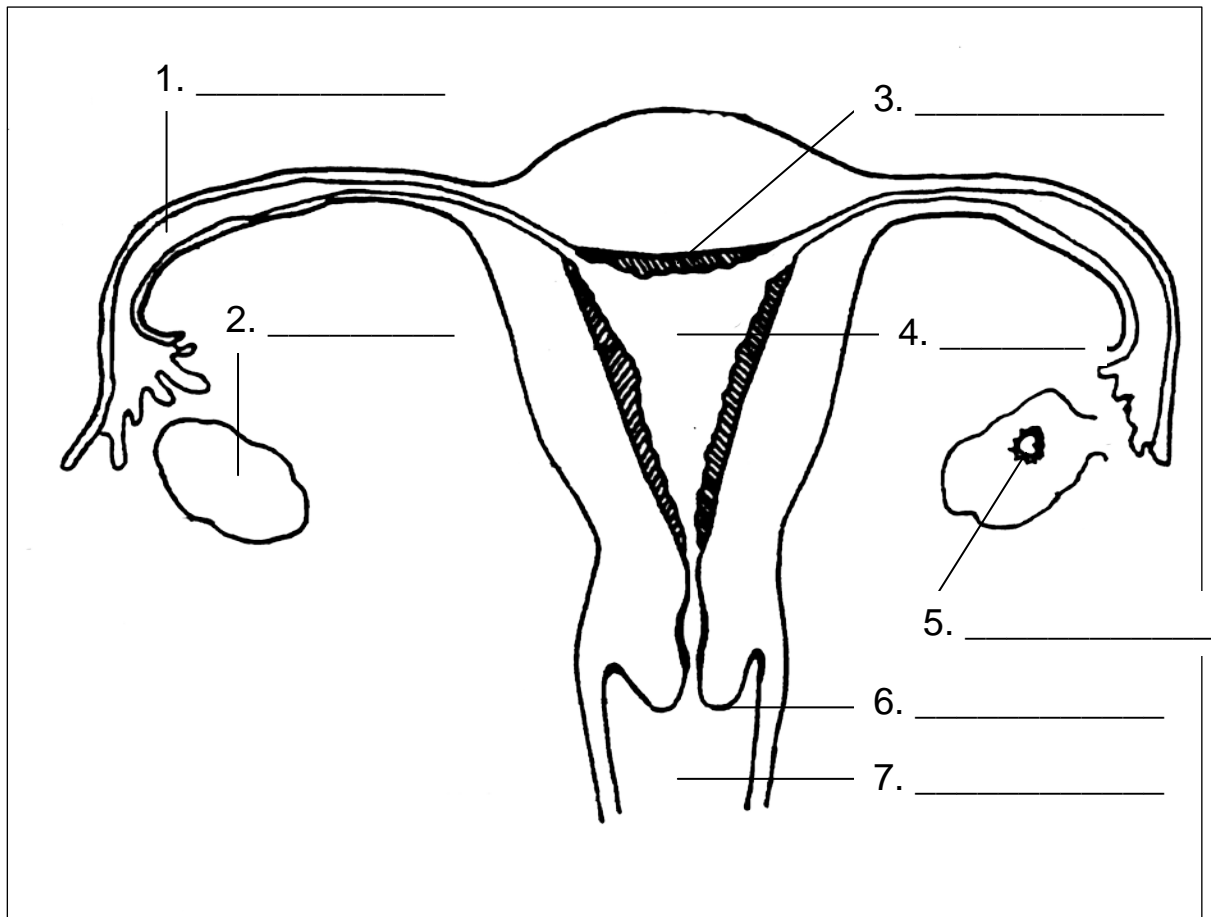
Label the major structures in this illustration:





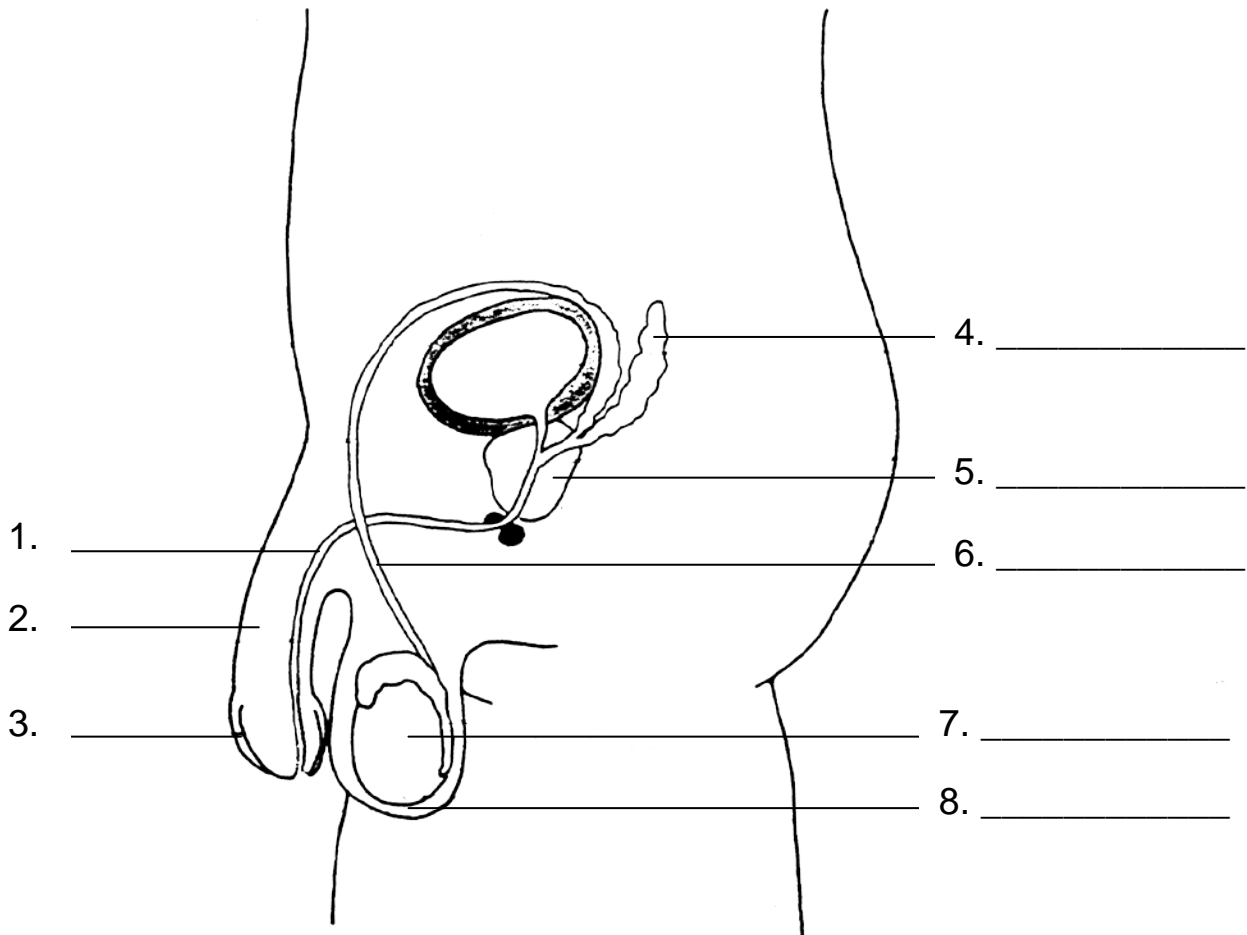
## Internal Female Reproductive Anatomy Assessment

Label the major organs and structures in this illustration:



## Male Reproductive Anatomy Assessment

Label all the major reproductive structures and organs in this illustration:



## Reproductive Systems Quiz Questions Answer Key

- F** \_\_ 1. Proteins control the changes in the ovaries and uterus associated with the reproductive cycle.
- T** \_\_ 2. The urethra is a tube through which semen is released from the body.
- F** \_\_ 3. The vas deferens are 2 thin tubes that carry sperm from the seminal vesicles to the testicles.
- F** \_\_ 4. Fertilization occurs in the uterus.
- T** \_\_ 5. The menstrual cycle begins with the first day of bleeding.
- F** \_\_ 6. The majority of women have menstrual cycles that last 28 days.
- F** \_\_ 7. Blood pools in the uterus during the month and is released during the menstrual phase of the menstrual cycle.
- F** \_\_ 8. During the proliferative phase of the menstrual cycle, endometrial glands secrete mucus, which prepares the uterus to receive a fertilized ovum.
- T** \_\_ 9. Fertilization is most likely to occur when unprotected sexual intercourse happens during the 2 days before ovulation or on the day of ovulation.
10. After ovulation, the ovum normally lives for **24 hours** (length of time) in the reproductive tract.
11. After ejaculation, sperm normally survive **2 days** (length of time) in the female reproductive tract.
12. If an ovum is fertilized, it continues to travel down the **Fallopian tube** toward the **uterus**.
13. A fertilized ovum implants into the **endometrium** about **5-7** days after fertilization.
14. At the end of the proliferative phase, ovulation occurs in the ovaries.
15. The phases of the menstrual cycle, in the order in which they occur, are **menstrual phase**, **proliferative phase**, and **secretory phase**.

# Anatomy Assessment Answer Key

## **External female reproductive anatomy**

1. clitoris
2. labia majora (outer lips)
3. urethra
4. vagina
5. labia minora (inner lips)
6. anus

## **Internal female reproductive anatomy**

1. Fallopian tube
2. ovary
3. endometrium
4. uterus
5. ovarian follicle
6. cervix
7. vagina

## **Male reproductive anatomy**

1. urethra
2. penis
3. foreskin
4. seminal vesicles
5. prostate
6. vas deferens
7. testicles
8. scrotum

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<http://info.k4health.org/globalhandbook/>

## Unit 4

# FAMILY PLANNING CLIENT ASSESSMENT AND WHO MEDICAL ELIGIBILITY CRITERIA

### Learning Objectives

By the end of this unit, learners will be able to:

- ❖ Describe the purpose of client assessment for family planning
- ❖ List the assessment tasks required for specific family planning methods
- ❖ Identify the basic information that can be gathered during family planning client assessment
- ❖ Determine how to be reasonably sure a client is not pregnant using the pregnancy checklist
- ❖ Identify medical conditions that make pregnancy especially risky
- ❖ List the signs of gender-based violence (GBV) to look for during the assessment
- ❖ Define the World Health Organization (WHO) Medical Eligibility Criteria (MEC)
- ❖ State the purpose of the MEC
- ❖ Explain the meaning of the four WHO MEC classification categories
- ❖ Describe the two-category MEC framework and how it can be used when clinical judgment is limited
- ❖ Demonstrate how to use MEC summary tables to find classifications of client conditions/situations and determine eligibility for specific methods.

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## Unit 4: Family Planning Client Assessment and WHO Medical Eligibility Criteria

### Key Points

- ❖ Medical requirements that are not essential to the provision of specific contraceptives act as major barriers to contraceptive choice and access to services.
- ❖ Only the provision of intrauterine contraceptive devices (IUCDs) and sterilisation require physical exams.
- ❖ Determining if a client is pregnant can be accomplished through use of the Pregnancy Checklist.
- ❖ Some medical conditions can make pregnancy riskier.
- ❖ Family planning providers should be alert to signs of gender-based violence in their clients.
- ❖ The MEC provide evidence-based criteria for determining if a client can safely use a contraceptive method.
- ❖ The MEC classification system uses 4 categories that describe whether a contraceptive method can be used in the presence of a given condition.
- ❖ A two-category MEC system exists for locations where resources for clinical judgment are limited.
- ❖ MEC Summary Tables provide an easy way to determine client eligibility for each method.
- ❖ MEC guidelines are regularly updated to reflect the latest medical knowledge and practice.

### 4.1 Purpose of Client Assessment for Family Planning

This section of the unit describes client assessment prior to provision of family planning methods. The **primary objectives** of this assessment, or screening, are to determine whether the family planning client:

- Is pregnant
- Has any conditions that affect the client's medical eligibility to start or continue using a particular method
- Has any special problems that require further assessment, treatment, or regular follow-up.

These objectives usually can be accomplished by asking a few key questions. Unless specific problems are identified, the safe provision of contraceptive methods, except IUCDs and voluntary female and male sterilisation, does **not** require **physical or pelvic examinations**.

Where resources are limited, requiring medical evaluation and/or laboratory testing (e.g., blood sugar and haemoglobin) before providing modern contraceptive methods is **not** justifiable.

Where demand for family planning services is high, medical requirements that are **not** essential to the provision of specific contraceptives act as major barriers to contraceptive choice and

access to services. To enable clients to obtain the contraceptive method of their choice, **only** those procedures that are essential and mandatory for **all** clients in **all** settings should be required.

(JHPIEGO, no date)

## 4.2 Assessment Tasks Required for Specific Methods

The table that follows summarizes the client assessment requirements for all contraceptive methods. Depending on answers given to the medical eligibility screening questions for specific methods, physical and pelvic examinations may be needed as indicated.

Table 4.1: Client Assessment Requirements for All Contraceptive Methods

Assessment	Fertility Awareness Methods (FAM), Lactational Amenorrhoea Method (LAM)	Barrier Methods (Male or Female Condoms)	Hormonal Methods*	IUCDs	Voluntary Sterilization (Female/Male)
Reproductive Health Background	No	No	No	No	No
STI History	No	No	No	Yes, to determine if at high personal risk	No
<b>Physical Examination</b>					
<b>Female</b>					
General (including BP)	No	No	No <sup>a</sup>	No <sup>a</sup>	Yes
Abdominal	No	No	No <sup>a</sup>	Yes	Yes
Pelvic Speculum	No	No	No <sup>a, b</sup>	Yes	Yes
Pelvic Bimanual	No	No	No <sup>b</sup>	Yes	Yes
<b>Male</b> (groin, penis, testes and scrotum)	N/A	No	N/A	N/A	Yes

(Adapted from Jhpiego, no date.)

\*Hormonal methods include combined oral contraceptive pills (COCs), progestin-only pills (POPs), contraceptive implants and injectables (DMPA).

<sup>a</sup> If screening checklist responses are all negative (No), examination is not necessary.

<sup>b</sup> This is only necessary if pregnancy is suspected and pregnancy test is not available.



## 4.3 Information Gathered During Client Assessment

Although taking a medical history is not required for providing contraceptive methods, it is helpful to gather basic information that will help the provider and the client discuss family planning method options, if the client agrees. This information can be gathered in a relaxed and friendly manner that puts the client at ease. Explain that for most family planning methods there will be no need for a physical or pelvic exam.

Information that can be gathered in a client history includes:

- Age of client (female)
- Number of living children
- Sex of living children
- Age of youngest child
- History of complications with pregnancy
- Current pregnancy status/date of last menstrual period
- Desire for more children
- Desired timing for birth of next child
- Breastfeeding status
- Regularity of menstrual cycle
- Number of current sexual partners
- Level of sexual activity (active, occasional, etc.)
- Chronic illnesses (i.e. heart disease, diabetes mellitus, hypertension, liver/jaundice problem, kidney/renal disease, cervical/breast cancer)
- Smoking status.

## 4.4 How to Be Reasonably Sure a Client is Not Pregnant

It is recommended that family planning providers assess whether a woman seeking contraceptive services might already be pregnant—because women who are currently pregnant do not require contraception. Further, the IUCD should never be inserted in pregnant women because doing so might lead to septic miscarriage. There is no known harm to the woman, the course of her pregnancy, or the foetus if COCs or DMPA are accidentally used during pregnancy.

You can be reasonably sure a client is not pregnant if she has no signs or symptoms of pregnancy (e.g., breast tenderness or nausea) and she answers “**Yes**” to at least one of the questions on the Pregnancy Checklist. This checklist, “How to be reasonably sure a client is not pregnant,” is highly effective and has been validated in Kenya, Guatemala, Senegal, Mali, and Egypt. When used correctly, it is more than 99% effective in ruling out pregnancy. (See Pregnancy Checklist in the Handouts section of this unit.)

**A pelvic examination is seldom necessary for family planning provision**, except to rule out pregnancy of more than 6 weeks, as measured from the last menstrual period (LMP).

**Pregnancy testing** is unnecessary except in cases where:

- It is difficult to confirm pregnancy (i.e., 6 weeks or less from the last menstrual period)
- The results of the pelvic examination are unclear (e.g., the client is overweight, making sizing the uterus difficult).

In these situations, a sensitive urine pregnancy test (i.e., detects <50 U/ml of human chorionic gonadotrophin hormone, or hCG) may be helpful, if readily available and affordable. If pregnancy testing is **not** available, counsel the client to use a temporary contraceptive method or abstain from intercourse until her menses occurs or pregnancy is confirmed.

### Using the Pregnancy Checklist

To use the Pregnancy Checklist, ask the client questions 1–6 on the checklist. As soon as the client answers "yes" to any question, stop and follow the instructions at the bottom of the checklist.

When a woman is **more than 6 months postpartum** you can still be reasonably sure she is not pregnant if she:

- Has kept her **breastfeeding frequency high**
- Has still had **no menstrual bleeding** (is amenorrheic)
- Has **no clinical signs or symptoms of pregnancy**.
- **Note:** The Pregnancy Checklist is also available for download from: <http://info.k4health.org/globalhandbook/book/tools/pregchecklist.shtml>. Hard copies of the checklist are available by contacting: [publications@fhi.org](mailto:publications@fhi.org).

## 4.5 Medical Conditions that Make Pregnancy Especially Risky

Some common medical conditions make pregnancy riskier to a woman's health. The effectiveness of her contraceptive method thus has special importance.

If a woman says that she has any of the common conditions listed below:

- She should be told that pregnancy could be especially risky to her health and, in some cases, to the health of her baby.
- During counselling, focus special attention on the effectiveness of methods. Clients who are considering a method that requires correct use with every act of sexual intercourse should think carefully about whether they can use the method effectively.

#### Reproductive tract infections and disorders

- Breast cancer
- Endometrial cancer
- Ovarian cancer
- Some sexually transmitted infections (gonorrhoea, chlamydia)
- Some vaginal infections (bacterial vaginosis)

#### Cardiovascular disease

- High blood pressure (systolic blood pressure higher than 160 mm Hg or diastolic blood pressure higher than 100 mm Hg)
- Complicated valvular heart disease
- Ischemic heart disease (heart disease due to narrowed arteries)
- Stroke

#### Other infections

- HIV/AIDS
- Tuberculosis
- Schistosomiasis with fibrosis of the liver

#### Endocrine conditions

- Diabetes if insulin dependent, with damage to arteries, kidneys, eyes, or nervous system (nephropathy, retinopathy, neuropathy), or of more than 20 years' duration

#### Anaemias

- Sickle cell disease

#### Gastrointestinal conditions

- Severe (decompensated) cirrhosis of the liver
- Malignant (cancerous) liver tumours (hepatoma)

(WHO/RHR and CCP, Knowledge for Health Project 2008)

## 4.6 Signs of Gender-Based Violence

A client's experience with GBV can play a role in her choice of family planning method because it may prevent her from negotiating the timing of sexual activity or the use of condoms. (More information about GBV is provided in Unit 2: Gender-Sensitive Family Planning Services.) The following signs that might be seen in the family planning clinic can indicate GBV and merit follow-up questions by the provider:

- Chronic, vague complaints that have no obvious physical cause
- Injuries that do not match the explanation of how they occur
- A male partner who is overly attentive, controlling, or unwilling to leave the woman's side
- A history of attempted suicide or suicidal thoughts
- Urinary tract infection
- Chronic irritable bowel syndrome
- Chronic pelvic pain
- An STI in a young girl
- Vaginal itching or bleeding
- Painful defecation or painful urination
- Abdominal or pelvic pain
- Sexual problems, lack of pleasure
- Vaginismus (spasms of the muscles around the opening of the vagina)
- Anxiety, depression, self-destructive behaviour
- Sleeping problems
- Having difficulty with or avoiding pelvic exams
- Extreme obesity.

## 4.7 Defining the WHO Medical Eligibility Criteria

The WHO document, *Medical Eligibility Criteria (MEC) for Contraceptive Use*, contains the WHO's evidence-based guidelines for the safe and effective use of family planning methods.

These guidelines, which are updated regularly, reflect the consensus of experts from the world's leading health organisations and are based on the latest clinical and epidemiological data. The 2009 edition of *MEC for Contraceptive Use* is now available online (see below). This edition includes the latest updates to the guidelines from the 2008 Working Group meeting.

*MEC for Contraceptive Use* guidelines are intended for use by policy-makers, programme managers and the scientific community in the preparation of national family planning/sexual and reproductive health programmes for delivery of contraceptives. They are not intended as a national guideline for family planning, but rather as a reference. This document may be downloaded at: [http://whqlibdoc.who.int/publications/2009/9789241563888\\_eng.pdf](http://whqlibdoc.who.int/publications/2009/9789241563888_eng.pdf) or can be obtained at no charge from: WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (Tel.: +41 22 791 3264; fax: +41 22 791 4857) e-mail: [bookorders@who.int](mailto:bookorders@who.int)

*MEC for Contraceptive Use* includes a comprehensive list of client characteristics and medical conditions and explains how these conditions and characteristics affect medical eligibility for starting or continuing each family planning method.

WHO has also published MEC Summary Tables, which summarize the guidelines contained in *MEC for Contraceptive Use* in a user-friendly format.

This section of the unit introduces the WHO Medical Eligibility Criteria, explains the MEC categories, and explains how to use the MEC Summary Tables to determine client eligibility for contraceptive methods.

## 4.8 The Purpose of the MEC

The WHO MEC:

- Provide guidance on whether a person with a specific health condition can safely start to use a specific contraceptive method or, if she or he develops a health condition, can continue to use the method safely
- Ensure that family planning service provision is based on the best available scientific evidence
- Address and correct misconceptions about who can and cannot safely use contraception
- Reduce medical, policy, and practice barriers to family planning services (i.e., those unjustified by the evidence)
- Improve quality, access, and use of family planning services.

## 4.9 WHO MEC Categories

For most of the contraceptive methods addressed, the WHO Expert Working Group by consensus classified conditions on a scale of 1 to 4. These categories explain whether, in the presence of a given individual characteristic or medical condition, a particular contraceptive method may safely be used. These categories are as follows:

**Category 1** Condition for which there is no restriction for use of the contraceptive method

**Category 2** Condition where the advantages of using the method generally outweigh the theoretical or proven risks

**Category 3** Condition where the theoretical or proven risks usually outweigh the

advantages of using the method

**Category 4** Condition that presents an unacceptable health risk if the contraceptive method is used.

According to this system, clients with conditions that are classified as **Category 1** can use the method in question, while those with a condition that is classified as **Category 4** should not use the method. Categories 2 and 3 are a little more complicated. Classification of a condition/characteristic as **Category 2** for a particular method indicates the method can generally be used, but careful follow-up may be required.

However, provision of a method to a client with a condition classified as **Category 3** requires careful clinical judgment and access to clinical services. For such a client, the severity of the condition and the availability, practicality, and acceptability of alternative methods should be taken into account. For a condition/method classified as Category 3, use of that method is not usually recommended unless other more appropriate methods are not available or acceptable. Careful follow-up will be required (WHO/RHR 2009).

**Where resources for clinical judgment are limited**, the four-category framework can be simplified into **two categories**. In the two-category system, Category 1 and 2 classification indicates that a woman is medically eligible to use the method. A Category 3 or 4 classification indicates that a woman is not medically eligible to use the method. (See Table 4.2.)

Table 4.2 MEC Categories of Temporary Methods

Category	With clinical judgment	With limited clinical judgment
1	Use method in any circumstances	Use the method
2	Generally use: Advantages outweigh risks	Use the method
3	Generally DO NOT use: Risks outweigh advantages	DO NOT use the method
4	DO NOT use the method	DO NOT use the method

(WHO/RHR 2009)

## 4.10 MEC Categories for Female and Male Sterilisation

The four numbered MEC categories above apply to all contraceptive methods **except** female and male sterilisation. For these methods, the WHO Expert Working Group developed a separate ranking system. Recommendations for surgical sterilization are defined according to the categories in the table below.

Table 4.3: WHO MEC Categories for Male and Female Sterilisation

Category	Definition
<b>Accept</b>	There is no medical reason to deny the method to a person with this condition or in this circumstance.
<b>Caution</b>	Provide the method in a routine setting but with extra preparations and precautions.
<b>Delay</b>	Delay use of the method until the condition is evaluated and/or corrected. Provide alternative, temporary methods of contraception.
<b>Refer</b>	<p>The procedure should be performed in a setting with an experienced surgeon and staff, equipment to provide general anaesthesia, and other backup medical support.</p> <p>This condition also requires the capacity to decide on the most appropriate procedure and anaesthesia support.</p> <p>Provide alternative, temporary methods of contraception if referral is required or if there is otherwise any delay.</p>

(WHO/RHR 2009)

## 4.11 Updates to WHO MEC Guidelines

- WHO periodically updates the MEC as new scientific information becomes available. To find the latest version of the Guidelines, see [http://www.who.int/reproductivehealth/publications/family\\_planning/en/index.html](http://www.who.int/reproductivehealth/publications/family_planning/en/index.html)

The WHO issued updates to the MEC in 2008, including the following:

- Most women with HIV infection generally can use IUCDs.
- Women generally can take hormonal contraceptives while on antiretroviral (ARV) therapy for HIV infection, although there are interactions between contraceptive hormones and certain ARV drugs. These interactions may alter the safety and effectiveness of both the hormonal contraceptive and the antiretroviral drug. Research in this area is ongoing.
- Women with clinical depression usually can take hormonal contraceptives.

## 4.12 Using the WHO MEC Summary Tables

The WHO MEC Summary Tables provide an easy way to determine the MEC categories that apply to a particular client. These tables, reprinted in the Handout section of this unit, can be used as follows:

- First, locate the client's medical condition(s) or situation in the left-hand column of the table.
- Then locate the table's columns corresponding to the methods she/he is considering.
- The number (1–4) displayed in each column indicates how the condition is categorised for that method.

## Example

A 25-year-old woman with a history of heavy menstrual bleeding has requested a progestin-only injectable. To find the classification of her condition for this injectable:

- First, locate the section of the MEC Summary Tables that contains the title: “Reproductive Tract Infections and Disorders.”
- In the left-hand column in this table, locate the row label for “Heavy or prolonged bleeding.”
- Then, move across that row to find the column under the heading of “Progestin-only Injectables.”
- The box in that column displays the number “2.” This means that the client may use the injectable because the advantages generally outweigh the risks in this situation.
- You may provide the method to this client.

Another resource that summarizes the WHO MEC for the most commonly used methods (COCs, DMPA, and IUCDs) is the Quick Reference Chart, also reprinted in the Handout section of this unit.

## 4.13 Medical Eligibility Screening Questions and Checklists

Medical Eligibility Screening Questions and Screening Checklists based on the WHO MEC are available for most of the most popular family planning methods. These screening tools are provided in the appropriate method unit in this guide. The questions and checklists give health workers an easy, accurate and reliable way to determine medical eligibility for family planning in a format that can be understood by both health care worker and client. Health providers at all levels, including community health workers, may use the Medical Eligibility Screening Questions and Screening Checklists.

Using these screening tools is important, because contraceptive provision in many areas continues to be based on outdated medical information, provider biases, and unproven, theoretical concerns. For instance, studies have found that in some countries, 25%-50% of women seeking contraception are unnecessarily refused services until they are menstruating. When provided with effective training, screening questions and checklists are important tools that enable providers at all levels to apply the latest WHO MEC and guidelines for contraceptive use without such unnecessary barriers (Callahan R. 2006).

## How to be Reasonably Sure a Client is Not Pregnant

Ask the client questions 1–6. As soon as the client answers **YES** to *any question*, stop, and follow the instructions.

<b>NO</b>	1. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	<b>YES</b>	
<b>NO</b>	2. Have you abstained from sexual intercourse since your last menstrual period or delivery?	<b>YES</b>	→
<b>NO</b>	3. Have you had a baby in the last 4 weeks?	<b>YES</b>	→
<b>NO</b>	4. Did your last menstrual period start within the past 7 days (or within the past 12 days if you are planning to use an IUD)?	<b>YES</b>	→
<b>NO</b>	5. Have you had a miscarriage or abortion in the past 7 days (or within the past 12 days if you are planning to use an IUD)?	<b>YES</b>	→
<b>NO</b>	6. Have you been using a reliable contraceptive method consistently and correctly?	<b>YES</b>	→

If the client answered **NO** to *all of the questions*, pregnancy cannot be ruled out. The client should await menses or use a pregnancy test.

If the client answered **YES** to *at least one of the questions* and she is free of signs or symptoms of pregnancy, provide client with desired method.





## Medical Eligibility Criteria for Contraceptive Use

The tables on these pages summarize the World Health Organization Medical Eligibility Criteria for using contraceptive methods.

(Reprinted with permission of the Center for Communications Programs (CCP), Knowledge for Health Project. Source: WHO/RHR and CCP, Knowledge for Health 2008.

[http://info.k4health.org/globalhandbook/book/fph\\_appendix\\_d/index.shtml](http://info.k4health.org/globalhandbook/book/fph_appendix_d/index.shtml)

### Categories for Temporary Methods

Category	With Clinical Judgment	With Limited Clinical Judgment
1	Use method in any circumstances	Yes (Use the method)
2	Generally use method	
3	Use of method not usually recommended unless other more appropriate methods are not available or not acceptable	No (Do not use the method)
4	Method not to be used	

Note: In the table beginning with Personal Characteristics and Reproductive History, Category 3 and 4 conditions are shaded to indicate that the method should not be provided where clinical judgment is limited.

See conditions relating to vasectomy, male and female condoms, spermicides, diaphragms, cervical caps, and lactational amenorrhea method. See conditions relating to fertility awareness methods.

### Categories for Female Sterilisation

<b>Accept (A)</b>	There is no medical reason to deny the method to a person with this condition or in this circumstance.
<b>Caution (C)</b>	The method is normally provided in a routine setting but with extra preparation and precautions.
<b>Delay (D)</b>	Use of the method should be delayed until the condition is evaluated and/or corrected. Alternative, temporary methods of contraception should be provided.
<b>Special (S)</b>	The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anaesthesia, and other backup medical support. The capacity to decide on the most appropriate procedure and anaesthesia support also is needed. Alternative, temporary methods of contraception should be provided if referral is required or there is otherwise any delay.

- = Use the method
- = Do not use the method
- I** = Initiation of the method
- C** = Continuation of the method
- = Use the method
- NA** = Not applicable

### Condition

	Combined oral contraceptives	Monthly injectables	Combined patch and combined vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device	Levonorgestrel intrauterine device	Female sterilisation*
<b>PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY</b>										
<b>Pregnant</b>	NA	NA	NA	NA	NA	NA	NA	4	4	D
<b>Age</b>	Menarche to < 40 years			Menarche to < 18 years				Menarche to < 20 years		Young age
	1	1	1	1	2	1	—	2	2	C
	≥ 40 years			18 to 45 years				≥ 20 years		
	2	2	2	1	1	1	—	1	1	
				> 45						
			1	2	1	—				
<b>Parity</b>										
Nulliparous (has not given birth)	1	1	1	1	1	1	—	2	2	A
Parous (has given birth)	1	1	1	1	1	1	—	1	1	A
<b>Breastfeeding</b>										
< 6 weeks postpartum	4	4	4	3 <sup>a</sup>	3 <sup>a</sup>	3 <sup>a</sup>	1	b	b	*
≥ 6 weeks to < 6 months postpartum (primarily breastfeeding)	3	3	3	1	1	1	1	b	b	A
≥ 6 months postpartum	2	2	2	1	1	1	1	b	b	A
<b>Postpartum (not breastfeeding)</b>										
< 21 days	3	3	3	1	1	1	—	b	b	*
≥ 21 days	1	1	1	1	1	1	—	b	b	
<b>Postabortion</b>										
First trimester	1	1	1	1	1	1	—	1	1	*
Second trimester	1	1	1	1	1	1	—	2	2	
Immediate post-septic abortion	1	1	1	1	1	1	—	4	4	
<b>Past ectopic pregnancy</b>	1	1	1	2	1	1	1	1	1	A
<b>History of pelvic surgery</b>	1	1	1	1	1	1	—	1	1	C
<b>Smoking</b>										
Age < 35 years	2	2	2	1	1	1	—	1	1	A
Age ≥ 35 years										
<15 cigarettes/day	3	2	3	1	1	1	—	1	1	A
≥15 cigarettes/day	4	3	4	1	1	1	—	1	1	A

\* See additional conditions relating to emergency contraceptive pills and female sterilisation.

- a In settings where pregnancy morbidity and mortality risks are high and this method is one of few widely available contraceptives, it may be made accessible to breastfeeding women immediately postpartum.
- b Postpartum IUD use: For the copper-bearing IUD, insertion at <48 hours is Category 1. For the LNG-IUD, insertion at <48 hours is Category 3 for breastfeeding women and Category 1 for women not breastfeeding. For all women and both IUD types, insertion from 48 hours to <4 weeks is Category 3; ≥4 weeks, Category 1; and puerperal sepsis, Category 4.

	Combined oral contraceptives	Monthly injectables	Combined patch and combined vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device	Levonorgestrel intrauterine device	Female sterilisation*
<input type="checkbox"/>	= Use the method									
<input type="checkbox"/>	= Do not use the method									
<b>I</b>	= Initiation of the method									
<b>C</b>	= Continuation of the method									
<input type="checkbox"/>	= Use the method									
NA	= Not applicable									
<b>Condition</b>										
<b>Obesity</b>										
>30 kg/m <sup>2</sup> body mass index	2	2	2	1	1**	1	—	1	1	C
<b>Blood pressure measurement unavailable</b>	NA <sup>c</sup>	NA <sup>c</sup>	NA <sup>c</sup>	NA <sup>c</sup>	NA <sup>c</sup>	NA <sup>c</sup>	—	NA	NA	NA
<b>CARDIOVASCULAR DISEASE</b>										
<b>Multiple risk factors for arterial cardiovascular disease</b> (older age, smoking, diabetes, and hypertension)	3/4 <sup>d</sup>	3/4 <sup>d</sup>	3/4 <sup>d</sup>	2	3	2	—	1	2	S
<b>Hypertension<sup>e</sup></b>										
History of hypertension, where blood pressure CANNOT be evaluated (including hypertension in pregnancy)	3	3	3	2 <sup>c</sup>	2 <sup>c</sup>	2 <sup>c</sup>	—	1	2	NA
Adequately controlled hypertension, where blood pressure CAN be evaluated	3	3	3	1	2	1	—	1	1	C
<b>Elevated blood pressure (properly measured)</b>										
Systolic 140–159 or diastolic 90–99	3	3	3	1	2	1	—	1	1	C <sup>f</sup>
Systolic ≥ 160 or diastolic ≥ 100 <sup>g</sup>	4	4	4	2	3	2	—	1	2	S <sup>f</sup>
Vascular disease	4	4	4	2	3	2	—	1	2	S
<b>History of high blood pressure during pregnancy</b> (where current blood pressure is measurable and normal)	2	2	2	1	1	1	—	1	1	A
<b>Deep venous thrombosis (DVT)/Pulmonary embolism (PE)</b>										
History of DVT/PE	4	4	4	2	2	2	*	1	2	A
Acute DVT/PE	4	4	4	3	3	3	*	1	3	D
Family history of DVT/PE (first-degree relatives)	2	2	2	1	1	1	*	1	1	A
DVT/PE and on anticoagulant therapy	4	4	4	2	2	2	*	1	2	S

\*\* From menarche to age <18 years, ≥30 kg/m<sup>2</sup> body mass index is Category 2 for DMPA, Category 1 for NET-EN.

- c In settings where pregnancy morbidity and mortality risks are high and this method is one of few widely available contraceptives, women should not be denied access simply because their blood pressure cannot be measured.
- d When multiple major risk factors exist, any of which alone would substantially increase the risk of cardiovascular disease, use of the method may increase her risk to an unacceptable level. However, a simple addition of categories for multiple risk factors is not intended. For example, a combination of factors assigned a Category 2 may not necessarily warrant a higher category.
- e Assuming no other risk factors for cardiovascular disease exist. A single reading of blood pressure is not sufficient to classify a woman as hypertensive.
- f Elevated blood pressure should be controlled before the procedure and monitored during the procedure.
- g This condition may make pregnancy an unacceptable health risk. Women should be advised that because of relatively higher pregnancy rates, as commonly used, spermicides, withdrawal, fertility awareness methods, cervical caps, diaphragms, or female or male condoms may not be the most appropriate choice.

	Combined oral contraceptives	Monthly injectables	Combined patch and combined vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device	Levonorgestrel intrauterine device	Female sterilisation*				
<input type="checkbox"/>	= Use the method													
<input type="checkbox"/>	= Do not use the method													
<b>I</b>	= Initiation of the method													
<b>C</b>	= Continuation of the method													
<input type="checkbox"/>	= Use the method													
NA	= Not applicable													
<b>Condition</b>														
<b>Major surgery</b>														
With prolonged immobilization	4	4	4	2	2	2	—	1	2	D				
Without prolonged immobilization	2	2	2	1	1	1	—	1	1	A				
Minor surgery without prolonged immobilization	1	1	1	1	1	1	—	1	1	A				
<b>Known thrombogenic mutations</b> (e.g., Factor V Leiden, Prothrombin mutation; Protein S, Protein C, and Antithrombin deficiencies) <sup>g</sup>	4	4	4	2	2	2	*	1	2	A				
<b>Superficial venous thrombosis</b>														
Varicose veins	1	1	1	1	1	1	—	1	1	A				
Superficial thrombophlebitis	2	2	2	1	1	1	—	1	1	A				
Ischemic heart disease <sup>a</sup>				<b>I C</b>		<b>I C</b>			<b>I C</b>					
Current	4	4	4	2	3	3	2	3	*	1	2	3	D	
History of													C	
<b>Stroke</b> (history of cerebrovascular accident) <sup>g</sup>	4	4	4	2	3	3	2	3	*	1	2		C	
<b>Known hyperlipidemias</b>	2/3 <sup>h</sup>	2/3 <sup>h</sup>	2/3 <sup>h</sup>	2	2	2	—	1	2				A	
<b>Valvular heart disease</b>														
Uncomplicated	2	2	2	1	1	1	—	1	1				C <sup>i</sup>	
Complicated <sup>g†</sup>	4	4	4	1	1	1	—	2 <sup>j</sup>	2 <sup>j</sup>				S <sup>*</sup>	
<b>SYSTEMIC LUPUS ERYTHEMATOSIS</b>														
Positive (or unknown) antiphospholipid antibodies	4	4	4	3	3	3	3	—	1	1	3		S	
Severe thrombocytopenia	2	2	2	2	3	2	2	—	3	2	2		S	
Immunosuppressive treatment	2	2	2	2	2	2	2	2	2	1	2		S	
None of the above	2	2	2	2	2	2	2	—	1	1	2		C	
<b>NEUROLOGICAL CONDITIONS</b>														
<b>Headaches<sup>l</sup></b>														
Nonmigrainous (mild or severe)	1	2	1	2	1	2	1	1	1	1	1	1	1	A
<b>Migraine</b>														
Without aura	<b>I C</b>	<b>I C</b>	<b>I C</b>	<b>I C</b>	<b>I C</b>	<b>I C</b>	<b>I C</b>	<b>I C</b>	<b>I C</b>	<b>I C</b>	<b>I C</b>	<b>I C</b>		
Age < 35	2	3	2	3	2	3	1	2	2	2	2	2	2	A
Age ≥ 35	3	4	3	4	3	4	1	2	2	2	2	2	2	A
With aura, at any age	4	4	4	4	4	4	2	3	2	3	2	3		A
<b>Epilepsy</b>	1 <sup>k</sup>	1 <sup>k</sup>	1 <sup>k</sup>	1 <sup>k</sup>	1 <sup>k</sup>	1 <sup>k</sup>	1 <sup>k</sup>	—	1	1	1		C	

h Assess according to the type and severity of hyperlipidemia and the presence of other cardiovascular risk factors.

i Prophylactic antibiotics are advised before providing the method.

j Category is for women without any other risk factors for stroke.

k If taking anticonvulsants, refer to section on [drug interactions](#).

† Pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis

	Combined oral contraceptives	Monthly injectables	Combined patch and combined vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device	Levonorgestrel intrauterine device	Female sterilisation*
<input type="checkbox"/>	= Use the method									
<input type="checkbox"/>	= Do not use the method									
<b>I</b>	= Initiation of the method									
<b>C</b>	= Continuation of the method									
<input type="checkbox"/>	= Use the method									
<b>NA</b>	= Not applicable									
<b>Condition</b>										
<b>DEPRESSIVE DISORDERS</b>										
Depressive disorders	1 <sup>1</sup>	1 <sup>1</sup>	1 <sup>1</sup>	1 <sup>1</sup>	1 <sup>1</sup>	1 <sup>1</sup>	—	1	1 <sup>1</sup>	C
<b>REPRODUCTIVE TRACT INFECTIONS AND DISORDERS</b>										
<b>Vaginal bleeding patterns</b>									<b>I C</b>	
Irregular pattern without heavy bleeding	1	1	1	2	2	2	—	1	1	A
Heavy or prolonged bleeding (including regular and irregular patterns)	1	1	1	2	2	2	—	2	1	A
Unexplained vaginal bleeding (suspicious for serious condition), before evaluation	2	2	2	2	3	3	—	<b>I C</b> 4 2	<b>I C</b> 4 2	D
<b>Endometriosis</b>	1	1	1	1	1	1	—	2	1	S
<b>Benign ovarian tumors</b> (including cysts)	1	1	1	1	1	1	—	1	1	A
<b>Severe dysmenorrhea</b>	1	1	1	1	1	1	—	2	1	A
<b>Trophoblast disease</b>										
β-hCG regression	1	1	1	1	1	1	—	3	3	A
β-hCG elevation <sup>9</sup>	1	1	1	1	1	1	—	4	4	D
<b>Cervical ectropion</b>	1	1	1	1	1	1	—	1	1	A
<b>Cervical intraepithelial neoplasia (CIN)</b>	2	2	2	1	2	2	—	1	2	A
<b>Cervical cancer (awaiting treatment)</b>	2	2	2	1	2	2	—	<b>I C</b> 4 2	<b>I C</b> 4 2	D
<b>Breast disease</b>										
Undiagnosed mass	2	2	2	2	2	2	—	1	2	A
Benign breast disease	1	1	1	1	1	1	—	1	1	A
Family history of cancer	1	1	1	1	1	1	—	1	1	A
<b>Breast cancer</b>										
Current <sup>9</sup>	4	4	4	4	4	4	—	1	4	C
Past, no evidence of disease for at least 5 years	3	3	3	3	3	3	—	1	3	A
<b>Endometrial cancer<sup>9</sup></b>	1	1	1	1	1	1	—	<b>I C</b> 4 2	<b>I C</b> 4 2	D
<b>Ovarian cancer<sup>9</sup></b>	1	1	1	1	1	1	—	3	2	D
<b>Uterine fibroids</b>										
Without distortion of the uterine cavity	1	1	1	1	1	1	—	1	1	C
With distortion of the uterine cavity	1	1	1	1	1	1	—	4	4	C

I Certain medications may interact with the method, making it less effective.

	Combined oral contraceptives	Monthly injectables	Combined patch and combined vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device	Levonorgestrel intrauterine device	Female sterilisation*		
<input type="checkbox"/>	= Use the method											
<input type="checkbox"/>	= Do not use the method											
<b>I</b>	= Initiation of the method											
<b>C</b>	= Continuation of the method											
<input type="checkbox"/>	= Use the method											
NA	= Not applicable											
<b>Condition</b>												
<b>Anatomical abnormalities</b>												
Distorted uterine cavity	—	—	—	—	—	—	—	4	4	—		
Other abnormalities not distorting the uterine cavity or interfering with IUD insertion (including cervical stenosis or lacerations)	—	—	—	—	—	—	—	2	2	—		
<b>Pelvic inflammatory disease (PID)</b>												
Past PID (assuming no current risk factors for STIs)								<b>I</b>	<b>C</b>	<b>I</b>	<b>C</b>	
With subsequent pregnancy	1	1	1	1	1	1	—	1	1	1	1	A
Without subsequent pregnancy	1	1	1	1	1	1	—	2	2	2	2	C
Current PID	1	1	1	1	1	1	—	4	2 <sup>m</sup>	4	2 <sup>m</sup>	D
<b>Sexually transmitted infections (STIs)<sup>g</sup></b>												
Current purulent cervicitis, chlamydia, or gonorrhea	1	1	1	1	1	1	—	4	2	4	2	D
Other STIs (excluding HIV and hepatitis)	1	1	1	1	1	1	—	2	2	2	2	A
Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	1	1	1	1	1	1	—	2	2	2	2	A
Increased risk of STIs	1	1	1	1	1	1	—	2/3 <sup>n</sup>	2	2/3 <sup>n</sup>	2	A
<b>HIV/AIDS<sup>g</sup></b>												
								<b>I</b>	<b>C</b>	<b>I</b>	<b>C</b>	
High risk of HIV	1	1	1	1	1	1	—	2	2	2	2	A
HIV-infected	1	1	1	1	1	1	—	2	2	2	2	A
AIDS	1	1	1	1	1	1	—	3	2	3	2	S <sup>o</sup>
Treated with NRTIs	1	1	1	1	1	1	—	2/3 <sup>p</sup>	2	2/3 <sup>p</sup>	2	—
Treated with NNRTIs	2	2	2	2	DMPA 1 NET- EN 2	2	—	2/3 <sup>p</sup>	2	2/3 <sup>p</sup>	2	—
<b>Treated with ritonavir-boosted protease inhibitors</b>	3	3	3	3	DMPA 1 NET- EN 2	2	—	2/3 <sup>p</sup>	2	2/3 <sup>p</sup>	2	—

**Note:** NRTIs = nucleoside reverse transcriptase inhibitors; NNRTIs = non-nucleoside reverse transcriptase inhibitors  
 m Treat PID using appropriate antibiotics. There is usually no need to remove the IUD if the client wishes to continue use.

n The condition is Category 3 if a woman has a very high individual likelihood of exposure to gonorrhea or chlamydia.

o Presence of an AIDS-related illness may require a delay in the procedure.

p AIDS is Category 2 for insertion for those clinically well on antiretroviral therapy; otherwise, Category 3 for insertion.

<input type="checkbox"/>	= Use the method
<input type="checkbox"/>	= Do not use the method
<b>I</b>	= Initiation of the method
<b>C</b>	= Continuation of the method
<input type="checkbox"/>	= Use the method
<b>NA</b>	= Not applicable

Condition	Combined oral contraceptives	Monthly injectables	Combined patch and combined vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device	Levonorgestrel intrauterine device	Female sterilisation*		
<b>OTHER INFECTIONS</b>												
Schistosomiasis												
Uncomplicated	1	1	1	1	1	1	—	1	1	A		
Fibrosis of liver (if severe, see cirrhosis, next page) <sup>q</sup>	1	1	1	1	1	1	—	1	1	C		
Tuberculosis <sup>q</sup>								<b>I</b>	<b>C</b>	<b>I</b>	<b>C</b>	
Non-pelvic	1	1	1	1	1	1	—	1	1	1	1	A
Known pelvic	1	1	1	1	1	1	—	4	3	4	3	S
Malaria	1	1	1	1	1	1	—	1	1			A
<b>ENDOCRINE CONDITIONS</b>												
<b>Diabetes</b>												
History of gestational diabetes	1	1	1	1	1	1	—	1	1			A <sup>q</sup>
Non-vascular diabetes												
Non-insulin dependent	2	2	2	2	2	2	—	1	2			C <sup>l,q</sup>
Insulin dependent <sup>q</sup>	2	2	2	2	2	2	—	1	2			C <sup>l,q</sup>
With kidney, eye, or nerve damage <sup>q</sup>	3/4 <sup>r</sup>	3/4 <sup>r</sup>	3/4 <sup>r</sup>	2	3	2	—	1	2			S
Other vascular disease or diabetes of >20 years' duration <sup>q</sup>	3/4 <sup>r</sup>	3/4 <sup>r</sup>	3/4 <sup>r</sup>	2	3	2	—	1	2			S
<b>Thyroid disorders</b>												
Simple goiter	1	1	1	1	1	1	—	1	1			A
Hyperthyroid	1	1	1	1	1	1	—	1	1			S
Hypothyroid	1	1	1	1	1	1	—	1	1			C
<b>GASTROINTESTINAL CONDITIONS</b>												
<b>Gall bladder disease</b>												
<b>Symptomatic</b>												
Treated by cholecystectomy	2	2	2	2	2	2	—	1	2			A
Medically treated	3	2	3	2	2	2	—	1	2			A
Current	3	2	3	2	2	2	—	1	2			D
Asymptomatic	2	2	2	2	2	2	—	1	2			A
<b>History of cholestasis</b>												
Pregnancy-related	2	2	2	1	1	1	—	1	1			A
Past combined oral contraceptives-related	3	2	3	2	2	2	—	1	2			A
<b>Viral hepatitis</b>												
Acute or flare	3/4 <sup>r</sup>	2	3	2	3/4 <sup>rs</sup>	2	1	1	1			2
Carrier	1	1	1	1	1	1	—	1	1			A
Chronic	1	1	1	1	1	1	—	1	1			A

q If blood glucose is not well controlled, referral to a higher-level facility is recommended.

r Assess according to severity of condition.

s In women with symptomatic viral hepatitis, withhold these methods until liver function returns to normal or three months after she becomes asymptomatic, whichever is earlier.

Condition	Combined oral contraceptives	Monthly injectables	Combined patch and combined vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device	Levonorgestrel intrauterine device	Female sterilisation*
	Cirrhosis									
Mild (compensated)	1	1	1	1	1	1	—	1	1	A
Severe (decompensated) <sup>g</sup>	4	3	4	3	3	3	—	1	3	S
Liver tumors										
Focal nodular hyperplasia	2	2	2	2	2	2	—	1	2	A
Hepatocellular adenoma	4	3	4	3	3	3	—		3	C <sup>t</sup>
Malignant (hepatoma) <sup>g</sup>	4	¾	4	3	3	3	—	1	3	C <sup>t</sup>
<b>ANEMIAS</b>										
Thalassemia	1	1	1	1	1	1	—	2	1	C
Sickle cell disease <sup>g</sup>	2	2	2	1	1	1	—	2	1	C
Iron-deficiency anemia	1	1	1	1	1	1	—	2	1	D/C <sup>u</sup>
<b>DRUG INTERACTIONS (for antiretroviral drugs, see HIV/AIDS)</b>										
<b>Anticonvulsant therapy</b>										
Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	3 <sup>l</sup>	2	3 <sup>l</sup>	3 <sup>l</sup>	DMP A 1 NET- EN 2	2 <sup>l</sup>	—	1	1	—
Lamotrigine	3 <sup>††</sup>	3 <sup>††</sup>	3 <sup>††</sup>	1	1	1	—	1	1	—
Antimicrobial therapy										
<b>Other antibiotics</b>	1	1	1	1	1	1	—	1	1	—
Antifungals and antiparasitics	1	1	1	1	1	1	—	1	1	—
Rifampicin or rifabutin therapy	3 <sup>l</sup>	2	3 <sup>l</sup>	3 <sup>l</sup>	DMP A 1 NET- EN 2	2	—	1	1	—

t Liver function should be evaluated.

u For hemoglobin < 7 g/dl, delay. For hemoglobin ≥ 7 to < 10 g/dl, caution.

†† Combined hormonal contraceptives may reduce the effectiveness of lamotrigine.

**Additional conditions relating to emergency contraceptive pills:**

*Category 1:* Repeated use; rape.

*Category 2:* History of severe cardiovascular complications (ischemic heart disease, cerebrovascular attack, or other thromboembolic conditions, and angina pectoralis).

**Additional conditions relating to female sterilization:**

*Caution:* Diaphragmatic hernia; kidney disease; severe nutritional deficiencies; previous abdominal or pelvic surgery; concurrent with elective surgery.

*Delay:* Abdominal skin infection; acute respiratory disease (bronchitis, pneumonia); systemic infection or gastroenteritis; emergency surgery (without previous counselling); surgery for an



infectious condition; certain postpartum conditions (7 to 41 days after childbirth); severe pre-eclampsia/eclampsia; prolonged rupture of membranes (24 hours or more); fever during or immediately after delivery; sepsis after delivery; severe hemorrhage; severe trauma to the genital tract; cervical or vaginal tear at time of delivery; certain postabortion conditions (sepsis, fever, or severe hemorrhage; severe trauma to the genital tract; cervical or vaginal tear at time of abortion; acute hematometra); subacute bacterial endocarditis; unmanaged atrial fibrillation.

*Special arrangements:* Coagulation disorders; chronic asthma, bronchitis, emphysema, or lung infection; fixed uterus due to previous surgery or infection; abdominal wall or umbilical hernia; postpartum uterine rupture or perforation; postabortion uterine perforation.

**Conditions relating to vasectomy:**

*No special considerations:* High risk of HIV, HIV-infected, sickle cell disease.

*Caution:* Young age; depressive disorders; diabetes; previous scrotal injury; large varicocele or hydrocele; cryptorchidism (may require referral); lupus with positive (or unknown) antiphospholipid antibodies; lupus and on immunosuppressive treatment.

*Delay:* Active STIs (excluding HIV and hepatitis); scrotal skin infection; balanitis; epididymitis or orchitis; systemic infection or gastroenteritis; filariasis; elephantiasis; intrascrotal mass.

*Special arrangements:* AIDS (AIDS-related illness may require delay); coagulation disorders; inguinal hernia; lupus with severe thrombocytopenia.

**Conditions relating to male and female condoms, spermicides, diaphragms, cervical caps, and the lactational amenorrhea method:** All other conditions listed on the previous pages that do not appear here are a Category 1 or NA for male and female condoms, spermicides, diaphragms, and cervical caps.

<div style="display: flex; flex-direction: column; align-items: flex-start;"> <div style="display: flex; align-items: center; margin-bottom: 5px;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <span>= Use the method</span> </div> <div style="display: flex; align-items: center; margin-bottom: 5px;"> <div style="width: 20px; height: 20px; background-color: #c6e0b4; border: 1px solid black; margin-right: 5px;"></div> <span>= Do not use the method</span> </div> <div style="display: flex; align-items: center; margin-bottom: 5px;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px; display: flex; align-items: center; justify-content: center;">—</div> <span>= Condition not listed; does not affect eligibility for method</span> </div> <div style="margin-top: 10px;"> <span>NA = Not applicable</span> </div> </div>	Male and female condoms	Spermicides <sup>1</sup>	Diaphragms	Cervical cps	Lactational amenorrhea method <sup>2</sup>
	<b>REPRODUCTIVE HISTORY</b>				
<b>Parity</b>					
Nulliparous (has not given birth)	1	1	1	1	—
Parous (has given birth)	1	1	2	2	—
< 6 weeks postpartum	1	1	NA <sup>v</sup>	NA <sup>v</sup>	—
<b>CARDIOVASCULAR DISEASE</b>					
Complicated valvular heart disease (pulmonary hypertension, risk of atrial fibrillation, history of subacute bacterial endocarditis) <sup>9</sup>	1	1	2	2	—
<b>REPRODUCTIVE TRACT INFECTIONS AND DISORDERS</b>					
Cervical intraepithelial neoplasia	1	1	1	4	—
Cervical cancer	1	2	1	4	—
Anatomical abnormalities	1	1	NA <sup>w</sup>	NA <sup>x</sup>	—
<b>HIV/AIDS<sup>9</sup></b>					
High risk of HIV	1	4	4	4	—
HIV-infected	1	3	3	3	C <sup>y</sup>
AIDS	1	3	3	3	C <sup>y</sup>
<b>OTHERS</b>					
History of toxic shock syndrome	1	1	3	3	—
Urinary tract infection	1	1	2	2	—
Allergy to latex <sup>z</sup>	3	1	3	3	—

v Wait to fit/use until uterine involution is complete.

- w Diaphragm cannot be used in certain cases of uterine prolapse.
- x Cap use is not appropriate for a client with severely distorted cervical anatomy.
- y Women with HIV or AIDS should avoid breastfeeding if replacement feeding is affordable, feasible, acceptable, sustainable, and safe. Otherwise, exclusive breastfeeding is recommended during the first 6 months of a baby's life and should then be discontinued over a period of 2 days to 3 weeks.
- z Does not apply to plastic condoms, diaphragms, and cervical caps.

**\*\*Additional conditions relating to lactational amenorrhea method:**

*Medication used during breastfeeding:* To protect infant health, breastfeeding is not recommended for women using such drugs as anti-metabolites, bromocriptine, certain anticoagulants, corticosteroids (high doses), cyclosporine, ergotamine, lithium, mood-altering drugs, radioactive drugs, and reserpine.

*Conditions affecting the newborn that may make breastfeeding difficult:* Congenital deformities of the mouth, jaw, or palate; newborns who are small-for-date or premature and needing intensive neonatal care; and certain metabolic disorders.

**Conditions relating to fertility awareness methods:**

<div style="display: inline-block; border: 1px solid black; padding: 2px; margin-right: 10px;">A</div> = Accept <div style="display: inline-block; border: 1px solid black; padding: 2px; margin-left: 20px; margin-right: 10px;">C</div> = Caution <div style="display: inline-block; border: 1px solid black; padding: 2px; margin-left: 20px;">D</div> = Delay	Symptoms-based methods	Calendar-based methods
<b>Condition</b>		
Age: post menarche or perimenopause	C	C
Breastfeeding < 6 weeks postpartum	D	D <sup>aa</sup>
Breastfeeding ≥ 6 weeks postpartum	C	D <sup>bb</sup>
Postpartum, not breastfeeding	D <sup>cc</sup>	D <sup>aa</sup>
Postabortion	C	D <sup>dd</sup>
Irregular vaginal bleeding	D	D
Vaginal discharge	D	A
Taking drugs that affect cycle regularity, hormones, and/or fertility signs	D/C <sup>ee</sup>	D/C <sup>ee</sup>
<b>Diseases that elevate body temperature</b>		
Acute	D	A
Chronic	C	A

aa Delay until she has had 3 regular menstrual cycles.

bb Use caution after monthly bleeding or normal secretions return (usually at least 6 weeks after childbirth).

cc Delay until monthly bleeding or normal secretions return (usually < 4 weeks postpartum).

dd Delay until she has had one regular menstrual cycle.

ee Delay until the drug's effect has been determined, then use caution.

**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), norethisterone enantate (NET-EN), copper intrauterine device (Cu-IUD)**

CONDITION	COC	DMPA/ NET-EN	Cu-IUD
Age	Menarche to 39 years		
	40 years or more		
	Menarche to 17 years		
	18 years to 45 years		
	More than 45 years		
	Menarche to 19 years		
Nulliparous	20 years or more		
Breastfeeding	Less than 6 weeks postpartum		*
	6 weeks to 6 months postpartum		
Smoking	6 months postpartum or more		
	Age < 35 years		
Hypertension	Age ≥ 35 years, < 15 cigarettes/day		
	Age ≥ 35 years, ≥ 15 cigarettes/day		
Headaches	History of hypertension where blood pressure: CANNOT be evaluated		
	Is controlled and CAN be evaluated		
History of deep venous thrombosis	Systolic 140 - 159 or diastolic 90 - 99		
	Systolic ≥ 160 or diastolic ≥ 100		
Superficial thrombophlebitis	Non-migrainous (mild or severe)	I C	I C
	Migraine without aura (age < 35 years)	I C	I C
Complicated valvular heart disease	Migraine with aura (age ≥ 35 years)	I C	I C
	Ischemic heart disease/stroke	I C	I C
Diabetes	Non-vascular disease	I C	I C
	Vascular disease or diabetes of > 20 years	I C	I C
Malaria			
Non-pelvic tuberculosis			
Thyroid disease			
Iron deficiency anemia			
Sickle cell anemia			

CONDITION	COC	DMPA/ NET-EN	Cu-IUD
Known hyperlipidemias			
Cancers			
Cervical ectropion			
Breast disease		**	**
Uterine fibroids without cavity distortion			
Endometriosis			
Trophoblast disease (malignant gestational)			
Vaginal bleeding patterns			
Cirrhosis			
Current symptomatic gall bladder disease			
Cholelithiasis			
Hepatitis			
Liver tumors			
STIs/PID			
HIV			
AIDS			
Use of:			

- **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.

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. For example, a client with current PID who wants to initiate IUD use would be considered as Category 4, and should not have an IUD inserted. However, if she develops PID while using the IUD, she would be considered as Category 2. This means she could generally continue using the IUD and be treated for PID with the IUD in place. Where I/C is not marked, a woman with that condition falls in the category indicated – whether or not she is initiating or continuing use of the method.

\* Breastfeeding does not affect initiation and use of the IUD. Regardless of breastfeeding status, postpartum insertion of the IUD is Category 2 up to 48 hours postpartum, Category 3 from 48 hours to four weeks, and Category 1 four weeks and after.

\*\* Evaluation should be pursued as soon as possible.

Source: Adapted from Medical Eligibility Criteria for Contraceptive Use. Geneva: World Health Organization. Third edition, 2004. Available: <http://www.who.int/reproductive-health/publications/MEC/>



# Family Planning Client Assessment and WHO MEC Case Studies

## Instructions for students

- Divide into small groups as directed by your teacher
- Select a recorder and reporter for your small group
- Read these directions and the attached case studies
- Discuss the case studies, recording your answers. Be prepared to share these answers with the larger group.

## Case Study 1

Mrs. N wants to start using an injectable contraceptive. Her last menses started 5 days ago. She has a negative health and obstetrical history. Can she start DMPA today? Why or why not?

## Case Study 2

Mrs. A is breastfeeding her 5-week-old baby. Can she start a hormonal method of family planning today? Why or why not?

## Case Study 3

Mrs. M is 8 months pregnant and is HIV-positive. She does not want any more children for at least 6 or 7 years, maybe no more, but she is uncertain. She is very concerned about her own health and her ability to take care of her children. She wants a very effective method. What methods would be appropriate?

## Case Study 4

Mrs. Z. has a sister who uses an IUCD and likes it very much. Mrs. Z admits to you that she has lower pelvic pain, painful intercourse, a bad smelling yellow vaginal discharge, and painful urination. She says one of her co-wives also has the same symptoms. She wants the IUCD to prevent another pregnancy. Is she eligible? Why or why not? What other methods could she use?

## Case Study 5

Mrs. T has a 6-month-old baby and has been using LAM. She has not had a menses since she delivered. She reports a normal medical and obstetrical history. Her BP is 110/76. She wants to start COCs. She took them before her last baby and had no problems. Can she start COCs today? Why or why not?

## Case Study 6

Mrs. C is 17 and has a 16-month-old child. During her pregnancy she had pre-eclampsia but received treatment so did not develop eclampsia. The hospital doctor told her she should wait at least 2 years to have another baby. She reports that she gets really bad headaches. She does not have any visual changes before or during them. She doesn't want the shot because she heard that it causes infertility. She thinks that she wants to start COCs. Her BP today is 110/72 and on physical exam, you notice that she has some superficial varicosities. Can she use COCs? Why or why not? What would you discuss with her?

# Family Planning Client Assessment and WHO MEC

## Case Studies Answer Key

Note: It may be desirable to permit students to use the MEC Summary Tables as a reference to answer these questions.

### Case Study 1

Mrs. N wants to start using an injectable contraceptive. Her last menses started 5 days ago. She has a negative health and obstetrical history. Can she start DMPA today? Why or why not?

**Yes. There are no reasons for her to not use or to delay starting this method.**

### Case Study 2

Mrs. A is breastfeeding her 5-week-old baby. Can she start a hormonal method of family planning today? Why or why not?

- **No, she cannot start a method today.**
- **Progestin-only methods can be started by nursing mothers after 6 weeks.**
- **COCs can be started after 6 months.**
- **Need to ask more about her breastfeeding. If she is using LAM, no other method is needed until she no longer is practicing LAM (exclusively or mostly breastfeeding, amenorrheic and baby is 6 months old or less).**
- 

### Case Study 3

Mrs. M is 8 months pregnant and is HIV- positive. She does not want any more children for at least 6 or 7 years, maybe no more, but she is uncertain. She is very concerned about her own health and her ability to take care of her children. She wants a very effective method. What methods would be appropriate?

- **Dual methods: condoms plus another method**
- **IUCD (A long-term method. Appropriate if she does not have AIDS or has AIDS but is well on antiretroviral therapy)**
- **Contraceptive implant (long-term method)**
- **Injectable**
- **COCs**
- **Tubal ligation is not appropriate since she has voiced uncertainty about wanting more children**

### Case Study 4

Mrs. Z. has a sister who uses an IUCD and likes it very much. Mrs. Z admits to you that she has lower pelvic pain, painful intercourse, a bad smelling yellow vaginal discharge, and painful urination. She says one of her co-wives also has the same symptoms. She wants the IUCD to prevent another pregnancy. Is she eligible? Why or why not? What other methods could she use?

- **Mrs. Z has the symptoms of an STI, probably chlamydia, maybe PID. She needs an evaluation, medication, and advice that her husband and co-wives need to be evaluated.**

- **An IUCD is not a good choice for her until the infection is resolved.**
- **She could use COCs or an injectable or implant.**
- **She could use male or female condoms until she is eligible for the IUCD.**
- **She should use male or female condoms to prevent a re-exposure (dual method).**

## Case Study 5

Mrs. T has a 6-month-old baby and has been using LAM. She has not had a menses since she delivered. She reports a normal medical and obstetrical history. Her BP is 110/76. She wants to start COCs. She took them before her last baby and had no problems. Can she start COCs today? Why or why not?

- **Yes, she can use a hormonal method since her baby is at least 6 months old.**

## Case Study 6

Mrs. C is 17 and has a 16-month-old child. During her pregnancy she had pre-eclampsia but received treatment so did not develop eclampsia. The hospital doctor told her she should wait at least 2 years to have another baby. She reports that she gets really bad headaches. She does not have any visual changes before or during them. She doesn't want the shot because she heard that it causes infertility. She thinks that she wants to start COCs. Her BP today is 110/72 and on physical exam, you notice that she has some superficial varicosities. Can she use COCs? Why or why not? What would you discuss with her?

- **Yes, her headaches are not migraines with aura.**
- **Discuss with her that injectables do not cause infertility. They may cause a delay in return to fertility sometimes up to 1 year, but usually fertility returns 3-6 months after the next injection is due.**

## Family Planning Client Assessment and WHO MEC Quiz Questions

1. A 36-year-old woman with three children comes to the health centre requesting oral contraceptives. She tells you she smokes 10 cigarettes per day.
  - a. Are oral contraceptives medically appropriate?
  - b. Does she have any other highly effective temporary contraceptive options?
2. A 25-year-old woman has just given birth and plans to breastfeed. She would like an injection for contraception prior to returning home. Which of the following options is medically appropriate? (Tick the correct answer.)
  - a. A progestin-only injectable contraceptive provided immediately
  - b. A progestin-only injectable provided at 6 weeks postpartum
  - c. A progestin-only injectable provided at 6 months postpartum
  - d. A progestin-only injectable is never appropriate for postpartum women
3. A pelvic exam is required before the following contraceptive method(s) can be provided (tick the best answer):
  - a. COCs
  - b. IUCDs
  - c. Progestin-only injectables
  - d. "b" and "c" above
  - e. All of the above

**Questions 4–7:** Indicate whether the following statements are **true** or **false** by writing a **"T"** for true or an **"F"** for false in the space provided before each statement.

- \_\_\_ 4. A woman and her foetus may be harmed if COCs or DMPA are accidentally used during pregnancy.
- \_\_\_ 5. If a woman comes to the clinic with chronic vague complaints that have no obvious physical cause, the provider should consider the possibility that she is experiencing GBV.
- \_\_\_ 6. WHO MEC Category 3 means that use of the method is not recommended because its risks generally outweigh its advantages.
- \_\_\_ 7. One of the purposes of client assessment prior to provision of a family planning method is to discover if she has any conditions that affect her medical eligibility to start or continue using a particular method.

# Family Planning Client Assessment and WHO MEC Quiz Questions Answer Key

Note: It may be desirable to permit students to use the MEC Summary Tables as a reference to answer these questions.

1. A 36-year-old woman with three children comes to the health centre requesting oral contraceptives. She tells you she smokes 10 cigarettes per day.

- a. Are oral contraceptives medically appropriate?

**No. Oral contraceptives are usually not appropriate for women over 35 who smoke. (Women over 35 who smoke <15 cigarettes/day = Category 3)**

- b. Does she have any other highly effective temporary contraceptive options?

**This client is medically eligible to use progestin-only pills, progestin-only injectables, implants and IUCDs (Category 1).**

2. A 25-year-old woman has just given birth and plans to breastfeed. She would like an injection for contraception prior to returning home. Which of the following options is medically appropriate?

- b. A progestin-only injectable provided at 6 weeks postpartum**

3. A pelvic exam is required before the following contraceptive method(s) can be provided:

- d. "b" and "c" above**

**F** \_\_\_ 4. A woman and her foetus may be harmed if COCs or DMPA are accidentally used during pregnancy.

**T** \_\_\_ 5. If a woman comes to the clinic with chronic vague complaints that have no obvious physical cause, the provider should consider the possibility that she is experiencing GBV.

**T** \_\_\_ 6. WHO MEC Category 3 means that use of the method is not recommended because its risks generally outweigh its advantages.

**T** \_\_\_ 7. One of the purposes of client assessment prior to provision of a family planning method is to discover if she has any conditions that affect her medical eligibility to start or continue using a particular method.



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# Unit 5

## COUNSELLING FOR FAMILY PLANNING

### Learning Objectives

By the end of this unit, learners will be able to:

- ❖ Define counselling
- ❖ List the benefits of family planning counselling
- ❖ Explain the concept of informed choice as it applies to family planning
- ❖ Define privacy and confidentiality in regard to family planning
- ❖ List clients' rights in regard to family planning services
- ❖ Describe the qualities of a good counsellor
- ❖ State the principles of effective counselling
- ❖ Describe the key communication and counselling skills the provider needs for effective family planning counselling
- ❖ List ways to make counselling gender-sensitive
- ❖ Describe the 4 stages of the Balanced Counselling Strategy Plus (BCS+) counselling process and the main steps of each stage
- ❖ List questions that help the provider discuss STI/HIV transmission and prevention and client's STI/HIV risk
- ❖ Describe how to conduct STI/HIV risk assessment during family planning counselling
- ❖ Demonstrate the use of key communication and counselling skills
- ❖ Demonstrate knowledge and skills in family planning counselling (using the 19 step process of BCS+).

### Teaching Resources in This Unit

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## Unit 5: Counselling for Family Planning

### Key Points

- Good family planning counselling supports informed and voluntary decision-making.**
- Counselling requires auditory and visual privacy.**
- Effective counselling increases client's satisfaction with family planning methods.**
- Avoid information overload—provide key information and instructions.**
- Listening is as important as giving correct information.**
- Open and accepting non-verbal behaviours facilitate communication.**
- The Balanced Counselling Strategy Plus integrates family planning and STI/HIV counselling.**

### 5.1 Defining Counselling

**Counselling** is a type of client-provider interaction that involves two-way communication between a health care staff member and a client for the purpose of confirming or facilitating an informed decision by the client or helping the client address problems or concerns.

Quality counselling is the main way that health workers support and safeguard the client's rights to informed and voluntary decision-making. (See Section 6.3.) This means never pressuring a client to choose one family planning method over another, or otherwise limiting a client's choices for any reason other than medical eligibility. Counselling can support all other clients' rights as well (ACQUIRE Project 2008).

**Counselling for family planning** helps clients choose and use family planning methods that suit clients' needs.

**Couples counselling** refers to counselling sessions in which a woman and her partner are present in discussions with the provider. All of the information and skills presented in this unit for counselling individuals may be applied to couples counselling. However, it must be recognized that couples counselling requires special sensitivity and skills to deal with gender-related issues.

### 5.2 Benefits of Effective Family Planning Counselling

In addition to protecting a client's right to informed and voluntary decision-making, effective counselling:

- Increases acceptance of family planning services
- Promotes effective use of family planning services
- Increases client's satisfaction with family planning methods and services
- Enhances continuation of family planning services
- Dispels rumours and corrects misunderstandings about contraceptive methods.

## 5.3 Informed and Voluntary Decision-Making and Informed Choice

Good client-provider interaction, including counselling, is one of the primary conditions that supports informed and voluntary decision-making and informed choice.

**Informed and voluntary decision-making** is the process through which an individual should arrive at a decision about health care. It assumes that clients have the right and the ability to make their own health care decisions, voluntarily and with full information and understanding of the consequences of each option.

**Informed choice** is an individual's well-considered, voluntary decision based on options, information, and understanding.

When applied to decisions about family planning, informed choice means that individuals freely choose **whether** to use a contraceptive method and, if so, which one they **want** to use, based on their awareness and understanding of accurate information about the methods. Clients use the process of informed and voluntary decision-making to arrive at their informed choice.

Examples of the decisions that clients make concerning family planning include:

- Whether to use contraception to delay, space, or end childbearing
- Which method to use
- Whether to continue using contraception if side effects occur
- Whether to switch methods when the current method is unsatisfactory
- Whether to involve one's partner(s) in decision-making about family planning.

Examples of decisions that clients make concerning HIV and other sexually transmitted infections (STIs) include:

- Whether to use a condom with every act of sexual intercourse
- Whether to use a dual-protection strategy (to prevent unintended pregnancy as well as protect against STI/HIV)
- Whether to limit the number of sexual partners
- Whether to seek treatment for apparent infection
- Whether to be tested for HIV
- Whether to inform partners if an infection is diagnosed.

Examples of decisions that clients make concerning their maternal health care include:

- Whether to seek antenatal care during pregnancy
- Whether to improve one's nutrition during pregnancy
- Whether and when to have sex during pregnancy
- Whether and when to go to a health care setting for assistance with childbirth
- Whether to breastfeed exclusively and for how long
- Whether and when to use contraception after childbirth.
  - (ACQUIRE Project 2008)

## 5.4 Privacy and Confidentiality

Family planning providers must safeguard the client's right to privacy and confidentiality.

**Privacy:** This is the client's right and power to control the information (about him/herself) that others possess.

**Confidentiality:** This means the provider cannot disclose private information to anyone else without the patient's consent. This is the mechanism through which the provider protects the client's right to privacy.

To uphold confidentiality, providers must counsel clients in areas that provide both auditory and visual privacy, so that no one not involved in the counselling session can see the client speaking or hear what is said in the session. Further, providers must maintain and enforce confidentiality of client medical records and other personal information about clients, and must not leave client records where other clients might see the records or have access to them nor give the records to the client's family members, friends or other health workers without the client's written permission.

## 5.5 Other Client Rights

In addition to the rights above, family planning clients, and clients in all sectors of health care, have the following rights:

**Right to accurate, appropriate, understandable, and unambiguous information** related to reproductive health and sexuality and to health overall.

**Right to access to services:** Services must be affordable and available, without social barriers such as discrimination based on gender, age, marital status, fertility, nationality or ethnicity, belief, social class, caste, or sexual orientation.

**Right to dignity, comfort and expression of opinion:** All clients have the right to be treated with respect and consideration. Providers must ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely, especially when clients' views differ from the views of service providers.

**Right to continuity of care:** This includes services, supplies, follow-up, and referral.

**Right to safety of services:** Services should be provided by clinicians with sufficient skill, with attention to infection prevention and using appropriate and effective medical practices.

(PATH and Global Health Council 2003, p. 23)

## 5.6 Characteristics of a Good Counsellor

A family planning counsellor should have or develop the following characteristics:

- Understanding of his/her own beliefs/biases so they do not enter into the counselling process
- Honesty: Always telling the truth to the client
- Understanding and empathy: The ability to feel what the client feels and to demonstrate to the client that the counsellor understands and accepts the clients' feelings without judgment
- Sensitivity to clients' needs and concerns
- Genuineness, acceptance, and respect
- Technical competence: Being well-trained and knowledgeable about family planning methods and services.

## 5.7 Principles of Effective Family Planning Counselling

The key principles for cultivating good client-provider interaction and effective family planning counselling include the following:

1. Show every client respect, and help each client feel at ease.
2. Ensure auditory and visual privacy and confidentiality.
3. Encourage the client to explain needs, express concerns, and ask questions.
4. Tailor the interaction to the client's needs, circumstances, and concerns.
5. Be alert to related needs such as protection from STIs/HIV, protection from gender-based violence, and support for condom use.
6. Listen carefully. Listening is as important as giving correct information.
7. Show empathy for the client's needs.
8. Remain nonjudgmental about values, behaviours, and decisions that differ from your own.
9. Remain patient with the client, and express interest.
10. Give just key information and instructions. Avoid information overload. Use words the client knows.
11. Demonstrate comfort in addressing sexual and gender issues.
12. Respect and support the client's informed and voluntary decisions.
13. Use and provide memory aids.

## 5.8 Communication and Counselling Skills

To fulfill the principles listed above for effective family planning counselling, it is important for the provider to demonstrate the following communication and counselling skills:

- Listens attentively and actively to what the client says (active listening), using nonverbal facial expressions and gestures, such as smiling and nodding, to further encourage the client
- Asks the client open-ended questions to increase the amount of information provided
- Paraphrases and summarizes what a client says and reflects back feelings, to show client that he/she is listening and to help client organize her/his thoughts
- Maintains a friendly tone of voice and never pressures the client to finish speaking
- Uses prompts as needed to help client continue a narrative
- Demonstrates sensitivity to cultural, religious, and other psychosocial factors that affect a woman's (or a couple's) decisions about family planning
- Keeps in mind that clients may become embarrassed discussing family planning and related issues
- Recognizes the potential importance of the partner's or other family members' views, and helps the client overcome potential barriers; teaches negotiation skills (such as to get her partner to use a condom), if needed
- Uses visual aids appropriately to increase clients' understanding and retention of information.

## Effective nonverbal communication

To facilitate communication, it is important for the provider to use open and accepting body language. The provider needs to pay attention to her/his body language to avoid sending unintentional nonverbal cues. Crossing the arms in front of the chest, for instance, sends a signal that the provider is “closed” or defensive. Smiles and nods communicate acceptance and are important and effective nonverbal signals.

It is often helpful to keep in mind the acronym “ROLES,” which refers to nonverbal behaviours that encourage communication and help put clients at ease:

- **R**- Relax
- **O**- Stay open and approachable
- **L**- Lean towards the client
- **E**-Encourage client by nodding and smiling
- **S**- Sit facing client and smile

## How to listen “actively”

- Meet with your clients in a private, comfortable place.
- Accept your clients as they are. Treat each as an individual.
- Listen to what your clients say and why they say it. Notice their tone of voice, choice of words, facial expressions, and gestures.
- Put yourself in your client’s place as she/he talks.
- Keep silent sometimes. Give your clients time to think, ask questions, and talk. Move at the client’s speed.
- Listen to your client carefully instead of thinking what you are going to say next.
- Every now and then, repeat what you have heard, paraphrasing in your own words what the client said. Then both you and your client know whether you have understood.

## How to ask questions effectively

- Use a tone of voice that shows interest, concern, and friendliness.
- Ask only one question at a time. Wait for an answer.
- Ask questions that let clients tell you their family planning needs. Examples are: “What does your partner think about family planning?” “How many children do you want?”
- Ask open-ended questions.
  - These are questions that cannot be answered “yes” or “no.” These types of questions encourage clients to say more.
  - Examples are: “How can I help you?” “What have you heard about implants?”
- Use short, prompting questions, such as “And then?” “Oh?” “Yes! Then what happened?” “You were saying?” (Nods and pauses are also useful as prompts.)
- Avoid starting questions with “why,” or “why didn’t you,” as this can sound as if you are blaming the client or finding fault.
- Repeat a question in a different way if it appears the client has not understood.

## 5.9 Gender-Sensitive Counselling

Family planning providers may encounter circumstances and problems related to gender that influence clients' access to and use of family planning. To address gender-related issues in family planning counselling:

- Sensitively elicit information about a client's power to make decisions and obtain family planning methods, and any gender-related fears and anxieties related to family planning use.
- Offer clients information related to their reproductive rights concerning family planning.
- Encourage clients to make their own sexual and reproductive health choices.
- Consult with clients on when or if to bring partners into family planning counselling.
- Demonstrate respect for the client's right to privacy and confidentiality about use of family planning.
- Assist client in identifying safe strategies to prevent pregnancy and/or STIs/HIV based on her informed choice of family planning.

**Note:** For more information about gender-related issues, please see Unit 2: Gender-Sensitive Family Planning Services.

The primary tasks, client-specific tasks, communication skills, and gender-sensitive strategies of quality family planning counselling, as described above, may be applied in a variety of counselling frameworks. The particular framework used is determined by local needs and policies. This unit describes the BCS+ as one strategy that can be used.

## 5.10 Introduction to BCS+

In the late 1990s, in response to the need to improve family planning counselling, the Population Council developed the Balanced Counselling Strategy (BCS). However, it soon became clear that in areas with high STI/HIV infection rates, there was a need to integrate other health services into the process. This led to the creation of the Balanced Counselling Strategy Plus, or BCS+.

The BCS+ combines family planning counselling with STI/HIV counselling, screening, and testing services. The BCS+ was tested in Kenya and South Africa and was found to be both effective and acceptable for clients and providers.

A key feature of the BCS+ is a set of user-friendly job aids. (A job aid is a memory tool that minimizes error and reduces the amount of recall necessary to perform job tasks.) The complete set of BCS+ tools consists of:

- An algorithm, or flow chart, to guide the provider through the process
- A set of method cards on all contraceptive methods, each of which gives 5-7 key features of the method (See sample card, Figure 5.1)
- Information materials for clients on each of the methods.

The provider starts by setting out all the method cards (if the cards are not available, the provider can display actual methods or photographs/illustrations of methods) and, by asking the client 4 questions, eliminates methods/cards that are not appropriate for the particular client. This allows the counsellor to focus on the most relevant information (the remaining methods/cards) in the time available.



The algorithm clearly sets out each step that the counsellor should follow in each of the 4 sections or stages of the BCS+ process.

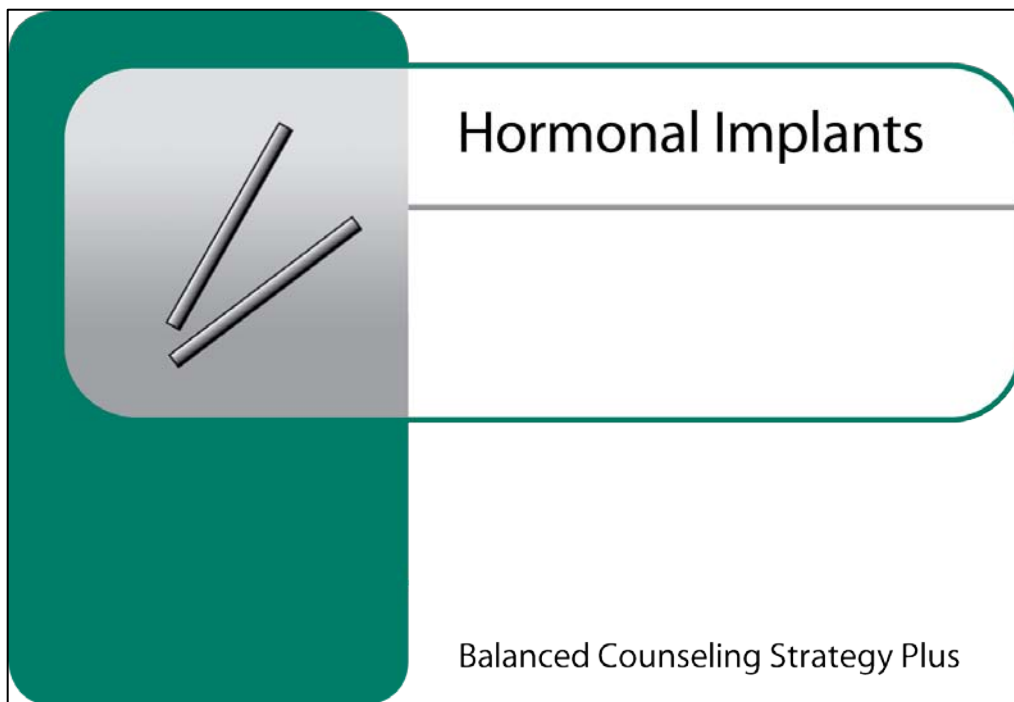
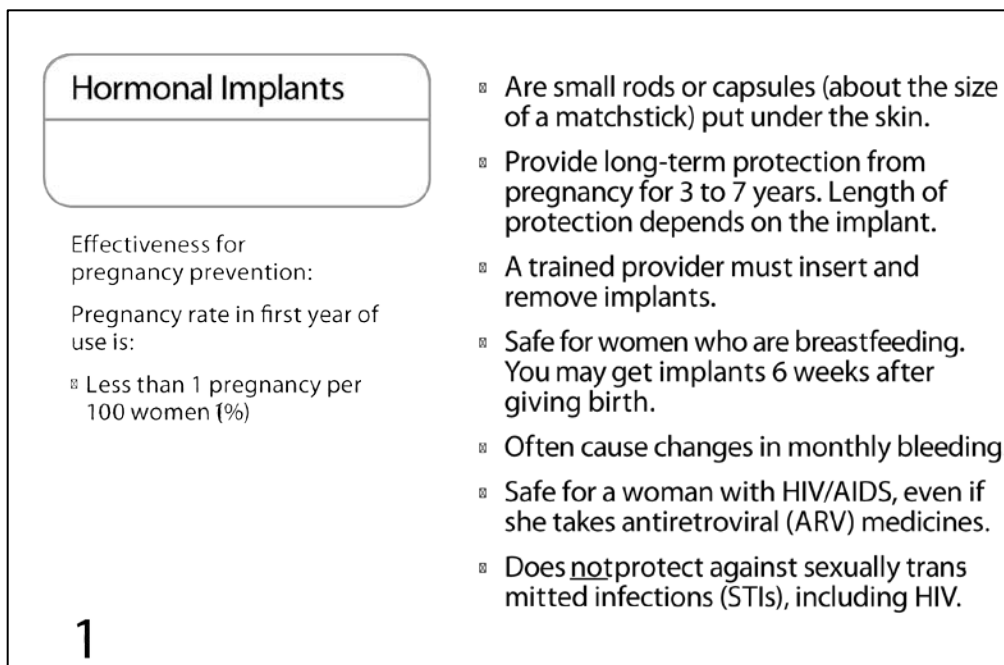


Figure 5.1: BCS+ Method Card for Implants. Front of card (above), and back of card (below)



## 5.11 Steps of BCS+

The BCS+ is divided into 4 counselling stages: starting with the Pre-Choice Stage, then the Method Choice Stage and the Post-Choice Stage, finishing with the STI/HIV Counselling Stage. Each stage contains a sequence of steps to follow. These steps must be performed in the order given, as each step builds upon the one before it. This outline provided below does not include

detailed sub-steps for every step of the BCS+ process. For more details, please see the BCS+ Toolkit and the BCS+ User's Guide, which can be downloaded from [http://www.popcouncil.org/publications/books/2008\\_BalancedCounselingStrategyPLUS.asp](http://www.popcouncil.org/publications/books/2008_BalancedCounselingStrategyPLUS.asp) Hard copies can be obtained by writing to: [publications@popcouncil.org](mailto:publications@popcouncil.org).

## A. Pre-Choice Stage:

During this stage, the provider creates the conditions that help a client select a family planning method.

- 1. Establish and maintain a warm, cordial relationship, and listen to the client's contraceptive needs.**
  - Introduce yourself and call the client by her/his name.
  - Demonstrate interest in what the client tells you.
  - Establish eye contact with the client.
  - Listen to and answer her/his questions.
  - Show support and understanding without judgment.
  - Ask questions to encourage participation.
  - Ask whether the client would like a family planning method.
- 2. Rule out pregnancy using the pregnancy card or Pregnancy Checklist.** (See Unit 4: Family Planning Client Assessment and the WHO Medical Eligibility Criteria [MEC] for this checklist.)
- 3. Display all of the methods using method cards, flip charts, actual methods, photographs, illustrations, or posters.** Arrange by method type: temporary methods, long term and permanent methods (LTPM), fertility awareness methods.
- 4. Set aside methods that are not appropriate for the client by asking the following 4 questions:**
  - a. Do you wish to have children in the future?*

If "Yes" set aside (or eliminate) vasectomy and female sterilisation. Explain why.  
If "No," keep all methods and continue.
  - b. Are you breastfeeding an infant who is less than 6 months old?*

If "Yes," set aside (or eliminate) combined oral contraceptives (COCs). Explain why.  
If "No," or she has begun her monthly bleeding again, set aside the lactation amenorrhoea method (LAM). Explain why.
  - c. Does your partner support you in family planning?*

If "Yes," continue with the next question.  
If "No," set aside the following cards: Standard Days Method® and TwoDay Method®.  
Explain why.
  - d. Are there any methods that you do not want to use or have not tolerated in the past?*

If "Yes," set aside or eliminate the method(s) that the client does not want.  
If "No," keep the rest of the methods or method cards.

- Setting aside these cards helps to avoid taking time to give information on methods that are not relevant to the client's needs.

## B. Method Choice Stage:

5. **Give information about the methods that have not been set aside, including their effectiveness.**
  - Arrange the remaining methods or method cards in order of effectiveness.
  - Starting with the most effective method, tell the client the 5-7 most important characteristics of each method. Ensure that the client fully understands the information given on each method before proceeding to the next one.
  - Explain that the condom (male and female) is the only method that provides dual protection against pregnancy and STIs, including HIV. Emphasize the following:
    - Male and female condoms significantly reduce the risk of infection with STIs, including HIV, when used correctly and consistently with every act of sexual intercourse.
    - When used consistently and correctly, condom use prevents 80%-95% of HIV transmission that would have occurred without condoms.
6. **Ask the client to choose the method that is most convenient for her/him.**
  - Ask the client whether she/he has any questions or comments about any method discussed. Respond to any questions. Resolve any doubts before proceeding.
  - Ask the client to choose the method that they prefer. You may give recommendations about a method, but allow the client to make the final choice.
  - Once the client selects a method, do not take the remaining methods/method cards off the table. You may need to return to them if the client is not medically eligible for the selected method or changes her/his mind.
  - If the client does not like any of the methods discussed or cannot make up her/his mind, give the client a back-up method, such as male or female condoms, to use until she/he decides on a method. Condoms can provide dual protection against pregnancy and STIs. Go to Step 12 (in the STI/HIV Prevention Stage).
7. **Determine client's medical eligibility for the chosen method.**
  - Use the MEC Screening Checklist, MEC Screening Questions, or the questions on the method brochure, if available. (See Unit 4 for more information on medical eligibility criteria.)
  - If client is not eligible for the method chosen, explain why and ask her/him to select another method from those that remain.

## C. Post-Choice Stage:

8. **Give the client complete information about the method that s/he has chosen, using the method brochure, if available, including:**
  - How the method works
  - Side effects
  - Health benefits (if applicable)
  - How to use
  - Follow-up (if applicable)
  - When to return to the health care facility.

9. **Check the client's comprehension and reinforce key information.**
10. **Make sure the client has made a definite decision. Give her/him the selected method, or a referral and back-up method, depending on the method selected.**
11. **Encourage the client to involve her/his partner(s) in decisions about contraception, either through discussion or a visit to the clinic.**

**D. STI/HIV Prevention, Risk Assessment, and Counselling and Testing Stage:**

**12. Discuss STI/HIV transmission and prevention and the client's HIV status using the counselling card. Be sure to mention the following:**

- Knowing your HIV status protects you, your partner and your family.
- You can become infected with an STI, including HIV, through unsafe or unprotected sexual activity. STIs are common. HIV is an STI that cannot be cured.
- HIV is transmitted through an exchange of bodily fluids such as semen, blood, and breast milk, and during delivery.
- Maternal transmission of HIV to the child can be substantially reduced by prevention of mother-to-child transmission (PMTCT) services.
- Some STIs can be treated. Because the infection is sexually transmitted, both partners must be treated to avoid re-infection.
- An infected person may not show symptoms. A person with an STI, including HIV, may appear to be healthy.
- Common STI symptoms are vaginal discharge, discharge from the penis, sores in the genital area, burning during urination for men and lower abdominal pain for women.
- Risk of infection can be reduced by using a condom, limiting the number of sex partners, periodically abstaining from sex, using alternatives to penetrative sex, and delaying sex (adolescents).

**13. Conduct STI/HIV risk assessment using the counselling card. If the client has STI symptoms, treat her/him syndromically.**

Discuss the following points; correct misinformation and answer any questions:

- Number of sexual partners, both currently and in the past
- Knowledge of partner's sexual practices and past partners
- Type of sex or sexual activities and behaviours client is practicing (e.g., mutual monogamy, whether partner has other sexual partners, oral sex, anal sex, dry sex, or use of detergents and/or spermicides)
- Current symptoms/treatment of STIs and history of previous STI Infections, symptoms, and treatment for self and partner(s)
- HIV status and HIV status of partner(s)
- Past and present condom use (including perception of partner's attitude) and whether client is aware that condoms protect against both STIs/HIV and pregnancy
- Home life situation (e.g., partner violence and social supports)
- Use of PMTCT services during pregnancy, delivery, and breastfeeding.

After obtaining a clearer picture of the client's sexual risks and social context, help the client make a plan to reduce risk, using any of the following strategies:

- Reducing the number of sexual partners
- Using a condom (male or female) correctly and consistently with every act of sexual intercourse. Condoms are the only method that protects against STIs, including HIV
- Making condoms available to partner(s) and encouraging condoms' correct and consistent use
- Avoiding the use of unclean skin-cutting instruments and/or injection needles
- Having any STI or cervical infection detected and treated immediately
- Undergoing procedures involving the genital tract in a clean, aseptic environment
- Practicing dual protection
- Knowing her/his HIV status.

If the client has an STI, treat her/him syndromically according to guidelines or refer her/him for tests, if available.

**14. Discuss dual protection using the counselling card. Offer male or female condoms and instruct the client in correct and consistent use.**

**15. Conduct HIV counselling and testing (C&T) using the counselling card. If client is known to be HIV-positive, skip to Step 17.**

Key points to cover:

- Knowing your HIV status can help you make decisions about protecting yourself and your sexual partner(s) and having children.
- A test is available to determine whether a person is infected with HIV. The test involves taking a sample of blood.
- The test is free and available at clinics, hospitals, and HIV C&T sites.
- No one can force you to have the test. Taking an HIV test is voluntary.
- Test results are confidential.
- When a person is first infected with HIV, it can take 3 to 6 months before the test can detect the infection. This is called the window period. It is the reason why repeat testing can be important.
- A positive test result means you are infected with HIV and can transmit the virus to others.
- A negative test result can mean you are not infected or that you are in the window period. You should retake the test in 3 months.
- If the test is still negative, you can still get HIV at a later date. Retest in the future if you have unprotected sex or any other risky exposure.
- HIV is an STI. It is important to ask your sexual partner(s) to be tested too.

**16. Discuss and offer the client an opportunity for HIV C&T. If willing, test the client and counsel her/him on the test results according to national protocols.**

- Emphasize to the client that prevention, early detection, and prompt management of STIs, including HIV, are beneficial to the client, her/his partner and family, and to the community at large.
- Discuss and offer the client opportunities for HIV C&T.
- **Remember:** Testing is voluntary and must be done with informed consent. No matter how much you believe the person should be tested, the person must make the decision herself/himself. If the client is sure of not wanting the test, do not push too hard or the

client may not return. Accept the client's position for now and have a similar discussion on the next visit. Some people need more time than others.

- 17. Encourage client to disclose HIV status to her/his partner(s). Inform her/him about the benefits and risks of disclosure.**
- 18. Give follow-up instructions, a brochure for the method selected, and a condom brochure.**
- 19. Invite the client to return at any time. Thank him/her for the visit and complete the session.**

## 5.12 Discussing STI/HIV Risk, Prevention and Testing With Clients

When encouraging family planning clients to know their status and take an HIV test, the conversation will be different from the "usual" family planning session. It can be difficult to begin a conversation about HIV with a client because the provider needs to ask very personal questions.

For people to be motivated to take an HIV test, they must believe they have been or are at risk. They also need to understand what HIV is and how it is transmitted. This is why the discussion about HIV status should begin with a discussion about HIV transmission and risk.

Any of the following questions might be used when talking to a client about STI/HIV risk and status. These questions may be adjusted as needed. Family planning providers and counsellors need to practice and become comfortable with asking these and other such questions because to reduce the stigma around HIV, health workers must be able to talk freely about sex and sexual health.

- Have you ever talked to your partner(s) about family planning?
- Have you ever talked to your partner(s) about your sexual life in general?
- Do you have more than one sexual partner?
- How many sexual partners have you had in the past?
- Do you ever use condoms?
- Have you ever used any form of contraception in your sexual relationships? Which ones? How often? How does/do your partner(s) feel about contraception?
- Have you ever talked to your partner about STIs or HIV?
- To your knowledge, have you or any of your past or current partners ever had an STI?
- Have you ever been tested for HIV?
- Has/Have your partner(s) ever been tested for HIV?
- How likely do you think it is that you may be at risk for STIs or HIV? How likely do you think it is that your partner(s) could be at risk for STIs or HIV?
- Do you think you or your partner(s) may have an STI now? Do you have any symptoms that worry you?
- Has anyone ever been violent with you and demanded sex?
- Has anyone ever forced you to have sex?

## Counselling for Family Planning Role Plays: General Counselling Skills

(Adapted from Macro International 2009)

### Directions

- Divide class into groups of 3.
- Ask each group to select at least 3 scenarios from those listed below. Each group should act out each scenario once, rotating the roles of counsellor, client, and observer so that each person practices each role.
- Tell students to spend a few minutes reading the background information and preparing for the exercise.
- Tell the groups that after they have finished, they will take turns performing their role play(s) in front of the larger class.
- Conduct a discussion highlighting the strengths and points to improve upon.

### Observer discussion questions

1. How did the clinician approach the client?
2. How did the client respond to the clinician? Did the clinician change her/his approach based on this response? If so, was it appropriate?
3. How might the clinician improve her/his interaction with the client?

### Role play scenarios

- 25-year-old woman using COCs but suffering from side effects wants to continue using family planning
- 40-year-old mother of 7 children who asks about family planning
- 16-year-old adolescent who had abortion yesterday
- 18-year-old man interested in condoms because he wants to avoid acquiring an STI
- 30-year-old woman with 2 children, engages in sex work for a living and recently heard about family planning
- 20-year-old woman with no children, living with HIV and sexually active.
- 25-year-old woman with 2 children, has never used family planning
- 30-year-old woman delivered a baby 1 week ago and is breastfeeding
- 30-year-old married woman; husband works in another region and comes home twice a year
- 17-year-old woman in school who is interested in learning about family planning; she is unmarried and sexually active
- 40-year-old woman with 4 children, has never used family planning
- 20-year-old woman has 2 boyfriends and no children

- 45-year-old man whose wife gave birth to fifth child 1 week ago
- 19-year-old, unmarried woman, having sexual relations with her fiancé, is worried about becoming pregnant before she is married
- 24-year-old woman with 3 children who wants to use family planning but is unsure about having any more children. She has heard that the IUCD causes a lot of bleeding.
- 20-year-old lactating woman with a 3-month-old baby, wants to postpone her next pregnancy. Her sister uses COCs and likes that method very much. The woman says she wants to use them too.



# Counselling for Family Planning Role Plays: Practicing the BCS+

(Adapted from Bruce, Linda, Wilson Liambila, Mantshi Menziwa, and Doctor Khoza 2008)

**Note:** The BCS+ method cards are required for this activity. They can be obtained from [http://www.popcouncil.org/publications/books/2008\\_BalancedCounselingStrategyPLUS.asp](http://www.popcouncil.org/publications/books/2008_BalancedCounselingStrategyPLUS.asp) or by writing to: [publications@popcouncil.org](mailto:publications@popcouncil.org).

## Materials and advance preparation

- Enough copies of the BCS+ methods cards so that each pair of students has a complete set.
- One role-play script for each student. (More than one student may play the same client role.) Copy the role-play scripts below, or make up your own scripts. **Note:** The most appropriate methods for each role are suggested in parentheses at the end of each script.

**Time required:** 90 minutes

## Instructions

1. Ask the students to form pairs, and ask each pair to decide who will play the role of “family planning client” and who will be a “family planning provider.” Give each participant playing the “client” a role-play script.
2. Ask students to begin the role play standing so that they can greet the client. After greeting the client, they may sit down and begin the counseling session.
3. Allow about 30 minutes for the role play.
4. During the role play, walk around and observe how participants are doing. Note anything you see that is not being done well and hold on to that information for when you are processing the role play.
5. After 25 minutes, tell participants that they have 5 minutes to wrap up their counseling session. (If some participants need extra time, give them another minute or so to finish.)
6. Process the role plays as described below.
7. Ask students to switch roles, and distribute the second role play scripts to the students playing the client role. Give them 30 minutes for the second role play.
8. Process the second role play in the same way as the first.

## Instructions for discussing/processing BCS+ role plays

1. Ask the learners who played the providers what it was like going through the entire BCS+ process (using the algorithm and job aids, if these were available).
2. Ask whether the learners have any questions or comments about the process, or about using the BCS+ algorithm, counselling cards, or method brochures to counsel their client.
3. Answer all questions and address all comments before proceeding.
4. Ask the learners who played the clients the following questions:
  - What was it like to be counselled using the BCS+ approach?
  - Was there anything confusing to you? If so, what?
  - Do you have any tips for the learners who played the provider?

5. Provide any positive reinforcement and input based on your observations during the role plays.

### BCS+ Role Play Scripts

You are a 23-year-old married woman who has 2 young children. You want to wait 2-3 years before getting pregnant again. Your husband does not care much about family planning. You have not used modern contraceptive methods before. Your youngest child is 5 months old, and you are breastfeeding. You are very scared to use the IUCD and refuse it if offered. You are not sure of your HIV status but think your husband had many partners before marriage.

**Appropriate methods:** *Implants, with male or female condoms for dual protection. Other possible methods would be injectables and COCs (once she is 6 months postpartum)*

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You are an 18-year-old girl. You started your menstrual bleeding 10 days ago. You are sexually active and have a boyfriend. You want to avoid getting pregnant and want COCs. Neither you nor your boyfriend wants to use condoms. Later on in the consult you reveal that you had unprotected sex 2 days ago. You have come to the clinic because you heard COCs prevent pregnancy. You have a slight vaginal discharge.

**Appropriate methods:** *Emergency contraceptive pills (ECPs) and COCs as an ongoing method. Other possible methods would be implants, an IUCD (if infection can be ruled out, or injectables).*

---

You are a 25-year-old woman with multiple sexual partners. You slowly reveal that you are a sex worker trying to earn enough money to support your 2 children. Your (paying) partners do not like to use condoms. You have heard of sexually transmitted infections and are afraid of getting one. You also cannot afford to get pregnant again.

**Appropriate methods:** *Female condoms for dual protection. Other possible methods would be implants, injectables, or COCs.*

---

You are a 30-year-old married woman who does not want any more children. You already have 4 and are tired and fed up with being pregnant. Your partner is interested in more children. Your husband likes having sex frequently and does not like using condoms. You are afraid of injections. You have had mild seizures in the past and sometimes take medicine for them. If offered oral contraceptives, explain that you are afraid you will forget to take the pill every day. Your husband travels occasionally, and you are not sure if he is faithful.

**Appropriate methods:** *IUCD or implant, with male or female condoms for dual protection. Another possible method would be female sterilisation.*

You are an adolescent boy who has come to the clinic with an STI but not HIV. You are concerned about getting an STI again. You have had several girlfriends. Your current girlfriend wants to get pregnant to show you that she loves you, but you are not so happy about the idea. If the provider offers you male condoms, agree. Before you leave, ask the provider how your girlfriend can avoid getting pregnant.

**Appropriate methods:** *Male condom for dual protection, and the provider should encourage the girlfriend to come in.*

---

You are a 20-year-old woman with a 4-month-old child that you are breastfeeding. Your husband is working on a farm as an immigrant laborer and is gone 22 days of the month. You have never used family planning but want to control your fertility. You are about to start your menstruation. It is Monday, and your husband is coming home this weekend. He does not like to use condoms and is not that supportive of family planning. If offered the IUD, explain that you cannot afford to go to the hospital, which is 100 miles away.

**Appropriate methods:** *Progestin-only pills—Minipill. She may also consider DMPA. Because her husband is not supportive of family planning, she should return for the injection within 7 days of the start of her monthly bleeding, so she would not need to use a back-up method.*

---

You are a 35-year-old married woman who has 3 children. The youngest child is 6 weeks old. You are not ready to have another child for a while. Your husband does not cooperate with family planning. You live fairly far from the health center. You have heard evil things about the IUD and refuse it if offered. If offered implants, explain that your husband would notice and be very angry with you. You had an extramarital affair several years ago.

**Appropriate methods:** *Progestin-only injectable — DMPA is best because client only has to return every 3 months.*

---

You are 18 years old and single. You have a boyfriend and do not want to get pregnant. You and your boyfriend go to school. You are about to begin your menstruation. If offered the IUD or Norplant, reveal that you do not want something foreign in your body. If offered injectables, scream and say you hate needles. If offered the minipill, explain that you have come to the clinic before for the minipill, but they are always out of stock. You have no conditions that prevent you from taking the Pill. Besides, there is a pharmacy in your community that carries the most popular Pill. You have had several boyfriends in the past.

**Appropriate method:** *Combined oral contraceptives.*

---

You are 29 years old and have been fully breastfeeding your child and using LAM as a birth control method. You are beginning to give your infant food. You want to make sure that using LAM is still the same. You have chosen LAM because you want to breastfeed your baby, and you are very religious. You and your husband do not believe in modern contraceptive methods. Your husband supports you in wanting to space your children. If TwoDay Method® is offered, you do not want to touch your genitals. Both you and your husband are monogamously faithful.

**Appropriate method:** *Standard Days Method®*

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You are a 22-year-old woman with a 1-year-old child. You are in a stable marriage, and your husband supports family planning. You do not like modern contraceptive methods. Sometimes he will use a condom but not consistently because it reduces feeling for him. You do not like the side effects of hormonal methods. You are religious and would not like a modern method. If the provider offers you a fertility awareness method, such as Standard Days Method® or TwoDay Method®, appear to be interested. Then, reveal that your monthly menstruation cycles are very irregular.

**Appropriate method:** *Female condom.*

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# Counselling for Family Planning Activity: Asking Questions about HIV Risk

(Adapted from Bruce, Linda, Wilson Liambila, Mantshi Menziwa, and Doctor Khoza 2008.)

## Instructions

1. Explain that when encouraging family planning clients to know their status and take an HIV test, the conversation will be different from the usual family planning session.
2. Point out that for people to be motivated to take an HIV test, they must believe they have been or are at risk. They also need to understand what HIV is and how it is transmitted.
3. Explain that it can be difficult to begin a conversation about HIV with a client because very personal questions will need to be asked.
4. Ask students to pair up and ask each other some of the questions (below). Have them note which questions they feel uncomfortable asking or answering.
5. After some time, bring students back to the large group and discuss. Remind students that discussing sex can be an uncomfortable experience, even for health professionals.
6. Point out that in order for clients to understand HIV, recognize their sexual behaviour, and believe they are at risk and ask to be tested, we must have these conversations about sex and be confident doing so. In addition, to reduce the stigma around HIV, we must talk freely about sex and sexual health.

## Questions for student pairs

- Have you ever talked to your partner(s) about family planning?
- Have you ever talked to your partner(s) about your sexual life in general?
- Do you have more than 1 sexual partner?
- How many sexual partners have you had in the past?
- Do you ever use condoms?
- Have you ever used any form of contraception in your sexual relationships? Which ones? How often? How does/do your partner(s) feel about contraception?
- Have you ever talked to your partner about STIs or HIV?
- To your knowledge, have you or any of your past or current partners ever had an STI?
- Have you ever been tested for HIV?
- Has/Have your partner(s) ever been tested for HIV?
- How likely do you think it is that you may be at risk for STIs or HIV? How likely do you think it is that your partner(s) could be at risk for STIs or HIV?
- Do you think you or your partner(s) may have an STI now? Do you have any symptoms that worry you?
- Has anyone ever been violent with you and demanded sex?
- Has anyone ever forced you to have sex?

## Counselling for Family Planning Quiz Questions

**Questions 1–12:** Indicate whether the following statements about male and female condoms are **true** or **false** by writing a “T” for true or an “F” for false in the space provided before each statement.

- 1. Family planning counselling is the activity in which a provider tells the client everything she/he needs to know about different contraceptive methods.
- 2. Privacy is the client’s right and power to control the information (about him/herself) that others possess.
- 3. A good counsellor knows when to tell the truth and when not to in order to show empathy with a client.
- 4. A good counsellor remains nonjudgmental of clients, even when he or she disagrees with a client’s behaviour or point of view.
- 5. The provider needs to pay attention to her/his body language to avoid sending unintentional nonverbal cues.
- 6. A counsellor should ask closed questions to get direct answers from clients and to reduce the time spent per counselling session.
- 7. The steps in the BCS+ can be performed out of order, as long as all the steps for a given stage are completed.
- 8. During the Method Choice Stage of BCS+, the provider presents the methods in order of effectiveness.
- 9. Male and female condoms are the only contraceptives that provide dual protection against pregnancy and STI/HIV.
- 10. The STI/HIV Prevention, Risk Assessment, and Counselling and Testing stage is the second stage of the BCS+.
- 10. During the BSC+ process, a client’s medical eligibility for selected methods is determined before asking the client to choose the method that is most convenient for her/him.
- 11. A discussion with a client about HIV status should begin with a discussion about HIV transmission and risk.
- 12. HIV counselling and testing is an integral part of BCS+.

**Questions 13–17:** Circle the letter that offers the best response to each question.

13. Informed choice means that a family planning client:
- a. Has been informed about all methods and agrees to use the contraceptive method the provider recommends
  - b. Has been informed about the side effects of the method she has chosen
  - c. Has informed the provider of the method she or he wants
  - d. Has the right to freely choose whether to use a contraceptive method and, if so, which one they want to use, based on their awareness and understanding of accurate information about the methods
14. Which one of the following is **not** a principle of good client-provider interaction?
- a. Encourage the client to ask questions

- b. Use and providing memory aids
  - c. Give all available information about all reproductive health issues
  - d. Provide just key information and instructions
  - e. All of the above are principles of good client-provider interaction.
15. To uphold confidentiality a provider must:
- a. Counsel clients in areas where the client cannot be seen
  - b. Counsel clients in areas where the discussion cannot be heard
  - c. Not share medical information with the client's family members without written permission
  - d. All of the above
16. Which of the following is one of the 4 questions asked during the BCS+ pre-choice stage?
- a. Have you tried any family planning methods in the past?
  - b. How will you pay for your method?
  - c. Does your partner support you in family planning?
  - d. Do you smoke?
  - e. All of the above
17. A plan to reduce the risk of STI/HIV infection includes which of the following strategies?
- a. Avoid the use of unclean skin-cutting instruments and/or injection needles.
  - b. Do not use a condom unless having sex with a partner whose HIV status is unknown.
  - e. Encourage partner(s) to shower every day.
  - f. All of the above.
18. List 2 benefits of family planning counselling:
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19. List 3 client rights in regard to family planning:
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20. List 2 ways to make family planning counselling gender-sensitive:

## Counselling for Family Planning Quiz Questions Answer Key

- F \_\_ 1. Family planning counselling is the activity in which a provider tells the client everything she/he needs to know about different contraceptive methods. **Family planning counselling involves two-way communication between a health care provider and a client for the purpose of confirming or facilitating an informed decision about family planning by the client or helping the client address problems or concerns.**
- T \_\_ 2. Privacy is the client's right and power to control the information (about him/herself) that others possess.
- F \_\_ 3. A good counsellor knows when to tell the truth and when not to in order to show empathy with a client. **A good counsellor always tells the truth.**
- T \_\_ 4. A good counsellor remains nonjudgmental of clients, even when he or she disagrees with a client's behaviour or point of view.
- T \_\_ 5. The provider needs to pay attention to her/his body language to avoid sending unintentional nonverbal cues.
- F \_\_ 6. A counsellor should ask closed questions to get direct answers from clients and to reduce the time spent per counselling session. **A counsellor should ask the client open-ended questions to help increase the amount of information provided.**
- F \_\_ 7. The steps in the BCS+ can be performed out of order, as long as all the steps for a given stage are completed. **The steps must be performed in the order given, as each step builds upon the one before it.**
- T \_\_ 8. During the Method Choice Stage of BCS+, the provider presents the methods in order of effectiveness.
- T \_\_ 9. Male and female condoms are the only contraceptives that provide dual protection against pregnancy and STI/HIV.
- F \_ 10. The STI/HIV Prevention, Risk Assessment, and Counselling and Testing Stage is the second stage of the BCS+. **This is the fourth and final stage of the BCS+ process.**
- F \_ 10. During the BSC+ process, a client's medical eligibility for selected methods is selected before asking the client to choose the method that is most convenient for her/him. **Ask first about convenience and then determine medical eligibility.**
- T \_ 11. A discussion with a client about HIV status should begin with a discussion about HIV transmission and risk.
- T \_ 12. HIV counselling and testing is an integral part of BCS+.
13. Informed choice means that a family planning client:
- d. Has the right to freely choose whether to use a contraceptive method and, if so, which one they want to use, based on their awareness and understanding of accurate information about the methods**
14. Which one of the following is not a principle of good client-provider interaction?
- c. Give all available information about all reproductive health issues**
15. To uphold confidentiality a provider must:

**d. All of the above**

16. Which of the following is one of the 4 questions asked during the BCS+ pre-choice stage?

**c. Does your partner support you in family planning?**

17. A plan to reduce risk of STI/HIV infection includes which of the following strategies?

**a. Avoid the use of unclean skin-cutting instruments and/or injection needles.**

18. List 2 benefits of family planning counselling:

**Any 2 of the following:**

- Increases acceptance of family planning services
- Promotes effective use of family planning services
- Increases client's satisfaction with family planning methods and services
- Enhances continuation of family planning services
- Dispels rumours and corrects misunderstandings about contraceptive methods.

19. List 3 client rights in regard to family planning:

**Any 3 of the following:**

- Right to privacy
- Right to confidentiality
- Right to accurate, appropriate, understandable, and unambiguous information
- Right to access to services
- Right to dignity, comfort, and expression of opinion
- Right to continuity of care
- Right to safety of services

20. List 2 ways to make family planning counselling gender-sensitive:

**Any 2 of the following:**

- Sensitively elicit information about a client's power to make decisions and obtain family planning methods, and any gender-related fears and anxieties related to family planning use.
- Offer clients information related to their reproductive rights concerning family planning.
- Encourage clients to make their own sexual and reproductive health choices.
- Consult with clients on when or if to bring partners into family planning counselling.
- Demonstrate respect for the client's right to privacy and confidentiality about use of family planning.
- Assist client in identifying safe strategies to prevent pregnancy and/or STIs/HIV based on her/his informed choice of family planning.



# Learning Guide for Balanced Counselling Strategy Plus

(to be used by participants)

Rate the performance of each step or task observed using the following rating scale:

- 1 **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
- 2 **Competently Performed:** Step or task performed correctly in proper sequence (if necessary) but participant not progressing from step to step efficiently
- 3 **Proficiently Performed:** Step or task efficiently and precisely performed in the proper sequence (if necessary)

Participant \_\_\_\_\_ Course Dates \_\_\_\_\_

<b>Learning Guide for BCS+</b>					
<b>Task/Activity</b>	<b>Cases</b>				
<b>PRE-CHOICE STAGE</b>					
STEP 1: ESTABLISH AND MAINTAIN A WARM, CORDIAL RELATIONSHIP, LISTEN TO THE CLIENT'S CONTRACEPTIVE NEEDS.					
1. Introduce yourself and call the client by her/his name.					
2. Demonstrate interest in what the client tells you.					
3. Establish eye contact with the client.					
4. Listen to and answer her/his questions.					
5. Show support and understanding without judgment.					
6. Ask questions to encourage participation.					
7. Ask whether the client would like a family planning method.					
STEP 2: RULE OUT PREGNANCY USING THE PREGNANCY CHECKLIST (See Unit 4: Family Planning Client Assessment and the WHO MEC for this checklist)					
STEP 3: DISPLAY ALL OF THE METHODS USING METHOD CARDS, FLIP CHARTS, ACTUAL METHODS, PHOTOGRAPHS, ILLUSTRATIONS, OR POSTERS. (Arrange by method type: temporary, long-term and permanent methods [LTPM], fertility awareness methods.)					
STEP 4: SET ASIDE METHODS THAT ARE NOT APPROPRIATE FOR THE CLIENT BY ASKING THE FOLLOWING 4 QUESTIONS:					
1. <i>Do you wish to have children in the future?</i> <ul style="list-style-type: none"> <li>• If "Yes" set aside (or eliminate) vasectomy and female sterilisation. Explain why.</li> <li>• If "No," keep all methods and continue.</li> </ul>					
2. <i>Are you breastfeeding an infant that is less than 6 months?</i> <ul style="list-style-type: none"> <li>• If "Yes," set aside (or eliminate) combined oral contraceptives (COCs). Explain why.</li> <li>• If "No," or she has begun her monthly bleeding again, set aside the</li> </ul>					

## Learning Guide for BCS+

Task/Activity	Cases				
lactation amenorrhoea method (LAM). Explain why.					
3. <i>Does your partner support you in family planning?</i> <ul style="list-style-type: none"> <li>If “Yes,” continue with the next question.</li> <li>If “No,” set aside: Standard Days Method© and Two Day Method. Explain why.</li> </ul>					
4. <i>Are there any methods that you do not want to use or have not tolerated in the past?</i> <ul style="list-style-type: none"> <li>If “Yes,” set aside or eliminate the method(s) that the client does not want.</li> <li>If “No,” keep the rest of the methods.</li> </ul>					
<b>METHOD CHOICE STAGE</b>					
STEP 5: GIVE INFORMATION ABOUT THE METHODS THAT HAVE NOT BEEN SET ASIDE, INCLUDING THEIR EFFECTIVENESS.					
1. Arrange the remaining methods in order of effectiveness.					
2. Starting with the most effective method, tell the client the 5 to 7 most important characteristics of each method. Ensure that the client fully understands the information given on each method before proceeding to the next one.					
3. Explain that the condom (male and female) is the only method that provides dual protection against pregnancy <u>and</u> STIs, including HIV. Emphasize the following: <ul style="list-style-type: none"> <li>Condoms significantly reduce the risk of infection with STIs/HIV when used correctly and consistently with every act of sexual intercourse.</li> <li>When used consistently and correctly, condom use prevents 80% to 95% of HIV transmission that would have occurred without condoms.</li> </ul>					
STEP 6: ASK THE CLIENT TO CHOOSE THE METHOD THAT IS MOST CONVENIENT FOR HER/HIM.					
1. Ask client whether she/he has any questions or comments about any method discussed. Respond to any questions. Resolve any doubts.					
2. Ask client to choose the method that she/he prefers. You may give recommendations, but allow the client to make the final choice.					
3. Once the client selects a method, keep remaining methods on the table.					
4. If the client does not like any of the methods discussed or cannot make up her/his mind, give the client a back-up method. Go to Step 12.					
STEP 7: DETERMINE CLIENT’S MEDICAL ELIGIBILITY FOR THE CHOSEN METHOD.					
1. Use the Screening Checklist, Screening Questions, or questions on the method brochure, if available. (See Unit 4)					
2. If client is not eligible for the method chosen, explain why and ask her/him to select another method from those that remain.					
<b>POST-CHOICE STAGE</b>					
STEP 8: GIVE THE CLIENT COMPLETE INFORMATION ABOUT THE METHOD THAT S/HE HAS CHOSEN, USING THE METHOD BROCHURE, IF AVAILABLE.					
1. Explain how the method works					
2. Describe side effects					

## Learning Guide for BCS+

Task/Activity	Cases				
3. Inform about health benefits (if applicable)					
4. Explain how to use					
5. Describe follow-up (if applicable)					
6. Explain when to return to the health care facility					
STEP 9: CHECK THE CLIENT'S COMPREHENSION AND REINFORCE KEY INFORMATION.					
STEP 10: MAKE SURE THE CLIENT HAS MADE A DEFINITE DECISION. GIVE HER/HIM THE SELECTED METHOD, OR A REFERRAL AND BACK-UP METHOD, IF NECESSARY.					
STEP 11: ENCOURAGE THE CLIENT TO INVOLVE HER/HIS PARTNER(S) IN DECISIONS ABOUT CONTRACEPTION, EITHER THROUGH DISCUSSION OR A VISIT TO THE CLINIC.					
<b>STI/HIV PREVENTION, RISK ASSESSMENT, AND COUNSELLING AND TESTING STAGE</b>					
STEP 12: DISCUSS STI/HIV TRANSMISSION AND PREVENTION AND THE CLIENT'S HIV STATUS. MENTION THE FOLLOWING:					
1. Knowing your HIV status protects you, your partner, and your family.					
2. You can become infected with an STI, including HIV, through unsafe or unprotected sexual activity. STIs are common. HIV is an STI that cannot be cured.					
3. HIV is transmitted through an exchange of bodily fluids such as semen, blood, and breast milk, and during delivery.					
4. Maternal transmission of HIV to the child can be substantially reduced by prevention of mother-to-child transmission (PMTCT) services.					
5. Some STIs can be treated. Because the infection is sexually transmitted, both partners must be treated to avoid re-infection.					
6. An infected person may not show symptoms and may appear to be healthy.					
7. Common STI symptoms are vaginal discharge, discharge from the penis, sores in the genital area, burning during urination for men and lower abdominal pain for women.					
8. Risk of infection can be reduced by using a condom, limiting the number of sex partners, periodically abstaining from sex, using alternatives to penetrative sex, and delaying sex (adolescents).					
STEP 13: CONDUCT STI/HIV RISK ASSESSMENT. IF THE CLIENT HAS STI SYMPTOMS, TREAT HER/HIM SYNDROMICALLY.					
1. Discuss the following; correct misinformation and answer any questions: <ul style="list-style-type: none"> <li>• Number of sexual partners, both currently and in the past</li> <li>• Knowledge of partner's sexual practices and past partners</li> <li>• Type of sex or sexual activities and behaviours client is practicing (e.g., mutual monogamy, whether partner has other sexual partners, oral sex, anal sex, dry sex, or use of detergents and/or spermicides)</li> <li>• Current symptoms/treatment of STIs and history of previous STI</li> </ul>					

## Learning Guide for BCS+

Task/Activity	Cases				
<p>Infections, symptoms, and treatment for self and partner(s)</p> <ul style="list-style-type: none"> <li>• HIV status and HIV status of partner(s)</li> <li>• Past and present condom use (including perception of partner's attitude) and whether client is aware that condoms protect against both STIs/HIV and pregnancy</li> <li>• Home life situation (e.g., partner violence and social supports)</li> <li>• Use of PMTCT services during pregnancy, delivery, and breastfeeding.</li> </ul>					
<p>2. Help the client make a plan to reduce risk, using any of the following strategies:</p> <ul style="list-style-type: none"> <li>• Reducing the number of sexual partners</li> <li>• Using a condom (male or female) correctly and consistently with every act of sexual intercourse. Condoms are the only method that protects against STIs, including HIV.</li> <li>• Making condoms available to partner(s) and encouraging their correct and consistent use</li> <li>• Avoiding the use of unclean skin-cutting instruments and/or injection needles</li> <li>• Having any STI or cervical infection detected and treated immediately</li> <li>• Undergoing procedures involving the genital tract in a clean, aseptic environment</li> <li>• Practicing dual protection</li> <li>• Knowing her/his HIV status.</li> </ul>					
<p>3. If the client has an STI, treat her/him syndromically according to guidelines or refer her/him for tests, if available.</p>					
<p><b>STEP 14: DISCUSS DUAL PROTECTION USING THE COUNSELLING CARD. OFFER MALE OR FEMALE CONDOMS AND INSTRUCT THE CLIENT IN CORRECT AND CONSISTENT USE.</b></p>					
<p><b>STEP 15: CONDUCT HIV COUNSELLING AND TESTING (C&amp;T). IF CLIENT IS KNOWN TO BE HIV-POSITIVE, SKIP TO STEP 17.</b></p>					
<p>Cover these key points:</p> <ul style="list-style-type: none"> <li>• Knowing your HIV status can help you make decisions about protecting yourself and your sexual partner(s) and having children.</li> <li>• A test is available to determine whether a person is infected with HIV. The test involves taking a sample of blood.</li> <li>• The test is free and available at clinics, hospitals, and HIV C&amp;T sites.</li> <li>• No one can force you to have the test. Taking an HIV test is voluntary.</li> <li>• Test results are confidential.</li> <li>• When a person is first infected with HIV, it can take 3 to 6 months before the test can detect the infection. This is called the window period. It is the reason why repeat testing can be important.</li> <li>• Testing positive means you are infected with HIV and can transmit the</li> </ul>					

## Learning Guide for BCS+

Task/Activity	Cases				
virus to others. <ul style="list-style-type: none"> <li>• A negative test result can mean you are not infected or that you are in the window period. You should retake the test in 3 months.</li> <li>• Retest in the future if you have unprotected sex or any other risky exposure.</li> <li>• HIV is an STI. Ask your sexual partner(s) to be tested too.</li> </ul>					
<b>STEP 16: DISCUSS AND OFFER THE CLIENT AN OPPORTUNITY FOR HIV C&amp;T. IF CLIENT IS WILLING, TEST THE CLIENT AND COUNSEL HER/HIM ON THE TEST RESULTS ACCORDING TO NATIONAL PROTOCOLS.</b>					
1. Emphasize to the client that prevention, early detection, and prompt management of STIs, including HIV, are beneficial to the client, her/his partner and family, and to the community at large.					
2. Discuss and offer the client opportunities for HIV C&T.					
<b>STEP 17: ENCOURAGE CLIENT TO DISCLOSE HIV STATUS TO HER/HIS PARTNER(S). INFORM HER/HIM ABOUT THE BENEFITS AND RISKS OF DISCLOSURE.</b>					
<b>STEP 18: GIVE FOLLOW-UP INSTRUCTIONS, A BROCHURE FOR THE METHOD THE CLIENT HAS SELECTED, AND A CONDOM BROCHURE.</b>					
<b>STEP 19: INVITE THE CLIENT TO RETURN AT ANY TIME. THANK HIM/HER FOR VISIT AND COMPLETE THE SESSION.</b>					

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# Unit 6

## HEALTHY TIMING AND SPACING OF PREGNANCY

### Learning Objectives

By the end of this unit, learners will be able to:

- ❖ Define Healthy Timing and Spacing of Pregnancy (HTSP)
- ❖ Explain the meaning of “timing” and “spacing” of pregnancy and how HTSP differs from “birth spacing”
- ❖ Describe the relationship between HTSP and family planning and the advantages of including HTSP messages in family planning counselling
- ❖ List the three key HTSP messages
- ❖ List the windows of opportunity for delivering HTSP messages to clients
- ❖ Discuss the health risks of not practicing HTSP
- ❖ List the benefits of HTSP for women, babies, and families
- ❖ Explain how HTSP messages can be routinely included in family planning counselling
- ❖ Respond to clients’ reasons for not practicing HTSP
- ❖ Provide HTSP messages in family planning counselling for adolescents and for postpartum and postabortion clients.

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## Unit 6: Healthy Timing and Spacing of Pregnancy

### Key Points

- ❖ **Delaying pregnancy at least 24 months after a previous birth improves health outcomes for women and their babies.**
- ❖ **Delaying pregnancy at least 6 months after an abortion or miscarriage improves health outcomes for women and their babies.**
- ❖ **Delaying first pregnancy until at least the age of 18 years improves health outcomes for women and their babies.**
- ❖ **In order to properly space pregnancies, family planning should be used before a woman’s fertility returns, which can be as soon as 28 days after childbirth and 11 days after abortion or miscarriage.**
- ❖ **It is important to systematically integrate family planning services with maternal, newborn, and infant services in order to achieve optimal HTSP.**

### 6.1 Defining Healthy Timing and Spacing of Pregnancy

Healthy Timing and Spacing of Pregnancy (HTSP) is an approach to family planning that helps 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.

HTSP is based on scientific research that identifies the healthiest time to become pregnant and the healthiest spacing between pregnancies

#### **Difference between timing and spacing**

**Timing** refers to when the first pregnancy should occur (not before age 18) and the age when pregnancy is no longer optimal (about age 35).

**Spacing** refers to the amount of time a woman should wait after a live birth, abortion, or miscarriage before attempting the next pregnancy.

#### **How HTSP differs from “birth spacing”**

Birth spacing recommendations refer to the interval between one birth and the next, whereas HTSP messages about spacing refer to the healthiest interval between a birth and the **next pregnancy**. Therefore, the HTSP recommendation to delay pregnancy for at least 24 months after giving birth results in an optimal birth spacing of about 33 months (24 months + 9 months of pregnancy). In addition, HTSP recommendations are evidence-based.

### 6.2 HTSP and Family Planning

HTSP is a part of family planning. Messages about healthy timing and spacing of pregnancies may be appropriate for family planning clients at all stages of their reproductive lives. However, the three key HTSP messages are intended specifically for pregnant and postpartum clients, clients receiving health care services for miscarriage or induced abortion, and adolescents.

HTSP counselling messages appeal to many clients because they place family planning in the context of promoting healthy pregnancies, mothers and babies, rather than the context of

limiting family size. Clients' understanding of HTSP messages can increase their acceptance and use of family planning services.

## 6.3 Key HTSP Messages

For women/couples who desire a next pregnancy after a live birth, the HTSP message is:

- For the health of the mother and baby, wait at least 24 months, but not more than 5 years, before trying to become pregnant again.
- Consider using a family planning method of your choice during that time.

For women/couples who decide to have a child after a miscarriage or abortion, the HTSP message is:

- For the health of the mother and baby, wait at least 6 months before trying to become pregnant again.
- Consider using a family planning method of your choice during that time.

For adolescents, the HTSP message is:

- For your health and your baby's health, wait until you are at least 18 years of age before trying to become pregnant.
- Consider using a family planning method of your choice until you are at least 18.

## 6.4 Windows of Opportunity to Deliver HTSP Messages

Messages about HTSP can and should be provided as a routine part of family planning in family planning clinics as well as in other health care settings serving adolescents, pregnant women, postpartum and postabortion clients, breastfeeding women, and women living with HIV.

Settings where HTSP messages can be provided include:

- Antenatal care
- Postpartum care
- Postabortion care
- Well-baby clinics
- Family planning services
- Emergency care
- HIV/AIDS services
- Community health outreach

## 6.5 Risks of Not Practicing HTSP

Numerous research studies have shown that adverse health outcomes for mothers and their babies are associated with early, late, closely spaced, and high parity pregnancies. The risks of not practicing HTSP include the following:

- Adolescents aged 15-19 are twice as likely to die during pregnancy or childbirth as those 20 and over; girls below the age of 15 are five times more likely to die. Pregnancy is the leading cause of death for young women aged 15-19 (UNFPA 2004).
- Women who experience closely spaced pregnancies are at increased risk of miscarriage, are more likely to experience iron-deficiency anaemia and pre-eclampsia, and are more likely to induce an abortion.

- Risk of newborn and infant mortality is higher. Newborns may be more likely to be pre-term, low-birth-weight or small for their gestational age.
- When breastfeeding stops before 6 months, the newborn does not continue to experience the health and nutritional benefits of breast milk.
- (Extending Service Delivery Project 2008)

## 6.6 Benefits of HTSP for Clients and Families

### Benefits for newborns and children

A newborn:

- Is more likely to be born strong and healthy
- Is more likely to survive past age five
- May be breastfed for a longer period of time, which allows the newborn to gain the health and nutritional benefits of breast milk
- May receive better care if mother is not caring for another child under the age of three.

### Benefits for mothers

A mother:

- Has reduced risk of complications associated with closely spaced pregnancies
- Has more energy and time to take care of a baby if she does not have the demands of a new pregnancy
- May breastfeed longer; longer duration of breastfeeding is linked to a reduced risk of breast and ovarian cancer.
- May be more rested and well-nourished so as to support the next healthy pregnancy
- Has more time for herself, her children and her partner, and to participate in educational, economic, and social activities.

### Benefits for fathers

A father:

- May feel an increased sense of satisfaction from safeguarding the health and well-being of his partner and children and supporting his partner in making healthy decisions regarding HTSP and family planning
- Has more time between births, which may allow him time to plan financially and emotionally before the birth of the next child.

### Benefits for families:

- Families can devote more resources to providing their children with food, clothing, housing, and education.

## 6.7 Providing HTSP Messages in Family Planning Counselling

The outline of steps below provides an example of how a provider may integrate HTSP messages into family planning counselling. This may be done in family planning clinics as well as in maternal and child care clinics, home visits, and other health care settings. The steps given here

begin after the provider has established rapport and gathered basic information about the woman's history, desired family size, and fertility intentions:

1. As needed, probe to determine whether the client is interested in becoming pregnant.
  - For postpartum women who want to become pregnant again, explain why spacing pregnancies at least two years and no more than five years after the previous birth is beneficial.
  - For postabortion or post-miscarriage women, explain that if she wants to become pregnant again, she should delay pregnancy for at least six months.
  - For adolescents, explain that it is important to wait until she is 18 before becoming pregnant.
2. Explain the potential risks of not practicing HTSP.
3. If the client is interested in HTSP, discuss methods of family planning that she can use to practice HTSP, based on her fertility intentions.
  - Inform your client about which FP methods are available.
  - Provide or refer her to obtain her selected method. (See Unit 5, FP Counselling, for more information).
4. If client is not interested in HTSP and wants to become pregnant, provide counselling on the importance of antenatal care.
5. If client is undecided about becoming pregnant, probe reasons for not spacing and discuss further. As appropriate, use the information from Table 6.1. (See table on next page.)

### **Couples counselling and HTSP**

Couples counselling that addresses family planning and HTSP provides men with important information on the health, social, and economic benefits of HTSP and family planning, and also provides an opportunity to discuss how men can act to protect their health and the health of their wives and children. However, couples counselling is not recommended unless the health worker has been trained in the additional skills and sensitivity required to effectively address gender-based issues in counselling.

Table 6.1: Responses to Common Reasons for Not Practicing HTSP

<b>Common reasons for not practicing HTSP:</b>	<b>Possible responses</b>
Her religion does not allow her to use family planning.	She can use the lactational amenorrhea method (LAM), fertility awareness methods, and other natural methods to plan her family.
Her husband is not interested in discussing family planning or pregnancy spacing and/or he feels that it is her responsibility, not his.	Pregnancy spacing should be a joint responsibility and there are many economic, social, and emotional advantages to spacing children. Even if he doesn't want to discuss it, she can still use family planning.
The man's virility may be questioned if his wife does not become pregnant quickly.	A responsible man knows that his family's health is important, and he is willing to take steps to ensure that his family is healthy by planning and spacing his children.
The woman's fertility may be questioned if she is not able to become pregnant quickly.	It is important to acknowledge the concerns and expectations of the husband and family, but the wife and husband must also understand the risks of closely spaced pregnancies to the health of the woman, her current and future children.
<b>Reasons for not waiting before youngest child is at least 2 years old:</b>	<b>Possible responses</b>
It is best to have the children one after the other while the mother is young so she is strong enough to raise them.	Even young mothers can be stressed and weakened by closely spaced pregnancies.
It is best to have children one after the other so that they can have a companion close to their age with whom they can play.	Children closely spaced together may demand more attention from the mother.
It is easier to raise two children close to each other in age because they can share clothes, toys, and the mother's time. It also saves money.	All mothers need time to regain their energy and health after childbirth to be ready for a healthy next pregnancy.
It is more convenient to complete the family quickly and then go for permanent methods like surgical sterilization.	The mother should give all of her children the needed attention to grow healthy, be well-fed, and loved. If she is exhausted from a new pregnancy, she may not be able to give any of them enough attention.
If a woman waits too long, she will be too old to have another child.	It is better for the whole family if the mother and children are healthy, which may not happen if the births are closely spaced.
<b>Reasons for not waiting until age 18</b>	<b>Possible responses</b>
It is best to have children while the woman is young so the mother is strong enough to raise them.	Adolescents need time to physically and psychologically mature so that they are prepared for pregnancy and childbirth. Delaying the first child until a young woman is at least 18 increases the chances of having a healthy pregnancy and a healthy child.
Members of her family, such as her husband or mother-in-law, are pressuring her to have a child as soon as possible. In many cases, It is important to demonstrate her fertility and/or produce a male child.	While it is important to acknowledge the concerns and expectations of her husband and family, the woman must also understand the risks of too early pregnancies to the health of the mother and her future children.

(Extending Service Delivery Project 2008)

## HTSP Case Studies

### Case Study 1

Mariam is 17. She has just married a man who is 10 years older than she is. She wants to wait at least a year before becoming pregnant.

What questions would you ask the client to gather needed information?

What topics would you discuss?

How would you advise her?

### Case Study 2

Anna is 22. She has a 6-month-old baby girl, but she is already thinking about having her next child because she really wants a boy. Even though she realizes that closely spaced pregnancies are risky, she does not want to wait until her daughter is two before she starts trying to become pregnant.

What questions would you ask the client to gather needed information?

What topics would you discuss?

How would you advise her?

### Case Study 3

Esther is 16 and is using injectables. She is not pregnant and does not want to become pregnant until she is older, but she is not happy with injectables because of some of the side effects.

What questions would you ask the client to gather needed information?

What topics would you discuss?

How would you advise her?

### Case Study 4

Rita is 18. She has been living with HIV since she was born. She is doing well on antiretroviral therapy (ARV) and is getting married soon. She is concerned about having children.

What questions would you ask the client to gather needed information?

What topics would you discuss?

How would you advise her?

# HTSP Case Studies Answer Key

## Case Study 1

Miriam is 17. She has just married a man who is 10 years older than she is. She wants to wait at least a year before becoming pregnant.

What questions would you ask the client to gather needed information?

What topics would you discuss?

How would you advise her?

(Note, these questions are the same for all the case studies.)

### **Possible responses:**

- **Inquire what Miriam knows about pregnancy and the menstrual cycle, and explain how fertility and conception work.**
- **Explain the health benefits of delaying the first pregnancy until she is at least 18 as well as the risks associated with early pregnancy.**
- **Ask her if she is experiencing pressure from her husband, family, or community for her to get pregnant quickly. As needed, discuss how to deal with such pressure.**
- **Ask her what she knows about family planning. What is her partner's attitude towards family planning? Do her religious beliefs conflict with her desire to use family planning? Do her beliefs support pregnancy spacing and breastfeeding?**
- **Discuss her options for contraceptive methods, depending on local availability, her beliefs, her medical eligibility, and the attitude of her partner.**
- **Provide her with, or refer her to obtain, her chosen method, fully explaining the correct use of the family planning method and needed follow-up services.**

## Case Study 2

Anna is 22. She has a six-month-old baby girl, but she is already thinking about having her next child because she really wants a boy. Even though she realizes that closely spaced pregnancies are risky, she does not want to wait until her daughter is two before she starts trying to become pregnant.

### **Possible responses:**

- **Determine why she is so anxious to get pregnant again.**
- **Clarify why she does not want to practice HTSP.**
- **Fully explain the benefits and risks to herself, her baby, and the unborn child.**
- **As needed, help her think of ways to deal with any pressure she feels from her husband and family.**
- **Assess her understanding and acceptance of family planning.**
- **Support and encourage her decision and provide her with appropriate information (e.g. contraception or antenatal care).**

### Case Study 3

Esther is 16 and is using injectables. She is not pregnant and does not want to become pregnant until she is older, but she is not happy with injectables because of some of the side effects.

#### **Possible responses:**

- **Assess her experience with injectables.**
- **As needed, correct any errors in its use and address issues of side effects.**
- **Determine if she wants to continue using this method now that she has more information.**
- **If she doesn't want to continue with injectables, discuss other contraceptive options, including benefits, limitations, correct use, and follow-up.**
- **Assess her partner's support for family planning, if appropriate.**
- **Reinforce that it would be beneficial if she did not become pregnant until she is at least 18, and a reliable method of contraception can help achieve this.**
- **Explain the benefits of delaying the first pregnancy until the age of 18.**

### Case Study 4

Rita is 18. She has been living with HIV since she was born. She is doing well on her ARVs and is getting married soon. She is concerned about having children.

#### **Possible responses:**

- **Assess her fertility intentions and desired family size and let her know it is possible for her to have children even though she has HIV.**
- **Advise her that pregnancy places a heavy burden on her body because of her HIV status, so she should space and limit the number of her pregnancies. Because she is HIV-positive, she is already at risk for low-birth weight and pre-term birth. Spacing her pregnancies will help lower the risk of these outcomes.**
- **She should give her body time to rest between pregnancies. She should space them through use of an appropriate method of family planning.**
- **There are medicines and methods of delivery that will reduce the chance of transmitting HIV to her children.**
- **During pregnancy it is important for her to attend antenatal care.**
- **She should discuss all the issues regarding her fertility intentions, number and spacing of pregnancies with her husband, as appropriate.**



# HTSP Role Plays

## Role Play 1

A 22-year-old woman recently had a miscarriage when she was three months pregnant. She has one child: a girl who is one year old. The woman has come to the health worker with her mother-in-law for advice because she feels very weak but wants to get pregnant again. She has lots of family pressure, both from her husband and her mother-in-law, to get pregnant again so that she can give them a son.

### Participants' roles

**Health Worker.** The health worker will assess the needs of the client and provide counselling on HTSP and family planning. The health worker will explain the benefits of HTSP and also talk about the potential risks if HTSP is not practiced. She will then give information about different contraceptive methods.

**Client.** The client is feeling pressure to get pregnant again so she can have a boy.

**Mother-in-Law.** The mother-in-law mentions that they need a grandson to continue the family name.

### Discussion questions

1. Did the health worker approach the client in a positive reassuring manner?
2. Did the health worker provide adequate information?
3. Were the client's concerns addressed?
4. Was it a good idea to involve the mother-in-law?
5. Were the benefits of HTSP and family planning clearly communicated?
6. What else could the health worker have done?

## Role Play 2

A 25-year-old woman with two children, a boy and a girl, is using injectable contraceptives. Her last-born child is seven months old and she does not want to have another child right away. She has no problem with her current contraceptive method except that it is difficult for her to come in regularly for injections.

### Participants' roles

**Health Worker.** The health worker will assess the needs of the woman and provide counselling on HTSP and family planning. She will then give information about different contraceptive methods.

**Client.** The client will ask questions and try to decide if she wants to practice HTSP and what family planning method she might use.

### Discussion questions

1. Did the health worker approach the client in a positive reassuring manner?
2. Did the health worker provide adequate information?
3. Were the client's concerns addressed?

4. Were the benefits of HTSP and family planning clearly communicated?
5. What else could the health worker have done?

### Role Play 3

A 34-year-old man has four sons. His wife is in poor health after the birth of their last child one month ago. The doctor advised them against having any more children. He is convinced, however, that contraceptive methods cause cancer.

#### Participants' roles

**Health Worker.** The health worker will assess the situation and give the couple information about different modern contraceptive methods and help the couple decide if they will use a method.

**Clients (2).** The clients (husband and wife) ask questions about family planning. They are concerned about side effects.

#### Discussion questions

1. Did the health worker approach the clients in a positive reassuring manner?
2. Did the health worker address the clients' needs and concerns?
3. Did the health worker provide enough information?
4. Were the benefits of HTSP and family planning clearly communicated?
5. What else could the health worker have done?

### Role Play 4

A 16-year-old woman is married to a 30-year-old man. She wants to delay her first pregnancy, but she is concerned because her mother-in-law wants her to get pregnant quickly.

#### Participants' roles

**Health Worker.** The health worker will assess the situation, and will explain the benefits of HTSP. She will give information about different contraceptive methods to help her delay pregnancy until 18.

**Client.** The client asks questions about HTSP and family planning and how she can convince her mother-in-law to delay her first pregnancy.

#### Discussion questions

1. Did the health worker approach the client in a positive reassuring manner?
2. Did the health worker address the client's needs and concerns?
3. Did the health worker provide enough information?
4. Were the benefits of HTSP and family planning clearly communicated?
5. What else could the health worker have done?

## HTSP Quiz Questions

1. What is Healthy Timing and Spacing of Pregnancy (HTSP)?
2. Timing in HTSP refers to (tick all that apply):
  - a. How long a woman should wait after a birth before giving birth to her next child
  - b. How long a woman should wait after a birth before attempting to become pregnant again
  - c. The youngest age that a woman should be before becoming pregnant for the first time
  - d. The length of time a woman is pregnant
3. Spacing in HTSP refers to (tick all that apply):
  - a. How long a woman should wait after a birth, miscarriage, or abortion before giving birth to her next child
  - b. How long a woman should wait after a birth, miscarriage, or abortion before attempting to become pregnant again
  - c. The youngest age that a woman should be before becoming pregnant for the first time
  - d. The oldest age that is optimal for healthy pregnancies.
4. Describe the relationship between HTSP and family planning?
5. What is the key HTSP message for women who have recently given birth?
6. What is the key HTSP message for women after a miscarriage or induced abortion?
7. What is the key HTSP message for adolescents?
8. List three benefits to women of practicing HTSP?
9. List three risks for newborns if HTSP is not practiced?

10. Counselling for HTSP can be given during (tick the best answer)

- a. Antenatal care
- b. Postpartum care
- c. Child health visits
- d. Emergency care
- e. HIV counselling and testing
- f. a, b and c
- g. All of the above

11. If a woman tells you during counselling that she is not interested in healthy spacing because she wants to complete her family size quickly, what might be a helpful response?

12. During what part of the family planning counselling process is it best to provide HTSP messages? (tick all that apply)

- a. Immediately after establishing rapport with the client
- b. After gathering basic information about how many children the client has, her fertility intentions, and desired family size
- c. After giving her information on the family planning methods available
- d. After she has chosen a family planning method
- e. After giving her instructions for how to use the family planning method she has chosen

# HTSP Quiz Questions Answer Key

1. What is Healthy Timing and Spacing of Pregnancy (HTSP)?

**HTSP is an approach to family planning that helps women have health pregnancies, healthy babies, and healthy children.**

2. Timing in HTSP refers to (tick all that apply):

**c. The youngest age that a woman should be before becoming pregnant for the first time.**

3. Spacing in HTSP refers to (tick all that apply):

**b. How long a woman should wait after a birth, miscarriage, or abortion before attempting to become pregnant again**

4. Describe the relationship between HTSP and family planning?

**HTSP is a part of family planning. HTSP places family planning in the context of promoting healthy pregnancies, healthy mothers, and healthy babies.**

5. What is the key HTSP message for women who have recently given birth?

**For the health of the mother and baby, wait at least 24 months, but not more than 5 years, before trying to become pregnant again. Use a family planning method of your choice during that time.**

6. What is the key HTSP message for women after a miscarriage or induced abortion?

**For the health of the mother and baby, wait at least 6 months before trying to become pregnant again. Use a family planning method of your choice during that time.**

7. What is the key HTSP message for adolescents?

**For your health and your baby's health, wait until you are at least 18 years old before trying to become pregnant. Use a family planning method of your choice until you are at least 18.**

8. List three benefits to women of practicing HTSP?

**Any three of the following:**

- **Lower risk of death**
- **Lower incidence of induced abortion**
- **Lower risk of pre-eclampsia**
- **Lower risk of miscarriage**
- **Lower risk of anaemia**
- **Allows women to continue to breastfeed for two years**

9. List three risks for newborns if HTSP is not practiced?

**Any three of the following:**

- **Greater risk of death**
- **Greater risk of preterm birth**
- **Greater risk of low birth weight**

- **Greater risk of being small for gestational age**
- **Less likely to continue to be breastfed for two years**

10. Counselling for HTSP can be given during (tick the best answer)

**g. All of the above**

11. If a woman tells you during counselling that she is not interested in healthy spacing because she wants to complete her family size quickly, what might be a helpful response?

**Any of the following responses:**

- **Children closely spaced together may demand more attention from the mother.**
- **All mothers need time to regain their energy and health after childbirth to be ready for a healthy next pregnancy.**
- **The mother should give all of her children the needed attention to grow healthy, be well fed, and loved. If she is exhausted from a new pregnancy, she may not be able to give any of them enough attention.**

12. During what part of the family planning counselling process is it best to provide HTSP messages? (tick all that apply)

**b. After gathering basic information about how many children the client has, her fertility intentions, and desired family size.**

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# Unit 7

## CONTRACEPTIVE IMPLANTS

### Learning Objectives

By the end of this unit, learners will be able to:

- ❖ Define contraceptive implants
- ❖ List the types of contraceptive implants available in Malawi
- ❖ State the effectiveness of implants and explain how they work
- ❖ List the characteristics of implants
- ❖ Correct misconceptions about implants
- ❖ State when women in different situations can start using implants
- ❖ Determine a client's medical eligibility for implant use
- ❖ Demonstrate knowledge and skills in counselling clients to make an informed choice to use implants
- ❖ List potential complications of implants and their warning signs
- ❖ Describe the procedures for implant insertion and removal
- ❖ Provide client instructions following implant insertion or removal
- ❖ Explain management of side effects or problems due to implants
- ❖ Demonstrate competence in the insertion and removal of implants.

### Teaching Resources in this Unit

#### Clinical Procedures

Clinical Procedures for Jadelle Insertion and Removal 140

#### Handout

Hormonal Implants: New, Improved and Popular When Available 146

#### Learning Activities

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#### Unit Assessment

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Quiz Questions Answer Key 153

Implants Clinical Skills Learning Guides 155



## Unit 7: Contraceptive Implants

### Key Points

- ❖ **Safe, highly effective contraception**
- ❖ **Long-term pregnancy protection**—very effective for 3 to 7 years, depending on product
- ❖ **Require a specifically trained provider to insert and remove**
- ❖ **Little required of the client once implants are in place**
- ❖ **Bleeding changes are common but not harmful:** typically, prolonged irregular bleeding over the first year, and then lighter, more regular bleeding or infrequent bleeding.

### 7.1 Defining Contraceptive Implants

Contraceptive implants are thin, flexible plastic rods or capsules, each about the size of a matchstick, that release a synthetic progestin, like the natural hormone progesterone in a woman's body.

A health provider performs a minor surgical procedure to insert the capsules just under the skin on the inside of a client's upper arm. The progestin diffuses slowly through the wall of the capsules in a continuous low dose.

Contraceptive implants do not contain oestrogen and so can be used throughout breastfeeding and by women who cannot use methods with oestrogen.

#### Types of implants and formulations

- **Jadelle:** 2 rods, each has 75 mg levonorgestrel, effective for 5 years. This is the primary implant available in Malawi.
- **Norplant:** 6 capsules, each has 36 mg levonorgestrel, labelled for 5 years but studies show that Norplant is effective for at least 7 years. (Norplant is being phased out in Malawi. See Question 11, Section 7.15.)
- **Sino-Implant (II):** 2 rods, each has 75 mg levonorgestrel, effective for 5 years
- **Implanon:** 1 rod, which has 68 mg etonogestrel, effective for 3 years

#### How contraceptive implants work

Implants work primarily by:

- Preventing release of eggs from the ovaries (ovulation)
- Thickening cervical mucus, which prevents sperm from meeting an egg
- Thinning endometrial lining, preventing implantation.

### 7.2 Effectiveness of Implants

One of the most effective, reversible and long-lasting methods:

- Less than 1 pregnancy occurs per 100 women using implants (5 per 10,000 women), or 99.95% effective.

- The risk of pregnancy after the first year depends on the type of implant used:
  - Over 5 years of Jadelle use: About 1 pregnancy per 100 women
  - Over 7 years of Norplant use: About 2 pregnancies per 100 women.

Jadelle and Norplant implants start to lose effectiveness sooner for heavier clients:

- For clients weighing 80 kg or more, Jadelle and Norplant become less effective after 4 years of use.
- For clients weighing 70–79 kg, Norplant becomes less effective after 5 years of use.

## 7.3 Characteristics

### Advantages

- Highly effective
- Long-term effectiveness
- Do not interfere with intercourse
- Rapid return to fertility
- Require no further action by user after insertion
- Can be provided by trained non-physician (nurses, clinical officers)

### Disadvantages

- Insertion and removal requires minor surgical procedure by trained provider.
- Barbituates, phenytoin (taken for epilepsy) and rifampicin (for tuberculosis) may make implants less effective.
- Do not protect against sexually transmitted infections (STIs), including HIV

### Side effects

Some users report the following:

- Changes in vaginal bleeding patterns, including:

#### First several months

- Lighter bleeding and fewer days of bleeding
- Irregular bleeding that lasts more than 8 days
- Infrequent bleeding
- No monthly bleeding

#### After about one year

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

- Headaches
- Abdominal pain
- Acne (can improve or worsen)
- Weight change
- Breast tenderness
- Dizziness, nausea
- Mood changes
- Enlarged ovarian follicles

## Health benefits

- Helps protect against symptomatic pelvic inflammatory disease
- May help prevent iron-deficiency anaemia
- May decrease menstrual cramps and bleeding

## Health risks

None

## Complications

### Uncommon:

- Infection at insertion site (most infections occur within first 2 months after insertion)
- Difficult removal

### Rare:

- Expulsion of implant (expulsion most often occurs within first 4 months after insertion)

## 7.4 Correcting Misconceptions

### Implants:

- Do not make women infertile
- Do not move to other parts of the body
- Substantially reduce the risk of ectopic pregnancy
- Can stop monthly bleeding, but this is not harmful. It is similar to not having monthly bleeding during pregnancy. Blood is not building up inside the woman.
- Stop working once they are removed. Their hormones do not remain in a woman's body after removal.



(Photo: David Alexander, CCP; courtesy of Photoshare)

- Do not cause health problems in children conceived after use.

(See Section 7.15, Questions and Answers, for more details.)

## 7.5 Women Who Can Use Implants

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

- Have or have not had children
- Are not married
- Are of any age, including adolescents
- Have just had an abortion, miscarriage or ectopic pregnancy
- Smoke cigarettes
- Are breastfeeding (starting as soon as 6 weeks after childbirth)

- Have anaemia now or have had it in the past
- Have varicose veins
- Are infected with HIV, whether or not on antiretroviral therapy.

## 7.6 Women Who Should Not Use Implants

Women who should not use implants include those with the following conditions:

### **WHO MEC Category 3**

- Breastfeeding a baby less than 6 weeks old
- Severe liver disease, liver infection, or liver tumour
- Current blood clot in deep veins of legs or in the lungs
- Unexplained, unusual vaginal bleeding
- Current breast cancer or history of breast cancer
- Taking barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate or rifampicin. These drugs reduce the effectiveness of implants.

(For a complete list of clients who should not use implants, see the WHO MEC Summary Tables in Unit 4: Family Planning Client Assessment and the WHO MEC.)

### **Women can access implants:**

- Without a pelvic examination
- Without any blood tests or other routine laboratory tests
- Without cervical cancer screening
- Without a breast examination
- When she is not having monthly bleeding, if it is reasonably certain she is not pregnant. (See Pregnancy Checklist in Unit 4, FP Client Assessment and the WHO MEC.)

## 7.7 Implants for Women Living with HIV

- Women who are infected with HIV, have AIDS, or are on antiretroviral therapy can safely use implants.
- Urge these women to use condoms along with implants. Used consistently and correctly, male and female condoms help prevent transmission of HIV and other STIs.

## 7.8 Screening Checklist

### Checklist for Screening Clients Who Want to Initiate Contraceptive Implants

To determine if the client is medically eligible to use implants, ask questions 1–6. As soon as the client answers **YES** to *any question*, stop, and follow the instructions after question 6.

NO	1. Have you ever been told you have breast cancer?	YES
NO	2. Do you currently have a blood clot in your legs or lungs?	YES
NO	3. Do you have a serious liver disease or jaundice (yellow skin or eyes)?	YES
NO	4. Have you ever been told that you have a rheumatic disease, such as lupus?	YES
NO	5. Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)?	YES
NO	6. Are you currently breastfeeding a baby less than 6 weeks old?	YES

If the client answered **NO** to *all of questions 1–6*, she can use implants. Proceed to questions 7–12.

If the client answered **YES** to *question 1*, she is not a good candidate for implants. Counsel about other available methods or refer.

If the client answered **YES** to *any of questions 2–5*, implants cannot be initiated without further evaluation. Evaluate or refer as appropriate, and give condoms to use in the meantime. See explanations for more instructions.

If the client answered **YES** to *question 6*, instruct her to return for implant insertion as soon as possible after the baby is six weeks old.

Ask questions 7–12 to be reasonably sure that the client is not pregnant. As soon as the client answers **YES** to *any question*, stop, and follow the instructions after question 12.

YES	7. Did your last menstrual period start within the past 7 days?	NO
YES	8. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	NO
YES	9. Have you abstained from sexual intercourse since your last menstrual period or delivery?	NO
YES	10. Have you had a baby in the last 4 weeks?	NO
YES	11. Have you had a miscarriage or abortion in the last 7 days?	NO
YES	12. Have you been using a reliable contraceptive method consistently and correctly?	NO

If the client answered **YES** to *at least one of questions 7–12* and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. The client can have implants inserted now.

If the client began her last menstrual period *within the past 7 days (5 days for Implanon)*, she can have implants inserted now. No additional contraceptive protection is needed.

If the client began her last menstrual period *more than 7 days ago (5 days for Implanon)*, she can *have implants inserted now*, but instruct her that she must *use condoms or abstain from sex for the next 7 days*. Give her condoms to use for the next 7 days.

If the client answered **NO** to *all of questions 7–12*, pregnancy cannot be ruled out.

She must use a pregnancy test or wait until her next menstrual period to have implants inserted.

Give her condoms to use in the meantime.



## 7.9 Timing: When to Start Implants

<b>Woman's Situation</b>	<b>When to Start</b>
<b>Having menstrual cycles, or switching from non-hormonal method</b>	<p>Can start any time of month.</p> <p>If starting within 7 days after start of her monthly bleeding (menses), there is no need for a backup method.</p> <p>If more than 7 days after start of her monthly bleeding, any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days.</p>
<b>Switching from a hormonal method</b>	<p>Immediately, if she has been using the hormonal method consistently and correctly, or if it is otherwise reasonably certain she is not pregnant.</p> <p>If switching from injectables, she can have implants inserted when the repeat injection would have been given. No backup method is needed.</p>
<b>Fully breastfeeding Less than 6 months after giving birth</b>	<p>If menses has not returned, she can have implants inserted any time between 6 weeks and 6 months. No backup method is needed.</p> <p>If her menses has returned, she can have implants inserted as advised for women having menstrual cycles. (See above.)</p>
<b>Fully breastfeeding More than 6 months after giving birth</b>	<p>If her menses has not returned, she can have implants inserted at any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion.</p> <p>If her menses has returned, she can have implants inserted as advised for women having menstrual cycles. (See above.)</p>
<b>Partially breastfeeding Less than 6 weeks after giving birth</b>	<p>Delay inserting implants until at least 6 weeks after she has given birth.</p>
<b>Partially breastfeeding More than 6 weeks after giving birth</b>	<p>If her menses has not returned, she can have implants inserted at any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.</p> <p>If her menses has returned, she can have implants inserted as advised for women having menstrual cycles. (See above.)</p>
<b>Not breastfeeding Less than 4 weeks after giving birth</b>	<p>She can have implants inserted at any time. No backup method is needed. (See above.)</p>
<b>Not breastfeeding More than 6 weeks after giving birth</b>	<p>If her menses has not returned, she can have implants inserted at any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion.</p> <p>If her menses has returned, she can have implants inserted as advised for women having menstrual cycles.</p>

<b>Woman's Situation</b>	<b>When to Start</b>
<b>After abortion or miscarriage</b>	Immediately. There is no need for a backup method if implants are inserted within 7 days after first- or second-trimester miscarriage or abortion.  If it is more than 7 days after, client can have implants inserted at any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the insertion.
<b>After taking emergency contraceptive pills (ECPs)</b>	Implants can be inserted within 7 days after the start of her next monthly bleeding, or any other time it is reasonably certain she is not pregnant. Give her a backup method, or oral contraceptives to start the day after she finished taking the ECPs to use until the implants are inserted.
<b>No monthly bleeding</b>	She can have implants inserted any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion.

## 7.10 Client Counselling and Instructions: Insertion

### Before insertion

- Explain the procedure to the client and show her the equipment that will be used. (See “Explaining the insertion procedure” below.)
- Encourage the client to ask questions.
- Tell her that she will feel a little discomfort for a few seconds when the local anaesthetic is injected but that the actual insertion of the implant capsules should be painless.

### Explaining the insertion procedure (Jadelle)

(**Note:** this description is a summary and not detailed instructions.)

1. The woman receives an injection of local anaesthetic under the skin of her arm to prevent pain while the implants are being inserted. This injection may sting. She stays fully awake throughout the procedure.
2. The provider makes a small incision in the skin on the inside of the upper arm.
3. The provider inserts the implants just under the skin. The woman may feel some pressure or tugging.
4. After both implants are inserted, the provider closes the incision with an adhesive bandage. Stitches are not needed. The provider covers the incision with an adhesive bandage and wraps the arm with gauze.

### After insertion

- Tell the client to keep the bandage clean and dry for 4 days. (She should avoid bumping the area, carrying heavy loads, or applying unusual pressure to the site for 3-5 days.)
- She should leave the gauze (outer) bandage in place for 48 hours, and leave the adhesive bandage in place for 5 days (until the incision heals). After it heals, she can wash the incision area and touch it with normal pressure.

- After the anaesthetic wears off, her arm may be sore for a few days. She also may have swelling and bruising at the insertion site. This is common and will go away without treatment.
- She can return after 5 days for a check-up in case of infection.
- If implants were inserted more than 7 days after the start of her monthly bleeding, tell her to use a backup method for the first 7 days after insertion.
- Certain drugs, such as the anti-TB drug rifampicin and anticonvulsant phenytoin (but not valproic acid) and griseofulvin, may reduce the effectiveness of implants.
- Implants do not provide protection against STIs, including HIV. Advise her to also use condoms, especially if either partner is at particular risk.
- She should return to the clinic or see another provider—before the implants start losing effectiveness (5 years)—for implant removal or replacement.
- Discuss how to remember the date to return.
- Give the woman the following information in writing on a reminder card, like the one shown below, if possible, and explain:
  - The type of implant she has
  - The date of implant insertion
  - The month and year when implants will need to be removed or replaced
  - Where to go if she has problems or questions with her implants.

<b>Implant Reminder Card</b>	
Client's name: _____	
Type of implant: _____	Lot number: _____
Date inserted: _____	
	Month                  Year
Remove or replace by: _____	
If you have any problems or questions, go to: _____	
(Name of facility and location)	

### Reasons to return

- Assure every client that she is welcome to come back any time—for example, if she has problems, questions, or wants another method; or has a major change in health status; or thinks she might be pregnant.
- Also she should return if she has any of the warning signs of potential complications of implants (See Section 7.11).



## 7.11 Warning Signs of Complications

- Pain, heat, pus, or redness at the insertion site (signs of infection)
- A rod is visible coming out of the insertion site (expulsion of implant).

## 7.12 Client Counselling and Instructions: Removal

**Important:** Providers must not refuse or delay when a woman asks to have her implants removed, whatever her reason, whether it is personal or medical. All staff must understand and agree that the client must not be pressured or forced to continue using implants.

- Show her the equipment that will be used for the implant removal and explain what you will be doing.
- Encourage the client to ask questions.
- Tell her that she will feel a little discomfort for a few seconds when the local anaesthetic is injected but that the actual removal of the implant capsules should be painless.

### Explaining implant removal

The same removal procedure is used for all types of implants.

1. The provider uses proper infection-prevention procedures.
2. The woman receives an injection of local anaesthetic under the skin of her arm to prevent pain during implant removal. This injection may sting. She stays fully awake throughout the procedure.
3. The provider makes a small incision in the skin on the inside of the upper arm, near the site of insertion.
4. The provider uses an instrument to pull out each implant. A woman may feel tugging, slight pain, or soreness during the procedure and for a few days after.
5. The provider closes the incision with an adhesive bandage. Stitches are not needed.
6. If a woman wants new implants, the provider places the new implants below the site of the previous implants, or in the other arm.

## 7.13 Management of Implant Side Effects and Complications

Problems with side effects and complications affect women’s satisfaction and use of implants. They deserve the provider’s attention. If the client reports any side effects or complications, listen to her concerns, give her advice, and, if appropriate, provide treatment.

Side Effect	How to Manage
<b>Amenorrhoea</b>	<ul style="list-style-type: none"> <li>• Check for pregnancy. If not pregnant, reassure her that some women stop having monthly bleeding when using implants, and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not infertile. Blood is not building up inside her. Advise her to return to clinic if amenorrhoea continues to be a concern. Do not attempt to induce bleeding.</li> </ul>
<b>Spotting, irregular bleeding</b>	<ul style="list-style-type: none"> <li>• Reassure her that many women using implants experience irregular bleeding. It is not harmful and usually becomes less or stops after the first year of use.</li> <li>• For modest, short-term relief, she can take ibuprofen, 800 mg 3 times daily after meals for 5 days, beginning when irregular bleeding starts.</li> <li>• If ibuprofen doesn’t help, she can be given combined oral contraceptives (COCs) that have levonorgestrel. Ask her to take one pill daily for 21 days. Alternatively she can take 50 µg ethinyl estradiol daily for 21 days.</li> <li>• If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use. (See Unexplained Vaginal Bleeding, Section 7.14.)</li> </ul>
<b>Heavy or prolonged bleeding</b> (Twice as much as usual or longer than 8 days)	<ul style="list-style-type: none"> <li>• Carefully review history and check haemoglobin, if possible. Check for gynaecological problem and treat appropriately.</li> <li>• Reassure her that some women using implants experience heavy or prolonged bleeding. It is generally not harmful and usually becomes less or stops after a few months.</li> <li>• For modest short-term relief, she can try one of the treatments for irregular bleeding, above, beginning when heavy bleeding starts. COCs with 50 µg of ethinyl estradiol may work better than lower-dose pills.</li> </ul>
<b>Breast tenderness</b>	<ul style="list-style-type: none"> <li>• Recommend that client wear a supportive bra (including during strenuous activity and sleep).</li> <li>• Try hot or cold compresses.</li> <li>• Suggest aspirin (300–600 mg), ibuprofen (200–400 mg), paracetamol (500–1000 mg), or other pain reliever.</li> </ul>
<b>Ordinary headaches</b> (nonmigrainous)	<ul style="list-style-type: none"> <li>• Suggest aspirin (300–600 mg), ibuprofen (200–400 mg), paracetamol (500–1000 mg), or other pain reliever.</li> <li>• Any headaches that get worse or occur more often during use of</li> </ul>

	implants should be evaluated.
<b>Weight change</b>	<ul style="list-style-type: none"> <li>• Review diet, and counsel as needed.</li> </ul>
<b>Acne</b>	<ul style="list-style-type: none"> <li>• If client wants to stop using implants because of acne, she can consider switching to COCs. Many women's acne improves with COC use.</li> </ul>
<b>Mild abdominal pain</b>	<ul style="list-style-type: none"> <li>• Suggest aspirin (300–600 mg), ibuprofen (200–400 mg), paracetamol (500–1000 mg), or other pain reliever.</li> </ul>
<b>Mood changes or changes in sex drive</b>	<ul style="list-style-type: none"> <li>• Ask about changes in her life that could affect her mood or sex drive, including changes in her relationship with her partner. Give her support as appropriate.</li> <li>• Clients who have serious mood changes, such as major depression, should be referred for care.</li> </ul>
<b>Pain after insertion or removal</b>	<ul style="list-style-type: none"> <li>• For pain after insertion, check that the bandage or gauze on her arm is not too tight.</li> <li>• Put a new bandage on the arm and advise her to avoid pressing on the site for a few days.</li> <li>• Give her aspirin (300–600 mg), ibuprofen (200–400 mg), paracetamol (500–1000 mg), or other pain reliever.</li> </ul>
<b>Infection at the insertion site</b> (redness, heat, pain, pus)	<ul style="list-style-type: none"> <li>• Do not remove the implants.</li> <li>• Clean the infected area with soap and water or antiseptic.</li> <li>• Give oral antibiotics for 7 to 10 days.</li> <li>• Ask the client to return after taking all antibiotics if the infection does not clear. If infection has not cleared, remove the implants or refer for removal.</li> <li>• Expulsion or partial expulsion often follows infection. Ask the client to return if she notices an implant coming out.</li> </ul>
<b>Abscess</b>	<ul style="list-style-type: none"> <li>• Clean the area with antiseptic.</li> <li>• Cut open (incise) and drain the abscess.</li> <li>• Treat the wound.</li> <li>• Give oral antibiotics for 7 to 10 days.</li> </ul>
<b>Expulsion</b>	<ul style="list-style-type: none"> <li>• Rare. Usually occurs within a few months of insertion or with infection.</li> <li>• If no infection is present, replace the expelled rod or capsule through a new incision near the other rods or capsules, or refer for replacement.</li> </ul>

## 7.14 New Problems that May Require Switching Methods

### **May or may not be due to the method**

#### **Unexplained vaginal bleeding (that suggests a medical condition not related to the method)**

- Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate.
- If no cause of bleeding can be found, consider removing implants to make diagnosis easier. Provide another method of her choice to use until the condition is evaluated and treated (not progestin-only injectables, or a copper-bearing IUCD).
- If bleeding is caused by a sexually transmitted infection or pelvic inflammatory disease, she can continue using implants during treatment.

#### **Migraine headaches**

- If she has migraine headaches without aura, she can continue to use implants if she wishes.
- If she has migraine aura, remove the implants. Help her choose a method without hormones.

#### **Certain serious health conditions (suspected blood clots in deep veins of legs or lungs, serious liver disease, or breast cancer).**

- Remove the implants or refer for removal.
- Give her a backup method to use until her condition is evaluated.
- Refer for diagnosis and care if not already under care.

#### **Heart disease due to blocked or narrowed arteries (ischemic heart disease) or stroke**

- A woman who has one of these conditions can safely start implants. If, however, the condition develops while she is using implants:
  - Remove the implants or refer for removal.
  - Help her choose a method without hormones.
  - Refer for diagnosis and care if not already under care.

#### **Suspected pregnancy**

- Assess for pregnancy, including ectopic pregnancy.
- Remove the implants or refer for removal if she will carry the pregnancy to term.
- There are no known risks to a foetus conceived while a woman has implants in place (see Question 5, Section 7.15).

## 7.15 Questions and Answers about Implants

### 1. Do users of implants require follow-up visits?

No. Routine periodic visits are not necessary for implant users. Annual visits may be helpful for other preventive care, but they are not required. Of course, women are welcome to return at any time with questions.

### 2. Can implants be left permanently in a woman's arm?

Leaving the implants in place beyond their effective lifespan is generally not recommended if the woman continues to be at risk of pregnancy. The implants themselves are not dangerous, but as the hormone levels in the implants drop, they become less and less effective.

### 3. Do implants cause cancer?

No. Studies have not shown increased risk of any cancer with use of contraceptive implants.

### 4. How long does it take to become pregnant after the implants are removed?

Women who stop using implants can become pregnant as quickly as women who stop nonhormonal methods. Implants do not delay the return of a woman's fertility after they are removed. The bleeding pattern a woman had before she used implants generally returns after the implants are removed. Some women may have to wait a few months before their usual bleeding pattern returns.

### 5. Do implants cause birth defects? Will the foetus be harmed if a woman accidentally becomes pregnant with implants in place?

No. Good evidence shows that implants will not cause birth defects and will not otherwise harm the foetus if a woman becomes pregnant while using them or accidentally has implants inserted when she is already pregnant.

### 6. Can implants move around within a woman's body or come out of her arm?

Implants do not move around in a woman's body. The implants remain where they are inserted until they are removed. Rarely, a rod or capsule may start to come out, most often in the first 4 months after insertion. This usually happens because they were not inserted well or because of an infection where they were inserted. In these cases, the woman will see the implants coming out. Some women may also experience a sudden change in bleeding pattern if her implants start coming out. If a woman notices a rod coming out, she should start using a backup method and return to the clinic at once.

### 7. Do implants increase the risk of ectopic pregnancy?

No. On the contrary, implants greatly reduce the risk of ectopic pregnancy. Ectopic pregnancies are extremely rare among implant users. The rate of ectopic pregnancy among women with implants is 6 per 100,000 women per year. The rate of ectopic pregnancy among women in the United States using no contraceptive method is 650 per 100,000 women per year.

On the very rare occasions that implants fail and pregnancy occurs, 10 to 17 of every 100 of these pregnancies are ectopic. Thus, the great majority of pregnancies after implants fail are not ectopic. Still, ectopic pregnancy can be life-threatening, so a provider should be aware that ectopic pregnancy is possible if implants fail.

**8. Do implants change women's mood or sex drive?**

Generally, no. Some women using implants report these complaints. The great majority of implant users do not report any such changes, however, and some report that both mood and sex drive improve. It is difficult to tell whether such changes are due to the implants or to other reasons. There is no evidence that implants affect women's sexual behaviour.

**9. Should heavy women avoid implants?**

No. These women should know, however, that they need to have implants replaced sooner to maintain a high level of protection from pregnancy. In studies of Norplant, pregnancy rates among women who weighed 70–79 kg were 2 per 100 women in the sixth year of use. Such women should have their implants replaced, if they wish, after 5 years. Among women who used Norplant or Jadelle implants and who weighed 80 kg or more, the pregnancy rate was 6 per 100 in the fifth year of use. These women should have their implants replaced after 4 years.

**10. What should be done if an implant user has an ovarian cyst?**

The great majority of cysts are not true cysts but actually fluid-filled structures in the ovary (follicles) that continue to grow beyond the usual size in a normal menstrual cycle. They may cause some mild abdominal pain, but they only require treatment if they grow abnormally large, twist, or burst. These follicles usually go away without treatment.

**11. When will Norplant implants no longer be available?**

The manufacturer intends to produce Norplant implants until 2011 and to replace Norplant with Jadelle. Jadelle is easier and faster to insert and remove because it has only 2 rods, compared with Norplant's 6 capsules. One study found that providers can easily switch from providing Norplant to providing Jadelle, and providers preferred the greater ease of inserting and removing Jadelle.

**12. Can a woman work soon after having implants inserted?**

Yes, a woman can do her usual work immediately after leaving the clinic as long as she does not bump the insertion site or get it wet.

**13. Must a woman have a pelvic examination before she can have implants inserted?**

No. Instead, asking the right questions can help the provider be reasonably certain she is not pregnant (see Pregnancy Checklist in Unit 4, Family Planning Client Assessment and the WHO MEC). No condition that can be detected by a pelvic examination rules out the use of implants.

(WHO/RHR and CCP, INFO Project 2008)

## Contraceptive Implants Clinical Procedures

### Implant Insertion: Jadelle

#### Equipment and supplies

- An examination table for client
- Antiseptic solution
- 5 ml syringe
- Scalpel with #11 blade
- Sterile implant insertion set:
  - Tray for equipment
  - Surgical drapes (2)
  - Gloves (no talcum powder)
  - #10 trocar
  - Cotton swabs
  - Tweezers
  - Straight forceps
- Local anaesthetic (Lignocaine 1%) without epinephrine
- One set of implants
- Bandage
- Strapping



#### Infection prevention guidelines during implant insertion

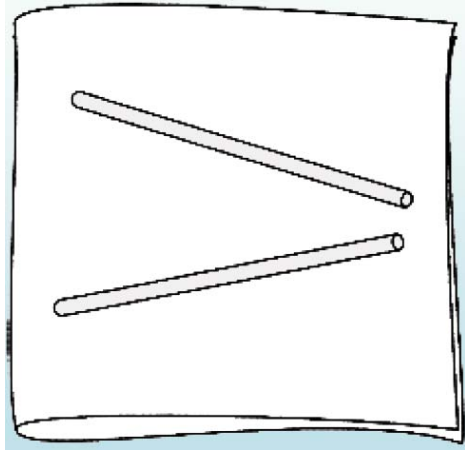
Although insertion and removal of implants are minor surgical procedures, careful infection-prevention procedures must be followed with every client. Infection prevention during insertion and removal involves aseptic technique (performing the procedures under sterile conditions).

- To minimize risk of infection and/or expulsion, make sure that the ends of the rods nearest to the incision are not too close (not less than 5 mm) to the incision. If the tip of the rod protrudes from or is too close to the incision, it should be carefully removed and reinserted in the proper position.
- Also, to enable easy removal of both rods from a single incision, it is important that the ends of the rods closest to the incision are not farther apart, one from the next, than the width (not length) of one implant.
- While inserting the implants, do not remove the trocar from the incision. Keeping the trocar in place minimizes tissue trauma, decreases the chances of infection, and minimizes insertion time.

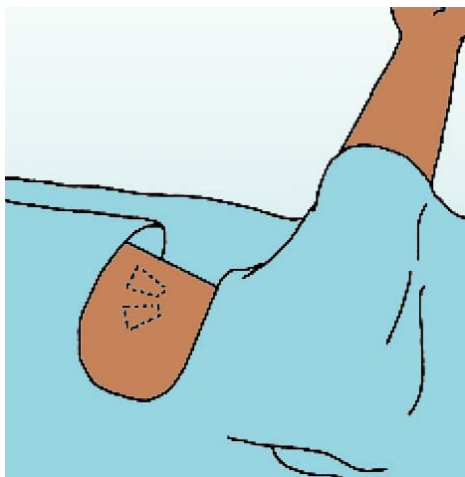


### Pre-insertion tasks

1. Have the client wash her entire arm and hand (the one she uses less often) with soap and water, and dry with clean towel or air-dry.
2. Help position the client on the table.
  - Have the patient lie on her back with her non-dominant arm flexed at the elbow and externally rotated.
  - The implants will be inserted subdermally and positioned in a “V” shape.

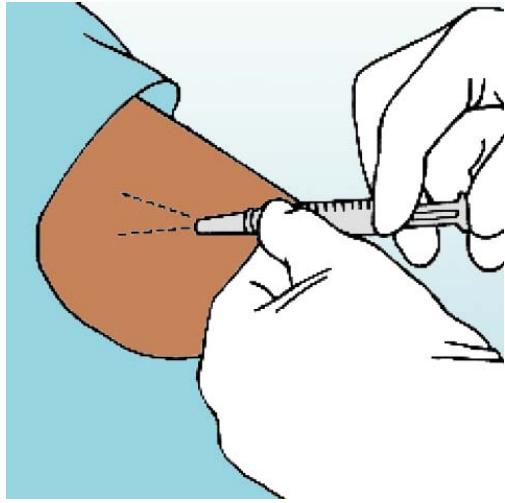


3. Determine that required sterile or high-level disinfected (HLD) instruments are present.
4. Open the sterile or HLD instrument pack without touching the instruments.
5. Open the sterile implants package by pulling apart the sheets of the pouch. Allow the 2 implants to fall onto a sterile drape.



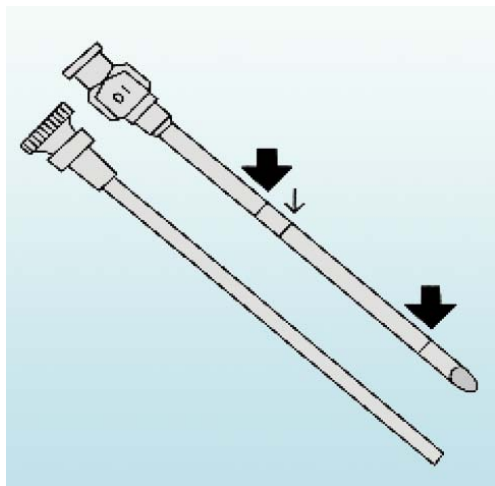
6. Wash hands thoroughly with antiseptic soap and dry. Put sterile gloves on both hands.
7. Clean the patient's upper arm with cotton or gauze swab soaked in antiseptic solution and held in a sterile or HLD forceps.
8. Frame the insertion area with a sterile drape that has an opening.



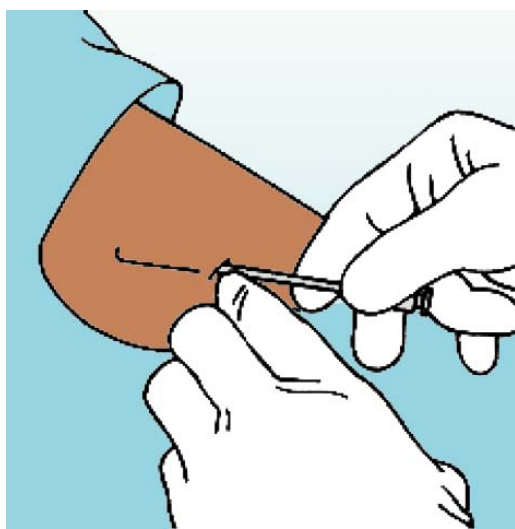


9. Fill a 5 ml syringe with the local anaesthetic (without epinephrine).
10. Insert the needle under the skin and inject a small amount of the anaesthetic.
11. Anaesthetize two areas about 4.5 cm long, to mimic the V shape of the implantation site.
12. Withdraw needle and place in a safe area to prevent accidental needle pricks.
13. Test incision site with tip of forceps for adequate anaesthesia. (If client feels pain, wait 2 minutes and retest incision site.)

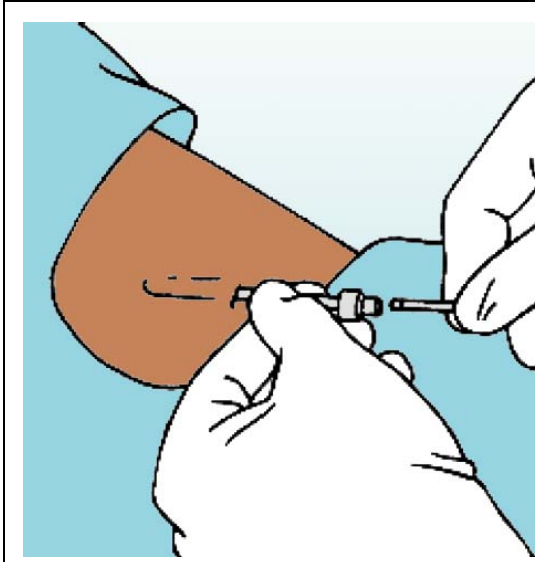
### Insertion procedure



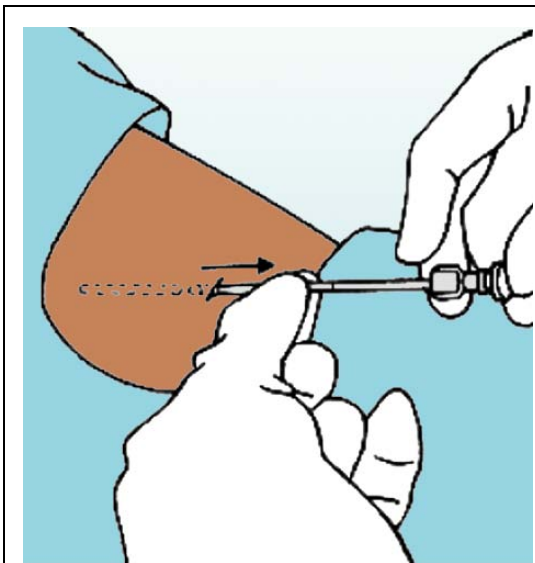
1. Use the scalpel to make a shallow, 2 mm skin incision at the insertion site.
- Note:** The trocar has 3 marks on it:
- The mark closest to the hub indicates how far the trocar should be introduced under the skin to place the Jadelle implants.
  - The middle mark is not used with Jadelle insertions.
  - The mark closest to the tip indicates how much of the trocar should remain under the skin following placement of the first implant.



2. Insert the tip of the trocar beneath the skin at a shallow angle with the bevel facing up.
3. Gently advance the trocar while lifting the skin; failure to do so may result in deep placement of the implants and could make removal more difficult.
4. Advance the trocar to the mark *nearest* the hub of the trocar.



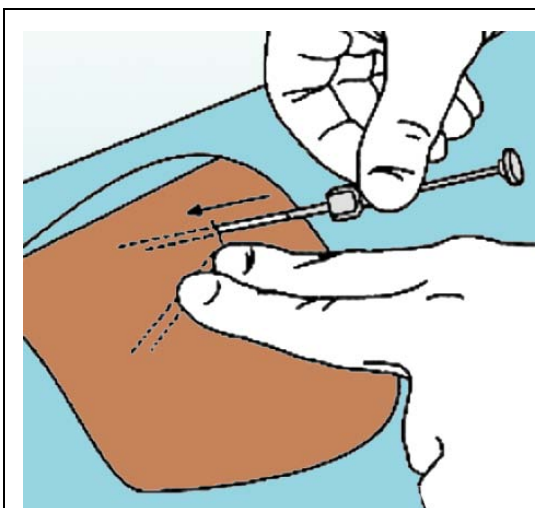
5. When the trocar has been inserted the appropriate distance, remove the plunger from the trocar and load the first implant into the trocar using the thumb and forefinger.
6. Reinsert the plunger and gently push implant towards the tip of the trocar until you feel resistance. Never force the plunger.



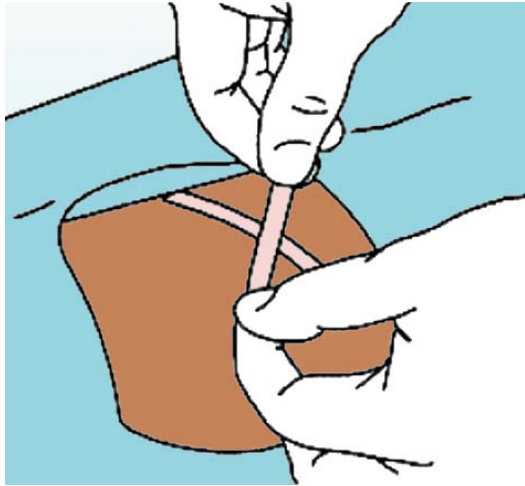
7. Holding the plunger stationary, *withdraw the trocar* to the mark closest to the trocar tip.
8. Keep the plunger stationary and do not push the implant into the tissue. (Do not completely remove the trocar from incision until both implants have been placed—withdraw only to the mark closest to its tip).

The implant should have been released under the skin when the mark closest to the tip of the trocar is visible at the insertion point.

9. Check release of the implant by palpation.
10. Load the second implant into the trocar and replace the plunger.



11. To place the second implant, align the trocar so that the second implant will be positioned at about a 30-degree angle relative to the first.
12. Fix the position of the previous implant with the forefinger and middle finger of the free hand, and advance the trocar along the tips of the fingers. (This will ensure a suitable distance between implants and keep the trocar from puncturing the previously inserted implant.)
13. Make sure that there is a distance of about 5 mm between the incision and the tips of the implants.
14. Remove the trocar from incision.



#### After insertion

1. After placement of the second implant, you may use sterile gauze to apply pressure briefly to the insertion site and ensure there is no bleeding.
  2. Palpate the distal ends of the implants to make sure that both have been properly placed.
  3. Press the edges of the incision together and close the incision with a skin closure.
  4. Remove the drape.
5. Cover the placement area with a dry compress. Wrap gauze around arm to ensure some pressure to control bleeding, but not so tight that it will cause pain and paleness in the arm.
  6. Observe the client for a few minutes for signs of bleeding from the insertion site before she is discharged.
  7. Flush needle and syringe with 0.5% chlorine solution 3 times and place in a puncture-resistant container.
  8. Before removing gloves, decontaminate the trocar, plunger, scalpel, and any other nondisposable instruments by soaking them in a 0.5% chlorine solution for 10 minutes.
  9. Dispose of contaminated objects (gauze, cotton, and other waste items) in a properly marked leak-proof container with a tight-fitting lid or in a plastic bag.
  10. If disposable gloves were used, immerse both gloved hands in a 0.5% chlorine solution. Carefully remove gloves by inverting and place in the waste container.
  11. Wash hands thoroughly with soap and water, and dry with clean paper towel or air dry.
  12. Complete client record, including drawing position of capsules.

Illustrations courtesy of FHI. Illustrations and procedure adapted from: Population Council. (no date). Norplant® II Levonorgestrel Implants (Jadelle®). NDA 20-544, Supplement 003. [http://www.popcouncil.org/pdfs/licensing/20544se2-003\\_jadelle\\_lbl.pdf](http://www.popcouncil.org/pdfs/licensing/20544se2-003_jadelle_lbl.pdf) (accessed April 24, 2010)

# Implant Removal

## Equipment and supplies

- An examining table for the patient
- Antiseptic solution (Lignocaine 1%)
- 5 ml syringe
- Local anesthetic
- Sterile implants removal set
  - Sterile tray for equipment
  - Sterile surgical cloths (2)
  - 2 curved mosquito forceps
  - Cotton swabs, cotton gauze
  - Sterile gloves (free of talcum powder)
  - Scalpel with #11 blade; scissors

## Removal procedure (Jadelle)

1. Assemble required instruments.
2. Palpate the area to locate both implants.
3. Clean the patient's upper arm with antiseptic solution and frame the area with a drape that has an opening.
4. Apply a small amount of local anaesthetic to the skin and under the ends of the implants. This will raise the ends of the implants.
5. Make a 4-mm incision with the scalpel close to the proximal ends of the implants (below the bottom of the "V"). Do not make a large incision.
6. Push each implant gently towards the incision with your fingers.
7. When the tip is visible or near to the incision, grasp it with mosquito forceps.
8. Use the scalpel, the other forceps, or gauze to very gently open the tissue sheath that has formed around the implant.
9. Grasp the proximal end of the implant with the second forceps and gently remove it. Repeat the procedure for the second implant. (For Norplant removal: repeat the procedure for each of the remaining 5 capsules.)
10. After the procedure is completed, close the incision, and cover with sterile gauze and a bandage.
  - The upper arm should be kept dry for a few days.
  - If the woman wants to keep using this method, insert a new set of implants through the same incision.
  - If the woman does not wish to continue using contraceptive implants and does not want to become pregnant, recommend another contraceptive method.

## Hormonal Implants:

### New, Improved, and Popular When Available

By Roy Jacobstein and John M. Pile, January 2008

- Hormonal implants are an excellent contraceptive option for women at all phases of their reproductive lives, whether they want to delay, space, or limit births.
- Though implants are the most costly contraceptive method, their availability in programs can reduce demand on other health services because of their high effectiveness and continuation rates.

#### Method-Specific Characteristics and Considerations

**Effectiveness:** Hormonal implants are highly effective, comparable to IUDs, female sterilisation, and vasectomy. The risk of failure (pregnancy) in the first year of use is 0.05% (for every 2,000 women using implants, 1,999 do not become pregnant in the first year). Overall, in 5 years of Jadelle use, 1 pregnancy occurs per 100 users. Sino-Implant (II) and Implanon have similar rates of effectiveness.

**Mechanism of Action:** Implants release a small amount of progestin steadily into the blood. The hormone prevents pregnancy mainly by inhibiting ovulation and by increasing the thickness of cervical mucus, which makes sperm penetration more difficult.

**Convenience:** Implants can be quickly inserted (in less than 5 minutes) and removed (in less than 10 minutes), without a pelvic exam and without any blood tests or other routine laboratory tests. Implants can be inserted at any time during a woman's menstrual cycle, so long as it is reasonably certain that she is not pregnant. No routine follow-up or other action by the client is needed once the implants are in place. Implants can be removed whenever a woman wishes to have them removed.

**Return to Fertility:** There is no delay in return to fertility upon removal of implants.

**Safety:** Implants are very safe. Complications are uncommon but may include infection at the insertion site (3–7% of insertions), expulsion (extremely rare), and difficult removal.

**Side Effects:** Changes in bleeding patterns are relatively common and may vary throughout the duration of use, although many bleeding disturbances diminish with continued use. Typical changes include lighter bleeding, fewer days of bleeding, irregular bleeding that lasts more than 8 days, infrequent bleeding, and no monthly bleeding. Other minor symptoms that may arise (in fewer than 20–30% of clients) include headache, mild abdominal pain, acne, weight change, breast tenderness, dizziness, mood changes, and nausea. Alerting clients to these possible side effects and discussing their management is an important aspect of counselling.

**HIV/AIDS:** Implants, like other hormonal contraceptives, do not protect against HIV (or other sexually transmitted infections). Women who are HIV-positive or who have AIDS, whether or not they are being treated with antiretroviral drugs, can use implants.

**Eligibility:** Nearly all women can use implants, including those of any age, those who have or have not had children, and those who are married or unmarried. Implants are suitable both for women who wish to space births and for those who wish to limit births. Implants can be inserted in women who have just had an abortion or a miscarriage, and in those who are breastfeeding (starting 6 weeks after childbirth).

## Service Program Considerations

**Availability and Use:** Because of their effectiveness and convenience, when implants are made available in family planning programs, they are popular, and demand for them appears high. More than 1% of women in union use implants in Burkina Faso, Ghana, Haiti, Indonesia, and Kenya, and in urban areas of Malawi, Nepal, Senegal, Uganda, and Zimbabwe.

**Counselling and Continuation:** Implant users discontinue use at much lower rates than do users of IUCDs and injectables. Women who experience menstrual disturbances are more likely to discontinue implant use. Thus, effective counselling needs to focus on the practical management of side effects and on the provision of reassurance that common changes in bleeding patterns and that side effects such as headaches, mild abdominal pain, and breast tenderness are easily treated and usually transient. This is critical to ensuring that women make appropriate, informed choices and also helps enhance continued method use. It is important as well to assure a woman that she can come back at any time she wants, for advice, treatment, or removal of the implant.

**Cost:** The one factor that limits more widespread use of implants in family planning programs is their relatively high commodity cost, though initial costs have been coming down. In programs supported by the U.S. Agency for International Development, the method costs around \$21 per implant (for Jadelle). Sino-Implant (II) is expected to cost \$5–\$8 if it is approved for use beyond China and Indonesia. Also, cost has many dimensions, and the ability of implants to prevent unintended pregnancies is another important cost consideration for programs. A simulation model using data from Kenya estimated that if 100,000 users of oral contraceptives switched to using implants, 26,000 unintended pregnancies would be prevented over 5 years, reducing attendant program costs and workloads, and health risks to women.

**Provider Cadres:** A number of cadres of health professionals, including nurses, nurse-midwives, clinical officers, and physicians, can safely provide implants. After 600 nurses were trained in Ghana and commodities were made available, 88,000 women chose Norplant, and the prevalence of implant use rose more than 10-fold, from 0.1% in 1998 to 1.2% in 2006.

**Service Provision:** Implants must be provided by well-trained and well-supervised providers in properly equipped and regularly supplied health facilities where attention is given to good surgical technique, infection prevention, and counselling. The fundamentals of care—safety, quality, and informed choice—must be ensured. There should be reliable access to both insertion and removal services, with no unjustified policy or practice barriers to provision (such as age and parity restrictions, marriage requirements, spousal or parental consent requirements, and/or provider bias), and no barriers to removal.

*Sources (as cited by authors):*

Johns Hopkins Bloomberg School of Public Health. 2007. Implants: the next generation. Population Reports Series K, no. 11. Baltimore: CCP

World Health Organization/Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs (CCP), Knowledge for Health Project. *Family Planning: A Global Handbook for Providers (2008 update)*. Baltimore and Geneva: CCP and WHO/RHR. <http://info.k4health.org/globalhandbook/>

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*This handout was adapted with permission of EngenderHealth from Jacobstein, Roy and John M. Pile 2008. © 2008 The ACQUIRE Project/EngenderHealth.*

# Contraceptive Implants Case Studies

## Case Study 1

Emma is 17 years old. She gave birth to a full-term stillborn baby 3 weeks ago, and she has not been sexually active since that time. Emma wants to start using a family planning method. She has heard about implants and wants something long-lasting. Emma is not sure of the identity of the baby's father.

1. Is Emma eligible to use implants?
2. When can she start the method?
3. Is there any additional information that should be given to the client?

## Case Study 2

Mrs. Banda is a recent widow who is 45 years old. She has used implants since she was 35, after the birth of her sixth child. Mrs. Banda is not sexually active. When she had her first implants removed, Mrs. Banda had an infection that was very painful. She is scared that the same thing might happen if the second implants are removed.

1. Should the provider insist on removing the expired implants?

## Case Study 3

Lilian is a 28-year-old mother of 4 children who had implants inserted 5 months ago. Since then she has been experiencing irregular bleeding. She finds this worrisome and comes back to find out what is wrong.

1. What information would you give to Lilian? What short-term treatment could you suggest?
2. If this treatment does not work, what would be your next step?

# Contraceptive Implants Case Studies Answer Key

## Case Study 1

Emma is 17 years old. She gave birth to a full-term stillborn baby 3 weeks ago and, she has not been sexually active since that time. Emma wants to start using a family planning method. She has heard about implants and wants something long-lasting. Emma is not sure of the identity of the baby's father.

1. Is Emma eligible to use implants?

**Yes. (MEC category 1)**

2. When can she start the method?

**She can have implants inserted at any time. No backup method is needed.**

3. Is there any additional information that should be given to the client?

**She should be advised that implants do not protect against STI/HIV, and she should be encouraged to use male or female condoms.**

## Case Study 2

Mrs. Banda is a recent widow who is 45 years old. She has used implants since she was 35, after the birth of her sixth child. Mrs. Banda is not currently sexually active. When her first implants were removed, she had an infection that was very painful. She is scared that the same thing might happen when the second implants are removed.

1. Should the provider insist on removing the expired implants?

**Even though it is not recommended to leave implants in beyond their effective lifespan, they are not dangerous. Since Mrs. Banda is currently not at risk of pregnancy she could choose to leave them in.**

## Case Study 3

Lilian is a 28-year-old mother of 4 children who had implants inserted 5 months ago. Since then she has been experiencing irregular bleeding. She finds this worrisome and comes back to find out what is wrong.

1. What information would you give to Lilian? What short-term treatment could you suggest?

**Reassure her that many women using implants experience irregular bleeding. It is not harmful and usually becomes less or stops after the first year of use. For modest, short-term relief, she can take ibuprofen, 800 mg 3 times daily after meals for 5 days, beginning when irregular bleeding starts.**

2. If this treatment does not work, what would be your next step?

**If ibuprofen doesn't help, she can be given COCs (with levonorgestrel). Ask her to take 1 pill daily for 21 days. Or, she could be given 50 µg ethinyl estradiol to take daily for 21 days. If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use. (See "Unexplained vaginal bleeding" Section 7.14.)**



# Implants Role Plays

## Role Play 1

### **Situation**

Mrs. Kaliya received Jadelle implants 6 months ago. Since that time she has heard from one friend that implants are dangerous because they can move around in the body and could get stuck in an organ. She has also heard that implants cause birth defects. Mrs. Kaliya wants to have more children in a couple of years, and what she has heard has scared her. She has come to the clinic to have her implants removed.

### **Observer(s)**

1. What counselling skills does the provider use to handle the situation? How could the communication be improved?
2. Does the provider encourage the client to express concerns, ask questions, and explain needs?
3. Does the provider give accurate, concise information?
4. Does the provider let the client make the decision?

## Role Play 2

### **Situation**

Margaret is a 21-year-old client with no children. She is a student who will be leaving soon for South Africa to do graduate studies for 2 years. Margaret had implants inserted 6 months ago. For the last 2 months she has had no bleeding. This worries her, especially since she is about to leave the country, and a pregnancy would jeopardize her studies.

### **Observer(s)**

1. What counselling skills does the provider use to handle the situation? How could the communication be improved?
2. Does the provider encourage the client to express concerns, ask questions, and explain needs?
3. Does the provider give accurate, concise information?

# Contraceptive Implants Quiz Questions

**Questions 1–10 :** Indicate whether the following statements are **true** or **false** by writing a **“T”** for true or an **“F”** for false in the space provided before each statement.

- \_\_\_1. Contraceptive implants are thin capsules that release oestrogen through the wall of the capsules in a continuous low dose.
- \_\_\_2. Jadelle is a type of contraceptive implant currently available in Malawi.
- \_\_\_3. Contraceptive implants are one of the most effective, reversible, and long-lasting methods.
- \_\_\_4. A common complication of implants is an infection at the insertion site.
- \_\_\_5. Implants substantially reduce the risk of ectopic pregnancy.
- \_\_\_6. The hormones from the implants remain in the woman’s body after the capsules have been removed.
- \_\_\_7. Women who smoke cigarettes may not use implants.
- \_\_\_8. Women who have not had children should not use implants because they may become infertile.
- \_\_\_9. Implants may decrease menstrual cramps and bleeding.
- \_\_\_10. If implants were inserted more than 7 days after the start of a client’s monthly bleeding, a client should use a backup method of contraception for the next 7 days.

**Questions 11–14:** Circle the letter next to the answer that best responds to the statements or questions below.

- 11. Implants work primarily by:
  - a. Preventing release of eggs from the ovaries
  - b. Thickening cervical mucus, which prevents sperm from meeting an egg
  - c. Thinning the endometrial lining, preventing implantation
  - d. All of the above
  - e. None of the above
- 12. Women who should not use implants include those with the following conditions:
  - a. Unexplained, unusual vaginal bleeding
  - b. Anaemia
  - c. Are infected with HIV
  - d. All of the above
  - e. None of the above
- 13. The following test(s) are necessary for a woman to access implants:
  - a. Pelvic exam
  - b. Cervical cancer screening
  - c. Breast exam
  - d. All of the above
  - e. None of the above

14. Breastfeeding women should wait at least how long before initiating use of a contraceptive implant?
- No delay is necessary; implants may be inserted immediately after delivery.
  - 1 week
  - 6 weeks
  - 6 months

**Short answer.** Provide short answers for the following questions.

15. List 2 advantages of implants:

16. List 2 disadvantages of implants:

17. List 3 side effects reported for implants:

18. What are the 4 steps, in order, of the insertion procedure (Jadelle) that should be explained to the client?

- 1.
- 2.
- 3.
- 4.

19. List 2 warning signs of complications for implants:

## Contraceptive Implants Quiz Questions Answer Key

- F\_\_1. Contraceptive implants are thin capsules that release oestrogen through the wall of the capsules in a continuous low dose.
- T\_\_2. Jadelle is a type of contraceptive implant currently available in Malawi.
- T\_\_3. Contraceptive implants are one of the most effective, reversible, and long-lasting methods.
- F\_\_4. A common complication of implants is an infection at the insertion site.
- T\_\_5. Implants substantially reduce the risk of ectopic pregnancy.
- F\_\_6. The hormones from the implants remain in the woman's body after the capsules have been removed.
- F\_\_7. Women who smoke cigarettes may not use implants.
- F\_\_8. Women who have not had children should not use implants because they may become infertile.
- T\_\_9. Implants may decrease menstrual cramps and bleeding.
- T\_\_10. If implants were inserted more than 7 days after the start of a client's monthly bleeding, a client should use a backup method of contraception for the next 7 days.
11. Implants work primarily by:  
**d. All of the above**
12. Women who should not use implants include those with the following conditions:  
**a. Unexplained, unusual vaginal bleeding**
13. The following test(s) are necessary for a woman to access implants:  
**e. None of the above**
14. Breastfeeding women should wait at least how long before initiating use of a contraceptive implant?  
**c. 6 weeks**
15. List 2 advantages of implants:  
**Any 2 of the following:**
- **Highly effective**
  - **Long-term effectiveness**
  - **Do not interfere with intercourse**
  - **Rapid return to fertility**
  - **Require no further activity by user after insertion**
  - **Can be provided by trained non-physicians**

16. List 2 disadvantages of implants:

**Any 2 of the following:**

- **Insertion and removal requires minor surgical procedure by trained provider.**
- **Certain medicines may make implants less effective.**
- **They do not protect against STIs, including HIV.**

17. List 3 side effects reported for implants:

**Any 3 of the following:**

- **Changes in vaginal bleeding pattern**
- **Headaches**
- **Abdominal pain**
- **Acne**
- **Weight change**
- **Breast tenderness**
- **Dizziness, nausea**
- **Mood changes**
- **Enlarged ovarian follicles**

18. What are the 4 steps, in order, of the insertion procedure (Jadelle) that should be explained to the client?

1. **The woman receives an injection of local anaesthetic.**
2. **The provider makes a small incision in the skin on the inside of the upper arm.**
3. **The provider inserts the implants just under the skin.**
4. **After the implants are inserted, the provider closes the incision with an adhesive bandage. No stitches are needed.**

19. List 2 warning signs of complications for implants:

- **Pain, redness, heat or pus at the incision site (sign of infection)**
- **Woman can see rod or capsule coming out of incision (expulsion of implant)**

# Learning Guide for Implants Clinical Skills: Insertion

(to be used by student)

Student's Name: \_\_\_\_\_ Dates: \_\_\_\_\_

**Instructions: Rate the performance of each task/activity observed using the following rating scale.**

1. **Needs Improvement:** Step not performed correctly or in sequence (if necessary) or is omitted
2. **Competently Performed:** Step performed correctly in proper sequence (if necessary) but participant not progressing from step to step efficiently
3. **Proficiently Performed:** Step efficiently and precisely performed in the proper sequence (if necessary)

**N/O Not Observed**

Learning Guide for Implants Clinical Skills: Insertion					
Task/Activity	Cases				
PRE-INSERTION COUNSELLING					
1. Greet client respectfully.					
2. Introduce yourself to client.					
3. Review client using screening checklist and further evaluate client, if indicated.					
4. Tell client what is going to be done and encourage her to ask questions.					
5. Ask about allergies to antiseptic solution and lignocaine for local anaesthetic					
6. Counsel the client on: <ul style="list-style-type: none"> <li>• Mechanisms of action</li> <li>• Duration of action of the implant</li> <li>• Benefits of the method</li> <li>• Site of insertion</li> <li>• Side effects and their management</li> <li>• Warning signs.</li> </ul>					
PRE-INSERTION TASKS					
1. Have the client wash her entire arm and hand (the one she uses less often) with soap and water, and dry with a clean towel or air dry.					
2 Help position client on table. <ul style="list-style-type: none"> <li>• Ask the client to lie on her back with her non-dominant arm flexed at the elbow and externally rotated.</li> <li>• Using template, mark position on arm for insertion of the 2 capsules (this should form a "V" open toward the shoulder).</li> </ul>					
3. Check that required sterile or high-level disinfected (HLD)					

## Learning Guide for Implants Clinical Skills: Insertion

Task/Activity	Cases				
instruments are present.					
4. Open sterile or high-level disinfected instrument pack without touching instruments.					
5. Open sterile implants package by pulling apart sheets of the pouch. Allow the 2 implants to fall onto a sterile drape.					
6. Wash hands thoroughly with antiseptic soap and water, and dry with clean, disposable paper towel or air dry. Put sterile gloves on both hands.					
7. Clean the patient's upper arm with cotton or gauze swab soaked in antiseptic solution and held in a sterile or HLD forceps.					
8. Frame the insertion area with a sterile surgical drape that has an opening.					
9. Fill a 5 ml sterile syringe with the local anaesthetic (without epinephrine).					
10. Insert the needle under the skin and inject a small amount of the anaesthetic.					
11. Anaesthetize 2 areas about 4.5 cm long to mimic the V shape of the implantation site.					
12. Withdraw needle and place in a safe area to prevent accidental needle pricks.					
13. Test incision site with tip of forceps for adequate anaesthesia. (If client feels pain, wait 2 minutes and retest incision site).					
<b>INSERTION PROCEDURE</b>					
1. Make a shallow, 2 mm incision with a scalpel just through the skin at insertion site.					
2. Insert trocar and plunger through the incision at a shallow angle beneath the skin with the bevel facing up.					
3. Slowly and smoothly advance trocar while lifting the skin and plunger towards mark (1) nearest the hub on the trocar.					
4. Advance the trocar to the mark <i>nearest</i> the hub of the trocar.					
5. When the trocar has been inserted the appropriate distance, remove plunger from the trocar and load the first implant into the trocar using the thumb and forefinger.					
6. Reinsert plunger and gently push implant towards the tip of the trocar until resistance is felt. Do not force the plunger.					
7. Holding the plunger stationary, withdraw the trocar out of incision to the mark closest to the trocar tip.					
8. Keep the plunger stationary and do not push the implant into the tissue. (Do not remove trocar from incision until both implants have been placed.)					
9. Check release of the implant by palpation.					
10. Load the second implant into the trocar and replace the plunger.					

## Learning Guide for Implants Clinical Skills: Insertion

Task/Activity	Cases				
11. To place the second implant, align the trocar so that the second implant will be positioned at about a 30 degree angle relative to the first.					
12. Fix the position of the previous implant with the forefinger and middle finger of the free hand, and advance the trocar along the tips of the fingers.					
13. Make sure that there is a distance of about 5 mm between the incision and the tips of the implants.					
14. Remove the trocar from the incision.					
<b>POST-INSERTION TASKS</b>					
1. After placing the second implant, use sterile gauze to apply pressure briefly to the insertion site and ensure there is no bleeding.					
2. Palpate the distal ends of the implants to make sure that both have been properly placed.					
3. Bring edges of incision together and close the incision with a skin closure.					
4. Remove the drape.					
5. Cover the insertion area with a dry compress. Wrap gauze bandage firmly around the arm to ensure some pressure to control bleeding and minimize bruising but not so tight that it will cause pain and paleness in the arm.					
6. Observe the client for a few minutes for signs of bleeding from the insertion site before she is discharged.					
7. Flush needle and syringe with 0.5% chlorine solution 3 times, and place in puncture-proof container.					
8. Before removing gloves, place all instruments in 0.5% chlorine solution for 10 minutes for decontamination, separating the plunger from the trocar.					
9. Dispose of waste materials by placing in a leak-proof container.					
10. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning inside out and place in leak-proof waste container or plastic bag.					
11. Wash hands thoroughly with soap and water, and dry with clean, disposable paper towel or air dry.					
12. Complete client record, including drawing position of implants.					
<b>POST-INSERTION COUNSELLING</b>					
1. Instruct client regarding wound care, and make return visit appointment, if needed.					
2. Discuss what to do if client experiences any problems or side effects following insertion.					
3. Ask client to repeat instructions.					
4. Answer client's questions.					



# Learning Guide for Implants Clinical Skills: Removal

(to be used by student)

Student's Name: \_\_\_\_\_ Dates: \_\_\_\_\_

**Instructions: Rate the performance of each task/activity observed using the following rating scale.**

1. **Needs Improvement:** Step not performed correctly or in sequence (if necessary) or is omitted
2. **Competently Performed:** Step performed correctly in proper sequence (if necessary) but participant not progressing from step to step efficiently
3. **Proficiently Performed:** Step efficiently and precisely performed in the proper sequence (if necessary)

**N/O Not Observed**

Learning Guide for Implants Clinical Skills: Removal					
Task/Activity	Cases				
PRE-REMOVAL COUNSELLING					
1. Greet client respectfully.					
2. Introduce yourself to client.					
3. Tell client what is going to be done and encourage her to ask questions.					
4. Ask about allergies to antiseptic solution and lignocaine for local anaesthetic.					
REMOVAL TASKS					
1. Assemble required instruments.					
2. Palpate the area to locate both implants.					
3. Clean the patient's upper arm with antiseptic solution, and frame the area with a drape that has an opening.					
4. Apply a small amount of local anesthetic to the skin and under the ends of the implants. This will raise the ends of the implants.					
5. Make a 4 mm incision with the scalpel close to the proximal ends of the implants (below the bottom of the "V"). Do not make a large incision.					
6. Push each implant gently towards the incision with your fingers.					
7. When the tip is visible or near to the incision, grasp it with mosquito forceps.					
8. Use the scalpel, the other forceps, or gauze to very gently open the tissue sheath that has formed around the implant.					
9. Grasp the proximal end of the implant with the second forceps					

## Learning Guide for Implants Clinical Skills: Removal

Task/Activity	Cases				
and gently remove it. Repeat the procedure for the second implant. (For Norplant removal: repeat the procedure for each of the remaining 5 capsules.)					
<p>10. After the procedure is completed, close the incision, and cover with sterile gauze and a bandage.</p> <ul style="list-style-type: none"> <li>• The upper arm should be kept dry for a few days.</li> <li>• If the woman wants to keep using this method, insert a new set of implants through the same incision.</li> <li>• If the woman does not wish to continue using contraceptive implants and does not want to become pregnant, you should recommend another contraceptive method.</li> </ul>					

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# Unit 8

## INTRAUTERINE CONTRACEPTIVE DEVICES

### Learning Objectives

By the end of this unit, learners will be able to:

- ❖ Define intrauterine contraceptive devices (IUCDs)
- ❖ Describe the type of IUCD available in Malawi
- ❖ State the effectiveness of IUCDs and explain how they work
- ❖ List the characteristics of IUCDs
- ❖ Correct myths and misconceptions about IUCDs
- ❖ Determine a client's medical eligibility criteria for IUCD use
- ❖ Explain when women in different situations can start using IUCDs
- ❖ Demonstrate knowledge and skills in counselling clients to make an informed choice to use IUCDs
- ❖ List potential complications of IUCDs and their warning signs
- ❖ Describe the procedures for IUCD insertion and removal
- ❖ Provide client instructions after IUCD insertion and the key counselling messages for follow-up visit
- ❖ Explain management of side effects and complications of IUCDs
- ❖ Demonstrate competency in insertion and removal of IUCDs.

### Teaching Resources in this Unit

#### IUCD Clinical Procedures

Clinical Procedures for Copper T Insertion, Sounding, Loading, Removal 179

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Learning Guide Loading the TCU 380A in its Sterile Package 202

Learning Guide for IUCD Removal 204

## Unit 8: Intrauterine Contraceptive Devices

### Key Points

- ❖ **Safe and highly effective contraception**
- ❖ **Long-term pregnancy protection**—TCu-380A shown to be very effective for 12 years, immediately reversible
- ❖ **Inserted into the uterus by a specifically trained provider**
- ❖ **Little required of the client once the IUCD 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.

## 8.1 Defining Intrauterine Contraceptive Devices

The intrauterine contraceptive device (IUCD) is a small, flexible contraceptive device made of plastic and other materials that is placed in the uterine cavity to prevent pregnancy. All types of IUCDs have one or two strings, or threads, attached to them. When the IUCD is in place, the strings hang through the opening of the cervix into the vagina. The IUCD provides safe, effective, reversible, long-term contraception for women—effective for up to 12 years for the TCu-380A. However, since they are easy to remove, they also may be used for shorter periods of time—for instance, for 2 or 3 years.

### Type of IUCD available in Malawi

The TCu-380A (or “Copper T”) is a copper-bearing IUCD with a coil of copper wire on its vertical arm and two copper sleeves, one on each horizontal arm. This unit focuses on the Copper T because it is the primary IUCD used in Malawi.

### How IUCDs work

Copper-bearing IUCDs work primarily by causing a chemical change that damages the sperm and egg before they can meet.

## 8.2 Effectiveness

Although labelled for up to 10 years, studies have found that the TCu-380A is effective for at least 12 years and is the IUCD of choice for women requiring long-term contraception.

- Less than 1 pregnancy per 100 women using an IUCD over the first year (6 to 8 per 1,000 women). This means that 992 to 994 of every 1,000 women using IUCDs will not become pregnant. Therefore IUCDs are 99.2%–99.4% effective.

### OTHER IUCDS

#### Other copper-bearing IUCDs

Other copper-bearing devices include Cu 375 (Multiload) and Cu 250 (Dalcept), but these are not used in Malawi.

#### Hormonal IUCDs

Levonorgestrel-releasing IUCD (also known as an intrauterine system, or IUS), is a T-shaped plastic device that steadily releases small amounts of levonorgestrel each day. It is effective for 5 years. Levonorgestrel (LNG) is a progestin also used in contraceptive implants and oral contraceptive pills. The LNG IUCD is not currently available in Malawi.

## 8.3 Characteristics

### Advantages

- Highly and immediately effective
- Long-term effectiveness, easily reversible
- Rapid return to fertility
- Requires no further action by user after insertion
- Has no further costs after insertion

### Disadvantages

- Can cause more cramping and pain during monthly bleeding
- Does not protect against sexually transmitted infections (STIs), including HIV

### 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

### Health benefits

- May help protect against endometrial cancer

### Health risks

- Uncommon: It may contribute to anaemia if woman already has low iron blood stores before insertion and the IUCD causes heavier monthly bleeding.
- Rare: Pelvic inflammatory disease (PID) may occur if the woman has chlamydia or gonorrhoea at the time of IUCD insertion.

### Complications

Rare:

- Puncturing (perforation) of the wall of the uterus by the IUCD or an instrument used for insertion. Usually heals without treatment.
- Miscarriage, preterm birth, or infection in the rare case that the woman becomes pregnant with the IUCD in place.

## 8.4 Correcting Misconceptions

Intrauterine contraceptive devices:

- Rarely lead to pelvic inflammatory disease (PID)
- Do not increase the risk of contracting STIs, including HIV
- Do not increase the risk of miscarriage when a woman becomes pregnant after the IUCD is removed
- Do not make woman infertile
- Do not cause birth defects
- Do not cause cancer
- Do not move to the heart or brain
- Do not cause discomfort or pain during sex
- Substantially reduce the risk of ectopic pregnancy.

### IUCDs AS EMERGENCY CONTRACEPTION

The Copper T IUCD can also be used to prevent pregnancy if inserted up to 5 days after intercourse. As emergency contraception, IUCDs are much more effective than emergency contraceptive pills (ECPs). IUCDs reduce the risk of pregnancy by 99%. Once inserted for emergency contraception, the IUCD can remain in place to prevent pregnancy for 12 years.

## 8.5 Women Who Can Use the Copper T

Most women can use the Copper T IUCD 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 (if no evidence of infection)
- Are breastfeeding
- Do hard physical work
- Have had ectopic pregnancy
- Have had PID
- Have vaginal infections
- Have anaemia
- Are infected with HIV or on antiretroviral therapy and doing well (see IUCDs for Women Living with HIV, Section 8.7).

Women can begin using IUCDs:

- Without STI testing
- Without an HIV test
- Without any blood tests or other routine laboratory tests
- Without cervical cancer screening
- Without a breast examination.

## 8.6 Women Who Should Not Use the Copper T

Usually, women with any of the conditions listed below should not have the Copper T inserted.

### WHO MEC Category 3

- Between 48 hours and 4 weeks since giving birth
- Noncancerous (benign) gestational trophoblast disease
- Current ovarian cancer (Category 3 for insertion; Category 2 for continuing use)
- Is at very high individual risk for gonorrhoea or chlamydia at the time of insertion
- Has AIDS and is not on antiretroviral therapy or is not clinically well (Category 3 for insertion; Category 2 for continuing use)
- Has systematic lupus erythematosus with severe thrombocytopenia

## 8.7 IUCDs for Women Living With HIV

Women who are at risk of HIV or are infected with HIV can safely have the IUCD inserted.

- Women who have AIDS, are on antiretroviral (ARV) therapy, and are clinically well can safely have the IUCD inserted.
- Women who have AIDS but who are not on ARV therapy or who are not clinically well should *not* have the IUCD inserted.
- If a woman develops AIDS while she has an IUCD in place, it does not need to be removed.
- IUCD users with AIDS should be monitored for pelvic inflammatory disease.
- Women with IUCDs should also be encouraged to use condoms along with the IUCD (dual protection). Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.



## 8.8 Screening Checklist

### Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD

First, be reasonably sure that the client is not pregnant. If she is not menstruating at the time of her visit, ask the client questions 1–6. As soon as the client answers **YES** to *any question*, stop, and follow the instructions after question 6.

← YES	1. Have you had a baby in the last 4 weeks?	NO
← YES	2. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	NO
← YES	3. Have you abstained from sexual intercourse since your last menstrual period or delivery?	NO
← YES	4. Did your last menstrual period start within the past 12 days?	NO
← YES	5. Have you had a miscarriage or abortion in the last 12 days?	NO
← YES	6. Have you been using a reliable contraceptive method consistently and correctly?	NO

If the client answered **YES** to *any one of questions 1–6* and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. Proceed to questions 7–14. However, if she answers **YES** to *question 1*, the insertion should be delayed until 4 weeks after delivery. Ask her to come back at that time.

If the client answered **NO** to *all of questions 1–6*, pregnancy cannot be ruled out. The client should await menses or use a pregnancy test.

To determine if the client is medically eligible to use an IUD, ask questions 7–14. As soon as the client answers **YES** to *any question*, stop, and follow the instructions after question 14.

NO	7. Do you have bleeding between menstrual periods that is unusual for you, or bleeding after intercourse (sex)?	YES
NO	8. Have you been told that you have any type of cancer in your genital organs, trophoblastic disease, or pelvic tuberculosis?	YES
NO	9. Have you ever been told that you have a rheumatic disease such as lupus?	YES
NO	10. Within the last 3 months, have you had more than one sexual partner?	YES
NO	11. Within the last 3 months, do you think your partner has had another sexual partner?	YES
NO	12. Within the last 3 months, have you been told you have an STI?	YES
NO	13. Within the last 3 months, has your partner been told that he has an STI, or do you know if he has had any symptoms – for example, penile discharge?	YES
NO	14. Are you HIV-positive, and have you developed AIDS?	YES

If the client answered **NO** to *all of questions 7–14*, proceed with the **PELVIC EXAM**.

If the client answered **YES** to *any of questions 7–9*, an IUD cannot be inserted. Further evaluation of the condition is required.

If the client answered **YES** to *any of questions 10–13*, she is not a good candidate for an IUD unless chlamydia and/or gonorrhea infection can be reliably ruled out.

If she answered **YES** to the *second part of question 14* and is not currently taking ARV drugs, IUD insertion is not usually recommended. If she is doing clinically well on ARVs, the IUD may generally be inserted. HIV-positive women without AIDS also generally can initiate IUD use.

During the pelvic exam, the provider should determine the answers to questions 15–21.

NO	15. Is there any type of ulcer on the vulva, vagina, or cervix?	YES
NO	16. Does the client feel pain in her lower abdomen when you move the cervix?	YES
NO	17. Is there adnexa tenderness?	YES
NO	18. Is there purulent cervical discharge?	YES
NO	19. Does the cervix bleed easily when touched?	YES
NO	20. Is there an anatomical abnormality of the uterine cavity that will not allow appropriate IUD insertion?	YES
NO	21. Were you unable to determine the size and/or position of the uterus?	YES

If the answer to *all of questions 15–21* is **NO**, you may insert the IUD.

If the answer to *any of questions 15–21* is **YES**, the IUD cannot be inserted without further evaluation. See explanations for more instructions.



## 8.9 Timing: When to Start the Copper T

Important: In many cases a woman can start the Copper T any time it is reasonably certain she is not pregnant. To be reasonably certain she is not pregnant, use the Pregnancy Checklist (see Unit 4: Client FP Assessment and the WHO MEC).

<b>Woman's situation</b>	<b>When to start</b>
<b>Having menstrual cycles</b>	Any time of the month If she is starting within 12 days after the start of her monthly bleeding, there is no need for a backup method. If it is more than 12 days after the start of her monthly bleeding, she can have the IUCD inserted any time it is reasonably certain she is not pregnant. There is no need for a backup method.
<b>Switching from another method</b>	Immediately, if she has been using the method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. There is no need to wait for her next monthly bleeding and no need for a backup method. If she is switching from injectables, she can have the IUCD inserted when the next injection would have been given. There is no need for a backup method.
<b>Soon after childbirth</b>	Any time within 48 hours after giving birth (requires a provider with specific training in postpartum insertion) If it is more than 48 hours after giving birth, delay IUCD insertion until 4 weeks or more after giving birth.
<b>Fully or nearly fully breastfeeding</b> <b>Less than 6 months after giving birth</b>	If her monthly bleeding has not returned, she can have the IUCD inserted any time between 4 weeks and 6 months after giving birth. There is no need for a backup method. If her monthly bleeding has returned, she can have the IUCD inserted as advised for women having menstrual cycles (see above).
<b>Fully or nearly fully breastfeeding</b> <b>More than 6 months after giving birth</b>	If her monthly bleeding has not returned, she can have the IUCD inserted any time it is reasonably certain she is not pregnant. There is no need for a backup method. If her monthly bleeding has returned, she can have the IUCD inserted as advised for women having menstrual cycles (see above).
<b>Partially breastfeeding or not breastfeeding</b> <b>More than 4 weeks after giving birth</b>	If her monthly bleeding has not returned, she can have the IUCD inserted if it can be determined that she is not pregnant. There is no need for a backup method. If her monthly bleeding has returned, she can have the IUCD inserted as advised for women having menstrual cycles (see above).
<b>No monthly bleeding (not related to childbirth or</b>	Any time if it can be determined that she is not pregnant. There is no need for a backup method.

<b>Woman's situation</b>	<b>When to start</b>
<b>breastfeeding)</b>	
<b>After miscarriage or abortion</b>	<p>Immediately, if the IUCD is inserted within 12 days after first- or second-trimester abortion or miscarriage and if no infection is present. There is no need for a backup method.</p> <p>If it is more than 12 days after first- or second-trimester miscarriage or abortion and no infection is present, she can have the IUCD inserted any time it is reasonably certain she is not pregnant. There is no need for a backup method.</p> <p>If infection is present, treat or refer and help the client choose another method. If she still wants the IUCD, it can be inserted after the infection has completely cleared.</p> <p>IUCD 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.</p>
<b>For emergency contraception</b>	<p>Within 5 days after unprotected sexual intercourse</p> <p>When the time of ovulation can be accurately estimated, she can have an IUCD inserted up to 5 days after ovulation. Sometimes this may be more than 5 days after unprotected sex.</p>
<b>After taking Emergency Contraceptive Pills (ECPs)</b>	<p>The IUCD can be inserted on the same day that she takes the ECPs.</p> <p>There is no need for a backup method.</p>

## 8.10 Copper T IUCD Insertion

(WHO /RHR and CCP, INFO Project 2007)

### Explaining the insertion procedure

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

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

## 8.11 Client Counselling and Instructions

**Important:** Be clear about the possibility of menstrual changes with the IUCD. If the woman knows what to expect, she is more likely to be satisfied with her choice and less likely to worry about side effects if they occur.

### Expect cramping and pain

- She may experience pain, light bleeding, and/or cramping immediately after IUCD insertion. The cramping may last for a few days.
- Many women experience heavier bleeding, longer bleeding, and more cramping than usual during their menstrual periods, and spotting between their periods. These symptoms usually lessen or go away within the first 3 to 6 months after IUCD insertion.
- Generally, these symptoms are not harmful and do not indicate a problem.
- Suggest ibuprofen (200-400 mg), paracetamol (325-1000 mg) or other pain reliever as needed.

### Possibility of expulsion

- IUCD expulsion is rare but is most likely to occur within the first few months after IUCD insertion (especially during menstruation.)
- The client can be shown how to reach into her vagina to check the IUCD strings. This is one way to verify that the device is in place.

- The client can check her menstrual cloth/pad/tampon for an expelled IUCD during her first few menstrual periods.
- If she suspects that her IUCD has been expelled, she should begin using a backup contraceptive method and return to the clinic immediately.

### Length of pregnancy protection and when to return

- The Copper T IUCD is effective immediately and is effective for 12 years.
- Discuss how to remember the date to return.
- Give each woman the following information in writing on a reminder card, like the one shown below, if possible, and explain:
  - What type of IUCD she has (“Copper T”)
  - The date of IUCD insertion
  - The month and year when IUCD will need to be removed or replaced
  - Where to go if she has problems or questions with her IUCD.

IUCD Reminder Card
Your IUCD is Copper T 380A
Client's name: _____
Please come for your next visit
on: _____/_____/_____
Family planning clinic _____
Date IUCD inserted: _____
Return to remove or replace by: _____

### Protection against STIs

- The IUCD provides no protection against HIV or other STIs.
- Tell the client:
  - She should use a condom for protection every time she has sex, especially if she thinks she or her partner could be at risk for exposure to HIV or other STIs.
  - She should feel free to bring her partner to the clinic at any time to further discuss this issue.

### Follow-up visit

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

### Reasons to return

Assure every client that she is welcome to come back any time—for example, if she has problems, questions, or wants another method; or she has a major change in health status; or wants the IUCD removed.

**She should also return to the clinic immediately if she has any of these warning signs:**

- She feels the strings are missing, or feels the hard plastic of an IUCD that has partially come out (expulsion).
- She has increasing or severe pain in the lower abdomen, pain during sex, unusual vaginal discharge, fever, chills, nausea, and/or vomiting (symptoms of PID), especially in the first 20 days after insertion.
- She thinks she might be pregnant (misses a period).

## 8.12 Post-Insertion Follow-Up Visit (3 to 6 Weeks)

A routine pelvic examination at the follow-up visit is not required. It may be appropriate in some settings or for some clients, however. Conduct a pelvic examination particularly if the client's answers lead you to suspect an STI or PID, or that the IUCD has partially or completely come out.

- Ask the client how she is doing with the method and whether she is satisfied.
- Ask if she has any questions or anything to discuss.
- Ask especially if she is concerned about bleeding changes. Give her any information or help that she needs.
- Ask her if she has:
  - Increasing or severe abdominal pain or pain during sex or urination
  - Unusual vaginal discharge
  - Fever or chills
  - Signs or symptoms of pregnancy
  - Not been able to feel strings (if she has checked them)
  - Felt the hard plastic of an IUCD that has partially come out.

## 8.13 IUCD Removal

**Important:** Providers must not refuse or delay when a woman asks to have her IUCD removed, whatever her reason, whether it is personal or medical. All staff must understand and agree that the client must not be pressured or forced to continue using the IUCD.

- If a woman is finding side effects difficult to tolerate, first discuss the problems she is having. See if she would rather try to manage the problem before having the IUCD removed.
- Removing an IUCD 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 cases of uterine perforation or if removal is not easy, refer the woman to an experienced clinician who can use an appropriate removal technique.

### Indications for IUCD removal

- The client wants it removed (for any reason)
- Severe abdominal pain which is intolerable
- Severe prolonged bleeding with anaemia
- Allergy to copper
- Evidence of partial perforation by history (such as pain, excess bleeding, tender abdomen)

### Explaining the removal procedure

Before removing the IUCD, explain what will happen during removal:

- The provider inserts a speculum to see the cervix and IUCD 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 IUCD strings slowly and gently until the IUCD comes completely out of the cervix.

## 8.14 Management of IUCD Side Effects or Complications

### **May or may not be due to the method.**

Problems with side effects or complications affect women's satisfaction and use of IUCDs. They deserve the provider's attention. If the client reports any side effects or complications, listen to her concerns, give her advice, and, if appropriate, treat.

Offer to help her choose another method—now, if she wishes, or if problems cannot be overcome.

### **Heavy or prolonged bleeding (twice as much as usual or longer than 8 days)**

- Reassure her that many women using IUCDs experience heavy or prolonged bleeding. It is generally not harmful and usually becomes less or stops after the first several months of use.
- For modest short-term relief she can try (one at a time):
  - Nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen (400 mg) or indomethacin (25 mg) 2 times daily after meals for 5 days, beginning when heavy bleeding starts. Other NSAIDs also may provide some relief of heavy or prolonged bleeding. Aspirin should not be used because it may increase bleeding.
- Provide iron tablets if possible and tell her it is important for her to eat foods containing iron (see Possible Anaemia below).
- If heavy or prolonged bleeding continues or starts after several months of normal bleeding or long after the IUCD was inserted, or if you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use (see Unexplained vaginal bleeding, Section 8.15).

### **Irregular bleeding (bleeding at unexpected times that bothers the client)**

- Reassure her that many women using IUCDs experience irregular bleeding. It is not harmful and usually becomes less or stops after the first several months of use.
- For modest short-term relief she can try NSAIDs such as ibuprofen (400 mg) or indomethacin (25 mg) 2 times daily after meals for 5 days, beginning when irregular bleeding starts.
- If irregular bleeding continues or starts after several months of normal bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use (see Unexplained vaginal bleeding, Section 8.15).

### **Cramping and pain**

- She can expect some cramping and pain for the first day or two after IUCD insertion.
- Explain that cramping also is common in the first 3 to 6 months of IUCD use, particularly during monthly bleeding. Generally, this is not harmful and usually decreases over time.
- Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever. If she also has heavy or prolonged bleeding, aspirin should not be used because it may increase bleeding.

If cramping continues and occurs outside of monthly bleeding:

- Evaluate for underlying health conditions and treat or refer.
- If no underlying condition is found and cramping is severe, discuss removing the IUCD.



- If the removed IUCD looks distorted, or if difficulties during removal suggest that the IUCD was out of proper position, explain to the client that she can have a new IUCD that may cause less cramping.

### **Possible anaemia**

- The copper-bearing IUCD may contribute to anaemia if a woman already has low iron blood stores before insertion and the IUCD causes heavier monthly bleeding.
- Pay special attention to IUCD users with any of the following signs and symptoms:
  - Inside of eyelids or underneath fingernails looks pale, pale skin, fatigue or weakness, dizziness, irritability, headache, ringing in the ears, sore tongue, or brittle nails
  - If blood testing is available, hemoglobin less than 9 g/dl or hematocrit less than 30.
- Provide iron tablets if possible.
- Tell her it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, lentils, and peas).

### **Partner can feel IUCD strings during sex**

- Explain that this happens sometimes when strings are cut too short.
- If partner finds the strings bothersome, describe available options:
  - Strings can be cut even shorter so they are not coming out of the cervical canal. Her partner will not feel the strings, but the woman will no longer be able to check her IUCD strings.
  - If the woman wants to be able to check her IUCD strings, the IUCD can be removed and a new one inserted. (To avoid discomfort, the strings should be cut so that 3 cm hang out of the cervix.)

### **Severe pain in lower abdomen (suspected pelvic inflammatory disease)**

- Some common signs and symptoms of PID often also occur with other abdominal conditions, such as ectopic pregnancy. If ectopic pregnancy is ruled out, assess for PID.
- If possible, do abdominal and pelvic examinations for signs that would indicate PID.
- If a pelvic examination is not possible, and she has a combination of the following signs and symptoms in addition to lower abdominal pain, suspect PID:
  - Unusual vaginal discharge
  - Fever or chills
  - Pain during sex or urination
  - Bleeding after sex or between monthly bleeding
  - Nausea and vomiting
  - A tender pelvic mass
  - Pain when the abdomen is gently pressed (direct abdominal tenderness) or when gently pressed and then suddenly released (rebound abdominal tenderness).
- Treat PID or immediately refer for treatment:
  - Because of the serious consequences of PID, health care providers should treat all suspected cases, based on the signs and symptoms above. Treatment should be started as soon as possible. Treatment is more effective at preventing long-term complications when appropriate antibiotics are given immediately.
  - Treat for gonorrhoea, chlamydia, and anaerobic bacterial infections. Counsel the client about condom use and, if possible, give her condoms.
  - There is no need to remove the IUCD if she wants to continue using it. If she wants it removed, take it out after starting antibiotic treatment.

### **Severe pain in lower abdomen (suspected ectopic pregnancy)**

- Many conditions can cause severe abdominal pain. Be particularly alert for additional signs or symptoms of ectopic pregnancy, which is rare but can be life-threatening.
- In the early stages of ectopic pregnancy, symptoms may be absent or mild, but eventually they will become severe. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy:
  - Unusual abdominal pain or tenderness
  - Abnormal vaginal bleeding or no monthly bleeding—especially if this is a change from her usual bleeding pattern
  - Light-headedness or dizziness
  - Fainting.
- If ectopic pregnancy or other serious health condition is suspected, refer at once for immediate diagnosis and care.
- If the client does not have these additional symptoms or signs, assess for PID.

### **Suspected uterine puncturing (perforation)**

- If puncturing is suspected at the time of insertion or sounding of the uterus, stop the procedure immediately (and remove the IUCD if inserted). Observe the client in the clinic carefully:
  - For the first hour, keep the woman at bed rest and check her vital signs (blood pressure, pulse, respiration, and temperature) every 5 to 10 minutes.
  - If the woman remains stable after one hour, check for signs of intra-abdominal bleeding, such as low hematocrit or hemoglobin, if possible, and her vital signs. Observe for several more hours. If she has no signs or symptoms, she can be sent home, but she should avoid sex for 2 weeks. Help her choose another method.
  - If she has a rapid pulse and falling blood pressure, or new pain or increasing pain around the uterus, refer her to a higher level of care.
  - If uterine perforation is suspected within 6 weeks after insertion or if it is suspected later and is causing symptoms, refer the client for evaluation to a clinician experienced at removing such IUCDs.

### **IUCD partially comes out (partial expulsion)**

- If the IUCD partially comes out, remove the IUCD. Discuss with the client whether she wants another IUCD or a different method. If she wants another IUCD, she can have one inserted at any time it is reasonably certain she is not pregnant. If the client does not want to continue using an IUCD, help her choose another method.

### **IUCD completely comes out (complete expulsion)**

- If the client reports that the IUCD came out, discuss with her whether she wants another IUCD or a different method. If she wants another IUCD, she can have one inserted at any time it is reasonably certain she is not pregnant.
- If complete expulsion is suspected, and the client does not know whether the IUCD came out, refer for x-ray or ultrasound to assess whether the IUCD might have moved to the abdominal cavity. Give her a backup method to use in the meantime.

### **Missing strings (suggesting possible pregnancy, uterine perforation, or expulsion)**

- Ask the client:
  - Whether and when she saw the IUCD 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 IUCD 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 IUCD 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 IUCD was expelled.

## 8.15 New Problems that May Require Switching Methods

### May or may not be due to the method

#### Unexplained vaginal bleeding (that suggests a medical condition not related to the method)

- Refer or evaluate by history or pelvic examination. Diagnose and treat as appropriate.
- She can continue using the IUCD while her condition is being evaluated.
- If bleeding is caused by STI or PID, she can continue using the IUCD during treatment.

#### Suspected pregnancy

- Assess for pregnancy, including ectopic pregnancy.
- Explain that an IUCD in the uterus during pregnancy increases the risk of preterm delivery or miscarriage, including infected (septic) miscarriage during the first or second trimester, which can be life-threatening.
- If the woman does not want to continue the pregnancy, counsel her according to program guidelines.
- If she continues the pregnancy:
  - Advise her that it is best to remove the IUCD.
  - Explain the risks of pregnancy with an IUCD in place. Early removal of the IUCD reduces these risks, although the removal procedure itself involves a small risk of miscarriage.
  - If she agrees to removal, gently remove the IUCD or refer for removal.
  - Explain that she should return at once if she develops any signs of miscarriage or septic miscarriage (vaginal bleeding, cramping, pain, abnormal vaginal discharge, or fever).
  - If she chooses to keep the IUCD, her pregnancy should be followed closely by a nurse or doctor. She should see a nurse or doctor at once if she develops any signs of septic miscarriage.
- If the IUCD strings cannot be found in the cervical canal and the IUCD cannot be safely retrieved, refer for ultrasound, if possible, to determine whether the IUCD is still in the uterus. If it is, or if ultrasound is not available, her pregnancy should be followed closely. She should seek care at once if she develops any signs of septic miscarriage.

## 8.16 Questions and Answers about IUCDs

**1. Can an IUCD travel from the woman's uterus to other parts of her body, such as her heart or her brain?**

No, an IUCD cannot travel to any other part of the body. It is too large to travel to other parts of the body. Very rarely, during insertion, an IUCD may perforate the uterine wall and enter the abdominal cavity. In that case it stays in the abdomen. If this happens, a clinician will have to perform a small operation to remove the IUCD. Show the client a picture or model of the uterus with the IUCD in place to help her understand where the IUCD will be placed.

**2. Can an IUCD cause discomfort to the sexual partner during sex?**

A correctly placed IUCD will not be felt by a partner during sex. Sometimes the IUCD strings may be felt, and can be shortened if necessary. If a partner reports feeling something hard on penetration, the IUCD placement should be checked to exclude partial protrusion through the cervix because, in addition to partner discomfort, this would put her at risk of pregnancy.

**3. Does the IUCD cause pelvic inflammatory disease?**

By itself, the IUCD does not cause PID. Gonorrhoea and chlamydia are the primary direct causes of PID. IUCD insertion when a woman has gonorrhoea or chlamydia may lead to PID, however. This does not happen often. When it does, it is most likely to occur in the first 20 days after IUCD insertion. It has been estimated that, in a group of clients where STIs are common and screening questions identify half the STI cases, there might be 1 case of PID in every 666 IUCD insertions (or fewer than 2 per 1,000).

**4. Can an IUCD make a woman permanently infertile?**

No. A woman who was fertile before having an IUCD will be fertile after its removal, as long as there has been no intervening tubal damage secondary to an episode of PID. A woman can become pregnant once the IUCD is removed just as quickly as a woman who has never used an IUCD. Good studies find no increased risk of infertility among women who have used IUCDs, including young women and women with no children.

**5. Can women who have not yet had children use IUCDs?**

Yes. Nulliparous women may use IUCDs if they are low risk for STIs and do not have a history of ectopic pregnancy. They do, however, have a slightly higher risk of IUCD expulsion because their uterus may be smaller than the uterus of a woman who has given birth.

**6. Should a woman have a "rest period" after using her IUCD for several years or after the IUCD reaches its recommended time for removal?**

No. This is not necessary, and it could be harmful. Removing the old IUCD and immediately inserting a new IUCD poses less risk of infection than 2 separate procedures. Also, a woman could become pregnant during a "rest period" before her new IUCD is inserted.

**7. Should antibiotics be routinely given before IUCD insertion?**

No. Most recent research done where STIs are not common suggests that PID risk is low with or without antibiotics. There is little risk of infection when appropriate questions to screen for STI risk are used and IUCD insertion is done with proper infection-prevention procedures, including the no-touch insertion technique (see Preventing Infection at IUCD

Insertion in the Clinical Procedures section below for more information on this technique). Antibiotics may be considered, however, in areas where STIs are common and STI screening is limited.

**8. Must an IUCD be inserted only during a woman's monthly bleeding?**

No. For a woman having menstrual cycles, an IUCD can be inserted at any time during her menstrual cycle if it is reasonably certain that the woman is not pregnant. Inserting the IUCD during her monthly bleeding may be a good time because she is not likely to be pregnant, and insertion may be easier. It is not as easy to see signs of infection during monthly bleeding, however.

**9. Should a woman be denied an IUCD because she does not want to check her IUCD strings?**

No. A woman should not be denied an IUCD because she is unwilling to check the strings. The importance of checking the IUCD strings has been overemphasized. It is uncommon for an IUCD to come out, and it is rare for it to come out without the woman noticing.

The IUCD is most likely to come out during the first few months after IUCD insertion, during monthly bleeding, among women who have had an IUCD inserted soon after childbirth, a second-trimester abortion, or miscarriage, and among women who have never been pregnant. A woman can check her IUCD strings if she wants reassurance that it is still in place. Or, if she does not want to check her strings, she can watch carefully in the first month or so and during monthly bleeding to see if the IUCD has come out.

**10. Do IUCDs increase the risk of ectopic pregnancy?**

No. On the contrary, IUCDs greatly reduce the risk of ectopic pregnancy. Ectopic pregnancies are rare among IUCD users. The rate of ectopic pregnancy among women with IUCDs is 12 per 10,000 women per year. The rate of ectopic pregnancy among women in the United States using no contraceptive method is 65 per 10,000 women per year.

On the rare occasions that the IUCD fails and pregnancy occurs, 6 to 8 of every 100 of these pregnancies are ectopic. Thus, the great majority of pregnancies after IUCD failure are not ectopic. Still, ectopic pregnancy can be life-threatening, so a provider should be aware that ectopic pregnancy is possible if the IUCD fails.

**11. If a current IUCD user has an STI or has become at very high individual risk of becoming infected with an STI, should her IUCD be removed?**

No. If a woman develops a new STI after her IUCD has been inserted, she is not especially at risk of developing PID because of the IUCD. She can continue to use the IUCD while she is being treated for the STI. Removing the IUCD has no benefit and may leave her at risk of unwanted pregnancy. Counsel her on condom use and other strategies to avoid STIs in the future.

## Copper T Clinical Procedures

*(Copper T clinical procedure steps adapted from Solter, Cathy 2008)*

### Insertion Procedure for TCu-380A IUCD

#### Instruments and essential supplies

The following items are recommended for each IUCD insertion

- IUCD in an unopened, undamaged, sterile package that is not beyond its expiration date
- Drape to cover the woman's pelvic area
- Clean cloth to place between the woman and the examination table
- Gloves (sterile or high-level disinfected gloves)
- Light source sufficient to visualize cervix
- Bowl containing antiseptic solution (chlorhexidine or povidone iodine) and gauze/ cotton balls
- Bivalve speculum
- Uterine tenaculum
- Uterine sound
- Sharp scissors for trimming threads
- Uterine dressing or sponge forceps
- Chlorine solution 0.5%
- 5 buckets
- 3 leak-proof containers
- Bin liners
- Detergent
- Brush
- Autoclave/steriliser/chemicals for high level disinfection
- Utility gloves
- Personal protective equipment
- Individual towel
- Soap and hand rub
- Dry gauze or cotton balls

#### Client Assessment Steps

1. Ensure that equipment and supplies are available and ready to use.
2. Have the client empty her bladder.
3. Help the client onto the examination table.
4. Tell the client what is going to be done, and ask her if she has any questions.
5. Wash hands thoroughly and dry them.
6. Palpate the abdomen.
7. Wash hands thoroughly and dry them again.
8. Put clean or HLD gloves on both hands.
9. Inspect the external genitalia.

Note:

- If findings are normal, perform the bimanual exam first and the speculum exam second.
- If there are potential problems (genital tract infection), perform the speculum exam first and a bimanual exam second.

10. Perform a bimanual exam to determine size, position, consistency, and mobility of the uterus. Any tenderness might indicate infection.
  - Perform rectovaginal exam only if indicated.
  - If rectovaginal exam is performed, change gloves before continuing.
11. Perform a speculum exam. Check for signs of genital tract infections. (Note: If laboratory testing is indicated and available, take samples now.)

## Inserting the Loaded Copper T

Using gentle, “no-touch” aseptic technique throughout, perform the following steps:

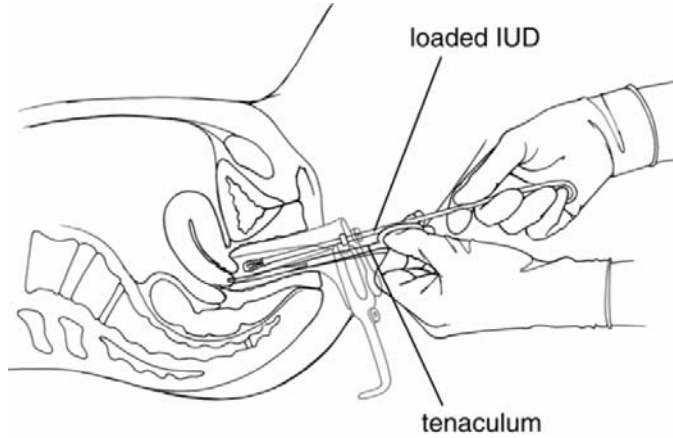
1. Prepare the client: Give the woman a brief overview of the procedure, encourage her to ask questions, and provide reassurance as needed. Remind her to let you know if she feels any pain.
2. Insert a speculum into the vagina to inspect the cervix.
3. Cleanse the cervical os and vaginal wall with appropriate antiseptic.
4. Slowly insert an HLD or sterile tenaculum through the speculum and gently grasp the cervix (ask the client to cough while grasping the cervix with the tenaculum) and apply gentle traction (to hold the cervix and uterus steady).
5. Slowly and gently insert the HLD or sterile sound through the cervix to measure the depth and position of uterus. (See procedure for sounding, below.)
6. Load the IUCD into the inserter while both are still in the unopened, sterile package using the “no touch” technique. (See procedure for Loading the Copper T.)
7. Set the blue depth-gauge to the measurement of the uterus.
8. Grasp the tenaculum (which is still in place on the cervix after sounding the uterus) and pull firmly to pull the uterine cavity and cervical canal in line with the vaginal canal.
  - Slowly and gently place the loaded inserter tube through the cervical canal. Keep the blue depth-gauge in a horizontal position. (**Figure 1**, below)
  - Gently advance the insertion tube until the blue depth-gauge touches the cervix or you feel a slight resistance of the uterine fundus. Keep the blue depth-gauge in a horizontal position. (**Figure 2**)
  - Hold the tenaculum and the white rod in place in one hand. With your other hand, withdraw (pull toward you) the inserter tube until it touches the thumb grip of the white rod. This will release the arms of the TCu 380A high in the uterine fundus. (**Figure 3**)
9. Once the arms have been released, again very gently and carefully, push the inserter tube upward, toward the top of the uterus, until you feel a slight resistance. (**Figure 4a**)
  - This step ensures that the arms of the T are as high as possible in the uterus.
  - Hold the inserter tube still while removing the white rod.
10. Gently and slowly withdraw the inserter tube from the cervical canal. The strings should be visible protruding from the uterus. (**Figure.4b**)
11. Use HLD or sterile scissors to cut the strings so that they protrude only 3 cm into the vagina or hanging out of the cervix.

- 12.** Gently remove the tenaculum and speculum and put all of the instruments used in 0.5% chlorine solution for 10 minutes for decontamination.
- 13.** Examine the cervix for bleeding. If the cervix is bleeding from the tenaculum site, press a swab to the site, using clean forceps, until the bleeding stops.
- 14.** Help the client get up from the table very slowly. (Advise the woman to remain on the examination table until she feels ready to get dressed.). Watch her in case she becomes dizzy or feels faint. Teach her how and when to check the strings. Ask her to check the strings now. Ask her if she has any questions and answer them in simple words she can understand. Tell her to return in 3 to 6 weeks. If she can read, give her written instructions or tell her the warning signs of problems and how to get help if she needs it.

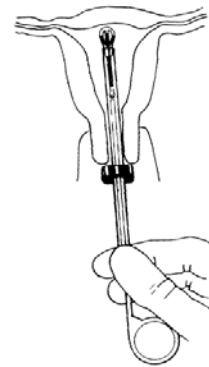
(The Population Council and PATH 1989)



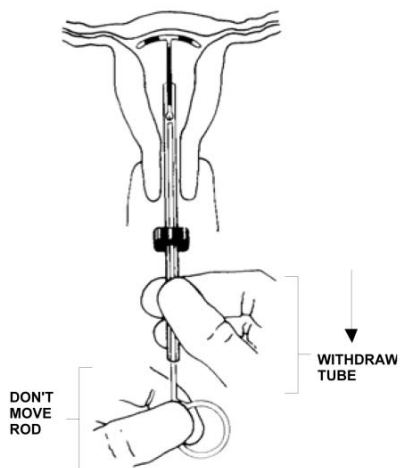
**Figure 1. Inserting loaded IUCD**



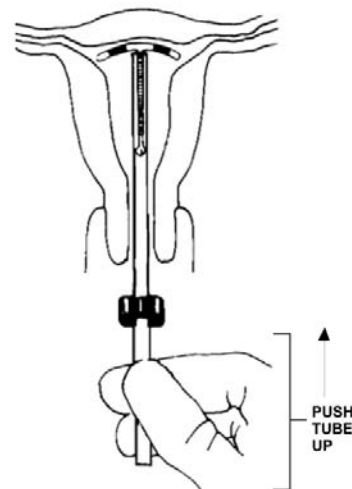
**Figure 2. Advancing the Loaded IUD**



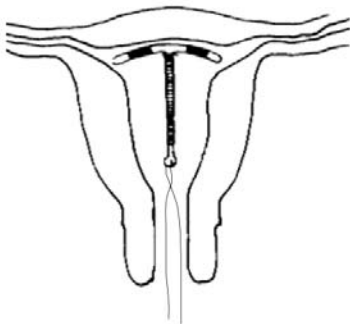
**Figure 3. Withdrawing the Insertion Tube to Release IUD Arms**



**Figure 4a. Positioning IUD High in the Uterus**



**Figure 4b. IUD Fully Inserted in Uterus**



*(Illustrations courtesy of Jhpiego. Source: Bluestone J, Chase R and Lu ER, 2006)*

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# Preventing Infection at IUCD Insertion

Proper insertion technique can help prevent many problems, such as infection, expulsion, and perforation.

- Follow proper infection-prevention procedures.
- Use high-level disinfected or sterile instruments.
- Use a new, sterile IUCD that is packaged with its inserter.
- Use the "no-touch" insertion technique. This includes not letting the loaded IUCD or uterine sound touch any unsterile surfaces (for example, hands, speculum, vagina, table top). The no-touch technique involves:
  - Loading the IUCD into the inserter while the IUCD is still in the sterile package, to avoid touching the IUCD directly
  - Cleaning the cervix thoroughly with antiseptic before IUCD insertion
  - Being careful not to touch the vaginal wall or speculum blades with the uterine sound or loaded IUCD inserter
  - Passing both the uterine sound and the loaded IUCD inserter only once each through the cervical canal.

(WHO/RHR and CCP/INFO Project 2008)

## Passing a Uterine Sound

### Purpose of sounding the uterus

- To check the position of the uterus (to confirm findings of the pelvic exam) and check for obstructions in the cervical canal
- To measure the direction of the cervical canal and uterine cavity, so that the inserter can be positioned appropriately to follow the canal
- To measure the length from external cervical os to the uterine fundus so that the blue depth-gauge on the TCu 380A insertion tube can be set at the same distance, so that the IUCD will be placed high in the uterine fundus.

### Procedure for sounding the uterus

Use gentle, no touch (aseptic) technique throughout.

**Note:** Before attempting to sound the uterus, a screening speculum and bimanual exam should have been performed to assess the position of the uterus and rule out the possibility of vaginal and cervical infection and to determine the size of the uterus.

1. Put on HLD or sterile gloves.
2. Insert the speculum (if not already done.) Thoroughly clean the cervix with an antiseptic solution.
3. Apply the HLD or sterile tenaculum at the 10 o'clock and 2 o'clock positions on the cervix. Close the tenaculum one notch at a time, slowly, and no further than necessary.
4. Pick up the handle of the sound, do not touch the tip. Turn the sound so that it is in the same direction as the uterus.

5. Gently pass the HLD or sterile tip of the uterine sound into the cervical canal. At the same time, keep a firm grip with the tenaculum. (Be careful not to touch the walls of the vagina with tip of the sound.)
  - Carefully and gently, insert the uterine sound in the direction of the uterus while gently pulling steadily downwards and outward on the tenaculum. If there is resistance at the internal os, use a smaller sound, if available.
  - Do **not** attempt to dilate the cervix unless well-qualified. **Gentle** traction on the tenaculum may enable the sound to pass more easily.
  - If client begins to show symptoms of fainting or pallor with slow heart rate, STOP.
6. Slowly withdraw the sound; it will be wet and darker where it was in the uterus.
  - Place the sound next to the IUCD and set the blue depth-gauge at the depth of the uterus. Determine the length of the uterus by noting the mucus and/or blood on the sound.
  - The average uterus will sound to a depth of 6 to 8 cm.
  - Note: If the uterus sounds to a depth of 10 cm or more, the sound may have perforated the uterus, or the uterus may be enlarged due to tumours or pregnancy. DO NOT insert an IUCD.
7. If perforation is suspected, observe the client in the clinic carefully.
  - For the first hour, keep the woman in bed and check the pulse and blood pressure every 5 to 10 minutes.
  - If the woman remains stable after 1 hour, check the hematocrit/hemoglobin if possible, allow her to walk, check vital signs as needed, and observe for several more hours. If she has no signs or symptoms, she can be sent home but should avoid intercourse for 2 weeks. Help her make an informed choice about a different (backup) contraceptive.
  - If there is a rapid pulse and falling blood pressure, or new pain or increasing pain around the uterus, hospitalization is needed.

## Loading the TCu 380A in Its Sterile Package

**Important: Do not open the IUCD's sterile package** or load it until the final decision to insert an IUCD has been made (i.e., until after the pelvic examination, including both bimanual and speculum exams, has been performed). In addition, do not bend the "arms" of the "T" into the insertion tube more than 5 minutes before it is introduced into the uterus.

While performing the following steps, do not allow the IUCD or the IUCD insertion assembly to touch any non-sterile surfaces (e.g., your hands, the table) that may contaminate it.

### Step 1:

**Make sure that the vertical stem of the T is fully inside the inserter tube** (the T can be shifted through the unopened package) and that the end of the inserter tube opposite the T is close to the **seal** at the end of the package. **(Figure 8b.1)**

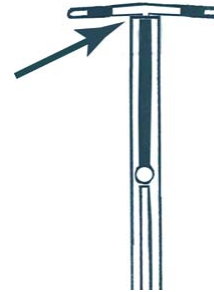


Figure 8b.1.

### Step 2:

Place the package on a clean, hard, flat surface with the **clear plastic side up**.

- Partially open the end of the package **farthest** from the IUCD.
- Open the package approximately halfway to the blue **depth-gauge**.

### Step 3:

Pick up the package, holding the open end up towards the ceiling so that the contents do not fall out.

- Bend the clear **plastic cover** and **white backing "flap"** at the open end of the package away from each other. (This will help maintain sterility of the **white rod** during loading.)
- Using your free hand, grasp the **white rod**, which is behind the **I.D. card**, by the thumb grip and remove it from the package. Be careful not to touch the tip of the white rod or brush it against another surface.
- Put the **white rod** inside the **inserter tube (Figure 8b.2)** and gently push the rod up into the inserter tube until it almost touches the bottom of the T. **(Figure 8b.3)**



Figure 8b.2: Placing white rod inside insertion tube.

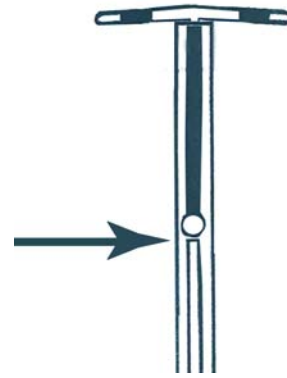


Figure 8b.3: White rod almost touching bottom of "T"

**Step 4:**

Release the **white backing flap** so that it is flat, and place the package on a flat surface with the **clear plastic side up**.

**Step 5:**

Through the **clear plastic cover**, place your thumb and index finger over the ends of the **horizontal arms** of the T and hold the T in place.

- At the open end of the package, use your free hand to push the I.D. card so that it slides underneath the T and stops at the top seal of the package.
- While still holding the tips of the horizontal arms of the T, use your free hand to grasp the inserter tube against the arms of the T, as indicated by the arrow in **Figure 8b.4**. This will start the arms of the T bending downward, towards the stem of the T, as indicated in the drawing on the I.D. card.

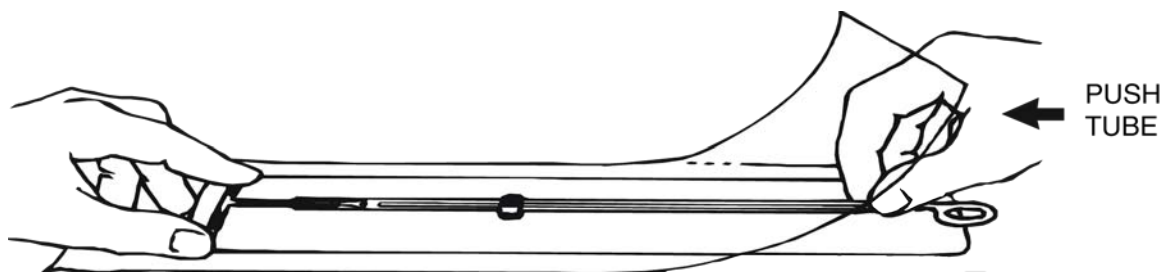


Figure 8b.4: Positioning the IUCD and bending arms of "T"

### Step 6:

Continue bending the arms of the T by bringing the thumb and index finger together.

- When the arms have folded enough to touch the sides of the inserter tube, pull the **inserter tube** out from under the tips of the arms. Then push and rotate the **inserter tube** onto the tips of the arms so that the arms become trapped inside the inserter tube next to the stem. **(Figure 8b.5)**
- Insert the folded arms into the tube only as far as necessary to ensure retention of the arms. **Do not try to push the copper bands on the arms into the inserter tube; they will not fit.**

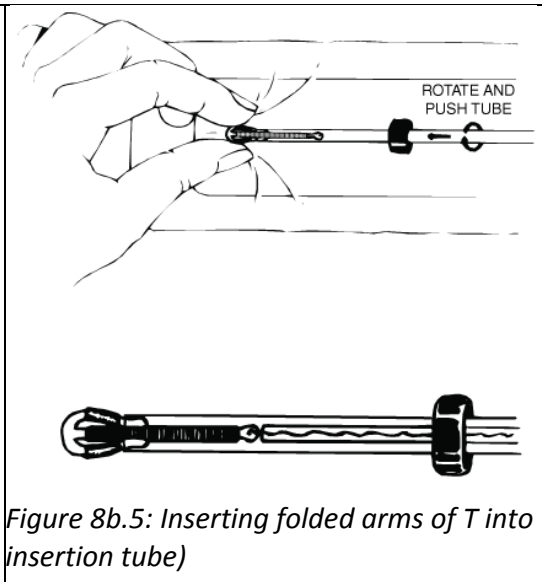


Figure 8b.5: Inserting folded arms of T into insertion tube)

### Step 7:

The **blue depth-gauge** on the **inserter tube** is used to mark the depth of the uterus and to show the direction in which the arms of the T will unfold once they are released from the inserter tube. Holding the blue depth-gauge in place through the clear plastic wrapper, grasp the inserter tube at the open end of the package with your free hand.

- Pull the inserter tube gently until the distance between the top of the folded T and the edge of the blue depth-gauge closest to the T is equal to the depth of the uterus as measured on the uterine sound.
- Rotate the inserter tube so that the long axis of the blue depth-gauge is on the same horizontal plane as the arms of the T. Set the blue depth-gauge to the appropriate measurement. **(Figure 8b.6)**

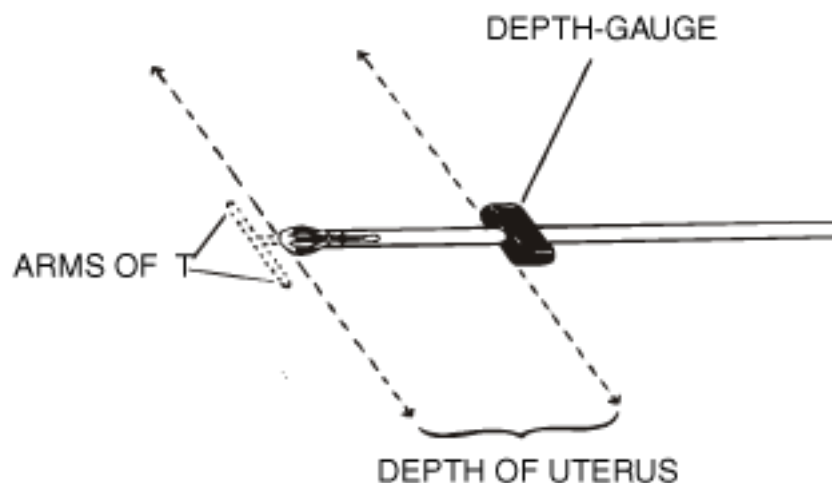
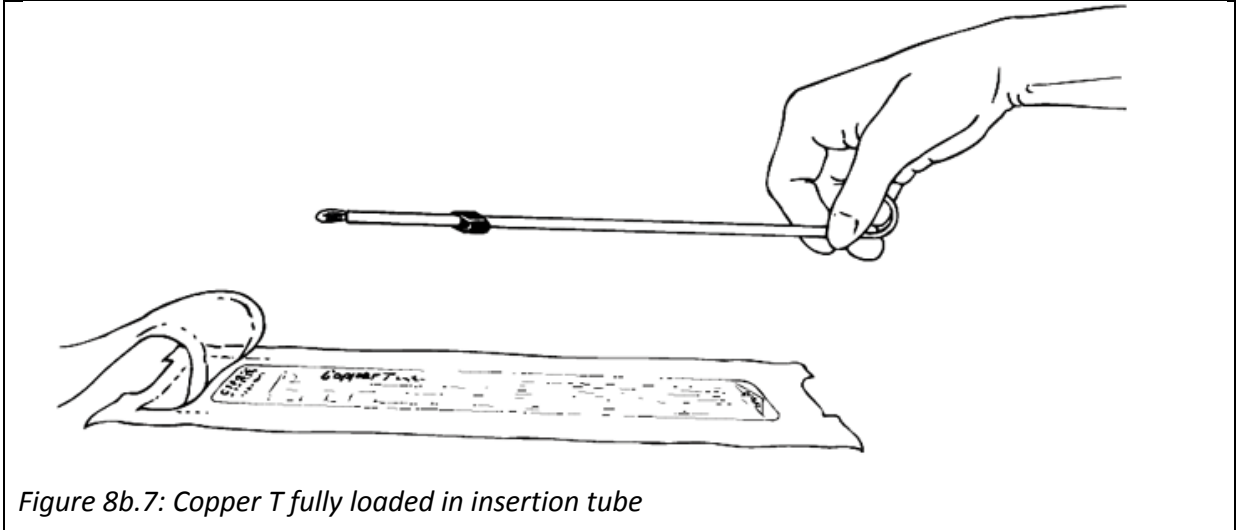


Figure 8b.6: Setting depth of uterus on insertion tube

### Step 8:

The IUCD is now ready to be placed in the woman's uterus. Carefully peel the clear plastic cover of the package away from the white backing.

- Lift the loaded inserter, keeping it horizontal, so that the T or white rod doesn't fall out (**Figure 8b.7**).
- Be careful not to push the white rod towards the T until you are ready to release the T in the fundus.
- **Do not let the inserter tube or the tip of the IUCD touch any unsterile surfaces. If it touches any unsterile surfaces, it must not be inserted in the uterus. Throw it away and get another one.**



*Figure 8b.7: Copper T fully loaded in insertion tube*

*(Illustrations courtesy of Jhpiego. Source: Bluestone, J., R. Chase and E.R. Lu 2006)*

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## IUCD Case Studies

(Adapted from Solter, Cathy 2008)

### Case Study 1

#### **Woman requests IUCD and is not having her menses**

A 21-year-old woman had normal delivery of her second child 8 weeks ago. She is exclusively breastfeeding. She has not had a menstrual period since delivery. She used an IUCD between her 2 pregnancies and was happy with it. She has had intercourse in the last month. A pelvic examination reveals that the uterus anterior is small, firm, and non-tender.

#### **Questions for discussion:**

1. Is it appropriate to insert an IUCD in this client today? Discuss the pros and cons.
2. If you do not provide her with an IUCD today, what information will you give her?
3. Under what circumstances is it appropriate to go ahead with an IUCD insertion in a client who is not during or just after her menstrual period?

### Case Study 2

#### **PID with IUCD**

A 20-year-old woman with 1 child has been using COCs for one year, but recently she has developed severe migraine headaches with aura. You recommended that she discontinue the pills, so she has chosen to try an IUCD. She had a TCu-380A inserted 5 months ago. She has returned and tells you that she noted a yellowish, bloody discharge and pain with intercourse starting 3 weeks ago.

#### **Examination findings:**

- Temp: 37 degrees
- BP: 120/75;
- Does not appear to be in any discomfort
- Abdominal exam shows no upper abdominal pain or guarding; lower abdomen slightly tender to pressure, no guarding
- Pelvic exam normal
- External genitalia and vagina: IUCD string protruding from os
- There is a mucopurulent discharge emanating from the cervix
- Bimanual exam elicits tenderness on cervical motion in any direction
- Adnexa are also tender to pressure, but no mass is noted
- Uterus is midposition, firm, tender to pressure, fairly mobile



**Questions for discussion:**

1. Do IUCDs cause PID?
2. What practices in the standard IUCD insertion protocol are specifically designed to prevent infections? (Use IUCD Learning Guides as aids in answering this question.)
3. How will you manage her case?

**Case Study 3****Missing strings**

A 28-year-old woman with 1 child who wishes to delay her next pregnancy for 3 years had a TCu-380A inserted 6 months ago. The insertion was very painful, and the pain persisted for several hours. She has had no problems since then and has been able to feel the strings herself. The client's last menses started 2 weeks ago, and it was normal; but since her menses, she has not been able to feel the IUCD strings. She did not see the IUCD come out during her period.

Abdominal exam and pelvic exam are normal; the uterus is retroverted, small, firm, nontender. Adnexa are nontender, and no masses or swelling are noted. The cervix is normal in appearance. No IUCD strings are visible.

**Questions for discussion:**

1. What are the possible reasons for the missing strings?
2. What will you recommend as a management plan for this woman?

# IUCD Case Studies Answer Key

## Case Study 1

### Woman requests IUCD and is not having her menses

#### Questions for discussion:

1. Is it appropriate to insert an IUCD in this client today? Discuss the pros and cons.
2. If you do not provide her with an IUCD today, what information will you give her?
3. Under what circumstances is it appropriate to go ahead with an IUCD insertion in a client when it is not during or just after her menstrual period?

#### Discussion

It is important that the practitioner be “reasonably certain” that the client is not pregnant. In this example, she is protected by the lactational amenorrhea method, so she should be provided with an IUCD if she has no other medical reasons to deny.

It is appropriate to insert an IUCD in a client when it is not during or just after her menstrual period if she has no medical conditions that contraindicate IUCD insertion and:

- She is less than 48 hours postpartum
- She is more than 4 weeks postpartum and has not had intercourse
- She is more than 4 weeks postpartum and has had intercourse, but has used a reliable method of contraception
- She is less than 6 months postpartum, exclusively breastfeeding, and has no menses
- She is less than 7 days postabortion and the uterus is not infected, or
- At any time in the menstrual cycle as long as the practitioner is “reasonably certain” that she is not pregnant.

## Case Study 2

### PID with IUCD

#### Questions for discussion:

1. Do IUCDs cause PID?
2. What practices in the standard IUCD insertion protocol are specifically designed to prevent infections? (Use Clinical and Counselling Skill Learning Guides founds at the end of this Unit as aids in answering this question.)
3. How will you manage her case?

#### Discussion

The IUCD does not cause PID. However, it does increase the risk of infection if the woman had an STI at the time of insertion. An infection in the first 3 weeks after insertion may be due to poor infection-prevention procedures at the time of insertion or due to presence of a cervical STI at the time of insertion. Since this infection developed several months post-insertion, it is probably due to new exposure to infection. Before selecting an IUCD the client should be asked

about her number of sexual partners, if her sexual partner(s) has/have other sexual partners, and her history of STIs.

**Plan:** If the client does have an infection, do not remove the IUCD, but treat the infection with antibiotics. She should be counselled about how to avoid STIs, advised to use condoms and to encourage her partner(s) to be seen for treatment. If the client wants the IUCD removed, treat the infection first and then remove the IUCD.

## Case Study 3

### Missing strings

#### Questions for discussion:

1. What are the possible reasons for the missing strings?
2. What will you recommend as a management plan for this woman?

#### Discussion

If a client cannot feel the strings of her IUCD, it could mean that the IUCD has perforated the uterus or that it has come out with the menses. In this case either could have happened. The fact that she had no problem feeling her strings for the first 6 months and then stopped being able to feel them after her period probably means that the IUCD came out with her period (even if she did not see it).

**Plan:** If strings are not noted on exam and client is not pregnant, see if strings can be located with gentle exploration of lower cervical canal with (sterile or HLD) narrow sponge forceps. If you are not able to locate the strings, refer the client to an ob/gyn for further management. Before the client leaves your office, provide her with a supply of condoms to protect her from pregnancy in case the IUCD is not in the uterus.

# IUCD Role Plays

(Adapted from Solter, Cathy 2008)

## Role Play 1: General Counselling about IUCDs

Participants should be able to demonstrate key messages about the IUCD. Playing the role of the provider, practice telling the key messages to:

- A very young woman
- A 40-year-old woman
- A woman who believes her husband has another partner.

## Role Play 2: Deciding to Choose an IUCD - Client Assessment and Counselling

Role-play an IUCD counselling session between a provider and client for each of the situations below.

- A 17-year-old woman with no children who wants to become pregnant in 3 years
- A 35-year-old woman with 4 children who has regular periods and does not want any more children
- A 27-year-old woman with 2 children who has had PID once since the birth of her last child and wants more children in the future
- A 20-year-old woman who is exclusively breastfeeding a 4-week-old baby
- A 19-year-old sex worker who has 4 children, a history of recurrent PID, hepatitis, and is HIV-infected
- A 32-year-old woman with 2 children who has heavy periods (she needs to change her pads every 2 hours and bleeds for 8 days) and on the first two days her cramps are so strong that she cannot go to her job
- A 27-year-old woman with 6 children; she is very pale. She says that after her last baby was born, 6 months ago, she bled so much she had to go to the hospital. She complains that she has no strength. She does not want any more children.
- A 30-year-old woman with 4 children; she is not sure if she wants any more children. She is in a mutually monogamous relationship.
- A 30-year-old woman with 4 children. She is not sure if she wants any more children. Her husband travels for work, and she thinks he may be having a relationship with a woman in another town.
- A 26-year-old woman with 3 children. Her husband is a transport worker and HIV-infected. She has AIDS, but is currently being treated with ARVs and feels well. He left her and took the 2 older children when she became ill.

## IUCD Quiz Questions

**Questions 1–17.** Indicate whether the following statements about IUCDs are **true** or **false** by writing a “T” for true or an “F” for false in the space provided before each statement.

- \_\_\_ 1. The IUCD is a small, flexible contraceptive device made of plastic and other materials that is placed in the uterine cavity to prevent pregnancy.
- \_\_\_ 2. The TCu-380A IUCD is effective for up to 7 years.
- \_\_\_ 3. Women experience a rapid return to fertility when an IUCD is removed.
- \_\_\_ 4. The most common side effects of the IUCD are cramping and pain during menstrual periods.
- \_\_\_ 5. A woman who engages in hard physical work is eligible for IUCDs.
- \_\_\_ 6. A woman who has gonorrhoea or chlamydia should NOT have an IUCD inserted until the infection has been resolved.
- \_\_\_ 7. A woman should NOT have an IUCD inserted during her monthly bleeding.
- \_\_\_ 8. A woman who has chosen an IUCD should be told what to expect during insertion.
- \_\_\_ 9. Prior to IUCD insertion, a pelvic exam is done to rule out infection, anatomical abnormalities, and the size and position of the uterus.
- \_\_\_ 10. The IUCD provides protection against some STIs.
- \_\_\_ 11. If a woman cannot come to a follow-up visit at the clinic where the IUCD will be inserted she should be denied an IUCD and told to have one inserted in a place that she can revisit.
- \_\_\_ 12. Severe prolonged bleeding with anaemia is an indication for IUCD removal.
- \_\_\_ 13. When it is time to remove an IUCD, it must be done during the woman’s monthly bleeding to avoid complications.
- \_\_\_ 14. It is best to dismiss a client’s side effects so that she will not want her IUCD removed.
- \_\_\_ 15. Non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen (400 mg) and aspirin (235-650 mg) can be used to treat heavy bleeding and irregular bleeding.
- \_\_\_ 16. A woman’s partner can sometimes be bothered by feeling the IUCD strings during sexual intercourse. This happens because the strings are cut too short.
- \_\_\_ 17. A woman who develops pelvic inflammatory disease (PID) must have her IUCD removed.

**Questions 18–25: Circle the letter that offers the best response to each question.**

18. The IUCD used in Malawi is:

- a. Called the Copper T or the TCu-380A
- b. Is effective for at least 12 years
- c. Has a coil of copper wire on its vertical arm and 2 copper sleeves
- d. All of the above

19. The TCu-380A IUCD works by:

- a. Preventing ovulation
- b. Thickening cervical mucus

- c. Preventing sperm from entering the fallopian tubes
  - d. Damaging sperm and egg before they meet
20. In counselling a woman about the advantages of the TCu-380A IUCD, a provider would inform her that the IUCD:
- a. Is permanent
  - b. Is highly effective
  - c. Has few side effects for most women
  - d. Is effective in preventing anaemia
21. Which of the following makes a woman ineligible for an IUCD?
- a. Is pregnant
  - b. Has no children
  - c. Has a history of ectopic pregnancy
  - d. Is under age 20
  - e. (b) and (d) above
22. Although rare, when is IUCD expulsion most likely to occur?
- a. During the first few hours after insertion
  - b. During the first few days after insertion
  - c. During the first few months after insertion
  - d. After 8 years
23. The “no-touch” IUCD insertion technique refers to:
- a. Proper hand washing without touching a towel
  - b. Not touching the abdomen without cleaning it with an antiseptic solution
  - c. Not touching instruments without putting gloves on first
  - d. Not letting the loaded IUCD or uterine sound touch any unsterile surface
24. Which of the following is a warning sign that a client may be having a problem with her IUCD and should seek medical attention:
- a. Pain with sexual intercourse
  - b. Cramping with menses
  - c. Increased length of menstrual cycle
  - d. Spotting in between periods
25. IUCD clients should be counselled
- a. Before the insertion
  - b. After insertion
  - c. During each follow-up visit
  - d. All of the above

## IUCD Quiz Questions Answer Key

**Questions 1–17.** Indicate whether the following statements about IUCDs are **true** or **false** by writing a **“T”** for true or an **“F”** for false in the space provided before each statement.

- T \_ 1. The IUCD is a small, flexible contraceptive device made of plastic and other materials that is placed in the uterine cavity to prevent pregnancy.
- F \_ 2. The TCu-380A IUCD is effective for up to 7 years. **The TCu-380A is effective for at least 12 years.**
- T \_ 3. Women experience a rapid return to fertility when an IUCD is removed.
- T \_ 4. The most common side effects of the IUCD are cramping and pain during menstrual periods.
- T \_ 5. A woman who engages in hard physical work is eligible for IUCDs.
- T \_ 6. A woman who has gonorrhoea or chlamydia should NOT have an IUCD inserted until the infection has been resolved.
- F \_ 7. A woman should NOT have an IUCD inserted during her monthly bleeding. **A woman who is having menstrual cycles can have an IUCD inserted at any time of the month.**
- T \_ 8. A woman who has chosen an IUCD should be told what to expect during insertion.
- T \_ 9. Prior to IUCD insertion, a pelvic exam is done to rule out infection, anatomical abnormalities and the size and position of the uterus.
- F \_ 10. The IUCD provides protection against some STIs. **The IUCD provides no protection against STIs/HIV.**
- F \_ 11. If a woman cannot come to a follow-up visit at the clinic where the IUCD will be inserted she should be denied an IUCD and told to have one inserted in a place that she can revisit. **No woman should be denied an IUCD because follow-up would be difficult or not possible.**
- T \_ 12. Severe prolonged bleeding with anaemia is an indication for IUCD removal.
- F \_ 13. When it is time to remove an IUCD, it must be done during the woman’s monthly bleeding to avoid complications. **Removal may be easier during monthly bleeding, but it can be done at any time of the month.**
- F \_ 14. It is best to dismiss a client’s side effects so that she will not want her IUCD removed. **Problems with side effects or complications affect women’s satisfaction and use of IUCDs. They deserve the provider’s attention. If the client reports any side effects or complications, listen to her concerns, give her advice, and, if appropriate, provide treatment.**
- F \_ 15. Non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen (400 mg) and aspirin (235-650 mg) can be used to treat heavy bleeding and irregular bleeding. **NSAIDs can be used to treat heavy bleeding and irregular bleeding; however, aspirin should not be given as it may increase bleeding.**
- T \_ 16. A woman’s partner can sometimes be bothered by feeling the IUCD strings during sexual intercourse. This happens because the strings are cut too short.

F \_ 17. A woman who develops pelvic inflammatory disease (PID) must have her IUCD removed.  
**There is no need to remove the IUCD if she wants to continue using it. If she wants it removed, take it out after starting antibiotic treatment.**

**Questions 18–25: Circle the letter that offers the best response to each question.**

18. The IUCD used in Malawi is:

**d. All of the above**

19. The TCU-380A IUCD works by:

**d. Damaging sperm and egg before they meet**

20. In counselling a woman about the advantages of the TCU-380A IUCD, a provider would inform her that the IUCD:

**b. Is highly effective**

21. Which of the following makes a woman ineligible for an IUCD?

**a. Pregnancy**

22. Although rare, when is IUCD expulsion most likely to occur?

**c. During the first few months after insertion**

23. The “no-touch” IUCD insertion technique refers to:

**d. Not letting the loaded IUCD or uterine sound touch any unsterile surface**

24. Which of the following is a warning sign that a client may be having a problem with her IUCD and should seek medical attention:

**a. Pain with sexual intercourse**

25. IUCD clients should be counselled

**d. All of the above**



# Learning Guide for IUCD Insertion (Copper T 380A)

(to be used by participants)

Rate the performance of each step or task observed using the following rating scale:	
1	<b>Needs Improvement:</b> Step or task not performed correctly or out of sequence (if necessary) or is omitted
2	<b>Competently Performed:</b> Step or task performed correctly in proper sequence (if necessary) but participant not progressing from step to step efficiently
3	<b>Proficiently Performed:</b> Step or task efficiently and precisely performed in the proper sequence (if necessary)

Participant \_\_\_\_\_ Course Dates \_\_\_\_\_

Learning Guide For IUCD Insertion (Copper T 380A)					
Task/Activity	Cases				
<b>BCS+ STEPS 1-9: SEE UNIT 5 FOR BCS+ LEARNING GUIDE</b>					
<b>BCS+ STEP 10: GIVE THE METHOD</b>					
PRE-INSERTION ASSESSMENT					
1. Assemble equipment and supplies.					
2. Have the client empty her bladder.					
3. Help the client onto the examination table.					
4. Tell the client what is going to be done, and ask her if she has any questions.					
5. Wash hands thoroughly and dry them.					
6. Palpate the abdomen.					
7. Wash hands thoroughly and dry them <u>again</u> .					
8. Put clean or high-level disinfected gloves on both hands.					
9. Inspect the external genitalia.					
Note: <ul style="list-style-type: none"> <li>• If findings are normal, perform the bimanual exam first and the speculum exam second.</li> <li>• If there are potential problems (genital tract infection), perform the speculum exam first and a bimanual exam second.</li> </ul>					
10. Perform a bimanual exam to determine size, position, consistency, and mobility of the uterus. Any tenderness might indicate infection. <ul style="list-style-type: none"> <li>• Perform rectovaginal exam only if indicated.</li> <li>• If rectovaginal exam is performed, change gloves before continuing.</li> </ul>					
11. Perform a speculum exam. Check for signs of genital tract infections.					
12. If laboratory testing is indicated and available, take samples.					
<b>INSERTING THE LOADED COPPER T (Use gentle, "no-touch" [aseptic] technique)</b>					
PRE-INSERTION					
1. Prepare the client: Give the woman a brief overview of the procedure, encourage her to ask questions, and provide reassurance as needed. Remind her to let you know if she feels any pain.					
2. Insert a speculum into the vagina to inspect the cervix.					
3. Cleanse the cervical os and vaginal wall with appropriate antiseptic.					
4. Slowly insert an HLD or sterile tenaculum through the speculum and					

## Learning Guide For IUCD Insertion (Copper T 380A)

Task/Activity	Cases				
gently grasp the cervix (ask the client to cough while grasping the cervix with the tenaculum) and apply gentle traction (to hold the cervix and uterus steady).					
5. Insert the HLD or sterile sound through the cervix to measure the depth and position of uterus. (See learning guide for sounding.)					
6. Load the IUCD into the inserter using the “no touch” technique. (See learning guide for loading the Copper T.)					
7. Set the blue depth-gauge to the measurement of the uterus.					
8. Grasp the tenaculum (still on cervix) and pull firmly to pull the uterine cavity and cervical canal in line with the vaginal canal.					
<b>INSERTION STEPS</b>					
1. Slowly and gently place the loaded inserter tube through the cervical canal. Keep the blue depth-gauge in a horizontal position.					
2. Gently advance the insertion tube until the blue depth-gauge touches the cervix or you feel a slight resistance. Keep the blue depth-gauge in a horizontal position.					
3. Hold the tenaculum and the white rod in place in one hand. With your other hand, withdraw the inserter tube until it touches the thumb grip of the white rod, releasing the arms of the Copper T.					
4. Once the arms are released, very gently and carefully, push the inserter tube toward the top of the uterus again, until you feel a slight resistance.					
5. Hold the inserter tube still while removing the white rod.					
6. Gently and slowly withdraw the inserter tube from the cervical canal. The strings should be visible protruding from the uterus.					
7. Use HLD or sterile scissors to cut the strings so that they protrude only 3 cm into the vagina or hanging out of the cervix.					
8. Gently remove the tenaculum and speculum and place all instruments used in 0.5% chlorine solution for 10 minutes for decontamination.					
9. Examine the cervix for bleeding. If bleeding, press a swab to the site, using clean forceps, until the bleeding stops.					
10. Ask client how she is feeling and advise her to remain on the examination table until she feels ready to get dressed.					
<b>POST-INSERTION STEPS</b>					
1. Make client comfortable. Watch in case she becomes dizzy or feels faint. Help her get up from the table when she feels ready.					
2. Teach her how and when to check the strings and ask her to check the strings now.					
2. Before removing the gloves, place all used instruments in 0.5% chlorine solution for 10 minutes for decontamination.					
3. Properly dispose of waste materials.					
4. Process gloves according to recommended infection prevention practices.					
5. Wash hands thoroughly and dry them.					
6. Provide post-insertion instructions (key messages for IUCD users): <ul style="list-style-type: none"> <li>• Basic facts about her IUCD (e.g., type, how long effective, when to replace/remove)</li> <li>• No protection against STIs/HIV; need for condoms if at risk</li> <li>• Possible side effects</li> </ul>					

Learning Guide For IUCD Insertion (Copper T 380A)					
Task/Activity	Cases				
<ul style="list-style-type: none"> <li>• Warning signs</li> <li>• Checking for possible IUCD expulsion</li> <li>• When to return to clinic (in 3 to 6 weeks for follow-up visit)</li> </ul>					
7. Complete client's records.					

# Learning Guide for Sounding the Uterus

Rate the performance of each step or task observed using the following rating scale:

- 1 **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
- 2 **Competently Performed:** Step or task performed correctly in proper sequence (if necessary) but participant not progressing from step to step efficiently
- 3 **Proficiently Performed:** Step or task efficiently and precisely performed in the proper sequence (if necessary)

Participant \_\_\_\_\_ Course Dates \_\_\_\_\_

Learning Guide for Sounding the Uterus					
Task/Activity (Use gentle, no touch (aseptic) technique)	Cases				
1. Put on HLD or sterile gloves.					
2. Insert the speculum (if not already done.) Thoroughly clean the cervix with an antiseptic solution.					
3. Apply the HLD or sterile tenaculum at the 10 o'clock and 2 o'clock positions on the cervix. Close the tenaculum 1 notch at a time, slowly, and no further than necessary.					
4. Pick up the handle of the sound; do not touch the tip. Turn the sound so that it is in the same direction as the uterus.					
5. Gently pass the HLD or sterile tip of the uterine sound into the cervical canal. At the same time, keep a firm grip with the tenaculum. (Be careful not to touch the walls of the vagina with tip of sound.) <ul style="list-style-type: none"> <li>• Carefully and gently, insert the uterine sound in the direction of the uterus while gently pulling steadily downwards and outward on the tenaculum. If there is resistance at the internal os, use a smaller sound, if available.</li> <li>• Do <b>not</b> attempt to dilate the cervix unless well-qualified. <b>Gentle</b> traction on the tenaculum may enable the sound to pass more easily.</li> <li>• <b>If client begins to show symptoms of fainting or pallor with slow heart rate, STOP.</b></li> </ul>					
6. Slowly withdraw the sound. The wet and darker (mucus and blood) part on the sound shows the length of the uterus.					
7. Place the sound next to the IUCD and set the blue depth-gauge at the depth of the uterus. <ul style="list-style-type: none"> <li>• The average uterus will sound to a depth of 6 to 8 cm.</li> <li>• Note: If the uterus sounds to a depth of 10 cm or more, the sound may have perforated the uterus, or the uterus may be enlarged due to tumours or pregnancy. <b>DO NOT insert an IUCD.</b></li> </ul>					
8. If perforation is suspected, observe the client in the clinic carefully. For first hour, keep woman in bed and check pulse and blood pressure every 5-10 minutes. <ul style="list-style-type: none"> <li>• If client remains stable after 1 hour, check hematocrit/hemoglobin. If possible, allow her to walk, check vital signs as needed, and observe for several more hours. If no signs or symptoms, send her home, but she should avoid intercourse for 2 weeks. Help her make an informed choice about a different (backup) contraceptive.</li> <li>• If there is a rapid pulse and falling blood pressure, or new pain or increasing pain around the uterus, hospitalization is needed.</li> </ul>					

# Learning Guide for Loading the TCu 380A in its Sterile Package

(to be used by participants)

Rate the performance of each step or task observed using the following rating scale:	
1	<b>Needs Improvement:</b> Step or task not performed correctly or out of sequence (if necessary) or is omitted
2	<b>Competently Performed:</b> Step or task performed correctly in proper sequence (if necessary) but participant not progressing from step to step efficiently
3	<b>Proficiently Performed:</b> Step or task efficiently and precisely performed in the proper sequence (if necessary)

Participant \_\_\_\_\_ Course Dates \_\_\_\_\_

**Important: Do not open the IUCD's sterile package** or load it until the final decision to insert an IUCD has been made (i.e., until after the pelvic examination, including both bimanual and speculum exams, has been performed). In addition, do not bend the "arms" of the "T" into the insertion tube more than 5 minutes before it is introduced into the uterus.

Do not allow the IUCD or the IUCD insertion assembly to touch any non-sterile surfaces (e.g., your hands, the table) that may contaminate it.

Learning Guide for Loading the TCu 380A in its Sterile Package	
Task/Activity	Cases
<b>PREPARE PACKAGE</b>	
1. Put on HLD or sterile gloves, if not already gloved.	
2. Make sure that the vertical stem of the T is fully inside the inserter tube and that the end of the inserter tube opposite the T is close to the seal at the end of the unopened package.	
<b>OPEN PACKAGE</b>	
1. Place package on a clean, hard, flat surface with clear plastic side up.	
2. Partially open the end of the package <b>farthest</b> from the IUCD.	
3. Open the package approximately halfway to the blue depth-gauge.	
<b>REMOVE WHITE ROD FROM PACKAGE</b>	
1. Pick up the package, holding the open end up towards the ceiling so that the contents do not fall out.	
2. Bend the clear <b>plastic cover</b> and <b>white backing "flap"</b> at the open end of the package away from each other.	
3. Grasp the <b>white rod</b> , behind the <b>I.D. card</b> , by the thumb grip and remove it from the package. Do not touch the tip of the white rod or brush it against another surface.	
4. Put the white rod inside the inserter tube and gently push the rod up into the inserter tube until it almost touches the bottom of the T.	
5. Release the white backing flap so that it is flat, and place the package on a flat surface with the clear plastic side up.	
<b>POSITION ARMS OF THE T</b>	

## Learning Guide for Loading the TCU 380A in its Sterile Package

Task/Activity	Cases				
1. Through the <b>clear plastic cover</b> , place your thumb and index finger over the ends of the <b>horizontal arms</b> of the T and hold the T in place.					
2. At open end of the package, use your free hand to push the I.D. card so that it slides underneath the T and stops at the top seal of the package.					
3. While still holding the tips of the horizontal arms of the T, use your free hand to grasp the inserter tube against the arms of the T, starting to bend the arms of the T downward, towards the stem of the T, as indicated in the drawing on the I.D. card.					
<b>INSERT "T" INTO INSERTER TUBE</b>					
1. Continue bending the arms of the T by bringing the thumb and index finger together.					
2. When arms have folded enough to touch the sides of the inserter tube, pull the inserter tube out from under the tips of the arms. Push and rotate the inserter tube onto the tips of the arms so that the arms become trapped inside the inserter tube next to the stem.					
3. Insert the folded arms into the tube only as far as necessary to ensure retention of the arms. <b>Copper bands on arms will not fit in tube.</b>					
<b>SET DEPTH-GAUGE</b>					
1. Holding blue depth-gauge in place through the clear plastic wrapper, grasp inserter tube at the open end of the package with your free hand.					
2. Pull the inserter tube gently until the distance between the top of the folded T and the edge of the blue depth-gauge closest to the T is equal to the depth of the uterus as measured on the uterine sound.					
3. Rotate the inserter tube so that the long axis of the blue depth-gauge is on the same horizontal plane as the arms of the T.					
4. Set the blue depth-gauge to the appropriate measurement.					
<b>PREPARE FOR INSERTION</b>					
1. Carefully peel the clear plastic cover of the package away from the white backing.					
2. Lift the loaded inserter, keeping it horizontal, so that the T or white rod doesn't fall out.					
3. Be careful not to push the white rod towards the T until you are ready to release the T in the fundus.					
4. Do not let the inserter tube or the tip of the IUCD touch any unsterile surfaces. If it touches any unsterile surfaces, it must not be inserted in the uterus. Throw it away and get another one.					

# Learning Guide for IUCD Removal

(to be used by participants)

Rate the performance of each step or task observed using the following rating scale:	
1	<b>Needs Improvement:</b> Step or task not performed correctly or out of sequence (if necessary) or is omitted
2	<b>Competently Performed:</b> Step or task performed correctly in proper sequence (if necessary) but participant not progressing from step to step efficiently
3	<b>Proficiently Performed:</b> Step or task efficiently and precisely performed in the proper sequence (if necessary)

Participant \_\_\_\_\_ Course Dates \_\_\_\_\_

Learning Guide for IUCD Removal					
Task/Activity	Cases				
<b>PRE-REMOVAL STEPS</b>					
1. Greet woman respectfully and with kindness.					
2. Assure privacy and confidentiality.					
3. Uses appropriate counselling/communication skills.					
4. Ask the woman her reason for having the IUCD removed.					
5. Determine whether she will have another IUCD inserted immediately, start a different method, or neither.					
6. Review the client's reproductive goals and need for STI/HIV protection, and counsel as appropriate.					
7. Ensure that equipment and supplies are available and ready to use.					
8. Have the client empty her bladder.					
9. Help the client onto the examination table.					
10. Wash hands thoroughly and dry them.					
11. Put clean or HLD gloves on both hands.					
<b>REMOVE THE IUCD</b>					
1. Explain the removal procedure. Remind her to let you know if she feels any pain.					
2. Gently insert the HLD (or sterile) speculum to visualize the strings, and cleanse the cervical os and vaginal wall with antiseptic.					
3. Alert the client immediately before you remove the IUCD.					
4. Grasp the IUCD strings close to the cervix with an HLD (or sterile) hemostat or other narrow forceps.					
5. Apply steady but gentle traction, pulling the strings toward you, to remove the IUCD. <b>Do not use excessive force.</b>					
6. Show the IUCD to client.					
7. If the woman is having a new IUCD inserted, insert it now if appropriate. [If she is not having a new IUCD inserted, gently remove the speculum and place it in 0.5% chlorine solution for 10 minutes for decontamination.]					
8. Ask how the client is feeling and begin performing the post-removal steps.					
<b>POST-REMOVAL STEPS</b>					
1. Before removing the gloves, place all used instruments and the IUCD in 0.5% chlorine solution for 10 minutes for decontamination.					

## Learning Guide for IUCD Removal

Task/Activity	Cases				
2. Properly dispose of waste materials.					
3. Process gloves according to recommended IP practices.					
4. Wash hands thoroughly and dry them.					
5. If the woman has had a new IUCD inserted, review key messages for IUCD users.					
6. Discuss what to do if client experiences any problems.					
7. Counsel client regarding new contraceptive method, if desired.					
8. Assist client in obtaining new contraceptive method or provide temporary method (barrier method until method of choice can be started).					



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<http://info.k4health.org/globalhandbook/>

# Unit 9

## VASECTOMY

### Learning Objectives

By the end of this unit, learners should be able to:

- ❖ Define vasectomy
- ❖ List the types of surgical techniques used for vasectomy
- ❖ Explain how vasectomy works
- ❖ State the effectiveness of vasectomy
- ❖ List the characteristics of vasectomy
- ❖ Describe the potential complications of vasectomy and their warning signs
- ❖ Correct misconceptions about vasectomy
- ❖ Determine a client's medical eligibility for vasectomy
- ❖ List the 6 points of informed consent for vasectomy
- ❖ List the client assessment tasks required for vasectomy
- ❖ Explain how to manage complications of vasectomy
- ❖ Describe the procedure for performing no-scalpel vasectomy
- ❖ Demonstrate knowledge and skills in counselling clients to make an informed choice about vasectomy
- ❖ Demonstrate competence in performing no-scalpel vasectomy (for the cadres performing the procedure)
- ❖ Provide counselling messages for clients following vasectomy.

### Teaching Resources In This Unit

#### Learning activities

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#### Unit assessment

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Learning Guide for No-Scalpel Vasectomy Clinical Skills	224

### Key Points

- ❖ **Highly effective and safe contraception**
- ❖ **Permanent.** Intended to provide life-long, protection against pregnancy. Reversal is usually not possible.
- ❖ **Involves a safe, simple surgical procedure**
- ❖ **Three-month delay in taking effect.** The man or couple must use condoms or other contraceptive methods for 3 months after the vasectomy.
- ❖ **Does not affect male sexual performance or desire**
- ❖ **Promotes male involvement in family planning.**

## 9.1 Defining Vasectomy

Vasectomy is permanent contraception for men who do not want more children. It is also called male sterilisation and male surgical contraception. Vasectomy involves cutting or blocking the vas deferens, the tubes that carry sperm to the penis.

### Types of vasectomy surgical procedures

There are two types of vasectomy procedures:

- **No-scalpel vasectomy (NSV)** is the recommended technique. It requires only one small puncture in the scrotum.
- **Conventional vasectomy:** In this technique, the provider makes one or two small incisions on the scrotum.

This unit focuses on no-scalpel vasectomy, which is the technique most often performed in Malawi. The advantages of NSV versus conventional vasectomy include:

- Less pain, bruising and bleeding, and quicker recovery because only 1 small puncture is made instead of 1-2 incisions
- Requires no stitches to close the skin
- Fewer infections and less likelihood of a hematoma (a collection of blood in the tissue)
- Shorter time required for procedure, when performed by skilled providers.

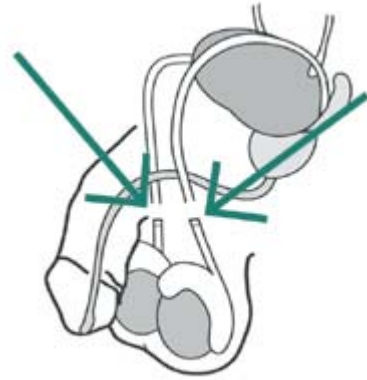
### How vasectomy works

Vasectomy works by closing off the vas deferens from each side of the testes, which prevents sperm from entering semen and fertilizing the ovum. Semen is ejaculated, but it does not contain sperm so cannot cause pregnancy.

## 9.2 Effectiveness

Vasectomy is highly effective in preventing pregnancy, with less than 1 pregnancy per 100 women in the first year (2 in 1,000) for women whose partners have undergone vasectomy, and even lower rates after the first year.

- Vasectomy is not fully effective for 3 months after the procedure because sperm that have already formed may still end up in the semen in the first few months.
- A small risk of pregnancy remains beyond the first year after the vasectomy. (Over 3 years of use: About 4 pregnancies per 100 women.)
- In the rare case of a man who has had a vasectomy impregnating his partner, it may be because:
  - The couple did not always use another method during the first 3 months after the procedure.
  - The provider did not cut/tie both vas deferens.
  - The cut ends of the vas deferens grew back together.



(Illustration by Rafael Avila and Rita Meyer)

### **Fertility does not return because vasectomy generally cannot be stopped or reversed.**

The procedure is intended to be permanent. Reversal surgery is difficult, expensive, and not available in most areas. When performed, reversal surgery often does not lead to pregnancy (see Question 7, Section 9.11).

## 9.3 Characteristics

### **Advantages**

- Permanent, safe, convenient contraception
- Can increase enjoyment and frequency of sex
- Takes burden off the woman because the man takes responsibility for contraception
- Has no long-lasting side effects.

### **Disadvantages**

- Cannot be reversed
- Does not protect against STIs, including HIV.

**Side effects, Health benefits, Health risks:** None

There are no side effects, other than short-term discomfort after the procedure. The procedure is simple, safe, and has no known health risks, other than a very small risk of complications, and does not have any known health benefits.

### **Complications**

- Uncommon to rare: Severe scrotal or testicular pain that lasts for months or years
- Uncommon to very rare: Infection at the incision site or inside the incision (uncommon with conventional incision technique; very rare with NSV)
- Rare: Bleeding under the skin that may cause swelling or bruising.

## 9.4 Correcting Misconceptions

Vasectomy:

- Does not remove the testicles. In vasectomy the tubes carrying sperm from the testicles are blocked. The testicles remain in place.

- Does not decrease sex drive
- Does not affect sexual function. A man's erection is as hard, it lasts as long, and he ejaculates semen the same as before. Only a very small amount of the volume of semen is made up of sperm.
- Does not cause a man to grow fat, become weak, experience back pain, feel less masculine or less productive
- Does not cause any diseases later in life
- Does not prevent transmission of sexually transmitted infections (STIs), including HIV.

## 9.5 Men Who Can Have a Vasectomy

### **Vasectomy is safe for all men**

With counselling and informed consent, any man can have a vasectomy safely, including men who:

- Have no children or few children
- Are not married
- Do not have their wife's permission
- Are young
- Have sickle cell disease
- Are at high risk of infection of HIV or another STI
- Are infected with HIV, whether or not on antiretroviral therapy.

In some of these situations, especially careful counselling is important to make sure the man will not regret his decision.

Men can have a vasectomy:

- Without any blood tests or routine laboratory tests
- Without a blood pressure check
- Without a haemoglobin test
- Without a cholesterol or liver function check
- Even if the semen cannot be examined by microscope later to see if it still contains sperm.

## 9.6 Vasectomy for Men Living with HIV

- Men who are infected with HIV, have AIDS or are on antiretroviral (ARV) therapy can safely have a vasectomy. Special arrangements are needed to perform vasectomy on a man with AIDS.
- Urge these men to use condoms in addition to vasectomy. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.
- No one should be coerced or pressured into getting a vasectomy, and that includes men with HIV.

## 9.7

### Medical Eligibility Criteria Screening Questions

#### For Vasectomy

The WHO MEC categories for permanent contraception (vasectomy and female sterilisation) are different than those for other contraceptive methods. Instead of using Categories 1- 4, the categories for these methods are: **Accept**, **Caution**, **Delay**, and **Special**.

In the case of vasectomy, no medical conditions prevent a man from using this method, although some conditions require **caution**, **delay**, or making **special** arrangements.

This list of screening questions asks the client about known medical conditions that may limit when, where, or how the vasectomy procedure should be performed. If the client answers "no" to all of the questions below, then the vasectomy procedure can be performed in a routine setting without delay. If he answers "yes" to any question below, follow the instructions provided, which recommend caution, delay, or special arrangements.

- *Caution* means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition.
- *Delay* means postpone the vasectomy. These conditions must be treated and resolved before vasectomy can be performed. Give the client another method to use until the procedure can be performed.
- *Special* means special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anaesthesia, and other backup medical support. Depending on the condition, it may not be possible to use the no-scalpel method of vasectomy. For these conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen also is needed. Give the client a backup method such as male or female condoms to use until the procedure can be performed.

#### 1. Do you have any problems with your genitals, such as infections, swelling, injuries, or lumps on your penis or scrotum? If so, what problems?

Action	Condition
If he has any of these, use <b>Caution</b>	<ul style="list-style-type: none"> <li>• Previous scrotal injury</li> <li>• Swollen scrotum due to swollen veins or membranes in the spermatic cord or testes (large varicocele or hydrocele)</li> <li>• Undescended testicle—one side only. (Vasectomy is performed only on the normal side. Then, if any sperm are present in a semen sample after 3 months, the other side must be done, too.)</li> </ul>
If he has any of these, <b>delay vasectomy</b>	<ul style="list-style-type: none"> <li>• Active sexually transmitted infection</li> <li>• Swollen, tender (inflamed) tip of the penis, sperm ducts (epididymis), or testicles</li> <li>• Scrotal skin infection or a mass in the scrotum</li> </ul>
If he has any of these, make <b>special</b>	<ul style="list-style-type: none"> <li>• Hernia in the groin. (If able, the provider can perform the vasectomy at the same time as repairing the hernia. If this is not</li> </ul>

<b>arrangements</b>	<p>possible, the hernia should be repaired first.)</p> <ul style="list-style-type: none"> <li>• Undescended testicles—both sides</li> </ul>
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**2. Do you have any other conditions or infections? If so, what?**

Action	Condition
If he has any of these, use <b>caution</b>	<ul style="list-style-type: none"> <li>• Diabetes</li> <li>• Depression</li> <li>• Young age</li> </ul>
If he has any of these, <b>delay vasectomy</b>	<ul style="list-style-type: none"> <li>• Lupus with positive (or unknown) antiphospholipid antibodies or on immunosuppressive treatment</li> <li>• Scrotal skin infection; active STI; swollen, tender tip of penis, sperm ducts, or testicles</li> <li>• Currently ill with AIDS-related illness</li> <li>• Systemic infection or gastroenteritis</li> <li>• Filariasis or elephantiasis</li> </ul>
If he has any of these, make <b>special arrangements</b>	<ul style="list-style-type: none"> <li>• AIDS (see Vasectomy for Men Living With HIV)</li> <li>• Blood fails to clot (coagulation disorders)</li> <li>• Lupus with severe thrombocytopenia</li> </ul>

## 9.8 Counselling for Informed Consent

Vasectomy counselling must cover all 6 points of informed consent. In some programs the client and the counsellor both sign an informed consent form. To give informed consent for vasectomy, the client must understand the following points:

- Temporary contraceptives are also available to the client.
- Vasectomy is a surgical procedure.
- 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.)
- If successful, the procedure will prevent the client from having any more children.
- The procedure is considered permanent and probably cannot be reversed.
- 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)

## 9.9 Client Assessment Required for Vasectomy

Once the client makes an informed and voluntary choice for vasectomy, the provider conducts a physical exam. Vasectomy requires an examination of the groin, penis, testes, and scrotum to rule out any temporary conditions such as a local infection or other contraindications that might require a specialist to perform the procedure or require a delay in performing the procedure.

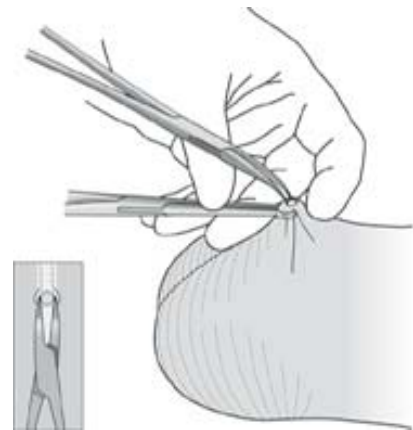
(For more information, see Table 4.1: “Client Assessment Tasks Required for All Contraceptive Methods” in Unit 4.)

## 9.10 Providing Vasectomy

**Note:** This description is a summary, not detailed instructions. Detailed procedure steps are included in the learning guide in the Teaching Resources section of this unit.

Before providing vasectomy, describe the procedure for the client:

- Before the procedure, the client washes and shaves the front part of his scrotum.
- The provider uses infection prevention procedures at all times.
- The provider gives the man an injection of local anaesthetic in his scrotum.
- The provider feels the skin of the scrotum to find each vas deferens—the tubes in the scrotum that carry sperm.
- The provider makes a puncture or incision in the skin:
  - Using the NSV technique, the provider grasps the tube with a specially designed clamp and makes a tiny puncture on the skin at the midline of the scrotum with a special surgical instrument.
  - Using the conventional procedure, the provider makes 1 or 2 small incisions in the skin with a scalpel.
- The provider lifts out a small loop of vas from the puncture or incision. The provider then cuts each tube and ties the cut ends closed with thread.
- The provider covers the puncture with an adhesive bandage, or closes the incision with stitches.
- The client rests for 15–30 minutes.



*(Illustration adapted by Rafael Avila from EngenderHealth)*

## 9.11 Client Counselling and Instructions After Vasectomy

- Rest at home for 2 days, if possible. Avoid riding a bicycle, lifting heavy objects, or performing strenuous activities for 5 days.
- The client may have some discomfort, swelling, and bruising. These should go away within 2 to 3 days. Suggest ibuprofen (200–400 mg), paracetamol (500–1000 mg), or other pain reliever.
- Wear snug underwear or trousers for 2 to 3 days to help support the scrotum. This will lessen swelling, bleeding, and pain.
- Keep the puncture/incision site clean and dry for 2 to 3 days. Client can use a towel to wipe his body clean but should not soak in water.
- Do not have sex for at least 2 to 3 days.
- Use male or female condoms or another effective family planning method for 3 months after the procedure. (The previously recommended alternative, to wait for 20 ejaculations, has proved less reliable than waiting 3 months and is no longer recommended.)
- Return in 3 months for semen analysis, if available (see Question 4, Section 9.11). However, no man should be denied a vasectomy because follow-up would be difficult or not possible.



## Reasons to return

- Assure every client that he is welcome to come back any time—for example, if he has problems or questions, or his partner thinks she might be pregnant. (A small number of vasectomies fail, and the men's partners become pregnant.)
- Also, he should return if he has bleeding, pain, pus, heat, swelling, or redness in the genital area that becomes worse or does not go away.

## 9.12 Managing Complications

Complications are very rare. However the client may experience the following:

### **Bleeding or blood clots after the procedure**

- Reassure him that minor bleeding and small uninfected blood clots usually go away without treatment within a couple of weeks.
- Large blood clots may need to be surgically drained.
- Infected blood clots require antibiotics and hospitalization.

### **Infection at the puncture or 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.

### **Abscess (a pocket of pus under the skin caused by infection)**

- Clean the area with antiseptic.
- Cut open (incise) and drain the abscess. This should be done by a provider who is familiar with vasectomy complications, preferably the provider who performed the procedure.
- Treat the wound.
- Give oral antibiotics for 7 to 10 days.
- Ask the client to return after taking all antibiotics if the wound produces heat, redness, pain, or drainage.

### **Pain lasting for months**

- Suggest elevating the scrotum with snug underwear, trousers, or an athletic supporter.
- Suggest soaking in warm water.
- Suggest aspirin (300–600 mg), ibuprofen (200–400 mg), paracetamol (500–1000 mg) or other pain reliever.
- Provide antibiotics if infection is suspected.
- If pain persists and cannot be tolerated, refer for further care (see Question 2, Section 9.11).

## 9.13 Questions and Answers about Vasectomy

### 1. Will vasectomy make a man lose his sexual ability? Will it make him weak or fat?

No. After vasectomy, a man will look and feel the same as before. He can have sex the same as before. His erections will be as hard and last as long as before, and ejaculations of semen will be the same. He can work as hard as before, and he will not gain weight because of the vasectomy.



*(Illustration by Rafael Avila and Rita Meyer)*

### 2. Will there be any long-lasting pain from vasectomy?

Some men report having chronic pain or discomfort in the scrotum or testicles that can last from 1 to 5 years or more after a vasectomy. In the largest studies, involving several thousand men, less than 1% reported pain in the scrotum or testicles that had to be treated with surgery. In smaller studies, of about 200 men, as many as 6% reported severe pain in the scrotum or testicles more than 3 years after the vasectomy. In a similar group of men who did not have vasectomies, however, 2% reported similar pain. Few men with severe pain say that they regret having the vasectomy. The cause of the pain is unknown. Treatment includes elevating the scrotum and taking pain relievers. An anaesthetic can be injected into the spermatic cord to numb the nerves to the testicles. Some providers report that surgery to remove the painful site or reversing the vasectomy relieves the pain. Severe, long-lasting pain following vasectomy is uncommon, but all men considering a vasectomy should be told about this risk.

### 3. Does a man need to use another contraceptive method after a vasectomy?

Yes, for the first 3 months. If his partner has been using a contraceptive method, she can continue to use it during this time. Not using another method for the first 3 months is the main cause of pregnancies in couples relying on vasectomy.

### 4. Is it possible to check if a vasectomy is working?

Yes. A provider can examine a semen sample under a microscope to see if it still contains sperm. If the provider sees no moving (motile) sperm, the vasectomy was successful. A semen examination is recommended at any time after 3 months following the procedure but is not essential.

If there is less than 1 non-motile sperm per 10 high-power fields (less than 100,000 sperm per millilitre) in the sample, the man can rely on his vasectomy and stop using a backup method for contraception. If his semen contains more moving sperm, the man should continue to use a backup method and return to the clinic monthly for a semen analysis. If his semen continues to have moving sperm, he may need to have a repeat vasectomy.

### 5. What if a man's partner gets pregnant?

Every man having a vasectomy should know that vasectomies sometimes fail, and his partner could become pregnant as a result. He should not make the assumption that his partner was unfaithful if she becomes pregnant. If a man's partner becomes pregnant during the first 3 months after his vasectomy, remind the man that for the first 3 months

they needed to use another contraceptive method. If possible, offer a semen analysis and, if sperm are found, repeat the vasectomy.

**6. Will the vasectomy stop working after a time?**

Generally, no. Vasectomy is intended to be permanent. In rare cases, however, the tubes that carry sperm grow back together, and the man will require a repeat vasectomy.

**7. Can a man have his vasectomy reversed if he decides that he wants another child?**

Generally, no. Vasectomy is intended to be permanent. People who may want more children should choose a different family planning method. Surgery to reverse vasectomy is possible for only some men, and reversal often does not lead to pregnancy. The reversal procedure is difficult and expensive, and providers who are able to perform such surgery are hard to find. Thus, vasectomy should be considered irreversible.

**8. Is it better for the man to have a vasectomy or for the woman to have female sterilisation?**

Each couple must decide for themselves which method is best for them. Both are very effective, safe, permanent methods for couples who know that they will not want more children. Ideally, a couple should consider both methods. If both are acceptable to the couple, vasectomy would be preferable because it is simpler, safer, easier, and less expensive than female sterilisation.

**9. How can health care providers help a man decide about vasectomy?**

Provide clear, balanced information about vasectomy and other family planning methods, and help the man (and his partner, if appropriate) to think through his decision fully. Thoroughly discuss with him his feelings about having children and ending his fertility. For example, help him think how he would feel about possible life changes such as a change of partner or a child's death. Review "The 6 Points of Informed Consent" (Section 9.7) to be sure the man understands the vasectomy procedure.

**10. Should vasectomy be offered only to men who have reached a certain age or have a certain number of children?**

No. There is no justification for denying vasectomy to a man just because of his age, the number of his living children, or his marital status. Each man must be allowed to decide for himself whether or not he will want more children and whether or not to have vasectomy.

**11. Does vasectomy increase a man's risk of cancer or heart disease later in life?**

No. Evidence from large, well-designed studies shows that vasectomy does not increase the risk of testicular cancer, prostate cancer, or heart disease.

**12. Can a man who has a vasectomy transmit or become infected with STIs, including HIV?**

Yes. Vasectomies do not protect against STIs, including HIV. All men at risk of STIs, including HIV, whether or not they have had vasectomies, need to use male or female condoms to protect themselves and their partners from infection.

**13. Where can vasectomies be performed?**

If no pre-existing medical conditions require special arrangements, vasectomy can be performed in almost any health facility, including health care centres, family planning clinics, and the treatment rooms of private doctors.

## Vasectomy Case Studies

(From EngenderHealth 2007, adapted by permission of EngenderHealth)

### Case Study 1

The client is a 29-year-old man who has 4 children and does not want any more. He does not want to tell his wife that he wants a vasectomy because she wants to have more children.

1. Is the client making a well-considered decision?
2. As a provider, what questions would you want to ask?
3. What signs indicate that the client's decision is sound? What are the possible warning signs?
4. What issues would you want to discuss with the client?

### Case Study 2

The client is a 20-year-old man who has 3 children, and his partner supports his decision to have a vasectomy.

1. Is the client making a well-considered decision?
2. As a provider, what questions would you want to ask?
3. What signs indicate that the client's decision is sound? What are the possible warning signs?
4. What issues would you want to discuss with the client?

### Case Study 3

The client is a 30-year-old man whose wife just survived a difficult labour delivering their third child. He has just lost his job.

1. Is the client making a well-considered decision?
2. As a provider, what questions would you want to ask?
3. What signs indicate that the client's decision is sound? What are the possible warning signs?
4. What issues would you want to discuss with the client?

# Vasectomy Case Studies Answer Key

## Case Study 1

### 1. Is the client making a well-considered decision?

Yes, in general if he already has 4 children and is certain that he doesn't want any more, he is making a responsible decision. Ideally, he and his wife would be in agreement about this, but he does not need her permission to undergo the procedure.

### 2. As a provider, what questions would you want to ask?

It is always better to discuss and agree with such important decisions with your partner, and the provider might want to ask why he hasn't told his wife and if he would consider doing so.

### 3. What signs indicate that the client's decision is sound? What are the possible warning signs?

The fact that he hasn't told his wife may mean that he is ambivalent about his decision.

### 4. What issues would you want to discuss with the client?

The provider might want to discuss if his wife found out he had a vasectomy, how would she react? What problems might it cause for their relationship and family?

## Case Study 2

### 1. Is the client making a well-considered decision?

Yes, in general it is a good decision if he already has 3 children and has discussed this with his partner.

### 2. As a provider, what questions would you want to ask?

This client is young to make this lifelong decision. The provider might want to ask if he would regret this decision if his wife died and he had another partner/wife who wanted more children, or if one or more of his children were sick and died. However, there is no reason to deny the procedure.

### 3. What signs indicate that the client's decision is sound? What are the possible warning signs?

Only that he is young, and this is a permanent decision.

### 4. What issues would you want to discuss with the client?

Same as above under question number 2.

## Case Study 3

### 1. Is the client making a well-considered decision?

Probably not. Though his desire to have a vasectomy may seem like a good decision to support his wife and because of financial concerns, both of these circumstances could change. However, there is no reason to deny the procedure.

### 2. As a provider, what questions would you want to ask?

The provider might want to ask if he has discussed this with his wife, how he might feel if his wife or one of his children gets ill or dies, and if he would want more children if he had another job.

**3. What signs indicate that the client's decision is sound? What are the possible warning signs?**

It is never a good idea to make a permanent decision such as vasectomy when you are under stress or have had big changes in your life.

**4. What issues would you want to discuss with the client?**

Encourage him to talk about it with his wife when she is feeling better and to take some time to think about it.

# Vasectomy Role Play

## Participant roles

**Clinician:** The clinician is a nurse who is knowledgeable about family planning and counselling.

**Client 1:** The client is 34 years old and has 5 living children. She has also had 4 babies who died in infancy. Her last pregnancy 3 years ago was extremely difficult, and both she and the baby almost died during delivery. The doctors have told her that it would be very dangerous for her to get pregnant again.

**Client 2:** The other client is the 45-year-old husband of Client 1. He agrees that they do not want additional children but is resistant to vasectomy.

## Situation

The client and her husband agree that sterilisation is a good option for them but are unsure who should be sterilised. They have come to the clinic today to get more information so that they can make a decision as soon as possible. The client is worried that if she is sterilised she will become fat and lazy and unable to care for all her children. Her husband has heard that vasectomy will make him weak and unable to work in the fields or support his family.

# Vasectomy Quiz Questions

(From EngenderHealth 2007, adapted by permission of EngenderHealth)

**Questions 1–5: Tick the best answer for each question.**

1. After vasectomy, when can the client resume sexual intercourse without backup methods?
  - a. After a month
  - b. After 3 months
  - c. After 20 ejaculations
  - d. After 6 months
2. Possible complications of vasectomy include all of the following except:
  - a. Wound infection
  - b. Haematoma
  - c. Hydrocoele
  - d. Pain lasting for months
3. Compared to bilateral tubal ligation, which of the following is an important issue to note with regard to vasectomy?
  - a. More effective
  - b. Less expensive
  - c. Safer
  - d. All of the above
4. Vasectomy has an effectiveness rate of:
  - a. 99.8%
  - b. 95%
  - c. 100%
  - d. 97.8%
5. Conditions or situations requiring precaution for vasectomy include:
  - a. Single/or no living children
  - b. Symptomatic heart disease
  - c. Diabetes mellitus
  - d. All of the above

**Questions 6–17. Indicate whether the following statements are true or false by writing a “T” for true or an “F” for false in the space provided before each statement.**

- \_\_\_ 6. A trained counsellor or provider is the best person to choose an appropriate contraceptive method for a couple.
- \_\_\_ 7. The vasectomy provider should verify a client’s informed consent by talking with him before the procedure.
- \_\_\_ 8. During vasectomy counselling the client should be assured that he can change his mind at any time before the procedure without losing the right to other medical services.
- \_\_\_ 9. A man with diabetes cannot have a vasectomy.
- \_\_\_ 10. A pre-vasectomy evaluation includes a medical history, a complete physical exam, and a hemoglobin count or hematocrit.



- \_\_\_ 11. A client with syphilis should be treated for the infection before having a vasectomy.
- \_\_\_ 12. A client whose vasectomy needs to be postponed should be counselled about alternative methods of contraception to use in the meantime.
- \_\_\_ 13. After vasectomy, a man should use an alternative contraceptive for 3 weeks.
- \_\_\_ 14. A man who has bruising and/or passes a blood clot during ejaculation should immediately return to his NSV provider.
- \_\_\_ 15. Following a vasectomy, a man should avoid strenuous activity and wear a snug undergarment for 48 hours.
- \_\_\_ 16. Vasectomy provides protection against pregnancy and sexually transmitted infections.
- \_\_\_ 17. Providing clients with clear post-vasectomy instructions is an important way to prevent complications.

## Vasectomy Quiz Questions Answer Key

1. After vasectomy, when can the client resume sexual intercourse without backup methods?  
**b. After 3 months**
2. Possible complications of vasectomy include all of the following except:  
**c. hydrocoele**
3. Compared to female sterilisation, which of the following is true of vasectomy?  
**d. All of the above**
4. Vasectomy has an effectiveness rate of:  
**a. 99.8%**
5. Conditions or situations requiring caution for vasectomy include:  
**c. Diabetes mellitus**

**Questions 6–17.** Indicate whether the following statements are **true** or **false** by writing a **“T”** for true or an **“F”** for false in the space provided before each statement.

- F\_\_** 6. A trained counsellor or provider is the best person to choose an appropriate contraceptive method for a couple.
- T\_\_** 7. The vasectomy provider should verify a client’s informed consent by talking with him before the procedure.
- T\_\_** 8. During vasectomy counselling the client should be assured that he can change his mind at any time before the procedure without losing the right to other medical services.
- F\_\_** 9. A man with diabetes cannot have a vasectomy.
- F\_\_** 10. A pre-vasectomy evaluation includes a medical history, a complete physical exam, and a hemoglobin count or hematocrit.
- T\_\_** 11. A client with syphilis should be treated for the infection before having a vasectomy.
- T\_\_** 12. A client whose vasectomy needs to be postponed should be counselled about alternative methods of contraception to use in the meantime.
- F\_\_** 13. After vasectomy, a man should use an alternative contraceptive for 3 weeks.
- F\_\_** 14. A man who has bruising and/or passes a blood clot during ejaculation should immediately return to his NSV provider.
- T\_\_** 15. Following a vasectomy, a man should avoid strenuous activity and wear a snug undergarment for 48 hours.
- F\_\_** 16. Vasectomy provides protection against pregnancy and sexually transmitted infections.
- F\_\_** 17. Providing clients with clear post-vasectomy instructions is an important way to prevent complications.

# Learning Guide for No-Scalpel Vasectomy Clinical Skills

(to be used by participants)

Rate the performance of each step or task observed using the following rating scale:	
1	<b>Needs Improvement:</b> Step or task not performed correctly or out of sequence (if necessary) or is omitted
2	<b>Competently Performed:</b> Step or task performed correctly in proper sequence (if necessary) but participant not progressing from step to step efficiently
3	<b>Proficiently Performed:</b> Step or task efficiently and precisely performed in the proper sequence (if necessary)

Participant \_\_\_\_\_ Course Dates \_\_\_\_\_

Learning Guide for No-Scalpel Vasectomy Clinical Skills					
Task/Activity	Cases				
<b>GETTING READY</b>					
1. Put on surgical mask, if appropriate.					
2. Greet client respectfully, establish rapport.					
3. Ensure that the patient did not take aspirin or other anti-inflammatory medication, and did not consume alcohol, since these substances may increase the risk of bleeding.					
4. Verify client's identity and check that informed consent was obtained.					
5. Ensure that client has emptied bladder.					
6. Check that client has thoroughly washed and shaved the front portion of the scrotum.					
7. Provide surgical or clean gown for the patient.					
<b>PRE-OPERATIVE TASKS</b>					
1. Ensure warm room temperature to relax the scrotum.					
2. Determine that sterile, high-level disinfected instruments (ringed clamp, dissecting forceps and straight scissors) and supplies, including suture, are available.					
3. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
4. Put new examination or high-level disinfectant surgical gloves on both hands.					
5. Examine the scrotal area by palpating the scrotum to assess the thickness of the scrotal skin.					
6. Gently wash the scrotum with a warm antiseptic solution.					
7. Wash and scrub your hands and forearms either with soap and water or antiseptic agents.					
8. Wear sterile theatre attire and sterile gloves.					
9. Ask the man to lie in supine position on the table and give him a small pillow to place under his head.					
10. Put the penis in a 12 o'clock position on the man's abdomen so that the median raphe is clearly visible.					
11. Place sterile drapes over the client to guard against infection.					
<b>VASECTOMY PROCEDURE</b>					

## Learning Guide for No-Scalpel Vasectomy Clinical Skills

Task/Activity	Cases				
1. Administer local anaesthesia away from the vasectomy site in the direction of the inguinal ring to make skin entry easier.					
2. Hold the vas in proper position using the three finger technique. Place left thumb at the juncture of the middle and upper thirds of the median raphe. With the middle finger of your left hand under the scrotum, palpate the vas and sweep it toward the raphe beneath your thumb.					
3. Raising the skin wheal, ensure the needle site is at the midline, over the vas deferens midway between the thumb and index finger. Insert the tip of the needle to raise a superficial skin wheal, 1 to 1.5 cm in diameter.					
4. Inject lignocaine without epinephrine into the dermis and subcutaneous tissues: 0.5cc is usually adequate.					
5. Make a small opening/puncture in the scrotum.					
6. Lift either the right or left vas deferens through the puncture hole.					
7. Competently cut the vas deferens. A section may or may not be removed.					
8. Heat seal or tie the two cut ends of the vas deferens before returning them to the scrotum. Repeat this procedure with the other vas deferens.					
9. If an incision was made in the scrotal skin, suture the opening and apply a sterile adhesive dressing to the wound.					
10. Give postoperative instructions.					
11. Ensure that client is safely transferred to the post-operative (recovery) area. Observe for 15-30 minutes prior to discharge.					
<b>POSTOPERATIVE TASKS</b>					
1. Dispose of sharps appropriately and disinfect surgical instruments before removing gloves.					
2. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					

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# Unit 10

## FEMALE STERILISATION

### Learning Objectives

- ❖ Define female sterilisation
- ❖ Describe the primary techniques of female sterilisation and how they work
- ❖ State the effectiveness of female sterilisation
- ❖ List the characteristics of female sterilisation
- ❖ List the potential complications of female sterilisation and how to manage them
- ❖ Correct misconceptions about female sterilisation
- ❖ Describe female sterilisation for HIV-positive clients
- ❖ Determine a client's medical eligibility for female sterilisation
- ❖ List the six points of informed consent for female sterilisation
- ❖ List the client assessment tasks required for female sterilisation
- ❖ Explain when women can undergo interval or postpartum minilaparotomy
- ❖ Describe the procedure for performing postpartum minilaparotomy
- ❖ Describe the procedure for performing interval minilaparotomy
- ❖ Demonstrate knowledge and skills in counselling clients to make an informed choice about female sterilisation
- ❖ Demonstrate competence in performing both postpartum minilaparotomy and interval minilaparotomy (for the cadres performing the procedure).

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## Unit 10: Female Sterilisation

### Key Points

- ❖ **Highly effective and safe contraception**
- ❖ **Permanent.** Intended to provide life-long protection against pregnancy. Reversal is usually not possible.
- ❖ **Involves a physical examination and surgery.** A specifically trained provider is needed for the procedure.
- ❖ **No long-term side effects.**

### 10.1 Defining Female Sterilisation

Female sterilisation is a procedure for permanently occluding the fallopian tubes for clients who do not want more children.

#### Techniques of female sterilisation

Female sterilisation is also called tubal sterilisation, tubal ligation, voluntary surgical contraception, tubectomy, bi-tubal ligation, tying the tubes, mini-lap and “the operation.” This unit provides information and instruction primarily for postpartum and interval minilaparotomy procedures.

Two surgical approaches are most commonly used:

- **Minilaparotomy (minilap)** involves making a 2-5 cm incision in the abdomen. The fallopian tubes are brought to the incision and cut or blocked. Minilaparotomy can be performed up to 7 days after childbirth (**postpartum minilap**), or 6 weeks or more after childbirth (**interval minilap**).
- **Laparoscopy** involves inserting a long thin tube with a lens in it into the abdomen through a small incision. Laparoscopy enables the clinician to see and block or cut the fallopian tubes in the abdomen without making a large incision in the skin. In general, laparoscopy is not performed postpartum.

Other surgical approaches for female sterilisation include the **transcervical approach**, which involves the use of special equipment to implant blocking devices in the fallopian tubes by passing through the cervix and uterus. Sterilisation can also be performed at the time of a **caesarean section** if the woman was counselled, and she gave her consent prior to the procedure.

#### How female sterilisation works

Sterilisation procedures work by blocking or cutting the fallopian tubes, usually by tying and cutting or through electrocautery. Eggs released from the ovaries are thereby prevented from moving down the tubes and meeting the sperm.

### 10.2 Effectiveness

Female sterilisation is one of the most effective contraceptive methods, but it has a small risk of failure.

- Less than 1 pregnancy occurs per 100 clients over the first year after having the sterilisation procedure (5 per 1,000). This means that 995 of every 1,000 clients relying on female sterilisation will not become pregnant, or it is 99.5% effective.
- A small risk of pregnancy remains beyond the first year of use and until the woman reaches menopause.

**Fertility does not return** because sterilisation generally cannot be stopped or reversed. The procedure is intended to be permanent. Reversal surgery is difficult, expensive, and not available in most areas.

## 10.3 Characteristics

### Advantages

- Highly effective
- Has no lasting side effects
- Permanent, no need to think about contraception again
- Does not affect sexual function, menstruation or breastfeeding
- Is easy to use, nothing to do or to remember

### Disadvantages

- Requires surgical procedure
- Does not provide protection from sexually transmitted infections (STIs), including HIV

### Side effects

None, except short-term effects of surgery.

### Health benefits

- May help protect against pelvic inflammatory disease (PID)
- May help protect against ovarian cancer

### Health risks

Uncommon to extremely rare:

- Complications of surgery and anaesthesia (see Section 10.4)

## 10.4 Complications of Surgery

Complications of female sterilisation are uncommon, but include:

- Adverse reactions to anaesthesia
- Infection or abscess of the incision site
- Bleeding in the abdomen (from the cut fallopian tubes)

Female sterilisation is a safe method of contraception. It requires surgery and anaesthesia, however, which carry some risks. Serious complications are uncommon. Death due to the procedure or anaesthesia is extremely rare. The risk of complications with local anaesthesia is significantly lower than with general anaesthesia.

## 10.5 Correcting Misconceptions

Female sterilisation:

- Does not lead to loss of femininity or sexual desire
- Does not make the woman weak or cause lasting pain in the back, uterus or abdomen



- Does not require removal of uterus or lead to a need to have it removed
- Does not cause heavier bleeding or otherwise change the woman's menstrual cycle
- Does not cause weight gain, or changes in appetite or appearance
- Does not cause hormonal imbalances, and eggs do not build up in the body.

## 10.6 Women Who Can Have Female Sterilisation

With proper counselling and informed consent, any woman can have female sterilisation safely, including clients who:

- Have no children or few children
- Are not married
- Are young
- Just gave birth (within the last 7 days)
- Just had an uncomplicated abortion or miscarriage
- Are breastfeeding
- Are infected with HIV, whether or not on antiretroviral (ARV) therapy.

In some of these situations, especially careful counselling is important to make sure the client will not regret her decision. Women can have female sterilisation:

- Without any blood tests or routine laboratory tests
- Without cervical cancer screening
- Even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant. (See the Pregnancy Checklist in Unit 4, Client FP Assessment and WHO MEC.)

## 10.7 Female Sterilisation for Women with HIV

- Clients who are infected with HIV, have AIDS, or are on ARV therapy can safely undergo female sterilisation. Special arrangements are needed to perform female sterilisation on a woman with AIDS. (See Medical Eligibility, Section 10.8.)
- These clients should be encouraged to use condoms in addition to female sterilisation. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.
- No one should be coerced or pressured into having female sterilisation, and that includes clients with HIV/AIDS.

## 10.8

### Medical Eligibility Criteria Screening Questions For Female Sterilisation

#### All women can have female sterilisation.

The WHO Medical Eligibility Criteria (MEC) categories for permanent contraception (vasectomy and female sterilisation) are different than those for other contraceptive methods. Instead of using Categories 1- 4, the categories for these methods are: **Accept**, **Caution**, **Delay**, and **Special**.

In the case of female sterilisation, no medical conditions prevent a woman from using this method, although some conditions require **caution**, **delay**, or making **special** arrangements.

These screening questions identify known medical conditions that may limit when, where, or how the female sterilisation procedure should be performed. Ask the client the questions below. If she answers "no" to all of the questions, then the female sterilisation procedure can be performed in a routine setting without delay. If no concerns are identified, the provider should perform a pelvic exam before scheduling the procedure. If she answers "yes" to a question, follow the instructions, which recommend caution, delay, or special arrangements.

In the set of screening questions below:

- *Caution* means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition.
- *Delay* means postpone female sterilisation. These conditions must be treated and resolved before female sterilisation can be performed. Give the client another method to use until the procedure can be performed.
- *Special* means special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anaesthesia, and other backup medical support. For these conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen also is needed. Give the client another method to use until the procedure can be performed.

#### 1. Do you have any current or past female conditions or problems (gynaecologic or obstetric conditions or problems), such as infection or cancer? If so, what problems?

Action	Condition
If she has any of these, use <b>caution</b>	<ul style="list-style-type: none"> <li>• Past pelvic inflammatory disease since last pregnancy</li> <li>• Uterine fibroids</li> <li>• Previous abdominal or pelvic surgery</li> </ul>
If she has any of these, <b>delay</b> female sterilisation	<ul style="list-style-type: none"> <li>• Current pregnancy</li> <li>• 7–42 days postpartum</li> <li>• Postpartum after a pregnancy with severe pre-eclampsia or eclampsia</li> <li>• Serious postpartum or postabortion complications (such as infection, hemorrhage, or trauma) except uterine rupture or</li> </ul>

	<p>perforation, which requires special arrangements (see below)</p> <ul style="list-style-type: none"> <li>• A large collection of blood in the uterus</li> <li>• Unexplained vaginal bleeding that suggests an underlying medical condition</li> <li>• Pelvic inflammatory disease</li> <li>• Purulent cervicitis, chlamydia, or gonorrhea</li> <li>• Pelvic cancers (treatment may make her sterile in any case)</li> <li>• Malignant trophoblast disease</li> </ul>
If she has any of these, make <b>special arrangements</b>	<ul style="list-style-type: none"> <li>• AIDS (see Female Sterilisation for Women With HIV, Section 10.7)</li> <li>• Fixed uterus due to previous surgery or infection</li> <li>• Endometriosis</li> <li>• Hernia (abdominal wall or umbilical)</li> <li>• Postpartum or postabortion uterine rupture or perforation</li> </ul>

2. Do you have any cardiovascular conditions, such as heart problems, stroke, high blood pressure, or complications of diabetes? If so, what?

Action	Condition
If she has any of these, use <b>caution</b>	<ul style="list-style-type: none"> <li>• Controlled high blood pressure</li> <li>• Mild high blood pressure (140/90 to 159/99 mm Hg)</li> <li>• Past stroke or heart disease without complications</li> </ul>
If she has any of these, <b>delay</b> female sterilisation	<ul style="list-style-type: none"> <li>• Heart disease due to blocked or narrowed arteries</li> <li>• Blood clots in deep veins of legs or lungs</li> </ul>
If she has any of these, make <b>special arrangements</b>	<ul style="list-style-type: none"> <li>• Several conditions together that increase chances of heart disease or stroke, such as older age, smoking, high blood pressure, or diabetes</li> <li>• Moderately high or severely high blood pressure (160/100 mm Hg or higher)</li> <li>• Diabetes for more than 20 years or damage to arteries, vision, kidneys, or nervous system caused by diabetes</li> <li>• Complicated valvular heart disease</li> </ul>

3. Do you have any lingering, long-term diseases or any other conditions? If so, what?

Action	Condition
If she has any of these, use <b>caution</b>	<ul style="list-style-type: none"> <li>• Epilepsy</li> <li>• Diabetes without damage to arteries, vision, kidneys, or nervous system</li> </ul>

	<ul style="list-style-type: none"> <li>• Hypothyroidism</li> <li>• Mild cirrhosis of the liver, liver tumours (Are her eyes or skin unusually yellow?), or schistosomiasis with liver fibrosis</li> <li>• Moderate iron-deficiency anaemia</li> <li>• Sickle cell disease</li> <li>• Inherited anaemia (thalassemia)</li> <li>• Kidney disease</li> <li>• Diaphragmatic hernia</li> <li>• Severe lack of nutrition (Is she extremely thin?)</li> <li>• Obesity (Is she extremely overweight?)</li> <li>• Elective abdominal surgery at time sterilisation is desired</li> <li>• Depression</li> <li>• Young age</li> <li>• Uncomplicated lupus</li> </ul>
If she has any of these, <b>delay</b> female sterilisation	<ul style="list-style-type: none"> <li>• Gallbladder disease with symptoms</li> <li>• Active viral hepatitis</li> <li>• Severe iron-deficiency anaemia (hemoglobin less than 7 g/dl)</li> <li>• Lung disease (bronchitis or pneumonia)</li> <li>• Systemic infection or significant gastroenteritis</li> <li>• Abdominal skin infection</li> <li>• Undergoing abdominal surgery for emergency or infection, or major surgery with prolonged immobilization</li> </ul>
If she has any of these, make <b>special arrangements</b>	<ul style="list-style-type: none"> <li>• Severe cirrhosis of the liver</li> <li>• Hyperthyroidism</li> <li>• Coagulation disorders (blood does not clot)</li> <li>• Chronic lung disease (asthma, bronchitis, emphysema, lung infection)</li> <li>• Pelvic tuberculosis</li> <li>• Lupus with positive (or unknown) antiphospholipid antibodies, with severe thrombocytopenia, or on immunosuppressive treatment</li> </ul>

## 10.9 The 6 Points of Informed Consent

Female sterilisation counselling must cover all 6 points of informed consent. In some programs the client and the counsellor both sign an informed consent form. To give informed consent for female sterilisation, the client must understand the following points:

- Temporary contraceptives are also available to the client.
- Sterilisation is a surgical procedure.

- 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.)
- If successful, the procedure will prevent the client from having any more children.
- The procedure is considered permanent and probably cannot be reversed.
- 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).

## 10.10 Timing: When to Provide Female Sterilisation

**Important:** If there is no medical reason to delay, a woman can have the female sterilisation procedure any time she wants, if it is reasonably certain she is not pregnant. To be reasonably certain she is not pregnant, use the Pregnancy Checklist. (See Unit 4: Client Family Planning Assessment and WHO MEC.)

Woman's Situation	When to Perform
Having menstrual cycles or switching from another method	<p><b>Any time of the month</b></p> <ul style="list-style-type: none"> <li>• Any time within 7 days after the start of her monthly bleeding. There is no need to use another method before the procedure.</li> <li>• If it is more than 7 days after the start of her monthly bleeding, she can have the procedure any time it is reasonably certain she is not pregnant.</li> <li>• If she is switching from oral contraceptives, she can continue taking pills until she has finished the pill pack to maintain her regular cycle.</li> <li>• If she is switching from an IUCD, she can have the procedure immediately.</li> </ul>
No monthly bleeding	<ul style="list-style-type: none"> <li>• Any time it is reasonably certain she is not pregnant</li> </ul>
After childbirth	<ul style="list-style-type: none"> <li>• Immediately or within 7 days after giving birth, if she has made a voluntary, informed choice in advance</li> <li>• Any time 6 weeks or more after childbirth if it is reasonably certain she is not pregnant</li> </ul>
After miscarriage or abortion	<ul style="list-style-type: none"> <li>• Within 48 hours after uncomplicated abortion, if she has made a voluntary, informed choice in advance</li> </ul>
After using emergency contraceptive pills (ECPs)	<ul style="list-style-type: none"> <li>• The sterilisation procedure can be done within 7 days after the start of her next monthly bleeding or any other time it is reasonably certain she is not pregnant. Give her a backup method or oral contraceptives to start the day after she finishes the ECPs to use until she can have the sterilisation.</li> </ul>

## 10.11 Client Instructions

### Explaining the procedure

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

### Postpartum minilap

1. The provider uses proper infection-prevention procedures at all times.
2. The provider performs a physical examination (cardiopulmonary, abdominal, and pelvic exam including bimanual). The pelvic examination is to assess the condition and mobility of the uterus and to be certain there are no signs of infection.
3. The client should not have anything to eat or drink prior to the procedure.
4. The provider usually gives the client local anaesthesia, which is injected at the lower edge of the navel to reduce pain. The client will feel a needle stick in her belly when the clinician injects the anaesthesia. The area around the injection will become numb.
5. The provider makes a small, horizontal incision 2-3 cm in the anesthetized area. The client will feel pressure, but it should not be painful.
6. The client stays awake throughout the procedure and feels little discomfort. She will probably feel some tugging, pulling, and slight cramping during the operation. The provider gives continual verbal feedback (verbal anaesthesia), explaining what he/she is doing, to reassure the client.
7. Each tube is cut and tied or cauterized.
8. The provider closes the incision with stitches and covers it with a sterile adhesive bandage.
9. The provider instructs the client what to do after she leaves the clinic or hospital.

### Interval minilap

1. The provider uses proper infection prevention procedures at all times.
2. The provider performs a physical examination (cardiopulmonary, abdominal, and pelvic exam, including bimanual). The pelvic examination is to assess the condition and mobility of the uterus and to be certain there are no signs of infection.
3. The client should not have anything to eat or drink prior to the procedure.
4. The provider may give the client medication to relax her, usually through an I.V. line.
5. The provider usually gives the client local anaesthesia, which is injected above the pubic hair line to reduce pain. The client will feel a needle stick in this area when the clinician injects the anaesthesia. The area around the injection will become numb.
6. The provider inserts a uterine elevator into the vagina, through the cervix and into the uterus. This helps to raise each of the 2 fallopian tubes so they are closer to the incision. This may cause discomfort but is not much different than having a regular pelvic exam with a speculum in the vagina.
7. The provider makes a transverse incision (2–3 cm) in the anaesthetized area.

8. The client stays awake throughout the procedure and feels little discomfort. She will probably feel some tugging, pulling, and slight cramping during the operation. The provider gives continual verbal feedback (verbal anaesthesia), explaining what he/she is doing, to reassure the client.
9. Each tube is tied and cut or cauterized.
10. The provider closes the incision with stitches and covers it with an adhesive bandage.
11. The provider instructs the client what to do after she leaves the clinic or hospital.

### **Preparing for the procedure**

#### **Tell the client the following:**

- Use another contraceptive until the procedure (for interval minilap).
- Do not eat anything for 8 hours before surgery. It is okay to drink clear liquids until 2 hours before surgery.
- Do not take any medication for 24 hours before the surgery unless told to do so.
- Wear clean, loose-fitting clothing to the health facility if possible.
- Do not wear nail polish or jewellery.
- Bring a friend or relative, if possible, to accompany you home afterwards, as you may feel weak from the anaesthesia.

### **After the procedure**

#### **Give instructions orally and in writing, if appropriate. Ask client to repeat instructions.**

- Rest for 2 days. Gradually resume normal activities as you feel able. You should be able to return to normal activities within 7 days.
- Keep the incision clean and dry for 2 days.
- Avoid heavy lifting and other strenuous physical activity for a week.
- Avoid rubbing the incision for 1 week.
- Do not have sex for at least 1 week and after resuming, stop if it is uncomfortable.
- It is normal to have some abdominal pain and local swelling after the procedure. It usually goes away within a few days. For pain relief take paracetamol (500–1000 mg) or ibuprofen every 4–6 hours.
- Return for follow-up 7 days after surgery.
- Return to the clinic immediately if you have any of the warning signs of possible complications. (See Section 10.12.)

## **10.12 Warning Signs of Complications**

- Bleeding or fluid coming from the incision, or heat swelling, or redness of the incision area
- Persistent or increasing abdominal pain
- Fever (greater than 38° C/100° F)
- Fainting, persistent light-headedness, or extreme dizziness, especially in the first week
- Signs or symptoms of pregnancy.

## 10.13 Managing Complications

Problems can affect women's satisfaction with female sterilisation, and they deserve the provider's attention. If the client reports complications of female sterilisation, listen to her concerns and, if appropriate, treat.

### **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 if the infection has not cleared after taking all antibiotics.

### **Abscess (a pocket of pus under the skin caused by infection)**

- Clean the area with antiseptic.
- Cut open (incise) and drain the abscess, and treat the wound.
- Give antibiotics for 7 to 10 days (may need intravenous antibiotics depending on the client's condition).
- Ask the client to return if she has heat, redness, pain, or drainage of the wound after taking all antibiotics.

### **Severe pain in lower abdomen, fainting with dizziness (suspected ectopic pregnancy)**

- See Managing Ectopic Pregnancy, below.

### **Suspected pregnancy**

- Assess for pregnancy, including ectopic pregnancy.

### **Managing ectopic pregnancy**

Ectopic pregnancy is any pregnancy that occurs outside the uterine cavity. Early diagnosis is important. Ectopic pregnancy is rare, but could be life-threatening and is more likely to happen after a woman has undergone sterilisation (see Question 11, Section 10.14).

- In the early stages of ectopic pregnancy, symptoms may be absent or mild, but eventually (usually by 6-8 weeks of pregnancy) they will become severe. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy:
  - Unusual abdominal pain or tenderness
  - Light-headedness or dizziness
  - Fainting.
- Abnormal vaginal bleeding or no monthly bleeding—especially if this is a change from her usual bleeding pattern
- Ruptured ectopic pregnancy: Sudden sharp or stabbing lower abdominal pain, sometimes on one side and sometimes throughout the body, suggests a ruptured ectopic pregnancy (when the fallopian tube breaks due to the pregnancy). Right shoulder pain may develop due to blood pressing on the diaphragm. Usually, within a few hours the abdomen becomes rigid, and the woman goes into shock.
- Care: Ectopic pregnancy is a life-threatening, emergency condition requiring immediate surgery. If ectopic pregnancy is suspected, perform a pelvic examination only if facilities



for immediate surgery are available. Otherwise, immediately refer and/or transport the woman to a facility where definitive diagnosis and surgical care can be provided.

## 10.14 Questions and Answers about Female Sterilisation

### 1. Will sterilisation change a woman's monthly bleeding or make monthly bleeding stop?

No. Most research finds no major changes in bleeding patterns after female sterilisation. If a woman was using a hormonal method or IUCD before sterilisation, her bleeding pattern will return to the way it was before she used these methods. For example, women switching from COCs to female sterilisation may notice heavier bleeding as their monthly bleeding returns to usual patterns. Note, however, that a woman's monthly bleeding usually becomes less regular as she approaches menopause.

### 2. Will sterilisation make a woman lose her sexual desire? Will it make her fat?

No. After sterilisation a woman will look and feel the same as before. She can have sex the same as before. She may find that she enjoys sex more because she does not have to worry about getting pregnant. She will not gain weight because of the sterilisation procedure.

### 3. Should sterilisation be offered only to women who have had a certain number of children, who have reached a certain age, or who are married?

No. There is no justification for denying sterilisation to a woman just because of her age, the number of her living children, or her marital status. Health care providers must not impose rigid rules about age, number of children, age of last child, or marital status. Each woman must be allowed to decide for herself whether or not she will want more children and whether or not to have sterilisation.

### 4. Is it not easier for the woman and the health care provider to use general anaesthesia? Why use local anaesthesia?

Local anaesthesia is safer. General anaesthesia is more risky than the sterilisation procedure itself. Correct use of local anaesthesia removes the single greatest source of risk in female sterilisation procedures—general anaesthesia. Also, after general anaesthesia, women usually feel nauseous. This does not happen as often after local anaesthesia.

When using local anaesthesia with sedation, however, providers must take care not to overdose the woman with the sedative. They also must handle the woman gently and talk with her throughout the procedure. This helps her to stay calm. With many clients, sedatives can be avoided, especially with good counselling and a skilled provider.

### 5. Does a woman who has had a sterilisation procedure ever have to worry about getting pregnant again?

Generally, no. Female sterilisation is very effective at preventing pregnancy and is intended to be permanent. It is not 100% effective, however. Women who have been sterilized have a slight risk of becoming pregnant: About 5 of every 1,000 women become pregnant within a year after the procedure. The small risk of pregnancy remains beyond the first year and until the woman reaches menopause.

### 6. Pregnancy after female sterilisation is rare, but why does it happen at all?

Most often it is because the woman was already pregnant at the time of sterilisation. In some cases an opening in the fallopian tube develops, permitting the egg to travel through

and meet the sperm. Pregnancy also can occur if the provider makes a cut in the wrong place instead of the fallopian tubes.

**7. Can sterilisation be reversed if the woman decides she wants another child?**

Generally, no. Sterilisation is intended to be permanent. People who may want more children should choose a different family planning method. Surgery to reverse sterilisation is possible for only some women, but, among these women, reversal often does not lead to pregnancy. The procedure is difficult and expensive, and providers who are able to perform such surgery are hard to find. When pregnancy does occur after reversal, the risk that the pregnancy will be ectopic is greater than usual. Thus, sterilisation should be considered irreversible.

**8. Is it better for the woman to have female sterilisation or the man to have a vasectomy?**

Each couple must decide for themselves which method is best for them. Both are very effective, safe, permanent methods for couples who know that they will not want more children. Ideally, a couple should consider both methods. If both are acceptable to the couple, vasectomy would be preferable because it is simpler, safer, easier, and less expensive than female sterilisation.

**9. Will the female sterilisation procedure hurt?**

Yes, a little. Women receive local anaesthetic to stop pain, and, except in special cases, they remain awake. A woman can feel the health care provider moving her uterus and fallopian tubes. This can be uncomfortable. If a trained anaesthetist or anaesthesiologist and suitable equipment are available, general anaesthesia may be chosen for women who are very frightened of pain. A woman may feel sore and weak for several days or even a few weeks after surgery, but she will soon regain her strength.

**10. How can health care providers help a woman decide about female sterilisation?**

Provide clear, balanced information about female sterilisation and other family planning methods, and help a woman think through her decision fully. Thoroughly discuss her feelings about having children and ending her fertility. For example, a provider can help a woman think how she would feel about possible life changes such as a change of partner or a child's death. Review the 6 Points of Informed Consent (Section 10.9) to be sure the woman understands the sterilisation procedure.

**11. Does female sterilisation increase the risk of ectopic pregnancy?**

No. On the contrary, female sterilisation greatly reduces the risk of ectopic pregnancy. Ectopic pregnancies are very rare among women who have had a sterilisation procedure. The rate of ectopic pregnancy among women after female sterilisation is 6 per 10,000 women per year. The rate of ectopic pregnancy among women in the United States using no contraceptive method is 65 per 10,000 women per year.

On the rare occasions that sterilisation fails and pregnancy occurs, 33 of every 100 (1 of every 3) of these pregnancies are ectopic. Thus, most pregnancies after sterilisation failure are not ectopic. Still, ectopic pregnancy can be life-threatening, so a provider should be aware that ectopic pregnancy is possible if sterilisation fails.

**12. Where can female sterilisation be performed?**

If no pre-existing medical conditions require special arrangements:

- Minilaparotomy can be provided in maternity centres and basic health facilities where surgery can be done. These include both permanent and temporary facilities that can refer the woman to a higher level of care in case of emergency.
- Laparoscopy requires a better equipped centre where the procedure is performed regularly, and where specialized equipment and an anaesthetist are available.

### **13. What are transcervical methods of sterilisation?**

Transcervical methods involve new ways of reaching the fallopian tubes, through the vagina and uterus. A microcoil, Essure, is already available in some countries. Essure is a spring-like device that a specifically trained clinician using a viewing instrument (hysteroscope) inserts through the vagina into the uterus and then into each fallopian tube. Over the 3 months following the procedure, scar tissue grows into the device. The scar tissue permanently plugs the fallopian tubes so that sperm cannot pass through to fertilize an egg. Essure is unlikely to be introduced in low-resource settings soon, however, because of the high cost and complexity of the viewing instrument required for insertion.

## Female Sterilisation Role Play

### Participant Roles

**Clinician:** The clinician is an experienced family planning service provider. She/he is calm and knowledgeable when counselling clients.

**Client:** The client is a 33-year-old woman with 2 children. She has successfully used DMPA as her method of family planning for 6 years and is very happy with it. Her husband is now certain that he is too old to raise any more children and has suggested that she be sterilised; he says he is also concerned about her taking so many hormones for such a long time.

### Situation

The client now comes to the clinic to get more information on sterilisation. She says that she too does not want to have any more children but is satisfied with DMPA and is not sure why she should change. She is also concerned, however, that she may be taking too much medication for too long a period of time. She repeatedly asks about the permanent nature of sterilisation.

# Female Sterilisation Quiz Questions

**Directions: Circle the best answer for each question**

1. As compared to vasectomy, which of the following is an important issue to note with regard to female sterilisation?
  - a. More effective
  - b. Less expensive
  - c. Safer
  - d. All of the above
  - e. None of the above
2. Possible complications of female sterilisation include all of the following except:
  - a. Infection at incision site
  - b. Loss of sexual function
  - c. Abscess
  - d. None of the above
3. Female sterilisation has an effectiveness rate of:
  - a. 95%
  - b. 97.5%
  - c. 99.5%
  - d. 100%
4. Types of female sterilisation procedures include:
  - a. Minilaparotomy
  - b. Laparoscopy
  - c. Vasectomy
  - d. (a) and (b) above
  - e. All of the above
5. Female sterilisation protects against pregnancy for an average of:
  - a. 3-5 years
  - b. 8-10 years
  - c. 15 years
  - d. Female sterilisation protects against pregnancy permanently.
6. Which of the following are true about female sterilisation? (Tick all that apply)
  - a. Can be performed within 7 days after giving birth, if voluntary informed consent is given in advance
  - b. Requires removal of the uterus
  - c. Ends menstruation in women who undergo the procedure
  - d. Should never be performed on a woman who has never had children
  - e. Requires a pelvic exam
7. Essential points about informed consent for female sterilisation include: (Tick all that apply)
  - a. Temporary contraceptives are also available.
  - b. Sterilisation involves a surgical procedure.
  - c. The sterilisation procedure involves no risks.
  - d. The sterilisation procedure can be reversed whenever the woman desires pregnancy.
  - e. All of the above

**Questions 8–16:** Indicate whether the following statements about female sterilisation are **true** or **false** by writing a **“T”** for true or an **“F”** for false in the space provided before each statement.

- \_\_\_ 8. A trained counsellor or provider is the best person to choose an appropriate contraceptive method for a couple.
- \_\_\_ 9. The female sterilisation provider should verify a client’s informed consent by talking with her before the procedure.
- \_\_\_ 10. During female sterilisation counselling the client should be assured that she can change her mind at any time before the procedure without losing the right to other medical services.
- \_\_\_ 11. A woman with uterine fibroids cannot undergo female sterilisation.
- \_\_\_ 12. A pre-female sterilisation evaluation includes a medical history, a complete physical exam, and a hemoglobin count or hematocrit.
- \_\_\_ 13. A client with chlamydia should delay female sterilisation until the infection is treated.
- \_\_\_ 14. A client whose female sterilisation needs to be delayed should be counselled about alternative methods of contraception to use in the meantime.
- \_\_\_ 15. After female sterilisation, a woman should use backup contraception for 3 weeks, until the sterilisation takes effect.
- \_\_\_ 16. Female sterilisation provides protection against pregnancy and sexually transmitted infections.

## Female Sterilisation Quiz Questions Answer Key

1. As compared to vasectomy, which of the following is an important issue to note with regard to female sterilisation?  
**e. None of the above**
2. Possible complications of female sterilisation include all of the following except:  
**b. Loss of sexual function**
3. Female sterilisation has an effectiveness rate of:  
**c. 99.5%**
4. Types of female sterilisation procedures include:  
**d. (a) and (b) above**
5. Female sterilisation protects against pregnancy for an average of:  
**d. Female sterilisation protects against pregnancy permanently.**
6. Which of the following are true about female sterilisation? (Tick all that apply)  
**a. Can be performed within 7 days after giving birth, if voluntary informed consent is given in advance**  
**e. Requires a pelvic exam**
7. Essential points about informed consent for female sterilisation include: (Tick all that apply)  
**a. Temporary contraceptives are also available.**  
**b. Sterilisation involves a surgical procedure.**

**Questions 8–16:** Indicate whether the following statements are **true** or **false** by writing a **“T”** for true or an **“F”** for false in the space provided before each statement.

- F**\_\_ 8. A trained counsellor or provider is the best person to choose an appropriate contraceptive method for a couple.
- T**\_\_ 9. The female sterilisation provider should verify a client’s informed consent by talking with her before the procedure.
- T**\_\_ 10. During female sterilisation counselling the client should be assured that she can change her mind at any time before the procedure without losing the right to other medical services.
- F**\_\_ 11. A woman with uterine fibroids cannot undergo female sterilisation.
- F**\_\_ 12. A pre-female sterilisation evaluation includes a medical history, a complete physical exam, and a hemoglobin count or hematocrit.
- T**\_\_ 13. A client with chlamydia should delay female sterilisation until the infection is treated.
- T**\_\_ 14. A client whose female sterilisation needs to be delayed should be counselled about alternative methods of contraception to use in the meantime.
- F**\_\_ 15. After female sterilisation, a woman should use backup contraception for 3 weeks, until the sterilisation takes effect.
- F**\_\_ 16. Female sterilisation provides protection against pregnancy and sexually transmitted infections.

## Minilap Learning Guides

### Learning Guide for Minilaparotomy Counselling Skills

(to be used by participants)

Rate the performance of each step or task observed using the following rating scale:	
1	<b>Needs Improvement:</b> Step or task not performed correctly or out of sequence (if necessary) or is omitted
2	<b>Competently Performed:</b> Step or task performed correctly in proper sequence (if necessary) but participant not progressing from step to step efficiently
3	<b>Proficiently Performed:</b> Step or task efficiently and precisely performed in the proper sequence (if necessary)

Participant \_\_\_\_\_ Course Dates \_\_\_\_\_

### Learning Guide for Minilaparotomy Counselling Skills

Task/Activity	Cases	1	2	3	4	5
<b>BCS+ STEPS 1-6: SEE UNIT 5 FOR BCS+ LEARNING GUIDE</b>						
<b>STEP 7: DETERMINE CLIENT'S MEDICAL ELIGIBILITY FOR THE CHOSEN METHOD.</b>						
1. Use the MEC Screening Questions for Female Sterilisation to determine if delay or special arrangements are indicated.						
2. Advise the client according to their answers to the screening questions.						
<b>STEP 8: GIVE THE CLIENT COMPLETE INFORMATION ABOUT THE METHOD THAT SHE HAS CHOSEN</b>						
1. Clearly discuss the benefits of minilap. Emphasize that it is a permanent method but there is a small chance of failure.						
2. Explain the importance of the spouse being involved in decision for MINILAP.						
3. (If woman has chosen Postpartum Minilap) Discuss whether the client's decision to have female sterilization might change if the baby were to die or suffer from health problems.						
4. Explain that minilap does not protect against STIs, including AIDS. (If the client is at risk, she may need to use a barrier contraceptive method also).						
5. Explain common complications of the surgical procedure and be sure they are fully understood.						
6. Explain the surgical procedure and what to expect during and afterwards.						
7. Discuss scheduling procedure and possible need for contraception prior to minilap.						
<b>STEP 9: CHECK THE CLIENT'S COMPREHENSION AND REINFORCE KEY INFORMATION</b>						
1. Check the client's comprehension and reinforce key information						
2. Obtain client's signature or mark on the informed consent form.						
<b>STEP 9A: (FOR PERMANENT METHODS) CONDUCT REQUIRED SCREENING EXAMINATIONS</b>						
1. Perform pelvic exam (speculum and bi-manual)						
2. Advise woman based on exam findings, and schedule minilap procedure as indicated.						
<b>STEP 10: MAKE SURE THE CLIENT HAS MADE A DEFINITE DECISION. GIVE HER/HIM</b>						



Learning Guide for Minilaparotomy Counselling Skills					
Task/Activity	Cases				
<b>THE SELECTED METHOD</b>					
<b>PRE-PROCEDURE (EXAMINATION/PROCEDURE AREA)</b>					
1. Review client history and physical examination to assure proper client selection.					
2. Verify client's identity and check that informed consent was obtained.					
3. Explain that she will feel discomfort and a little pain during the procedure and she should inform a member of the surgical team if she feels significant pain at any time.					
<b>POST PROCEDURE</b>					
1. After sedation has worn off, give postoperative instructions, orally and in writing if appropriate. Ask client to repeat instructions.					
2. Discuss what to do if the client experiences any problems.					
3. Schedule a return visit within 7 days (according to local protocols).					
4. Discuss arrangements for discharge (e.g., person accompanying client home).					
5. Assure client she can return to the same clinic at any time to receive advice or medical attention.					
6. Answer client questions.					
7. Complete client record.					

# Learning Guide for Postpartum Minilaparotomy Operating Provider Skills

(to be used by participants)

Rate the performance of each step or task observed using the following rating scale:	
1	<b>Needs Improvement:</b> Step or task not performed correctly or out of sequence (if necessary) or is omitted
2	<b>Competently Performed:</b> Step or task performed correctly in proper sequence (if necessary) but participant not progressing from step to step efficiently
3	<b>Proficiently Performed:</b> Step or task efficiently and precisely performed in the proper sequence (if necessary)

Participant \_\_\_\_\_ Course Dates \_\_\_\_\_

Learning Guide for Postpartum Minilaparotomy Operating Provider Skills	
Task/Activity	Cases
<b>GETTING READY</b>	
1. Change into surgical apparel (scrub suit or dress, cap and mask).	
2. Greet client respectfully and establish rapport.	
3. Review client history and physical examination.	
4. Verify client's identity and check that informed consent was obtained.	
5. Confirm that the client has not consumed solid foods for 6 hours and fluids for 2 hours before surgery.	
6. Check that client has thoroughly washed and rinsed abdominal and perineal areas.	
7. Check that client has recently emptied her bladder.	
<b>PRE-OPERATIVE TASKS</b>	
1. Help position client flat on her back on operating table.	
2. Determine that sterile or high-level disinfected instruments and emergency tray are present.	
3. Give IV medication, if needed (initial or maximum dose based on client's weight).	
4. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.	
5. Determine height of the uterine fundus.	
6. Perform surgical scrub (3 to 5 minutes) and put on sterile gown.	
7. Put sterile or high-level disinfected surgical gloves on both hands.	
8. Apply antiseptic solution to the incision area 2 times using a circular motion.	
9. Drape client for the procedure.	
10. Throughout procedure talk to client (verbal anaesthesia).	

# Learning Guide for Postpartum Minilaparotomy Operating Provider Skills

Task/Activity	Cases				
<b>ML/LA PROCEDURE</b>					
<b>LOCAL ANAESTHESIA: SUBUMBILICAL INCISION</b>					
1a. Raise a small skin wheal at centre of incision site using 1% local anaesthetic (e.g., lignocaine without epinephrine) in a 10 or 20 ml sterile or high-level disinfected syringe (maximum total dose for procedure of 4.5mg/kg).					
1b. Starting at the centre of the planned incision, administer local anaesthetic (about 3-5 ml) just under the skin along both sides of the incision line.					
1c. Again starting at the centre of the incision line, insert needle into the fascia with the needle directed along the upper half of incision line.					
1d. Aspirate to ensure the needle is not in a blood vessel; then withdraw the needle slowly while injecting additional 3-5 ml of lignocaine without epinephrine. (Repeat on other half of incision line).					
2. Withdraw needle and place in a safe area to prevent accidental needle sticks.					
3. Massage the skin to spread the anaesthetic within the tissues.					
4. Test incision site for adequate anaesthesia. (If client feels pain, wait 2-3 more minutes and retest incision site).					
<b>ABDOMINAL ENTRY: TRANSVERSE SUBUMBILICAL INCISION</b>					
5. Make a transverse skin incision, approximately 3 cm long, about 1 cm inferior to uterine fundus.					
6. Bluntly dissect subcutaneous tissues with scissor tips (use retractors as needed).					
7. Identify anterior rectus sheath, grasp sheath at 2 places with forceps and cut transversely with scissors.					
8. Separate rectus muscles in the midline (longitudinally) using blunt dissection with hemostat and clean off preperitoneal tissue, if needed.					
9. Use retractors to adequately expose the peritoneum and grasp it with forceps, (If client feels pain, provide more local anaesthesia).					
10. Confirm identification of peritoneum. Move bowel or other abdominal tissue away from planned entry site with fingers or a small retractor.					
11. While elevating the peritoneum with the forceps and watching carefully to avoid bowel, make a small incision in the peritoneum with scissors.					
12. Enlarge opening vertically with scissors, place hemostat on upper and lower (superior and inferior) cut edges of peritoneum and reposition retractors (longitudinally) within abdominal cavity. (Place client in slight head-down, Trendelenburg position, as needed).					
13. Use retractors to move abdominal contents away from operative site. If necessary, insert ribbon gauze to keep abdominal tissues from incision site.					
<b>LOCATING FALLOPIAN TUBES</b>					

## Learning Guide for Postpartum Minilaparotomy Operating Provider Skills

Task/Activity	Cases				
14. Visually confirm presence of uterine fundus underneath incision site.					
15. With the retractors in place, gently reposition the incision over the right or left adnexa by manipulating the uterus through the abdominal wall.					
16. Visually confirm presence of corneal portion of tube at incision site.					
<b>GRASPING THE FALLOPIAN TUBES: FORCEPS METHOD (MODIFIED POMEROY)</b>					
17. Identify midportion of tube and gently grasp it with the Babcock forceps.					
18. Gently bring the tube through incision. (Do not lock forceps and avoid grasping the cornu).					
19. Identify fimbriated end of the tube by “walking” the forceps laterally.					
<b>TUBAL OCCLUSION</b>					
20. While grasping the midportion (isthmus) of tube, place single free tie (absorbable suture) around a 1-2 cm loop of tube (about 3 cm from cornu) and tie square knot.					
21. Cut out a loop of tube with scissors and while still holding ligature, inspect the stump for hemostasis.					
22. Cut ligature 1 cm from stump and release tube allowing it to return to abdomen.					
23. Repeat procedure on opposite side for second tube.					
<b>CLOSURE (WHEN HEMOSTASIS ASSURED, CLOSE WOUND IN LAYERS)</b>					
24. Secure rectus fascial edges with interrupted sutures.					
25. Close skin with absorbable suture material.					
26. Dress the wound with a sterile dressing.					
<b>POST-OPERATIVE TASKS</b>					
1. Ensure that client is safely transferred to the recovery area.					
2. Fill syringe (with needle attached) with 0.5% chlorine solution and soak for 10 minutes. Process syringe and needle according to infection prevention guidelines for reuse.					
3. Place instruments in 0.5% chlorine solution for decontamination and soak for 10 minutes.					
4. Dispose of waste materials according to guidelines.					
5. Briefly immerse gloved hands in chlorine solution. If disposing of gloves, place in leak-proof container or plastic bag. If reusing gloves, soak gloves in chlorine solution for 10 minutes.					
6. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
7. Ensure that client is monitored at regular intervals and that vital signs are taken.					
8. Determine that client is ready for discharge (at least 2 hours after any IV medications have been administered).					

# Learning Guide for Interval Minilaparotomy Operating Provider Skills

(to be used by participants)

Rate the performance of each step or task observed using the following rating scale:	
4	<b>Needs Improvement:</b> Step or task not performed correctly or out of sequence (if necessary) or is omitted
5	<b>Competently Performed:</b> Step or task performed correctly in proper sequence (if necessary) but participant not progressing from step to step efficiently
6	<b>Proficiently Performed:</b> Step or task efficiently and precisely performed in the proper sequence (if necessary)

Participant \_\_\_\_\_ Course Dates \_\_\_\_\_

Learning Guide for Interval Minilaparotomy Operating Provider Skills					
Task/Activity	Cases				
<b>GETTING READY</b>					
1. Change into surgical apparel (scrub suit or dress, cap and mask).					
2. Greet client respectfully and with kindness, and establish rapport.					
3. Review client history and physical examination.					
4. Verify client's identity and check that informed consent was obtained.					
5. Check that client has thoroughly washed and rinsed abdominal and pelvic areas.					
6. Check that client has recently emptied her bladder.					
<b>PRE-OPERATIVE TASKS</b>					
1. Help position client flat on her back on operating table, in the "frog leg" position (or in stirrups if available).					
2. Determine that sterile or high-level disinfected instruments and emergency tray are present.					
3. Give IV medication, if needed (initial or maximum dose based on client's weight).					
4. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
5. Put new examination or high-level disinfected surgical gloves on both hands.					
6. Perform a gentle bimanual pelvic examination to assess uterine size, position, and mobility and presence of any pelvic abnormality.					
7. Insert vaginal speculum to see the cervix.					
8. Apply antiseptic solution 2 times to the cervix (especially the os) and vagina.					
9. Insert uterine elevator into the cervix without touching the vaginal walls.					
10. Remove the vaginal speculum and tenaculum without dislodging uterine elevator and place in 0.5% chlorine solution for decontamination.					

## Learning Guide for Interval Minilaparotomy Operating Provider Skills

<b>Task/Activity</b>	<b>Cases</b>				
11. Determine fundal height by gently pushing down on exposed end of uterine elevator and palpating abdominally.					
12. Select incision site.					
13. Position client's leg flat on the operating table with handle of elevator between her thighs.					
14. Briefly immerse gloved hands in chlorine solution. If disposing of gloves, place in leak-proof container or plastic bag. If reusing gloves, soak gloves in chlorine solution for 10 minutes.					
15. Perform surgical scrub (3-5 minutes) and put on sterile gown.					
16. Put sterile surgical gloves on both hands.					
17. Apply antiseptic solution to the incision area 2 times using a circular motion.					
18. Drape client for the procedure.					
19. Throughout procedure talk to client (verbal anaesthesia).					
<b>ML/LA PROCEDURE</b>					
<b>LOCAL ANAESTHESIA</b>					
1. Raise a small skin wheal at centre of incision site using 1% local anaesthetic (e.g., lignocaine) in a 10 or 20 ml sterile or high-level disinfected syringe (maximum dose for entire procedure of 4.5 mg/kg).					
2. Starting at the centre of the planned incision, administer local anaesthetic (about 3-5 ml) just under the skin along both sides of the incision line.					
3. Again starting at the centre of the incision line, insert needle into the fascia at 45° angle with the needle directed slightly above the incision line.					
4. Aspirate to ensure the needle is not in a blood vessel; then withdraw the needle slowly while injecting 3-5 ml of lignocaine without epinephrine. (Repeat at 45° angle directly below incision line.)					
5. Insert the needle down through the rectus sheath to the perineum, aspirate and inject 1-2 ml into the peritoneal layer.					
6. Withdraw needle and place in a safe area to prevent accidental needle sticks.					
7. Massage the skin to spread the anaesthetic within the tissues.					
8. Test incision site with tissue forceps for adequate anaesthesia. (If client feels pain, wait 2-3 more minutes and retest incision site).					
<b>ABDOMINAL ENTRY</b>					
9. Make a 3 cm transverse incision in the skin about 3 cm above the pubic symphysis (usually 1 cm below the height of the uterine fundus). Do not incise subcutaneous tissue. Control small bleeding vessels, if any.					
10. Bluntly dissect subcutaneous tissues with scissor tips (use retractors as needed).					
11. Identify and grasp fascia with Kelly forceps and incise transversely with scissors until rectus muscle can be seen on either side of the sheath.					

## Learning Guide for Interval Minilaparotomy Operating Provider Skills

Task/Activity	Cases
12. Separate rectus muscles in the midline (longitudinally) using blunt dissection with hemostat and clean off preperitoneal tissue.	
13. Use retractors to adequately expose the peritoneum and grasp it with forceps. (If client feels pain, provide more local anaesthesia).	
14. Confirm identification of peritoneum. Move bowel or other abdominal tissue away from planned entry site.	
15. While elevating the peritoneum with the forceps to avoid bowel, make a small incision in the peritoneum with scissors.	
16. Enlarge opening with scissors, place hemostat on upper and lower cut edges of peritoneum and reposition retractors (vertically) within abdominal cavity.	
17. Use retractors to move abdominal contents away from operative site.	
<b>LOCATING FALLOPIAN TUBES</b>	
18. Gently push down on handle of uterine elevator to bring uterine fundus toward incision. (Place client in head-down, Trendelenburg position, as needed).	
19. Visually confirm presence of uterine fundus underneath incision site.	
20. Rotate uterine elevator around its long axis to bring right or left cornu and fallopian tube under incision site.	
21. Visually confirm presence of corneal portion of tube at incision site.	
<b>GRASPING THE FALLOPIAN TUBES: FORCEPS METHOD</b>	
22a. Identify midportion of tube and gently grasp it with the Babcock forceps.	
22b. Gently bring the tube through incision. (Do not lock forceps and avoid grasping the cornu).	
22c. Identify fimbriated end of the tube by “walking” the forceps laterally.	
<b>GRASPING THE FALLOPIAN TUBES: TUBAL HOOK METHOD</b>	
22a. Insert tubal hook behind uterus and move one end of hook laterally until it is positioned behind the mesosalpinx.	
22b. Press the handle against the abdominal wall until parallel (flat) with it.	
22c. Visualize mid-portion of the tube held by tubal hook and bring it up to the incision.	
22d. Insert a Babcock forceps and gently grasp the tube.	
22e. With the Babcock forceps grasp the midportion of the tube gently and bring it through the incision. (Do not lock forceps and avoid grasping the cornu).	
22f. Identify the fimbriated end of the tube by “walking” the forceps laterally.	
<b>TUBAL OCCLUSION</b>	
23. While grasping the midportion (isthmus) of tube, place single free tie (absorbable suture) around a 1-2 cm loop of tube (about 3 cm from cornu) and tie square knot.	

## Learning Guide for Interval Minilaparotomy Operating Provider Skills

Task/Activity	Cases				
24. Cut out a loop of tube with scissors and while still holding ligature, inspect the stump for hemostasis.					
25. Cut ligature 1 cm from stump and release tube allowing it to return to abdomen.					
26. Repeat procedure on opposite side for second tube.					
<b>CLOSURE (WHEN HEMOSTASIS ASSURED, CLOSE WOUND IN LAYERS)</b>					
27. Secure fascial sheath edges with 2 interrupted sutures.					
28. Close skin with absorbable suture material.					
29. Apply a sterile dressing to the incision.					
<b>POST-OPERATIVE TASKS</b>					
1. Remove the uterine elevator and place in 0.5% chlorine solution.					
2. Ensure that client is safely transferred to the post-operative (recovery) area.					
3. Fill syringe (with needle attached) with 0.5% chlorine solution and soak for 10 minutes. Process syringe and needle according to infection prevention guidelines for reuse.					
4. Place instruments in 0.5% chlorine solution for decontamination and soak for 10 minutes.					
5. Dispose of waste materials according to guidelines.					
6. Briefly immerse gloved hands in chlorine solution. If disposing of gloves, place in leak-proof container or plastic bag. If reusing gloves, soak gloves in chlorine solution for 10 minutes.					
7. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
8. Ensure that client is monitored at regular intervals and that vital signs are taken.					
9. Determine that client is ready for discharge (at least 2 hours after IV medications).					



# Learning Guide for Minilaparotomy Circulating Nurse Skills

(to be used by participants)

Rate the performance of each step or task observed using the following rating scale:
1 <b>Needs Improvement:</b> Step or task not performed correctly or out of sequence (if necessary) or is omitted
2 <b>Competently Performed:</b> Step or task performed correctly in proper sequence (if necessary) but participant not progressing from step to step efficiently
3 <b>Proficiently Performed:</b> Step or task efficiently and precisely performed in the proper sequence (if necessary)

Participant \_\_\_\_\_ Course Dates \_\_\_\_\_

Learning Guide for Minilaparotomy Circulating Nurse Skills					
Task/Activity	Cases				
<b>PRE-OPERATIVE</b>					
1. Change into surgical apparel (scrub suit or dress, cap and mask).					
2. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
3. Ensure that all supplies including sedatives and lignocaine without epinephrine are present and equipment for monitoring vital signs is available.					
4. Greet client, review record, and assure that informed consent was obtained by the provider performing the minilaparotomy.					
5. Bring client to operating room and assist her onto operating table.					
6. Position client flat on her back on operating table.					
7. Take and record vital signs.					
8. Assist operating provider in tying surgical gown when he/she has scrubbed.					
9. Give IV analgesia for pain management.					
10. Prepare vaginal instruments for operating provider for internal examination.					
11. Assist with vaginal exam, and preparation and insertion of uterine elevator when operating provider directs (interval procedure only).					
12. Assist surgical assistant in handling of local anaesthesia.					
<b>DURING SURGERY</b>					
1. Talk to the client and be supportive of client during procedure.					
2. Anticipate and respond to needs of surgical team: <ul style="list-style-type: none"> <li>• Provide local anaesthetic to nursing assistant</li> <li>• Obtain extra/special instruments as required</li> <li>• Tie gowns of surgical team</li> <li>• Adjust lights.</li> </ul>					

## Learning Guide for Minilaparotomy Circulating Nurse Skills

Task/Activity	Cases				
3. Monitor and record client's vital signs during procedure and report any deviation from accepted norms to operating provider.					
4. Report to the operating provider any increase in client's discomfort or stress regarding: <ul style="list-style-type: none"> <li>• Pain level</li> <li>• Level of consciousness</li> <li>• Signs of reaction to medication including: itching, nausea/vomiting, difficulty breathing, or swelling of lips and tongue.</li> </ul>					
<b>POST-OPERATIVE</b>					
1. Provide dressing to cover incision after the procedure.					
2. Record vital signs before leaving operating room.					
3. Keep appropriate records during procedure and ensure record is complete regarding: <ul style="list-style-type: none"> <li>• Vital signs</li> <li>• Instrument and gauze counts after procedure is complete</li> <li>• Time of procedure (total and skin to skin).</li> </ul>					
4. Assist client transfer to the post-operative (recovery) area.					
5. Introduce client to post-operative area personnel and brief them on her condition (vital signs and any complications or problems).					

# Learning Guide for Minilaparotomy Surgical Assistant Skills

(to be used by participants)

Rate the performance of each step or task observed using the following rating scale:	
1	<b>Needs Improvement:</b> Step or task not performed correctly or out of sequence (if necessary) or is omitted
2	<b>Competently Performed:</b> Step or task performed correctly in proper sequence (if necessary) but participant not progressing from step to step efficiently
3	<b>Proficiently Performed:</b> Step or task efficiently and precisely performed in the proper sequence (if necessary)

Participant \_\_\_\_\_ Course Dates \_\_\_\_\_

Learning Guide for Minilaparotomy Surgical Assistant Skills					
Task/Activity	Cases				
<b>PRE-OPERATIVE</b>					
1. Change into surgical apparel (scrub suit or dress, cap and mask)					
2. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
3. Prepare instruments for procedure and: <ul style="list-style-type: none"> <li>• Ensure that sterile or high-level disinfected instruments are available and ready</li> <li>• Ensure that emergency instruments, equipment, drugs are available</li> <li>• Place sterile or high-level disinfected packs on the table.</li> </ul>					
4. Perform surgical scrub (3-5 minutes) and put on sterile gown.					
5. Put sterile or high-level disinfected surgical gloves on both hands.					
6. Arrange instruments on instrument table.					
7. Assist operating provider in draping the client.					
8. After verifying drug strength, withdraw local anaesthetic from vial held by circulating nurse.					
9. Note start time of surgery for circulator to record.					
<b>DURING SURGERY</b>					
1. Throughout the procedure, talk to the client.					
2. Assist during surgery, working as a team with operating provider.					
3. Take gauze and instrument counts and report findings to circulator.					
4. Record end time of surgery for circulator to record.					
5. Place dressing on wound at end of procedure.					
<b>POST-OPERATIVE</b>					
1. Remove drape when wound is dressed.					
2. Check that uterine elevator has been removed (interval procedure only).					
3. Ensure that client is transferred to the post-operative (recovery) area.					
4. Place instruments and other items in 0.5% chlorine solution for decontamination (in OR).					
5. Dispose of specimen of tube according to guidelines.					

Learning Guide for Minilaparotomy Surgical Assistant Skills					
Task/Activity	Cases				
6. Briefly immerse gloved hands in chlorine solution. If disposing of gloves, place in leak-proof container or plastic bag. If reusing gloves, soak in chlorine solution for 10 minutes.					
7. Wash hands with soap and water and dry with clean, dry cloth or air dry.					
8. Prepare instruments and operating room table for next case.					

## Learning Guide for Verbal Anaesthesia

These guidelines apply to the entire surgical team: operating provider, circulating nurse, surgical assistant.

(to be used by participants)

Rate the performance of each step or task observed using the following rating scale:
1 <b>Needs Improvement:</b> Step or task not performed correctly or out of sequence (if necessary) or is omitted
2 <b>Competently Performed:</b> Step or task performed correctly in proper sequence (if necessary) but participant not progressing from step to step efficiently
3 <b>Proficiently Performed:</b> Step or task efficiently and precisely performed in the proper sequence (if necessary)

Participant \_\_\_\_\_ Course Dates \_\_\_\_\_

Learning Guide for Verbal Anaesthesia					
Task/Activity	Cases				
<b>GETTING READY</b>					
1. Greet client respectfully and with kindness.					
2. Tell client what you are going to do and encourage her to ask questions.					
3. Tell client she may feel discomfort during some of the steps and you will tell her in advance.					
4. Assess need for additional pain medication or sedation.					
<b>PROCEDURE</b>					
1. Explain each step of the procedure prior to performing it.					
2. Wait after performing each step or task for client to prepare for next one.					
3. Move slowly, without jerky or quick motions.					
4. Use instruments with confidence.					
5. Avoid saying things like "This won't hurt" when it will hurt; or "I'm almost done" when you're not.					
6. Talk with the client clearly and gently throughout the procedure.					

## References

Malawi Ministry of Health and United Nations Population Fund. 2008. Sexual and reproductive health learning package for Malawi preservice education: Vol. 2. Lilongwe, Malawi: Malawi Ministry of Health.

World Health Organization/Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs (CCP), Knowledge for Health Project. *Family planning: A global handbook for providers (2008 update)*. Baltimore and Geneva: CCP and WHO/RHR.

<http://info.k4health.org/globalhandbook/>

# Unit 12

## COMBINED ORAL CONTRACEPTIVES

### Learning Objectives

By the end of this unit, learners will be able to:

- ❖ Define combined oral contraceptives (COCs)
- ❖ List the types and formulations of COCs available in Malawi and how they work
- ❖ State the effectiveness of COCs
- ❖ List the characteristics of COCs
- ❖ Correct misconceptions associated with COCs
- ❖ Determine a client's medical eligibility for COC use
- ❖ Explain when women in different situations can start COCs
- ❖ Describe the interactions that may occur between COCs and some drugs
- ❖ Provide client instructions for using COCs
- ❖ Describe the warning signs of COC health risks/complications
- ❖ Explain management of side effects and missed COCs
- ❖ Demonstrate knowledge and skills in counselling clients to make an informed choice about COCs.

### Teaching Resources in this Unit

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## Unit 12: Combined Oral Contraceptives

### Key Points

- ❖ **COCs are safe and effective.**
- ❖ **One pill is taken each 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, a woman experiences 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 makes some side effects worse.
- ❖ **COCs can be given to women at any time to start taking later.** If pregnancy cannot be ruled out, a provider can give a client pills to take later, when her monthly bleeding begins.

### 12.1 Defining Combined Oral Contraceptives

Combined oral contraceptives are pills containing low doses of two synthetic hormones, a progestin and an oestrogen. These hormones are very similar to the natural hormones progesterone and oestrogen naturally present in the woman's body. Combined oral contraceptives (COCs) are also called "the pill," or low-dose combined pills.

#### Types of COCs available in Malawi

- Microgynon: 30 µg ethinyl estradiol and 0.15 mg levonorgestrel per pill
- Lo-Feminal (to be phased out): 30 µg ethinyl estradiol and 0.30 mg norgestrel per pill

#### How COCs work

COCs work primarily by preventing the release of eggs from the ovaries (ovulation).

- Both oestrogen and progesterone prevent ovulation, which then prevents release of FSH and LH from the pituitary gland.
- The hormones also thicken the cervical mucus, which prevents passage of sperm.

#### TRIPHASIC COCS

Monophasic pills (such as Microgynon) provide the same amount of oestrogen and progestin in every hormonal pill. Biphasic and triphasic pills change the amount of oestrogen and progestin at different points of the pill-taking cycle. In *biphasic* COCs, the doses vary in two phases, and in *triphasic* COCs, the doses vary in three phases. Biphasic and triphasic pills are considerably more expensive than monophasic pills, though effectiveness and side effects are about the same. Triphasics are not currently available in Malawi.

## 12.2 Effectiveness of COCs

COCs are 92%–99.7% effective.

Effectiveness depends on the user: Risk of pregnancy is greatest when a woman starts a new pill pack 3 or more days late, or misses 3 or more pills near the beginning or end of a pill pack.

- As commonly used, about 8 pregnancies occur per year for every 100 women using COCs. (This means that 92 of every 100 women using COCs will not become pregnant.) This is known as “typical use.”
- With no pill-taking mistakes, fewer than 1 pregnancy occurs per year for every 100 women using COCs. This is known as “perfect use.”

## 12.3 Characteristics of COCs

### Advantages

- Highly effective
- Effective immediately if initiated within the first 7 days of menstrual cycle
- Do not interfere with intercourse
- User can stop at any time she wishes to conceive.
- Fertility returns immediately after stopping.

### Disadvantages

- Need to be taken daily; missed pills are common
- May cause some side effects
- Effectiveness can be reduced by interactions with certain drugs.
- Do not protect against STIs, including HIV
- Can have effects on metabolism (decreases HDL cholesterol, can increase blood pressure)

### Side effects

Some users report the following:

- Changes in bleeding patterns including:
  - Lighter bleeding and fewer days of bleeding
  - Irregular bleeding
  - Infrequent bleeding
  - No monthly bleeding
- Dizziness
- Headaches
- Nausea
- Breast tenderness
- Weight change
- Mood change
- Acne (can improve or worsen, but usually improves)
- Other possible physical changes: Blood pressure increases a few points (mm Hg). When increase is due to COCs, blood pressure declines quickly after use of COCs stops.



## Health benefits

- Help protect against cancer of the lining of the uterus (endometrial cancer), ovarian cancer, symptomatic pelvic inflammatory disease (PID)
- May help protect against ovarian cysts and iron-deficiency anaemia
- Reduce menstrual cramps, menstrual bleeding problems, ovulation pain, excess hair on face or body, symptoms of polycystic ovarian syndrome (irregular bleeding, acne, excess hair on face or body), symptoms of endometriosis (pelvic pain, irregular bleeding)

## Health risks/complications

### Very rare:

- Blood clot in deep veins of legs or lungs [deep vein thrombosis (DVT) or pulmonary embolism]

### Extremely rare:

- Stroke
- Heart attack

## 12.4 Correcting Misconceptions

Combined oral contraceptives:

- Do not build up in a woman's body (women do not need a "rest" from taking COCs)
- Must be taken every day, whether or not a woman has sex that day
- Do not make women infertile
- Do not cause birth defects or multiple births
- Do not change women's sexual behaviour
- Do not collect in the stomach; instead, the pill dissolves each day
- Do not disrupt an existing pregnancy.

## 12.5 Who Can Use COCs

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

- Smoke cigarettes—if under 35 years old
- Have anaemia now or had in the past
- Have varicose veins
- Are infected with HIV.

## 12.6 Who Should Not Use COCs

Women with the following conditions **should not use** COCs:

### WHO Category 3

- Not breastfeeding and less than 3 weeks since giving birth
- Primarily breastfeeding between 6 weeks and 6 months since giving birth
- Age 35 or older and smokes fewer than 15 cigarettes a day
- High blood pressure (systolic blood pressure between 140 and 159 mm Hg or diastolic blood pressure between 90 and 99 mm Hg)
- Controlled high blood pressure, where continuing evaluation is possible

- History of high blood pressure, where blood pressure cannot be taken (including pregnancy-related high blood pressure)
- History of jaundice while using COCs in the past
- Gall bladder disease (current or medically treated)
- Age 35 or older and has migraine headaches without aura
- Younger than age 35 and has migraine headaches without aura that have developed or have gotten worse while using COCs
- Had breast cancer more than 5 years ago, and it has not returned
- Taking barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate or rifampicin.

#### **WHO Category 3/4**

- Diabetes for more than 20 years or damage to arteries, vision, kidneys, or nervous system caused by diabetes (Assess according to severity of condition.)
- Multiple risk factors for arterial cardiovascular disease such as older age, smoking, diabetes, and high blood pressure (Category 4 if more than 1 risk factor)

#### **WHO Category 4**

- Breastfeeding and less than 6 weeks since giving birth
- Age 35 or older and smokes 15 or more cigarettes a day
- High blood pressure (systolic blood pressure 160 mm Hg and higher or diastolic blood pressure 100 mm Hg or higher)
- Vascular disease
- Current or history of deep venous thrombosis/pulmonary embolism

(For a more comprehensive list of conditions, see the MEC Summary Tables in Unit 4.)

## **12.7 Combined Oral Contraceptives for Clients with HIV**

Women with AIDS who are treated with ritonavir-boosted protease inhibitors, a class of antiretroviral (ARV) drugs, generally should not use COCs. (MEC 3). These ARV drugs may make the contraceptive method less effective. These women can use progestin-only injectables, implants, and other methods. Women taking other classes of ARVs can use any hormonal method.

## 12.8 Screening Checklist

### Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives

To determine if the client is medically eligible to use COCs, ask questions 1–11. As soon as the client answers **YES** to *any question*, stop, and follow the instructions after question 11.

NO	1. Are you currently breastfeeding a baby less than six months of age?	YES
NO	2. Have you given birth in the last 3 weeks?	YES
NO	3. Do you smoke cigarettes <i>and</i> are you more than 35 years of age?	YES
NO	4. Do you have repeated severe headaches, often on one side, and/or pulsating, causing nausea, and which are made worse by light, noise, or movement?	YES
NO	5. Have you ever been told you have breast cancer?	YES
NO	6. Have you ever had a stroke, blood clot in your legs or lungs, or heart attack?	YES
NO	7. Do you regularly take any pills for tuberculosis (TB), seizures (fits), or ritonavir for ARV therapy?	YES
NO	8. Do you have gall bladder disease or serious liver disease or jaundice (yellow skin or eyes)?	YES
NO	9. Have you ever been told you have high blood pressure?	YES
NO	10. Have you ever been told you have diabetes (high sugar in your blood)?	YES
NO	11. Have you ever been told that you have a rheumatic disease such as lupus?	YES

If the client answered **NO** to *all of questions 1–11*, the client can use COCs. Proceed to questions 12–17.

If the client answered **YES** to *any of questions 1–7*, she is not a good candidate for COCs. Counsel about other available methods or refer.

If the client answered **YES** to *any of questions 8–11*, COCs cannot be initiated without further evaluation. Evaluate or refer as appropriate, and give condoms to use in the meantime. See explanations for more instructions.

Ask questions 12–17 to be reasonably sure that the client is not pregnant. As soon as the client answers **YES** to *any question*, stop, and follow the instructions after question 17.

YES	12. Did your last menstrual period start within the past 7 days?	NO
YES	13. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	NO
YES	14. Have you abstained from sexual intercourse since your last menstrual period or delivery?	NO
YES	15. Have you had a baby in the last 4 weeks?	NO
YES	16. Have you had a miscarriage or abortion in the last 7 days?	NO
YES	17. Have you been using a reliable contraceptive method consistently and correctly?	NO

If the client answered **YES** to *at least one of questions 12–17* and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. The client can start COCs now.

If the client began her last menstrual period *within the past 5 days*, she can start COCs now. No additional contraceptive protection is needed.

If the client began her last menstrual period *more than 5 days ago*, tell her to *begin taking COCs now*, but instruct her that she must *use condoms or abstain from sex for the next 7 days*. Give her condoms to use for the next 7 days.

If the client answered **NO** to *all of questions 12–17*, pregnancy cannot be ruled out. The client should await menses or use a pregnancy test.

Give her the COCs but instruct her to start using them anytime during the first 5 days of her next menstrual period.

Give her condoms to use in the meantime.



## 12.9 Timing: When to Start COCs

**Important:** A woman can start using COCs any time she wants if it is reasonably certain she is not pregnant. To be reasonably certain she is not pregnant, use the Pregnancy Checklist (see previous page). Also, a woman can be given COCs at any time and told when to start taking them, if not immediately.

Woman's situation	When to start
<b>Having menstrual cycles or switching from a nonhormonal method</b>	<p>Any time of the month</p> <p>If she is starting within 5 days after the start of her monthly bleeding, there is no need for a backup method.</p> <p>If it is more than 5 days after the start of her monthly bleeding, she can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method* for the first 7 days of taking pills. (If you cannot be reasonably certain, give her COCs now and tell her to start taking them during her next monthly bleeding.)</p> <p>If she is switching from an IUCD, she can start COCs immediately.</p>
<b>Switching from a hormonal method</b>	<p>Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method.</p> <p>If she is switching from injectables, she can begin taking COCs when the repeat injection would have been given. No need for a backup method.</p>
<b>Fully or nearly fully breastfeeding</b> Less than 6 months after giving birth	<p>Give her COCs and tell her to start taking them 6 months after giving birth or when breast milk is no longer the baby's main food— whichever comes first.</p>
More than 6 months after giving birth	<p>If her monthly bleeding has not returned, she can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills. (If you cannot be reasonably certain, give her COCs now and tell her to start taking them during her next monthly bleeding.)</p> <p>If her monthly bleeding has returned, she can start COCs as advised for women having menstrual cycles.</p>
<b>Partially breastfeeding</b> Less than 6 weeks after giving birth	<p>Give her COCs and tell her to start taking them 6 weeks after giving birth. Give her a backup method to use until 6 weeks after giving birth if her monthly bleeding returns before this time.</p>
More than 6 weeks after giving birth	<p>If her monthly bleeding has not returned, she can start COCs any time it is reasonably certain she is not pregnant.† She will need a backup method for the first 7 days of taking pills. (If you cannot be reasonably certain, give her COCs now and tell her to start taking them during her next monthly bleeding.)</p>

<b>Woman's situation</b>	<b>When to start</b>
	If her monthly bleeding has returned, she can start COCs as advised for women having menstrual cycles.
<b>Not breastfeeding</b> Less than 4 weeks after giving birth	She can start COCs at any time on days 21–28 after giving birth. Give her pills any time to start during these 7 days. There is no need for a backup method.
More than 4 weeks after giving birth	If her monthly bleeding has not returned, she can start COCs any time it is reasonably certain she is not pregnant.† She will need a backup method for the first 7 days of taking pills. (If you cannot be reasonably certain, give her COCs now and tell her to start taking them during her next monthly bleeding.)  If her monthly bleeding has returned, she can start COCs as advised for women having menstrual cycles.
<b>No monthly bleeding</b> (Not related to childbirth or breastfeeding)	She can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills.
<b>After miscarriage or abortion</b>	Immediately. If she is starting within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method.  If it is more than 7 days after first- or second-trimester miscarriage or abortion, she can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills. (If you cannot be reasonably certain, give her COCs now and tell her to start taking them during her next monthly bleeding.)
<b>After taking emergency contraceptive pills (ECPs)</b>	She can start COCs the day after she finishes taking the ECPs. There is no need to wait for her next monthly bleeding to start her pills.  A new COC user should begin a new pill pack.  A continuing user who needed ECPs due to pill-taking errors can continue where she left off with her current pack.  All women will need to use a backup method for the first 7 days of taking pills.

(WHO/RHR and CCP, Knowledge for Health Project 2008)

\* Backup methods include male and female condoms.

† Where a visit 6 weeks after childbirth is routinely recommended and other opportunities to obtain contraception limited, some providers and programs may give COCs at the 6-week visit, without further evidence that the woman is not pregnant, if her monthly bleeding has not yet returned.

## 12.10 Client Counselling Instructions

### Explain about side effects

- Describe the most common side effects:
  - In the first few months, bleeding at unexpected times (irregular bleeding); then lighter, shorter, and more regular monthly bleeding
  - Headaches, breast tenderness, weight change, and possibly other side effects.
- Explain about these side effects:
  - Side effects are not signs of illness.
  - Most side effects usually become less or stop within the first few months of using COCs.
  - Side effects are common, but some women do not have them.
- Explain what to do in case of side effects:
  - Keep taking COCs. Skipping pills risks pregnancy and can make some side effects worse.
  - Take each pill at the same time every day to help reduce irregular bleeding and also help with remembering.
  - Take pills with food or at bedtime to help avoid nausea.
- The client can come back for help if side effects bother her.

### Give pills

- Give two pill packs.
- Show the packs.

### Explain the COC pill pack

- Show her the kind of pack she will be using (21 pills or 28 pills). With 28-pill packs, point out that the last 7 pills are a different colour and do not contain hormones.
- Show her how to take the first pill from the pack and then how to follow the directions or arrows on the pack to take the rest of the pills.

### Give key instructions on how to take pills

- **Take one pill each day** until the pack is empty.
- Discuss cues for taking a pill every day. Linking pill-taking to a daily activity, such as cleaning her teeth, may help her remember.
- Taking pills at the same time each day helps a client remember them and may help reduce some side effects.

### Explain starting next pack

- 28-pill packs: When she finishes one pack, she should take the first pill from the next pack on the very next day.
- 21-pill packs: After she takes the last pill from one pack, she should wait 7 days, no more, and then take the first pill from the next pack.
- It is very important to start the next pack on time. Starting a pack late risks pregnancy.

### Provide backup method and explain use

- Sometimes she may need to use a backup method, such as when she misses pills.
- Backup methods include male and female condoms. Give her condoms, if possible.

## Explain what to do if she misses pills (see “How to Manage Missed Pills,” Section 12.14)

### Give reasons to return

- Assure every client that she is welcome to come back any time. For example:
  - If she has problems, questions, or wants another method
  - If she has any major change in health status
  - If she thinks she might be pregnant
  - If she lost her pills or started a new pack more than 3 days late and also had sex during this time. She may wish to consider ECPs.
- General health advice: Anyone who suddenly feels that something is seriously wrong with her health should immediately seek medical care from a provider. Her contraceptive method is most likely not the cause of the condition, but she should tell the nurse or doctor what method she is using.

### Plan the next visit

- Encourage her to come back for more pills before she uses up her supply of pills.
- Agree on a date for the next visit—in 2 to 3 months depending on how many pill packs you give her.
- Some women can benefit from contact after 3 months of COC use. This offers an opportunity to answer any questions, help with any problems, and check on correct use.

## 12.11 Warning Signs of Complications

- Blood clot in deep veins of legs or lungs (deep vein thrombosis or pulmonary embolism). **Warning signs include a sharp pain in the leg or abdomen.**
- Stroke—**warning signs include severe headache with vision problems.**
- Heart attack—**warning signs include severe chest pain or shortness of breath.**

## 12.12 Helping Continuing Users

1. Ask how the client is doing with the method and whether she is satisfied. Ask if she has any questions or anything to discuss.
2. Ask especially if she is concerned about bleeding changes. Give her any information or help that she needs (see Managing Side Effects, Section 12.15).
3. Ask if she often has problems remembering to take a pill every day. If so, discuss ways to remember, making up missed pills, ECPs, or choosing another method.
4. Give her more pill packs—a full year’s supply (13 packs), if possible. Plan her next resupply visit before she will need more pills.
5. Every year or so, check blood pressure if possible.
6. Ask a long-term client if she has had any new health problems since her last visit. Address problems as appropriate. See New Health Problems that may Require Switching Methods, Section 12.16.
7. Ask a long-term client about major life changes that may affect her needs—particularly plans for having children and her STI/HIV risk. Follow up as needed.

## 12.13 Extended and Continuous Use of COCs

Some COC users do not follow the usual cycle of 3 weeks taking hormonal pills followed by one week without hormones. Some clients take hormonal pills for 12 weeks without a break, followed by one week of non-hormonal pills (or no pills). This is **extended use**. Other women take hormonal pills without any breaks at all. This is **continuous use**. Monophasic pills are recommended for such use (see Question 16 in Section 12.17).

Women easily manage taking COCs in different ways when properly advised how to do so. Many women value controlling when they have monthly bleeding—if any—and tailoring pill use as they wish.

### Benefits

- Women have vaginal bleeding only 4 times a year or not at all.
- COCs reduce how often some women suffer headaches, premenstrual syndrome, mood changes, and heavy or painful bleeding during the week without hormonal pills.

### Disadvantages

- Irregular bleeding may last as long as the first 6 months of use—especially among women who have never before used COCs.
- More supplies are needed—15 to 17 packs every year instead of 13.

### Extended use instructions



*Illustration by Rafael Avila and Rita Meyer*

- Skip the last week of pills (without hormones) in 3 packs in a row. (21-day users skip the 7-day waits between the first 3 packs.) No backup method is needed during this time.
- Take all 4 weeks of pills in the 4th pack. (21-day users take all 3 weeks of pills in the 4th pack.) Expect some bleeding during the 4th week.
- Start the next pack of pills the day after taking the last pill in the 4th pack. (21-day users wait 7 days before starting the next pack.)

### Continuous use instructions

The woman should take one hormonal pill every day for as long as she wishes to use COCs. If bothersome irregular bleeding occurs, a woman can stop taking pills for 3 or 4 days and then start taking hormonal pills continuously again.



## 12.14 How to Manage Missed Pills

It is easy to forget a pill or to be late in taking it. COC users should know what to do if they forget to take pills. **If a woman misses one or more pills, she should follow these instructions:**

<b>Key Instructions</b>	<ul style="list-style-type: none"> <li>• Take a missed hormonal pill as soon as possible.</li> <li>• Keep taking pills as usual, one each day. (She may take 2 pills at the same time or on the same day.)</li> </ul>
<b>Missed 1 or 2 pills? Started new pack 1 or 2 days late?</b>	<ul style="list-style-type: none"> <li>• Take a hormonal pill as soon as possible.</li> <li>• There is little or no risk of pregnancy.</li> </ul>
<b>Missed 3 or more pills in the first or second week? Started new pack 3 or more days late?</b>	<ul style="list-style-type: none"> <li>• Take a hormonal pill as soon as possible.</li> <li>• Use a backup method for the next 7 days.</li> <li>• Also, if she had sex in the past 5 days, can consider taking ECPs (See Emergency Contraceptive Pills, Unit 14)</li> </ul>
<b>Missed 3 or more pills in the third week?</b>	<ul style="list-style-type: none"> <li>• Take a hormonal pill as soon as possible.</li> <li>• Finish all hormonal pills in the pack. Throw away the 7 non-hormonal pills in a 28-pill pack.</li> <li>• Start a new pack the next day.</li> <li>• Use a backup method for the next 7 days.</li> <li>• Also, if she had sex in the past 5 days, she can consider taking ECPs.</li> </ul>
<b>Missed any non-hormonal pills? (last 7 pills in 28-pill pack)</b>	<ul style="list-style-type: none"> <li>• Discard the missed non-hormonal pill(s).</li> <li>• Keep taking COCs, one each day. Start the new pack as usual.</li> </ul>
<b>Severe vomiting or diarrhoea</b>	<ul style="list-style-type: none"> <li>• If she vomits within 2 hours after taking a pill, she should take another pill from her pack as soon as possible, then keep taking pills as usual.</li> <li>• If she has vomiting or diarrhoea for more than 2 days, follow instructions for 1 or 2 missed pills above.</li> </ul>

## 12.15 Managing Side Effects

### Problems Reported as Side Effects or Problems With Use

Problems with side effects affect women’s satisfaction and use of COCs. They deserve the provider’s attention. If the client reports side effects or problems, listen to her concerns, give her advice, and, if appropriate, provide treatment.

Side Effect	How to Manage
Missed pills	See “How to Manage Missed Pills,” Section 12.14
Irregular bleeding (bleeding at unexpected times that bothers the client)	<ul style="list-style-type: none"> <li>● Reassure her that many women using COCs experience irregular bleeding. It is not harmful and usually becomes less or stops after the first few months of use.</li> <li>● Other possible causes of irregular bleeding: Missed pills; taking pills at different times every day; vomiting or diarrhoea; taking anticonvulsants or rifampicin</li> <li>● To reduce irregular bleeding:               <ul style="list-style-type: none"> <li>- Take a pill each day and at the same time each day.</li> <li>- Make up for missed pills properly, including after vomiting or diarrhoea.</li> </ul> </li> <li>● For modest short-term relief, she can take 800 mg ibuprofen 3 times daily after meals for 5 days, or another nonsteroidal anti-inflammatory drug (NSAID), beginning when irregular bleeding starts. NSAIDs provide some relief of irregular bleeding for implants, progestin-only injectables, and IUCDs, and they may also help for COCs.</li> <li>● If she has been taking the pills for more than a few months and NSAIDs do not help, give her a different COC formulation, if available. Ask her to try the new pills for at least 3 months.</li> <li>● If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.</li> </ul>
No monthly bleeding	<ul style="list-style-type: none"> <li>● Ask if she is having any bleeding at all. (She may have just a small stain on her underclothing and not recognize it as monthly bleeding.) If she is, reassure her.</li> <li>● Tell her that some women using COCs stop having monthly bleeding, and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not infertile. Blood is not building up inside her.</li> <li>● Ask if she has been taking a pill every day. If so, reassure her that she is not likely to be pregnant. She can continue taking her COCs as before.</li> <li>● If she skipped the 7-day break between packs (21-day packs) or skipped the 7 non-hormonal pills (28-day pack), reassure her that she is not pregnant. She can continue using COCs.</li> <li>● If she has missed hormonal pills or started a new pack late: She can continue using COCs.</li> </ul>

	<ul style="list-style-type: none"> <li>• Tell a woman who has missed 3 or more pills or started a new pack 3 or more days late to return if she has signs and symptoms of early pregnancy.</li> </ul>
<b>Ordinary headaches (non-migrainous)</b>	<ul style="list-style-type: none"> <li>• Try the following (one at a time): <ul style="list-style-type: none"> <li>- Suggest aspirin (300–600 mg), ibuprofen (200–400 mg), paracetamol (500–1000 mg), or other pain reliever.</li> <li>- Some women get headaches during the hormone-free week (the 7 days a woman does not take hormonal pills). Consider extended use (see Extended and Continuous Use of Combined Oral Contraceptives, Section 12.13).</li> </ul> </li> <li>• Any headaches that get worse or occur more often during COC use should be evaluated.</li> </ul>
<b>Nausea or dizziness</b>	<ul style="list-style-type: none"> <li>• For nausea, suggest taking COCs at bedtime or with food.</li> <li>• If symptoms continue, consider locally available remedies.</li> <li>• Consider extended use if her nausea comes after she starts a new pill pack</li> </ul>
<b>Breast tenderness</b>	<ul style="list-style-type: none"> <li>• Recommend that she wear a supportive bra (including during strenuous activity and sleep).</li> <li>• Try hot or cold compresses.</li> <li>• Suggest aspirin (300–600 mg), ibuprofen (200–400 mg), paracetamol (500–1000 mg), or other pain reliever.</li> </ul>
<b>Weight change</b>	<ul style="list-style-type: none"> <li>• Review diet and counsel as needed.</li> </ul>
<b>Mood changes or changes in sex drive</b>	<ul style="list-style-type: none"> <li>• Some women have changes in mood during the hormone-free week (the 7 days when a woman does not take hormonal pills). Consider extended use (See Section 12.13).</li> <li>• Ask about changes in her life that could affect her mood or sex drive, including changes in her relationship with her partner. Give her support as appropriate.</li> <li>• Clients who have serious mood changes such as major depression should be referred for care.</li> <li>• Consider locally available remedies.</li> </ul>
<b>Acne</b>	<ul style="list-style-type: none"> <li>• Acne usually improves with COC use. It may worsen for a few women. If she has been taking pills for more than a few months and acne persists, give her a different COC formulation, if available.</li> <li>• Ask her to try the new pills for at least 3 months.</li> <li>• Consider locally available remedies.</li> </ul>

## 12.16 New Problems That May Require Switching Methods

<b>May or may not be due to the method</b>
<b>Unexplained vaginal bleeding (that suggests a medical condition not related to the method) or heavy or prolonged bleeding</b>
<ul style="list-style-type: none"><li>• Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate. She can continue using COCs while her condition is being evaluated.</li><li>• If bleeding is caused by sexually transmitted infection or pelvic inflammatory disease, she can continue using COCs during treatment.</li></ul>
<b>Starting treatment with anticonvulsants or rifampicin</b>
<ul style="list-style-type: none"><li>• Barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, and rifampicin may make COCs less effective. If using these medications long-term, she may want a different method, such as progestin-only injectables or a copper-bearing IUCD.</li><li>• If using these medications short-term, she can use a backup method along with COCs.</li></ul>
<b>Migraine headaches</b>
<ul style="list-style-type: none"><li>• Regardless of her age, a woman who develops migraine headaches, with or without aura, or whose migraine headaches become worse while using COCs should stop using COCs. Help her choose a method without oestrogen.</li></ul>
<b>Circumstances that will keep her from walking for one week or more</b>
<ul style="list-style-type: none"><li>• If she is having major surgery, or her leg is in a cast, or for other reasons she will be unable to move about for several weeks, tell her to:<ul style="list-style-type: none"><li>- Stop taking COCs and use a backup method during this period.</li><li>- Restart COCs 2 weeks after she can move about again.</li></ul></li></ul>
<b>Certain serious health conditions (suspected heart or liver disease, high blood pressure, blood clots in deep veins of legs or lungs, stroke, breast cancer, damage to arteries, vision, kidneys or nervous system due to diabetes, or gall bladder disease)</b>
<ul style="list-style-type: none"><li>• Tell her to stop taking COCs.</li><li>• Give her a backup method to use until the condition is evaluated.</li><li>• Refer for diagnosis and care if not already under care.</li></ul>
<b>Suspected pregnancy</b>
<ul style="list-style-type: none"><li>• Assess for pregnancy.</li><li>• Tell her to stop taking COCs if pregnancy is confirmed.</li><li>• Assure her there are no known risks to a foetus conceived while a woman is taking COCs.</li></ul>

## 12.17 Questions and Answers about COCs

**1. Should a woman take a “rest” from COCs after taking them for a time?**

No. There is no evidence that taking a “rest” is helpful. In fact, taking a “rest” from COCs can lead to unintended pregnancy. COCs can safely be used for many years without having to stop taking them periodically.

**2. If a woman has been taking COCs for a long time, will she still be protected from pregnancy after she stops taking COCs?**

No. A woman is protected only as long as she takes her pills regularly.

**3. How long does it take to become pregnant after stopping COCs?**

Women who stop using COCs can become pregnant as quickly as women who stop using nonhormonal methods. COCs do not delay the return of a woman’s fertility after she stops taking them. The bleeding pattern a woman had before she used COCs generally returns after she stops taking them. Some women may have to wait a few months before their usual bleeding pattern returns.

**4. Do COCs cause abortion?**

No. Research on COCs finds that they do not disrupt an existing pregnancy.

**5. Do COCs cause birth defects? Will the foetus be harmed if a woman accidentally takes COCs while she is pregnant?**

No. Good evidence shows that COCs will not cause birth defects and will not otherwise harm the foetus if a woman becomes pregnant while taking COCs or accidentally starts to take COCs when she is already pregnant.

**6. Do COCs cause women to gain or lose a lot of weight?**

No. Most women do not gain or lose weight due to COCs. Weight changes naturally as life circumstances change and as people age. Because these changes in weight are so common, many women think that COCs cause these gains or losses in weight. Studies find, however, that, on average, COCs do not affect weight. A few women experience sudden changes in weight when using COCs. These changes reverse after they stop taking COCs. It is not known why these women respond to COCs in this way.

**7. Do COCs change women’s mood or sex drive?**

Generally, no. Some women using COCs report these complaints. The great majority of COC users do not report any such changes, however, and some report that both mood and sex drive improve. It is difficult to tell whether such changes are due to the COCs or to other reasons. Providers can help a client with these problems (see “Mood changes or changes in sex drive” under Managing Side Effects, Section 12.15.). There is no evidence that COCs affect women's sexual behaviour.

**8. What can a provider say to a client asking about COCs and breast cancer?**

The provider can point out that both COC users and women who do not use COCs can have breast cancer. In scientific studies breast cancer was slightly more common among women using COCs and those who had used COCs in the past 10 years than among other women. Scientists do not know whether or not COCs actually caused the slight increase in breast

cancers. It is possible that the cancers were already there before COC use but were found sooner in COC users.

**9. Can COCs be used as a pregnancy test?**

No. A woman may experience some vaginal bleeding (a “withdrawal bleed”) as a result of taking several COCs or one full cycle of COCs, but studies suggest that this practice does not accurately identify who is or is not pregnant. Thus, giving a woman COCs to see if she has bleeding later is not recommended as a way to tell if she is pregnant. COCs should not be given to women as a pregnancy test of sorts because they do not produce accurate results.

**10. Must a woman have a pelvic examination before she can start COCs or at follow-up visits?**

No. Instead, asking the right questions usually can help to make reasonably certain that a woman is not pregnant (see Pregnancy Checklist, Section 12.8). No condition that could be detected by a pelvic examination rules out COC use.

**11. Can women with varicose veins use COCs?**

Yes. COCs are safe for women with varicose veins. Varicose veins are enlarged blood vessels close to the surface of the skin. They are not dangerous. They are not blood clots, nor are these veins the deep veins in the legs where a blood clot can be dangerous (deep vein thrombosis). A woman who has or has had deep vein thrombosis should not use COCs.

**12. Can a woman safely take COCs throughout her life?**

Yes. There is no minimum or maximum age for COC use. COCs can be an appropriate method for most women from onset of monthly bleeding (menarche) to menopause.

**13. What if a client wants to use COCs but it is not reasonably certain that she is not pregnant after using the pregnancy checklist?**

If pregnancy tests are not available, a woman can be given COCs to take home with instructions to begin their use within 5 days after the start of her next monthly bleeding. She should use a backup method such as male or female condoms until then.

**14. Can COCs be used as ECPs after unprotected sex?**

Yes. As soon as possible, but no more than 5 days after unprotected sex, a woman can take COCs as ECPs. Progestin-only pills, however, are more effective and cause fewer side effects such as nausea and stomach upset.

**15. Is it important for a woman to take her COCs at the same time each day?**

Yes, for 2 reasons. Taking the pill at the same time each day may reduce some side effects. Also, taking a pill at the same time each day can help women remember to take their pills more consistently. Linking pill taking with a daily activity also helps women remember to take their pills.

(WHO/RHR and CCP, Knowledge for Health Project 2008)

## Case Studies

(Adapted from Jhpiego, no date)

### Case Study 1

The client is a 19-year-old mother of two, the younger of whom is 9 months old. Her last pregnancy was a difficult one, and she does not want another child for several years. She came to the clinic two months ago and after initial counselling decided to use COCs as her family planning method.

She has now returned to the clinic complaining of spotting and nausea since taking her first packet of pills. She is very worried that she is losing too much blood from the spotting, and she is also losing weight because she isn't eating due to the nausea. She is thinking about switching to another method.

### Questions

1. What are the possible causes of her spotting and nausea?
2. What else do you need to know to identify the cause of her spotting and nausea? What questions would you ask her, and what examinations would you perform?
3. Finding no other causes, what would you tell her about spotting and nausea and use of COCs?
4. How would you manage this client?
5. If the client decides she would prefer to use another family planning method, which one(s) may be appropriate for her? Why?

## Case Study 2

The client is a 31-year-old mother of five. While she is not certain that she has all the children she wants, she does know that she is not interested in having another child for at least several years. She is frightened of injections, and her husband does not like to use condoms. She has heard that COCs are easy to use and effective; she'd like to give them a try.

You conduct some basic screening and obtain the following information: BP 140/90; she was diagnosed with tuberculosis 8 months ago; she smokes 6–8 cigarettes a day; you observe mild varicosities on both lower legs.

### Questions

1. What other information do you need to obtain in order to assess whether COCs are the best choice for her?
2. The rest of the client's history and assessment do not reveal any precautions for COC use. Are COCs an appropriate choice for this client? Why or why not?
3. If she does use COCs, what counselling and information does she need?
4. If COCs are not an appropriate choice, what other methods might be? Why?



# COC Case Studies Answer Key

## Case Study 1

### Questions

1. What are the possible causes of her spotting and nausea?

**Taking pills at different times each day; taking pills without food; missed pills; taking anticonvulsants or rifampicin; pregnancy**

2. What else do you need to know to identify the cause of her spotting and nausea? What questions would you ask her, and what examinations would you perform?

**When does she usually take pills? Does she take them at the same time each day? Does she have difficulty remembering to take the pills, and, if so, how many has she missed? How does she make up for missed pills, if any? Is she taking any anti-convulsants or rifampicin?**

3. Finding no other causes, what would you tell her about spotting and nausea and use of COCs?

**That irregular bleeding is common in the first few months of taking COCs. It is harmless and usually becomes less and stops after a few months. Nausea may be a result of taking pills without food or missing pills.**

4. How would you manage this client?

**Suggest that she take the pills at the same time each day to lessen both nausea and spotting. She could take them at bedtime with food. She should make up for missed pills promptly, according to instructions.**

**For short-term relief of spotting, she could take 800 mg ibuprofen three times a day, after meals, for 5 days.**

**She may also try Continuous Use of COCs (see Section 12.13).**

5. If the client decides she would prefer to use another family planning method, which one(s) may be appropriate for her? Why?

**Because she does not want another child for several years, contraceptive implants or an IUCD may be good choices. With either, she would not have to remember to take a pill every day. Also, implants don't have oestrogenic side effects, though she would need to be aware about the possible side effects of bleeding changes and spotting. IUCDs don't have hormonal side effects, though spotting is possible with these as well.**

## Case Study 2

### Questions

1. What other information do you need to obtain in order to assess whether COCs are the best choice for her?

**Nothing else is needed. Elevated blood pressure of 140/90 is a contraindication for COC use (MEC category 3).**

2. The rest of the client's history and assessment do not reveal any precautions for COC use. Are COCs an appropriate choice for this client? Why or why not?

**No. Because she has elevated blood pressure, she is not a good candidate for COCs.**

3. If she does use COCs, what counselling and information does she need?

**She should not use COCs.**

4. If COCs are not an appropriate choice, what other methods might be? Why?

**Implants or IUCDs would be good, long-term choices since she does not want another child for at least several years.**

**Note:** for additional case studies, see the Pathfinder International website:

<http://www.pathfind.org/pf/pubs/module4.pdf>

# COC Role Plays

## Role Play 1

(Adapted from Jhpiego, no date)

### Participant roles

**Clinician:** The clinician is an experienced family planning provider, who is skilled in counselling.

**Client:** The client is 31 years old and began taking COCs after the birth of her fifth child 2 years ago. At that time, she was screened for medical conditions that might be a precaution for COC use, but none were found. She has had no problems with COCs, once she got over the initial nausea and breast tenderness. Her husband died several months ago, and she has had to take a second job in order to provide for her children. She never gets more than 4 hours of sleep each night.

### Situation

The client has now returned to the clinic complaining of headaches that she believes are caused by the COCs. She is very nervous. Her mother-in-law told her about someone who, after using COCs for years and suffering bad headaches, died because the COCs caused something in her head to burst.

### Focus of the role play

The focus of the role play is on the interaction between the clinician and the client. The clinician needs to assess the extent of the client's headaches and their possible relationship with COCs. She needs to counsel and reassure the client and recommend a plan of management. The client should remain adamant in her belief that the COCs are causing her headaches until the clinician provides her with the information and management plan that will calm her concerns.

### Observer discussion questions

1. How did the clinician approach the client?
2. How did the client respond to the clinician? Did the clinician change her approach based on this response? If so, was it appropriate?
3. Did the clinician accurately assess the relationship of the headaches to the COCs? Did she outline an appropriate management plan?
4. How might the clinician improve her interaction with the client?

(The following role plays are adapted from Solter, Cathy 1999)

## Role Play 2

### Participant roles

**Clinician:** The clinician is an experienced family planning provider who is skilled in counselling.

**Client:** A 24-year-old woman comes to see her provider because she has heavy menstrual periods lasting 7 to 8 days each month and feels "run down" since the birth of her last child. She has 4 children: a boy of 7 months and 3 daughters, ages 2 years, 3 years, and 4½ years. She has never used a contraceptive method, and she and her husband want to have at least 1 more son.

### Suggested questions to address during role play simulation

1. How would the provider introduce the topic of family planning, and what might s/he say to counsel this client about adopting a child-spacing method?
2. What questions might the client raise in regard to child-spacing methods (including some rumours she has heard)?
3. What information regarding benefits, advantages, and risks should the provider give to guide this client to select an appropriate method for her?
4. What specific method instructions should the provider give the client, including possible side effects and warning signs, and returning for follow-up?

## Role Play 3

### Participant roles

**Clinician:** The clinician is an experienced family planning provider who is skilled in counselling.

**Clients:** A young couple, wife age 18 and husband age 22, married for 7 weeks, come to the clinic because they want to postpone their first child until they both have completed their university studies in 2 years. They are currently using condoms, but neither like this method. The wife has heard about COCs and wants to use this method. The husband is against this, as he has heard that the pill could cause his wife to become sterile.

### Suggested questions to address during role play simulation

1. What should the provider say to the husband with regard to the question of the COCs causing sterility?
2. What should the provider say regarding the effectiveness, safety, advantages, disadvantages, and possible side effects of the COCs when counselling this couple?
3. What other contraceptive options might the provider suggest?

## Role Play 4

### Participant roles

**Clinician:** The clinician is an experienced family planning provider who is skilled in counselling.

**Clients:** A married woman, age 22, comes to your office accompanied by her mother-in-law. She has 3 small children under the age of 5. She wants to use the pill, but her mother-in-law is very much opposed to this; she has heard that the pill causes cancer.

### Suggested questions to address during role play simulation

1. How should the provider respond to the mother-in-law with regard to the COCs causing cancer?
2. What should the provider say regarding the effectiveness, safety, advantages, disadvantages, and possible side effects of COCs when dealing with the mother-in-law and client?
3. What specific instructions should the provider give with regard to the use of the pill?
4. What other contraceptive options might the provider suggest?

## Role Play 5

### Participant roles

**Clinician:** The clinician is an experienced family planning provider who is skilled in counselling.

**Client:** A 41-year-old woman with 3 teenage boys and a 12-year-old girl wants contraceptive protection. She used an IUCD in the past for about 4 months but had it removed because of heavy bleeding, cramping, and pain. She absolutely refuses to consider sterilisation or another IUCD. She has heard that she is too old to take the pill.

### Suggested questions to address during role play simulation

1. How should the clinician respond to this client's belief that she is too old for the pill?
2. What important questions should the clinician ask this client to ascertain if COCs are appropriate for her?
3. What benefits of COCs should the clinician discuss with this client?
4. What other contraceptive options might the provider suggest?

## Role Play 6:

### Participant roles

A 23-year-old man and his 19-year-old wife, 6 months postpartum, bring their baby in to see the paediatrician because the baby has a cold and fever. The mother is partially breastfeeding. She uses this visit to ask how she could prevent another pregnancy for a year or two. She would like to try COCs, but her husband is not in favour of the idea; he believes the pill could harm the baby through the mother's milk.

**Suggested questions to address during role play simulation:**

1. What should the clinician say to the husband regarding his belief that the pill would harm the baby?
2. What guidance regarding the effectiveness, safety, advantages, disadvantages, possible side effects, and warning signs should the doctor discuss with this couple?

## Role Play 7

**Participant roles**

Three physicians (one obstetrician/gynaecologist, one general practitioner, and one paediatrician) are having lunch together and discussing various family planning methods. The paediatrician and general practitioner are not generally in favour of COCs. The paediatrician states, "I don't like pills, because you have to take them into your body. If used for a long time, they can cause cancer or infertility." The general practitioner agrees with this statement and adds that he is "too busy to bother with family planning; treatment of illness is more important." Both claim they never initiate discussion of family planning with patients or advise couples to consider spacing their children. They would be concerned about offending patients by bringing up a sensitive topic.

The obstetrician is upset by the views of her colleagues.

**Suggested questions to address during role play simulation:**

What would the obstetrician say to convince the others that their views do not conform to scientific facts, such as the clearly established benefits of family planning to mother and child health, and facts regarding the safety and effectiveness of low-dose COCs?

# COC Quiz Questions

## Questions 1–7: Circle all answers that apply.

1. Actual/typical use effectiveness of the COC is:
  - a. No pregnancies per 100 women
  - b. 1 pregnancy per 100 women
  - c. 2 pregnancies per 100 women
  - d. 8 pregnancies per 100 women
  - e. 5 pregnancies per 100 women
2. Major advantages of COCs include that they:
  - a. Are highly effective if taken correctly
  - b. Protect against HIV/AIDS
  - c. Protect against ovarian and endometrial cancer
  - d. Decrease the risk of ectopic pregnancy
  - e. Protect against breast cancer
3. The COC may be an appropriate choice for:
  - a. A woman who desires a prompt return of fertility
  - b. A nulliparous woman
  - c. A woman over 35 who smokes
  - d. A woman who is breastfeeding a newborn baby
  - e. A woman with a history of benign, functional ovarian cysts
4. COCs are not appropriate for the following women:
  - a. A woman with suspected pregnancy
  - b. A woman with liver disease (cirrhosis)
  - c. A woman age 36 and a heavy smoker
  - d. A woman with family history of ovarian cancer
  - e. A woman with high blood pressure
  - f. A woman with breast cancer
  - g. A woman living with HIV
5. Common side effects of COCs include:
  - a. Spotting
  - b. Severe vaginal bleeding
  - c. Dysmenorrhoea
  - d. Amenorrhea
  - e. Nausea
  - f. Breast tenderness
  - g. Hypotension
  - h. Insomnia
  - i. Anaemia
6. A woman comes to the clinic on day 7 of her menstrual cycle and requests COCs. She has not had intercourse since the first day of her period. Which of the following is medically appropriate? (Circle the correct answer.)
  - a. Advise her to return to clinic on the first day of her next period.
  - b. Provide her with pills and tell her that she can start now without any further precautions.

- c. Provide her with pills and tell her that she can start now, but she should abstain from sex or use additional contraceptive protection for the next 7 days.
7. If a client forgets to take 1 pill, she should:
- a. Take the forgotten pill as soon as she remembers
  - b. Discard the forgotten pill
  - c. Take 2 pills as soon as she remembers
  - d. Take the next pill at the regular time
  - e. Continue to take 1 pill a day until the package is finished
  - f. Start a new pack of pills

**Questions 8–18: Tick either "Yes" or "No" in the space provided.**

8. Is it appropriate to counsel a client that spotting increases after the first several cycles on the COC? Yes \_\_\_ No \_\_\_
9. If a client has taken a cycle of COCs perfectly (every day) and misses her period (no bleeding at all), can she start her next package of pills on schedule? Yes \_\_\_ No \_\_\_
10. Is it appropriate to prescribe COCs for a 20-year-old woman whose sister has hypertension and whose father had a heart attack at age 48? Yes \_\_\_ No \_\_\_
11. Can women with cyclic cystic breast changes use COCs? Yes \_\_\_ No \_\_\_
12. If a client had a blood pressure of 120/80 prior to using COCs that increased to 150/98 after 3 months on COCs, is it advisable for her to continue the pills? Yes \_\_\_ No \_\_\_
13. COCs may be prescribed for a 20-year-old smoker. Yes \_\_\_ No \_\_\_
14. It is usually recommended that fully breastfeeding women use COCs for the first 6 months postpartum. Yes \_\_\_ No \_\_\_
15. Rifampin decreases the effectiveness of COCs. Yes \_\_\_ No \_\_\_
16. COCs should not be prescribed for a 45-year-old woman. Correct? Yes \_\_\_ No \_\_\_
17. COCs should not be prescribed for an anaemic, malnourished woman. Correct?  
Yes \_\_\_ No \_\_\_
18. It is recommended that women using COCs take a break from the pill every few months. Yes \_\_\_ No \_\_\_



## COC Quiz Questions Answer Key

### Questions 1–7: Circle all answers that apply.

- Actual/typical use effectiveness of the COC is:
  - d. 8 pregnancies per 100 women**
- Major advantages of COCs include that they:
  - a. Are highly effective if taken correctly**
  - c. Protect against ovarian and endometrial cancer**
  - d. Decrease the risk of ectopic pregnancy**
- The COC may be an appropriate choice for:
  - a. A woman who desires a prompt return of fertility**
  - b. A nulliparous woman**
  - e. A woman with a history of benign, functional ovarian cysts**
- COCs are not appropriate for the following women:
  - a. A woman with suspected pregnancy**
  - b. A woman with liver disease (cirrhosis)**
  - c. A woman age 36 and a heavy smoker**
  - e. A woman with high blood pressure**
  - f. A woman with breast cancer**
- Common side effects of COCs include:
  - a. Spotting**
  - e. Breast tenderness**
- A woman comes to the clinic on day 7 of her menstrual cycle and requests COCs. She has not had intercourse since the first day of her period. Which of the following is medically appropriate? (Circle the correct answer.)
  - c. Provide her with pills and tell her that she can start now, but she should abstain from sex or use additional contraceptive protection for the next 7 days.**
- If a client forgets to take 1 pill, she should:
  - a. Take the forgotten pill as soon as she remembers**
  - d. Take the next pill at the regular time**
  - e. Continue to take 1 pill a day until the package is finished**

### Questions 8–18: Tick either "Yes" or "No" in the space provided.

- Is it appropriate to counsel a client that spotting increases after the first several cycles on the COC? Yes \_\_\_ **No** \_\_\_
- If a client has taken a cycle of COCs perfectly (every day) and misses her period (no bleeding at all), can she start her next package of pills on schedule? **Yes** \_\_\_ No \_\_\_
- Is it appropriate to prescribe COCs for a 20-year-old woman whose sister has hypertension and whose father had a heart attack at age 48? **Yes** \_\_\_ No \_\_\_
- Can women with cyclic cystic breast changes use COCs? **Yes** \_\_\_ No \_\_\_
- If a client had a blood pressure of 120/80 prior to using COCs that increased to 150/98 after 3 months on COCs, is it advisable for her to continue the pills? Yes \_\_\_ **No** \_\_\_

13. COCs may be prescribed for a 20-year-old smoker. **Yes** \_\_\_ No \_\_\_
14. It is usually recommended that fully breastfeeding women use COCs for the first 6 months postpartum. Yes \_\_\_ **No** \_\_\_
15. Rifampin decreases the effectiveness of COCs. **Yes** \_\_\_ No \_\_\_
16. COCs should not be prescribed for a 45-year-old woman. Correct? Yes \_\_\_ **No** \_\_\_
17. COCs should not be prescribed for an anaemic, malnourished woman. Correct?  
Yes \_\_\_ **No** \_\_\_
18. It is recommended that women using COCs take a break from the pill every few months. Yes \_\_\_ **No** \_\_\_

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# Unit 12

## PROGESTIN-ONLY INJECTABLES (DMPA)

### Learning Objectives

By the end of this unit, learners will be able to:

- ❖ Define progestin-only injectable contraceptives
- ❖ Describe the types of progestin-only injectables and how they work
- ❖ State the effectiveness of this method
- ❖ List the characteristics of DMPA
- ❖ Determine a client's medical eligibility for DMPA use
- ❖ Explain when women in different situations can start using DMPA
- ❖ Correct misconceptions about DMPA
- ❖ Demonstrate knowledge and skills in counselling clients to make an informed choice about DMPA
- ❖ Describe the procedure for administering DMPA
- ❖ Demonstrate the procedure for administering DMPA
- ❖ Provide client instructions for using DMPA
- ❖ Explain how to manage side effects due to DMPA and new problems that may or may not be due to the method.

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## Unit 12: Progestin-Only Injectables (DMPA)

### Key Points

- ❖ **Progestin-only injectable contraception is safe and very effective.**
- ❖ **Bleeding changes caused by DMPA are common but not harmful.** Typically, irregular bleeding occurs during the first several months and then monthly bleeding stops.
- ❖ **Users must return for injections regularly to prevent pregnancy.** Coming back every 3 months (13 weeks) for DMPA is important for greatest effectiveness.
- ❖ **Injection can be as much as 4 weeks late for DMPA.** A client should come back, even if later.
- ❖ **Gradual weight gain is common.**
- ❖ **Return of fertility is often delayed.** It takes several months longer on average to become pregnant after stopping DMPA than after other methods.

### 12.1 Defining Progestin-Only Injectables

Progestin-only injectables are contraceptives that are given by injection. They contain a synthetic hormone, progestin, which is similar to the natural hormone progesterone in a woman's body. Progestin, an ester of progesterone, has delayed absorption and metabolism in the body, which makes it effective for 2 to 3 months, depending on the formulation.

Progestin-only injectables do not contain oestrogen, so can be used while breastfeeding and by women who cannot use methods with oestrogen.

#### Formulations

- **DMPA** (depot medroxy progesterone acetate) is the most widely used progestin-only injectable. Since it is **the only one used in Malawi, DMPA it is the main subject of this unit.** DMPA is also known as "the shot," "the jab," "Depo," and "Depo-Provera." It is injected as 150 mg of the drug in 1 ml into the muscle (intramuscular injection) of the buttocks or upper arm every 3 months. A subcutaneous formulation (DMPA-SC) is injected under the skin, but this is not available in Malawi. (See box.)
- **NET-EN** (norethisterone enanthate, Noristerat) is not used in Malawi. It is injected every 2 months or 8 weeks.

#### How DMPA works

Progestin-only injectables work mainly by preventing release of eggs from the ovaries (ovulation). Progesterone suppresses the release of follicle stimulating hormone (FSH) and luteinizing hormone (LH), thereby inhibiting follicular development and ovulation.

### 12.2 Effectiveness

Very effective, 97%–99.7%

*Effectiveness depends on getting injections regularly.* Risk of pregnancy is greatest when a woman misses an injection.

- When women receive injections on time, less than one pregnancy occurs per 100 women (3 per 1,000 women).
- As commonly used, about 3 pregnancies occur per 100 women.

## 12.3 Characteristics of DMPA

### Advantages

- Is rapidly highly effective
- Does not interfere with sexual intercourse
- Is private: no one else can tell that a woman is using the method
- Does not require supplies
- Requires only four clinic visits per year
- Has high continuation rates

### Side effects

Some users report the following:

- Changes in bleeding patterns

First 3 months: Irregular bleeding, prolonged bleeding

At one year: No monthly bleeding, infrequent bleeding, irregular bleeding

- Abdominal bloating and discomfort

### Disadvantages

- Delays return of fertility 6 to 18 months—about 9 months, on average
- Is user-dependent
- Does not provide protection against STIs/HIV/AIDS

- Weight gain
- Headaches
- Dizziness
- Mood changes
- Reduced sex drive
- Loss of bone density

### Health benefits

- Helps protect against cancer of the lining of the uterus, and uterine fibroids
- May help protect against symptomatic pelvic inflammatory disease (PID) and iron deficiency anaemia
- Reduces sickle cell crises among women with sickle cell anaemia, and reduces symptoms of endometriosis (pelvic pain, irregular bleeding)
- Has no oestrogenic side effects

### Health risks

None

-

## 12.4 Correcting Misconceptions

DMPA:

- Can stop monthly bleeding, but this is not harmful. It is similar to not having monthly bleeding during pregnancy. Blood is not building up inside the woman.
- Do not disrupt an existing pregnancy
- Do not make women infertile
- Do not cause birth defects.

(For more information, see “Questions and Answers,” Section 12.14.)

## 12.5 Women Who Can Use DMPA

Nearly all women can use DMPA, including women who:

- Have or have not had children, or are not married, or are of any age
- Are breastfeeding (starting as soon as 6 weeks after childbirth)
- Have just had an abortion or miscarriage
- Smoke cigarettes, regardless of age or number of cigarettes smoked
- Are infected with HIV, whether or not they are taking antiretroviral medications (ARVs)
- 

### SUBCUTANEOUS DMPA

A formulation of DMPA, known as DMPA-SC, has been developed for injection into the tissue just under the skin (subcutaneously). DMPA-SC must be delivered by subcutaneous injection. It is not completely effective if injected in other ways.

The dose of DMPA-SC is 30% lower than for intramuscular DMPA—104 mg instead of 150 mg. Thus, it may cause fewer side effects, such as weight gain. Contraceptive effectiveness is similar. Like users of intramuscular DMPA, users of DMPA-SC receive injections every three months.

In the future, DMPA-SC will be available in prefilled syringes, including the single-use **Uniject**<sup>®</sup> system. With these syringes, women could inject DMPA themselves.

**Note:** DMPA-SC is not yet available in Malawi.

## 12.6 Women Who Should Not Use DMPA

Usually, a woman who has any of the following **should not use** DMPA:

### WHO MEC Categories 3 and 4

- Breastfeeding a baby less than six weeks old
- Systolic blood pressure 160 mm Hg or higher or diastolic 100 mm Hg or higher
- Diabetes for more than 20 years or damage to arteries, vision, kidneys, nervous system due to diabetes
- History of heart attack, heart disease due to blocked or narrowed arteries, or stroke or current blood clot in the deep veins of legs or in the lungs
- Unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition
- Current or history of breast cancer
- Serious liver disease, infection or tumour.

# 12.7 Screening Checklist

## Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN)

To determine if the client is medically eligible to use DMPA, ask questions 1–8. As soon as the client answers **YES** to **any question**, stop, and follow the instructions after question 8.

NO	1. Have you ever been told you have breast cancer?	YES
NO	2. Have you ever had a stroke or heart attack, or do you currently have a blood clot in your legs or lungs?	YES
NO	3. Do you have a serious liver disease or jaundice (yellow skin or eyes)?	YES
NO	4. Have you ever been told you have diabetes (high sugar in your blood)?	YES
NO	5. Have you ever been told you have high blood pressure?	YES
NO	6. Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)?	YES
NO	7. Have you ever been told that you have a rheumatic disease such as lupus?	YES
NO	8. Are you currently breastfeeding a baby less than 6 weeks old?	YES

If the client answered **NO** to **all of questions 1–8**, the client can use DMPA. Proceed to questions 9–14.

If the client answered **YES** to **question 1**, she is not a good candidate for DMPA. Counsel about other available methods or refer.

If the client answered **YES** to **any of questions 2–7**, DMPA cannot be initiated without further evaluation. Evaluate or refer as appropriate, and give condoms to use in the meantime. See explanations for more instructions.

If the client answered **YES** to **question 8**, instruct her to return for DMPA as soon as possible after the baby is six weeks old.

Ask questions 9–14 to be reasonably sure that the client is not pregnant. As soon as the client answers **YES** to **any question**, stop, and follow the instructions after question 14.

YES	9. Did your last menstrual period start within the past 7 days?	NO
YES	10. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	NO
YES	11. Have you abstained from sexual intercourse since your last menstrual period or delivery?	NO
YES	12. Have you had a baby in the last 4 weeks?	NO
YES	13. Have you had a miscarriage or abortion in the last 7 days?	NO
YES	14. Have you been using a reliable contraceptive method consistently and correctly?	NO

If the client answered **YES** to **at least one of questions 9–14** and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. The client can start DMPA now.

If the client began her last menstrual period **within the past 7 days**, she can start DMPA immediately. No additional contraceptive protection is needed.

If the client began her last menstrual period **more than 7 days ago**, she can **be given DMPA now**, but instruct her that she must **use condoms or abstain from sex for the next 7 days**. Give her condoms to use for the next 7 days.

If the client answered **NO** to **all of questions 9–14**, pregnancy cannot be ruled out.

She must use a pregnancy test or wait until her next menstrual period to be given DMPA.

Give her condoms to use in the meantime.





## 12.8 Timing: When to Start DMPA

**Important:** A woman can start using DMPA any time she wants if it is reasonably certain she is not pregnant. To be reasonably certain she is not pregnant, use the Pregnancy Checklist (see previous page).

Woman's Situation	When to Start
<b>Having menstrual cycles, or switching from non-hormonal method</b>	<p>Can start any time of month</p> <p>If starting less than 7 days after start of her monthly bleeding (menses), there is no need for a backup method.</p> <p>If more than 7 days after start of her monthly bleeding, client will need a backup method for the first seven days.</p>
<b>Switching from a hormonal method</b>	<p>Immediately, if she has been using hormonal method consistently and correctly, or if it is otherwise reasonably certain she is not pregnant.</p>
<b>Fully breastfeeding, less than 6 months after giving birth</b>	<p>If menses has not returned, she can start any time between 6 weeks and 6 months. No backup method is needed.</p> <p>If her menses has returned, she can start DMPA as advised for women having menstrual cycles.</p>
<b>Fully breastfeeding, more than 6 months after giving birth</b>	<p>If menses has not returned, she can start DMPA at any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.</p> <p>If menses has returned, she can start as advised for women having menstrual cycles.</p>
<b>Partially breastfeeding, less than 6 weeks after giving birth</b>	<p>Delay her first injection until at least 6 weeks after giving birth.</p>
<b>Partially breastfeeding, more than 6 weeks after giving birth</b>	<p>If her menses has not returned, she can start DMPA at any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.</p> <p>If menses has returned, she can start as advised for women having menstrual cycles.</p>
<b>Not breastfeeding, less than 4 weeks after giving birth</b>	<p>She can start DMPA at any time. No backup method is needed.</p>
<b>Not breastfeeding, more than 4 weeks after giving birth</b>	<p>If her menses has not returned, she can start DMPA at any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.</p> <p>If menses has returned, she can start as advised for women having menstrual cycles.</p>

Woman's Situation	When to Start
After abortion or miscarriage	She can start DMPA immediately. There is no need for a backup method if she is starting within 7 days of a miscarriage or abortion. More than 7 days after, the client can start at any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.
After taking emergency contraceptive pills	She can start DMPA on the same day as the ECPs, or within 7 days after the start of her monthly bleeding. She will need a backup method for the first 7 days after the injection. She should return if she has signs or symptoms of pregnancy other than not having monthly bleeding.

## 12.9 Providing DMPA

- Assemble equipment and supplies:

A 2 ml syringe and a 21–23 gauge intramuscular needle

A single-dose vial, preferably.

- Explain the procedure and show client the equipment.
- Check expiry date on DMPA vial.
- Wash hands thoroughly with soap and water and air dry.
- Prepare the vial:

Shake vial gently, making sure that solution has dissolved completely.

If vial is cold, warm to skin temperature before giving injection.

- Fill syringe: Pierce top of vial with sterile needle and fill syringe with proper dose (150 mg).
- Clean skin above deltoid muscle with soap and water if necessary.
- Insert needle deep into the muscle, and inject DMPA.
- Apply pressure to injection site with dry cotton swab.
- Do not massage injection site.
- Discard used syringe and needle according to guidelines.
- Wash hands thoroughly with soap and water and air dry.

- Combined Injectables

In addition to progestin-only injectable contraceptives, a combined injectable (CIC) has also been developed. Much like combined oral contraceptives (COCs), it contains not only progestin but also an oestrogen. Combined injectables need to be given monthly rather than every three months. For this reason, they are sometimes referred to as monthly injectables. CICs work primarily by preventing the release of eggs from the ovaries (ovulation).

- **Note:** Combined injectables are not currently available in Malawi.

## 12.10 Client Counselling and Instructions

- Do not massage the injection site.
- Write down or remember the name of the injection: “DMPA” or “Depo.”
- Set a return date in 3 months for the next injection. Find a way to remember it.

- Come back on time for the next injection, but she can come up to 2 weeks early or 4 weeks late and still get an injection.
- Come back no matter how late she is for her next injection.
- If she is more than 4 weeks late, she should abstain from sex or use condoms until she can get an injection. She can use emergency contraceptive pills if she is more than 4 weeks late and she has had unprotected sex in the past 5 days.
- Be aware that DMPA does not protect against STIs/HIV; use condoms for dual protection.

**Reasons to return**

- Come back any time for problems, questions, and/or to find out if she has a change in health status or if she thinks she might be pregnant.

## 12.11 Managing Side Effects

### Problems Reported as Side Effects or Problems With Use

Side effects can affect women’s satisfaction and use of DMPA. If the client reports a side effect as a problem, listen to her concerns, give her advice and, if appropriate, provide treatment.

Side Effect	How to Manage
<b>Prolonged/ heavy bleeding</b>	<ul style="list-style-type: none"> <li>● Reassure her that some women using DMPA experience heavy or prolonged bleeding. It is not harmful and usually becomes less or stops after a few months.</li> <li>● For modest, short-term relief she can try (one at a time): combined oral contraceptives (COCs), taking one pill daily for 21 days, beginning when heavy bleeding starts; OR 50 µg of ethinyl estradiol daily for 21 days, beginning when heavy bleeding starts.</li> <li>● If bleeding becomes a health threat or if the woman wants, help her choose another method. In the meantime, she can take ethinyl estradiol or COCs as above to help reduce bleeding.</li> <li>● To help prevent anaemia, suggest she take iron tablets and tell her it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).</li> <li>● If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use (see “Unexplained vaginal bleeding,” in the “New Problems” box, Section 12.12).</li> </ul>
<b>No monthly bleeding</b>	<ul style="list-style-type: none"> <li>● Reassure her that most women using DMPA stop having monthly bleeding over time, and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not infertile. Blood is not building up inside her.</li> <li>● Advise her to return to the clinic if amenorrhea continues to be a concern.</li> </ul>
<b>Spotting (irregular bleeding)</b>	<ul style="list-style-type: none"> <li>● Reassure her that many women using DMPA experience irregular bleeding. It is not harmful and usually becomes less or stops after the first few months of use.</li> <li>● Advise her to take ibuprofen, 800 mg, three times a day, for five days, for short-term relief.</li> </ul>

<b>Headache or dizziness</b>	<ul style="list-style-type: none"> <li>• For headache (non migrainous) suggest aspirin (300-600 mg), ibuprofen (200–400 mg), paracetamol (500–1000 mg), or other pain reliever.</li> <li>• If headache persists or gets worse, evaluate further.</li> <li>• For dizziness, consider locally available remedies.</li> </ul>
<b>Weight gain</b>	<ul style="list-style-type: none"> <li>• Reassure client that fluctuations of 1 kg–2 kg are common with DMPA.</li> <li>• Review diet and lifestyle, and counsel as needed.</li> </ul>
<b>Abdominal bloating and discomfort</b>	<ul style="list-style-type: none"> <li>• Use locally available remedies.</li> <li>• Advise her to eat whenever she is hungry.</li> </ul>
<b>Loss of libido, or mood changes</b>	<ul style="list-style-type: none"> <li>• Ask about changes in her life that could affect her mood or sex drive, including changes in her relationship with her partner. Give support as appropriate.</li> <li>• Refer her for care if she has serious mood changes, such as major depression.</li> <li>• Consider locally available remedies.</li> </ul>

## 12.12 New Problems that May Require Switching Methods

<b>May or may not be due to DMPA</b>
<b>Migraine headaches</b>
<ul style="list-style-type: none"><li>• If she has migraine headaches without aura, she can continue to use DMPA if she wishes.</li><li>• If she has migraine aura, do not give the injection. Help her choose a method without hormones.</li></ul>
<b>Unexplained vaginal bleeding (that suggests a medical condition not related to the method).</b>
<ul style="list-style-type: none"><li>• Refer, or evaluate by history and pelvic examination. Diagnose and treat as appropriate.</li><li>• If no cause of bleeding can be found, consider stopping DMPA to make diagnosis easier. Provide another method of her choice to use until the condition is evaluated and treated (not implants or IUCD).</li><li>• If bleeding is caused by STI or pelvic inflammatory disease, she can continue using DMPA during treatment.</li></ul>
<b>Certain serious health conditions (suspected blocked or narrowed arteries, liver disease, severe high blood pressure, blood clots in deep veins of legs or in the lungs, stroke, breast cancer, or damage to arteries, vision, kidneys, or nervous system caused by diabetes.)</b>
<ul style="list-style-type: none"><li>• Do not give next injection.</li><li>• Give her a backup method to use until the condition is evaluated.</li><li>• Refer for diagnosis and care if not already under care.</li><li>• If you suspect pregnancy: Assess client for pregnancy. Stop injections if pregnancy is confirmed.</li><li>• Reassure client that there are no known risks to a foetus conceived while a woman is using DMPA.</li></ul>

## 12.13 Managing Late Injections

- If the client is less than 4 weeks late for a repeat injection of DMPA, she can receive her next injection. There is no need for tests, evaluation, or a backup method.
- A client who is more than 4 weeks late for DMPA can receive her next injection if one of the following is true:

She has not had sex since *two weeks after* she should have had her last injection.

She has used a backup method or has taken emergency contraceptive pills (ECPs) after any unprotected sex since *two weeks after* she should have had her last injection. She is exclusively breastfeeding, and she gave birth less than six months ago.

- She will need a backup method for the first seven days after the injection.
- If the client is more than 4 weeks late for DMPA, and she does not meet one of the above criteria, additional steps can be taken to be reasonably certain she is not pregnant. (See “Further Options to Assess for Pregnancy” in Unit 4: Client FP Assessment and WHO MEC.) These steps are helpful because many women who have been using progestin-only injectables will have no monthly bleeding for at least a few months after discontinuation. Thus, asking her to come back during her next monthly bleeding means her next injection could be unnecessarily delayed. She may be left without contraceptive protection.
- Discuss why the client was late and come up with solutions. Remind her that she should keep trying to come back every 3 months for DMPA. If coming back on time is often a problem, discuss using a backup method when she is late for her next injection, taking ECPs or choosing another method.

(WHO/RHR and CCP, Knowledge for Health Project 2008)

## 12.14 Questions and Answers about DMPA

### 1. Can women who could get STIs use DMPA?

Yes. Women at risk for STIs can use DMPA. The few studies available have found that women using DMPA were more likely to acquire chlamydia than women not using hormonal contraception. The reason for this difference is not known. Like anyone else at risk for STIs, a user of DMPA who may be at risk for STIs should be advised to use condoms correctly every time she has sexual intercourse. Consistent and correct condom use will reduce her risk of becoming infected if she is exposed to an STI.

### 2. If a woman does not have monthly bleeding while using DMPA, does this mean that she is pregnant?

Probably not, especially if she is breastfeeding. Eventually most women using DMPA will not have monthly bleeding. If she has been getting her injections on time, she is probably not pregnant and can keep using DMPA. If she is still worried after being reassured, she can be offered a pregnancy test, if available, or referred for one. If not having monthly bleeding bothers her, switching to another method may help.

### 3. Can a woman who is breastfeeding safely use DMPA?

Yes, starting as early as 6 weeks after childbirth. This is a good choice for a breastfeeding mother who wants a hormonal method. DMPA is safe for both the mother and the baby. It does not affect milk production.

### 4. How much weight do women gain when they use DMPA?

Women gain an average of 1–2 kg per year when using DMPA. Some of the weight increase may be the usual weight gain as people age. Some women, particularly overweight adolescents, have gained much more than 1–2 kg per year. At the same time, some users of progestin-only injectables lose weight or have no significant change in weight.

### 5. Does DMPA cause abortion?

No. Research on progestin-only injectables finds that they do not disrupt an existing pregnancy.

### 6. Does DMPA make a woman infertile?

No. There may be a delay in regaining fertility after stopping DMPA, but in time the woman will be able to become pregnant as before, although fertility decreases as women get older. The bleeding pattern a woman had before she used DMPA generally returns several months after the last injection even if she had no monthly bleeding while using DMPA. Some women may have to wait several months before their usual bleeding pattern returns.

### 7. How long does it take to become pregnant after stopping DMPA?

Women who stop using DMPA wait about four months longer on average to become pregnant than women who have used other methods. This means they become pregnant on average nine months after their last injection. But this is an average figure. A woman should not be worried if she has not become pregnant even as much as 12 months after stopping DMPA use. The length of time a woman has used DMPA makes no difference to how quickly she becomes pregnant once she stops having injections. After stopping DMPA, a woman may ovulate before her monthly bleeding returns—and thus can become



pregnant. If she wants to continue avoiding pregnancy, she should start another method before monthly bleeding returns.

**8. Does DMPA cause cancer?**

Many studies show that DMPA does not cause cancer. DMPA use helps protect against cancer of the lining of the uterus (endometrial cancer). Findings of the few studies on DMPA use and breast cancer are similar to findings with combined oral contraceptives: Women using DMPA were slightly more likely to be diagnosed with breast cancer while using DMPA or within 10 years after they stopped. It is unclear whether these findings are explained by earlier detection of existing breast cancers among DMPA users or by a biologic effect of DMPA on breast cancer.

A few studies on DMPA use and cervical cancer suggest that there may be a slightly increased risk of cervical cancer among women using DMPA for 5 years or more. Cervical cancer cannot develop because of DMPA alone, however. It is caused by persistent infection with human papillomavirus (HPV).

**9. How does DMPA affect bone density?**

DMPA use decreases bone density. Research has not found that DMPA users of any age are likely to have more broken bones, however. When DMPA use stops, bone density increases again for women of reproductive age. Among adults who stop using DMPA, after 2 to 3 years their bone density appears to be similar to that of women who have not used DMPA. Among adolescents, it is not clear whether the loss in bone density prevents them from reaching their potential peak bone mass.

**10. Does DMPA cause birth defects? Will the foetus be harmed if a woman accidentally uses DMPA while she is pregnant?**

No. Good evidence shows that DMPA will not cause birth defects and will not otherwise harm the foetus if a woman becomes pregnant while using DMPA or accidentally starts DMPA when she is already pregnant.

**11. Does DMPA change women's mood or sex drive?**

Generally, no. Some women using DMPA report these complaints. The great majority of DMPA users do not report any such changes, however. It is difficult to tell whether such changes are due to DMPA or to other reasons. Providers can help a client with these problems. There is no evidence that DMPA affects women's sexual behaviour.

**12. What if a woman returns for her next injection late?**

Current World Health Organization guidance recommends giving a woman her next DMPA injection if she is up to 4 weeks late without the need for further evidence that she is not pregnant. Some women return even later for their repeat injection, however. Providers can use "Further Options to Assess for Pregnancy" (in Unit 4: Client FP Assessment and WHO MEC) if a DMPA user is more than 4 weeks late for her repeat injection.

(WHO/RHR and CCP, Knowledge for Health Project 2008)

## DMPA Case Studies

(Adapted from Solter, Cathy 1999)

### Case Study 1

The client is a 28-year-old mother of three children. Her youngest child is 4 years old, and his birth was very difficult. She does not want to have any more children and her husband agrees. To prevent further pregnancies, she began taking DMPA injections about 1 year ago. It is not yet time for her next injection, but she has returned to the clinic because she is worried—she has not had a menstrual period for 2 months and is afraid that the menstrual blood is building up inside of her.

### Questions

1. What are the possible causes of the client's amenorrhea?
2. What additional information do you need to determine the most likely cause? What questions will you ask? What examinations will you perform?
3. You find no cause for the amenorrhea other than the DMPA. How would you manage this client?
4. Despite your explanations, the client insists on stopping the DMPA. What other family planning methods might be appropriate for her? Why?

## Case Study 2

The client is a 25-year-old woman. She is married and has four children. Her youngest child is 1 year old. She wants no more children for several years. Her husband, a truck driver, will not use condoms, so she began taking DMPA injections 7 months ago. Just last month she received her third injection. At that time, she reported having some light spotting between periods. Now she has returned to the health post saying that she has been having heavy bleeding for the past 10 days. She is very frightened and concerned.

### Questions

1. What should you tell her about the light spotting?
2. What are the possible causes of her heavy bleeding?
3. Upon examination and history, no other abnormalities are found. What would you tell her about the bleeding? Is there any other information or counselling she needs?
4. If there is no response to the treatment or the client decides that she wishes to change to another family planning method, which methods may be appropriate for her?

# DMPA Case Studies Answer Key

## Case Study 1

### Questions

1. What are the possible causes of the client's amenorrhea?

**Amenorrhea is normal after 1 year of DMPA use. Pregnancy is also a possibility.**

2. What additional information do you need to determine the most likely cause? What questions will you ask? What examinations will you perform?

**Administer a pregnancy test (if not available, use the Pregnancy Checklist).**

3. You find no cause for the amenorrhea other than the DMPA. How would you manage this client?

**Reassure her that amenorrhea is normal after 1 year of DMPA use. Blood is not building up in her body. She can continue using DMPA without concern or she could consider switching to a long-term or permanent method (LTPM), since she and her husband want no more children.**

4. Despite your explanations, the client insists on stopping the DMPA. What other family planning methods might be appropriate for her? Why?

**Long-term or permanent methods (LTPMs) would be most appropriate since she and her husband want no more children: vasectomy, female sterilisation, IUCD, or contraceptive implant. COCs are another option.**

## Case study 2

### Questions

1. What should you tell her about the light spotting?

**Irregular bleeding and spotting is normal with DMPA use. It is not harmful.**

2. What are the possible causes of her heavy bleeding?

**Heavy bleeding can be normal with DMPA use. It is not harmful and usually lessens or stops after the first months.**

**If heavy bleeding continues, something may be wrong for other reasons. Consider underlying conditions unrelated to the DMPA use (see Section 12.12).**

3. Upon examination and history, no other abnormalities are found. What would you tell her about the bleeding? Is there any other information or counselling she needs?

**Reassure her that heavy bleeding can be normal with DMPA use. It is not harmful and usually lessens or stops after the first months.**

**She could take COCs for 21 days to lessen bleeding.**

**If she is anaemic, should could take iron tablets and consume more iron in her diet.**

**She can continue using DMPA without concern, or she could consider switching to another method.**

4. If there is no response to the treatment or the client decides that she wishes to change to another family planning method, which methods may be appropriate for her?

**Long-term methods (IUCD, contraceptive implant) would be most appropriate since she does not want more children for at least several years.**

**COCs are another option.**

**She should also consider using female condoms in addition (dual method use), especially if she thinks she could be at risk for an STI/HIV.**

For additional case studies and role plays, see the following websites:

[http://www.pathfind.org/pf/pubs/module\\_6.pdf](http://www.pathfind.org/pf/pubs/module_6.pdf) and

<http://www.fhi.org/training/en/modules/INJ/default.htm>

# DMPA Role Play: Counselling About Side Effects

(Adapted from Solter, Cathy 1999)

## Participant roles

**Clinician:** The clinician is an experienced family planning service provider. S/he is calm and knowledgeable when counselling clients.

**Client:** The client is a 29-year-old woman with 6 children. She has been using Depo-Provera starting 6 weeks after the birth of her youngest child 2½ years ago. She says that she had trouble breastfeeding her child because of the Depo. She kept taking the Depo, however, because she was more concerned about another pregnancy than about her problems with breastfeeding.

## Situation

The client now comes to the clinic complaining of feeling very tired and unable to do her work for the past several months. She is sure it is because she has been taking Depo for such a long time. She thinks it would be a good idea to take a rest period from Depo.

## Focus of the role play

The focus of the role play is on the interaction between the clinician and the client. The clinician needs to assess the relationship between the client's problems and her use of DMPA. S/he also needs to counsel and reassure the client regarding her misconceptions about DMPA. The client should remain firm in her wish to take a rest from DMPA until the clinician provides her with the information that will calm her fears and concerns.

## Observer discussion questions

1. How did the service provider approach the client?
2. How might the service provider improve her/his interaction with the client?
3. Are the client's past or present problems related to her use of Depo-Provera? Did the service provider explain this in an appropriate and convincing manner?
4. What might be better or alternative contraceptive choices for her? Why?

# Progestin-Only Injectables Quiz Questions

(Adapted from Solter, Cathy 1999; Family Health International 1999)

Directions: Circle the correct/best answer.

1. DMPA is composed of:
  - a. An oestrogen and progesterone
  - b. A synthetic hormone, depot medroxy progesterone acetate, similar to the natural hormone progesterone
  - c. Norethindrone enanthate
  - d. A synthetic oestrogen derived from the natural hormone oestrogen
2. The standard regime (dose and schedule) of DMPA is:
  - a. 100 mg every 8 weeks
  - b. 100 mg every 12 weeks
  - c. 150 mg every 8 weeks
  - d. 150 mg every 12 weeks
3. The dose of DMPA depends on:
  - a. The age of the client
  - b. Weight of the client
  - c. Parity of the client
  - d. All of the above
  - e. None of the above
4. The DMPA route of administration is:
  - a. Oral liquid
  - b. Subcutaneous using 25 gauge 2.5 cm needle
  - c. Intravenous using 24 gauge 2.5 cm needle
  - d. Deep intramuscular using 2 ml syringe and 21–23 gauge needle
  - e. An implant
5. Some of the disadvantages of DMPA include (circle all that apply):
  - a. Frequent bleeding abnormalities
  - b. It can cause permanent infertility.
  - c. It often causes nausea.
  - d. It does not protect from STIs/HIV.
  - e. It is not very effective.
6. You may give a subsequent injection without requiring special lab tests or examinations to a woman who returns at (circle all that apply):
  - a. 10 weeks after the previous injection
  - b. 12 weeks after the previous injection
  - c. 14 weeks after the previous injection
  - d. 18 weeks after the previous injection
7. DMPA may be an appropriate choice for a (circle all that apply):
  - a. Woman over 40, smoker, with estrogen precautions
  - b. Breastfeeding woman (more than six weeks postpartum)
  - c. Woman taking rifampin

- d. Woman wishing to postpone pregnancy for 2 or more years
  - e. Woman wishing to prevent future pregnancies but unable or unwilling to undergo female sterilisation
  - f. All of the above
8. DMPA precautions apply to (circle all you consider a precaution):
- a. Nulliparous women
  - b. Breastfeeding women (more than six weeks postpartum)
  - c. Women with suspected pregnancy
  - d. Women with benign/malignant liver disease
  - e. Women with undiagnosed vaginal bleeding
  - f. Obese women
  - g. Women under age 30 years
9. If a woman comes for her first DMPA injection on day 8 of her menstrual cycle:
- a. She needs to wait for her next menstrual period before receiving DMPA injection.
  - b. She should be given DMPA but needs to use a backup method for up to 7 days following the injection.
  - c. She needs to be given a higher dose of DMPA.
  - d. She can be given a DMPA injection and do nothing.
10. When counselling for DMPA use, the clinician must discuss the following with a potential client (circle all that apply):
- a. Potential side effects
  - b. Mechanism of action
  - c. Myths and rumours
  - d. Timing and frequency of injections
  - e. Backup method (if required)
  - f. Delay in return to fertility
  - g. All of the above
11. Beyond spotting and amenorrhea the main and most common side effects of DMPA are (circle all you consider correct):
- a. Irregular bleeding
  - b. Anaemia
  - c. Lethargy
  - d. Insomnia
  - e. Weight gain
  - f. Weight loss
12. Amenorrhea caused by DMPA calls for (circle one):
- a. Discontinuation of method because woman is menopausal
  - b. Concern that it may be causing complications
  - c. Reassuring client that she is not pregnant
  - d. Giving woman an oestrogen injection
13. Following discontinuation of DMPA, the average delay in return of fertility is (circle one):
- a. Immediately after discontinuation of DMPA
  - b. 4 months
  - c. 9 months
  - d. 2 years



14. The vast majority of women who develop DMPA side effects:
- Must be referred to a specialist
  - Can be counselled and have side effects managed
  - Need to discontinue DMPA immediately
  - Should be discouraged from complaining
15. If a woman using DMPA returns with a complaint of slight bleeding for 10 days you would:
- Refer her immediately to a specialist
  - Counsel her that this problem is not harmful and is likely to improve
  - Advise her she needs a D & C (dilation and curettage) to investigate the cause
  - Advise her to try another method
16. If a woman tells you she has heard that an injectable contraceptive should not be used to space pregnancies because it causes infertility, you could respond:
- She is correct. Only women who wish no future pregnancies can use DMPA.
  - She must not listen to silly gossip and must do what the clinician tells her.
  - Actually, studies conducted with many hundreds of thousands of women who used DMPA show that it does not cause infertility but rather only some delay in return to fertility.
17. A woman returns to the clinic complaining that she has bleeding equal to her regular menstruation, but it has lasted twice as long (14 days). She is frightened and wants the bleeding to stop. What is the appropriate treatment to reduce or stop this bleeding episode?
- Vitamin K injection, 25mg intramuscular
  - Vitamin K in daily multivitamin pills, 2 pills daily for 14 days.
  - Low dose combined oral contraceptives, one pill daily for 21 days
  - Aspirin, 325mg, 4 times daily for 7 days
18. Typical one-year pregnancy rates for injectable contraceptives are:
- 0.4% or less.
  - 1%
  - 10%
  - 15%

**Questions 19–29.** Indicate whether the following statements are **true** or **false** by writing a **“T”** for true or an **“F”** for false in the space provided before each statement.

- \_\_\_ 19. Because most women are very familiar with injections, DMPA services do not require as much time for counselling as other methods.
- \_\_\_ 20. Because most providers are very familiar with giving injections, there is no need for training them in how to provide DMPA services.
- \_\_\_ 21. DMPA causes permanent infertility if used for more than 3 years.
- \_\_\_ 22. Injectables are nearly as effective as female sterilisation in preventing pregnancy.
- \_\_\_ 23. Injectables depend to a large extent on daily user compliance.
- \_\_\_ 24. The primary mechanism of action of injectables is suppression of ovulation.
- \_\_\_ 25. DMPA is a reversible method of contraception.
- \_\_\_ 26. DMPA provides protection from endometrial cancer.
- \_\_\_ 27. DMPA does not have a negative effect on lactation; however, it is recommended that a woman who is breastfeeding wait until her child is 6 weeks old before using it.
- \_\_\_ 28. DMPA does not cause menstrual changes.
- \_\_\_ 29. Health workers who provide injectable contraceptives need to be trained in both technical skills and counselling skills.

## Injectables Quiz Questions Answer Key

1. DMPA is composed of:
  - b. A synthetic hormone, depot medroxy progesterone acetate, similar to the natural hormone progesterone**
2. The standard regime (dose and schedule) of DMPA is:
  - d. 150 mg every 12 weeks**
3. The dose of DMPA depends on:
  - e. None of the above**
4. DMPA route of administration is:
  - d. Deep intramuscular using 2 ml syringe and 21–23 gauge needle**
5. Some of the disadvantages of DMPA include (circle all that apply):
  - a. Frequent bleeding abnormalities**
  - d. It does not protect from STIs/HIV.**
6. You may give a subsequent injection without requiring special lab tests or examinations to a woman who returns at (circle all that apply):
  - a. 10 weeks after the previous injection**
  - b. 12 weeks after the previous injection**
  - c. 14 weeks after the previous injection**
7. DMPA may be an appropriate choice for (circle all that apply):
  - f. All of the above**
8. DMPA precautions apply to (circle all you consider a precaution):
  - c. Woman with suspected pregnancy**
  - d. Woman with benign/malignant liver disease**
  - e. Woman with undiagnosed vaginal bleeding**
9. If a woman comes for her first DMPA injection on day 8 of her menstrual cycle:
  - b. She is given DMPA but needs to use a backup method for up to 7 days following the injection.**
10. When counselling for DMPA use, the clinician must discuss the following with a potential client (circle all that apply):
  - g. All of the above**
11. Beyond spotting and amenorrhea the main and most common side effects of DMPA are (circle all you consider correct):
  - a. Irregular bleeding**
  - e. Weight gain**
12. Amenorrhea caused by DMPA calls for (circle one):
  - c. Reassuring client that she is not pregnant**
13. Following discontinuation of DMPA, the average delay in return of fertility is (circle one):
  - c. 9 months**

14. The vast majority of women who develop DMPA side effects:
- b. Can be counselled and have side effects managed**
15. If a woman using DMPA returns with a complaint of slight bleeding for 10 days you would:
- b. Counsel her that this problem is not harmful and is likely to improve.**
16. If a woman tells you she has heard that an injectable contraceptive should not be used to space pregnancies because it causes infertility, you could respond:
- c. Actually, studies conducted with many hundreds of thousands of women who used DMPA show that it does not cause infertility but rather only some delay in return to fertility.**
17. A woman returns to the clinic complaining that she has bleeding equal to her regular menstruation but it has lasted twice as long (14 days). She is frightened and wants the bleeding to stop. What is the appropriate treatment to reduce or stop this bleeding episode?
- c. Low dose combined oral contraceptives, one pill daily for 21 days**
18. Typical one-year pregnancy rates for injectable contraceptives are:
- a. 0.4% or less**

**Questions 19–29.** Indicate whether the following statements are **true** or **false** by writing a **“T”** for true or an **“F”** for false in the space provided before each statement.

- F**\_\_19. Because most women are very familiar with injections, DMPA services do not require as much time for counselling as other methods.
- F**\_\_20. Because most providers are very familiar with giving injections, there is no need for training them in how to provide DMPA services.
- F**\_\_21. DMPA causes permanent infertility if used for more than 3 years.
- T**\_\_22. Injectables are nearly as effective as female sterilisation in preventing pregnancy.
- F**\_\_23. Injectables depend to a large extent on daily user compliance.
- T**\_\_24. The primary mechanism of action of injectables is suppression of ovulation.
- T**\_\_25. DMPA is a reversible method of contraception.
- T**\_\_26. DMPA provides protection from endometrial cancer.
- T**\_\_27. DMPA does not have a negative effect on lactation; however, it is recommended that a woman who is breastfeeding wait until her child is 6 weeks old before using it.
- F**\_\_28. DMPA does not cause menstrual changes.
- T**\_\_29. Health workers who provide injectable contraceptives need to be trained in both technical skills and counselling skills.

# Learning Guides for DMPA

(to be used by participants)

Rate the performance of each step or task observed using the following rating scale:	
1	<b>Needs Improvement:</b> Step or task not performed correctly or out of sequence (if necessary) or is omitted
2	<b>Competently Performed:</b> Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently
3	<b>Proficiently Performed:</b> Step or task efficiently and precisely performed in the proper sequence (if necessary)

Participant \_\_\_\_\_ Course Dates \_\_\_\_\_

**Note:** This learning guide does not include the Pre-Choice and Method Choice Stages of BCS+

<b>Learning Guide For DMPA: Provision</b>					
<b>Task/Activity</b>	<b>Cases</b>				
<b>BCS+ STEPS 1-9: SEE UNIT 5 FOR BCS+ LEARNING GUIDE</b>					
<b>BCS+ STEP 10: GIVE THE METHOD</b>					
1. Assemble equipment and supplies: <ul style="list-style-type: none"> <li>● A 2 ml syringe and a 21–23 gauge intramuscular needle</li> <li>● A single-dose vial, preferably</li> </ul>					
2. Explain the procedure and show client the equipment.					
3. Check expiry date on DMPA vial.					
4. Wash hands thoroughly with soap and water and dry them on a clean, dry cloth or air dry.					
5. Prepare the vial: <ul style="list-style-type: none"> <li>● Shake vial gently, making sure that solution has dissolved completely.</li> <li>● If vial is cold, warm to skin temperature before giving injection</li> </ul>					
6. Fill syringe: Pierce top of vial with sterile needle and fill syringe with proper dose (150 mg)					
7. Clean skin above deltoid muscle with soap and clean water, if necessary.					
8. Insert needle deep into the muscle and aspirate for blood.					
9. Inject 150 mg DMPA.					
10. Apply pressure to injection site with dry cotton swab. Do not massage the injection site.					
11. Discard used syringe and needle according to guidelines.					
12. Wash hands thoroughly with soap and water and dry them on a clean, dry cloth or air dry.					
<b>BCS+ STEPS 11-17: SEE UNIT 5 FOR BCS+ LEARNING GUIDE</b>					
<b>BCS+ STEP 18: GIVE FOLLOW-UP INSTRUCTIONS, A METHOD BROCHURE AND CONDOM BROCHURE</b>					
1. Schedule a return visit for the next injection according to the information presented in the reference manual. Usually, this is in 13 weeks for DMPA, but clients may get next injection 2 weeks before or 4 weeks after this date and still be protected from pregnancy.					
2. Record return date(s).					

## Learning Guide For DMPA: Provision

3. Check that client understands the importance of returning for her repeat injections, and when exactly she is to return.					
4. Correct any misinformation or misunderstanding. Be certain the client understands she can return anytime if she has problems.					
<b>BCS+ STEP 19: SEE UNIT 5 FOR BCS+ LEARNING GUIDE</b>					
<b>RECORD VISIT</b>					
1. Record details of visit in the clinic register and client's health record.					

## Learning Guide For DMPA: Follow-up Visit

Task/Activity	Cases
<b>ESTABLISH RAPPORT</b>	
1. Greet and welcome client.	
2. Offer seat and ensure privacy.	
3. Introduce yourself.	
4. Establish reason for visit and ask for client record.	
5. Check method being used and retrieve client's clinic card.	
<b>REVIEW CLIENT'S RECORDS</b>	
1. Review previous findings on history and examination.	
2. Update information on client's health record as necessary.	
<b>TAKE AND RECORD RECENT HISTORY FROM CLIENT</b>	
1. Ask if client and partner are satisfied with method and if there have been any concerning side effects or problems with it.	
2. Ask whether client has any of the side effects (list the specific side-effects for the method as per the information presented in the reference manual).	
3. Ask whether the client has had any signs of complications (list the specific signs of complications as per the information presented in the reference manual).	
<b>MANAGE CLIENT ACCORDING TO SCREENING FINDINGS</b>	
1. Manage any side effects or complications following the information presented in the reference manual.	
2. Provider her with DMPA reinjection following the information presented in the reference manual, if the client has no precautions/complications.	
<b>SCHEDULE NEXT FOLLOW-UP VISIT</b>	
1. Schedule the next follow-up visit according to the information presented in the reference manual. Thirteen weeks (or between two weeks before and four weeks after this date)	
2. Review client's understanding of return date(s) and when to return for complications.	
3. Ask for any questions from the client and answer them.	
<b>RECORD VISIT</b>	
1. Record details of visit in the clinic register and client's health record.	

## References

Family Health International (FHI). 1999. Injectable Contraceptives. In *Contraceptive Technology and Reproductive Health Series*. <http://www.fhi.org/training/en/modules/INJ/default.htm> (accessed April 12, 2010).

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Solter, Cathy. 1999. Module 6: DMPA injectable contraceptive. In *Comprehensive reproductive health and family planning training curriculum*. Watertown, MA: Pathfinder International. [http://www.pathfind.org/pf/pubs/module\\_6.pdf](http://www.pathfind.org/pf/pubs/module_6.pdf) (accessed April 12, 2010).

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# Unit 13

## PROGESTIN-ONLY PILLS

### Learning Objectives

By the end of this unit, learners will be able to:

- ❖ Define progestin-only pills (POPs)
- ❖ List the types and formulations of POPs available in Malawi
- ❖ Explain how POPs work
- ❖ State the effectiveness of POPs
- ❖ Describe the characteristics of POPs
- ❖ List the side effects of POPs
- ❖ Determine a client's medical eligibility for POP use
- ❖ Explain when women in different situations can start the method
- ❖ Describe potential complications of POPs and list their warning signs
- ❖ Respond to and correct rumours and misconceptions associated with POPs
- ❖ Describe key counselling messages for women with HIV who use POPs
- ❖ Provide client instructions for using POPs
- ❖ Explain how to manage side effects of POPs
- ❖ Demonstrate knowledge and skills in counselling to assist clients in making an informed choice about using POPs.

### Teaching Resources in this Unit

#### Learning Activities

Role Plays 333

#### Unit Assessment

Quiz Questions 334

Quiz Questions Answer Key 336



## Unit 13: Progestin-Only Pills

### Key Points

- ❖ **POPs are safe and effective.**
- ❖ **Take one pill every day, with no breaks between packs.**
- ❖ **POPs are safe for breastfeeding women and their babies.** POPs do not affect milk production.
- ❖ **Bleeding changes are common but not harmful.** Typically, pills lengthen how long breastfeeding women have no monthly bleeding.
- ❖ **POPs can be given to a woman at any time to start later.** If pregnancy cannot be ruled out, a provider can give her pills to take later, when her monthly bleeding begins.

### 13.1 Defining Progestin-Only Pills

Progestin-only pills contain very low doses of a synthetic hormone known as progestin, which is like the natural hormone progesterone in a woman's body. POPs are also called "minipills" and progestin-only oral contraceptives.

#### Formulations of POPs available in Malawi

- Microlut (35-pill pack): contains norgestrel
- Ovrette (28-pill pack): contains 0.075 mg norgestrel per pill

#### How POPs work

POPs thicken cervical mucus (this blocks sperm from meeting an ovum). They disrupt the menstrual cycle, including preventing the release of eggs from the ovaries (ovulation).

### 13.2 Effectiveness

Effectiveness depends on the user: For women who have monthly bleeding, the risk of pregnancy is greatest if pills are taken late or missed completely.

- If breastfeeding, 99 of every 100 women using POPs over the first year postpartum will not become pregnant. This means that they are 99% effective for these women.
- If the client is not breastfeeding, 90 to 97 of every 100 women will not become pregnant. This means that they are 90%–97% effective for these women.

## 13.3 Characteristics

### Advantages

- Can be used while breastfeeding
- Can be stopped at any time without a provider's help
- Do not interfere with sex
- Are controlled by the woman
- Do not cause delay in return to fertility once pills are stopped
- Can be provided by trained, non-medical staff
- Decrease menstrual flow and cramps
- May prevent or control anaemia.

### Disadvantages

- Are user-dependent
- Must be taken at the same time every day
- May be less effective in patients who are taking phenytoin, barbiturates, and rifampicin
- Do not protect against sexually transmitted infections (STIs), including HIV.

### Side effects

Some women report the following:

- Changes in bleeding patterns including:

Frequent bleeding

No monthly bleeding

Heavy or prolonged bleeding

Irregular bleeding

- For breastfeeding women, longer delay in return of menstrual bleeding after childbirth (lengthened postpartum amenorrhea)
- Headaches
- Dizziness
- Mood changes
- Breast tenderness
- Abdominal pain
- Nausea
- Weight gain or loss

**Health benefits and Health risks: None**

## 13.4 Correcting Misconceptions

Progestin-only pills:

- Do not cause a breastfeeding woman's milk to dry up
- Must be taken every day, whether or not a woman has sex that day
- Do not make women infertile
- Do not cause diarrhoea in breastfeeding babies

- Reduce the risk of ectopic pregnancy.

## 13.5 Women Who Can Use POPs

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

- Are breastfeeding (starting as soon as 6 weeks after childbirth)
- 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, miscarriage, or ectopic pregnancy
- Smoke cigarettes, regardless of woman's age or number of cigarettes smoked
- Have anaemia now or had in the past
- Have varicose veins
- Are infected with HIV, whether or not on antiretroviral (ARV) therapy.

## 13.6 Women Who Should Not Use POPs

Usually, clients who have the following conditions **should not use POPs**:

### **WHO MEC Categories 3 and 4**

- Breastfeeding babies less than 6 weeks since giving birth
- Severe liver disease, a liver infection, or liver tumour
- Current blood clot (not superficial) in deep veins of legs or in the lungs
- Taking barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, or rifampicin
- Current or history of breast cancer

## 13.7 POPs for Clients with HIV

Women who are infected with HIV, have AIDS, or are on antiretroviral (ARV) therapy can safely use POPs. Urge these women to use condoms along with POPs. Condoms help prevent transmission of HIV and other STIs if used consistently and correctly. They also provide extra contraceptive protection for women on ARV therapy. It is not certain whether ARV medications reduce the effectiveness of POPs.

## 13.8

### Medical Eligibility Screening Questions

#### For Progestin-Only Pills

Ask the woman the questions below about known medical conditions. Examinations and tests are not necessary. If she answers “no” to **all** of the questions, then she can start POPs if she wants. If she answers “yes” to **any** question, follow the instructions. In some cases she can still start POPs.

**1. Are you breastfeeding a baby less than 6 weeks old?**

**YES** She can start taking POPs as soon as 6 weeks after childbirth. Give her POPs now and tell her when to start taking them. (See Fully or nearly fully breastfeeding or Partially breastfeeding, under “Timing: When to Start the Method” Section 13.9)

**2. Do you have cirrhosis of the liver, a liver infection, or liver tumour? (Are her eyes or skin unusually yellow? [signs of jaundice])**

**YES** If she reports serious active liver disease (jaundice, active hepatitis, severe cirrhosis, liver), do not provide POPs. Help her choose a method without hormones.

**3. Do you have a serious problem now with a blood clot in your legs or lungs?**

**YES** If she reports a current blood clot (not superficial clots), do not provide POPs. Help her choose a method without hormones.

**4. Are you taking medication for seizures? Are you taking rifampicin for tuberculosis or other illness?**

**YES** If she is taking barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, or rifampicin, do not provide POPs. These medications can make POPs less effective. Help her choose another method, but not combined oral contraceptives (COCs) or implants.

**5. Do you have or have you ever had breast cancer?**

**YES** Do not provide POPs. Help her choose a method without hormones.

Explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable, when relevant to the client.

## 13.9 Timing: When to Start POPs

Woman's situation	When to start
<p>Fully or nearly fully breastfeeding <b>Less than 6 months after giving birth</b></p>	<p>If she gave birth less than 6 weeks ago, give her POPs and tell her to start taking them 6 weeks after giving birth.</p> <p>If her monthly bleeding has not returned, she can start POPs any time between 6 weeks and 6 months. There is no need for a backup method.</p> <p>If her monthly bleeding has returned, she can start POPs as advised for women having menstrual cycles.</p>
<p><b>More than 6 months after giving birth</b></p>	<p>If her monthly bleeding has not returned, she can start POPs any time it is reasonably certain she is not pregnant. She will need a backup method* for the first 2 days of taking pills. (If you cannot be reasonably certain, give her POPs now and tell her to start taking them during her next monthly bleeding.)</p> <p>If her monthly bleeding has returned, she can start POPs as advised for women having menstrual cycles.</p>
<p>Partially breastfeeding <b>Less than 6 weeks after giving birth</b></p>	<p>Give her POPs and tell her to start taking them 6 weeks after giving birth.</p> <p>Also give her a backup method to use until 6 weeks after giving birth if her monthly bleeding returns before this time.</p>
<p><b>More than 6 weeks after giving birth</b></p>	<p>If her monthly bleeding has not returned, she can start POPs any time it is reasonably certain she is not pregnant.† She will need a backup method for the first 2 days of taking pills. (If you cannot be reasonably certain, give her POPs now and tell her to start taking them during her next monthly bleeding.)</p> <p>If her monthly bleeding has returned, she can start POPs as advised for women having menstrual cycles.</p>
<p>Not breastfeeding <b>Less than 4 weeks after giving birth</b></p>	<p>She can start POPs at any time. There is no need for a backup method.</p>
<p><b>More than 4 weeks after giving birth</b></p>	<p>If her monthly bleeding has not returned, she can start POPs any time it is reasonably certain she is not pregnant.† She will need a backup method for the first 2 days of taking pills. (If you cannot be reasonably certain, give her POPs now and tell her to start taking them during her next monthly bleeding.)</p> <p>If her monthly bleeding has returned, she can start POPs as advised for women having menstrual cycles.</p>
<p><b>Switching from a hormonal method</b></p>	<p>Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not</p>

Woman's situation	When to start
	<p>pregnant. There is no need to wait for her next monthly bleeding, and there is no need for a backup method.</p> <p>If she is switching from injectables, she can begin taking POPs when the repeat injection would have been given. There is no need for a backup method.</p>
<p><b>Having menstrual cycles or switching from a nonhormonal method</b></p>	<p>Any time of the month</p> <p>If she is starting within 5 days after the start of her monthly bleeding, there is no need for a backup method.</p> <p>If it is more than 5 days after the start of her monthly bleeding, she can start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking pills. (If you cannot be reasonably certain, give her POPs now and tell her to start taking them during her next monthly bleeding.)</p> <p>If she is switching from an IUCD, she can start POPs immediately.</p>
<p><b>No monthly bleeding (not related to childbirth or breastfeeding)</b></p>	<p>She can start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking pills.</p>
<p><b>After miscarriage or abortion</b></p>	<p>Immediately. If she is starting within 7 days after first- or second-trimester miscarriage or abortion, there is no need for a backup method.</p> <p>If it is more than 7 days after first- or second-trimester miscarriage or abortion, she can start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking pills. (If you cannot be reasonably certain, give her POPs now and tell her to start taking them during her next monthly bleeding.)</p>
<p><b>After taking emergency contraceptive pills (ECPs)</b></p>	<p>She can start POPs the day after she finishes taking the ECPs. There is no need to wait for her next monthly bleeding to start her pills.</p> <p>A new POP user should begin a new pill pack.</p> <p>A continuing user who needed ECPs due to pill-taking errors can continue where she left off with her current pack.</p> <p>All women will need to use a backup method for the first 2 days of taking pills.</p>
<p><i>* Backup methods include male and female condoms</i></p>	
<p><i>† Where a visit 6 weeks after childbirth is routinely recommended and other opportunities to obtain contraception limited, some providers and programs may allow a woman to start POPs at the 6-week visit, without further evidence that the woman is not pregnant, if her monthly bleeding has not yet returned.</i></p>	

## 13.10 Counselling about Side Effects

Thorough counselling about bleeding changes and other side effects is an important part of providing the method. Counselling about bleeding changes may be the most important help a woman needs to keep using the method.

### Describe the most common side effects:

- Breastfeeding women normally do not have monthly bleeding for several months after giving birth. POPs lengthen this period of time.
- Women who are not breastfeeding may have frequent or irregular bleeding for the first several months, followed by regular bleeding or continued irregular bleeding.
- Other side effects include headaches, dizziness, and breast tenderness.

### Explain that these side effects:

- Are not signs of illness
- Usually become less or stop within the first few months of using POPs, though bleeding changes usually persist
- Are common, but some women do not have them.

### Explain what to do in case of side effects:

- Keep taking POPs. Skipping pills risks pregnancy.
- Try taking pills with food or at bedtime to help avoid nausea.
- Come back for help if side effects bother you.

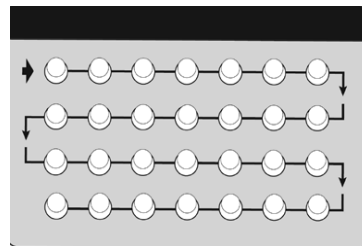
## 13.11 Explaining How to Use POPs

### 1. Give pills

- Give 2 packs initially. (Schedule for a return visit after 6 weeks for a resupply of 4 packs.)

### 2. Explain pill pack

- Show which kind of pack she will be using—28 pills or 35 pills.
- Explain that all pills in POP packs are the same colour and all are active pills, containing a hormone that prevents pregnancy.
- Show how to take the first pill from the pack and then how to follow the directions or arrows on the pack to take the rest of the pills.



*Illustration by Rafael Avila and Rita Meyer*



*Photo by Cheikh Fall, CCP, courtesy of Photoshare*

### 3. Give key instructions

- Take one pill each day until the pack is empty.
- Set up cues for taking a pill every day. Linking pill-taking to a daily activity—such as cleaning her teeth—may help her remember.
- Taking pills at the same time each day helps to remember them.



*Illustration by Rafael Avila and Rita Meyer*

### Explain starting the next pack

- When she finishes one pack, she should take the first pill from the next pack on the very next day.
- It is very important to start the next pack on time. Starting a pack late risks pregnancy.

### Provide a backup method and explain its use

- Sometimes she may need to use a backup method, such as when she misses pills.
- Backup methods include male or female condoms. Give her condoms, if possible.

### Explain that effectiveness decreases when breastfeeding stops

- Without the additional protection of breastfeeding itself, POPs are not as effective as most other hormonal methods.
- When she stops breastfeeding, she can continue taking POPs if she is satisfied with the method, or she is welcome to come back for another method.

### Plan the next visit

- Encourage her to come back in 6 weeks for more pills before she uses up her supply of pills.
- If the client misses 2 or more menstrual periods, she should come to the clinic to rule out pregnancy, but she should not stop taking the pills unless it's certain that she is pregnant.
- The client should inform the service provider if she has been put on anti-TB or anti-epileptic drugs whilst on POPs.
- Encourage her to use condoms, especially if at risk of exposure to HIV.

## 13.12 Warning Signs: Reasons to Return

- Delayed menstrual return after several months of regular cycles (sign of pregnancy)
- Severe lower abdominal pain (symptom of ectopic pregnancy)
- Heavy vaginal bleeding (twice as much as normal) or prolonged bleeding of more than 8 days duration.
- Repeated migraine (vascular) headaches, very painful headaches or blurred vision.



## 13.13 Counselling Messages on Managing Missed Pills

It is easy to forget a pill or to be late in taking it. POP users should know what to do if they forget to take pills.

**Tell the woman to follow the instructions below if she is 3 or more hours late taking a pill or misses one completely.** For breastfeeding women, whether missing a pill places her at risk of pregnancy depends on whether or not her monthly bleeding has returned.

**Key message:**

- Take a missed pill as soon as possible.
- Keep taking pills as usual, one each day. (She may take 2 pills at the same time or on the same day.)

**If she has monthly bleeding:**

- If yes, she also should use a backup method for the next 2 days.
- Also, if she had sex in the past 5 days, she can consider taking ECPs.

**If she has severe vomiting or diarrhoea:**

- If she vomits within 2 hours after taking a pill, the client should take another pill from her pack as soon as possible, and keep taking pills as usual.
- If her vomiting or diarrhoea continues, follow the instructions for making up missed pills above.

## 13.14 Managing Side Effects

Problems Reported as Side Effects or Problems With Use <b>May or may not be due to the method.</b>	
<p>Problems with side effects affect women’s satisfaction and use of POPs. They deserve the provider’s attention. If the client reports side effects or problems, listen to her concerns, give her advice, and, if appropriate, provide treatment.</p> <p>Encourage her to keep taking a pill every day even if she has side effects. Missing pills can risk pregnancy.</p> <p>Many side effects will subside after a few months of use. For a woman whose side effects persist, give her a different POP formulation, if available, for at least 3 months.</p> <p>Offer to help the client choose another method—now, if she wishes, or if problems cannot be overcome.</p>	
<p><b>No monthly bleeding</b></p>	<ul style="list-style-type: none"> <li>• Breastfeeding woman: Reassure her that this is normal during breastfeeding. It is not harmful.</li> <li>• Woman not breastfeeding: Reassure her that some women using POPs stop having monthly bleeding, and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not infertile. Blood is not building up inside her. (Some women are happy to be free from monthly bleeding.)</li> </ul>
<p><b>Irregular bleeding</b> (Bleeding at unexpected times that bothers the client)</p>	<ul style="list-style-type: none"> <li>• Reassure her that many women using POPs experience irregular bleeding—whether breastfeeding or not. Breastfeeding itself also can cause irregular bleeding. It is not harmful and sometimes becomes less or stops after the first several months of use. Some women have irregular bleeding the entire time they are taking POPs, however.</li> <li>• Other possible causes of irregular bleeding include: Vomiting or diarrhoea Taking anticonvulsants or rifampicin</li> <li>• To reduce irregular bleeding: Teach her to make up for missed pills properly, including after vomiting or diarrhoea (see “Managing Missed Pills,” Section 13.13.) For modest short-term relief she can try 800 mg ibuprofen 3 times daily after meals for 5 days, or another nonsteroidal anti-inflammatory drug (NSAID), beginning when irregular bleeding starts. NSAIDs provide some relief of irregular bleeding for implants, progestin-only injectables, and IUCDs, and NSAIDs may also help POP users. If she has been taking the pills for more than a few months and NSAIDs do not help, give her a different POP formulation, if available. Ask her to try the new pills for at least 3 months.</li> <li>• If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use (see “Unexplained vaginal bleeding,” Section 13.15).</li> </ul>

<p><b>Heavy or prolonged bleeding</b> (Twice as much as usual or longer than 8 days)</p>	<ul style="list-style-type: none"> <li>• Reassure her that some women using POPs experience heavy or prolonged bleeding. It is generally not harmful and usually becomes less or stops after a few months.</li> <li>• For modest short-term relief she can try NSAIDs, beginning when heavy bleeding starts. Try the same treatments as for irregular bleeding.</li> <li>• To help prevent anaemia, suggest she take iron tablets, and tell her it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).</li> <li>• If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use (see “Unexplained vaginal bleeding,” Section 13.15).</li> </ul>
<p><b>Missed pills</b></p>	<ul style="list-style-type: none"> <li>• See Managing Missed Pills, Section 13.13.</li> </ul>
<p><b>Ordinary headaches</b> (Non-migrainous)</p>	<ul style="list-style-type: none"> <li>• Suggest aspirin (300mg), ibuprofen (200–400 mg), paracetamol (500 mg), or other pain reliever.</li> <li>• Any headaches that get worse or occur more often during POP use should be evaluated.</li> </ul>
<p><b>Mood changes or changes in sex drive</b></p>	<ul style="list-style-type: none"> <li>• Ask about changes in her life that could affect her mood or sex drive, including changes in her relationship with her partner. Give her support as appropriate.</li> <li>• Some women experience depression in the year after giving birth. This is not related to POPs. Clients who have serious mood changes such as major depression should be referred for care.</li> <li>• Suggest she consider locally available remedies.</li> </ul>
<p><b>Breast tenderness</b> (Women not breastfeeding)</p>	<ul style="list-style-type: none"> <li>• Recommend that she wear a supportive bra (including during strenuous activity and sleep).</li> <li>• Suggest she try hot or cold compresses.</li> <li>• Suggest aspirin (300 mg), ibuprofen (200–400 mg), paracetamol (500 mg), or other pain reliever.</li> <li>• Recommend that she consider locally available remedies.</li> </ul>
<p><b>Severe pain in lower abdomen</b> (Suspected ectopic pregnancy or enlarged ovarian follicles or cysts)</p>	<ul style="list-style-type: none"> <li>• Many conditions can cause severe abdominal pain. Be particularly alert for additional signs or symptoms of ectopic pregnancy, which is rare but can be life-threatening (see Question 12, Section 13.16).</li> <li>• In the early stages of ectopic pregnancy, symptoms may be absent or mild, but eventually they will become severe. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy: Unusual abdominal pain or tenderness Abnormal vaginal bleeding or no monthly bleeding—especially if this is a change from her usual bleeding pattern Light-headedness or dizziness Fainting</li> <li>• If ectopic pregnancy or another serious health condition is suspected,</li> </ul>

	<p>refer at once for immediate diagnosis and care. (See Unit 10: Female Sterilization, Managing Complications, Section 10.13 for more on ectopic pregnancies.)</p> <ul style="list-style-type: none"> <li>• Abdominal pain may be due to other problems such as enlarged ovarian follicles or cysts.</li> <li>• A woman can continue to use POPs during evaluation and treatment.</li> <li>• There is no need to treat enlarged ovarian follicles or cysts unless they grow abnormally large, twist, or burst. Reassure the client that they usually disappear on their own. To be sure the problem is resolving, see the client again in 6 weeks, if possible.</li> </ul>
<b>Nausea or dizziness</b>	<ul style="list-style-type: none"> <li>• For nausea, suggest she take POPs at bedtime or with food.</li> <li>• If symptoms continue, consider locally available remedies.</li> </ul>

## 13.15 New Problems that May Require Switching Methods

### **May or may not be due to the method**

#### **Unexplained vaginal bleeding (that suggests a medical condition not related to the method)**

- Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate.
- She can continue using POPs while her condition is being evaluated.
- If bleeding is caused by a sexually transmitted infection or pelvic inflammatory disease, she can continue using POPs during treatment.

#### **Starting treatment with anticonvulsants, rifampicin, rifabutin or ritonavir**

- Barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, rifabutin, and ritonavir may make POPs less effective. If using these medications long-term, she may want a different method, such as progestin-only injectables or an IUCD.
- If using these medications short-term, she can use a backup method along with POPs.

#### **Migraine headaches**

- If she has migraine headaches without aura, she can continue to use POPs if she wishes.
- If she has migraine aura, stop POPs. Help her choose a method without hormones.

#### **Certain serious health conditions (suspected blood clots in deep veins of legs or lungs, liver disease, or breast cancer)**

- Tell her to stop taking POPs.
- Give her a backup method to use until the condition is evaluated.
- Refer for diagnosis and care if not already under care.

#### **Heart disease due to blocked or narrowed arteries (ischemic heart disease) or stroke**

- A woman who has one of these conditions can safely start POPs. If, however, the condition develops after she starts using POPs, she should stop. Help her choose a method without hormones.
- Refer for diagnosis and care if not already under care.

#### **Suspected pregnancy**

- Assess for pregnancy, including ectopic pregnancy.
- Tell her to stop taking POPs if pregnancy is confirmed.
- Assure her that there are no known risks to a foetus conceived while a woman is taking POPs.

## 13.16 Questions and Answers about POPs

### 1. **Can a woman who is breastfeeding safely use POPs?**

Yes. This is a good choice for a breastfeeding mother who wants to use pills. POPs are safe for both the mother and the baby, starting as early as 6 weeks after giving birth. They do not affect milk production.

### 2. **What should a woman do when she stops breastfeeding her baby? Can she continue taking POPs?**

A woman who is satisfied with using POPs can continue using them when she has stopped breastfeeding. She is less protected from pregnancy than when breastfeeding, however. She can switch to another method if she wishes.

### 3. **Do POPs cause birth defects? Will the foetus be harmed if a woman accidentally takes POPs while she is pregnant?**

No. Good evidence shows that POPs will not cause birth defects and will not otherwise harm the foetus if a woman becomes pregnant while taking POPs or accidentally takes POPs when she is already pregnant.

### 4. **How long does it take to become pregnant after stopping POPs?**

Women who stop using POPs can become pregnant as quickly as women who stop nonhormonal methods. POPs do not delay the return of a woman's fertility after she stops taking them. The bleeding pattern a woman had before she used POPs generally returns after she stops taking them. Some women may have to wait a few months before their usual bleeding pattern returns.

### 5. **If a woman does not have monthly bleeding while taking POPs, does this mean that she is pregnant?**

Probably not, especially if she is breastfeeding. If she has been taking her pills every day, she is probably not pregnant and can keep taking her pills. If she is still worried after being reassured, she can be offered a pregnancy test, if available, or referred for one. If not having monthly bleeding bothers her, switching to another method may help—but not to a progestin-only injectable (which can also cause amenorrhea).

### 6. **Must the POP be taken every day?**

Yes. All of the pills in the POP package contain the hormone that prevents pregnancy. If a woman does not take a pill every day—especially a woman who is not breastfeeding—she could become pregnant. (In contrast, the last 7 pills in a 28-pill pack of combined oral contraceptives are not active. They contain no hormones.)

### 7. **Is it important for a woman to take her POPs at the same time each day?**

Yes, for 2 reasons. POPs contain very little hormone, and taking a pill more than 3 hours late could reduce their effectiveness for women who are not breastfeeding. (Breastfeeding women have the additional protection from pregnancy that breastfeeding provides, so taking pills late is not as risky.) Also, taking a pill at the same time each day can help women remember to take their pills more consistently. Linking pill taking with a daily activity also helps women remember to take their pills.

### 8. **Do POPs cause cancer?**

No. Few large studies exist on POPs and cancer, but smaller studies of POPs are reassuring. Larger studies of implants have not shown any increased risk of cancer. Implants contain

hormones similar to those used in POPs, and, during the first few years of implant use, at about twice the dosage.

**9. Can POPs be used as emergency contraceptive pills (ECPs) after unprotected sex?**

Yes. As soon as possible, but no more than 5 days after unprotected sex, a woman can take POPs as ECPs. (See Unit 14: Emergency Contraceptive Pills, Pill Formulations and Dosing.) Depending on the type of POP, she will have to take 40 to 50 pills. Taking such a large number of POPs is safe because the hormone dose in each pill is small.

**10. Do POPs change women's mood or sex drive?**

Generally, no. Some women using POPs report these complaints. The great majority of POP users do not report any such changes, however, and some report that both mood and sex drive improve. It is difficult to tell whether such changes are due to the POPs or to other reasons. Providers can help a client with these problems. There is no evidence that POPs affect women's sexual behaviour.

**11. What should be done if a POP user has an ovarian cyst?**

The great majority of cysts are not true cysts but actually fluid-filled structures in the ovary (follicles) that continue to grow beyond the usual size in a normal menstrual cycle. They may cause some mild abdominal pain, but they only require treatment if they grow abnormally large, twist or burst. These follicles usually go away without treatment.

**12. Do POPs increase the risk of ectopic pregnancy?**

No. On the contrary, POPs reduce the risk of ectopic pregnancy. Ectopic pregnancies are rare among POP users. The rate of ectopic pregnancy among women using POPs is 48 per 10,000 women per year. The rate of ectopic pregnancy among women in the United States using no contraceptive method is 65 per 10,000 women per year.

On the uncommon occasions that POPs fail and pregnancy occurs, 5 to 10 of every 100 of these pregnancies are ectopic. Thus, the great majority of pregnancies after POPs fail are not ectopic. Still, ectopic pregnancy can be life-threatening, so a provider should be aware that ectopic pregnancy is possible if POPs fail.

## Progestin-Only Pills Learning Activities

### Role Plays

#### Role Play 1

##### **Participant roles**

Mrs. Sipano, 32 years old, has three children. Her youngest baby is 3 weeks old. She has come to your family planning clinic to get POPs. Use your counselling skills and your knowledge of POPs to assist this client.

#### Role Play 2

##### **Participant roles**

Mrs. Sanudi, 18 years old, has one child. She is at your clinic today with her 2-week-old baby whom she is breastfeeding. Mrs Sanudi tells you that she has just heard from her husband that there are several contraceptives that can be used to prevent her from having babies too close together. Assist her to choose an appropriate method.



## POP Quiz Questions

Questions 1–7: Tick the letter of all answers that apply. (Some questions may have more than one correct answer.)

1. A progestin-only pill (POP) may be defined as one containing:
  - a. Oestrogen and a progestin
  - b. Progestin only
  - c. Oestrogen only
  - d. None of the above
2. The mechanism of action of POPs includes (tick all that apply):
  - a. Inhibition of ovulation
  - b. Destruction of the ovum
  - c. Thickening of the cervical mucus (making it more difficult for sperm to penetrate)
  - d. Destruction of sperm
3. Major advantages of POPs include:
  - a. Can be used by nursing mothers starting 6 weeks after childbirth
  - b. Protect against HIV/AIDS
  - c. Are a good method for adolescents
  - d. Do not need to be taken every day
4. POPs may be an appropriate choice for (tick all that apply):
  - a. Women who have breast cancer
  - b. Women who are breastfeeding
  - c. Women who have oestrogen-related side effects from COCs
  - d. Women who are over 35 and smoke
  - e. Women who have unexplained vaginal bleeding
5. POPs should not be given to women who (tick all that apply):
  - a. Have unexplained vaginal bleeding
  - b. Have breast cancer
  - c. Are over 35 and smoke
  - d. Have high blood pressure
  - e. Have viral hepatitis or cirrhosis
6. Common side effects of POPs include which of the following? (tick all that apply)
  - a. Dysmenorrhoea
  - b. Anaemia
  - c. Irregular menstruation or spotting
  - d. Amenorrhoea
  - e. Headaches and breast tenderness
7. When can women who are breastfeeding start taking POPs?
  - a. At 6 weeks postpartum
  - b. Immediately after giving birth
  - c. At 6 months postpartum
  - d. Can't start POPs while breastfeeding

**Questions 8–12: Write either “Yes” or “No” in the space provided.**

- \_\_\_ 8. Is it appropriate to give POPs to a woman who has unexplained vaginal bleeding?
- \_\_\_ 9. If a client has spotting and sees this as a problem, should you give her another method?
- \_\_\_ 10. If a woman who has had regular periods while taking POPs comes to the clinic reporting amenorrhea, could she be pregnant?
- \_\_\_ 11. Can a breastfeeding woman switch from POPs to other hormonal methods any time the new method is appropriate?
- \_\_\_ 12. If a woman is spotting while taking POPs, does she need to stop taking them?

## POP Quiz Questions Answer Key

1. A progestin-only pill (POP) may be defined as one containing:
  - b. Progestin only**
2. The mechanism of action of POPs includes (tick all that apply):
  - a. Inhibition of ovulation**
  - c. Thickening of the cervical mucus (making it more difficult for sperm to penetrate)**
3. Major advantages of POPs include:
  - a. Can be used by nursing mothers starting 6 weeks after childbirth**
4. POPs may be an appropriate choice for (tick all that apply):
  - b. Women who are breastfeeding**
  - c. Women who have oestrogen-related side effects from COCs**
  - d. Women who are over 35 and smoke**
5. POPs should not be given to women who (tick all that apply):
  - a. Have unexplained vaginal bleeding**
  - b. Have breast cancer**
  - e. Have viral hepatitis or cirrhosis**
6. Common side effects of POPs include which of the following? (tick all that apply)
  - c. Irregular menstruation or spotting**
  - d. Amenorrhea**
  - e. Headaches and breast tenderness**
7. When can women who are breastfeeding start taking POPs?
  - a. At 6 weeks postpartum**
- N\_\_8.** Is it appropriate to give POPs to a woman who has unexplained vaginal bleeding?
- Y\_\_9.** If a client has spotting and sees this as a problem, should you give her another method?
- Y\_\_10.** If a woman who has had regular periods while taking POPs comes to the clinic reporting amenorrhea, could she be pregnant?
- Y\_\_11.** Can a breastfeeding woman switch from POPs to other hormonal methods any time the new method is appropriate?
- N\_\_12.** If a woman is spotting while taking POPs, does she need to stop taking them?

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<http://info.k4health.org/globalhandbook/>



# Unit 14

## EMERGENCY CONTRACEPTIVE PILLS

### Learning Objectives

At the end of this unit, learners should be able to:

- ❖ Define emergency contraception
- ❖ List the types and formulations of emergency contraceptive pills (ECPs) available in Malawi
- ❖ Explain how ECPs work
- ❖ State the effectiveness of ECPs
- ❖ List the characteristics of ECPs
- ❖ Determine a client's medical eligibility for ECP use
- ❖ Correct myths and misconceptions associated with ECPs
- ❖ Provide client instructions for using ECPs and the key counselling messages
- ❖ Demonstrate skills in counselling clients about using ECPs.

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## Unit 14: Emergency Contraceptive Pills

### Key Points

Emergency contraceptive pills:

- ❖ **Help to prevent pregnancy when taken up to 5 days (120 hours) after unprotected sex.** The sooner they are taken, the better.
- ❖ **Do not disrupt an existing pregnancy.**
- ❖ **Are safe and effective 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.**
- ❖ **Are available in several formulations**—dedicated products, POPs and COCs all can act as emergency contraceptives.

### 14.1 Defining Emergency Contraception

Emergency contraception is a method of preventing pregnancy after unprotected sexual intercourse. ECPs are pills used for this purpose. They can be progestin-only pills (POPs), containing a progestin alone, or combined oral contraceptives (COCs), containing a progestin and an oestrogen together. There are also pills that are specifically formulated and packaged for emergency contraception use.

ECPs are sometimes called “morning-after pills” or post coital contraceptives.

#### Types of ECPs available in Malawi

- Postinor-2 (pills specifically formulated and packaged for emergency contraceptive use, containing the progestin levonorgestrel)
- Progestin-only pills (Ovrette, Microlut) containing norgestrel
- Combined oral contraceptive pills (Microgynon, Lo-Femenal) containing an oestrogen and a progestin

#### IUCDs FOR EMERGENCY CONTRACEPTION

Intrauterine Contraceptive Devices (IUCDs) may also be used as emergency contraception if inserted within 5 days after unprotected sexual intercourse. As emergency contraception, the Copper-T IUCD is much more effective than emergency contraceptive pills because it reduces the risk of getting pregnant by more than 99%. Another advantage to the Copper-T IUCD is that, if desired, clients can keep it in place to prevent pregnancy for up to 12 years.

#### How ECPs work

ECPs work primarily by preventing or delaying the release of eggs from the ovaries (ovulation). They do not work if a woman is already pregnant and do not harm existing pregnancies.

## 14.2 Effectiveness of ECPs

- If 100 women each had sex once during the second or third week of the menstrual cycle without using contraception, 8 would likely become pregnant.
- If all 100 women used progestin-only ECPs, one would likely become pregnant.
- If all 100 women used oestrogen and progestin combined pills for ECPs, 2 would likely become pregnant.

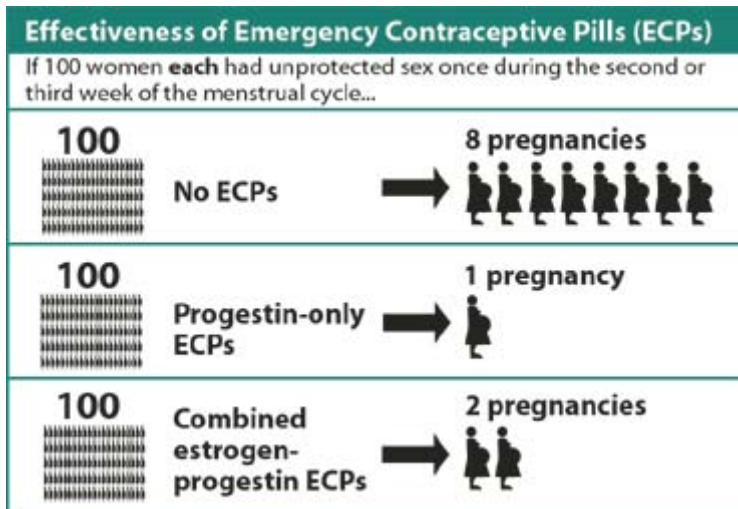


Illustration by Francine Mueller, CCP

### Return of fertility

A woman can become pregnant immediately after taking ECPs. Taking ECPs prevents pregnancy only from acts of sex that took place during the previous 5 days. They will not protect a woman from pregnancy from acts of intercourse after she takes ECPs—not even on the next day. To stay protected from pregnancy, women must begin to use another contraceptive method at once.

## 14.3 Characteristics

### Advantages

- Are controlled by the woman
- May reduce need for abortion
- Can be used after a regular contraceptive method fails (i.e. condom breaks) or following rape or other unplanned intercourse

### Disadvantages

- Not as effective as contraceptive methods that are used before or during sex, like COCs or condoms. Not to be used as primary protection against pregnancy.
- Do not protect against sexually transmitted infections (STIs), including HIV.



## Side effects

Some users report the following:

- Changes in bleeding patterns including:

Slight irregular bleeding for 1–2 days after taking ECPs

Monthly bleeding that starts earlier or later than expected

- In the first 24 hours after taking ECPs, the client may complain of:
  - Nausea, vomiting and/or dizziness
  - Abdominal pain
  - Fatigue
  - Headaches
  - Breast tenderness
- **Note:** Progestin-only ECPs are less likely to cause side effects than ECPs that contain oestrogen.

**Health benefits and Health risks:** None

## 14.4 Correcting Misconceptions

Emergency contraceptive pills:

- Do not cause abortion
- Do not cause birth defects if pregnancy occurs
- Are not dangerous to a woman's health
- Do not promote sexual risk-taking or promiscuity
- Do not make women infertile.

## 14.5 Women Who Can Use ECPs

ECPs are safe and suitable for all women, including women who cannot use ongoing hormonal contraception. There are no contraindications for ECP use.

## 14.6 Medical Eligibility Criteria for ECPs

- There are no contraindications for ECP use.
- Tests and examinations are not necessary for using ECPs.
- All women can use ECPs safely and effectively, including women who cannot use ongoing hormonal contraceptive methods. There are no medical conditions that make ECPs unsafe for any woman because of the short-term nature of their use.

## 14.7 Timing: When to Use ECPs

**Anytime within 120 hours (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 thinks that she might become pregnant, such as:
- After forced sex (rape), coerced sex or any unprotected sex
- After contraceptive mistakes, 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 days late

IUCD has come out of place

Woman is more than 4 weeks late for her repeat DMPA injection.



*Illustration by Rafael Avila and Rita Meyer*

## 14.8 Providing ECPs

### Dosing information

- Progestin-only pills

Postinor-2 (1.5 mg lovonorgestrel), 2 pills in a single dose (the preferred choice)

Ovrette (norgestrel 0.075 mg), 40 pills taken at one time in a single dose

- Combined oral contraceptives:

Lo-Feminal (0.03 mg ethinyl estradiol, 0.3 mg norgestrel), 4 pills at one time, followed by 4 pills 12 hours later.

### Give pills

- The client can take them immediately.
- Tell her to take the next dose in 12 hours, if required by product instructions.

### Describe the most common side effects and explain that they are not signs of illness

- Nausea, abdominal pain, possibly others
- Slight bleeding or change in timing of monthly bleeding.

### Explain what to do about side effects

- Nausea:

Not recommended to use anti-nausea medication routinely

If she has had nausea with previous ECP use or with the first dose of a 2-dose regimen, she can take anti-nausea medication, such as 50 mg meclizine, one-half hour to one hour before taking ECPs.

- Vomiting:

If the woman vomits within 2 hours after taking ECPs, she should take another dose. (She can use anti-nausea medication with this repeat dose, as above.)

If vomiting continues, she can take the repeat dose by placing the pills high in her vagina.  
If vomiting occurs more than 2 hours after taking ECPs, she does not need to take any extra pills.

### **Give more ECPs and help her start an ongoing contraceptive method**

- If possible, give her more ECPs to take home in case she needs them in the future. This is known as “advanced provision” and has proven to be effective since women who already have the pills available are more likely to take them and to take them sooner after unprotected intercourse (when they are more effective).
- Explain that ECPs will not protect her from pregnancy for any future sex—even the next day. Therefore, they are not to be used as a regular family planning method.
- Counsel the client to choose a family planning method to start using after the emergency contraception, if she does not plan for pregnancy immediately.
- Advise the client when to start contraception after ECP use. She can start most contraceptive methods (e.g. implants, injectables) on the same day as ECPs. (See table in Section 14.9.)
- If she does not want to start a contraceptive method now, give her condoms or COCs and ask her to use them if she changes her mind. Give instructions on use. Invite her to come back any time if she wants another method or has any questions or problems.
- Tell her that ECPs do not protect from STIs/HIV.
- Explain that ECPs will not harm an existing pregnancy.
- Advise the client to return if her next monthly bleeding:

Is unusually light (possible pregnancy)

Does not start within 4 weeks (possible pregnancy)

Is unusually painful (possible ectopic pregnancy)

## 14.9 When to Start Contraception after ECP Use

Method	When to start
<b>Combined oral contraceptives, progestin-only pills</b>	<ul style="list-style-type: none"> <li>• She can begin the day after she takes the ECPs. There is no need to wait for her next monthly bleeding.               <ul style="list-style-type: none"> <li>- New users should begin a new pill pack.</li> <li>- A continuing user who needed ECPs due to error can resume use as before.</li> </ul> </li> <li>• All women need to use a backup method*—for the first 7 days.</li> </ul>
<b>Progestin-only injectables/DMPA</b>	<ul style="list-style-type: none"> <li>• She can start progestin-only injectables/DMPA on the same day as the ECPs, or if preferred, within 7 days after the start of her monthly bleeding. She will need a backup method for the first 7 days after the injection. She should return if she has signs or symptoms of pregnancy other than not having monthly bleeding.</li> </ul>
<b>Implants</b>	<ul style="list-style-type: none"> <li>• She can start after her monthly bleeding has returned. Give her a backup method* or oral contraceptives to use until then, starting the day after she finishes taking the ECPs.</li> </ul>
<b>Intrauterine contraceptive device (IUCD)</b>	<ul style="list-style-type: none"> <li>• A copper-bearing IUCD can be used for emergency contraception. This is a good option for a woman who wants an IUCD as her long-term method (see IUCDs, Unit 8).</li> <li>• If she decides to use an IUCD after taking ECPs, the IUCD can be inserted on the same day she takes the ECPs. There is no need for a backup method.</li> </ul>
<b>Male and female condoms</b>	<ul style="list-style-type: none"> <li>• Immediately.</li> </ul>
<b>Fertility awareness methods</b>	<ul style="list-style-type: none"> <li>• Standard Days Method®: With the start of her next monthly bleeding.</li> <li>• TwoDay Method®: Once normal secretions have returned.</li> <li>• Give her a backup method* or oral contraceptives to use until she can begin the method of her choice.</li> </ul>
<p>* Backup methods include male and female condoms. If possible, give her condoms.</p>	

## 14.10 Questions and Answers about ECPs

### 1. Do ECPs disrupt an existing pregnancy?

No. ECPs do not work if a woman is already pregnant. When taken before a woman has ovulated, ECPs prevent the release of an egg from the ovary or delay its release by 5 to 7 days. By then, any sperm in the woman's reproductive tract will have died, since sperm can survive there for only about 5 days.

### 2. Do ECPs cause birth defects? Will the foetus be harmed if a woman accidentally takes ECPs while she is pregnant?

No. Good evidence shows that ECPs will not cause birth defects and will not otherwise harm the foetus if a woman is already pregnant when she takes ECPs or if ECPs fail to prevent pregnancy.

### 3. How long do ECPs protect a woman from pregnancy?

Women who take ECPs should understand that they could become pregnant the next time they have sex unless they begin to use another method of contraception at once. Because ECPs delay ovulation in some women, she may be most fertile soon after taking ECPs. If she wants ongoing protection from pregnancy, she must start using another contraceptive method at once.

### 4. What oral contraceptive pills can be used as ECPs?

Many combined (oestrogen-progestin) oral contraceptives and progestin-only pills can be used as ECPs. Any pills containing the hormones used for emergency contraception—levonorgestrel, norgestrel, norethindrone, and these progestins together with oestrogen (ethinyl estradiol)—can be used. (See “Formulations and Dosage Required for Emergency Contraception” in the Teaching Resources section for examples of what pills can be used.)

### 5. Is it safe to take 40 or 50 progestin-only pills as ECPs?

Yes. Progestin-only pills contain very small amounts of hormone. Thus, it is necessary to take many pills in order to receive the total ECP dose needed (unless specially formulated progestin-only ECPs such as Postinor II are available). In contrast, the ECP dosage with combined (oestrogen-progestin) oral contraceptives is generally only 2 to 5 pills in each of 2 doses 12 hours apart. Women should not take 40 or 50 combined (oestrogen-progestin) oral contraceptive pills as ECPs.

### 6. Are ECPs safe for women with HIV or AIDS? Can women on antiretroviral therapy safely use ECPs?

Yes. Women with HIV, AIDS, and those on antiretroviral therapy can safely use ECPs. There are no contraindications for ECP use; ECPs are safe and suitable for all women.

### 7. Are ECPs safe for adolescents?

Yes. There are no contraindications for ECP use; ECPs are safe and suitable for all women.

A study of ECP use among girls 13 to 16 years old found it safe. Furthermore, all of the study participants were able to use ECPs correctly.

### 8. Can a woman who cannot use combined (oestrogen-progestin) oral contraceptives or progestin-only pills as an ongoing method still safely use ECPs?

Yes. This is because ECP treatment is very brief. There are no contraindications for ECP use; ECPs are safe and suitable for all women.

**9. If ECPs failed to prevent pregnancy, does a woman have a greater chance of that pregnancy being an ectopic pregnancy?**

No. To date, no evidence suggests that ECPs increase the risk of ectopic pregnancy. Worldwide studies of progestin-only ECPs, including a United States Food and Drug Administration review, have not found higher rates of ectopic pregnancy after ECPs failed than are found among pregnancies generally.

**10. Why give women ECPs before they need them? Won't that discourage or otherwise affect contraceptive use?**

No. Studies of women given ECPs in advance report these findings:

- Women who have ECPs on hand took them sooner after having unprotected sex than women who had to seek out ECPs. Taken sooner, the ECPs are more likely to be effective.
- Women given ECPs ahead of time were more likely to use ECPs than women who had to go to a provider to get ECPs.
- Women continued to use other contraceptive methods as they did before obtaining ECPs in advance.

**11. Should women use ECPs as a regular method of contraception?**

No. Nearly all other contraceptive methods are more effective in preventing pregnancy. A woman who uses ECPs regularly for contraception is more likely to have an unintended pregnancy than a woman who uses another contraceptive regularly. Still, women using other methods of contraception should know about ECPs and how to obtain them if needed—for example, if a condom breaks or a woman misses 3 or more COCs.

## Emergency Contraceptive Pills Teaching Resources

### Formulations and Dosage Required for Emergency Contraception

Formulation	Common Brand Names	1st Dose	2nd Dose	Timing of Administration
LNG .75mg <b>Note:</b> There are 2 possible regimens for Postinor and NorLevo	Postinor, NorLevo	2 pills (1.5mg) in a single dose		<b>One dose (two pills) should be taken as soon as possible within 120 hours of unprotected sexual intercourse.</b>  <b>First dose as soon as possible within 120 hours of unprotected sexual intercourse; second dose 12 hours later</b>
LNG 0.75mg <b>Note:</b> There are 2 possible regimens for Postinor and NorLevo	Postinor, NorLevo	1 pill	1 pill	
LNG 0.03mg	Microlut, Norgeston, Microval	25 pills	25 pills	
NG 0.075mg	Ovrette	20 pills	20 pills	
EE 50 mcg + LNG 0.25mg	Neogynon, Noral, Nordiol, Ovidon, Ovrán	2 pills	2 pills	
EE 50 mcg + NG 0.50 mg	Eugynon 50, Ovral	2 pills	2 pills	
EE 30 mcg + LNG 0.15mg	Microgynon 30, Nordette, Rigevidon, Levlen	4 pills	4 pills	
EE 30 mcg + NG 0.30 mg	Lo/Femenal, Lo/Ovral	4 pills	4 pills	

EE = ethinyl estradiol      LNG =levonorgestrel      NG =norgestrel

**Note:** Treatment using either regimen (estrogen and progestin or progestin only) should not be delayed unnecessarily as efficacy declines over time.

(Adapted from: Salvador-Davila, Graciela 2007)

# ECPs Case Studies

(Adapted from: Salvador-Davila, Graciela 2007)

## Case Study 1

Miss M. is 21 years old and is coming to you today for ECPs. Her last menstrual period (LMP) was five days ago, she has had two pregnancies, both aborted. The client says she smokes five cigarettes per day. There is no history of blood clots in the veins, high blood pressure, migraines, or cancer of the reproductive organs. She had unprotected intercourse this morning at 1:00 a.m. Miss M. has not been using contraceptives since she has not been sexually active, and this is a new relationship, but she is interested in using pills.

*Can this client use ECPs?*

## Case Study 2

Today is 5 February 2010. Miss S. is a 16-year-old who has come to see you at your clinic. Her last menstrual period, which was normal, started on 8 January. She has never been pregnant, does not smoke, and has no history of medical conditions. She had unprotected intercourse on 3 February. She has been using condoms for contraception. Upon further history-taking you find that she used ECPs in September 2008 and again in March 2009.

*Can this client use ECPs?*

## Case Study 3

Mrs. R. is 33 years old. Her LMP was two weeks ago. She has a history of asthma and herpes, and she smokes one pack of cigarettes per day. There is no other history of medical conditions. She had unprotected intercourse yesterday morning. She usually uses condoms for contraception.

*Can this client use ECPs?*

## Case Study 4

Miss P. is 17 years old and has never been pregnant, and she has a negative medical history. Her LMP was three weeks ago. She had unprotected intercourse three days ago, and she was using condoms and states that the condom broke.

*Can this client use ECPs?*



## Case Study 5

Mrs. B. is 37 years old, has one living child, and had one spontaneous abortion at six weeks of pregnancy. She comes to you today for help because it has been two weeks since she aborted, and she had unprotected sexual intercourse yesterday morning. She wants to use a contraceptive method that she does not have to “worry about doing something” when she has sexual intercourse.

*Can this client use ECPs?*

## Case Study 6

Ms. T. is 28 years old and has one child. Her LMP was two weeks ago and normal. She has no health problems. She comes to you today for ECPs. She had unprotected sexual intercourse 4 days ago when her husband forced her to have sex. She does not want any more children, but her husband will not agree. She is willing to use a contraceptive without his knowledge.

*Can this client use ECPs?*

## Case Study 7

Ms. Q. brings her 17 year-old sister to you because the sister was raped last night on her way home from work. The family filed a complaint with the police, and the sister was “treated” at the hospital with a tranquilizer. A neighbour suggested that they get ECPs for the sister to prevent a pregnancy. The sister has never had sexual intercourse before and thinks her LMP was three weeks ago. There is only a history of an appendectomy at age 12.

*Can this client use ECPs?*

## Case Study 8

Ms. W. is a first-time family planning client. After discussing various contraceptive options, she has selected condoms as her preferred method. She has never used them before, but she paid close attention to your demonstration of how to use condoms.

- a. Would you tell this client about ECPs? Why or why not?
  
- b. Would you provide ECPs to this client during this visit? Why or why not?

# ECPs Case Studies Answer Key

(Adapted from: Salvador-Davila, Graciela 2007)

## Case Study 1

Can this client use ECPs? **Yes.**

## Case Study 2

Can this client use ECPs? **Yes.**

## Case Study 3

Can this client use ECPs? **Yes.**

## Case Study 4

Can this client use ECPs? **Yes.**

## Case Study 5

Can this client use ECPs? **Yes.**

## Case Study 6

Can this client use ECPs? **Yes.**

## Case Study 7

Can this client use ECPs? **Yes.**

## Case Study 8

a. Would you tell this client about ECPs? Why or why not?

**Yes. Clients need to know that ECPs are available and the correct time period for their use. Providing this information to your client will help her act responsibly and quickly in the event she fails to use a condom or experiences condom breakage.**

b. Would you provide ECPs to this client during this visit? Why or why not?

**Yes, if your program's protocols include prophylactic provision of ECPs. Having an advance supply of the method will make it easier for her to take ECPs as soon after unprotected sexual intercourse as possible in the event she needs it.**

# ECPs Role Plays

(Adapted from: Salvador-Davila, Graciela 2007)

## Role Play 1

### Client role

Today you will play the role of Miss M., a 20-year-old woman. Tell the provider that you have heard about emergency contraception from friends and think you might need it, but you are scared to try it because you think that it might make you infertile and that it might not be safe because you smoke.

Background information that you may need to answer questions your provider asks you:

- You had unprotected sexual intercourse last night (you were not expecting to have sex with your new boyfriend and did not have any contraceptive protection nearby).
- Your last menstrual period ended 5 days ago and was normal.
- You are a heavy smoker and have herpes but have no other health problems.
- You have been pregnant twice before and had abortions both times and are scared of having another.
- You have not been sexually active for a while but are starting a new relationship.
- You are interested in learning more about the pill for ongoing contraception.

## Role Play 2

### Client role

Today you will play the role of Mrs. R., a 31-year-old woman. Tell the provider that you had sexual intercourse on Friday night and the condom broke. Now it's Tuesday, and you are very worried you may have gotten pregnant. You would have come to the clinic earlier, but you couldn't find transportation and child care. You want to know if there is anything you can do now to prevent pregnancy and if there is a more reliable method you can use in the future.

Background information that you may need to answer questions your provider asks you:

- Your last menstrual period started three weeks ago and was normal.
- You are married and have two children.
- Your physician told you that you couldn't use the pill because of your severe migraine headaches, so you and your husband use condoms.
- You have diabetes and had a severe case of hepatitis a year ago.
- You and your husband are considering sterilization, but you want to wait a few years until your youngest child is a little older.

## Role Play 3

### Client role

Today you will play the role of Mrs. Q., a 25-year-old woman. Tell the provider that you have heard there is a pill you can take after having sexual intercourse to prevent pregnancy and that you want to get some to use for contraception. You have used regular contraceptive pills on and off for the past few years but often forget to take them. In fact, you got pregnant with your third child while you were using the pill. You were really excited to hear about this new pill from friends because you have heard it is very effective, and you know it will be a lot easier to remember to take than the daily pill. You need the new kind of pills right away because you just had sexual intercourse last night, and you have not yet started your new pill pack so are not protected.

Background information that you may need to answer questions your provider asks you:

- Your last menstrual period started 5 weeks ago.
- You have been using pills but think you forgot to take quite a few of them this month; you haven't yet started your new pack because you are waiting for your period to start.
- You and your husband have been having sexual intercourse regularly; your most recent sex was last night.
- You have asthma.
- You really want to use a method that is easy to remember.

# ECPs Role Play Processing Guide

(Adapted from: Salvador-Davila, Graciela 2007)

## Key points to discuss in Role Play 1

- Client is eligible for ECPs (within 120 hours of unprotected sex, last menstrual period normal).
- Client is concerned about safety of ECPs (fears infertility and is concerned about smoking) and should have been given special counselling on these topics.
- Client is motivated to practice contraception (fear of having another abortion) and has a desire for more information on the pill; provider should have given contraceptive information and services.
- Client's relationship is new, and she has a history of herpes; provider should have emphasized STI protection with client.

## Key points to discuss in Role Play 2

- Client is within the 120-hour window of opportunity for ECPs; provider can give ECPs but should counsel client that effectiveness decreases as time passes.
- Even though the client has been told she should not use oral contraceptives, she has no medical contraindications to ECP use.
- Since the client and her husband are considering sterilisation in the future, she might want to consider using a long-term method (IUCD or implants) since they are extremely effective/reliable but reversible.

## Key points to discuss in Role Play 3

- Client may be pregnant already (based on LMP). A pregnancy test should be given. If not available, the Pregnancy Checklist can be used. If she is not pregnant, she can receive ECPs. If she is, she should be referred for appropriate services.
- Provider should have corrected client's misperception that ECPs can be used as a routine method and discussed which of the regular contraceptives might meet her needs for future contraception.
- Depending on her reproductive intentions, she might want to consider a long-term method (IUCD, implant) since these methods do not require daily action. DMPA could also be appropriate.

# ECPs Activity: Myth or Fact?

(Adapted from Advocates for Youth)

## Directions

1. In advance, make two signs—one that says “Myth” and another that says “Fact.” Tape them to the walls at opposite ends of the room.
2. Select the questions you want to include from the list, or use all of the ones provided.
3. Ask the students to stand. Tell them that you are going to read a series of statements about emergency contraceptive pills. If they believe the statement is true, they are stand under the sign that says “Fact.” If they believe the statement is false, they are to stand under the sign that says “Myth.”
4. Check to see if there are any questions.
5. Read the statements below (without the answers!). After each statement, ask the group standing under the incorrect sign first to explain why they chose that answer. Then ask the group standing under the correct answer to explain why they chose their answer. Be sure to gently dispel any myths and stress that the goal of the activity is to become more educated about the topic, not to embarrass anyone.
6. After the activity, ask everyone to take a seat again. Ask what they learned about ECPs that surprised them. Do they know anyone that knows about ECPs or where to get them?
7. Brainstorm about the benefits of ECPs and also some of the concerns about them.

## Questions and answers to ECP Myth or Fact activity

1. Emergency contraceptive pills are a type of birth control that must be used before a person has sex.  
**False. ECPs are used after a person has unprotected sexual intercourse.**
2. ECPs can reduce a woman’s risk of pregnancy by 75% when taken within 120 hours of unprotected sexual intercourse.  
**True. Women should use ECPs within 120 hours (5 days) after unprotected sexual intercourse. The sooner the better!**
3. ECPs do not cause side effects.  
**False. Some women taking ECPs may feel nauseous, dizzy, or tired. Some women vomit and have a headache or sore breasts. These side effects are temporary and should last less than a day or two. There are no medical risks in taking ECPs.**
4. ECPs may be harmful to adolescent women.  
**False. ECPs are a safe and effective option for adolescent women. In fact, research shows the ECPs are safer than aspirin. Furthermore, they do not cause birth defects or abortion if a woman is already pregnant when she takes them.**
5. ECPs protect against STIs, including HIV.  
**False. ECPs prevent pregnancy, not STIs. Using condoms every time a person has intercourse is the best way to prevent STIs.**
6. ECPs can cause abortion.

**False. ECPs work by preventing pregnancy, not by causing abortion.**

## ECPs Grab Bag Activity

(Adapted from: Salvador-Davila, Graciela 2007)

### Directions

- In advance, photocopy the questions on the next page and cut them so that there is one question on each piece of paper. Put the pieces of paper in a hat or box.
- Select the questions you want to include, or use all of the ones provided. Make sure that the content of each question selected was covered during class or in assigned readings.
- Tell the students that you are going to ask them, one by one, to pick a piece of paper out of the hat/box (without being able to read it in advance). You will then read the question written on the paper, and the student should provide the correct answer.
- Proceed with this activity until all of the questions have been discussed.

### Answers to the ECP Grab Bag questions:

1. Why is pregnancy the only contraindication for using ECPs when there are several contraindications for the routine use of the same COCs?

**The duration of use of ECPs is short; blood clotting does not change with this short exposure. Therefore, the risk of complications related to blood clotting, such as heart attack or blood clots in the legs, is probably very low.**

2. Can progestin-only pills be used for ECPs?

**Yes, a special high-dose progestin-only pill, Postinor, is sold specifically for emergency contraception. Where available, Postinor should be included as an ECP option. POPs or mini-pills also can be used.**

3. Should we provide ECPs if the woman had unprotected sexual intercourse on a day when her risk of pregnancy was not very high? Why or why not?

**Yes, a woman cannot be sure she is infertile at any time during her cycle.**

4. If knowledge of ECPs becomes widespread, could incorrect use or overuse of ECPs become a problem? Why or why not?

**Misuse is not likely. In countries where ECPs have been publicized and made readily available, misuse has not been a problem. Making ECPs readily available with accurate instructions through established family planning services, whether clinic or community-based, will help reduce any risk of incorrect or frequent use and will ensure appropriate follow-up counselling and contraceptive services.**

5. Is it a problem if a woman uses ECPs as her standard contraceptive? Why or why not?

**Yes. Contraceptive protection will be low. The 2% failure rate of ECPs is for one menstrual cycle. Most women will have 13 menstrual cycles in a year; therefore, the cumulative failure rate for 1 year would be very high among sexually active women. However, since nausea typically occurs in around 40% of women using combined ECPs and close to 20% of women using progestin-only ECPs, it is unlikely that many women would rely on ECPs for contraception if other more effective options are readily available. Use of ECPs on a**

**frequent basis also may result in disrupted menstrual cycles and erratic intermenstrual bleeding. Providers must fully inform women that ECPs are not effective or suitable as a regular method of contraception.**

### **ECPs Grab Bag Questions**

1. Why is pregnancy the only contraindication for using ECPs when there are several contraindications for the routine use of the same COCs?
2. Can progestin-only pills be used for ECPs?
3. Should we provide ECPs if the woman had unprotected sexual intercourse on a day when her risk of pregnancy was not very high? Why or why not?
4. If knowledge of ECPs becomes widespread, could incorrect use or overuse of ECPs become a problem? Why or why not?
5. Is it a problem if a woman uses ECPs as her standard contraceptive? Why or why not?



# ECPs Quiz Questions

(Adapted from Salvador-Davila, Graciela 2007)

1. Emergency Contraceptive Pills (ECPs) may be used:
  - a. Up to 24 hours after unprotected sex
  - b. Up to 72 hours after unprotected sex
  - c. Up to 120 hours after unprotected sex
  - d. Up to one week after unprotected sex
2. Following ECP use with progestin-only pills, the percentage of women who become pregnant is approximately:
  - a. 20%
  - b. 10%
  - c. 2%
  - d. 1%
3. The most common side effects of ECPs are (tick all that apply):
  - a. Nausea
  - b. Vomiting
  - c. Blurry vision
  - d. Weight gain
  - e. None of the above
4. ECPs are appropriate for use in the following situations:
  - a. In cases of contraceptive failure
  - b. In cases of sexual assault
  - c. In cases of contraceptive non-use
  - d. All of the above

**Questions 5–13:** Indicate whether each of the following statements is **true** or **false** by marking **“T”** for **“True”** or **“F”** for **“False”** in the space provided before each statement.

- \_\_\_5. ECPs cannot cause abortion.
- \_\_\_6. All clients should undergo full pelvic exams before receiving ECPs.
- \_\_\_7. Only pills containing both estrogen and a progestin may be used for emergency contraception.
- \_\_\_8. ECPs cause nausea in 70% of users.
- \_\_\_9. ECPs provide contraceptive protection for the duration of the menstrual cycle in which they are used.
- \_\_\_10. Condom use may be initiated immediately following ECP use.
- \_\_\_11. The only contraindication to ECP use is a current pregnancy.
- \_\_\_12. ECPs provide protection against HIV/AIDS and other STIs.
- \_\_\_13. ECPs are effective when used as a regular contraceptive method.

## ECPs Quiz Questions Answer Key

1. Emergency Contraceptive Pills (ECPs) may be used:  
**c. Up to 120 hours after unprotected sex**
2. Following ECP use with progestin-only pills, the percentage of women who become pregnant is approximately:  
**d. 1%**
3. The most common side effects of ECPs are (tick all that apply):  
**a. Nausea**  
**b. Vomiting**
4. ECPs are appropriate for use in the following situations:  
**d. All of the above**

**Questions 5–13:** Indicate whether each of the following statements is **true** or **false** by marking **“T”** for **“True”** or **“F”** for **“False”** in the space provided before each statement.

- T\_\_** 5. ECPs cannot cause abortion.
- F\_\_** 6. All clients should undergo full pelvic exams before receiving ECPs.
- F\_\_** 7. Only pills containing both oestrogen and a progestin may be used for emergency contraception.
- F\_\_** 8. ECPs cause nausea in 70% of users.
- F\_\_** 9. ECPs provide contraceptive protection for the duration of the menstrual cycle in which they are used.
- T\_\_** 10. Condom use may be initiated immediately following ECP use.
- T\_\_** 11. The only contraindication to ECP use is a current pregnancy.
- F\_\_** 12. ECPs provide protection against HIV/AIDS and other STIs.
- F\_\_** 13. ECPs are effective when used as a regular contraceptive method.

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<http://info.k4health.org/globalhandbook/>

# Unit 15

## LACTATIONAL AMENORRHEA METHOD

### Learning Objectives

By the end of this unit, learners will be able to:

- ❖ Define Lactational Amenorrhea Method (LAM)
- ❖ Explain how LAM works
- ❖ State the effectiveness of LAM
- ❖ Describe the 3 criteria for using LAM
- ❖ List the characteristics of LAM
- ❖ Correct misconceptions about LAM
- ❖ Explain LAM use for women living with HIV
- ❖ Describe when and how women who use LAM should transition to another family planning method.

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## Unit 15: Lactational Amenorrhea Method

### ❖ Key Points

- ❖ **LAM is a safe and effective contraceptive method.**
- ❖ **LAM is based on breastfeeding and can be effective for up to 6 months after childbirth** as long as monthly bleeding has not returned and the woman is exclusively breastfeeding.
- ❖ **LAM offers significant non-contraceptive benefits for the mother and baby.**
- ❖ **LAM can be used by women who are living with HIV.**
- ❖ **LAM users should transition to another, ongoing family planning method before LAM expires to avoid a gap in pregnancy protection.**

## 15.1 Defining the Lactational Amenorrhea Method

The LAM is a highly effective, temporary family planning method for breastfeeding women. LAM provides natural protection against pregnancy for up to 6 months after giving birth and encourages the timely transition to other modern methods of contraception.

Lactational = Related to breastfeeding

Amenorrhea = No vaginal bleeding (after 2 months postpartum)

Method = A temporary (up to 6 months postpartum) family planning method

LAM is based on a woman's natural infertility resulting from breastfeeding exclusively, along with an absence of menstrual bleeding during the first 6 months after the baby is born.

### **Difference between breastfeeding and LAM**

- LAM is a contraceptive method that uses a pattern of breastfeeding that can effectively suppress ovulation and prevent pregnancy.
- Breastfeeding is a method of infant feeding, not a contraceptive method.

Breastfeeding alone cannot be relied upon to prevent pregnancy. Rather, it is the period of lactational amenorrhea, together with effective breastfeeding practices, that provides this protection.

Although its use is limited to the first 6 months postpartum, LAM provides a woman with very effective contraception (more than 98% as commonly used) and, because it involves breastfeeding, contributes to the health and nutrition of her baby.

### **How LAM works**

LAM works primarily by preventing the release of eggs from the ovaries (ovulation). Exclusive breastfeeding temporarily inhibits the release of the natural hormones that cause ovulation.

- **First, the baby's suckling stimulates the mother's nipple.** When breastfeeding, the baby squeezes and rubs the nipple with his/her gums and palate, causing pressure on— or “mechanical stimulation” of—the nipple.

- **Second, this stimulation of the nipple sends a signal to the mother’s brain.** The nipple stimulation triggers a neural signal to the mother’s pituitary gland, which produces and secretes hormones related to many bodily processes—including ovulation.
- Third, this signal to the mother’s brain disrupts the production of hormones that would normally stimulate the ovaries. In response to the suckling stimuli and the resulting neural signal:

There is increased production by the pituitary of the hormone prolactin.

This increased level of prolactin inhibits the normal secretion of gonadotropin-releasing hormone (GnRH) by the hypothalamus.

This disruption in the release of GnRH, in turn, disrupts the pituitary’s production and release of follicle-stimulating hormone (FSH) and luteinizing hormone (LH), both directly responsible for ovulation.

- **Fourth, ovulation is prevented.** Disruption in the release of FSH impedes the normal maturation of the egg by the ovary; disruption in the release of LH impedes the release of a mature egg by the ovary.

## 15.2 Effectiveness

If used correctly, LAM is 98-99% effective. Risk of pregnancy is greatest when the woman does not exclusively breastfeed her infant.

- As commonly used, about two pregnancies occur per 100 women using LAM. This means that 98 of every 100 women relying on LAM will not become pregnant.
- When used correctly, less than one pregnancy will occur per 100 women using LAM.

## 15.3 The Three Criteria for LAM

LAM effectively protects a woman from pregnancy as long as she meets the following 3 criteria or conditions:

1. The woman’s menstrual bleeding has not returned since her baby was born, and
2. The baby is exclusively breastfed, meaning the woman breastfeeds her baby “on demand,” day and night, and does not give any other food, water or liquid, and
3. The baby is less than 6 months old.

When any one of these 3 criteria is not met, or the woman wishes to begin using another modern method of contraception, she should start on that next method **immediately** if she does not want to become pregnant.

Counseling about the woman’s next method, to which she will transition from LAM, should begin as early as possible, such as when LAM counseling is initiated (ideally before the baby is born). Waiting until one of the 3 criteria is no longer met to begin considering the next method of contraception will be too late—leaving a “gap” in contraceptive protection and greatly increasing the woman’s risk of becoming pregnant.

The **rationales** for the 3 LAM criteria follow:

**The woman’s menstrual bleeding has not returned since her baby was born**—After childbirth, the return of menses is a significant signal that a woman’s fertility has returned. Once a woman starts to menstruate again, it is likely that ovulation has also resumed. Note that vaginal bleeding during the first 2 months postpartum is not considered menstrual bleeding.

**The baby is exclusively breastfed**—This means that breast milk is the **only** food or fluid given to the baby (other than occasional vaccines, medication or ritual drops/sips). The baby should be breastfed “on demand,” which means that whenever the baby shows signs of wanting to be fed, whether day or night, the mother breastfeeds the baby. The baby is not given artificial teats, nipples, or pacifiers. All of a baby’s nutritional, hunger, thirst, and sucking needs are met with breastfeeding.

**The baby is less than 6 months old**—At 6 months of age, the baby should begin receiving complementary foods while continuing to breastfeed. Introduction of complementary food and/or fluids can reduce suckling, allowing the hormonal mechanism that causes ovulation and menses to resume.

Again, if any one of these conditions changes, the woman can no longer rely on LAM for protection from pregnancy and should immediately transition to another method of contraception.

## 15.4 Characteristics of LAM

### Advantages

- Natural method with no systemic side effects, effective immediately
- Readily available at no cost, no supplies required
- Promotes optimal breastfeeding patterns, with resulting health benefits
- Promotes mother-child bonding
- Does not interfere with sexual intercourse
- No medical supervision necessary
- Often serves as an entry point to family planning services

### Disadvantages

- Requires clear understanding and practice of the 3 LAM criteria
- May be difficult to practice due to social circumstances like work and school
- Highly effective, but only temporary
- Does not protect from HIV/AIDS and other sexually transmitted infections (STIs)
- Possibility of transmitting HIV/AIDS to the baby through breast milk

**Side effects** - None. Any problems are the same as for other breastfeeding women.

### Health benefits for mother

- Promotes uterine involution and may help decrease postpartum bleeding
- Reduces risk of anaemia

### Health risks/ complications

None

- 

### Health benefits for child

- Passive immunization
- Best source of nutrition: human milk is perfect food for human babies and only food they need for first 6 months
- Decreased exposure to contaminants in water, other milk or formula and utensils
- Promotes bonding with mother

## 15.5 Correcting Misconceptions

LAM:

- Is highly effective when a woman meets all 3 LAM criteria
- Is just as effective in fat or thin women
- Can be used by women with normal nutrition. No special foods are required.
- Can be used for a full 6 months without the need for supplementary foods. Mother's milk alone can fully nourish a baby for the first 6 months of life. In fact, it is the ideal food for this time in a baby's life.
- Can be used for 6 months without worry that the woman will run out of milk. Milk will continue to be produced through 6 months and longer in response to the baby's suckling or the mother's expression of her milk.

## 15.6 Women Who Can Use LAM

All breastfeeding women can use LAM safely and effectively as long as they meet the 3 criteria.

## 15.7 Women Who Can Not Use LAM

Women who do not meet the 3 LAM criteria **cannot use** the method. This includes:

- Women whose menses have returned
- Women who are **not** exclusively breastfeeding
- Women whose babies are more than 6 months old.

## 15.8 LAM for Women with HIV

WHO UPDATE (November 2009)

For women known to be infected with HIV and intending to breastfeed, antiretroviral (ARV) therapy is recommended for mother and infant throughout the breastfeeding period.

- Women who are living with HIV or who have AIDS can use the method. However, there is a chance of transmitting HIV infection to the baby through breastfeeding. This possibility is reduced if the mother breastfeeds exclusively (as required by LAM) as opposed to partial breastfeeding.
- ARV therapy during the first weeks of breastfeeding may reduce the risk of HIV transmission. If women continue ARVs while breastfeeding, the risk of transmission of HIV through breast milk is reduced.
- Replacement feeding poses no risk for HIV transmission although this means that LAM is no longer being used.
- If replacement feeding is not AFASS (affordable, feasible, acceptable, sustainable and safe), exclusive breastfeeding is recommended for the first 6 months. (WHO 2009)
- Condoms should be used consistently and correctly to prevent transmission of HIV and other STIs (dual protection).



## 15.9

### Medical Eligibility Criteria Screening Questions

#### For the Lactational Amenorrhea Method (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 (See LAM for Women with HIV, above.)
- 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).

## 15.10 Timing: When to Start LAM

Woman's situation	When to start
Within 6 months after childbirth	<p>Start breastfeeding immediately (within 1 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.</p> <p>Any time if she has been exclusively breastfeeding her baby since it was born, and her monthly bleeding has not returned.</p>

## 15.11 Client Counselling and Instructions

- The mother should breastfeed exclusively (with the infant receiving only breast milk and no additional food or drink, not even water).
- Start the baby on other foods at 6 months. At this age, breast milk can no longer fully nourish a growing baby. At this point, protection from pregnancy through the use of LAM ends.
- Plan for the next client visit while the LAM criteria still apply, so that the mother can choose another method without a gap in pregnancy protection when LAM expires.
- If possible, give the mother condoms now. She can start to use them if the baby is no longer exclusively breastfeeding, if her monthly bleeding returns, or if the baby reaches 6 months of age before she can come back for another method. Plan for a follow-on method for the longer-term.
- Assure every client that she is welcome to come back any time—for example, if she has problems, questions, or wants another method; if she has a major change in health status; or if she thinks she might be pregnant. Also, if she no longer meets one or more of the 3 LAM criteria and so can no longer rely on LAM.

## 15.12 Helping Clients Transition to an Ongoing Method

Transitioning to another contraceptive method before LAM expires is essential for pregnancy protection. The provider should discuss other contraceptive options with the woman and help her select a new method before she needs it. If she will continue to breastfeed after she is no longer using LAM, she can choose from several hormonal or non-hormonal methods, depending on how much time has passed since childbirth. (See Unit 19, Postpartum and Postabortion Family Planning, for more detail on the timing for use of family planning methods after pregnancy.)

- A woman can switch to another method any time she wants while using LAM. If she still meets all 3 LAM criteria, it is reasonably certain she is not pregnant. She can start a new method with no need for a pregnancy test, examinations, or evaluation.
- To continue preventing pregnancy, a woman must switch to another method as soon as any one of the 3 LAM criteria no longer applies.

## 15.13 Questions and Answers about LAM

### 1. Can LAM be an effective method of family planning?

Yes. LAM is very effective if the woman's monthly bleeding has not returned, she is exclusively breastfeeding, and her baby is less than 6 months old.

### 2. When should a mother start giving her baby other foods besides breast milk?

Ideally, when the baby is 6 months old. Along with other foods, breast milk should be a major part of the child's diet through the child's second year or longer.

### 3. Can women use LAM if they work away from home?

Yes. Women who are able to keep their infants with them at work or nearby and are able to breastfeed frequently can rely on LAM as long as they meet all 3 criteria for LAM. Women who are separated from their infants can use LAM if breastfeedings are less than 4 hours apart. Women can also express their breast milk at least every 4 hours, but pregnancy rates may be slightly higher for women who are separated from their infants. The one study that assessed use of LAM among working women estimated a pregnancy rate of 5 per 100 women during the first 6 months after childbirth, compared with about 2 per 100 women as LAM is commonly used.

### 4. What if a woman learns that she has HIV while she is using LAM? Can she continue breastfeeding and using LAM?

If a woman is newly infected with HIV, the risk of transmission through breastfeeding is much higher than if she were infected earlier, because there is more HIV in her body. The breastfeeding recommendation is the same as for other HIV-infected women, however. If replacement feeding is an option, she should be counselled that, with such replacement feeding, her baby will have no risk of HIV infection through breastfeeding although she will also no longer be using LAM and will need to use another FP method if she wants to prevent pregnancy. If replacement feeding is not an option, she should breastfeed exclusively during the first 6 months. Thus, she can continue relying on LAM. (After 6 months, breast milk alone is no longer enough nutritionally for the baby, and she should switch from LAM to another contraceptive method.) If a woman learns that she has HIV while using LAM, and she chooses to stop breastfeeding, she should stop completely over a period of about 2 days to 3 weeks. Abruptly stopping breastfeeding is not advisable.

## LAM Case Studies

(Adapted from ACCESS-FP 2009; Farrell 1997)

### Case Study 1

- 1 January—the baby is born
- 15 June—the mother begins to give tastes of semi-solid food every 2 days
- 12 through 17 July—the mother's menstrual period begins

**When does lactational amenorrhea end?**

**When does LAM end?**

### Case Study 2

- 1 March—the baby is born
- 5 July—the mother gives 2-3 feeds in the late afternoon and evening with porridge because the baby now sleeps through the night but she still breastfeeds him 5-6 times during the day.
- 25 August—the mother's menses returns

When does lactational amenorrhea end?

When does LAM end?

### Case Study 3

- 8 June—the baby is born
- 3 December—the mother's menses returns and lasts 5 days
- 15 December—infant receives porridge both in the morning and evening

When does lactational amenorrhea end?

When does LAM end?

### Case Study 4

Dr. Mwale has just addressed a gathering of the Innerwheel Club, a women's association, on the benefits of breastfeeding. During the presentation she stressed the lactational amenorrhea method of contraception (LAM).

During the question-answer period, Alice, a lactating woman 6 months postpartum, and Charity, a woman with a 6-week-old grandson, each had a few questions to ask the doctor. Alice expressed great interest in using LAM as her preferred contraceptive method. Charity wondered if this method might suit her daughter-in-law with the 6-week-old baby.

1. Can Alice use LAM?
2. What information would Dr. Mwale give to Alice concerning her use of LAM as a contraceptive method? What other advice might she give Alice?
3. Can Charity's daughter-in-law use LAM?
4. What would Dr. Mwale tell Charity about LAM?

## Case Study 5

A 20-year-old with 1 child gave birth 4 months ago, and she has been using LAM. She has had only 1 menstrual period, 3 weeks ago, and she plans to have an IUD inserted with her next menses. She reports that she and her husband are using condoms until then. Last night her husband did not withdraw until flaccid, and the condom remained in her vagina with some ejaculate spilling when the condom was removed. This woman definitely does not want another pregnancy now and has come to you for advice.

The provider observes: the young woman is clearly upset and in semi-panic. Breasts normal, lactating and somewhat full. Pelvic examination normal; uterus retroverted, small, regular and firm. No evidence of genital tract infection.

1. Is this woman justified in worrying that she may become pregnant from this condom accident?
2. What advice are you going to give her under the circumstances? Are there any other alternatives to managing her case?
3. Would you give her the same advice if she had been breastfeeding exclusively and had not menstruated?

# Answers to LAM Case Studies

## Case Study 1

When does lactational amenorrhea end? **12 July**

When does LAM end? **15 June, when exclusive breastfeeding ends**

## Case Study 2

When does lactational amenorrhea end? **25 August**

When does LAM end? **5 July when she started supplementing her breast milk**

## Case Study 3

When does lactational amenorrhea end? **3 December with return of menses**

When does LAM end? **8 December with return to menses which occurred prior to giving complementary infant feeding**

## Case Study 4

1. Can Alice use LAM?

**No, Alice cannot use LAM since she is already 6 months postpartum.**

2. What information would Dr. Mwale give to Alice concerning her use of LAM as a contraceptive method? What other advice might she give Alice?

**Alice does not now fit the criteria for LAM since the infant is 6 months or older.**

**The infant now needs to be introduced to appropriate complementary foods. Consequently, Alice can no longer breastfeed exclusively.**

**Alice can continue breastfeeding (there are many advantages), but she should begin using a contraceptive method immediately if she wants to prevent pregnancy.**

3. Can Charity's daughter-in-law use LAM?

**Yes, if she fits the criteria for LAM (has been breastfeeding exclusively since the baby was born and will continue to do so until the baby is 6 months old).**

4. What would Dr. Mwale tell Charity about LAM?

**Charity's daughter-in-law must be willing to breastfeed exclusively. Dr. Mwale should inform Charity that there are other contraceptive methods compatible with breastfeeding and that her daughter-in-law should choose one of these methods before one of the criteria for LAM is no longer met.**

## Case Study 5

1. Is this woman justified in worrying that she may become pregnant from this condom accident?

**Somewhat, although the first menses after lactational amenorrhea may be anovulatory (without ovulation), the subsequent menses are more likely to be preceded by ovulation. Since this may have already occurred, the risk of pregnancy is present.**

2. What advice are you going to give her under the circumstances? Are there any other alternatives to managing her case?

**Offer her emergency contraception since the unprotected sex occurred less than 120 hours before. This can be either through emergency contraceptive pills (ECPS, see unit 14 for more information) or the insertion of an IUCD (that can then be left in place since she desires to use one anyway).**

**Explain to her that she is no longer using LAM since she has had a menstrual period. If she does not choose to have the IUCD inserted as emergency contraception, she will need to choose another ongoing method in order to prevent pregnancy. If she does not want another pregnancy for at least 2-3 years, she could use contraceptive implants (another long-term method). She could also use any other method except COCs, which would need to be delayed until she is at least 6 months postpartum if she continues to breastfeed.**

3. Would you give her the same advice if she had been breastfeeding exclusively and had not menstruated?

**No. If she were breastfeeding exclusively and not menstruating, her risk of pregnancy would be very low— less than 2% because of the protection that LAM provides.**

# LAM Role Plays

(Adapted from ACCESS-FP 2009; Farrell 1997)

## Role Play 1

Mwandida is four weeks postpartum, HIV-positive, and breastfeeding as much as she can. She gave the baby formula when it was first born but cannot afford to feed the baby formula all the time now. Her husband is feeling well on ARVs and is able to work. Mwandida is not symptomatic of HIV, but she is very anaemic. She wants to wait at least 3 years before her next pregnancy.

1. What are Mwandida's counselling needs?
2. What are her contraceptive options?

**Demonstrate how you will help Mwandida, attending to her counselling needs and her contraceptive options in your role play.**

## Role Play 2

Mrs. Ndongo, 26 years old, has come to your clinic today with a breastfeeding concern. She has a 6-week-old baby who cries a lot in the evening, and she thinks the baby is not getting enough milk, so she intends to introduce complementary feeds. Her first baby stopped breastfeeding at 3 months after she had started giving her complementary feeds. She has not menstruated since the birth of this baby. Mrs. Ndongo would like assistance in choosing a method of contraception.

**Demonstrate how you will help Mrs. Ndongo.**

# LAM Role Plays Processing Guide

## Role Play 1

1. What are Mwandida's counselling needs?

- She is not protected by LAM because she has not been exclusively breastfeeding.
- The baby is not being protected from HIV; both should start on ARV therapy.
- If she has an AFASS alternative, she should consider discontinuing breastfeeding.
- She needs to start contraception immediately in order to avoid pregnancy.
- She should use male or female condoms with each act of sexual intercourse in order to avoid re-infection (dual method use).

2. What are her contraceptive options?

- If she continues breastfeeding:

**Male or female condoms plus another method (dual method use)**

**Long-term methods: IUCD or implants (condoms until 6 weeks postpartum)**

**DMPA (condoms until 6 weeks postpartum)**

**COCs (condoms until 6 months postpartum)**

**POPs (condoms until 6 weeks postpartum)**

- If she discontinues breastfeeding:

**Male or female condoms plus another method (dual method use)**

**Long-term methods: IUCD or implants**

**DMPA**

**COCs**

## Role Play 2

**Demonstrate how you will help Mrs. Ndongo.**

- Explain that the baby is getting enough nutrition from breast milk and should continue to do so until he/she is 6 months old.
- Determine if there are clinical reasons why the baby is crying and, if not, counsel Mrs. Ndongo that this is normal.
- As long as she continues to exclusively breastfeed and her menses has not resumed, Mrs. Ndongo can rely on LAM for pregnancy protection. However, she can start another method now if she wishes. She will have to transition to another method by the time the baby is 6 months old or when her menses resumes (whichever comes first).
- If she wishes to start using a method other than LAM, she can use:

**Male or female condoms plus another method for increased pregnancy protection (dual method use)**

**Permanent methods: female sterilisation or vasectomy (if she and her husband do not want additional children)**

**Long-term methods: IUCD or implants (if pregnancy not wanted for at least 2 years)**

**DMPA**

**POPs; COCs (use condoms until 6 months postpartum)**



# LAM Quiz Questions

(Adapted from ACCESS-FP 2009)

1. What is LAM?
2. List the 3 criteria of LAM.
3. What is the difference between breastfeeding and LAM?
4. When does LAM end?
5. What is the difference between LAM and amenorrhea?
6. Describe exclusive breastfeeding.
7. List 3 advantages of LAM?

8. A LAM user has a 3-month-old baby. She wants to switch to another method and continue breastfeeding. Which methods could she use?
  
9. A mother has a 4-month-old baby and has not had her menses. She works outside the home for 3 hours a day and leaves the baby with her mother. She breastfeeds her baby exclusively. Is she practicing LAM?
  
10. A mother has a 7-week-old baby. Even though she has been exclusively breastfeeding him, she had spotting and brown discharge up to a week ago. Is she practicing LAM?
  
11. A mother with a 4-month-old baby breastfeeds him and gives him sugar water 3 times a day. Her menses has not yet returned. Is she practicing LAM?
  
12. True or false: The majority of women in sub-Saharan Africa use LAM as a method of family planning.
  
13. When established criteria exist and instructions are followed, LAM is:
  - a. 70% effective
  - b. 80% effective
  - c. 90% effective
  - d. 98% effective
  - e. 100% effective

## LAM Quiz Questions Answer Key

1. What is LAM?

**The Lactational Amenorrhea Method is a contraceptive method based on the natural infertility resulting from breastfeeding.**

2. List the 3 criteria of LAM.

**1) The mother's menses has not resumed, 2) she is exclusively breastfeeding and 3) the infant is 6 months old or less.**

3. What is the difference between breastfeeding and LAM?

**Breastfeeding is a method of infant feeding—NOT a contraceptive method. LAM is a contraceptive method that uses a pattern of breastfeeding that can effectively suppress ovulation and prevent pregnancy up to 6 months postpartum.**

4. When does LAM end?

**LAM ends when the woman's menstrual periods have returned or when the pattern of breastfeeding changes to regularly include water, other liquids or solid food, or when the infant is more than 6 months old.**

5. What is the difference between LAM and amenorrhea?

**Many women who breastfeed will have delay in return of menses. Only those women who breastfeed their babies exclusively with no supplements and whose infants are 6 months or less can be more than 98% confident that they will not conceive.**

6. Describe exclusive breastfeeding.

**Exclusive breastfeeding is when no liquid or food, not even water, is given to an infant other than breast milk.**

7. List 3 advantages of LAM.

**Any 3 of the following:**

- **More than 98% effective**
- **Can be started immediately postpartum**
- **No side effects**
- **Motivates mothers to exclusively breastfeed**
- **Facilitates transition to another method**
- **"Natural" method**
- **No cost**

8. A LAM user has a 3-month-old baby. She wants to switch to another method and continue breastfeeding. Which methods could she use?

**Female sterilisation (if she wants no more children), IUCD, implants, injectables, POPs, male or female condoms**

9. A mother has a 4-month-old baby and has not had her menses. She works outside the home for 3 hours a day and leaves the baby with her mother. She breastfeeds her baby exclusively. Is she practicing LAM? **Yes.**

10. A mother has a 7-week-old baby. Even though she has been exclusively breastfeeding him, she had spotting and brown discharge up to a week ago. Is she practicing LAM?

**Yes, because spotting and bleeding during the first 2 months is related to lochia and not menses.**

11. A mother with a 4-month-old baby breastfeeds him and gives him sugar water 3 times a day. Her menses has not yet returned. Is she practicing LAM?

**No, because she is not exclusively breastfeeding her baby.**

12. True or false: The majority of women in sub-Saharan Africa use LAM as a method of family planning.

**FALSE—while the majority of women breastfeed, and breastfeeding provides some contraceptive benefit, they are not practicing LAM. The practice of LAM means being aware of the 3 criteria and actively seeking another method should any of those criteria no longer apply.**

13. When established criteria exist and instructions are followed, LAM is:

**d. 98% effective**

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# Unit 16

## FERTILITY AWARENESS METHODS

### Learning Objectives

By the end of this unit, learners should be able to:

- ❖ Define fertility awareness methods of contraception
- ❖ Describe the 2 categories of fertility awareness methods and the primary method in each category
- ❖ Explain how the Standard Days Method® (SDM) and the TwoDay Method® (TDM) work
- ❖ State the effectiveness of the SDM and the TDM
- ❖ Describe the characteristics of these methods
- ❖ Determine medical eligibility for these methods
- ❖ Provide client instructions for the SDM and the TDM
- ❖ Explain how to manage problems with the SDM and the TDM
- ❖ Demonstrate competence in counselling clients for these methods.

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## Unit 16: Fertility Awareness Methods

### Key Points

Fertility awareness methods:

- ❖ **Are only moderately effective** at preventing pregnancy as typically used
- ❖ **Require partners' cooperation.** A couple must be committed to abstaining or using another method on fertile days.
- ❖ **Require women to be aware of body changes or keep track of their menstrual cycles,** according to the rules of the specific method
- ❖ **Have no side effects or health risks**
- ❖ **The Standard Days Method® (SDM) is a calendar-based method** that requires abstinence from sexual intercourse or the use of condoms during days 8-19 of the menstrual cycle.
- ❖ **The TwoDay Method® (TDM) is a symptoms-based method** that requires abstinence from sexual intercourse or the use of condoms on each day with vaginal secretions and each day following a day with secretions.

### 16.1 Defining Fertility Awareness Methods

Fertility awareness methods are methods of planning or avoiding pregnancy by observing natural signs and symptoms of the fertile and infertile phases of the menstrual cycle. "Fertility awareness" means that a woman knows how to tell when the fertile time of her menstrual cycle starts and ends. (The fertile time is when she can become pregnant.)

These methods are sometimes called periodic abstinence or natural family planning.

A woman can use a fertility awareness method alone, or in combination with other fertility awareness methods, to tell when her fertile time begins and ends.

#### Types of fertility awareness methods

Fertility awareness methods fall into 2 broad categories:

##### Calendar-based methods

These involve keeping track of the days of the menstrual cycle to identify the start and end of the fertile time. Examples are:

- SDM
- Calendar rhythm method.

##### Symptoms-based methods

These methods depend on observing signs of fertility, primarily by using cervical secretions and basal body temperature:

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).

Examples of symptoms-based methods are:

- TDM
- Basal Body Temperature (BBT)
- Symptothermal Method
- Ovulation method (also known as the Billings method or cervical mucus method).

This unit will be concerned primarily with the **SDM** and the **TDM** since these are the two fertility awareness methods for which there is the most evidence as to their effectiveness and ease of use.

### How SDM and TDM work

The methods work primarily by helping a woman know when she could become pregnant. The couple prevents pregnancy by avoiding unprotected vaginal sex during the woman's fertile days—usually by abstaining or by using condoms. Some couples use withdrawal (see Unit 18) on these days, but this is among the least effective methods.

The **SDM** is based on research that shows that the fertile window, or the time during which a woman can get pregnant, occurs between days 8 to 19 of the menstrual cycle.

The **TDM** works by tracking cervical secretions, which are reliable indicators of fertility. Since these secretions are necessary for the woman to be fertile, if there are no secretions, she cannot become pregnant. The efficacy of this method is enhanced because if ovulation (and therefore the fertile period) happens earlier or later than usual one month, the woman will know this by noticing secretions earlier or later.

## 16.2 Effectiveness of Fertility Awareness Methods

If used correctly and consistently, fertility awareness methods are 81% to 99% effective. However, effectiveness depends on the user. Risk of pregnancy is greatest when couples have sex on the fertile days without using another method.

As commonly used, about 25 pregnancies occur per 100 women when using fertility awareness methods. This means that 75 out of every 100 women relying on periodic abstinence will not become pregnant, or that fertility awareness methods are about 75% effective. The SDM and the TDM may be easier to use and, thus, somewhat more effective.

Pregnancy rates with consistent and correct use vary for different types of fertility awareness methods (see table, below). In general, abstaining during fertile times is more effective than using another method at these times.



Table 16.1: Pregnancy Rates of Fertility Awareness Methods

Method	Pregnancies per 100 women over the first year
<b>Calendar-based methods</b>	
Standard Days Method®	5
Calendar rhythm method	9
<b>Symptoms-based methods</b>	
TwoDay Method®	4
Basal body temperature (BBT) method	1
Ovulation method	3
Symptothermal method	2

## 16.3 Characteristics of Fertility Awareness Methods

### Advantages

- Have no side effects
- Immediately reversible
- Help women learn about their bodies and fertility
- Allow some couples to adhere to their religious or cultural norms about contraception
- Promote male involvement in family planning
- Enhance self-discipline, mutual respect, and communication

### Disadvantages

- Only moderately effective in preventing pregnancy
- Require training/intensive counselling for proper use
- Can require long periods of abstinence or use of condoms
- Can require daily observations
- TDM difficult to use when a woman has vaginal infections—true reading of cervical mucus can be masked
- Do not protect against sexually transmitted infections (STIs), including HIV

**Side effects, health benefits, health risks:** None

## 16.4 Correcting Misconceptions

Fertility awareness methods:

- Can be very effective if used consistently and correctly
- Do not require literacy or advanced education
- Do not harm men who abstain from sex
- Do not work when a couple is mistaken about when the fertile time occurs, such as thinking it occurs during monthly bleeding.

## 16.5 Calendar-Based Methods

Medical Eligibility Criteria Screening Questions	
For Calendar-Based Methods	
<p><b>All women can use calendar-based methods.</b> No medical conditions prevent the use of these methods, but some conditions can make them harder to use effectively.</p> <p>The WHO MEC uses a different system for categorizing fertility awareness methods. This system includes:</p> <p><b>Accept</b> means that the method can be used.</p> <p><b>Caution</b> means that additional or special counselling may be needed to ensure correct use of the method.</p> <p><b>Delay</b> means that use of a particular method should be delayed until the condition is evaluated or corrected. The client should be given another method to use until she can start the calendar-based method.</p>	
<p><b>In the following situations, use caution</b> with calendar-based methods:</p> <ul style="list-style-type: none"><li>• Menstrual cycles have just started or have become less frequent or stopped due to older age, making it difficult to identify the fertile time.</li><li>• Women whose partner(s) will not abstain during the fertile phases of the menstrual cycle.</li></ul>	
<p><b>In the following situations, delay</b> starting calendar-based methods:</p> <ul style="list-style-type: none"><li>• Recently gave birth or is breastfeeding (<i>delay</i> 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 <i>caution</i>.)</li><li>• Recently had an abortion or miscarriage (<i>delay</i> until the start of her next monthly bleeding.)</li><li>• Irregular vaginal bleeding</li></ul>	
<p><b>In the following situations <i>delay</i> or use <i>caution</i></b> with calendar-based methods:</p> <ul style="list-style-type: none"><li>• 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 nonsteroidal antiinflammatory drug (such as aspirin, ibuprofen, or paracetamol). These drugs may delay ovulation.</li></ul>	

## 16.6 Timing: When to Start the SDM

Woman's situation	When to start
Having regular menstrual cycles	<ul style="list-style-type: none"> <li>• Any time of the month</li> <li>• No need to wait until the start of next monthly bleeding</li> </ul>
No monthly bleeding	<ul style="list-style-type: none"> <li>• Delay the SDM until monthly bleeding returns.</li> </ul>
After childbirth (whether or not breastfeeding)	<ul style="list-style-type: none"> <li>• Delay the SDM until she has had 3 menstrual cycles and the most recent one was 26–32 days long.</li> <li>• Regular cycles will return later in breastfeeding women than in women who are not breastfeeding.</li> </ul>
After miscarriage or abortion	<ul style="list-style-type: none"> <li>• Delay the SDM until the start of her next monthly bleeding, when she can start if she has no bleeding due to injury to the genital tract.</li> </ul>
Switching from a hormonal method	<ul style="list-style-type: none"> <li>• Delay starting the SDM until the start of her next monthly bleeding.</li> <li>• If she is switching from injectables, delay the SDM at least until her repeat injection would have been given, and then start it at the beginning of her next monthly bleeding.</li> </ul>
After taking emergency contraceptive pills	<ul style="list-style-type: none"> <li>• Delay the SDM until the start of her next monthly bleeding.</li> </ul>

## 16.7 Counselling and Instructions for the SDM

**Important:** The SDM is a contraceptive method in which the woman counts each day of her menstrual cycle and abstains from sexual intercourse (or uses another method such as condoms) during her fertile days. A woman can use the SDM 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 SDM will be less effective and she may want to choose another method.

If she meets the criteria and the materials are available, a SDM chart and CycleBeads® can be provided to help her track her fertile period. CycleBeads® contain 32 colour-coded beads representing the menstrual cycle, with each bead representing a new day. (See the Illustration below for more information.)

### **ASSESS if the SDM is appropriate for the woman and her partner:**

- Determine if the client's menstrual cycle length is 26 to 32 days.
- Determine if there is any circumstance or condition that may affect the woman's cycle length (recent pregnancy or use of other methods).
- Help the client decide whether this method will work for her and her partner.
- Determine when the woman can start using the SDM.

### **INFORM the client how the SDM works:**

- Tell her to keep track of the days of the menstrual cycle, counting the first day of monthly bleeding as day 1.
- Advise her to 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 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.

- Suggest she use CycleBeads® or mark a calendar as memory aids if needed. CycleBeads® is a colour-coded string of beads that indicates fertile and non-fertile days of a cycle. (See Figure 16.1.)

### **CONFIRM that the client understands the key points for using the method. Repeat and clarify as needed.**

### **SUPPORT the couple's use of the SDM:**

- Identify problems the couple may have using the SDM and encourage behaviours that will support correct use of the method.
- Help the couple identify possible solutions to the problems they have identified. Help the client explore ways of talking with her partner about the method and how to handle and negotiate avoiding unprotected sex on days when she can get pregnant.
- Remind the client/couple to return to the clinic if she/they have questions or is/are not satisfied with the method. Schedule a follow-up visit if necessary.

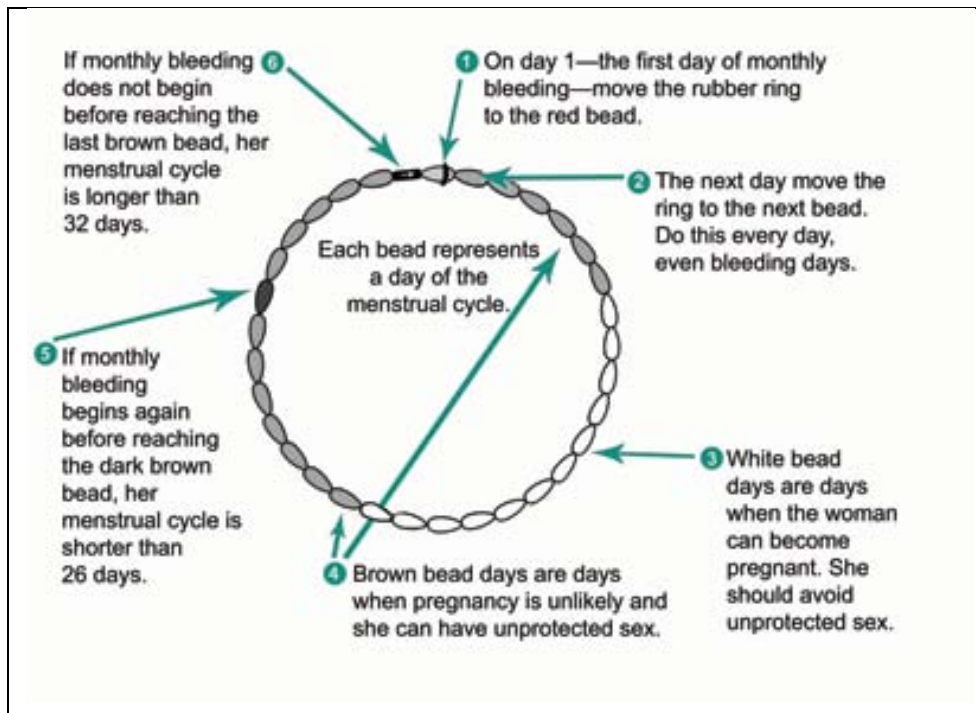


Figure 16.1: CycleBeads®

## 16.8 Symptoms-Based Methods

### Medical Eligibility Criteria Screening Questions

#### For Symptoms-Based Methods

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

The WHO MEC uses a different system for categorizing fertility awareness methods. This system includes:

**Accept** means that the method can be used.

**Caution** means that additional or special counselling 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. The client should use another method until she can start the symptoms-based method.

**In the following situations, use caution** with symptoms-based methods:

- Client recently had an abortion or miscarriage.
- Her menstrual cycles have just started or have become less frequent or stopped due to older age, making it difficult to identify the fertile time.
- She has a chronic condition that raises her body temperature (for basal body temperature and symptothermal methods).

**In the following situations, delay** starting symptoms-based methods:

- 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.

**In the following situations, delay or use caution** with symptoms-based methods:

- 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 nonsteroidal anti-inflammatory drug (such as aspirin, ibuprofen, or paracetamol), or antihistamines
- These drugs may affect cervical secretions, raise body temperature, or delay ovulation.

## 16.9 Timing: When to Start the TDM

Once trained, a woman or couple usually can begin using symptoms-based methods at any time. Clients who cannot start immediately should be given another method to use until they can start.

<b>Woman's Situation</b>	<b>When to Start</b>
<b>Having regular menstrual cycles</b>	<ul style="list-style-type: none"> <li>• Any time of the month</li> <li>• No need to wait until the start of next monthly bleeding.</li> </ul>
<b>No monthly bleeding</b>	<ul style="list-style-type: none"> <li>• Delay symptoms-based methods until monthly bleeding returns.</li> </ul>
<b>After childbirth (whether or not breastfeeding)</b>	<ul style="list-style-type: none"> <li>• She can start symptoms-based methods once normal secretions have returned.</li> <li>• Normal secretions will return later in breastfeeding women than in women who are not breastfeeding.</li> </ul>
<b>After miscarriage or abortion</b>	<ul style="list-style-type: none"> <li>• She can start symptoms-based methods immediately with special counselling and support, if she has no infection-related secretions or bleeding due to injury to the genital tract.</li> </ul>
<b>Switching from a hormonal method</b>	<ul style="list-style-type: none"> <li>• She can start symptoms-based methods in the next menstrual cycle after stopping a hormonal method.</li> </ul>
<b>After taking emergency contraceptive pills</b>	<ul style="list-style-type: none"> <li>• She can start symptoms-based methods once normal secretions have returned.</li> </ul>

## 16.10 Counselling and Instructions for the TDM

**Important:** If a woman has a vaginal infection or another condition that changes cervical mucus, the TDM will be difficult to use.

### **Check for secretions.**



- The woman checks for cervical secretions every afternoon and/or evening, on fingers, underwear, 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 on each day with secretions and on each day following a day with secretions.

### **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.

Another way to think about this is for the user of the TDM asks herself two questions every day:

- Did I note any secretions today?
- Did I note any secretions yesterday?

If she noticed any secretions today OR yesterday, she is potentially fertile today and should avoid unprotected intercourse today to prevent pregnancy. If she did not notice any secretions today and yesterday (2 consecutive dry days), pregnancy is very unlikely today.



## 16.11 Managing Any Problems with Fertility Awareness Methods

Problems with fertility awareness methods affect women's satisfaction with, and use of, the method. Problems deserve the provider's attention. If the client reports any problems, listen to her concerns and give her advice.

Offer to help the client choose another method—now, if she wishes, or later if problems cannot be overcome.

<b>Problem</b>	<b>How to Manage</b>
<b>Inability to abstain from sex during the fertile time</b>	<ul style="list-style-type: none"> <li>• Discuss the problem openly with the couple and help them feel at ease, not embarrassed.</li> <li>• Discuss possible use of male or female condoms or sexual contact without vaginal intercourse during the fertile time.</li> <li>• If she has had unprotected sex in the past 5 days she can consider emergency contraceptive pills (ECPs) (see Unit 14: Emergency Contraceptive Pills).</li> </ul>
<b>Calendar-Based Methods (SDM)</b>	
<b>Cycles are outside the 26–32 day range for the SDM</b>	<ul style="list-style-type: none"> <li>• If she has 2 or more cycles outside the 26 to 32 day range within any 12 months, suggest she use the TDM instead.</li> </ul>
<b>Very irregular menstrual cycles</b>	<ul style="list-style-type: none"> <li>• Suggest she use the TDM instead.</li> </ul>
<b>Symptoms-Based Methods (TDM)</b>	
<b>Difficulty recognizing different types of secretions</b>	<ul style="list-style-type: none"> <li>• Counsel the client and help her learn how to interpret cervical secretions.</li> </ul>
<b>Difficulty recognizing the presence of secretions</b>	<ul style="list-style-type: none"> <li>• Provide additional guidance on how to recognize secretions.</li> <li>• Suggest she use the SDM instead.</li> </ul>

-

## Fertility Awareness Methods Case Studies - SDM

(Adapted from the Institute for Reproductive Health 2009)

### Case Study 1: Mary

*Date of last period:* 25 October

*Date expects next period:* 24 November, period is always regular

*Date of visit to clinic:* 30 October

**Note:** Mary recently finished her last pack of pills. Her cycle prior to this was 32 days long, and the one before that one was 30 days long. She and her partner get along well.

- What is the client's menstrual cycle length?
- Can she use the SDM?
- If the method is suitable for her, when can she start using it?
- What special recommendations would you give to her?

### Case Study 2: Florence

*Date last period:* 19 May

*Date expects next period:* 16 June

*Date of visit to clinic:* 28 May

**Note:** Florence has been breastfeeding her son for the last 15 months. Her period started 8 months ago on a regular basis. Maria's husband travels often, at least twice a month and for several days at a time. They have decided together to use a natural method.

- What is the client's menstrual cycle length?
- Can she use the SDM?
- If the method is suitable for her, when can she start using it?
- What special recommendations would you give to her?

## Case Study 3: Charity

*Date last period:* 14 October

*Date expects next period:* Her period is often very light and sometimes doesn't come at all, but before she began using the 3-month injection, her period came each month.

*Date of visit to clinic:* 29 November

**Note:** Charity has used DMPA for about 2 years. Her most recent injection was due 3 weeks ago. She wishes to change methods because she is overweight and thinks it is because of the injection.

- What is the client's menstrual cycle length?
- Can she use the SDM?
- If the method is suitable for her, when can she start using it?
- What special recommendations would you give to her?

## Case Study 4: Ruth

*Date last period:* 12 August

*Date expects next period:* Not sure because she just had her IUCD removed today

*Date of visit to clinic:* 22 August

**Note:** Ruth doesn't keep track of her cycles, but her periods come just about every month. She also has several days of spotting in between her periods. She's tired of the spotting and the heavy flow during her periods, so she had her IUCD removed today. Her husband supports her decision to choose a new method.

- What is the client's menstrual cycle length?
- Can she use the SDM?
- If the method is suitable for her, when can she start using it?
- What special recommendations would you give to her?

# Answers to Fertility Awareness Methods Case Studies - SDM

(Adapted from the Institute for Reproductive Health 2009)

## Case Study 1: Mary

- What is the client's menstrual cycle length? **30 days**
- Can she use the SDM? **Yes**
- If the method is suitable for her, when can she start using it? **Immediately**
- What special recommendations would you give to her?  
**She should monitor her cycle length over time. Make sure she knows how to check for short or long cycles.**  
**Confirm that both partners can avoid unprotected sex on her fertile days.**

## Case Study 2: Florence

- What is the client's menstrual cycle length? **28 days**
- Can she use the SDM? **Yes**
- If the method is suitable for her, when can she start using it? **Immediately**
- What special recommendations would you give to her?  
**She should discuss with her partner about method and agree in advance how to handle her fertile days.**  
**If they already had sex during this cycle, she may already be pregnant. Test or refer accordingly.**  
**Emphasize explanation on checking for short or long cycles.**

## Case Study 3: Charity

- What is the client's menstrual cycle length? **We don't know**
- Can she use the SDM? **Not at this time**
- If the method is suitable for her, when can she start using it? **Not yet**
- What special recommendations would you give to her?  
**She should wait for her periods to resume and to have a cycle within the 26-32 day range.**  
**She should use another family planning method in the meantime.**

## Case Study 4: Ruth

- What is the client's menstrual cycle length? **Probably within 26-32 day range**
- Can she use the SDM? **Yes**
- If the method is suitable for her, when can she start using it? **Immediately**
- What special recommendations would you give to her?  
**She should place ring on bead corresponding to today's date and keep track of current cycle length.**  
**Emphasize that she should return to clinic if her current cycle is too short or too long.**

# Fertility Awareness Methods Role Plays

(Adapted from the Institute for Reproductive Health 2009)

## Role Play 1

### **Situation**

The client has arrived at the centre; she has been greeted and asked the reason for her visit. Her biographical information has been taken, and her clinical history has been filled out, if applicable. She has also been given general information about all available contraceptive methods. In this case, she has decided that she would like to use the SDM.

### **Provider role**

Start the counselling session by assessing whether the method is suitable for the client, continue by informing the client how to use it, and conclude by exploring aspects of couple communication and offering support to the client in using the method with her partner. (Follow the steps outlined in the text under Counselling and Instructions for SDM, Section 16.7.)

## Role Play 2

### **Client role**

The client is 27 years old. She has a 10-month-old baby, whom she breastfeeds. Seven months ago she began menstruating again, and in the last 3 months her periods have come at about the same time each month. Before becoming pregnant, she used combined oral contraceptives (COCs) for 5 years but decided to discontinue them because it gave her headaches. Since her last child was born she has not used contraception. She and her partner don't want to have any more children for now, and she doesn't want to use COCs again—she would rather opt for a natural method. She comes to the clinic on February 4 because she has heard that a natural method is being offered at this facility and she wants to know if she can use it. The first day of her last menstrual period was January 31.

### **Provider role**

Start the counselling session by assessing whether the fertility awareness method is suitable for the client, continue by informing the client how to use both SDM and TDM, and conclude by exploring aspects of couple communication and offering support to the client in using her selected method with her partner. She selects the TDM. (Follow the steps outlined in the text under Counselling and Instructions for TDM, Section 16.10.)

# Fertility Awareness Methods Quiz Questions

(Adapted from the Institute for Reproductive Health 2009)

**Directions: Tick the letter corresponding to the correct answer for each question.**

1. A woman is more likely to get pregnant:
  - a. At the beginning of her cycle
  - b. Midway through her cycle
  - c. 10 days before menstruating
2. Which of the following is a characteristic of the Standard Days Method® (SDM)?
  - a. It protects couples against STIs.
  - b. It has no side effects.
  - c. Several people can use the same CycleBeads®.
3. If a woman has cycles between 26 and 32 days before she started using COCs, she can use the SDM:
  - a. While taking the pill
  - b. Two months after she stops taking the pill
  - c. As soon as she starts her period after stopping the pill
4. To use the SDM the woman must have menstrual cycles lasting:
  - a. 5 to 7 days
  - b. 26 to 32 days
  - c. 28 days
5. How long does the woman's menstrual cycle last if the first day of her period is 2 October, she has menstrual bleeding for 3 days, and her period arrives again 31 October?
  - a. 3 days
  - b. 29 days
  - c. 30 days
6. How effective is the SDM when it is used correctly?
  - a. 70%
  - b. 95%
  - c. 75%
7. The TwoDay Method® (TDM) is an example of what type of fertility awareness method?
  - a. Symptoms-based method
  - b. Calendar-based method
  - c. Both symptoms-based and calendar-based
  - d. None of the above
8. Which of the following is a characteristic of the TDM?
  - a. It protects couples against STIs.
  - b. It has no side effects.
  - c. It can be used by women with irregular periods.
  - d. "b" and "c" above

9. If using the TDM, it is important for the user to:
  - a. Notice if she had cervical secretions today or yesterday
  - b. Avoid sexual intercourse if she has cervical secretions today
  - c. Avoid sexual intercourse if she is not having secretions today
  - d. "a" and "b" above
  - e. "a" and "c" above

## Fertility Awareness Methods Quiz Questions Answer Key

1. A woman is more likely to get pregnant:  
**b. Midway through her cycle**
2. Which of the following is a characteristic of the SDM?  
**b. It has no side effects.**
3. If a woman has cycles between 26 and 32 days before she started using COCs, she can use the SDM:  
**c. As soon as she starts her period after stopping the pill**
4. To use the SDM the woman must have menstrual cycles lasting:  
**b. 26 to 32 days**
5. How long does the woman's menstrual cycle last if the first day of her period is 2 October, she has menstrual bleeding for 3 days, and her period arrives again 31 October?  
**b. 29 days**
6. How effective is the SDM when it is used correctly?  
**b. 95%**
7. The TDM is an example of what type of fertility awareness method?  
**a. Symptoms-based method**
8. Which of the following is a characteristic of the TDM?  
**d. b and c above**
9. If using the TDM, it is important for the user to:  
**d. a and b above**



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# Unit 17

## BARRIER METHODS

### (MALE AND FEMALE CONDOMS)

#### Learning Objectives

By the end of this unit, learners will be able to:

- ❖ Describe condoms
- ❖ Explain the effectiveness of condoms and how they work
- ❖ List the characteristics of male condoms and of female condoms
- ❖ State the medical eligibility criteria (MEC) for use of male condoms and female condoms
- ❖ Correct myths and misconceptions about male and female condoms
- ❖ Demonstrate skills in counselling clients to make informed choices about condoms
- ❖ Provide clients with strategies and skills to negotiate condom use with partners
- ❖ Demonstrate how to use male condoms and female condoms
- ❖ Provide client instructions for using male and female condoms.

#### Teaching Resources in this Unit

##### Learning Activities

Role Plays 412

##### Unit Assessment

Quiz Questions 413

Quiz Questions Answer Key 414

## Unit 17: Barrier Methods (Male and Female Condoms)

### Key Points

#### Male and female condoms:

- ❖ **Help protect against sexually transmitted infections (STIs), including HIV.**  
Condoms are the only contraceptive method that can protect against both pregnancy and STIs.
- ❖ **Require correct use with every act of sexual intercourse**
- ❖ **Require both male and female partner's cooperation.** Talking about condom use before sex can improve the chances one will be used.
- ❖ **May require some practice.** Putting on a male condom and inserting and removing the female condom from the vagina become easier with experience.

### 17.1 Defining Condoms

Condoms are a method of preventing pregnancy in which a plastic, latex, or animal-skin sheath creates a physical barrier preventing sperm from entering the woman's uterus. They are the most widely-used examples of barrier methods, which are contraceptive methods that work by creating physical or chemical barriers.

#### Types of condoms

There are two types of condoms:

- Male condoms
- Female condoms.

Both are available in Malawi.

#### How male and female condoms work

Both male and female condoms work by forming a mechanical barrier that keeps sperm out of the vagina, preventing pregnancy. They also help prevent infections present in semen, on the penis, or in the vagina from infecting the sexual partner. Condoms and other barrier methods require correct use with every act of intercourse.

## OTHER BARRIER METHODS

These other barrier methods do not provide protection against STIs, including HIV.

### Diaphragms

A bowl-shaped latex cup with a flexible rim that is inserted into the vagina to cover the cervix before intercourse. It requires fitting by a specifically trained provider. (Rarely used in Malawi)

### Cervical cap

A soft, deep, latex or plastic cup that is placed over the cervix before intercourse. It snugly covers the cervix. Requires fitting by a specifically trained provider. (Not available in Malawi)

### Spermicides

Spermicides are sperm-killing substances inserted deeply in the vagina shortly before intercourse. They work by breaking the membranes on sperm cells, killing the cells or slowing their movement. This keeps the sperm from meeting the egg. Spermicides are one of the least effective contraceptive methods. Available in several forms:

- Jellies, creams, and foam can be used alone, with a diaphragm or with condoms.
- Films, foaming tablets or suppositories can be used alone or with condoms.

## MALE CONDOMS

### 17.2 Male Condoms Description

- Sheaths, or coverings, that fit over a man's erect penis
- Also called rubbers, "raincoats," "umbrellas," skins, and prophylactics; known by many different brand names
- Most are made of thin latex rubber.

### 17.3 Effectiveness of Male Condoms

*Effectiveness depends on the user:* Risk of pregnancy or STI is greatest when condoms are not used with every act of intercourse. Inconsistent condom use results in far more pregnancies and infections than does incorrect use, slips, or breaks.

#### Protection against pregnancy:

- When used correctly with every act of sex, about 2 pregnancies per year occur in every 100 women whose partners use male condoms. This is known as "perfect use."
- As commonly used, about 15 pregnancies per year occur in every 100 women whose partners use male condoms. This means that 85 of every 100 women whose partners use male condoms will not become pregnant. This is known as "typical use."

#### Protection against STIs/HIV:

- Male condoms significantly reduce the risk of transmission of HIV and other STIs when used correctly with every act of sexual intercourse.
- Male condoms prevent 80% to 95% of HIV transmission that would have occurred without condoms.

Protect best against STIs spread by discharge, such as HIV, gonorrhoea and Chlamydia  
Also protect against STIs spread by skin-to-skin contact, such as herpes and human papillomavirus.

## 17.4 Characteristics of Male Condoms

### Advantages

- If properly and consistently used, are very effective
- Have no side effects
- Can be used as a backup to other methods
- Can be used without seeing a health care provider
- Are inexpensive in the short-term
- Promote partner communication
- Promote male involvement in family planning
- May prolong erection time
- Are sold in many places and generally easy to obtain
- Help protect against STIs, including HIV.

### Disadvantages

- Latex condoms may cause itching for people who are allergic to latex.
- They may decrease sensation, making maintenance of erection more difficult.
- Couple must take the time to put the condom on the erect penis
- Supply must be readily available.
- Condom may slip off or break during sexual intercourse.
- Partner's cooperation is essential for a woman to protect herself from pregnancy.

### Side effects—None

### Health benefits

- Help protect against STIs, including HIV
- May help protect against conditions caused by STIs: Recurring pelvic inflammatory disease and chronic pelvic pain; cervical cancer; infertility (male and female).

### Health risks

Extremely rare:

- Severe allergic reaction (among people with latex allergy)

## 17.5 Correcting Misconceptions

Male condoms:

- Do not make men sterile, impotent, or weak
- Do not decrease men's sex drive
- Cannot get lost in a woman's body
- Do not cause illness in a woman because they prevent semen or sperm from entering her body
- Do not cause illness in men because sperm "backs up"
- Can be used by married couples, not only for use outside marriage.

## 17.6 Barriers to Male Condom Use

- Not always available
- Provider attitudes possibly hindering adoption
- Myths and misconceptions
- Stigma
- Cultural/religious beliefs and practices
- Gender related issues.

## 17.7 Clients Who Can Use Male Condoms

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

## 17.8 Counselling about Using Male Condoms

**Important:** Whenever possible, **show clients how to put on a condom.** (See instructions below.) Use a model of a penis, if available, or some other item, like a banana, to demonstrate.

Key counselling messages:

- Use a condom every time you have intercourse.
- Keep a supply of condoms available.
- Condoms can be weakened in their effectiveness if stored in too much heat, sunlight, or humidity.
- Do not use oil-based lubricants on the condom. These products can cause rubber to tear.

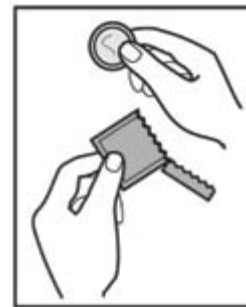
## How to put on a condom

### Basic Steps

1. **Use a new condom for each act of sex.**
2. **Before any physical contact, place the condom on the tip of the erect penis with the rolled side out.**
3. **Unroll the condom all the way to the base of the erect penis.**
4. **Immediately after ejaculation, hold the rim of the condom in place and withdraw the penis while it is still erect.**
5. **Dispose of the used condom safely.**

### Important Details

- 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.
- For the most protection, put the condom on before the penis makes any genital, oral, or anal contact.
- 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.
- 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.
- Wrap the condom in its package and put it in the rubbish or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing.



## 17.9 Managing Problems with Male Condoms

Problem	How to Manage
Condom might have holes or tears (noticed before intercourse)	<ul style="list-style-type: none"><li>• Discard and use a different condom.</li></ul>
Condom breaks or slips off (during intercourse)	<ul style="list-style-type: none"><li>• Withdraw the penis immediately and put on a new condom. Consider emergency contraception, HIV testing and post-exposure prophylaxis of HIV treatment.</li></ul>
Suspected allergic reaction to condom	<ul style="list-style-type: none"><li>• Rule out infection, allergy, or mechanical reaction. If allergy to a latex condom is established, help the client choose another method.</li></ul>

## FEMALE CONDOMS

### 17.10 Female Condoms Description

Female condoms are sheaths or linings made of thin, soft, transparent plastic film that fits loosely inside a woman's vagina. They have flexible rings at both ends, one ring at the closed end helps to insert the condom while the ring at the open end holds part of the condom outside the vagina. They are lubricated with a silicone-based lubricant on the inside and outside.

### 17.11 Effectiveness of Female Condoms

Effectiveness depends on the user:

- When used correctly with every act of intercourse, about 5 pregnancies occur per 100 women using female condoms (95% effective). This is known as "perfect use."
- As commonly used, about 21 pregnancies occur per 100 women using female condoms. This means that 79 of every 100 women using female condoms will not become pregnant (79% effective). This is known as "typical use."

Protection against HIV and other STIs:

- Female condoms reduce the risk of infection with HIV and other STIs when used correctly with every act of sexual intercourse.



## 17.12 Characteristics of Female Condoms

Advantages	Disadvantages
<ul style="list-style-type: none"><li>• Help protect against both pregnancy and STIs, including HIV</li><li>• Women can initiate their use.</li><li>• Can be used without seeing a health care provider</li><li>• Can be inserted ahead of time so do not interrupt sex</li><li>• Are not tight or constricting for men like male condoms can be</li><li>• Do not dull the sensation of sex like male condoms sometimes do</li><li>• Do not have to be removed immediately after ejaculation.</li></ul>	<ul style="list-style-type: none"><li>• Expensive</li><li>• Woman must take the time to correctly insert the condom in the vagina.</li></ul>

**Side Effects: None**

**Health Benefits:** Help protect against STIs, including HIV

**Health Risks: None**

## 17.13 Correcting Misconceptions

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
- Do not cause illness in a woman because they prevent semen or sperm from entering her body
- Can be used by married couples. They are not only for use outside marriage.

## 17.14 Barriers to Female Condom Use

- Not always available
- Provider attitudes possibly hindering adoption
- Myths and misconceptions
- Stigma
- Cultural/religious beliefs and practices
- Gender-related issues.

## 17.15 Clients Who Can Use Female Condoms

All women can safely use plastic female condoms. No medical condition prevents the use of this method.

## 17.16 Counselling about Using Female Condoms

### 1. Explain how to use female condoms.

(See instructions below.)

### 2. Ensure client understands correct use.

- Ask the client to explain the 5 basic steps of using the female condom while handling one.
- If a model is available, the client can practice inserting the condom in the model and then taking it out.

### 3. Ask the client how many condoms she thinks she will need until she can return.

- Give plenty of condoms.
- Tell the client where she can buy female condoms, if needed.

### 4. Explain why using a condom with every act of sexual intercourse is important.

- Just one unprotected act of intercourse can lead to pregnancy or STI—or both.
- If a condom is not used for one act of intercourse, try to use one the next time. A mistake once or twice does not mean that it is pointless to use condoms in the future.

### 5. Explain about emergency contraceptive pills (ECPs).

- Explain emergency contraception use in case of errors in condom use—including not using a condom—to help prevent pregnancy (see Unit 14: Emergency Contraceptive Pills). Give ECPs in advance, if available.

### 6. Discuss ways to talk about using condoms.

- Discuss skills and techniques for negotiating condom use with partners. (See section below on negotiating condom use.)

#### TIPS FOR NEW USERS

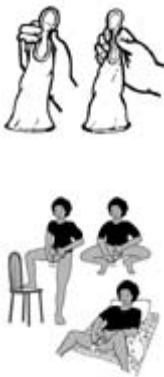
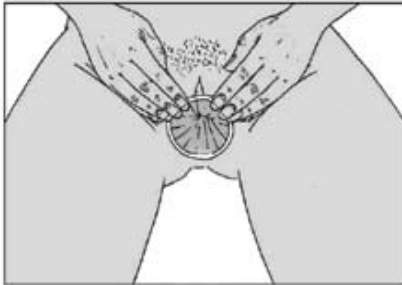

Suggest to a new user that she practice putting in and taking out the condom before the next time she has sex.



Reassure her that correct use becomes easier with practice. She may need to use the female condom several times before she is comfortable with it.

Suggest she try different positions to see which way insertion is easiest for her. The female condom is slippery. Some women find insertion easier if they put it in slowly, especially the first few times.

If a client is switching from another method to the female condom, suggest that she continue with the previous method until she can use the female condom with confidence.

## 17.17 How to Use a Female Condom

Basic steps	Important details
<p>1. Use a new female condom for each act of sex.</p>	<ul style="list-style-type: none"> <li>• Check the condom package. Do not use if torn or damaged. Avoid using a condom past the expiration date—do so only if newer condoms are not available.</li> <li>• If possible, wash your hands with mild soap and clean water before inserting the condom.</li> </ul>
<p>2. Before any physical contact, insert the condom into the vagina.</p> 	<ul style="list-style-type: none"> <li>• Can be inserted up to 8 hours before sex. For the most protection, insert the condom before the penis comes in contact with the vagina.</li> <li>• Choose a position that is comfortable for insertion—squat, raise one leg, sit or lie down.</li> <li>• Rub the sides of the female condom together to spread the lubricant evenly.</li> <li>• Grasp the ring at the closed end and squeeze it so it becomes long and narrow.</li> <li>• With the other hand, separate the outer lips (labia) and locate the opening of the vagina.</li> <li>• 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 2–3 cm of the condom and the outer ring remain outside the vagina.</li> </ul>
<p>3. Ensure that the penis enters the condom and stays inside the condom.</p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• If the condom is accidentally pulled out of the vagina or pushed into it during sex, put the condom back in place.</li> </ul> 
<p>4. After the man withdraws his penis, hold the outer ring of the condom, twist to seal in contents, and gently pull it out of the vagina.</p>	<ul style="list-style-type: none"> <li>• The female condom does not need to be removed immediately after sex.</li> <li>• Remove the condom before standing up, to avoid spilling semen.</li> <li>• If the couple has sex again, they should use a new condom.</li> <li>• Reuse of female condoms is not recommended</li> </ul> 

Basic steps	Important details
<p>5. <b>Dispose of the used condom safely.</b></p>	<ul style="list-style-type: none"> <li>• Wrap the condom in its package and put it in the rubbish or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing.</li> </ul> <div style="display: flex; justify-content: space-around; align-items: center;">   </div>

## 17.18 Reasons to Return

Assure every client that she is welcome to come back any time—for example, if she has problems, questions, or wants another method; she has any major change in health status; or she thinks she might be pregnant. Also if:

- She has difficulty using female condoms correctly or every time she has sex.
- She recently had unprotected sex and wants to avoid pregnancy. She may be able to use emergency contraception (see Emergency Contraceptive Pills, Unit 14).

## 17.19 Managing Problems with Female Condoms

<b>May or may not be due to the method</b>	
<p>Problems with female condoms affect clients' satisfaction and use of the method. They deserve the provider's attention. If the client reports any problems, listen to her concerns and give advice. Male condoms can be given instead to provide protection from STIs, including HIV.</p>	
<b>Difficulty inserting the female condom</b>	<ul style="list-style-type: none"> <li>• Ask the client how she inserts a female condom. If a model is available, ask her to demonstrate and let her practice with the model. If not, ask her to demonstrate using her hands. Correct any errors.</li> </ul>
<b>Inner ring uncomfortable or painful</b>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>
<b>Condom squeaks or makes noise during sex</b>	<ul style="list-style-type: none"> <li>• Suggest adding more lubricant to the inside of the condom or onto the penis.</li> </ul>
<b>Condom slips, is not used, or is used incorrectly</b>	<ul style="list-style-type: none"> <li>• Emergency contraception can help prevent pregnancy (see Emergency Contraceptive Pills, Unit 14).</li> <li>• Little can be done to reduce the risk of STIs if a condom breaks, slips, or is not used. If the client has signs or symptoms of STIs after having unprotected sex, assess or refer.</li> <li>• If a client reports slips, she may be inserting the female condom incorrectly. Ask her to show how she is inserting the condom, using a model or demonstrating with her hands. Correct any errors.</li> </ul>
<b>Difficulty persuading partner to use condoms; not able to use every time</b>	<ul style="list-style-type: none"> <li>• Discuss ways to talk with her partner about the importance of condom use for protection from pregnancy and STIs. (See "Negotiating Condom Use," below.)</li> </ul>
<b>Mild irritation in or around the vagina or penis (itching, redness, or rash)</b>	<ul style="list-style-type: none"> <li>• It usually goes away on its own without treatment.</li> <li>• Suggest adding lubricant to the inside of the condom or onto the penis to reduce rubbing that may cause irritation.</li> <li>• If symptoms persist, assess and treat for possible vaginal infection or STI, as appropriate.               <ul style="list-style-type: none"> <li>• If there is no infection, help the client choose another method.</li> </ul> </li> <li>• For clients at risk of STIs, including HIV, suggest using male condoms. If using male condoms is not possible, urge continued use of female condoms despite discomfort.</li> <li>• If neither partner has an infection, a mutually faithful sexual relationship provides STI protection without requiring condom use but does not protect against pregnancy.</li> </ul>
<b>Suspected pregnancy</b>	<ul style="list-style-type: none"> <li>• Assess for pregnancy.</li> <li>• It is safe to use female condoms during pregnancy for STI protection.</li> </ul>

## 17.20 Negotiating Male or Female Condom Use

There are many reasons why clients may feel that they cannot discuss condom use with their partners. Identifying them is an important first step in helping clients determine whether they can find ways to start this important conversation.

It is equally important to address the deeper fears or social issues behind client's reasons for not talking with their partners. Identifying these root factors can help clients understand their fears and anxieties related to talking with their partners and develop strategies for overcoming them.

If a client does not feel that she is able to discuss condoms, do not force her. She knows her relationship best. Urging her to press this issue when there is a power imbalance, especially when violence or abuse may occur, could place the woman's health and life in danger. Do not criticize the partner or spouse. Encourage the client to come back for further discussion, if appropriate.

### **Giving clients strategies and skills for negotiating condom use**

**Suggest to the client that she try one or more of the following strategies, as appropriate:**

- Identify areas of family life or relationships that they do talk about. See if there is some way that these issues can be included in those discussions.
- Start the conversation by saying that this is something that she heard about in a talk at the clinic and by wondering if the partner knows anything about these issues.
- Say that she has some health issues that the provider wants to discuss with him or some decision that he needs to make with her.
- Identify family members (his family or hers) who may be supportive and ask them to help her communicate about these issues with her partner.

### **Use role playing with the client to practice these strategies.**

- It may be helpful at first for the client to practice being the partner and for you to play the role of the client, to model how these issues can be discussed.
- Then switch roles, to give the client a chance to practice saying these things herself.

### **Be non-judgemental of the partner as well as of the client.**

- Criticizing the woman's partner may threaten her sense of well-being and end your counselling relationship.

### **Respect the client's willingness and ability to negotiate with her partner.**

- If she says that she cannot discuss this with her partner, explore other options.
- If there are truly no other options, schedule a follow-up visit and address the topic again.

(EngenderHealth 2003)

## Condom Negotiation Role Plays

(Adapted from Family Health International 1996)

### Directions for teacher

1. Divide students into pairs and instruct them to role play condom negotiation skills in the situations listed below.
2. Assign specific situations to each pair.
3. After they have role played, have the students come back to the larger group to discuss the process, review selected role plays and discuss what they learned, what was difficult, etc. Ask students to provide feedback on the effectiveness of the communication skills of the person negotiating condom use. Include any points you observed in the interactions.
4. Key messages should include:
  - Condoms contribute to pregnancy prevention and disease protection.
  - Partner communication and negotiation are critical skills for condom use.
  - Condoms are effective only when used correctly and consistently.
  - Counsellors should be able to demonstrate the use of a condom to a client in a counselling session.
  - Knowing one's HIV sero-status is an important factor in the decision to use condoms.

### Role play situations

- One partner is drunk.
- One partner is older.
- One partner is known to be violent.
- Money or gifts are offered for sex without a condom.
- The male partner is being aggressive.
- The female partner suggests condom use with a long-time boyfriend or with her husband.
- The male partner suggests condom use with a long-term girlfriend.

## Condoms Quiz Questions

(Adapted from Family Health International 1996)

**Questions 1–6.** Indicate whether the following statements are **true** or **false** by writing a **“T”** for true or an **“F”** for false in the space provided before each statement.

- \_\_\_ 1. Consistent and correct use of male or female condoms is an effective way to prevent pregnancy.
  - \_\_\_ 2. Male and female condoms do not protect against most types of STIs, including HIV.
  - \_\_\_ 3. Most male and female condom breakage is due to human error.
  - \_\_\_ 4. Laboratory studies have found that female condoms likely protect against both bacterial and viral STIs.
  - \_\_\_ 5. A new male condom should be used for each act of intercourse.
  - \_\_\_ 6. Opening a condom package with teeth or a sharp object or unrolling condoms before putting them on can cause breakage or slippage of the male condom.
7. Male condoms prevent the passage of:
- a. Sperm only
  - b. Sperm and bacterial STIs
  - c. Sperm, bacterial STIs and HIV
  - d. None of the above
8. Although when used correctly with every act of sexual intercourse male condoms are 98% effective, with typical use they are only:
- a. 95% effective
  - b. 85% effective
  - c. 65% effective
  - d. 45% effective
9. Which of the following are true about male condoms (tick all that apply):
- a. Male condoms may cause infertility in men.
  - b. Male condoms have no side effects.
  - c. Male condoms are inexpensive in the short run.
  - d. Male condoms are only for use outside of marriage.
  - e. None of the above are true about male condoms.
10. Which of the following are true about female condoms (tick all that apply):
- a. Female condoms must be removed immediately after ejaculation.
  - b. Female condoms do not protect against STIs, including HIV.
  - c. Female condoms can get lost in the woman’s body.
  - d. Female condoms can be inserted up to 8 hours before sex.
  - e. None of the above are true about female condoms.
11. Male and female condoms are examples of which type of contraceptive method?
- a. Barrier methods
  - b. Hormonal methods
  - c. Standard Days Method (SDM)
  - d. Implants
  - e. None of the above



# Condoms Quiz Questions Answer Key

**Questions 1–6.** Indicate whether the following statements are **true** or **false** by writing a **“T”** for true or an **“F”** for false in the space provided before each statement.

- T\_\_1. Consistent and correct use of male or female condoms is an effective way to prevent pregnancy.
- F\_\_2. Male and female condoms do not protect against most types of STIs, including HIV.
- T\_\_3. Most male and female condom breakage is due to human error.
- T\_\_4. Laboratory studies have found that female condoms likely protect against both bacterial and viral STIs.
- T\_\_5. A new male condom should be used for each act of intercourse.
- T\_\_6. Opening a condom package with teeth or a sharp object or unrolling condoms before putting them on can cause breakage or slippage of the male condom.
7. Male condoms prevent the passage of:  
c. Sperm, bacterial STIs and HIV
8. Although when used correctly with every act of sexual intercourse male condoms are 98% effective, with typical use they are only:  
b. 85% effective
9. Which of the following are true about male condoms (tick all that apply):  
b. Male condoms have no side effects.  
c. Male condoms are inexpensive in the short run.
10. Which of the following are true about female condoms (tick all that apply):  
d. Female condoms can be inserted up to 8 hours before sex.
11. Male and female condoms are examples of which type of contraceptive method?  
a. Barrier methods

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<http://info.k4health.org/globalhandbook/>

# Unit 18

## WITHDRAWAL

### Learning Objectives

By the end of this unit, learners should be able to:

- ❖ Describe withdrawal as a contraceptive method and how it works
- ❖ State the effectiveness of this method
- ❖ Describe the characteristics of this method
- ❖ Determine medical eligibility for this method
- ❖ Provide client instructions for using this method
- ❖ Demonstrate competence in counselling clients about this method.

### Teaching Resources in this Unit

#### Learning Activities

Role Play 419

#### Unit Assessment

Quiz Questions 419

Quiz Questions Answer Key 420

## Unit 18: Withdrawal

### Key Points

Withdrawal:

- ❖ **Is always available in every situation.** It can be used as a primary method or as a backup method.
- ❖ **Requires no supplies and no clinic or pharmacy visit**
- ❖ **Is one of the least effective contraceptive methods.** Some men use this method effectively, however. Withdrawal offers better pregnancy protection than no method at all.
- ❖ **Promotes male involvement and couple communication.**

### 18.1 Describing Withdrawal

Withdrawal is a contraceptive method in which the man withdraws his penis from his partner's vagina and ejaculates outside the vagina, keeping his semen away from her external genitalia.

- Withdrawal is also known as coitus interruptus and "pulling out."
- It works by keeping sperm out of the woman's body.

### 18.2 Effectiveness of Withdrawal

*Effectiveness depends on the user:* Risk of pregnancy is greatest when the man does not withdraw his penis from the vagina before he ejaculates with every act of sexual intercourse.

- When used correctly with every act of intercourse, about 4 pregnancies occur per 100 women whose partners use withdrawal.
- However, as commonly used, about 27 pregnancies occur per 100 women whose partner uses withdrawal. This means that 73 of every 100 women whose partners use withdrawal will not become pregnant. Therefore, withdrawal is one of the least effective methods in typical use.

## 18.3 Characteristics of Withdrawal

### Advantages

- Always available in any situation
- Requires no supplies and no clinic or pharmacy visit
- Promotes male involvement and couple communication

### Disadvantages

- One of the least effective methods
- Does not protect against sexually transmitted infections (STIs), including HIV
- Can disrupt sexual activities
- Can be difficult to use successfully

### Side effects, health benefits, and health risks

None

## 18.4

### Medical Eligibility Criteria

#### For Withdrawal

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

## 18.5 Timing: When to Use Withdrawal

- Withdrawal can be used at any time.
- 
- 18.6 Explaining How to Use

<b>When the man feels close to ejaculating</b>	<ul style="list-style-type: none"><li>• He should withdraw his penis from the woman's vagina and ejaculate outside the vagina, keeping his semen away from her external genitalia.</li></ul>
<b>If man has ejaculated recently</b>	<ul style="list-style-type: none"><li>• Before sexual intercourse, he should urinate and wipe the tip of his penis to remove any sperm remaining.</li></ul>

## 18.7 Counselling Messages on Use

<b>Learning proper use can take time.</b>	<ul style="list-style-type: none"><li>• Suggest the couple also use another method until the man feels that he can use withdrawal correctly with every act of intercourse.</li></ul>
<b>Greater protection from pregnancy is available.</b>	<ul style="list-style-type: none"><li>• Suggest an additional or alternative family planning method. (Couples who have been using withdrawal effectively should not be discouraged from continuing.)</li></ul>
<b>Some men may have difficulty using withdrawal.</b>	<ul style="list-style-type: none"><li>• Advise that withdrawal is not a suitable method for:<ul style="list-style-type: none"><li>• Men who cannot sense consistently when ejaculation is about to occur</li><li>• Men who ejaculate prematurely.</li></ul></li></ul>
<b>Couples can use emergency contraceptive pills (ECPs).</b>	<ul style="list-style-type: none"><li>• Explain ECP use in case a man ejaculates before withdrawing (see Emergency Contraceptive Pills, Unit 14). Give ECPs if possible.</li></ul>

## Withdrawal Role Play

### Situation

A married couple comes into the clinic seeking a contraceptive method. They want to use a “natural” method but, because the woman’s menstrual periods are not regular, the couple understands that they should not use “natural” methods. They want to know what other options they may have.

## Withdrawal Quiz Questions

1. The withdrawal method of family planning requires:
  - a. Withdrawal of the penis from the vagina after sexual intercourse
  - b. Sex without penetration of the vagina
  - c. Withdrawal of the penis from the vagina during sexual intercourse, before ejaculation
  - d. None of the above
2. As commonly used, withdrawal has an effectiveness rate of:
  - a. 4%
  - b. 17%
  - c. 27%
  - d. 38%
3. Men with the following conditions are not eligible to use the withdrawal method of family planning:
  - a. Have AIDS and are taking ARVs
  - b. Have a history of cardiovascular problems
  - c. Have had a vasectomy
  - d. All men are eligible to use withdrawal; there are no medical contraindications for the method.

## Withdrawal Quiz Questions Answer Key

1. The withdrawal method of family planning requires:
  - c. **Withdrawal of the penis from the vagina during sexual intercourse, before ejaculation**
2. As commonly used, withdrawal has an effectiveness rate of:
  - c. **27%**
3. Men with the following conditions are not eligible to use the withdrawal method of family planning:
  - d. **All men are eligible to use withdrawal; there are no medical contraindications for the method.**

## References

World Health Organization/Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs (CCP), Knowledge for Health Project. *Family Planning: A global handbook for providers (2008 update)*. Baltimore and Geneva: CCP and WHO/RHR. <http://info.k4health.org/globalhandbook/>

# Unit 19

## POSTPARTUM AND POSTABORTION FAMILY PLANNING

### Learning Objectives

By the end of this unit, learners will be able to:

- ❖ Define the postpartum period and postpartum family planning
- ❖ State the timing of return of fertility for breastfeeding and non-breastfeeding women after childbirth
- ❖ Discuss the unmet need for postpartum contraception
- ❖ Describe key messages for postpartum contraceptive counselling
- ❖ List postpartum contraceptive options and their timing
- ❖ Discuss postpartum contraception for women living with HIV
- ❖ Define postabortion family planning
- ❖ State the timing of return to fertility after abortion/miscarriage
- ❖ Explain the importance of postabortion family planning services
- ❖ Describe key messages for postabortion contraceptive counselling
- ❖ List postabortion contraceptive options and their timing
- ❖ Explain how infection and genital trauma affect choice or timing of postabortion contraceptive options.

### Teaching Resources in this Unit

#### Handout

When Postpartum Family Planning Methods Can Be Started After Childbirth	428
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#### Learning Activities

Case Studies	429
Case Studies Answer Key	430

#### Unit Assessment

Quiz Questions	432
Quiz Questions Answer Key	434



## Unit 19: Postpartum and Postabortion Family Planning

### Key Points

- ❖ **Mothers and babies receive health benefits when subsequent pregnancies are delayed** at least 24 months after giving birth or 6 months after abortion or miscarriage (Healthy Timing and Spacing of Pregnancy (HTSP)).
- ❖ **If pregnancy is not desired, family planning should be used before a woman's fertility returns after childbirth or abortion**, which can be as soon as 28 days after childbirth and 11 days after abortion or miscarriage.
- ❖ **When a woman should and can start family planning methods after childbirth depends on her breastfeeding status, method of choice, and reproductive goals.**
- ❖ **In general, women living with HIV/AIDS can use any hormonal method**, with some restrictions for women on antiretroviral (ARV) therapy.
- ❖ **Women who have just experienced abortion or who have just been treated for postabortion complications need immediate and easy access to family planning services.**
- ❖ **Most family planning methods can be started immediately after abortion** although intrauterine contraceptive devices (IUCDs), female sterilisation and fertility awareness methods (FAM) need to be delayed if there is infection or genital injury.

### 19.1 The Postpartum Period

The postpartum period is defined as the year after childbirth. It is a time of transition, adjustment, and adaptation along with significant biological, social, and psychological changes. In terms of changes in the woman's body, the postpartum period starts from the first minutes after delivery of a baby and placenta, and lasts as follows:

- **Post-placental period:** The first 10 minutes after placenta delivery
- **Immediate postpartum:** Up to 48 hours after giving birth
- **Early postpartum:** 48 hours to 6 weeks after giving birth
- **Extended postpartum:** 6 weeks to 1 year after giving birth.

The postpartum period is a critical time for appropriate health interventions, as the majority of maternal and infant deaths and illness occur during this period.

### 19.2 Defining Postpartum Family Planning

Postpartum family planning is generally defined as the initiation and use of family planning methods following childbirth. By spacing the next pregnancy by at least 2 years, family planning can continue to have beneficial effects on the well-being of children under 5. (For more information about pregnancy spacing and family planning messages for postpartum clients, see Unit 6: Healthy Timing and Spacing of Pregnancy.)

## 19.3 Return to Fertility after Childbirth

The timing of a woman's return to fertility after childbirth is difficult to predict and depends on her circumstances and breastfeeding schedule. It is important for postpartum women to initiate use of a family planning method before their fertility returns in order to avoid an unintended or mistimed pregnancy.

### Breastfeeding women

- For postpartum women who breastfeed **exclusively** (breastfeed often, on demand, 8 to 10 times a day, without giving any other liquids or foods to the baby), have no menses, and have an infant less than 6 months of age—which are the 3 criteria for the lactational amenorrhoea method, or LAM—there is a 1% risk of conception. Once 1 of these 3 criteria is no longer present, the woman is no longer protected from pregnancy. (For more information about LAM, see Unit 15.)

### Non-breastfeeding women

- On average, women who do not breastfeed ovulate by the 45th day after childbirth, and possibly as soon as the 28th day after childbirth. (Speroff et al 2008).
- Fertility begins prior to return of menses in 2 out of 3 women.

### Women who are partially breastfeeding

- Women who are partially breastfeeding are not using LAM and, therefore, are not protected from pregnancy. Return to fertility may occur prior to resumption of menses.

## 19.4 Unmet Need for Postpartum Family Planning

Unmet need for family planning is defined as non-use of contraception among married women of reproductive age who are able to become pregnant and would like space or limit future pregnancies but are not currently using any method of contraception.

Data from 27 countries show that as many as two-thirds of women who gave birth in the last year have unmet need for contraception, yet as few as 3%-8% want another child within the next 2 years. Nearly 65% of women in the first year postpartum intend to use a family planning method but are not yet doing so. (Ross and Winfrey 2001). They have an unmet need for family planning.

Women in their first year postpartum and their families are a priority group to reach with family planning information and services. For this reason, it is important to systematically integrate family planning services with maternal, newborn, and infant services.

## 19.5 Postpartum Family Planning Counselling Messages

- Promote optimum health by advising exclusive breastfeeding and using LAM, which is 99% effective when used correctly. (See Unit 15: LAM for more information.)
- Discuss health benefits to the mother and baby of waiting at least 24 months before trying to become pregnant again. (See Unit 6: Healthy Timing and Spacing of Pregnancy for a list of benefits.)
- Discuss return to sexual activity and provide information about return to fertility.

A woman who is not exclusively breastfeeding is able to become pregnant as soon as 4 to 6 weeks after childbirth.

A woman who is exclusively breastfeeding is able to become pregnant as soon as 6 months postpartum.

Advise that, for maximum protection, a woman should not wait until the return of monthly bleeding to start a contraceptive method, but instead she should start as soon as medical guidance allows.

- Offer and discuss family planning options for postpartum women, including long-term and permanent methods (LTPM), as appropriate and according to the client’s wishes.

## 19.6 Timing: When Postpartum Women Can Start Family Planning Methods

When a woman should and can start family planning methods after childbirth depends on her breastfeeding status, method of choice and reproductive goals.

Table 19.1: Earliest Times a Client May Start Family Planning after Childbirth

Family Planning Method	Exclusively Breastfeeding	Partially Breastfeeding or Not Breastfeeding
<b>Lactational Amenorrhea Method</b>	Immediately	(Not applicable)
<b>Vasectomy</b>	Immediately or during partner's pregnancy	
<b>Male or female condoms</b>	Immediately	
<b>Copper-bearing IUCD</b>	Within 48 hours, otherwise wait 4 weeks	
<b>Female sterilization</b>	Within 7 days, otherwise wait 6 weeks	
<b>Fertility awareness methods</b>	Start when normal secretions have returned (for symptoms-based methods like TwoDay Method) or when she has had 3 regular menstrual cycles (for calendar-based methods like Standard Days Method). This will occur later for breastfeeding women than for women who are not breastfeeding.	
<b>Progestin-only pills (POPs)</b>	6 weeks after childbirth	Immediately if not breastfeeding
<b>Progestin-only injectables (DMPA)</b>		6 weeks after childbirth if partially breastfeeding
<b>Implants</b>		
<b>Combined oral contraceptives (COCs)</b>	6 months after childbirth	21 days after childbirth if not breastfeeding 6 months after childbirth if partially breastfeeding

(WHO/RHR and CCP, INFO Project 2007)

### Use of IUCD postpartum

The IUCD is an excellent family planning method for postpartum women who do not want another pregnancy for at least 2 years. It can be inserted immediately after childbirth and up to 48 hours afterwards. IUCD insertion up to 48 hours after childbirth requires a specially trained provider. The IUCD is a long-acting method (up to 12 years with Copper T 380A) but also can be used by women who are interested in spacing for at least 2 years.

## 19.7 Postpartum Contraception Options for Women Living with HIV/AIDS

- In general, women living with HIV/AIDS can use any **hormonal method**—COCs, POPs, progestin-only injectables, contraceptive implants—with some restrictions for women on ARV therapy. (See table below.)
- **LAM:** If replacement feeding is acceptable, feasible, affordable, sustainable, and safe (AFASS), women living with HIV should avoid breastfeeding and not rely on LAM. But if replacement feeding does not meet these conditions, a woman living with HIV should breastfeed exclusively for the first 6 months, thereby using LAM (until her menses resumes).
- **FAM:** Women who are infected with HIV, have AIDS, or are on ARV therapy can safely use fertility awareness methods after 3 menstrual cycles or normal secretions have returned.
- **Condoms:** All clients, including clients living with HIV, should be counselled on condom use for dual protection and to prevent transmission of HIV to partners.

The WHO MEC classifications for hormonal methods and copper-bearing IUCDs for women at high risk for or living with HIV are listed in Table 19.2.

Table 19.2: MEC Classifications for Women Living with or at High Risk of HIV

HIV Status/Condition	MEC Categories for Hormonal Methods	MEC Categories for Copper-Bearing IUCD
High risk of HIV:	Category 1	Category 2
HIV infected	Category 1	Category 2
Has AIDS	Category 1	Category 3 for insertion, Category 2 for continued use
Clinically well on antiretroviral therapy	Category 2*	Category 2 for insertion and continued use
Not clinically well on antiretroviral therapy	Category 2*	Category 3 for insertion, Category 2 for continued use

\* The exception to this is if the woman is using Ritonavir-boosted protease inhibitors. In these cases, use of COCs and POPs is contraindicated (MEC category 3). Use of implants for these women is Category 2 and use of DMPA is Category 1.

## 19.8 Defining Postabortion Family Planning

Postabortion family planning is the initiation and use of family planning methods at the time of treatment for an abortion, or before fertility returns after an abortion (within 11-14 days after the abortion occurred).

### Importance of postabortion family planning

Women who have just experienced abortion or who have just been treated for postabortion complications need immediate and easy access to family planning services. Ideally, these services should be integrated with postabortion care and offered immediately postabortion, increasing the likelihood that these women use contraception to avoid unintended pregnancy. (WHO/RHR and CCP, INFO Project 2007).

Reducing the incidence of induced abortion through family planning use can avert many associated problems:

- 20 million unsafe abortions occur each year globally.
- 70,000 women die from complications of unsafe abortion each year.
- 1 in 8 pregnancy-related deaths are due to unsafe abortion.
- Family planning could prevent 90% of maternal mortality associated with unsafe abortion.

### **Factors contributing to repeat unsafe abortions**

- Lack of recognition of the problem of unsafe abortion and clients' needs for family planning
- Lack of family planning services for some groups, for example, adolescents
- Family planning services not integrated with postabortion emergency services

## **19.9 Postabortion Counselling**

A woman who has had an abortion needs support. A woman who has faced the double risk of pregnancy and unsafe induced abortion especially needs help and support. Good counselling gives a postabortion client much needed support. In particular, the counsellor should:

- Try to understand what the client has been through
- Treat her with respect and avoid judgment and criticism
- Ensure privacy and confidentiality
- Ask if she wants someone she trusts to be present during counselling.

### **Postabortion counselling messages**

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

- **Fertility returns quickly**—within 11 days after a first-trimester abortion or miscarriage and within 4 weeks after a second-trimester abortion or miscarriage. Therefore, she needs protection from pregnancy almost immediately.
- **She can choose from among many different family planning methods** that can be started at once (see *When to Start Contraceptive Methods*, Section 19.10). Methods that women should not use immediately after giving birth pose no special risks after abortion.
- She can wait before choosing a contraceptive method for ongoing use, but she should consider using a backup method 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, oral contraceptives, or emergency 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.
- **She should wait at least 6 months before trying to become pregnant.** Waiting at least 6 months reduces the chances of low birth weight, premature birth, and maternal anaemia. (For more information about the benefits of healthy spacing of pregnancies after abortion or miscarriage, see Unit 6: Healthy Timing and Spacing of Pregnancy.)

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

## 19.10 When to Start Contraceptive Methods after Abortion

### Can be started immediately

- Combined oral contraceptives
- Progestin-only pills
- Progestin-only injectables
- Contraceptive implants
- Male and female condoms

### Can be started once infection is ruled out or resolved

- IUCDs
- Female sterilisation
- Fertility awareness methods

### Can be started once any injury to the genital tract has healed

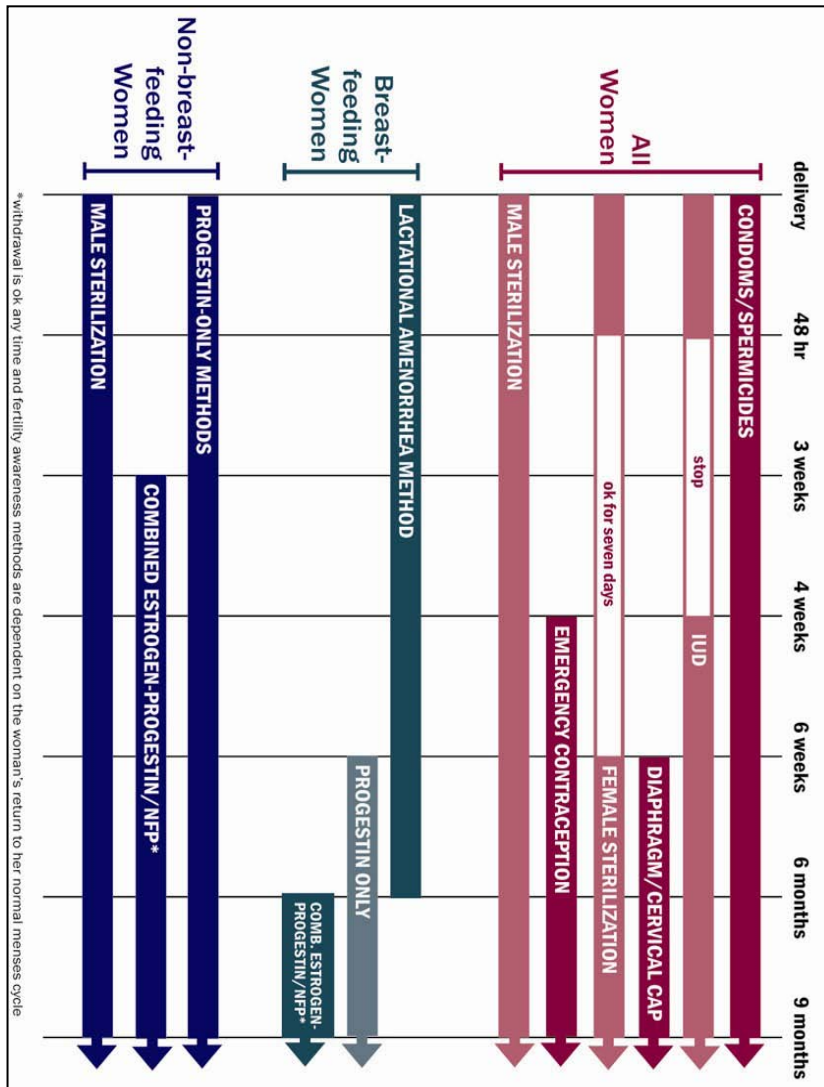
- IUCDs
- Female sterilisation
- Fertility awareness methods

### Special considerations

- **IUCD insertion** immediately after a second-trimester abortion requires a specifically trained provider.
- **Female sterilisation** 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 as another option.
- **Fertility awareness methods:** A woman can start symptoms-based methods like the TwoDay Method once she has no infection-related secretions or bleeding due to injury to the genital tract. She can start calendar-based methods like the Standard Days Method with her next monthly bleeding, if she does not have bleeding due to injury to the genital tract.

# Postpartum and Postabortion Family Planning Teaching Resources

## When Postpartum Family Planning Methods Can Be Started after Childbirth



# Postpartum and Postabortion Family Planning Case Studies

(Adapted from Family Health International 1996)

1. A 20-year-old woman is 2 weeks postpartum after giving birth to her first child. She is generally healthy and is breastfeeding. She possibly wants more children.

What contraceptive methods can she initiate at this time?

2. A 32-year-old woman is immediately postpartum after giving birth by caesarean section. This is her fourth healthy child. She is generally healthy and is planning to breastfeed.

What contraceptive methods can she initiate at this time?

3. A 23-year-old woman is 6 week postpartum after giving birth to her second child, who died soon after delivery. She had a difficult pregnancy and is not planning to have another child soon.

What contraceptive methods can she initiate at this time?

4. A 26-year-old woman is 4 months postpartum after giving birth to her first child. She is breastfeeding, and both mother and child are healthy. She wants to postpone her next pregnancy for a few years.

What contraceptive methods can she initiate at this time?

5. A 28-year-old woman is 2 weeks postpartum with her third child. She is breastfeeding but does not want to rely on LAM. She wants to use another method and feels strongly about not having more children.

What contraceptive methods can she initiate at this time?

6. A 29-year-old woman experienced a first-trimester uncomplicated miscarriage 2 weeks ago. She would like to get pregnant again but wants to delay it for a few months.

What contraceptive methods can she initiate at this time?

7. A 36-year-old woman underwent a second-trimester abortion 1 week ago, complicated by an infection that has not yet completely resolved. She does not want any more children.

What contraceptive methods can she initiate at this time?



## Postpartum and Postabortion Family Planning Case Studies Answer Key

1. A 20-year-old woman is 2 week postpartum after giving birth to her first child. She is generally healthy and is breastfeeding. She possibly wants more children.

What contraceptive methods can she initiate at this time?

**LAM, male and female condoms**

2. A 32-year-old woman is immediately postpartum after giving birth by caesarean section. This is her fourth healthy child. She is generally healthy and is planning to breastfeed.

What contraceptive methods can she initiate at this time?

**LAM, male and female condoms, copper IUCD (up to 48 hours postpartum or delay 4 weeks), female sterilisation (if discussed and consent given in advance) or vasectomy (if discussed and consent given in advance)**

3. A 23-year-old woman is 6 weeks postpartum after giving birth to her second child, who died soon after delivery. She had a difficult pregnancy and is not planning to have another child soon.

What contraceptive methods can she initiate at this time?

**She may be interested in a long-term method such as implants or copper IUCD. Other appropriate methods include injectables, COCs, and POPs. FAM and male and female condoms are also possibilities.**

4. A 26-year-old woman is 4 months postpartum after giving birth to her first child. She is breastfeeding, and both mother and child are healthy. She wants to postpone her next pregnancy for a few years.

What contraceptive methods can she initiate at this time?

**She may be interested in a long-term method such as implants or copper IUCD. Other appropriate methods include injectables, COCs, and POPs. FAM and male and female condoms are also possibilities.**

5. A 28-year-old woman is 2 weeks postpartum with her third child. She is breastfeeding but does not want to rely on LAM. She wants to use another method and feels strongly about not having more children.

What contraceptive methods can she initiate at this time?

**Since she wants no more children, she might be interested in female sterilisation (or vasectomy if she is in a stable relationship) if these permanent methods were discussed and consent given in advance. While vasectomy can be conducted at any time (with backup until it takes effect), she would need to wait until she is 6 week postpartum to undergo female sterilisation (and use a backup method in the interim). Also, long-term methods like IUCD and implants would be appropriate, but she would need to wait until she is 4 weeks postpartum to have an IUCD inserted and 6 weeks postpartum to get implants. At 6 weeks postpartum she could also initiate POPs or injectables. Until she is 4 weeks postpartum, however, the only methods she may use are male and female condoms.**

6. A 29-year-old woman experienced a first-trimester uncomplicated miscarriage 2 weeks ago. She would like to get pregnant again but wants to delay it for a few months.

What contraceptive methods can she initiate at this time?

**Male and female condoms, COCs, POPs, FAM**

7. A 36-year-old woman underwent a second-trimester abortion 1 week ago, complicated by an infection that has not yet completely resolved. She does not want any more children.

What contraceptive methods can she initiate at this time?

**Since she wants no more children, she might be interested in female sterilisation (or vasectomy if she is in a stable relationship) if these permanent methods were discussed and consent given in advance. While her partner could have a vasectomy at any time (with backup methods until it takes effect), she could undergo female sterilisation after the infection has resolved. Also, long-term methods like implants and an IUCD would be appropriate. She could have the IUCD inserted by a specially trained provider after the infection has resolved, but she could have implants inserted immediately. She could also immediately start using shorter-term methods like male and female condoms, injectables, or COCs. Fertility awareness methods probably would not be a good choice because she does not want any more children, and this method is less reliable than others. At any rate, she would need to wait until after the infection resolved to start symptoms based methods.**

# Postpartum and Postabortion Family Planning Quiz Questions

**Questions 1–5:** Indicate whether the following statements are **true** or **false** by writing a **“T”** for true or an **“F”** for false in the space provided before each statement.

1. It is difficult to predict with certainty when fertility will return after childbirth.
2. Breastfeeding alone usually protects a woman from becoming pregnant.
3. A postpartum woman’s fertility usually returns after her menses begin again.
4. Non-breastfeeding women may ovulate by 4 weeks after childbirth.
5. A postpartum woman should start using a family planning method immediately after her first monthly bleeding.

**Questions 6–11:** Circle the letter that offers the best response to each question.

6. Early postpartum is defined as:
  - a. The first 2 weeks after giving birth
  - b. The first 10 minutes after placenta delivery
  - c. From 48 hours after giving birth until the woman leaves facility
  - d. From 48 hours to 6 weeks after giving birth
  - e. From 6 weeks to 1 year after giving birth
7. What percent of women in the first year postpartum intend to use a family planning method, but are not yet doing so?
  - a. 25%
  - b. 45%
  - c. 55 %
  - d. 65%
  - e. 75%
8. Contraceptive options for a woman who is exclusively breastfeeding a 2-month-old baby include:
  - a. COCs
  - b. LAM
  - c. FAM
  - e. Copper-bearing IUCD
  - f. Sterilisation
  - g. LAM, IUCD, Sterilisation
  - h. All of the above
9. An IUCD may be inserted postpartum (circle all that apply):
  - a. Anytime within 48 hours of childbirth
  - b. Anytime within 4 days of childbirth
  - c. 2 weeks after childbirth or later
  - e. 4 weeks after childbirth or later

10. Postpartum contraception options for a woman at 3 weeks postpartum, who is HIV-infected, does not have AIDS, and is not breastfeeding include:
  - a. COCs
  - b. Progestin-only injectables
  - c. Contraceptive implants
  - d. Copper-bearing IUCD
  - e. Sterilisation
  - f. COCs, progestin-only injectables, and contraceptive implants
  - g. COCs, progestin-only injectables, contraceptive implants, and sterilisation
11. After a first-trimester abortion/miscarriage, fertility usually returns:
  - a. Within 2 days
  - b. Within 5 to 7 days
  - c. Within 7 days
  - d. Within 11 days
  - e. In 14 to 20 days
12. What is postpartum family planning?
13. Define unmet need for postpartum contraception:
14. List 3 key messages for postpartum contraceptive counselling:
15. Define postabortion family planning:
16. It is vitally important to integrate family planning services as a part of postabortion care because:
17. List 3 key messages of postabortion counselling:
18. What contraceptive methods can be started immediately after abortion?
19. Explain how infections or genital trauma affect choice or timing of postabortion contraceptive options:

## Postpartum and Postabortion Family Planning Quiz Questions Answer Key

- T 1. It is difficult to predict with certainty when fertility will return after childbirth.
- F 2. Breastfeeding alone usually protects a woman from becoming pregnant.
- F 3. A postpartum woman's fertility usually returns after her menses begin again.
- T 4. Non-breastfeeding women may ovulate by 4 weeks after childbirth.
- F 5. A postpartum woman should start using a family planning method immediately after her first monthly bleeding.
6. Early postpartum is defined as:  
**d. From 48 hours to 6 weeks after giving birth**
7. What percent of women in the first year postpartum intend to use a family planning method, but are not yet doing so?  
**d. 65%**
8. Contraceptive options for a woman who is exclusively breastfeeding a 2-month-old baby include:  
**f. LAM, IUCD, Sterilisation**
9. An IUCD may be inserted postpartum (tick all that apply):  
**a. Anytime within 48 hours of childbirth**  
**d. 4 weeks after childbirth or later**
10. Postpartum contraception options for a woman at 3 weeks postpartum, who is HIV-infected, does not have AIDS, and is not breastfeeding include:  
**f. COCs, progestin-only injectables, and contraceptive implants**
11. After a first-trimester abortion/miscarriage, fertility usually returns:  
**d. Within 11 days**
12. What is postpartum family planning?  
**The initiation and use of family planning methods following childbirth**
13. Define unmet need for postpartum contraception:  
**Non-use of contraception among married women of reproductive age who are able to become pregnant and would like to space or limit future pregnancies but are not currently using any method of contraception**
14. List 3 key messages for postpartum contraceptive counselling:  
**Any 3 of the following:**
- **Discuss health benefits to the mother and baby of waiting at least 24 months before trying to become pregnant again.**
  - **Discuss return to sexual activity and provide information about return to fertility.**
  - **Advise that mother can use the lactational amenorrhoea method (LAM), which is 99% effective when used correctly, if exclusively breastfeeding, menses has not returned, and the baby is less than 6 months old.**

- Offer and discuss options for family planning methods for postpartum women, as appropriate and according to the woman's wishes.

15. Define postabortion family planning:

**The initiation and use of family planning methods at the time of treatment for an abortion, or before fertility returns after an abortion (within 11-14 days after the abortion occurred)**

16. Including family planning services as a part of postabortion care is important because:

**Women who have experienced an abortion are more likely to use contraception to avoid unintended pregnancies if family planning services are available immediately following treatment for the abortion. Death due to unsafe abortions is a worldwide problem; providing family planning services as part of postabortion care could save lives and prevent trauma by reducing unintended pregnancies.**

17. List 3 key messages of postabortion counselling:

**Any 3 of the following:**

- Fertility returns quickly, within 11 days after a first-trimester abortion or miscarriage and within 4 weeks after a second-trimester abortion or miscarriage. Therefore, the woman needs protection from pregnancy almost immediately.
- She can choose from among many different family planning methods that she can start at once.
- She can wait before choosing a contraceptive for ongoing use, but she should consider using a backup method in the meantime if she has sex.
- To avoid infection, she should not have sex until bleeding stops—about 5 to 7 days.
- It is recommended that she wait at least 6 months before trying to become pregnant again.

18. What contraceptive methods can be started immediately after abortion?

- COCs
- Progestin-only pills
- Progestin-only injectables
- Contraceptive implants
- Male and female condoms
- Vasectomy
- (Delay IUCD, female sterilisation, and FAM until any infection is resolved or injury healed)

19. Explain how infections or genital trauma affect choice or timing of postabortion contraceptive options.

**Infections need to be treated and resolved, and genital trauma needs to heal before the woman can begin using FAM, have an IUCD inserted, or undergo female sterilisation.**

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# Unit 20

## FAMILY PLANNING AND SEXUALLY TRANSMITTED INFECTIONS INCLUDING HIV

### Learning Objectives

By the end of this unit, learners will be able to:

- ❖ Define sexually transmitted infections (STIs)
- ❖ Outline groups at risk for STI and cervical cancer
- ❖ Explain common symptoms that suggest possible STIs
- ❖ List the benefits of offering family planning to clients with STIs/ human immunodeficiency virus (HIV)
- ❖ Explore the range of family planning choices for clients with HIV and related issues
- ❖ List contraceptive methods available to women and couples with HIV
- ❖ Explain the reasons for using the dual protection strategy
- ❖ Describe how the presence of HIV, AIDS and the use of antiretroviral (ARV) therapy affects method eligibility
- ❖ Explain the concerns, theoretical or otherwise, related to the use of hormonal contraception among women with HIV, including those who are taking ARV drugs.

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### Key Points

- ❖ STIs are infectious diseases caused by bacteria and viruses spread through sexual contact.
- ❖ Family planning providers can play an important role in preventing the transmission of STIs, including HIV.
- ❖ Most family planning methods are appropriate for use by clients with STIs/HIV/AIDS.
- ❖ Condoms are the only family planning method proven to reduce the risk of STIs, including HIV.
- ❖ Dual protection, a strategy for protecting users against both unintended pregnancy and disease transmission, is particularly important for those at risk of STI/HIV.
- ❖ Clients with HIV, AIDS or who are on ARV therapy can initiate and continue use of most family planning methods.

### 20.1 Defining Sexually Transmitted Infections

STIs, including infection with the HIV, are infectious diseases affecting men and women caused by bacteria and viruses spread through sexual contact.

#### Groups at risk for STIs

- Adolescents
- Individuals with multiple partners
- Individuals whose partners have multiple partners
- Individuals involved in unprotected sex
- Mobile workers
- Sex workers
- Migrant populations.

#### Sexual behaviours that can increase exposure to STIs include

- Sex with a partner who has STI symptoms
- Sex with a partner who has recently been diagnosed with or treated for an STI
- Sex with more than one partner—the more partners, the more risk
- Sex with a partner who has sex with others and does not always use condoms
- Where many people in the community are infected with STIs, sex without a condom may be risky with almost any new partner.

## 20.2 STI Detection

Early identification of STIs is not always possible; however, it is important both to avoid passing on the infection to others and to avoid more serious long-term health consequences. To help detect STIs early, a provider can:

- Ask whether the client or the client’s partner has genital sores or unusual discharge
- Look for signs of STIs when doing a pelvic or genital examination for another reason
- Know how to advise a client who may have an STI
- Promptly diagnose and treat if the client has STI signs or symptoms, or else refer for appropriate care
- Advise clients to notice genital sores, warts, or unusual discharge on themselves or on their sexual partners.

Table 20.1: Common Signs and Symptoms of STIs

Symptoms	Suggested STI
Discharge from the penis—pus, clear or yellow-green drip	Commonly: Chlamydia, gonorrhoea Sometimes: Trichomoniasis
Abnormal vaginal bleeding or bleeding after sex	Chlamydia, gonorrhoea, pelvic inflammatory disease
Burning or pain during urination	Chlamydia, gonorrhoea, herpes
Lower abdominal pain or pain during sex	Chlamydia, gonorrhoea, pelvic inflammatory disease
Swollen and/or painful testicles	Chlamydia, gonorrhoea
Itching or tingling in the genital area	Commonly: Trichomoniasis Sometimes: Herpes
Blisters or sores on the genitals, anus, surrounding areas, or mouth	Herpes, syphilis, Chancroid
Warts on the genitals, anus, or surrounding areas	Human papillomavirus
Unusual vaginal discharge—changes from normal vaginal discharge in colour, consistency, amount, and/or odour	Most commonly: Bacterial vaginosis, candidiasis (not STIs) Commonly: Trichomoniasis Sometimes: Chlamydia, gonorrhoea

(WHO/RHR and CCP/Knowledge for Health Project 2008)

### Cervical cancer

Cervical cancer is caused by certain types of human papillomavirus (HPV). HPV is a common STI that usually clears up on its own without treatment but sometimes persists.

### **Persons at risk for cervical cancer include persons who:**

- Had first sex before age of 18
- Have many sexual partners now or over the years
- Have a sexual partner who has or has had many other sexual partners
- Had many births (the more births, the greater the risk)
- Smoke cigarettes
- Have a weak immune system (includes women with HIV/AIDS)
- Burn wood indoors (as for cooking)
- Have had other sexually transmitted infections
- Have used combined oral contraceptives (COCs) for more than 5 years.
- (WHO/RHR and CCP/Knowledge for Health Project 2008)

### **HIV/AIDS**

HIV is the **human immunodeficiency virus** that causes **acquired immunodeficiency syndrome (AIDS)**, a disease in which the body's immune system breaks down and is unable to fight off certain infections, known as opportunistic infections, and other illnesses that take advantage of a weakened immune system. One of the ways HIV is transmitted is through the exchange of bodily fluids (blood, semen, and vaginal secretions) during sexual contact.

## **20.3 Integrating Family Planning and STI/HIV Services**

For a long time STIs/HIV and cervical cancer were not comprehensively addressed in family planning clinics. However, family planning providers can assist their clients to prevent the acquisition of STIs, HIV, and cervical cancer; prevent the transmission of STI/HIV; and decrease the likelihood of HIV infection in children. Likewise, providing integrated reproductive health services—that include family planning counseling and access to contraception—to women and couples with HIV can improve their lives and those of their families.

### **Benefits of providing family planning services for women and couples with HIV**

- Improves health and well-being of families and communities (spacing/limiting births)
- Prevents unintended pregnancies, thus reducing the number of:
  - Women with pregnancy complications due to HIV
  - Infants born HIV-positive
  - Orphans.

### **The role of a family planning service provider in offering STI/HIV services**

- Thoroughly screen family planning clients for STIs and cervical cancer.
- Provide information on the following:
  - Mode of transmission of STIs
  - STIs/HIV testing and counseling
  - Dual protection (see next page)
  - Prevention of mother-to-child transmission (PMTCT) for HIV-positive women.
- Conduct STI/HIV and reproductive health risk assessment.
- Offer counselling on HIV testing.

- Counsel clients appropriately regarding the following risky traditional and cultural beliefs and practices:
  - Multiple sexual partners, including polygamy
  - Wife/husband inheritance
  - Initiation rituals/practice of hiring a man for sex and conception (fisi)
  - Sexual cleansing rituals (kusasa fumbi)
  - Death rituals (kupita kufa)
  - Insertion of herbs into the vagina for dry sex
  - Prolonged postpartum abstinence which predisposes a man to promiscuity
  - Traditional treatment of vulva/vaginal warts and hemorrhoids (e.g. by cutting)
  - Traditional healer practices such as sexual intercourse with the healer as a cure for infertility.
- Provide STIs/HIV and related services
 

<ul style="list-style-type: none"> <li>Education</li> <li>Behaviour change communication</li> <li>Counselling</li> <li>Testing</li> <li>Treatment of opportunistic infections and other associated conditions</li> </ul>	<ul style="list-style-type: none"> <li>Social support</li> <li>Nutritional counselling</li> <li>Home-based care</li> <li>ARV therapy</li> <li>Palliative care</li> </ul>
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- Treat patients syndromically following the flowcharts in the **Malawi STI Management Guidelines**.
- Help clients to choose suitable contraceptive methods according to the World Health Organization's (WHO) medical eligibility criteria (MEC).

## 20.4 Family Planning Choices for Clients with HIV

Women with HIV and their partners often need to make a variety of reproductive health decisions about pregnancy, childbearing, and contraceptive practice. They should be free to make these reproductive choices for themselves, just as other women and couples do. However, being HIV-positive may make women more vulnerable to societal, religious, or family pressures than women without HIV. Counsellors must take special care to ensure that women with HIV do not feel coerced or pressured into making certain reproductive choices.

Many sexually active women with HIV might not want to bear children and therefore desire contraception, for the same reasons as those of women who are not HIV-positive. In addition, an HIV-positive woman might have additional reasons, such as:

- Concern that pregnancy will further compromise her health (Note that pregnancy does not alter disease progression in women with HIV)
- Fear of transmitting HIV to children she might conceive
- Fear of leaving orphans
- Fear that others will be unwilling to care for the family during illness due to AIDS-related stigma and discrimination.

Contraceptive options for women with HIV are similar to those of women without HIV and include barrier methods, hormonal methods, the IUCD, female and male sterilisation, the lactational amenorrhoea method (LAM), and fertility awareness-based methods (FAM).

Condoms are the only method proven to reduce the risk of all STIs, including HIV. Condoms are most effective in preventing STIs that are transmitted through bodily fluids, such as HIV, gonorrhoea, and chlamydia. They are less effective against STIs that are transmitted through skin-to-skin contact, such as genital herpes and warts.

## 20.5 Dual Protection

Dual protection is a strategy that protects clients from *both* unintended pregnancy *and* STI/HIV infection/re-infection. Possible strategies include:

- Use condoms alone (male or female) consistently and correctly, with emergency contraception for pregnancy prevention should a condom accident occur
- Use male or female condoms plus another contraceptive method for added protection against pregnancy (*dual method use*)
- Maintain a *closed sexual relationship* (no other sexual partners) between uninfected partners combined with a contraceptive method
- Engage in other satisfying but safe forms of intimacy (actions that avoid contact with a partner’s semen or vaginal secretions)
- Avoid unprotected penetrative sex (abstinence) and delay sexual debut.

For clients with HIV, use of a dual method is encouraged to reduce HIV transmission. Dual method use may not be easy to achieve. Providers need to help these clients understand the benefits of dual method use by considering the following:

- The limitations of a single-method approach
- Their individual risk of pregnancy and the implications of an unintended pregnancy
- Whether their partners have HIV or another STI
- The negative consequences of acquiring or transmitting HIV, especially as resistant strains of the virus emerge.

It is also important for providers to teach skills for negotiating condom use and the correct use of condoms. (See Unit 17: Barrier Methods.)

(WHO/RHR and CCP/Knowledge for Health Project 2008)

## 20.6 Family Planning Considerations for Clients with STIs, HIV, AIDS or on Antiretroviral Therapy

Clients with STIs, HIV, AIDS, or on ARV therapy can start and continue to use most contraceptive methods safely. However there are a few limitations:

Table 20.2: Special Considerations for Clients with STIs, HIV, AIDS or on Antiretroviral Therapy

Method	Has STIs	Has HIV or AIDS	On Antiretroviral (ARV) Therapy
<b>Intrauterine contraceptive device</b>	Do not insert an IUCD into a woman who is at very high individual risk for gonorrhoea and chlamydia, or who currently has gonorrhoea, chlamydia,	A woman with HIV can have an IUCD inserted. A woman with AIDS should not have an IUCD inserted unless she is clinically well on ARV therapy.	Do not insert an IUCD if client is not clinically well.

Method	Has STIs	Has HIV or AIDS	On Antiretroviral (ARV) Therapy
	purulent cervicitis, or pelvic inflammatory disease (PID). A current IUCD user who becomes infected with gonorrhea or chlamydia or develops PID can safely continue using an IUCD during and after treatment.	A woman who develops AIDS while using an IUCD can safely continue using the IUCD.	
<b>Female sterilisation</b>	If client has gonorrhea, chlamydia, purulent cervicitis, or PID, delay sterilisation until the condition is treated and cured.	Women who are infected with HIV, have AIDS, or are on ARV therapy can safely undergo female sterilisation. Special arrangements are needed to perform female sterilisation on a woman with AIDS. Delay the procedure if she is currently ill with AIDS-related illness.	
<b>Vasectomy</b>	If client has scrotal skin infection, active STI, swollen, tender tip of penis, sperm ducts, or testicles, delay sterilisation until the condition is treated and cured.	Men who are infected with HIV, have AIDS, or are on ARV therapy can safely undergo vasectomy. Special arrangements are needed to perform vasectomy on a man with AIDS. Delay the procedure if he is currently ill with AIDS-related illness.	
<b>Hormonal methods</b> (combined oral contraceptives, progestin-only pills, progestin-only injectables, implants)	Can safely use any hormonal method.	Can safely use any hormonal method, unless she is on ARV therapy that includes a ritonavir-boosted protease inhibitor. (See column to right. →)  Except if she is taking antituberculosis antibiotics, <b>rifampicin</b> or <b>rifabutin</b> . Co-infection with tuberculosis is common among patients with HIV, and these antibiotics speed up the metabolism of contraceptive hormones, reducing the effectiveness of oral contraceptives.	If her ARV therapy includes a <b>ritonavir</b> -boosted protease inhibitor, she generally should not use COCs or POPs (MEC category 3). This type of ARV may make these methods less effective. She can use progestin-only injectables (MEC Category 1) or implants (MEC Category 2). Women whose ARV therapy does not include a ritonavir-boosted protease inhibitor can use any hormonal method.
<b>LAM</b>	Can safely use LAM.	Can safely use LAM although there is a risk ( $\approx 16\%$ ) of HIV transmission to the infant through breast milk. However, exclusive breastfeeding is still recommended unless	Can safely use LAM. ARV therapy during the first weeks of breastfeeding may reduce the risk of HIV transmission.

Method	Has STIs	Has HIV or AIDS	On Antiretroviral (ARV) Therapy
		replacement feeding is acceptable, feasible, affordable, sustainable and safe.	
<b>FAM</b>	Can safely use FAM	Can safely use FAM	Can safely use FAM

(WHO/RHR and CCP/Knowledge for Health Project 2008)

## Contraceptive methods for clients living with HIV

### IUCD

Current evidence suggests that IUCDs do not increase HIV transmission. The following situations are classified as WHO MEC Category 2 (can generally use):

- An IUCD can be provided to a woman with HIV if she has no symptoms of AIDS.
- A woman who developed AIDS while using an IUCD can continue to use the device.
- A woman with AIDS who is clinically well on ARV therapy—meaning that the symptoms of AIDS are controlled by the ARVs—can both initiate and continue IUCD use.
- IUCD initiation is generally not recommended in women who already have AIDS (MEC Category 3) because of the theoretical risk that advanced immunosuppression could increase the risk of IUCD-related complications.

### Sterilisation

For women and couples with HIV who have decided to have no more children, female or male sterilisation may be a good option.

- There are no medical reasons to deny sterilisation to clients with HIV.
- The procedure may be delayed in event of acute HIV-related infection.
- Encourage condom use to prevent STI/HIV transmission.

### Hormonal methods

- Do not protect against STI/HIV— dual methods should be promoted.
- They may increase the risk of acquiring cervical STI infections, which theoretically could increase risk of HIV transmission to a partner.
- Some antiretroviral drugs can affect blood levels of contraceptive hormones, so theoretically:
  - Reduced concentrations could reduce the effectiveness of hormonal contraceptives.
  - Increased concentrations could increase hormone-related side effects.
- Some hormonal contraceptives may affect the efficacy of some ARV drugs.

Most of the existing research examines the interaction between ARV drugs and combined oral contraceptives. Further research is needed about:

- Possible effects of hormonal contraception on HIV-positive women's infectivity
- Possible relationships between hormonal contraception and HIV disease progression.

It is important to balance concerns, which are primarily theoretical, against the real risk of unintended pregnancy and its impact on maternal and infant morbidity and mortality.

### **Injectables and implants**

These can be used without restriction (MEC Category 1) by women with HIV, who may or may not have AIDS, and women on any type of ARV regimen.

### **Emergency contraceptive pills**

- ECPs are safe and should be available to all women, including women with HIV or AIDS, or those on ARV therapy.
- Currently, no data are available on the extent and outcomes of interaction between emergency contraceptive regimens and ARV therapy.

### **Lactational amenorrhea method**

- It does not protect against STI/HIV—dual method should be promoted.
- Advise that infants can become infected (risk of acquisition through breast milk is about 16%).
- Exclusive breastfeeding during first six months reduces risk of acquisition by infant (compared to mixed feeding or partial breastfeeding), a recommendation which is also in line with the requirements of LAM.

### **Fertility awareness methods (FAM)**

Women who are HIV-positive who may or may not have AIDS and those on ARV therapy can use FAM without restriction; however:

- Women who want to use the Standard Days Method should have regular menstrual cycles.
- FAM provide no protection from STI and HIV transmission; thus, users should be encouraged to use condoms even on days when risk of pregnancy is low.
- Couples with HIV who do not want to have children may consider other, less client-dependent methods of contraception.



## Family Planning and STI/HIV Case Studies

### Case Study 1

Miss Lamba is a single woman, 25 years old, HIV-positive, with a six-week old baby. She is devoted to making sure her baby stays healthy. She decided not to breastfeed and is using formula. She is feeling well and enjoying being a first-time mother—spending many hours caring for her new infant. She wishes to use a family planning method to properly space her next pregnancy—she hopes to stay healthy and have at least 1 more child. She sometimes used condoms before. She does not live with the baby’s father, but she still sees him; she is also sure that he is seeing other women.

What family planning methods should she consider?

### Case Study 2

Esther is a 29-year-old mother. She works in a bar and sometimes has sex for money so she can feed her two children. She has come to the health centre to get medicine for a sore in her vagina. She does not use condoms because some men have threatened not to pay for sex if she insists on using a condom. She does not use contraception because her periods are not regular and she thinks she cannot get pregnant. She definitely does not want another child.

What contraceptive methods would be the most appropriate for her?

### Case Study 3

Lillian is a 32-year-old widow and mother of 5 children. Her youngest child is 2 years old. Lillian has come to the family planning clinic because she has recently started having sexual relations with an older man, but she has no plans to remarry. She does not wish to have more children. She has suffered from gonorrhoea in the past.

What forms of family planning should she consider?

# Answers to Family Planning and STI/HIV Case Studies

## Case Study 1

What family planning methods should she consider?

**Male or female condoms (dual protection or dual method use) recommended.**

In addition:

- **Long-term methods—implants, IUCD**
- **COCs**
- **DMPA**
- **FAM (after menses returns and periods are regular)**

## Case Study 2

What contraceptive methods would be the most appropriate for her?

**Female condoms (for dual protection or dual method use)**

In addition:

- **Long-term and permanent methods—implants, female sterilisation**
- **COCs**
- **DMPA**

## Case Study 3

What forms of family planning should she consider?

- **Long-term and permanent methods—implants, IUCD, female sterilisation (if no current STI)**
- **Male or female condoms (dual protection or dual method use)**
- **DMPA**
- **COCs**
- **FAM**

## Family Planning and STI/HIV Role plays

The following are role-play scenarios for family planning counselling with women and couples who are HIV-positive. Refer to the Counselling Unit for counselling steps and guidelines and to the Effective Teaching Appendix for how to conduct and observe role plays.

### Role Play 1

**Client:** You are a 20-year-old single student. You have been sexually active since you were 17, and you have been treated for chlamydia once. You have recently started a relationship with a man who has told you that he is HIV-positive. You have been using a condom during sex, but you want to make sure that you don't get pregnant.

**Provider:** Explain dual protection to your client and explore her contraceptive options.

### Role Play 2

**Client:** You are a 35-year-old man who has come to the clinic because your testicles are swollen, and you have noticed a discharge from your penis. You are not married, but are having occasional sexual relations with two women. The provider has just diagnosed and treated you for gonorrhoea and now wants to talk to you about family planning.

**Provider:** You have just diagnosed and prescribed a treatment to your client for gonorrhoea. Now turn the discussion to family planning and dual protection.

### Role Play 3

**Client:** You are a 22-year-old, HIV-positive teacher who is 8 months pregnant. Your husband, who works at a bank, is also HIV-positive and knows your status, and the two of you communicate well about HIV. Your husband's family does not know that you are HIV-positive. You are confused and nervous about passing HIV to your baby and about how you should feed the baby with the least risk of HIV transmission. You are also nervous about the family and neighbours finding out that you are HIV-positive because of your job as a school teacher. You both would like to have more children, but you understand the benefits of child spacing and would like to wait a few years.

**Provider:** Counsel this client about feeding her baby and family planning, and keep in mind the additional pressures HIV-positive women face when making family planning decisions.

### Role Play 4

**Client:** You are a 30-year-old woman with HIV who has just started ARV therapy (not a ritonavir-boosted protease inhibitor). You have been using COCs for 3 years, and you are very happy with them. When you were prescribed your ARV, the nurse told you that it would be safest to stop using the COCs and told you to see the family planning clinic. You don't want to change your contraceptive method, but you have come to the family planning clinic to find out more.

**Provider:** Answer the client's questions about ARVs and COCs and explore other options if the client is so inclined.

**Note to observer:** Make sure that the provider uses simple language to explain why the client should or should not change their contraceptive method.

## Family Planning and STI/HIV Quiz Questions

**Questions 1–11.** Indicate whether the following statements about infection prevention are **true** or **false** by writing a “T” for true or an “F” for false in the space provided before each statement.

1. All STIs are infectious diseases caused by viruses that are spread by sexual contact.
2. As a group, adolescents are at risk for STIs.
3. Early identification of STIs is important to avoid passing the infection to others and to avoid more serious long-term health consequences.
4. Women with HIV should not have children, so family planning counsellors should make sure that they use contraception.
5. Contraceptive options for women with HIV are similar to those of women without HIV and include barrier methods, hormonal methods, the IUCD, female sterilisation, LAM and FAM.
6. Male and female condoms are the only contraceptive methods proven to reduce the risk of STIs, including HIV.
7. A man with an active STI can undergo vasectomy.
8. Current evidence suggests that IUCDs do not increase HIV transmission.
9. In dual method use, people use condoms to prevent HIV or STI transmission plus an additional family planning method for increased pregnancy prevention.
10. Emergency contraceptive pills should NOT be used by women on ARV therapy.
11. The risk of an infant acquiring HIV through breast milk is about 80%.
12. One example of dual method use entails using the condom as the primary method for both STI and pregnancy prevention, with the use of emergency contraception as a backup if the condom is not used, breaks, or slips.

**Questions 13–16:** Circle the letter next to each answer that correctly responds to the statements or questions below. Note that one, two, or even all answers may be correct and, if so, should be circled.

13. All clients seeking family planning services have the right to:
  - a. Access information and services, free from any barriers
  - b. Choose from a variety of modern contraceptive methods
  - c. Be supported to make an informed, voluntary choice of contraceptive method
  - d. Receive the contraceptive method of their choice, even though they may not be medically eligible
  - e. Have a knowledgeable provider who will choose the contraceptive method that he or she considers to be the best choice for the client
14. Which of the following statements accurately describes the role that family planning service providers can play in caring for clients with STIs/HIV?
  - a. Provide information on the mode of transmission of STIs
  - b. Counsel clients about risky traditional and cultural beliefs and practices
  - c. Educate clients about harmful effects of pregnancy on HIV disease progression

- d. Treat patients syndromically for STIs/HIV following the Malawi STI Management guidelines
  - e. Help ensure that clients with HIV do not have children
15. Which of the following statements concerning the use of hormonal contraceptives by women who take ARV drugs are true?
- a. Research has proven that combined oral contraceptives do not affect the efficacy of ARV drugs.
  - b. Some ARV drugs reduce the blood levels of contraceptive hormones; lower blood levels could reduce the effectiveness of hormonal contraceptives.
  - c. Some ARV drugs increase the blood levels of contraceptive hormones; higher blood levels could increase the side effects of hormonal contraceptives.
  - d. Women who take ritonavir as part of their ARV therapy should not use any method of hormonal contraception.
16. Which of the following statements accurately summarizes the WHO MEC recommendations?
- a. There are no restrictions on the use of male or female condoms by clients with HIV/AIDS.
  - b. With the exception of ritonavir-boosted protease inhibitors, women on ARV drugs can use (MEC Category 1) or generally can use (MEC Category 2) COCs.
  - c. Injectables and implants are usually not recommended for women who are taking ARV therapy.
  - d. An IUCD can generally be inserted in a woman with HIV if she has no symptoms of AIDS.
  - e. A woman who develops AIDS while using an IUCD should have the IUCD removed.
  - f. There are no medical reasons to deny sterilisation to clients with HIV as long as they are not experiencing any acute AIDS-related illness, in which case the procedure should be delayed.
  - g. Women with HIV should never use the LAM because of the risk of transmitting the infection to the infant through breast milk.
  - h. Women with HIV and AIDS can use FAM without restrictions.

## Family Planning and STI/HIV Quiz Questions Answer Key

- F 1. All STIs are infectious diseases caused by viruses that are spread by sexual contact. ***STIs are caused by viruses and bacteria.***
- T 2. As a group, adolescents are at risk for STIs.
- T 3. Early identification of STIs is important to avoid passing the infection to others and to avoid more serious long-term health consequences.
- F 4. Women with HIV should not have children, so family planning counsellors should make sure that they use contraception. Women with HIV should be free to make these reproductive choices for themselves, just as other women and couples do. Counsellors must take special care to ensure that women with HIV do not feel coerced or pressured into making certain reproductive choices.
- T 5. Contraceptive options for women with HIV are similar to those of women without HIV and include barrier methods, hormonal methods, the IUCD, female sterilisation, LAM and FAM.
- T 6. Male and female condoms are the only contraceptive methods proven to reduce the risk of STIs, including HIV.
- F 7. A man with an active STI can undergo vasectomy. Sterilization should be delayed until the STI is treated and cured.
- T 8. Current evidence suggests that IUCDs do not increase HIV transmission.
- T 9. In dual method use, people use condoms to prevent HIV or STI transmission plus an additional family planning method for increased pregnancy prevention.
- F 10. Emergency contraceptive pills should NOT be used by women on ARV therapy. ***ECPs are safe and should be available to all women.***
- F 11. The risk of an infant acquiring HIV through breast milk is about 80%. ***The risk is about 16%.***
- T 12. One example of dual method use entails using the condom as the primary method for both STI and pregnancy prevention, with the use of emergency contraception as a backup if the condom is not used, breaks, or slips.
13. All clients seeking family planning services have the right to:
- Access information and services, free from any barriers**
  - Choose from a variety of modern contraceptive methods**
  - Be supported to make an informed, voluntary choice of contraceptive method**
14. Which of the following statements accurately describe the roles that family planning service providers can play in caring for clients with STIs/HIV?
- Provide information on the mode of transmission of STIs**
  - Counsel clients about risky traditional and cultural beliefs and practices**
  - Treat patients syndromically for STIs/HIV following the Malawi STI Management guidelines**

15. Which of the following statements concerning the use of hormonal contraceptives by women who take ARV drugs are true:
- b. Some ARV drugs reduce the blood levels of contraceptive hormones; lower blood levels could reduce the effectiveness of hormonal contraceptives.**
  - c. Some ARV drugs increase the blood levels of contraceptive hormones; higher blood levels could increase the side effects of hormonal contraceptives.**
16. Which of the following statements accurately summarizes the WHO MEC recommendations:
- a. There are no restrictions on the use of male or female condoms by clients with HIV/AIDS.**
  - b. With the exception of ritonavir-boosted protease inhibitors, women on ARV drugs can generally use COCs.**
  - d. An IUCD can generally be inserted in a woman with HIV if she has no symptoms of AIDS.**
  - f. There are no medical reasons to deny sterilisation to clients with HIV as long as they are not experiencing any acute AIDS-related illness, in which case the procedure should be delayed.**
  - h. Women with HIV and AIDS can use FAM without restrictions.**

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# Unit 21

## ADOLESCENTS AND FAMILY PLANNING

### Learning Objectives

By end of this unit, learners will be able to:

- ❖ Define adolescence
- ❖ Describe the physical, emotional, and social changes that occur in adolescents
- ❖ State the fertility rate for adolescents in Malawi
- ❖ Discuss the reproductive health knowledge and behaviours of adolescents in Malawi
- ❖ Explain the importance of family planning services for adolescents
- ❖ Describe strategies for reducing adolescent pregnancy rates and adverse health consequences of risky sexual behaviours
- ❖ Describe what adolescents need to know to choose and use family planning methods
- ❖ Explain how providers and policy makers can improve adolescents' access to family planning services
- ❖ Describe information for counselling adolescents
- ❖ Determine medical eligibility for adolescents
- ❖ Describe issues to consider when providing family planning methods to adolescents
- ❖ Demonstrate skills in family planning counselling for adolescents.

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## Unit 21: Adolescents and Family Planning

### Key Points

- ❖ All contraceptive methods are safe for adolescents.
- ❖ Adolescents in Malawi are at high risk for sexually transmitted infections (STIs), including HIV.
- ❖ Many youth do not have the information they need to avoid unsafe sexual behaviours.
- ❖ Nearly two-thirds of adolescent girls in Malawi have given birth by age 20.
- ❖ Misinformation about how pregnancy occurs is common.
- ❖ Most teenage boys in Malawi do not use condoms when having sexual intercourse.
- ❖ Fear and embarrassment keep some adolescents from seeking sexual and reproductive health care.
- ❖ Adolescents need nonjudgmental and respectful family planning services tailored to their situations.
- ❖ Unmarried and married youth often have different sexual and reproductive health needs.

### 21.1 Defining Adolescence

According to the United Nations, adolescents are individuals from ages 10 to 19 years of age. This age group poses special challenges for service providers because it is a very diverse population. There are married and unmarried adolescents, adolescents who are parents, and adolescents who are not yet physically mature enough to have children. Some adolescents are sexually active by choice; some adolescents are sexually active but not by choice; and other adolescents are not yet sexually active. Many adolescents are in school, and many are not in school. Because of this diversity, different groups of adolescents are likely to have different concerns and needs.

### 21.2 Adolescent Sexual Activity in Malawi

Numerous studies have shown that large numbers of Malawian adolescents are sexually active. A 2007 Malawi survey that gathered information about adolescents' reproductive health knowledge and behaviour found that, among 15–19-year-olds, 26% of females and 49% of males are unmarried and sexually active. Among 20–24-year-olds, 16% of females and 9% of males had had sexual intercourse by age 15, and by age 20, 79% of females and 74% of males had had sex.

Other findings of the survey include:

- Male condoms are the most commonly used contraceptive method among adolescents in Malawi. Among those who have used a method, 40% of females and nearly all males have used a male condom.

- However, most adolescent males in Malawi did not use a male condom the last time they had sexual intercourse. Among 12–19-year-old males who had sex in the previous year, 57% had one sexual partner and did not use a condom at last sex; 8% had two or more partners and did not use a condom at last sex.
- Nearly 40% of adolescents in Malawi do not know of any place to obtain contraceptive methods.
- 10% of 15–19-year-old women report having been physically forced or threatened into having sexual intercourse at some point.
- Transactional sex is common among youth who have had sex with someone other than a spouse in the past year; 80% of females and 9% of males have received something in exchange.
- Sixty-three percent of women aged 20 have had a child. Among them, 18% wanted the child later, and 15% did not want to have a child at all.

(Wittenberg, Jonathan, Alister Munthali, Ann Moore et al. 2007)

### Fertility rate of adolescents in Malawi

The average age of first sexual intercourse in Malawi, for both boys and girls, is 17 years (Population Reference Bureau 2010). Malawi's adolescent fertility rate, defined as the number of births per 1,000 women aged 15-19, was 178 for the years 2000–2007, one of the highest in the world (World Health Organization Statistical Information System 2009).

As a result of not using or having access to effective contraception, many adolescents in Malawi are at risk of having unintended pregnancies and consequently are also at risk of unsafe abortion and obstetrical complications.

- According to the 2004 Demographic and Health Surveys report, only 16.6% of currently married Malawian women aged 15-19 are currently using a modern contraceptive method.
- For women aged 20-24, this figure rises somewhat to 25.4%. By far, the most common method used by these women is DMPA.

### Risk of STIs/HIV

Adolescents tend to engage in unpredictable or risky behaviours, motivated by convenience and the need to assert their independence and be accepted by their peers. This can put adolescents at risk not only for unintended pregnancy but also for STIs, including HIV. This is particularly a problem for adolescent girls who tend to have less power in their relationships than do their male peers.

- According to the 2008 report of the Joint United Nations Programme on HIV and AIDS (UNAIDS), Malawian women aged 15–24 years have an HIV prevalence rate of 8.4%. This rate in men of the same age is only 2.4%.

## 21.3 Importance of Family Planning for Adolescents

As these data indicate, many adolescents in Malawi need clear and accurate family planning information and counselling as well as access to safe and effective contraceptive methods. Providing these services will help adolescents improve their health and well-being and reduce the adverse consequences of risky behaviours. These consequences include:

- **Medical:** Unsafe abortion; STIs and HIV infections; risk of mother-to-child transmission of HIV if HIV-infected; infertility; nutritional deficiencies; obstetrical complications; death
- **Psychological:** Truancy, depression and suicidal tendencies

- **Social:** Early marriages, poor education as a result of dropping out of school
- **Economic:** Unemployment; prostitution; low-wage jobs, inability to afford and provide basic amenities for self and child.

(Ministry of Health 2007)

## 21.4 Strategies for Reducing Adolescent Pregnancy and Risk of STI/HIV Infection

Improving the health and well-being of adolescents, reducing their pregnancy rates and reducing the adverse health consequences noted above require a three-part strategy:

- 1. Providing adolescents with the information and understanding they need to avoid unsafe behaviours and use family planning methods**
- 2. Increasing adolescents' access to family planning services**
- 3. Providing adolescents with effective, "youth-friendly" family planning counselling.**

## 21.5 What Adolescents Need to Know

Adolescents need to know that their bodies are capable of reproduction. Girls can get pregnant even before their menstrual periods become regular, and most girls usually begin menstruating between the ages of 9 and 16.

Many adolescent girls believe they cannot get pregnant until they have had intercourse several times. Many boys believe this, too. Therefore, adolescents need to know that each and every act of unprotected sex represents the possibility for pregnancy and/or acquiring an STI or HIV.

Adolescents need to know:

- That there are safe and effective methods for preventing pregnancy, STIs, and HIV/AIDS, and where to obtain these methods
- That these methods are available to them and that they are not required to have parental or spousal consent to receive a contraceptive method
- Ways to say no to unwanted sexual advances or to negotiate with a partner about condom use
- How to resist peer pressure and establish relationships that are healthy and respectful of themselves and of their partners
- The potential consequences of irresponsible sexual behaviour, including the consequences of unwanted pregnancies, unsafe abortion, STIs, and HIV/AIDS
- How to protect themselves from STIs and HIV/AIDS
- Basic, accurate information about their sexuality, how their reproductive organs function, and how family planning methods work, including simple and clear information about the menstrual cycle and when a female can become pregnant
- Information about emergency contraceptive pills (ECPs) and where to obtain them.

This information should be offered during family planning counselling, during the provision of other health care services, and in as many other situations and activities as possible. For example:

- Offer life-skills education and counselling on sexuality and nutrition during youth outreach and recreational activities

- Provide family life education to young people, both in and out of school, before they begin sexual activity
- Promote peer-to-peer youth education
- Educate parents about adolescents' problems and needs and how the parents can assist their adolescent children.

## 21.6 Improving Adolescents' Access to Family Planning Services

Improving adolescents' access to family planning services involves coordinated efforts by family planning providers, family planning service managers, and local and national health officials. Strategies include:

- Training providers to offer "youth-friendly" counselling (see Section 21.7)
- Dedicating special areas of family planning clinics for adolescents, to help ensure privacy
- Using outreach and mobile clinics with staff trained to respond to adolescents' needs
- Offering clinic hours convenient for youth, such as after school and during weekends
- Locating services in convenient, safe areas
- Educating community-based contraceptive distributors and primary health workers (extension workers) about adolescents' challenges and needs and how they can assist them appropriately
- Offering youth a full range of family planning services, including ECPs and STI/HIV counselling and testing
- Providing psychosocial support and education about rape and harmful sexual practices and beliefs, such as ritual sexual cleansing
- Strengthening policies related to adolescent reproductive health services
- Obtaining political and community acceptance and support
- Offering services free or at low cost.

## 21.7 Tips for Effective, Youth-Friendly Counselling

The process used in effective counselling is the same for both adolescents and adults. However, often adolescents face different reproductive health issues and have different family planning needs than older clients. Counselling young adults requires being even more open, more flexible, more knowledgeable, and more understanding. Making a good connection with young people also requires specific knowledge of their needs and a greater willingness to be honest and to respect them as clients who need to make informed choices. It is especially important to show that you are listening, ask appropriate questions and not criticise.

Tips for providing effective, “youth-friendly” family planning counselling include:

- Show young people that you enjoy working with them.
- Develop a relationship that is based on respect for him or her as an individual.
- Counsel in private areas where you cannot be seen or overheard. Assure the client of confidentiality.
- Use simple language. Avoid terms such as “family planning,” which may seem irrelevant to youth who are not married.
- Help clients believe that they have some control over their own lives and that they can make their own decisions, act on those decisions, and evaluate the consequences.
- Pay close attention to non-verbal cues—those subtle behaviours that often say as much or more as the words we use.
- Speak without expressing judgment. For example, say, “You can” rather than “You should.” Do not criticise, even if you do not approve of what the young person is saying or doing.
- Make sure that a young woman’s choices are her own and not the result of pressure from her partner or her family. In particular, if she is being pressured to have sex and does not want to, help her think about what she can say and do to resist that pressure. Practice skills to negotiate condom use.
- Pay close attention to peer interaction when in a group education session and note for follow-up when peer pressure may be affecting an individual’s participation or responses.
- Help adolescent clients examine available alternatives and make positive changes by encouraging them to talk through possible courses of action and the consequences of those actions.
- Take time to fully address questions, fears and misinformation about sex, STIs, and contraception. Many youth 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.



(Photo: Helen Hawkings, courtesy of Photoshare)

(WHO/RHR and CCP, Knowledge for Health Project 2008, and Kiplinger, N. 1999)

## 21.8 Medical Eligibility Criteria for Adolescents

**All contraceptive methods are safe for adolescents.**

## 21.9 Adolescent Contraception

Adolescents are **medically eligible to use any method of contraception and must have access to a variety of contraceptive choices**. Age alone does not constitute a medical reason for denying any method to adolescents. While some concerns have been expressed regarding adolescents' use of certain contraceptive methods (such as DMPA by youth under 18), these concerns must be balanced against the advantages of avoiding pregnancy.

Social and behavioural issues should be important considerations in the choice of contraceptive methods by adolescents.

- In some settings, adolescents may be at increased risk for STIs, including HIV.
- Methods that do not require a daily regimen may be preferred by some adolescents.
- Adolescents have been shown to be generally less tolerant of side effects than older adults, which is one reason why adolescents have higher discontinuation rates.
- Method choice may also be influenced by factors such as sporadic patterns of intercourse and the need to conceal sexual activity and contraceptive use.

Expanding the number of method choices offered can lead to improved satisfaction, increased acceptance and increased prevalence of contraceptive use. Proper education and counselling both before and at the time of method selection can help adolescents make informed and voluntary decisions. (WHO/RHR 2004)

### Considerations for specific contraceptive methods

#### Hormonal contraceptives (oral contraceptives, injectables and implants)

- Injectables can be used without others knowing.
- Some young women find regular pill-taking difficult.

#### Emergency contraceptive pills

- Young women may have less control than older women over having sex and using contraception. They may need ECPs more often.
- ECPs can be provided in advance, for use when needed. ECPs can be used whenever a client has unprotected sexual intercourse, including sex against her will, or after contraceptive failure.

#### Male and female condoms

- They protect against both STIs and pregnancy, which many young people need.
- They are readily available, 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 contraceptive devices (IUCDs)

- IUCDs are more likely to come out among women who have not given birth because their uteruses are small, although this is not a reason to deny them to young women.

#### Female sterilisation and vasectomy

- These should be provided with great caution since young people are among those most likely to regret sterilisation. However, there is no medical reason to deny these methods.

## Adolescents and Family Planning Case Study

### **Situation**

Chifundo is a 17-year-old school girl with a 1-year-old child. Her parents are supporting her because the father of the child refused to marry her. She has recently started being sexually active again and is frightened that she might get pregnant for a second time. She comes to the family planning clinic seeking help.

### **Questions**

1. What information would you cover during family planning counselling?
2. What contraceptive methods would be suitable for this client?
3. What specific behavioural issues can be addressed during counselling?

# Adolescents and Family Planning Case Study Answer Key

## Questions about case study

1. What information would you cover during family planning counselling?
  - **That there are safe and effective methods for preventing pregnancy, STIs and HIV/AIDS and where to obtain them**
  - **That these methods are available to her and that parental consent is not needed to receive a family planning method**
  - **Ways to say no to unwanted sexual advances or to negotiate with a partner about condom use**
  - **How to resist peer pressure and establish relationships that are healthy and respectful of themselves and of their partners**
  - **The potential consequences of irresponsible sexual behaviour, including the consequences of unwanted pregnancies, unsafe abortion, STIs, and HIV/AIDS**
  - **How to protect herself from STIs and HIV/AIDS**
  - **Basic, accurate information about her sexuality, how her reproductive organs function, how family planning methods work, including simple and clear information about the menstrual cycle and when she can become pregnant**
  - **Information about ECPs and how to obtain them.**
  
2. What contraceptive methods would be suitable for this client?

**She is medically eligible for any method. However, some methods might be more appropriate than others. If she does not want to become pregnant again for at least 2 years, a long-term method (implant, IUCD) might be preferable. Male or female condoms may be appropriate for dual protection. Other methods could be DMPA, combined oral contraceptives (COCs) or fertility awareness methods (FAM).**
  
3. What specific behavioural issues can be addressed during counselling?
  - **In some settings, adolescents may be at increased risk for STIs, including HIV.**
  - **Methods that do not require a daily regimen may be preferable.**
  - **Adolescents have been shown to be less tolerant of side effects than older adults, one reason why they have higher discontinuation rates.**
  - **Method choice may be influenced by factors such as sporadic patterns of intercourse and the need to conceal sexual activity and contraceptive use.**



# Adolescents and Family Planning Role Plays

**Note:** See Unit 5: Family Planning Counselling, for the steps of a family planning counselling session and the Effective Teaching Appendix for guidelines about conducting role plays.

## Role Play 1: Seeking Family Planning

### Participant roles

**Provider:** You are an experienced family planning service provider. You do not, however, believe that adolescents should use any family planning method other than condoms, even though national policies state that adolescents may use any method.

**Client:** You are a 16-year-old girl. You and your boyfriend recently became sexually active. You have tried to use male condoms, but the boyfriend doesn't like them, and neither of you really know how to use them.

You go to the clinic looking for another family planning method because you are afraid of getting pregnant. Several of your friends are using oral contraceptives, and they haven't gotten pregnant yet, even though they sometimes forget to take the pills. You think pills would be good for you too, but you are nervous and ill at ease.

### Focus of the role play

The focus of the role play is on the interaction between the clinician and the client. The clinician needs to assess the client's knowledge and understanding of family planning, specifically COCs and condom use. She needs to assess the appropriateness of these methods for the client.

### Discussion questions

1. How did the service provider approach the client? How did personal biases affect this interaction?
2. How did the client respond to the service provider?
3. Did the service provider help the client to make the best decision for her? Did she provide the client with all the information she needed?
4. How might the service provider improve her interaction with the client?

## Role Play 2: Family Planning Counselling for Adolescents

### Participant roles

**Provider:** You are an experienced family planning service provider who often counsels adolescents. You are seeing a client who has come to the regular service for abdominal pains. You cannot find a physical cause for these pains. The girl is very anxious about something, and this may be the cause of the pain.

**Client:** You are a 13-year-old girl. You have come to the clinic because you told your mother you had bad stomach pains and couldn't go to school. You are very anxious. A 20-year-old neighbour said he likes you and offered to take you for a ride on his motorcycle. The boy's offer made you feel proud and big, but you are scared because your older sister died in childbirth after becoming pregnant at age 15, and you have heard rumours that you might get pregnant if you are alone with a boy. Your mother won't talk about sex and only tells you that "boys are bad." You haven't told anyone about what the boy said. You decide to confide in the provider.

### Focus of the role play

The focus of the role play is on how the provider can explain in simple terms the information the girl needs to know about her body, how girls get pregnant, the potential consequences of unprotected sex, the availability of family planning, as well as the girl's feelings and concerns about her changing body, about sex, and about how to handle pressure to have sex.

### Observer

Note the way that the provider counsels the client. Does the provider:

- Help the client explore her feelings?
- Offer encouragement?
- Use active listening skills?
- Speak without expressing judgement?
- Help the client take control of her body and her sexuality?
- Provide information in a way that the client can fully understand?
- Answer questions fully?

### Discussion questions

#### For provider:

1. What was the most difficult part of playing the role?
2. What would you like to have done better?

#### For client:

1. What did the provider do that made sharing your story easier?
2. What did the provider do that made you want to come back if you needed more services?
3. What did the provider do that made you feel uncomfortable or unwelcome?

## Role Play 3: Seeking Family Planning

### Participant roles

**Provider:** You are an experienced family planning service provider.

**Client:** You are a 17-year-old girl. You have a new boyfriend with whom you are sexually active. You want to have a baby, but you want to wait until your boyfriend gets a job and can support you and the baby. You go to the clinic for a family planning method.

### Focus of the role play

The focus of the role play is on the interaction between the clinician and the client. The clinician needs to assess the client's knowledge and understanding of how her body functions, pregnancy, and family planning. She needs to help the client explore methods and assess the appropriateness of these methods for the client.

### Discussion questions

1. How did the service provider interact with the client?
2. How did the client respond to the service provider?
3. Did the provider give the client all the information she needed?
4. Did the service provider help the client to make the best decision for her?
5. How might the service provider improve her interaction with the client?

# Adolescents and Family Planning Small Group Activity - Brainstorming

## Instructions

1. Divide the class into groups to brainstorm about different aspects of providing “youth-friendly” family planning services. Give each group flip chart paper to record their responses. Assign one of the topics below to each group (or assign topics you have created), ask them to pick a recorder, and give them 10–15 minutes to work.
2. Reunite the class and have each group present their findings. Allow time for input and discussion from other students.
3. Summarise findings and remind students that providing adolescents with effective, youth-friendly family planning services is one of the key strategies for reducing adolescent pregnancy and adolescents’ risk of STI/HIV infection.

## Suggested topics for brainstorming

- Create a youth-friendly lexicon: What simple terms can be used to discuss sexuality and family planning with young people (terms for menstruation, male and female anatomy, contraception, STI, HIV, condom, etc.)
- Myth busters: Identify common myths and misunderstandings that adolescents may have about sex and family planning. Write a list of myths in one column and how providers can respond to those myths in a second column.
- Be a youth-friendly provider: Make a list of “dos” and “don’ts” for the way providers should talk and behave in order to be a youth-friendly provider.
- Message maker: What are the most important messages to pass on to adolescents about their sexuality and family planning? Are there some messages just for girls? Are there some messages just for boys? What opportunities exist, or can be created, outside of the family planning clinic, for delivering these messages to adolescents?

## Adolescents and Family Planning Quiz Questions

**Questions 1–14.** Indicate whether the following statements about adolescents are **true** or **false** by writing a **“T”** for true or an **“F”** for false in the space provided before each statement.

1. Adolescents are defined by the United Nations as individuals from ages 10 to 19.
  2. According to a 2007 study, most males ages 12-19 in Malawi use condoms regularly.
  3. Nearly 40% of adolescents in Malawi do not know where to obtain contraceptive methods.
  4. Adolescent males in Malawi are at greater risk of STIs and HIV than adolescent females because males have more partners.
  5. Girls can get pregnant before their menstrual periods become regular.
  6. Most adolescents understand that a girl can get pregnant the first time she has sex.
  7. Adolescents need to know that contraceptive methods are available to them, and they do not require parental or spousal consent.
  8. Because of privacy issues, providers should only offer family planning counselling to adolescents when they are at the family planning clinic.
  9. Malawi’s adolescent fertility rate from 2000-2007, defined as the number of births per 1,000 women aged 15-19, was 178—one of the highest in the world.
  10. An adolescent will pay closer attention to what a provider says if the provider criticises the client’s risky sexual behaviour.
  11. All contraceptive methods are safe for adolescents.
  12. Adolescents have been shown to be more tolerant of side effects than older adults and can therefore easily tolerate any contraceptive method.
  13. Young women should be provided with ECPs in advance, for use when needed.
  14. Young men may be less successful than older men at using condoms correctly.
15. Why is it important to offer family planning services to adolescents?
16. List three strategies to improve adolescent access to family planning services:

17. List three tips for providing effective, youth-friendly family planning counselling:

18. List two social or behavioural issues that should be considered when adolescents choose contraceptive methods:

# Adolescents and Family Planning Quiz Questions

## Answer Key

- T 1. Adolescents are defined by the United Nations as individuals from ages 10 to 19.
- F 2. According to a 2007 study, most males ages 12-19 in Malawi use condoms regularly. ***The majority of males reported not having used a condom at last sex.***
- T 3. Nearly 40% of adolescents in Malawi do not know where to obtain contraceptive methods.
- F 4. Adolescent males in Malawi are at greater risk of STIs and HIV than adolescent females because males have more partners. STIs/HIV are more of a problem for girls who have less power in their relationships than do boys. The rate of HIV among adolescent females in Malawi is almost 3 times higher than the rate among adolescent males.
- T 5. Girls can get pregnant before their menstrual periods become regular.
- F 6. Most adolescents understand that a girl can get pregnant the first time she has sex. Many believe that girls cannot get pregnant until they have had intercourse several times.
- T 7. Adolescents need to know that contraceptive methods are available to them and they do not require parental or spousal consent.
- F 8. Because of privacy issues, providers should only offer family planning counselling to adolescents when they are at the family planning clinic. ***Offer family planning counselling when providing other health care services for youth and in as many other situations and activities as possible.***
- T 9. Malawi's adolescent fertility rate from 2000-2007, defined as the number of births per 1000 women aged 15-19, was 178—one of the highest in the world.
- F 10. An adolescent will pay closer attention to what a provider says if the provider criticises the client's risky sexual behaviour. ***Do not criticise, even if you do not approve of what the young person is saying or doing.***
- T 11. All contraceptive methods are safe for adolescents.
- F 12. Adolescents have been shown to be more tolerant of side effects than older adults and can therefore easily tolerate any contraceptive method. ***Adolescents have been shown to be less tolerant of side effects, one reason why adolescents have high discontinuation rates for some methods.***
- T 13. Young women should be provided with ECPs in advance, for use when needed. Young women may have less control than older women over having sex and using contraception. They may need ECPs more often.
- T 14. Young men may be less successful than older men at using condoms correctly. ***Young men may need practice putting condoms on.***
15. Why is it important to offer family planning services to adolescents?  
**To help prevent and reduce the adverse consequences of risky behaviours (unintended pregnancy, STIs/HIV).**

16. List three strategies to improve adolescent access to family planning services:

**Any three of the following:**

- **Train providers to offer youth-friendly counselling.**
- **Dedicate special areas of family planning clinics for adolescents, to help ensure privacy.**
- **Use outreach and mobile clinics with staff trained to respond to adolescents' needs.**
- **Offer clinic hours convenient for youth, such as after school and during weekends.**
- **Locate services in convenient, safe areas.**
- **Educate community-based contraceptive distributors and primary health workers (extension workers) about adolescents' challenges and needs and how they can assist them appropriately.**
- **Offer youth a full range of family planning services, including ECPs and STI/HIV counselling and testing.**
- **Provide psychosocial support and education about rape and harmful sexual practices and beliefs, such as ritual sexual cleansing.**
- **Strengthen policies related to adolescent reproductive health services**
- **Obtain political and community acceptance and support**
- **Offer services free or at low cost.**

17. List three tips for providing effective, youth-friendly family planning counselling:

**Any three of the following:**

- **Show young people that you enjoy working with them.**
- **Develop a relationship that is based on respect for him or her as an individual.**
- **Counsel in private areas where you cannot be seen or overheard. Assure the client of confidentiality.**
- **Use simple language. Avoid terms such as "family planning," which may seem irrelevant to youth who are not married.**
- **Help clients believe that they have some control over their own lives, that they can make their own decisions, that they can act on those decisions and evaluate the consequences.**
- **Pay close attention to non-verbal cues, those subtle behaviours that often say as much or more as the words we use.**
- **Speak without expressing judgment. For example, say, "You can" rather than "You should." Do not criticise, even if you do not approve of what the young person is saying or doing.**
- **Make sure that a young woman's choices are her own and not the result of pressure from her partner or her family. In particular, if she is being pressured to have sex and does not want to, help her think about what she can say and do to resist that pressure. Practice skills to negotiate condom use.**
- **Pay close attention to peer interaction when in a group education session and note for follow-up when peer pressure may be affecting an individual's participation or responses.**
- **Help adolescent clients examine available alternatives and make positive changes by encouraging them to talk through possible courses of action and the consequences of those actions.**
- **Take time to fully address questions, fears, and misinformation about sex, STIs, and**



**contraception. Many youth 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.**

18. List two social or behavioural issues that should be considered when adolescents choose contraceptive methods:

**Any two of the following:**

- **In some settings, adolescents may be at increased risk for STIs, including HIV.**
- **Methods that do not require a daily regimen may be preferred by some adolescents.**
- **Adolescents have been shown to be generally less tolerant of side effects than older adults, one reason why they have higher discontinuation rates.**
- **Method choice may also be influenced by factors such as sporadic patterns of intercourse and the need to conceal sexual activity and contraceptive use.**

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# Unit 22

## INFECTION PREVENTION

### Learning Objectives

By the end of this unit, learners will be able to:

- ❖ Define infection prevention
- ❖ List the family planning methods for which infection prevention practices are particularly important
- ❖ Describe ways to protect oneself and others from infection, focusing on hand washing, use of gloves and other protective gear, injection safety, and proper waste disposal
- ❖ Describe the steps for decontaminating instruments
- ❖ Calculate how to make a 0.5 percent chlorine decontamination solution
- ❖ Describe proper waste management and disposal
- ❖ Describe the steps to take if potentially exposed to HIV.

### Teaching Resources in this Unit

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### Key Points

- ❖ **Everyone (clinic staff and clients) is potentially infectious AND at risk of infection.**
- ❖ **Hand washing is the single most important practice for preventing infection.**
- ❖ **Physical barriers (gloves and other protective gear) should be worn to avoid exposure to body fluids, soiled items, and contaminated waste.**
- ❖ **When handling and disposing of sharp instruments, use safe methods to avoid accidents.**
- ❖ **Proper waste disposal prevents the spread of infection to the people who handle the waste and to the local community.**
- ❖ **Proper processing of reusable instruments reduces the risk of transmitting infections. The steps are decontamination, cleaning, sterilisation or high-level disinfection and storage.**
- ❖ **In case of potential exposure to HIV, follow guidelines to reduce the risk of transmission.**

**Infection prevention** is a combination of efforts made to prevent transmission of infections between clients, service providers, and the community. Every person (client or staff) is considered potentially infectious.

It is essential that all staff, including providers of family planning, follow infection prevention practices while at work. While the provision of some family planning methods, such as condoms and pills, does not involve exposure to pathogens, the provision of other methods does. These include surgical methods such as female sterilisation and vasectomy, as well as IUCD insertion/removal, implant insertion/removal, and the provision of injectables.

Information about the basic principles of infection prevention practices is available elsewhere. This unit covers the infection prevention practices specific to family planning, based on the 2006 Malawi Ministry of Health publication, Performance and Quality Improvement Process for Infection Prevention in Hospitals.

## 22.1 Hand Washing

**Hand washing is the single most important practice for preventing cross-contamination.**

- Preferably: wash hands with running water and soap for 10–15 seconds. Be sure to clean between the fingers and under fingernails. Dry with an individual clean towel, paper towel, or air-dry, **or**
- **If water and soap are not available:** rub hands with 3–5 ml of an alcohol-based solution until the hands are dry (if hands **are not** visibly soiled).
- Always wash hands:
  - When arriving at work, after using the toilet or latrine, before and after eating, and when leaving work

- Before and after examining or treating each client or giving an injection
- After handling soiled instruments or touching any blood or body fluids, even if gloves are worn
- Before putting on gloves, after removing gloves (the gloves may have very small holes), and whenever hands get dirty.

## 22.2 Physical Barriers to Infection

### Gloves

Wear gloves (both hands) when:

- Performing a procedure that risks touching blood, other body fluids, mucous membranes or broken skin

**Sterile or** high-level disinfected (HLD) surgical gloves should be used when performing invasive medical or surgical procedures such as the insertion of contraceptive implants. Non-sterile examination gloves provide protection to health care workers for procedures that touch intact mucous membranes or generally to avoid exposure to body fluids (e.g., pelvic exam).

- Handling soiled items (e.g., instruments and gloves) or disposing of contaminated waste (clean **utility** or **heavy-duty household gloves**).

Gloves are not needed for activities such as taking a patient's blood pressure; giving injections; or providing pills, condoms, or counselling.

- A separate pair of gloves must be used for each client to avoid cross-contamination.
- Disposable gloves are preferred, but when resources are limited, surgical gloves can be reused. They should be decontaminated by soaking in 0.5 percent chlorine for 10 minutes, washed and rinsed, then examined carefully for any tears or small holes. They should then be sterilised by steam sterilisation or autoclaving. To avoid gloves sticking together, powdering with absorbable powder such as starch may be helpful before sterilisation. Single-use or disposable sterile surgical gloves should not be reused more than three times because invisible tears may occur.

### Protective gear

Use protective goggles, face masks, aprons, and closed protective shoes when cleaning contaminated instruments. Protective gear is not usually necessary for other family planning activities.

## 22.3 Preventing Contact with Infection Agents

### Prevent splashes

- Avoid snapping the gloves when removing, as this may cause contaminants to splash into the eyes, mouth, or on to skin or others.
- Hold instruments and other items under the surface of the water while scrubbing and cleaning to avoid splashing.
- Place items gently into the decontamination bucket to avoid splashes.

### Use antiseptic agents

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

- Cleanse the client’s skin prior to surgery with an alcohol-based antiseptic product.
- When giving an injection, no antiseptic is necessary unless the skin is visibly dirty.
- Prepare antiseptics in small, reusable containers for daily use and label with the type of antiseptic, the concentration, and the date each time they are refilled [e.g., isopropyl alcohol (90%) 9:30 AM/March 10, 2010].
- Wash reusable containers with soap and water, rinse with clean water, and dry before refilling.
- Store instruments, gauze, and cotton wool in dry covered containers without antiseptics.

## 22.4 Handling Sharp Instruments

Do not leave sharp instruments or needles (“sharps”) in places other than “safe” zones:

- Use a tray or basin to carry and pass sharp items during surgical procedures.
- Pass instruments with the handle (not the sharp end) pointing toward the receiver.
- Announce to others before passing any sharp instrument.

### Needles and syringes

- Use each needle and syringe only once.
- Do not take needle and syringe apart after use.
- Do not recap, bend, or break needles before disposal.
- Decontaminate disposable syringes and needles by flushing them three times with a 0.5% chlorine solution before disposal. (The person performing this should be wearing heavy-duty, non-sterile gloves.)
- Dispose of needles and syringes in a puncture-proof container.

## 22.5 Waste Disposal

The purpose of waste disposal is to prevent the spread of infection to people who handle the waste, prevent the spread of infection to the local community, and protect those who handle waste from accidental injury.

In family planning services, medical waste is produced during female sterilisation and vasectomy procedures, IUCD insertion/removal, implant insertion/removal, and the provision of injectables.

### Medical waste (cotton wool, gauze, etc.)

- Place medical waste in a washable container with a leak-proof plastic bag.
- Close and collect bags when three-quarters full, or daily if not three-quarters full.
- Burn and bury bags of waste in a deep pit.
- Pour liquid waste down a drain, a flushable toilet, or pour into a deep pit and bury it.
- Contaminated linens which will not be washed/bleached and re-sterilized should also be burned and buried.
- Wash hands, gloves, and containers after disposal of medical waste.

### Sharps

- Place sharps in a puncture-resistant, single-use container (empty plastic container, metal container with small opening).

- Seal and collect containers when  $\frac{3}{4}$  full and then burn and bury in a deep pit.

### Cleaning equipment

Buckets, brushes, and cleaning cloths should be:

- Decontaminated by soaking for 10 minutes in 0.5% chlorine solution or other approved disinfectant
- Washed in detergent and water
- Rinsed in clean water
- Dried completely before reuse or storage.

## 22.6 The Steps of Processing Instruments

The steps of processing instruments (used during female sterilisation, vasectomy, IUCD insertion/removal, and implant insertion/removal) include first soaking in a 0.5% chlorine solution, physically cleaning any visible contamination with a brush, and putting them through a HLD/sterilisation procedure.

Table 22.1: Benefits of Each Step of Instrument Processing

Processing step	Benefit
<b>Decontaminate</b>	<ul style="list-style-type: none"> <li>• Kills viruses (hepatitis B and C, HIV) and many other germs</li> <li>• Makes items safer to handle during cleaning</li> <li>• Makes items easier to clean</li> <li>• Common decontamination process: soak in 0.5% chlorine solution for 10 minutes immediately after use (extended soaking can cause instruments to rust)</li> </ul>
<b>Clean</b>	<ul style="list-style-type: none"> <li>• Removes blood, other body fluids, tissue, and dirt, making sterilisation or HLD effective</li> <li>• To clean: using a soft brush, gently brush items with soap and water and rinse with clean water</li> </ul>
<b>High-level disinfect (HLD)</b>	<ul style="list-style-type: none"> <li>• Kills all germs except some endospores (dormant, resistant forms of bacteria responsible for tetanus, gangrene, tuberculosis, etc.)</li> <li>• Use for items that have been in contact with broken skin or intact mucous membranes, such as vaginal specula and gloves for pelvic examinations and items which have been in contact with blood</li> <li>• Can be done by boiling or steaming items for 20 minutes or chemical disinfection using 0.1% chlorine solution for 20 minutes</li> </ul>
<b>OR</b>	
<b>Sterilize</b>	<ul style="list-style-type: none"> <li>• Kills all germs including endospores</li> <li>• Used for instruments that touch tissue beneath the skin such as surgical instruments</li> <li>• Can be done by dry (oven) or wet heat (autoclave) or chemically (soak in 2% glutaraldehyde for 20 minutes)</li> </ul>

### Storage

Proper storage is as important as proper processing. If items are stored properly after processing they should not become contaminated. Items that are not being used should be stored in an HLD container, away from clinic traffic, for up to one week after completing the first three processing steps (before sterilisation).



## Making a chlorine solution

Chlorine solutions (0.5% for decontamination or 0.1% for HLD can be made from:

- Liquid household bleach (sodium hypochlorite)
- Bleach powder or chlorine compounds available in powder form (calcium hypochlorite or chlorinated lime).

Chlorine-containing compounds contain a certain percentage of "active" (or available) chlorine. Active chlorine in these products kills microorganisms. Different products may contain different concentrations of available chlorine, and the concentration should be checked before use.

Household bleach preparations can lose some of their chlorine over time. Use newly manufactured bleach if possible. If the bleach does not smell strongly of chlorine it may not be satisfactory for the purpose and should not be used. Chlorine solution should be clear, not cloudy.

### When preparing chlorine solutions for use note that:

- Organic matter destroys chlorine; thus, freshly diluted solutions must be prepared with clear water whenever the solution looks as though it needs to be changed (cloudy or heavily contaminated with blood or other body fluids).
- Chlorine solutions must be prepared daily as they gradually lose strength.
- Use plastic containers for mixing and storing bleach solutions as metal containers corrode rapidly and also affect the bleach.
- Prepare bleach solutions in a well-ventilated area because they give off chlorine.
- Label the container with "(0.1 or 0.5) percent chlorine decontamination or HLD solution" and note the day and time prepared.
- Any bleach solution can be caustic. Avoid direct contact with skin and eyes.

### Calculating the water to liquid bleach ratio

Chlorine content in liquid bleach is available in different concentrations. Any concentration can be used to make a 0.5 percent chlorine solution by using the following formula:

$$\text{Parts clean water} = \frac{\% \text{ chlorine in concentrated solution}}{0.5\% \text{ (desired diluted concentration)}} - 1$$

**Note:** "Parts" can be any unit of measure (e.g., litre, gallon, cup, pitcher, container, etc.).

**For example:** The number of parts water used per part 3.5% liquid chlorine solution to make a 0.5 percent chlorine solution would be:

$$\text{Parts clean water} = \frac{3.5\%}{0.5\%} - 1 = 7 - 1 = 6$$



## Calculating the water to bleach powder ratio

When using bleach powder to make a decontamination solution, calculate the ratio of bleach to water using the following formula to find how many grams of powder to add to each litre of clean water:

$$\text{Grams/litre} = \frac{0.5\% \text{ (desired diluted concentration)}}{\% \text{ chlorine in powder}} \times 1000$$

**For example:** The number of grams of calcium hypochlorite powder containing 35% available chlorine needs to be added to one litre of clean water to make a 0.5 percent chlorine solution would be:

$$\text{Grams/litre} = \frac{0.5\%}{35\%} \times 1000 = 0.0143 \times 1000 = 14.3 \text{ g/l}$$

Therefore, dissolve 14 grams of calcium hypochlorite powder in one litre of clean water in order to get a 0.5% chlorine solution.

## 22.7 Exposure to HIV

Family planning service providers may be exposed to HIV through needle sticks, mucous membranes, or broken skin, but the risk of infection is low:

- Needle sticks or cuts are the most likely causes of the transmission of HIV to providers in family planning clinics. The average risk of HIV infection after a needle stick exposure to HIV-infected blood is 3 infections per 1,000 needle sticks.
- The risk after exposure of the eye, nose, or mouth to HIV-infected blood is estimated to be about 1 infection per 1,000 exposures. Following universal precautions is the best way that providers can avoid workplace exposure to HIV and other fluid-borne infections.

### What a service provider should do if potentially exposed to HIV

If exposure is to:	Do the following:
Intact skin, mouth, or nose	Immediately wash with soap under running water
Cut or punctured skin	Remove gloves Wash with water and soap, preferably antiseptic
Eye	Irrigate with clean water or normal saline

### Post-exposure prophylaxis (PEP)

- Report to the PEP service provider on duty as soon as possible
- Have blood samples (client and provider) taken for HIV testing. If positive for the client and negative for provider start antiretroviral (ARV) therapy. If HIV testing is not available, start PEP while waiting for the client's results
- Follow up HIV testing for the provider at 6 weeks, 3 months, 6 months and 12 months.

## Infection Prevention Case Studies

### Case Study 1

Mrs Banda has two children and has come to the family planning clinic—where you are a provider—to receive a contraceptive method. After counselling, she has chosen DMPA. How will you ensure an infection transmission-free environment before, during, and after administration of the DMPA?

### Case Study 2

You find out that the housekeeper has been leaving the health centre in the evening and, on her way home, has been throwing the clinic's waste in a big waste bin located behind a nearby school. What should you explain to the housekeeper?

### Case Study 3

You are not paying attention while discarding a syringe with a needle into the sharps container, and you accidentally stick yourself. What should you do?

# Infection Prevention Case Studies Answer Key

## Case Study 1

Mrs Banda has two children and has come to the family planning clinic—where you are a provider—to receive a contraceptive method. After counselling, she has chosen DMPA. How will you ensure an infection transmission-free environment before, during, and after administration of the DMPA?

- **Wash hands with soap and water**
- **If injection site is dirty, wash it with soap and water (No need to wipe site with antiseptic)**
- **Use sterile syringe and needle**
- **Dispose the used vial, syringe, and needle in a puncture-proof sharps container**
- **Wash hands after the procedure with soap and water.**

## Case Study 2

You find out that the housekeeper has been leaving the health centre in the evening and, on her way home, has been throwing the clinic's waste in a big waste bin located behind a nearby school. What should you explain to the housekeeper?

**Proper handling of contaminated waste (such as items with blood or body fluids) is required to minimize the spread of infection to her and the community. Proper handling includes:**

- **Wearing heavy-duty gloves**
- **Sealing and either burning or incinerating the puncture-proof sharps container when three-quarters full**
- **Carefully pouring liquid waste down a drain or flushable toilet**
- **Burning and/or burying contaminated solid waste in a deep pit**
- **Washing hands, gloves, and containers after disposal of infectious waste.**

## Case Study 3

You are not paying attention while discarding a syringe with a needle into the sharps container, and you accidentally stick yourself. What should you do?

- **Wash with soap (preferably antiseptic) and water**
- **Report to the PEP service provider on duty as soon as possible**
- **Have blood samples (client and provider) taken for HIV testing. If positive for the client and negative for provider, start ARV therapy**
- **If HIV testing is not available, start PEP while waiting for the client's results**
- **Follow up HIV testing at 6 weeks, 3 months, 6 months and 12 months.**

## Infection Prevention Quiz Questions

**Questions 1–11.** Indicate whether the following statements about infection prevention are **true** or **false** by writing a **“T”** for true or an **“F”** for false in the space provided before each statement.

- \_\_\_ 1. Hand washing is the single most effective practice for preventing cross-contamination in the family planning clinic.
- \_\_\_ 2. Gloves provide a barrier against possible infectious microorganisms that can be found in blood, other body fluids, and waste.
- \_\_\_ 3. Gloves must be worn when administering DMPA.
- \_\_\_ 4. To reduce the risk of a needle stick, recap a needle by holding the syringe in one hand and holding the needle in the other hand.
- \_\_\_ 5. Everyone who handles medical waste—from the point generated until final disposal—is at risk of infections and injury.
- \_\_\_ 6. Liquid medical waste can be disposed down a sink, drain, toilet, or latrine.
- \_\_\_ 7. Decontamination kills all microorganisms on soiled instruments and other item.
- \_\_\_ 8. When preparing a chlorine solution for decontamination, it is important to know the amount of active chlorine in the product used.
- \_\_\_ 9. Cleaning instruments before sterilising them is not necessary if they were soaked in a 0.5 percent chlorine solution for 10 minutes.
- \_\_\_ 10. High-level disinfection kills all microorganisms.
- \_\_\_ 11. Family planning providers are at high risk for exposure to HIV.

**Questions 12–19:** For each practice or situation described below, indicate whether it is an acceptable or unacceptable practice by **writing an “A” for acceptable or a “U” for unacceptable** in the space provided before each statement.

- \_\_\_ 12. A doctor washes her hands by dipping them in a basin of water before examining a patient.
- \_\_\_ 13. Staff members wash their hands for approximately fifteen seconds.
- \_\_\_ 14. A staff member arrives at the family planning clinic to find many people waiting for her, so she immediately begins seeing clients without washing her hands.
- \_\_\_ 15. A service provider keeps her gloves on throughout the morning and is careful to wash them with soap and water in between patients.
- \_\_\_ 16. Break a hypodermic needle before disposal.
- \_\_\_ 17. Wash a needle stick or cut with soap and water.
- \_\_\_ 18. The provider drops instruments into a bucket with decontamination solution to avoid contact with the solution.
- \_\_\_ 19. Irrigate eyes well with water when blood or body fluids splash in them.

**Questions 20–25:** Circle the letter that offers the best response to each question.

20. The primary objective of infection prevention for family planning services is to:
- Minimize the cost of drugs and supplies used in surgery
  - Develop standards for use of prophylactic antibiotics
  - Minimize transmission of infections including hepatitis b (HBV) and HIV/AIDS to clients, providers and other staff
  - All of the above
21. Bacterial endospores which cause tetanus, gangrene and tuberculosis are reliably killed by:
- Soaking in a 0.5% chlorine solution
  - Fumigation
  - Boiling (high-level disinfection)
  - Sterilisation (autoclave or dry heat)
22. Hand washing is indicated before:
- Examining a client (direct contact)
  - Performing a pelvic examination
  - Putting on high-level, disinfected gloves to insert an IUCD
  - All of the above
23. To make a 0.5% solution of chlorine from a concentrated liquid solution containing 5.0% chlorine as sodium hypochlorite, add one part concentrated chlorine solution to:
- 3 parts water
  - 5 parts water
  - 7 parts water
  - 9 parts water
24. If sterile gloves are NOT available, high-level disinfected gloves are the ONLY acceptable alternative for which of the following procedures?
- Performing a pelvic examination
  - Giving an injection
  - Performing a minilaparotomy
  - All of the above
25. When preparing to insert a contraceptive implant, which steps should be taken?
- Wash hands, put on surgical gloves, clean client's skin with an antiseptic
  - Wash hands, put on surgical gloves
  - Put on examination gloves, clean client's skin with an antiseptic
  - Wash hands, put on examination gloves, clean client's skin with an antiseptic

## Infection Prevention Quiz Questions Answer Key

**Questions 1–11.** Indicate whether the following statements about infection prevention are **true** or **false** by writing a “T” for true or an “F” for false in the space provided before each statement.

- T 1. Hand washing is the single most effective practice for preventing cross-contamination in the family planning clinic.
- T 2. Gloves provide a barrier against possible infectious microorganisms that can be found in blood, other body fluids, and waste.
- F 3. Gloves must be worn when administering DMPA. ***Gloves are not required for giving injections.***
- F 4. To reduce the risk of a needle stick, recap a needle by holding the syringe in one hand and holding the needle in the other hand. ***One should avoid recapping needles.***
- T 5. Everyone who handles medical waste—from the point generated until final disposal—is at risk of infections and injury. ***A large percentage of staff report having experienced waste-related injuries and infection.***
- T 6. Liquid medical waste can be disposed down a sink, drain, toilet, or latrine. ***If this is not possible, bury it along with solid medical waste.***
- F 7. Decontamination kills all microorganisms on soiled instruments and other items. Decontamination kills viruses such as HIV and many—but not all—other microorganisms.
- T 8. When preparing a chlorine solution for decontamination, it is important to know the amount of active chlorine in the product used. ***It is important to know the amount of active chlorine in order to make a solution of the correct strength for decontamination.***
- F 9. Cleaning instruments before sterilising them is not necessary if they were soaked in a 0.5 percent chlorine solution for 10 minutes. ***Although decontamination makes items safer to handle, cleaning is still necessary to remove organic material, dirt, and other matter that can interfere with further processing.***
- F 10. Sharps should be put into special containers that are then emptied with other medical waste and washed for reuse. ***Sharps containers should be used once. They should be sealed and burned once three-quarters full.***
- F 11. Family planning providers are at high risk for exposure to HIV. They are at a low risk through needle sticks and contact with mucous and body fluids.

**Questions 12–19:** For each practice or situation described below, indicate whether it is an acceptable or unacceptable practice by writing an “A” for acceptable or a “U” for unacceptable in the space provided before each statement.

- U 12. A doctor washes her hands by dipping them in a basin of water before examining a patient. ***Hands can be contaminated by dipping them in a basin of water. Standing water can easily become contaminated even if antiseptic is added.***
- A 13. Staff members wash their hands for approximately fifteen seconds.

- U** 14. A staff member arrives at the family planning clinic to find many people waiting for her, so she immediately begins seeing clients without washing her hands. **Staff should wash their hands when they arrive and before they leave a health facility.**
- U** 15. A service provider keeps her gloves on throughout the morning and is careful to wash them with soap and water in between patients. **A separate pair of gloves must be used for each client. It is not necessary to wear gloves for activities that do not involve contact with blood or other potentially infectious materials.**
- U** 16. Break a hypodermic needle before disposal. **Providers are at risk if they break a needle after using it and before disposal. Sharps can cause injury and transmission of serious infections, including HIV and hepatitis B.**
- A** 17. Wash a needle stick or cut with soap and water.
- U** 18. The provider drops instruments into a bucket with decontamination solution to avoid contact with the solution. **Place items in the decontamination bucket without splashing the solution.**
- A** 19. Irrigate eyes well with water when blood or body fluids splash in them.
20. The primary objective of infection prevention for family planning services is to:
- c. Minimize transmission of infections including hepatitis b (HBV) and HIV/AIDS to clients, providers, and other staff.**
21. Bacterial endospores that cause tetanus, gangrene and tuberculosis are reliably killed by:
- d. Sterilisation (autoclave or dry heat)**
22. Hand washing is indicated before:
- d. All of the above**
23. To make a 0.5% solution of chlorine from a concentrated liquid solution containing 5.0% chlorine as sodium hypochlorite, add one part concentrated chlorine solution to:
- d. 9 parts water**
24. If sterile gloves are NOT available, high-level disinfected gloves are the ONLY acceptable alternative for which of the following procedures?
- c. Performing a minilaparotomy**
25. When preparing to insert a contraceptive implant, which steps should be taken?
- a. Wash hands, put on surgical gloves, clean client's skin with an antiseptic**



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## Unit 23

# CONTRACEPTIVE LOGISTICS

### Learning Objectives

By the end of this unit, learners will be able to:

- ❖ Define contraceptive logistics
- ❖ List the six “rights” of the logistics system
- ❖ List the four major activities of the logistics cycle and explain how they are interdependent
- ❖ Explain the Malawi health commodity logistics management system
- ❖ Describe the logistics responsibilities of clinic-based family planning providers
- ❖ Define the Malawi contraceptive logistics management information system (LMIS)
- ❖ Identify the four primary LMIS forms, the staff person responsible for completing each form, and when each form should be completed
- ❖ Describe guidelines for proper storage of contraceptive supplies.

### Teaching Resources in this Unit

#### Unit Assessment

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## Unit 23: Contraceptive Logistics

### Key Points

- ❖ **Contraceptive logistics is the system for the management of contraceptive supplies in the health care system.**
- ❖ **The logistics system includes six “rights:” ensuring that the *right* goods in the *right* quantities and in the *right* condition are delivered to the *right* place at the *right* time for the *right* cost.**
- ❖ **The four major activities in the logistics cycle are serving customers, selecting products, forecasting and procurement, and managing inventory.**
- ❖ **Family planning providers are an important link in the contraceptive supply chain.**
- ❖ **Logistics management requires accurate and timely reports and orders.**
- ❖ **Proper storage of health commodities helps ensure that products are available, accessible and in good condition.**

### 23.1 Defining Contraceptive Logistics

Logistics is the system through which materials are procured, maintained, distributed, and replaced. Contraceptive logistics, specifically, is the system used for the management and movement of contraceptive supplies and commodities in the health care system.

### 23.2 The Logistics System

The logistics system includes six “rights:” ensuring that the *right* goods in the *right* quantities and in the *right* condition are delivered to the *right* place at the *right* time for the *right* cost. Health systems can suffer when logistics problems affect their ability to fulfil one or more of these rights.

Logistics system activities that support these six rights are depicted in the logistics cycle (see Figure 23.1 below). The four major activities in this cycle are:

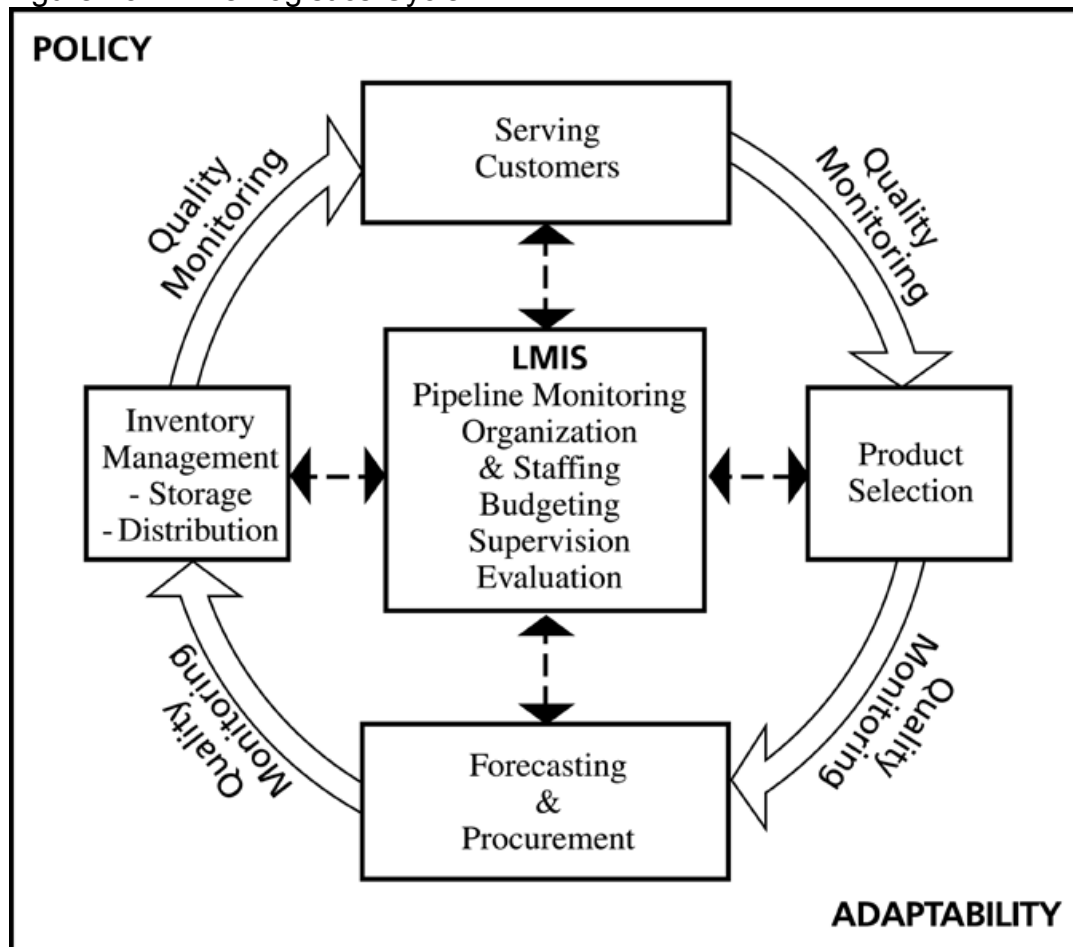
- **Serving customers:** Each person who works in logistics must remember that he or she selects, procures, stores, and distributes products to meet customer needs. All of the activities in the logistics cycle contribute to providing excellent customer service.
- **Selecting products:** In a health logistics system, product selection may be the responsibility of a national formulary and therapeutics committee, pharmaceutical board, board of physicians, or other government-appointed group.
- **Forecasting and procurement:** After the products are selected, the quantity of each product needed must be determined and procured. It is important that the system provide sufficient quantities of commodities without providing so many that a large number are not used (wasting products as well as funds).
- **Managing inventory (storage and distribution):** After an item has been procured and received, it must be stored until the customer needs it. Determining how much stock

should be stored is an important decision and is closely linked with the forecasting of needs.

As can be seen in the illustration, these activities are interdependent. For instance, product selection is based on serving customers since it is important to select and procure products that are acceptable to them. In turn, storage systems depend on the needs of the products that are procured. For example, male condoms need to be stored in a cool, dry place.

(MOH and DELIVER 2009)

Figure 23.1: The Logistics Cycle



### 23.3 The Importance of the Contraceptive Logistics System

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

Contraceptive logistics management requires accurate and timely reports and orders from providers. These documents help supply chain managers determine what products are needed, how much to buy, and where to distribute them.

Clinic staff members do their part when they properly manage contraceptive inventory, accurately record and report what commodities are used, and promptly order new supplies.

Family planning staff members need to be familiar with, and work within, whatever systems are in place at their worksites to make certain that they have the supplies that are needed.

(WHO/RHR and CCP, Knowledge for Health Project 2008)

## 23.4 The Malawi Community-Based Contraceptive Logistics Management System

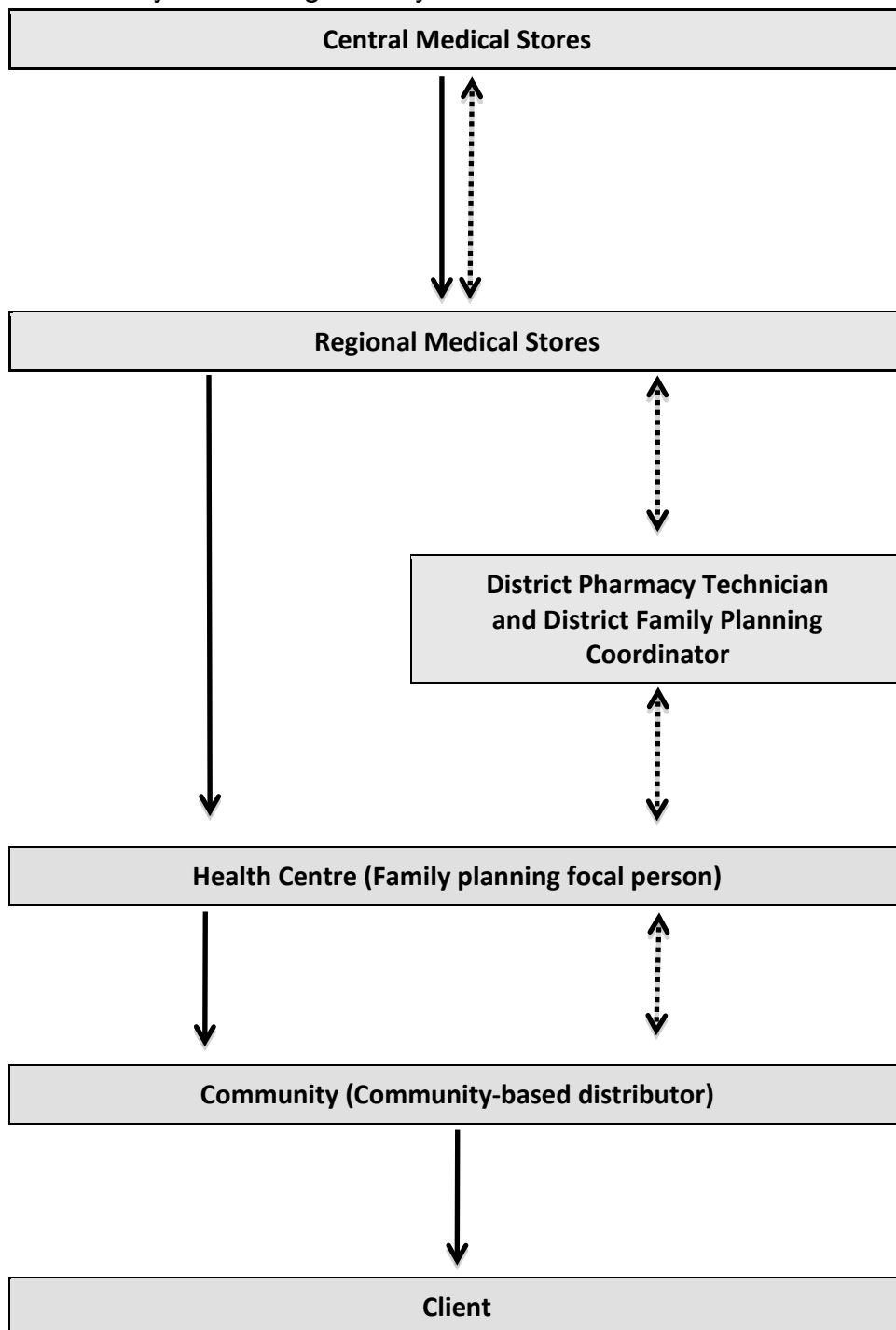
The Malawi health commodities logistics management system is the MOH’s system for managing inventories of drugs, contraceptives, HIV tests, laboratory reagents and consumables and medical supplies. This system helps ensure that all Malawians receive the medical products and services they need and receive quality treatment when they visit a service delivery point, laboratory, HIV testing and counselling centre, or are visited by a community-based distribution agent. This system helps ensure that the six logistics “rights” are fulfilled.

The following table lists some of the key personnel who manage the MOH logistics management system, their activities, and when these activities should take place.

Who	Action	When
Health Center In-Charge/ Lab Assistant	Receives health commodities from Regional Medical Stores and signs off on the delivery note to confirm about quantities received. Dispenses health commodities to clients. Performs tests for clients. (Lab Assistant) Completes the HIV tests Daily Activity Register (DAR) and other laboratory test DARs every time they test a client. (Lab Assistant) Records information about transactions on the stock card (Form LMIS-SC) and in-patient registers. Completes the Health Center Monthly LMIS Report (Form LMIS-01A).	During the month  Monthly
Community Clinics In-charge	Completes the Community Clinic Drugs Requisition Form (Form LMIS-01F). Records daily transactions in the out-patient register (Form HMIS-5).	Weekly Daily
CHAM/NGO In-Charge	Completes the Clinic Monthly LMIS Report (Form LMIS-01C). Records information about transactions on the stock card (Form LMIS-SC).	Monthly
District AIDS Coordinator	While the District AIDS Coordinators do not obtain or hold commodities for HIV/AIDS control, they do coordinate with staff at various levels to ensure that sufficient commodities, including HIV tests, are available.	Daily
Zonal Laboratory Supervisor	Coordinates with staff at district and central laboratories to ensure that the right commodities are available in the right quantity. Supervises laboratory logistics activities throughout the zone.	Daily Monthly

The flow of the commodities and information can be seen in Figure 23.2 below.

Figure 23.2: Flow of Commodities and Information in the Community-Based Logistics System



*Solid arrow* = Contraceptive commodities flow  
*Dotted arrow* = Information flow

## 23.5 Logistics Responsibilities for Family Planning Providers in the Clinic

Workers at all levels of the health system, including those at the central, regional, district, health centre and community levels, play a role in ensuring that the contraceptives logistics system functions effectively. While specific supply chain procedures can vary across settings, clinical officers, medical assistants, nurses and laboratory assistants are typically responsible for the following common activities:

1. Receive and store drugs, contraceptives, HIV tests and other medical supplies in the health centre according to recommended storage guidelines.
2. Record all issues and receipts of health commodities on the stock card (Form LMIS-SC).
3. Issue products to service providers or to the laboratory work bench according to FEFO (first-to-expire, first-out) distribution.
4. Conduct a physical inventory of commodities monthly and update the stock card (Form LMIS-SC).
5. Consolidate data on usage of commodities by all user units affiliated to the health centre.
6. Complete the Health Centre Monthly LMIS Report (Form LMIS-01A) and send to the District Pharmacist/Pharmacy Technician by the 5<sup>th</sup> of every month. (Health Centre Clinical Officer/Medical Assistant/Nurse)
7. Complete the Health Centre Monthly LMIS Report (Form LMIS-01ALab) and send to the District Laboratory Manager by the 5<sup>th</sup> of every month. (Laboratory Assistant)

(MOH and DELIVER 2009)

## 23.6 Contraceptive Logistics Record Keeping

### **The Malawi Logistics Management Information System (LMIS)**

Timely and accurate information is an essential piece of the logistics cycle; without it, the logistics system would not run smoothly. To aid in the collection and analysis of this information, a logistics management information system (LMIS) is used.

The Malawi LMIS consists of records and reports used to collect and transmit information about contraceptives and other related medical supplies dispensed to clients. LMIS forms are used to record information about the three essential logistics data elements:

- Stock on hand (quantity of supplies that are available for use at the facility)
- Consumption rate (rate at which commodities are used)
- Losses and adjustments.

### **LMIS records and reports**

The records and reports used in the Malawi contraceptive LMIS include:

- Community-based distribution (CBD) Client & Contraceptive Tally Sheet
- CBD Monthly DMPA Worksheet
- CBD Supervision Monthly Contraceptive Summary

- Requisition and Issue Voucher.

Samples of these forms can be found in the *Malawi MOH Community-Based Supply Chain Management System for Injectable Contraceptives*. Staff members responsible for completing these forms and the monthly schedule for when they should be completed are listed in Table 23.1.

Table 23.1: Malawi Contraceptive LMIS Records and Reports

Report/Record Name	LMIS Number	Staff Responsible for Completing	When Completed
CBD Client & Contraceptive Tally Sheet	LMIS-01G	Health Surveillance Assistant (HSA)	During the month
CBD Monthly DMPA Worksheet	LMIS-01K	HSA	By the 3 <sup>rd</sup> day of each month
CBD Supervision Monthly Contraceptive Summary	LMIS-01J	Family planning focal person together with HSA	By the 3 <sup>rd</sup> day of each month
Requisition and Issue Voucher	RIV	Family planning focal person	When collecting contraceptives from drug store

## 23.7 Storing Contraceptives and Related Medical Supplies

### Purpose of storage

Proper storage of health commodities helps ensure that products are always available, accessible and in good condition. Appropriate storage:

- Protects the quality of the contraceptives and other supplies
- Preserves the integrity of the packaging and makes supplies available for use.

### Shelf life

- Shelf life is the length of time a product may be stored under ideal conditions without affecting its usability, safety, purity, or potency.
- When the product reaches the end of its shelf life, it has expired and should not be distributed.
- If a product is not stored correctly, the shelf life may be shortened.
- To make sure that health commodities do not expire before they are dispensed, First-to-Expire, First-Out (FEFO) should be followed. With this system, the commodities with the shortest remaining shelf life are used first. First-In, First-Out (FIFO) should not be used because some health commodities may have earlier expiry dates even though they were obtained more recently.

### Contraceptive storage guidelines

- Store contraceptives in containers supplied by the community-based supply chain programme only.
- Clean the storage area regularly. Take precautions to prevent harmful insects and rodents from entering the storage area.



- Store health commodities in a dry area, away from water, direct sunlight, and fire.
- Keep contraceptives locked to ensure that unauthorized people cannot access them.
- Protect storeroom from water penetration.
- Keep fire safety equipment available, accessible, and functional. Train employees to use it.
- Store latex products away from electric motors and fluorescent lights.
- Maintain cold storage, including a cold chain, as required.
- Stack cartons at least 10 cm off the floor, 30 cm away from the walls and other stacks, and no more than 2.5m high.
- Arrange cartons with arrows pointing up with identification labels, expiry dates, and manufacturing dates clearly visible.
- Store health commodities away from insecticides, chemicals, flammable products, hazardous materials, old files, office supplies, and equipment. Always take appropriate safety precautions.

(MOH and DELIVER 2009)

## Contraceptive Logistics Quiz Questions

1. Define contraceptive logistics:
2. The six “rights” of the management system are:
3. The four major interdependent activities of the logistics cycle are:
4. List three contraceptive logistics responsibilities for family planning clinic staff:
5. “LMIS” stands for:

**Questions 6–12:** Indicate whether the following statements are **true** or **false** by writing a “**T**” for true or an “**F**” for false in the space provided before each statement.

- \_\_\_ 6. Workers at the regional level of the health system are solely responsible for ensuring that the contraceptive logistics system functions effectively.
- \_\_\_ 7. Contraceptive commodities should be issued to service providers according to First-In, First-Out (FIFO) distribution.
- \_\_\_ 8. The flow of information in the Malawi community-based contraceptive supply system is one way from the district pharmacy technician to the regional medical stores.
- \_\_\_ 9. Commodities in the Malawi community-based contraceptive supply system move from central medical stores directly to the local health centres.
- \_\_\_ 10. Contraceptives should only be stored in the containers provided by the Malawi community-based supply chain programme.
- \_\_\_ 11. LMIS forms are used to collect information about essential logistics data elements.
- \_\_\_ 12. The HSA is responsible for completing the CBD monthly DMPA worksheet.

## Contraceptive Logistics Quiz Questions Answer Key

1. Define contraceptive logistics:

**The system used for the management and movement of contraceptive supplies in the health care system.**

2. The six “rights” of the management system are:

**Ensuring that the *right* goods in the *right* quantities and in the *right* condition are delivered to the *right* place at the *right* time for the *right* cost.**

3. The four major interdependent activities of the logistics cycle are:

**Serving customers, selecting products, forecasting and procurement, and managing inventory.**

4. List three contraceptive logistics responsibilities for family planning clinic staff:

**Any three of the following:**

- **Receive and store drugs, contraceptives, HIV tests and other medical supplies in the health centre according to recommended storage guidelines.**
- **Record all issues and receipts of health commodities on the stock card (Form LMIS-SC).**
- **Issue products to service providers or to the laboratory work bench according to FEFO (first-to-expire, first-out) distribution.**
- **Conduct a physical inventory of commodities monthly and update the stock card (Form LMIS-SC).**
- **Consolidate data on usage of commodities by all user units affiliated to the health centre.**
- **Complete the Health Centre Monthly LMIS Report (Form LMIS-01A) and send to the District Pharmacist/Pharmacy Technician by the 5<sup>th</sup> of every month. (Health Centre Clinical Officer/Medical Assistant/Nurse)**
- **Complete the Health Centre Monthly LMIS Report (Form LMIS-01ALab) and send to the District Laboratory Manager by the 5<sup>th</sup> of every month. (Laboratory Assistant)**

5. “LMIS” stands for:

**Logistics Management Information System.**

**F\_\_6.** Workers at the regional level of the health system are solely responsible for ensuring that the contraceptive logistics system functions effectively.

**F\_\_7.** Contraceptive commodities should be issued to service providers according to First-In, First-Out (FIFO) distribution.

**F\_\_8.** The flow of information in the Malawi community-based contraceptive supply system is one way from the district pharmacy technician to the regional medical stores.

**F\_\_9.** Commodities in the Malawi community-based contraceptive supply system move from central medical stores directly to the local health centres.

- T\_\_10. Contraceptives should only be stored in the containers provided by the Malawi community-based supply chain programme.
- T\_\_11. LMIS forms are used to collect information about essential logistics data elements.
- T\_\_12. The HSA is responsible for completing the CBD monthly DMPA worksheet.

## References

Ministry of Health and Deliver Project. n.d. Community-based supply chain management system for injectable contraceptives: Participant's manual. Lilongwe, Malawi: Ministry of Health.

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# Appendix

## EFFECTIVE TEACHING

### Key Points

- ❖ **Clear, measurable objectives, based on core competencies, are the key to planning effective courses.**
- ❖ **Students retain more information when they are actively involved in learning.**
- ❖ **A variety of teaching methods and learning activities should be used to engage and involve students.**
- ❖ **Competency-based learning tools (such as checklists, learning guides) should be used to support learning and to assess new skills.**
- ❖ **Feedback should be given to encourage students to continue applying new knowledge and trying new skills, with specific plans for how to make improvements.**
- ❖ **Assessment should be used to measure students' progress in achieving core competencies.**

**(Note:** This appendix summarises key points for strengthening faculty teaching skills. This information is adapted from: The World Health Organization (WHO) and Jhpiego. 2005. *Effective teaching: A guide for educating health care providers*. Geneva: WHO.)

### A.1 Introduction

**Teaching** can be defined as the conscious manipulation of the students' environment in a way that allows their activities to contribute to their development.

**Learning** can be defined as a change in behaviour, perceptions, insights, attitudes, or any combination of these that can be repeated when the need arises.

Good teaching supports learning. Research shows that students retain more information when a combination of teaching methods is used (e.g., verbal, written, and visual), and students recall the most when they are actively involved in learning through activities such as role plays, case studies, and practice.

In general, teaching and learning are more effective when:

- Students are ready and want to learn.
- Students are aware of what they need to learn (there are clear learning objectives).
- New knowledge, skills and attitudes build on what students already know or have experienced.
- Students are active and participate in their learning.
- Students are encouraged to apply critical thinking and alternative approaches supported by sound reasons.

- Numerous opportunities are given for students to practice both ideas and skills, and to receive feedback on their performance through self-, peer, or teacher assessment.
- Feedback to students on their performance is immediate, constructive, and nonjudgmental.
- Teaching moves step by step from simple to complex and is organized, logical, and practical.
- Ideas and concepts are presented clearly, alternative explanations are presented, and teachers check frequently for students' understanding.

## A.2 Steps for Writing a Curriculum or Preparing a Course

### 1. Identify core competencies.

These are the aspects of a subject that are common to all students, essential to practice, and essential to master in order to graduate from an academic program and enter into professional practice. An example of a core competency would be “manage side effects and any related complications of family planning methods.”

### 2. Define objectives.

These are statements that describe what students will know or be able to do when they finish your course. Write learning objectives to define what learners must know (knowledge), do (skills), and/or believe (attitudes) to achieve the core competencies. Clear, measurable objectives will help you determine the course content, decide how you will teach the course, and identify how students' learning should be assessed.

Examples of learning objectives for the competency “manage side effects and any related complications” are:

- List the common side effects for each family planning method (knowledge)
- Use effective communication techniques when counselling clients (skill)
- Identify personal experience and beliefs regarding use of family planning (attitude).

This reference guide includes suggested learning objectives for each unit that you can use, when appropriate, in preparing your courses. Content, learning activities, and suggested assessment questions with answers are provided for these different learning objectives.

### 3. Choose how to assess that students have achieved the learning objectives for the course.

Changes in knowledge, skills, and attitudes can be measured in different ways. Frequently they are assessed like this:

- Knowledge: quizzes, tests, case studies
- Skills: observations using checklists
- Attitudes: observations, case studies.

### 4. Select appropriate teaching methods.

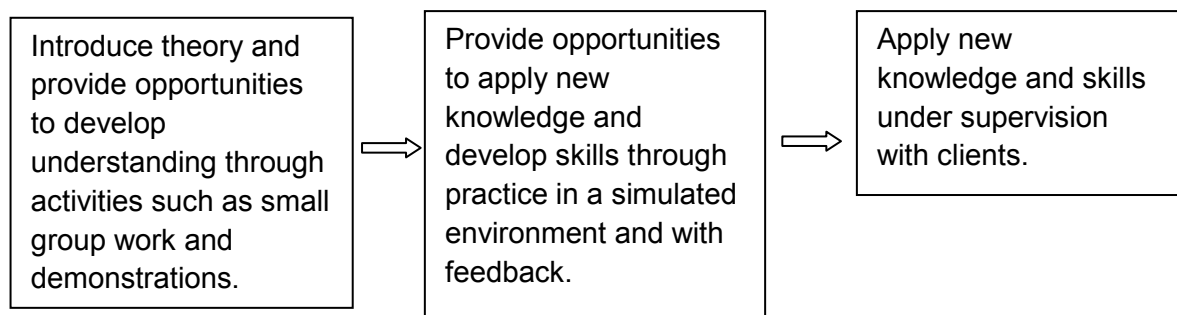
Select teaching methods that are appropriate for achieving the learning objectives and that provide an opportunity for sufficient practice. Use a variety of methods.

Basic teaching methods and learning activities that can be used with objectives in this reference guide are listed in the table below.

Table A.1: Teaching Methods and Domains

Method/Activity	Definition	Domain(s)
<b>Brainstorming</b>	Students generate a list of ideas, thoughts, or solutions on a specific topic or problem. Stimulates thought and creativity and is often followed by group discussion	Knowledge
<b>Case study</b>	Student problem-solving or reaction to realistic scenarios that focus on a specific issue. Done individually or in group	Knowledge, attitude
<b>Demonstration</b>	Teacher explains procedures, presents the steps necessary for completion of a procedure or clinical task or activity, and models correct performance of the skill.	Skill
<b>Discussion</b>	Interactive process in which students share their ideas, thoughts, questions, and answers in a group setting with a facilitator	Knowledge, attitude
<b>Facilitated practice</b>	Opportunity for students to practice or apply new skills (with models, simulated clients, or real clients)	Skill, attitude
<b>Guest speaker</b>	Presentation conducted by an expert in the field	Knowledge, attitude
<b>Role play</b>	Students act out roles in a simulated situation.	Knowledge, some skills (communication skills), attitude

When planning, remember that learning builds on experiences:



### 5. Create, select, and/or modify teaching materials.

This reference guide contains some of the teaching materials you can use during your courses. You may photocopy checklists and summary tables to use as handouts, and copy role play and case study descriptions for learning activities, etc. More teaching materials can be found at the online references listed for each unit or you can create materials to fit your specific learning objectives.



## A.3 Use Teaching Methods Effectively

### Presentations

In the past, most classes consisted mostly of a teacher presenting information orally from the front of the class with students listening and taking notes. Student participation in the class was very limited. Today we know that students learn better if they are actively involved in their learning. Oral presentations are still an important part of many courses, but it is possible to increase student participation.

Careful planning makes for interesting, effective presentations that are easy to deliver. Group learning activities (e.g., case studies, role plays, brainstorming) can be used to enhance presentations. When making a lesson plan, include:

- The learning objective(s)
- An outline of key points (listed on a handout, chalk board, flipchart, or projected using a computer or other projector)
- Questions to involve the students
- Reminders of planned activities during the presentation, use of visual aids, learning activities, etc.
- Summary questions, comments, or activities.

### Effective presentation techniques

1. Plan your presentation (create an outline based on objectives).
2. Introduce each presentation.
3. Use effective presentation skills:
  - Communicate in a way that is easy to understand (avoid jargon, unfamiliar acronyms).
  - Interact with students (use eye contact and students' names, ask questions).
  - Show enthusiasm for the topic and its importance.
  - Use appropriate visual aids.
  - Provide positive feedback ("Very good point, Mary!").
  - Provide smooth transitions between topics.
4. Use questioning techniques:
  - Ask a question of the entire group ("Would someone please tell me why...?").
  - State the question, pause, and then direct the question to a specific student (everyone has to pay attention).
  - Target the question to one student by using the person's name before asking the question.
  - Repeat students' correct answers.
  - Provide positive reinforcement for responses (even if the answer is incorrect).
  - When students ask you a question, respond in one of the following ways:
    - Answer the question
    - Respond with another question
    - Refer to a later section in the course when the question will be answered
    - Admit you don't know the answer but that you will try to find out.
5. Summarise your presentation.

## Demonstrations and Facilitated Practice

Students of nursing and related disciplines must develop many skills during the course of their study. Health care skills are best developed by:

- Introducing and demonstrating the skill
- Observing students as they practice the skill
- Giving feedback on their performance of the skill
- Assessing students for competency in the skill.

### Competency-based learning tools

Competency-based learning tools such as learning guides, decision trees, flowcharts, algorithms, and charts greatly facilitate the demonstration, practice, feedback, and assessment of skills. These types of tools are found throughout this reference guide to make it easy to incorporate them into your courses. Some of the ways competency-based learning tools can be used include:

- Students follow the steps in the tool while a teacher or other students demonstrate a skill.
- Pairs of students work together with one performing the skill while the other prompts, as needed, on the steps involved in the skill.
- Teachers use the tool as a reference standard for observing and giving feedback.
- The tool is used for self-assessment, peer assessment, or teacher assessment.

### Tips for demonstrating skills

Different ways to demonstrate a skill in accordance with accepted performance standards include showing slides or videos in which the steps and their sequence are illustrated, performing a role play, using anatomic models to demonstrate the skill, or using simulated or real clients. Be as realistic as possible, using actual equipment and materials.

For long or multi-part procedures, follow the “whole-part-whole” process. Demonstrate the whole procedure from beginning to end, then isolate or break down the procedure into parts, allowing students to practice the individual parts. Then demonstrate the whole procedure again and allow students to practice it from beginning to end.

Before demonstrating a skill, it is essential that you introduce it and provide an overview. Include:

- What the skill is
- Why it is important
- When it should be used
- The objectives of the demonstration
- The steps involved in performing the skill
- Questions to find out how well the students have understood the information you have shared
- Handout copies or references to competency-based learning tools.

During the demonstration, you should:

- Make sure that everyone can see what you are doing
- Ask students to follow along with the learning tool, if applicable

- Always demonstrate the skill correctly
- Interact with students: explain what is being done and ask students questions to keep them involved
- Use equipment and materials correctly
- Follow infection prevention guidelines while performing the steps.

After the demonstration, discuss the procedure and ask the students if they have any questions. Briefly review the learning tool and resolve any problems with its use.

### **Tips for facilitating practice**

The most important step in teaching and learning skills is practice—when students perform a skill in the presence of a teacher or other observer. Practice can be done in simulated (with models) or real conditions. With dangerous or complicated procedures, it is recommended that students show proficiency using models before being allowed to practice on clients.

- Make the practice situation as close to reality as possible, using real equipment and materials, if available.
- Observe and interact with students as they practice a skill. Listen, question, give feedback, and help students overcome problems.
- Start with relatively easy and short skills so that students experience success and reinforcing feedback right away. As students become more proficient, introduce more difficult skills.
- Have students use competency-based learning tools such as checklists while they practice a skill.

### **Feedback**

Feedback is information given to students about the quality of their performance. If given correctly, feedback encourages students to try a new behaviour again, with specific plans for how to improve. To be effective, feedback must be specific, constructive, and nonjudgmental.

Conduct a feedback session immediately after practice. First, ask students how they felt about their own performance. Ask them what they believed they did well and what they would like to improve or do differently. Refer to a competency-based learning tool for a quick review of the steps and ask students where they experienced difficulty. Discuss the observed strengths of their performance and offer specific suggestions for improvement. Determine if they need additional practice.

Tips:

- Give feedback during practice only if critical information is needed to avoid a negative outcome.
- Avoid embarrassment. Pointing out a single student's errors in front of other students will only serve to embarrass the student and create a negative learning environment.
- Be specific. Describe specific behaviours and reactions, particularly those that the student should continue and those that should be changed.
- Do not criticize. Describe the consequences of the behaviour; do not judge the person.
- Be encouraging. Conclude your feedback with words of encouragement, reaffirming approval of the performance and the expectation that improvement will continue.

- Convey positive feedback by facial expression and tone of voice rather than words, when appropriate.
- Give students an opportunity to respond to the feedback, while you actively listen during this response.

## Role Play

A role play is a learning activity in which students play out roles in a simulated situation that relates to 1 or more learning objectives. Role plays:

- Promote learning through imitation, observation, feedback, analysis, and conceptualization
  - Help students develop communication skills
  - Are useful for exploring, discussing, and influencing students' behaviours and attitudes.
- Role plays are used in 2 ways—as role play demonstration, or as role play practice:
- In role play demonstration, the role play is performed by volunteers in front of the whole class, with the rest of the class as observers. This is especially useful for introducing skills students will later practice in small groups.
  - In role play practice, the role plays are conducted in small groups with some group members responsible for playing the different roles and others responsible for observation and feedback. Members' duties can shift for different scenarios.

## Advantages of role plays

- Encourage student participation and stimulate thinking
- Help students understand another person's perspective or situation
- Can be used to assess and improve a variety of skills and attitudes such as:
  - Communication and interpersonal skills
  - Attitudes such as caring, compassion, and understanding
- Give students opportunities to receive feedback in a safe setting.

## Facilitation

Before:

- Explain the objective(s) of the exercise.
- Define the setting and situation of the role play (distribute role play handouts to participants).
- Brief the participants on their roles, or give them time to read the information and prepare for the role play.
- Explain what the other students should observe and what kind of feedback they should give (provide observer checklists when appropriate, see below).
- Keep role play brief and to the point.

During role play practice:

- Circulate among the small groups to observe the interactions, and make note of points to discuss with the whole group.
- Set time limits for each role play with feedback from observer(s).
- Allow participants to switch roles.

After:

- Engage students in a follow-up discussion.
- Provide feedback and suggestions for improvement.
- Summarise what happened in the session, what was learned, and how it applies to the skill being learned.

### Role play observer checklist

Checklists can be developed to help the observer(s) focus on the attitudes, behaviours and skills that should be demonstrated during the role play. The following is an example of a checklist that could be used when observing a role play of a family planning counselling session.

### Role Play Observer Checklist: General Counselling Skills

<b>Instructions:</b> As you observe the role play, tick the skills demonstrated by the “provider” and make comments when appropriate (use the back of the page if necessary).	
Skills	Skills Observed/Comments
Assures privacy and confidentiality	
Uses active listening techniques (eye contact, non-verbal cues, paraphrase/summarise client concerns)	
Asks mainly open-ended, non-leading questions	
Maintains a friendly tone of voice	
Encourages client to express concerns, ask questions, and explain needs	
Demonstrates sensitivity to cultural, religious, and other factors that affect a client’s decision-making	
Gives accurate, concise information requested by the client	
Uses visual aids appropriately to increase understanding and retention of information	
Lets client make the decision	
Summarises the discussion with the client	
Other:	

### Case Study

A case study is a learning activity that uses realistic written situations focusing on a specific issue, topic, or problem. Students typically read, study, and react to the case study individually or in small groups.

Case studies:

- Develop problem-solving and decision-making skills

- Strengthen students' ability to apply information
- Clarify and expand students' knowledge
- Explore and change attitudes.

### **Advantages**

- Participatory, actively encourages students to interact with one another
- Cases relate directly to course and often to the future work environment
- Student reactions often provide different perspectives and different solutions to problems presented in the case study.

### **Facilitation**

- Before: provide clear directions of how to complete the case study, how to present answers, and what the time limit is.
- During: Students should be given the opportunity to react to the case in one or several ways:
  - Analyze the situation and determine the source of the problem
  - Respond to case study questions
  - Offer possible solutions for the situation being presented.
- After individual or group work, students should be given time to discuss the responses given by different people/groups. You can confirm key points and add any other points you think the participants may have missed.

### **Brainstorming**

Brainstorming is a teaching method that generates a list of ideas, thoughts, or alternative solutions to a specific topic or problem. It is often used along with group discussions. The key to brainstorming is to separate the generation of ideas, or possible solutions to a problem, from the evaluation of these ideas or solutions.

### **Advantages**

- Allows students to share their ideas without criticism
- Allows for creative thinking
- Generates ideas
- Allows for expressing opinions.

### **Facilitation tips**

- Share the objective of the session
- Explain the rules:
  - All ideas will be accepted.
  - Discussions of suggestions will be delayed until after the activity.
  - No criticism of suggestions is allowed.
- State the topic or problem
- Maintain a written record on a flipchart or writing board to prevent repetition and keep students focused
- Provide opportunities for anonymous brainstorming by giving the students cards on which they can write their comments or questions

- Involve all students and provide positive feedback (do not let a few students monopolize the session)
- Review written ideas and suggestions periodically to stimulate additional ideas
- Conclude brainstorming by summarizing and reviewing all suggestions and by placing ideas in categories, if useful.

## **Group Discussions**

Group discussions give students the opportunity to share their ideas, thoughts, questions, and answers in a group setting with a facilitator. The key to an effective discussion is keeping it focused on the learning objectives. Group discussions can be used in support of other teaching methods to:

- Conclude a presentation
- Summarise the main points of an audiovisual presentation
- Check students' understanding of a clinical demonstration
- Examine alternative solutions to a case study
- Explore attitudes exhibited during a role play
- Analyze the results of a brainstorming session.

## **Advantages**

- Provides a forum to discuss attitudes
- Emphasizes key points
- Creates interest and stimulates thinking about a topic
- Encourages active participation.

## **Facilitation tips**

Your role as the discussion facilitator is to keep the discussion focused, ensure that all students have equal opportunity to participate, and intervene when the discussion moves away from the objectives.

- State the topic as part of the introduction.
- Shift the conversation to the students. Encourage all students to participate.
- Allow the group to direct the discussion; act as a referee and intercede only when necessary to ensure the discussion stays on the topic.
- Summarise key points periodically. Provide feedback when appropriate.
- Ensure that no one student dominates the discussion.

## **Tips for Group Learning Activities**

Different learning activities can be used to support students' gains in knowledge and skill mastery. The following tips on conducting group activities should help you incorporate these activities into your courses.

- Before dividing students into groups, clearly describe the activity to all students, ask if any clarification is needed, explain how each group should record its decisions, and suggest how each group's discussion should be reported back to the larger group.
- During group work, move among the students to monitor the work of each group.

- After the groups have completed their activity, bring them together as a large group to discuss the activity.

## A.4 Prepare Knowledge and Skills Assessments

As with all decisions regarding choice of methods and materials, how to assess student knowledge and skills is based directly on learning objectives (which themselves are based on core competencies for becoming a nurse, midwife, or other health worker). Objectives can target gains in knowledge, mastery of skills, or changes in attitude. The type of assessment will depend on the type of objective. For example, you cannot assess how well a student performs an IUCD insertion by means of a written test. You can, however, assess knowledge about the procedure (steps and sequence, etc.). In general, knowledge can be assessed by written or oral tests, case studies, project reports; skills can be assessed by observation of skill performance; and attitudes can be assessed by both.

### Assessing knowledge

Sample multiple choice, true/false, and short answer questions and case studies have been included in the units of this reference guide to assess mastery of many of the defined learning objectives. These can be used, as is, if they respond directly to your own course's learning objectives and the content that you provide. They can also be modified, as appropriate.

In general, follow these guidelines when preparing an assessment of knowledge:

- Identify the learning objectives or outcomes to be assessed and make sure that questions reflect the conditions stated in the objective (for example "identify" is not the same as "list").
- Use simple and clear language in all questions, as well as correct grammar.
- Include at least 1 item per objective.
- Make sure that incorrect answers in multiple choice questions are reasonable and similar in structure and length to correct answers.
- Make each test item separate from every other item. Do not build a test item upon the response to a previous test item.
- Provide clear instructions for each type of item.
- Use answer keys or checklists for scoring.

### Assessing mastery of skills

Direct observation is the most valid way to assess students' skills. It can be difficult to observe each individual student; nevertheless, several techniques can be used to overcome obstacles:

- Staggering assessments by dividing students into small groups for practice and assessment at different times
- Asking other teachers and staff to help with assessment.

### Checklists

The more persons involved with assessing skills, the more important it is to use a standardized checklist to reduce variations in scoring. A checklist is a list of steps needed to perform a skill correctly, given in the correct sequence. It can be developed based on the competency-based learning tools, but only contain sufficient detail to help the assessor evaluate and record the student's performance. The checklist should identify the standards or minimum level of performance for each of the key steps or tasks to be observed.



## **Use assessment results to improve performance**

Make every effort to help your students achieve the core competencies. To help students learn from the assessment of their knowledge and skills:

- Give students an opportunity to ask questions about topics/problems/steps they did not understand or they performed incorrectly
- Tell students to re-study or practice the topics/steps they did not get right/perform correctly
- If many students had trouble with the same information/tasks, there may be a problem with the teaching methods or materials or how a task was defined. Do not be afraid to revise problematic learning objectives or to adapt teaching methods and materials to better address the content.

## **References**

The World Health Organization (WHO) and Jhpiego. 2005. Effective teaching: A guide for educating health care providers. Geneva: WHO.

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