

# Family Planning Manual for Merrygold Health Network

Participant's Manual  
2008



Uttar Pradesh Social Franchising Project

**A project supported by USAID & SIFPSA. Implemented by HLPFPT**



# Preface

HLFPPT is an organization committed to work with various partners pioneering innovations for bettering health outcomes for the poor. Merrygold Health Network is one of such innovations in the field of Social Franchising.

Merrygold Health Network, aims towards achieving an objective of improving Maternal and Child Health through increased access to low cost – high quality healthcare services, for rural and urban working poor in Uttar Pradesh. In U.P. Social Franchising Project (supported by USAID and SIFPSA), HLPPT as an implementing agency, will be establishing 70 fully franchised Merrygold Hospitals at district level, 700 partially franchised Merrysilver Clinics at block level and will be working with more than 10,000 Tarang partners (ASHAs, Chemists, Fare price shop owners, Tarang health committee members, Opinion leaders, Anganwadi workers, Depot holders) and AYUSH practitioners at the village level by 2010. Two model hospitals are already established in Kanpur and Agra focusing on maternal and child health care.

In our endeavour to make this a successful model, it was felt that training of doctors, nurses and other team members will be a key component to improve the quality of service delivery and equip the staff with appropriate knowledge and skill.

Quality of care in delivery of contraceptive services plays important influence on acceptance of any method, continuation and ultimately client satisfaction. Understanding the need for evidence-based practice of family planning the training team of UPSF with technical experts has designed “*Family Planning Manual for Merrygold Health Network - 2008*” for the Family Planning service providers. It has been pre-tested at Merrygold L0 hospitals at Kanpur and Agra. The inputs and feedbacks from the hospital staff and comments of review committee members from SIFPSA and ITAP, has given this manual the present shape.

I am sure that this manual along with the Protocols on Family planning, when used by service providers in the Social Franchising Project will work as an enabling tool towards excellent service delivery.

**HLFPPT**

# Acknowledgement

Family planning means that a couple decides when to have children and when not to have them. It is the right of a couple to have children by choice and not by chance. I present this *“Family Planning Manual for Merrygold Health Network - 2008”* for the doctors of Merrygold Health Network to improve their skills through standard guidelines for providing Family Planning Services. This manual is the result of sincere intent, aspirations and hard work of all those who are an integral part of the network.

I am grateful to Mr. G. Manoj, (CEO, HLPPT) who has shown faith in my entire team to undertake this task.

My sincere thanks to Mr. Rajeev Kapoor I.A.S. (Executive Director - SIFPSA & Mission Director - NRHM), Mr. S. Krishnaswamy (General Manager Private Sector - SIFPSA), Dr. M. K. Sinha (General Manager Public Sector – SIFPSA), Ms. Savita Chauhan (Dy. General Manager Private Sector - SIFPSA), Dr. Lovleen Johari (Senior Reproductive Health Advisor, USAID) and Ms. Shuvi Sharma (Manager - Social Marketing & Franchising, ITAP) for their support and encouragement for developing this manual.

I express my deep appreciation and thanks to Dr. Brinda Frey and Dr. Amrita Kansal from HLPPT, for developing and designing this manual. I also thank Ms. Divya Babbar for providing secretarial assistance.

I express deep appreciation and thanks to Dr. Manju Shukla, Dr. Veena Bajpai, Dr. Humaira Aquil, Dr. Ravi Anand, Dr. Nisha Gupta for reviewing this manual and providing their valuable comments.

This manual has been pre tested at both the L0 hospitals at Kanpur and Agra. Efforts made by Mr. Alok Tabela, Mr. B. K. Mishra from HLPPT, in organizing the trainings and involvement of entire Merrygold hospital staff in trainings was commendable.

Special mention needs to be made of Mr. Sharad Agarwal, Dr. Sanjeev Yadav, Dr. Brinda Frey, Mr. Rajeev Shukla, Mr. Gajendra Verma, Ms. Preeti Dwivedi and entire U.P. Social Franchising team for their efforts, valuable time and support for arranging and organizing training program based on this manual.

**Dr. Vasanthi Krishnan**  
**Head, Technical Services Division**  
**HLPPT**

**Design and Development Team –**

<b>S N</b>	<b>Names</b>	<b>Designation &amp; Organization</b>
1.	Dr. Vasanthi Krishnan	Head, TSD, HLPPT
2.	Dr. Brinda Frey	Head, Clinical Services - Merrygold Health Network, HLPPT
3.	Dr. Amrita Kansal	Consultant, HLPPT

**Review Team –**

<b>S.N.</b>	<b>Names</b>	<b>Designation &amp; Organization</b>
1.	Dr. Manju Shukla	Professor of Gynaecology, Queen Mary's Hospital, KGMU, Lucknow
2.	Dr. Veena Bajpai	PC-PS, SIFPSA, Lucknow
3.	Dr. Humaira Aquil	APC-PS, SIFPSA, Lucknow
4.	Dr. Ravi Anand	DIMPA Program Manager & Technical Advisor, PSP - One
5.	Dr. Nisha Gupta	Associate Director, FHI

# Abbreviations

AIDS	Acquired Immuno Defeciency Syndrome
COC	Combined Oral Contraceptive Pills
CSW	Commercial Sex Workers
DMPA	Depot Medroxy Progesterone Acetate
ECP	Emergency Contraceptive Pills
FC	Female Condom
FP	Family Planning
HIV	Human Immuno Defeciency Virus
IUCD	Intra Uterine Contraceptive Device
LAM	Lactational Amenorrhoea Method
MOHFW	Ministry of Health and Family Welfare
MTP	Medical Termination of Pregnancy
NET – EN	Nor – Ethisterone Enanthate
NFHS	National Family Health Survey
NSAID	Nonsteroidal anti-inflammatory drug
NSV	No scalpel Vasectomy
OBSI	Optimal Birth Spacing Interval
OCP	Oral Contraceptive Pills
PID	Pelvic Inflammatory Disease
POI	Progestin only injectables
POP	Progesteron Only Pills
SDM	Standard Days Method
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection

# Index

No.	Contents	Page
	<b>About the Manual</b>	
<b>Module 1</b>	<b>Introduction to Family Planning and its scenario in India</b>	
Unit 1.1	Introduction to Family Planning	
Unit 1.2	Current scenario in India	
<b>Module 2</b>	<b>Counselling in Family Planning</b>	
Unit 2.1	Introduction to Counselling	
<b>Module 3</b>	<b>Contraceptive Methods</b>	
Unit 3.1	Oral Contraceptive Pills	
Unit 3.2	Injectable Contraceptives	
Unit 3.3	Barrier methods	
Unit 3.4	Intra Uterine Contraceptive Device (IUCD)	
Unit 3.5	Natural methods	
Unit 3.6	Permanent Methods	
Unit 3.7	Emergency Contraceptive Methods	
<b>Module 4</b>	<b>Family Planning for Special Groups</b>	
Unit 4.1	Serving Special Groups	
	<b>Annexure</b>	
	<b>References</b>	

## List of Tables

S.N.	Title of the Table	Page No.
1	When to Start Pills	
2	How to deal with common problems of pills	
3	When can a woman start POP	
4	Managing problems of POP	
5	Managing problems occurring from the use of condom	
6	When to start an IUCD	
7	The Lactational Amenorrhea Method (LAM)	
8	Eligibility of providers performing male Sterilization	
9	Eligibility of Providers for Performing Female Sterilization	
10	Earliest time that a woman can start a family planning method after childbirth.	
11	Special family planning considerations for clients with STIs, HIV, AIDS, or on Antiretroviral Therapy.	

## List of Figures

Fig No.	Figure Name	Page
1	Protocol for Missed pill	
2	Cycle beads for SDM	

## About the Manual

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 freedom are:

1. The rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law,
2. The right of access to appropriate health-care services that will enable women to safely go through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

The current trend in family planning in India shows that knowledge is almost universal among eligible couples, yet the acceptance remains low, especially for spacing methods. Female sterilization remains the most widely used family planning (FP) method in spite of efforts to popularize male sterilization. The current unmet need for family planning (2005-06) is about 13 percent, 6% of which the need for spacing is about 7% for limiting births, which needs to be met through programmatic interventions. Poor access to and quality of family planning services are two important issues in catering to the unmet demand. Therefore, the trained family planning providers in both the public and private sectors need to be up-to-date with the recent developments in the contraceptive technology, so that they can provide high-quality family planning services to those who voluntarily want to accept contraception.

Keeping in view the above points this manual is developed for Merrygold Health Network to give a comprehensive knowledge of various aspects of family planning services. The practical, up-to-date guidance in this manual will help to improve the quality of family planning services and maximize people's access to them. It can help family planning providers to assist clients choosing a family planning method, to support effective use, and to solve clients' problems.



# MODULE 1

## Introduction and Current Scenario in India

Unit 1.1	Introduction to Family Planning
Unit 1.2	Current Scenario in India.

# About this Module

Contraceptive use has been increasing in India over the last few decades. It is characterised by the predominance of non-reversible methods, limited use of male / couple-dependent methods, considerable levels of discontinuation, and negligible use of contraceptives among both married and unmarried adolescents.

According to official statistics out of the estimated 171 million eligible couples in India, 87 million eligible couples were effectively protected against conception by various contraceptive methods in 2000 (MOHFW 2003). However, at the same time, there is a substantial unmet need for contraception.

In this manual Family Planning in the perspective of reproductive rights and current scenario in the country will be discussed.

## Unit 1.1 Introduction to Family Planning

### Learning Objectives

At the end of the session, the participants should be able to:

- Explain Family Planning (FP) within reproductive rights perspectives.
- Mention about how access to quality contraceptive services is critical.

**Family planning** means that a couple decides when to have children and when not to have them. It is the right of a couple to have children by choice and not by chance.

When a couple gets married, they should discuss when they want to have a child. It is beneficial to have the first child after 2-3 years of marriage as a couple gets time to adjust to each other and married life. Young brides should not become mothers before 18 years as it is dangerous for their life and health and chances of having a healthy baby is less if the mother is below 18 years.

Once the couple has one child, they should delay the second baby by 3-5 years. This is called **Optimal Birth Spacing Interval (OBSI)** and is best for mother's health and also for children's health. It has been proved by many research studies there is a strong direct relationship between Optimal Birth Spacing Interval and maternal mortality/ infant mortality.

Having small families is good for all the family members. Once the couple has the desired number of children, and they have decided not to have any more children in future, they can limit the family size by use of family Planning Methods.

## Unit 1.2 Current Scenario in India (Findings from NFHS-3)

### Learning Objectives

At the end of this session the participants will be able to learn

- Current scenario of Family Planning methods usage and discontinuation of use in India.
- Sources of contraceptive methods used in India.
- Magnitude of unmet need.

### Ever Use of contraception

- Two-thirds of currently married women have used a family planning method at sometime in their lives. Since NFHS-2, ever use of any method among currently married women has increased by 11 percentage points. The increase is greatest for spacing methods; ever use of condoms and the rhythm method has increased by 6 percentage points each.

### Current use

- The contraceptive prevalence rate for currently married women in India is 56 percent, up from 48 percent in NFHS-2.
- Female sterilization, with a prevalence of 37 percent, accounts for 66 percent of all contraceptive use, down from 71 percent of all contraceptive use at the time of NFHS-2. The use of female sterilization is higher for women with less education and women who are employed for cash than for most other groups of women. The highest adoption rate of female sterilization, at 67 percent, is among women with three children who have two sons.
- The most common spacing methods are condoms and the rhythm method, each used by 5 percent of currently married women.
- Contraceptive use among currently married women varies markedly by education, religion, caste, and wealth.
- Current use of contraception varies greatly with parity too; first increasing from 34 percent for women with one child to 74 percent for women with three children, and then declining to 63 percent for women with 4 or more children. At each parity, women who have sons are much more likely than women who have no sons to be using contraception.

### Source of contraceptive method

- Seventy-one percent of modern contraceptive users obtained their method from a public sector source.
- Eighty-four percent of sterilized women had the operation in a government facility, usually in a government or municipal hospital.

- By contrast, just over half of IUCD users utilized the private medical sector for their IUCD insertion.
- Almost two-thirds of pill users got their most recent supply from the private medical sector, which is also the most common source for condoms.
- According to women's reports, 62 percent of pill users and 44 percent of condom users who knew the brand name of their method were using socially-marketed brands.

### **Discontinuation**

- Discontinuation rates for temporary methods are fairly high: 39 percent of users of temporary methods discontinue use within 12 months of initiating use.
- About half of pill users discontinue use within the first year of adopting the method, and discontinuation is also high for condoms (45 percent). One-year discontinuation rates are also substantial for users of the rhythm method (32 percent) and withdrawal (35 percent), the methods with the highest failure rates.

### **Magnitude of Unmet Need**

Unmet need for family planning among currently married women is 13 percent, down from 16 percent in NFHS-2. Unmet need decreases with age, from 27 percent for women age 15-19, to 2 percent for women age 45-49. Younger women (age 15-24) have a greater unmet need for spacing than for limiting. Rural women have higher unmet need than urban women for both spacing and limiting. Unmet need for family planning varies greatly by state; more than 20 percent of women have an unmet need for contraception in Uttar Pradesh.

# MODULE 2

## Counselling in Family Planning

Unit 2.1      Introduction to Counselling

# About this Module

Counselling is a process of helping clients confirm or make informed and voluntary decisions about their individual care. It should be always be responsive to each client's need s and values.

This Module will help the participants to learn the tips for effective counselling and Reproductive rights of client.

## Unit 2.1 Introduction to Counselling

### Learning objectives

At the end of the session, the participants should be able to:

- Explain GATHER technique and tips for effective counselling.
- Tips for effective counselling.
- Reproductive rights of clients.

**Counselling** is a two – way process of exchanging information that involves listening to client and providing them accurate information, option and understanding of the matter. During counselling session service provider must ensure that the clients make free, informed and well – considered decision about their own contraceptive practices, child bearing and spacing.

### 2.1.1 Steps for counselling

It has six basic elements, commonly known as **GATHER** steps (each letter stands for one-steps)

**G** - Greet Clients

**A** - Ask Clients about Their needs and desires

**T** - Tell Clients about their Choices to make an informed choice

**H** - Help Clients Choose the method in terms of her own needs and circumstances

**E** - Explain how to use the method

**R** - Return for Follow- Up

### 2.1.2 Three phases of Family planning counselling

**General family planning counselling** – it is based on information on a range of methods and to assist in choosing a method that is appropriate for her.

**Method specific counselling** - the client is provided more information about the method, as well as instructions on how to use it safely and effectively.

**Follow- up counselling (during each visit)** - The client's satisfaction with the product is assessed, and any problems or concerns are discussed.

### 2.1.3 Tips for effective counselling

An effective counsellor understands the client's feeling and needs by actively listening to them. With this the counsellor adapts counselling to suit each client. He/she can perform well if they,

- Show that you understand and care about them. Maintain eye contact with the client. Build Rapport.
- Privacy and confidentiality should be maintained during counselling.
- Listen attentively to what the client has to say, using non- verbal gestures, such as nodding to encourage her.
- Are patient and never forces client to finish speaking.
- Give clients useful, accurate information. Help them understand what this information means to them.
- Create a two-way interaction with clients by listening attentively and encouraging clients to ask questions and express concerns.
- Help clients to make their own choices, based on clear information and their own feelings, situation, and needs.
- Help them remember key information.

### 2.1.4 Rights of Client

While serving clients, it is important to remember that they have the right of -

- **Information:** to understand the advantages and availability of family planning
- **Access:** to be able to obtain services, regardless of race, creed, social status or lifestyle
- **Choice:** to make decisions freely regarding family planning and contraceptive methods
- **Safety:** to practice safe and effective family planning
- **Privacy:** access to a private space for receiving counseling and services
- **Confidentiality:** to be certain that any personal information will be kept confidential
- **Dignity:** to be treated with courtesy, consideration and complete attention
- **Comfort:** to feel comfortable when receiving services

- **Continuity:** to receive family planning services and supplies at the times when they are necessary
- **Opinion:** to express points of view regarding the services being offered
- **Refuse:** any type of examination.



# MODULE 3

## Contraceptive Methods

- Unit 3.1 Oral Contraceptive Pills
- Unit 3.2 Injectables Contraceptives
- Unit 3.3 Barrier Methods
- Unit 3.4 Intrauterine Contraceptive Devices
- Unit 3.5 Natural Methods
- Unit 3.6 Permanent Methods
- Unit 3.7 Emergency Contraceptive Methods

# About this Module

Preventive methods to help couple avoid unwanted pregnancies can be broadly grouped into two classes - **Spacing methods and Terminal methods**. In this module participants will learn about the various commonly used methods. In this module we will also discuss About “Emergency contraception” which is an important strategy to prevent unwanted pregnancy as well as the number of unsafe abortions. The entire module is divided into nine units covering all the methods of contraception.

## Unit 3.1 Oral Contraceptive Pills

### Learning Objectives

At the end of the session, the participants should be able to understand:

- Different types of oral contraceptives pills (OCP)
- The mechanism of action of OCP
- The major advantages and disadvantages of OCP
- Client Screening Guidelines for OCP
- Client instructions for effective use of the OCP
- Steps for management of common side effects of OCP
- Administration of ECP

### 3.1.1 Combined Oral Contraceptive Pills (COC)

COC is widely accepted, reliable, reversible, inexpensive, independent of coitus, safe and effective, (acronym- ARISE) method of contraception.

#### a) Mechanism of action and effectiveness

COC has an effectiveness of 99.97% to 99.99%. The failure rate is 0.3 % as commonly used and only 0.1% on correct and consistent use.

The mechanism of action is as follows:

- Inhibition of ovulation by suppressing FSH and LH
- Alternation of endometrium to make it unsuitable for implantation even if the ovum is fertilized.
- Changes in cervical mucus, which make it hostile to the sperm

## **b) Important health benefits**

### **Fertility-related benefits**

- Prevention of pregnancy
- Offers protection against ectopic pregnancy

### **Menstrual benefits**

- Menstrual cycle stabilization
- Lesser iron deficiency anaemia due to lighter menstrual cycles
- More regular menstrual cycles
- Less dysmenorrhoea
- Less severe premenstrual symptoms

### **Protection from some cancers**

- Protection against cancers e.g. endometrial and ovarian cancer
- Protection against benign diseases e.g. benign breast diseases like fibrocystic and fibroadenomatosis disease decreased by 50-70%

### **Other possible health benefits**

- Protection against pelvic inflammatory diseases when compared to non-users
- Reduces risk of follicular cyst by 50% and corpus luteal cyst by 80%.
- Past contraceptive use protects women after they reach menopause where reduced risk of low bone mineral density was documented
- Reduction in acne
- Decreased incidence of rheumatoid arthritis

## **c) Client Screening Guidelines for COC**

Combined Oral Contraceptive Pills can be given to all women except in the following conditions

1. Pregnancy (suspected or confirmed)
2. Breastfeeding infant less than six months
3. Heavy smoker whose age is 35 years or more
4. High blood pressure  $\geq 140/90$  mm Hg
5. Vascular Disease
6. Current or history of Deep Vein thrombosis or Pulmonary Embolism
7. Current or history of Ischaemic Heart Disease or complicated Valvular Heart Disease
8. History of Stroke
9. Migraine with aura or without aura
10. Current or past history of Breast Cancer
11. Diabetes of more than 20 yrs duration or complicated with nephropathy/retinopathy/neuropathy
12. Current Gall Bladder Disease
13. Active viral hepatitis/ benign or malignant liver tumours/severe cirrhosis
14. Taking medicines like rifampicin, phenytoin, carbamezine and barbiturates.

**Source:** WHO Medical Eligibility Criteria for Contraceptive Use, 2004, category 3 and 4

**Table 1: When to Start Pills**

<b>Phase</b>	<b>Recommended Guidelines</b>
Having a menstrual cycle	<ul style="list-style-type: none"> <li>• Within 5 days after the start of her menstrual bleeding.</li> </ul>
Amenorrhoea	<ul style="list-style-type: none"> <li>• Any day if she is reasonably certain that she is not pregnant</li> </ul>
Breastfeeding	<ul style="list-style-type: none"> <li>• For women who are less than 6 months postpartum and primarily breastfeeding, use of COC is usually not recommended.</li> <li>• <b>If not breastfeeding</b>, she can start COC at any time, if she is reasonably certain that she is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.</li> <li>• If she is more than 6 months postpartum and amenorrhoeic, she can start COC as advised above.</li> <li>• If she is more than 6 months postpartum and her menstrual cycles have returned, she can start COC as advised for other women with menstrual cycles</li> </ul>
Switching from another hormonal method	<ul style="list-style-type: none"> <li>• Women using the hormonal method consistently and correctly, who are reasonably certain that they are not pregnant can, start COC immediately. There is no need to wait for the next menstrual period.</li> <li>• If her previous method was an injectable, she should start COC when the repeat injection would have been given. No additional contraceptive protection is required.</li> </ul>
Switching from non-hormonal method	<ul style="list-style-type: none"> <li>• She can start COC within 5 days after the start of her menstrual bleeding. She can also start immediately or at any other time, if it reasonably certain that she is not pregnant. If it has been more than 5 days after the menstrual bleeding started, she will need to abstain from sex or use additional contraceptive protection for the next 7 days</li> </ul>
Switching from IUCD (including hormonal)	<ul style="list-style-type: none"> <li>• She can start COC within 5 days after the start of her menstrual bleeding. No additional contraceptive protection is required. The IUCD can be removed at that time.</li> <li>• She can also start immediately or at any other time, if it reasonably certain that she is not pregnant. If she has been sexually active during this menstrual cycle, and it has been more than 5 days since menstrual bleeding started, it is recommended that IUCD should be removed at the time of her next menstrual period.</li> </ul>

**Source:**

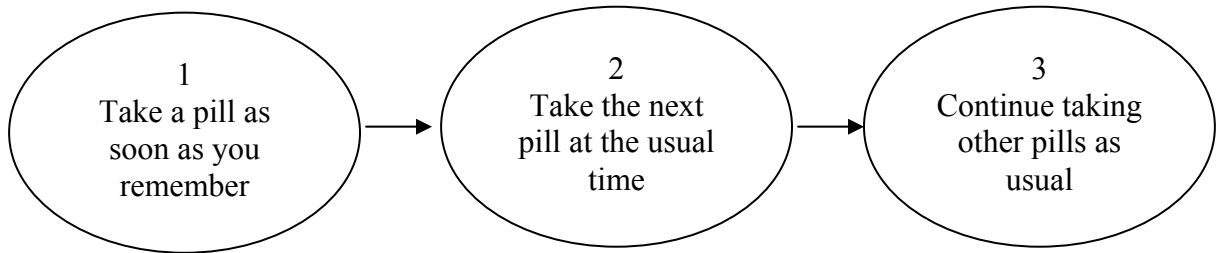
- Family Planning – A global Handbook for providers, A WHO family planning cornerstone, 2007.
- Contraceptive Updates, Reference manual for Doctors, Oct. 2007, MOHFW, Govt. of India.

**d)            How to use the 28 pills packet**

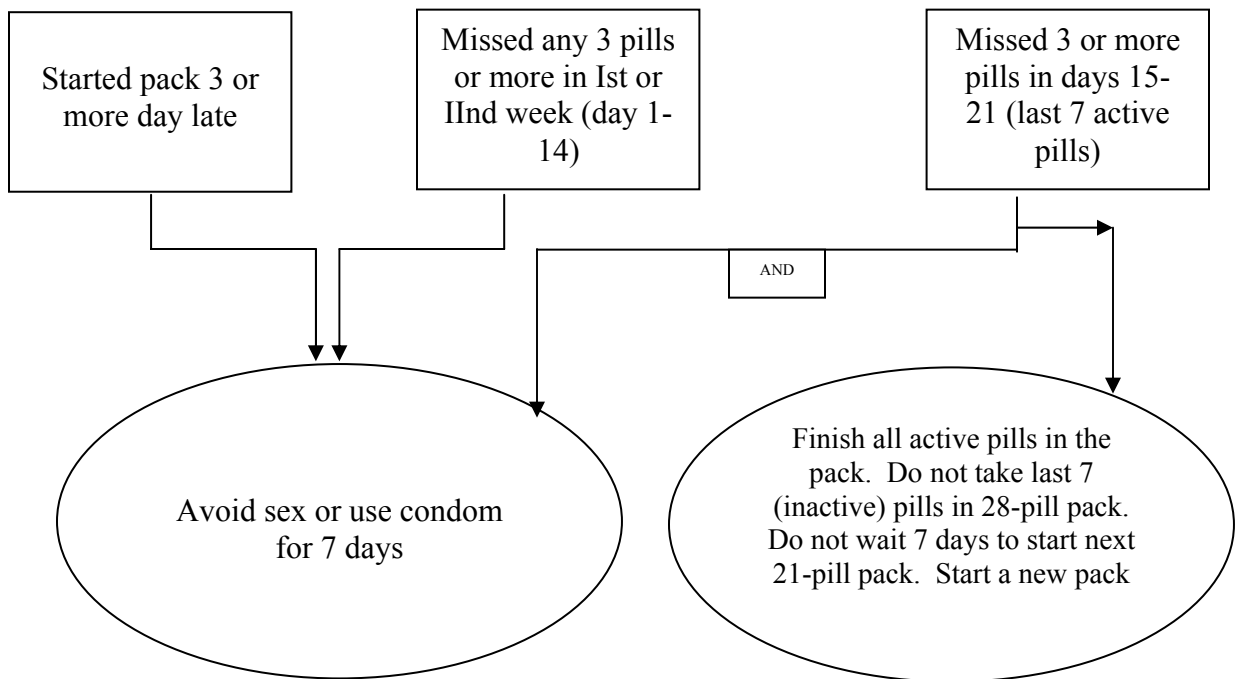
- Advise the client to follow the direction or arrows on the packet, one each day. Taking the pill at the same (fixed) time of the day might help her to remember taking them.
- With the 28-pill packets, last 7, dark coloured pills (Reminder Pills) do not contain hormones. Even if she forgets to take the reminder pills she is still protected from pregnancy.
- When she finishes one pack, she should take the first pill from the next pack on the very next day.
- Instruct her on what to do in case she misses a pill (see the protocol for missed pill given below).
- Tell the client that it does not provide any protection against transmission of HIV/STIs.

**Fig 1: Protocol for Missed pill**

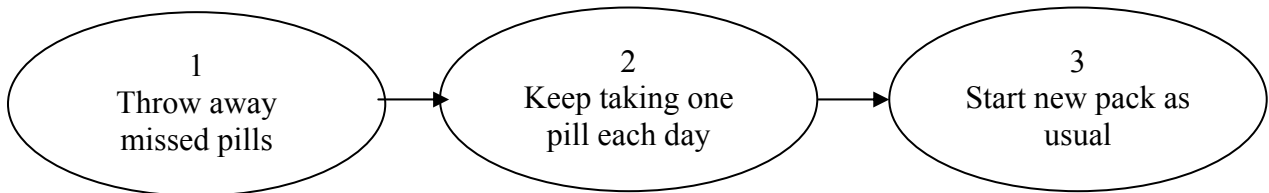
**If one or more active pills (1-21) is missed:**



**In these special cases, ALSO follow these special rules.**



**If any of the 7 inactive pills is missed (in a 28 pill pack only):**



**e) Follow-up**

- The client can return for more pills at her convenience any time before her supply runs out. **Helping clients at any routine return visit.**
- Ask if the client has any questions or anything to discuss.
- Ask the client about her experience with the method. Give her any information she needs and invite her to return again any time for help. If she has problems that cannot be resolved, help her choose another method.
- If she has not developed any problems which prevent use of COC, provide more supplies if needed. Plan for the next visit before she will need more pills.

**f) Common Side- Effects and their Management**

- Changes in bleeding patterns including:
  - Lighter bleeding and fewer days of bleeding
  - Irregular bleeding
  - Infrequent bleeding
  - No monthly bleeding
- Headaches
- Dizziness
- Nausea
- Breast tenderness
- Weight change Mood changes
- 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 COC, blood pressure declines quickly after use of COC stops.

**g) Managing Any Problems**

- Problems Reported as Side Effects or Problems with use may or may not be due to the method.
- Problems with side effects affect women's satisfaction and use of COC. They deserve the provider's attention. If the client reports side effects or problems, listen to her concerns, give her advice, and, if appropriate, treat.
- Encourage her to keep taking a pill every day even if she has side effects. Missing pills can risk pregnancy and may make some side effects worse.
- Many side effects will subside after a few months of use. For a woman whose side effects persist, give her a different COC formulation, if available, for at least 3 months.
- Offer to help the client choose another method—now, if she wishes, or if problems cannot be overcome.

**Table 2: How to deal with common problems of pills**

<b>Problem</b>	<b>Remedies</b>
Nausea	Suggest taking pills at night or with food
Minor Headaches	Suggest taking ibuprofen, aspirin, paracetamol, or other non/steroidal anti-inflammatory drug
Amenorrhea (no monthly bleeding period) common, not usually a sign of pregnancy	<ul style="list-style-type: none"> <li>• Ask is she is having any bleeding at all. (She may just have a small stain on her underclothing and not recognize it as vaginal bleeding). If so, reassure her.</li> <li>• Ask if she is sure she has been taking the pill every day. If she has, reassure her that she is not likely to be pregnant. She should start the next packet of pills on time.</li> </ul> <p>If she is unsure:</p> <ul style="list-style-type: none"> <li>• Ask her if she might have missed the 7-day break between the 21-day packets. This may have caused period. Reassure her that she is probably not pregnant.</li> <li>• Ask is she has missed 3 or more active hormone pills in a row. If so, assess whether or not she is pregnant. If she may be pregnant, tell her. Ask her to stop taking oral pills. Offer her condoms. She can use them until her next period or until clear about whether or not she is pregnant.</li> <li>• Ask if she has recently stopped taking pills               <ul style="list-style-type: none"> <li>- If she is not pregnant, her periods may take a few months to return.</li> <li>- Ask if she had irregular periods before she starting the COC. If so, her periods may be irregular again after the stops the pills.</li> </ul> </li> </ul>
Spotting or bleeding between monthly periods over several months	<ul style="list-style-type: none"> <li>• Ask is she has missed any pills. Explain that missing pills can cause bleeding between periods, even when taking pills every day</li> <li>• Ask if she has had vomiting or diarrhoea.</li> <li>• Ask is she is taking rifampicin or medicines for seizure, which may make COC less effective. Encourage her to use condoms.</li> </ul>
Very bad headaches (migraines)	A woman who develops migraine while using COC should switch to an alternative method. She should not choose a POP (progesterone only pill) method if she has blurred vision, brief loss of vision, sees flashing lights or has brief trouble in speaking or moving before, during or after the headaches.
Breast tenderness	<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, ibuprofen, paracetamol or other pain reliever.</li> <li>• Consider locally available remedies.</li> </ul>
Weight Change	<ul style="list-style-type: none"> <li>• Review diet and counsel as needed</li> </ul>



Mood changes or changes in sex drive	<ul style="list-style-type: none"> <li>• Some women have changes in mood during the hormone-free week.</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>
Acne	<ul style="list-style-type: none"> <li>• Acne usually improves with COC use. It may worsen for a few women.</li> <li>• If she has been taking pills for more than a few months and acne persists, give her a different COC formulation, if available for at least 3 months.</li> <li>• Consider locally available remedies</li> </ul>

**New Problems That May Require Switching Methods may or may not be due to the method.**

1. **Unexplained vaginal bleeding-** Evaluate to diagnose and treat as appropriate. If bleeding is caused by sexually transmitted infection or pelvic inflammatory disease, she can continue using COC during treatment.
2. **Starting treatment with anticonvulsants or rifampicin** -They make COC less effective. If using these medications long-term, she may want a different method, such as monthly injectables, progestin-only injectables, or a copper-bearing IUCD. If using these medications short-term, she can use a backup method along with COC.
3. **Migraine headaches** -Regardless of her age, a woman who develops migraine headaches, with or without aura, or whose migraine headaches become worse while using COC should stop using COC. Help her choose a method without estrogen.
4. **Circumstances that will keep her from walking for one week or more:** e.g. major surgery, or her leg is in a cast, or for other reasons, she should:
  - Tell her doctors that she is using COC.
  - Stop taking COC and use a backup method during this period.
  - Restart COC 2 weeks after she can move about again.
5. **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 caused by diabetes, or gall bladder disease). Tell her to stop taking COC. Give her a backup method to use.
6. **Suspected pregnancy** Assess for pregnancy. Tell her to stop taking COC if pregnancy is confirmed. There are no known risks to a fetus conceived while a woman is taking

### 3.1.2 Progesterone only Pills (Minipill)

Progesterone-only Pills are one of the best options available to a woman during lactation. POP does not affect the quality and quantity of breast milk and has no estrogens related side effects.

**a) Mechanism of action:** primarily acts by-

- Thickening of cervical mucous
- Suppression of ovulation
- Involution of endometrium

**b) Effectiveness**

It is 99.95% effective with correct and consistent use. The failure rate is of only 0.5% in the first year in breastfeeding women. The failure rates are higher in younger women than in women over 40. These are most effective, when taken at about same time every day.

**c) Advantages**

- Can be used by lactating mothers 6 weeks after childbirth. Quantity and quality of breast milk remains unaffected.
- No estrogen side-effects. Does not increase risk of estrogen-related complications such as heart attack or stroke.
- The client has to take 1 pill every day with no break, which is easier to remember than taking 21- day COC.
- Can be very effective during breastfeeding.
- Even less risk of progestin-related side effects, such as acne and weight gain, than with COC.
- May help prevent benign breast disease, endometrial and ovarian cancer and pelvic inflammatory disease

**d) Disadvantages**

- POP need to be taken at about the same time each day to work best. For women who are not breastfeeding, even taking a pill more than a few hours late increases the risk of pregnancy, and missing 2 or more pills increases the risk greatly.
- Does not prevent ectopic pregnancy.

**e) Client Screening Guidelines for Progestin only Pills (POP)**

POP can be given to all women except in the following conditions-

1. Pregnancy (suspected or confirmed)
2. Breastfeeding infant less than six weeks
3. Current Deep Vein thrombosis or Pulmonary Embolism

4. Current or history of Ischemic Heart Disease
5. History of Stroke
6. Migraine with aura
7. Current or past history of Breast Cancer
8. Active viral hepatitis/ benign or malignant liver tumours/severe cirrhosis
9. Taking medicines like rifampicin, phenytoin, carbamazepine, barbiturates, Primidone, Topiramate, Oxcarbazepine.

**Source:** WHO Medical Eligibility Criteria for Contraceptive Use, 2004, category 3 and 4

## f) When can a Woman Start POP?

**Table 3: When can a woman start POP**

<b>Women's situation</b>	<b>When to start</b>
During menstrual cycle	<ul style="list-style-type: none"> <li>• She can start POP within 5 days after the start of her menstrual bleeding. No additional contraception is needed. She can also start POP at any other time, if she is reasonably certain that she is not pregnant.</li> </ul>
Breastfeeding	<ul style="list-style-type: none"> <li>• <b>If her menstrual bleeding has not returned</b> and it is reasonably certain that she is not pregnant, she can start POP anytime after 6 weeks of giving birth. If POP are started after 6 month of giving birth, she should be advised to abstain from sex or use additional contraceptive protection for the next 2 days.</li> <li>• <b>If her menstrual cycle has returned</b>, she can start POP as advised for any other woman with a menstrual cycle.</li> <li>• For women who are less than 6 weeks postpartum and primarily breastfeeding, use of POP is not recommended.</li> </ul>
Switching from another hormonal method	<ul style="list-style-type: none"> <li>• She can start POP immediately, if she has been using her hormonal method consistently and correctly, or if she is otherwise reasonably certain that she is not pregnant. There is no need to wait for the next menstrual period.</li> <li>• If her previous method was an injectable, she should start POP at the time when the repeat injection would have been given. NO additional contraceptive protection is needed.</li> <li>• She can start POP within 5 days after the start of her menstrual bleeding. No additional contraceptive protection is needed.</li> </ul>
Switching from a non-hormonal method (other than IUCD)	<ul style="list-style-type: none"> <li>• She can also start immediately or any other time, if is reasonably certain that she is not pregnant. If it has been more than 5 days since menstrual bleeding started, she will need to abstain from sex or use additional contraceptive protection for the next 2 days.</li> </ul>
No Monthly Bleeding	<ul style="list-style-type: none"> <li>• She can start POP anytime it is reasonably certain that she is not pregnant. She will need a backup method for the first two days of taking pills.</li> </ul>
After miscarriage or abortion	<ul style="list-style-type: none"> <li>• Immediately. If she is starting within 7 days after first or second trimester miscarriage or abortion, no need for backup method.</li> <li>• If it is more than 7 days after first or second trimester miscarriage or abortion, she can start POP anytime it is reasonably certain that she is not pregnant. She will need a backup method for the first 2 days of taking pill</li> </ul>

**g) Explaining how to use POP**

- The client should always take one pill every day.
- It is best to take the pill at the same time each day if possible, as even taking a pill more than a few hours late increases the risk of pregnancy. Missing two or more pills in a row greatly increases the risk of pregnancy.

**h) Starting the next packet**

- There is to be no gap between packets, she should take the first pill from the next package on the very next day (All pills are active, hormonal pills)

**i) Managing Missed Pills**

If a woman is 3 or more hours late in taking a pill or misses one completely she should take a missed pill as soon as she remembers and then keep taking one pill every day as usual.

- A breastfeeding woman using POP for extra protection is still protected if she misses the pill.
- A woman who is not breastfeeding or who is breastfeeding but whose menses have resumed is 3 hours late or misses one completely should also use condoms or else avoid sex for two days. She should also take last missed pill as soon as she can. Then she should keep taking one pill every day as usual.

**j) Following up POP users**

Helping clients at any routine return visit

- Same as in COC
- If the client has developed active liver disease, ask her to stop the pill and do not provide her with any further pill. Refer her to care and help her to choose a non-hormonal contraceptive.
- If she is taking medicine for seizures, rifampicin or griseofulvin, provide condoms to use along with POP. If she prefers, or if she is on long-term treatment, help her choose another effective contraceptive method.
- If she has developed breast cancer, discontinue the pills and help her choose another non-hormonal contraceptive.
- It is important to note that if the client is dissatisfied with treatment and counselling, it is imperative that she be helped to choose another method of contraception, to ensure protection against pregnancy as per her wish.

**k) Side Effects**

Changes in menstrual bleeding, irregular periods, spotting or bleeding between periods and amenorrhea or missed periods, possibly for several months. A few women may have

prolonged or heavy periods, headaches, dizziness, breast tenderness and possibly other side effects.

## 1) Managing Problems

**Table 4: Managing problems of POP**

Problem	Plan of Action
Amenorrhoea (no monthly bleeding period) or irregular bleeding and spotting in a breastfeeding woman	<ul style="list-style-type: none"> <li>• Reassure the woman that this is normal during breastfeeding or not a woman is using progestin – only oral contraceptives.</li> <li>• Ask if she has been having regular monthly periods while taking POP and then suddenly had no periods. She may have been ovulating. Rule out pregnancy.</li> <li>• If not likely that she is pregnant, tell the client that these bleeding patterns are normal with POP. They are not harmful. She is losing less blood than she would if she were not using family planning. Explain to her that this can improve her health as it helps prevent anaemia.</li> </ul>
Unexplained abnormal vaginal bleeding that suggests pregnancy or underlying medical condition.	<ul style="list-style-type: none"> <li>• She can continue using POP contraceptives while her condition is being evaluated.</li> <li>• Explain that POP contraceptives sometimes change the vaginal bleeding pattern, and that this is not harmful.</li> <li>• Evaluate and treat any underlying medical condition, including ectopic pregnancy, or refer her to care.</li> </ul>
Heart disease due to blocked arteries (ischemic heart disease or stroke)	<ul style="list-style-type: none"> <li>• A woman who has this condition can safely start using progestin only contraceptives. IF, however, the condition develops after she starts using them, she should switch to a method without hormones.</li> <li>• Refer her to care as appropriate</li> </ul>
Very bad headaches (migraines) with blurred vision	<ul style="list-style-type: none"> <li>• A woman who gets migraines can safely start using progestin-only contraceptives. However, she should switch to a method without hormones if these headaches start or become worse after she begins using progestin-only oral contraceptives, more so if these headaches involve blurred vision, temporary loss of vision, seeing flashing lights or zigzag lines or difficulty in speaking or moving.</li> <li>• Refer her to care as appropriate.</li> </ul>

### **3.1.3 Non hormonal Pills - Centchroman (Saheli)**

- Centchroman is nonsteroidal, highly effective, safe and easy to use oral contraceptive.
- It is free of the side effects commonly associated with contraceptives containing both estrogen and progestin.
- However, it should be avoided in polycystic ovarian disease, liver and kidney diseases and tuberculosis.

#### **a) How to Use**

It is taken orally twice a week for the first three months and then once-a-week.

## Unit 3.2 Injectable Contraceptives

### Learning Objectives

At the end of the session, the participants should be able to:

- List commonly used injectable contraceptives.
- Describe effectiveness and mechanism of action of DMPA
- List advantages and disadvantages of DMPA
- List key issues for medical eligibility for DMPA
- Describe key steps in providing injectable contraceptives.
- Explain the process of follow-up of client.
- Describe the key steps for management of common problems of DMPA

### 3.2.1 Introduction

- Highly effective, long lasting, reversible, convenient and can be used privately.
- Breastfeeding women can use progestin-only injectables like, DMPA or NET-EN.
- Available through commercial channels, social marketing organisations and NGOs

### 3.2.2 Types of Injectable contraceptives

- Progestin - only injectables** - They do not contain oestrogen. They are 3-monthly-DMPA (Depo-Provera ,Depo Progestin, Khushi) and 2-monthly-Noristerat (NET-EN)
- Combined injectables** - They contain both oestrogen and progestin. They are one-Monthly Injectables (Cyclofem, Cyclo- Provera).

### 3.2.3 Progestin only Injectable (DMPA and NET- EN):

They are not available in Government Hospitals or Health Centres but are available in the private sector only.

**Mechanism of Action:** Primarily inhibit ovulation by:

- Preventing the LH surge and lowering FSH and LH.
- By thickening the cervical mucous and rendering the endometrium less suitable for implantation
- By hindering the rate of ovum transport.

**Effectiveness:** Effectiveness depends on getting injections regularly: Risk of pregnancy is greatest when a woman misses an injection. When women have injections on time, failure rate is only 0.3%.

## Side Effects, Health Benefits and Limitations

### a) Side Effects

- Some users report the following changes in bleeding patterns including, with DMPA:
  - First 3 months:
    - Irregular bleeding
    - Prolonged bleeding
  - At one year:
    - No monthly bleeding
    - Infrequent bleeding
    - Irregular bleeding
- NET-EN affects bleeding patterns less than DMPA. NET-EN users have fewer days of bleeding in the first 6 months and are less likely to have no monthly bleeding after one year than DMPA users.
- Weight gain
- Headaches
- Dizziness
- Abdominal bloating and discomfort
- Mood changes
- Less sex drive

**Other possible physical changes :** Loss of bone density

**Serious side effects:** No serious side effect, but a client may have:

- Heavy and prolonged bleeding for which she should go to a doctor immediately.
- Abscess at injection site, if it was administered without infection-prevention precautions.

### b) Known Health Benefits

**DMPA - Helps protect against:**

- Risks of pregnancy
- Cancer of the lining of the uterus (endometrial cancer)
- Uterine fibroids

**May help protect against:**

- Symptomatic pelvic inflammatory disease
- Iron-deficiency anemia

**Reduces:**

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



**NET-EN - Helps protect against:**

- Iron-deficiency anemia

NET-EN may offer many of the same health benefits as DMPA, but this list of benefits includes only those for which there is available research evidence.

**Other Advantages:**

- Very effective
- Confidential
- Long-term pregnancy protection, but reversible.
- No daily pill taking. Allows some flexibility in return visits. Clients can return as much as up to 2 weeks early (although this is not ideal) and up to 2 weeks late for next injection.
- Quantity and quality of breast milk not affected. Can be used by lactating mothers as soon as 6 weeks after childbirth.
- No estrogen side-effects. Does not increase the risk of estrogen-related complications, such as heart attack.
- Helps prevent ectopic pregnancies.

**c) Limitations:**

- Does not protect against STIs/HIV
- Most women experience change in their menstrual pattern, e.g., slight bleeding may occur off and on and then periods usually stop for many months. Rarely, women may have heavy or prolonged bleeding.
- It is provider-dependent, i.e., private doctors give it to the client.
- It has delayed return of fertility - an average of about 4 months longer for DMPA and 1 month longer for NET-EN than with most other methods.
- Cannot be withdrawn from body after injection is given.

**3.2.5 Client Screening Guidelines for POI**

DMPA can be given to all women except in the following conditions

1. Pregnancy (suspected or confirmed)
2. Breastfeeding infant less than six weeks
3. Multiple risk factors for arterial cardiovascular disease( age above 35 years, smoking, diabetes and hypertension)
4. High blood pressure  $\geq 160/100$  mm Hg
5. Vascular Disease
6. Current Deep Vein thrombosis or Pulmonary Embolism
7. Current or history of Ischaemic Heart Disease
8. History of Stroke
9. Migraine with aura
10. Unexplained Vaginal Bleeding(suspicious for serious condition) before evaluation
11. Current or past history of Breast Cancer
12. Diabetes of more than 20 yrs duration or complicated with nephropathy/retinopathy/neuropathy
13. Active viral hepatitis/ benign or malignant liver tumours/severe cirrhosis

**Source:** WHO Medical Eligibility Criteria for Contraceptive Use, 2004, category 3

### 3.2.6 When to start POI

- Any day between first to seventh day of menstrual cycle or any day the provider is reasonably sure that the client is not pregnant.
- Immediately after abortion or within seven days post abortion, even if infection is present.
- After delivery - after six weeks if breastfeeding; after three weeks if not breastfeeding. DMPA becomes effective immediately.
- Switching from a Hormonal Method- Immediately, if using correctly and consistently or if it is reasonably certain that she is not pregnant. In case of switching from other injectables, she can have the new injectable when the repeat injection would have been given. No need for back up method.

#### **Injection is administered in the following way:**

- After the client makes an informed choice, examination of the client including weight, blood pressure should be done.
- The site of injection (upper arm or buttock) is cleaned, e.g. with spirit - swab.
- The vial (bottle) of injection is shaken gently and is filled-up in a sterile disposal syringe.
- It is injected deep inside the muscle of the arm or buttock. **Injection site is not rubbed** (to prevent fast absorption of the long lasting injection.)
- Dispose the needles and syringes safely.
- Plan for the next injection – after 3 months for DMPA or 2 months for NET-EN. Ask her to come on time (however, she may come up to 2 weeks early or 2 weeks late and still get an injection.

#### **Note:**

- *Client is given a card/doctor's prescription with instructions to come for the next injection on time.*
- *A trained person should provide injection with disposable syringes.*

### 3.2.7 Follow up

- Help the clients at the routine return visit and ask the following questions:
  - Ask if the client has any questions or anything to discuss.
  - Ask the client about her experience with the method, whether she is satisfied, and whether she has any problems. Give her any information or help that she needs and invite her to return any time she has questions or concerns. If she has problems that cannot be resolved, help her choose another method.
  - Ask about her bleeding pattern.
  - If the client has developed heart disease due to blocked arteries, stroke, blood clot (except superficial clots), breast cancer, severe high blood pressure, or active liver disease, help her to choose another method without hormones.
  - If the client has developed very bad headaches, help her manage it.

### **3.2.8 Managing Common Problems**

- At first probably she will have bleeding at unexpected times. The amount of bleeding usually decreases over time. After 6 to 12 months of use, she probably will have little vaginal bleeding or none at all.
- These changes are common, normal and not harmful. They do not mean that she is pregnant or sick or that the composition of her blood is changing. Little or no bleeding can in fact make some women healthier as this helps prevent anaemia.
- She may gain weight. This also is common, normal and not harmful. On an average, DMPA users gain 1.5 kg to 2.0 kg in the first year. The range of weight change is wide.
- Advice on possible delay for return of fertility
- A woman who gets migraine headaches can safely start using DMPA. But she should switch to a method without hormones, however, if these headaches start or become worse after she begins using DMPA and also if there is blurred vision, temporary loss of vision, seeing flashing lights or zigzag lines, or any trouble speaking or moving. Manage her appropriately.
- Invite the client to come back any time she needs more help with any problems or she requires a different method.

### **3.2.9 Explain specific reasons to see a nurse or doctor**

- Serious complications of DMPA are rare. Still a woman should see a doctor or nurse or return to the clinic if she has questions or problems or any of the following possible symptoms, which may or may not be caused by DMPA.
  - Botherome and extremely heavy bleeding (twice as long or twice as much as usual for her).
  - Very bad headache that starts or becomes worse after taking DMPA.
  - Skin or eyes become unusually yellow.

## Unit 3.3 Barrier Methods

### Learning Objectives

At the end of the session, the participants should be able to:

- Describe the effectiveness and mechanism of action of male and female condom.
- List advantages and disadvantages of male and female condoms.
- List key issues for medical eligibility for condoms.
- Explaining how to use condoms

#### 3.3.1 Male Condoms

- Safe, simple but very effective method.
- Provides **Triple Protection**:
  - unwanted pregnancy
  - sexually transmitted infections
  - HIV infection

##### a) Effectiveness

If the partners of 100 women start using condoms, with typical use there is likelihood of 14 of these women getting pregnant in the first year of use of condoms. With correct and consistent use every time, there are 3 pregnancies per 100 women in the first year of use.

##### b) Advantages

- Prevent STIs including HIV, as well as pregnancy, when used correctly and consistently with every act of sexual intercourse.
- Can be used soon after childbirth
- Safe. No hormonal side effects.
- Help prevent ectopic pregnancies
- Can be stopped at any time.
- Offer occasional contraception with no daily upkeep.
- Easy to keep at hand in case sex occurs unexpectedly.
- Can be used by men of any age.
- Can be used without seeing a healthcare provider first.
- Usually easy to obtain and sold at most places.
- Enables a man to take responsibility of preventing pregnancy and disease.
- Often help to prevent premature ejaculation.

##### c) Disadvantages

- Latex condoms may cause itching for a few people who are allergic to latex. Also, some people may be allergic to the lubricant on some brands of condoms.

- The couple must take the time to put the condom on the erect penis before sex.
- Small possibility that condom might slip off or break during sexual intercourse.
- If not properly stored or if used with oil-based lubricants, condoms can go weak and break.

#### **d) Side Effects, Health Benefits, and Health Risks**

**Side Effects:** None

##### **Known Health Benefits**

Help protect against:

- Risks of pregnancy
- STIs, including HIV

May help protect against conditions caused by STIs:

- Recurring pelvic inflammatory disease and chronic pelvic pain
- Cervical cancer
- Infertility (male and female)

**Known Health Risks (Extremely rare):** Severe allergic reaction (among people with latex allergy)

#### **e) Medical Eligibility**

- All men can use condoms. If the client complains of severe allergic reaction after using it then only, condoms are not recommended.
- But if the client is at risk of STIs or HIV, she/he should continue to use condoms during sexual intercourse despite allergy.

#### **f) Explaining how to use condoms**

1. You can show the client how to put on and take off a condom by using a model or 2 fingers.
2. The condom is fitted on the erect penis before intercourse.
3. Hold the pack at its edge and open by tearing from a ribbed edge.
4. Hold the condom at the tip, so that the air is expelled from the teat end to make room for the ejaculate.
5. Unroll the condom all the way to the base of erect penis. The condom should unroll easily. If it does not, it is probably backwards. If more condoms are available, throw this one away and use a new condom.
6. Most of the condoms are already lubricated; hence there is no need to apply any additional lubricant. This may damage the condom.
7. After sexual intercourse (ejaculation), hold the rim of the condom to the base of the penis so it will not slip. The man should pull his penis out of the vagina before completely losing his erection.
8. Move away from vagina and take off the condom without soiling semen on the vaginal opening.
9. Tie a knot at the rim of the condom. Dispose it off by burying or burning it.

**g) Explain specific reasons to see a health care provider**

Urge clients to return to a health care provider, if they or their sex partners:

- Have symptoms of STIs such as sores on the genitals, pain when urinating or a discharge.
- Have an allergic reaction to condoms (itching, rash, irritation).

**Other specific reasons to return:**

Need more condoms, dissatisfied with condoms for any reasons, have any questions or problems.

**h) Helping clients at any routine return visits**

1. Ask if the client has any questions or anything to discuss.
2. Ask the client about his or her experience with condoms, whether the client is satisfied, and whether the client has any problems. Is the client able to use the condom correctly every time? Also, you can check if the client knows how to use a condom; ask the client to put a condom on a model or a stick. Give any information and advice that the client needs. If the client has problems that cannot be resolved, help the client choose another method of contraception.

**Urge clients at risk of STIs including HIV to keep using condoms despite any dissatisfaction. Explain that only condoms protect against STIs during sex.**

**If clients are satisfied:**

- Give them more condoms.
- Remind them to return if they or their partner have symptoms of STIs, or if they are dissatisfied with condoms.
- Invite them to return again at any time they have questions or concerns.

**i) Managing any problems**

- Do not dismiss the client’s concerns or take them lightly.
- If the client is not satisfied after counselling, help the client think about the risk of STIs. If the client has or might get a STI, encourage continued condom use. If not, help the client choose another method if he or she wishes.

**Table 5: Managing problems occurring from the use of condom**

<b>Possible Problems</b>	<b>Solutions</b>
Condom or lubricant causes itching or rash on genitals	<ol style="list-style-type: none"><li>1. Suggest using water as lubricant (if additional lubricant is desired).</li><li>2. If itching continues, clients should be assessed for infection (both partners.)</li><li>3. If there is no infection and allergy to latex seems likely, help the client choose another method of contraception unless client is at risk of STIs.</li></ol>

	<p>If the client is using lubricated condoms or condoms with spermicide.</p> <ol style="list-style-type: none"> <li>1. Recommend a dry condom one without spermicide (can use water as lubricant)</li> <li>2. If the problem continues, help the client choose another method of contraception, unless the client is at risk of STIs.</li> </ol> <p>For clients at risk of STIs including HIV, urge continued use of condoms despite discomfort. Explain that the only way to be reasonably sure of not getting STIs are:</p> <ul style="list-style-type: none"> <li>• Using condoms every time you have sex, or,</li> <li>• Having sex with only one partner who does not have STIs and does not have any other partners, or,</li> <li>• Not having sex (abstinence)</li> </ul>
<p>Man cannot maintain an erection while putting on or using a condom.</p>	<ul style="list-style-type: none"> <li>• Often due to embarrassment. Discuss how to make condom use more enjoyable and less embarrassing. If a woman put on condom for a man, this may make use more enjoyable. Explain that, with experience, more couples are less embarrassed.</li> <li>• Suggest a small amount of water or water-based lubricant on the penis and extra lubricant on the outside. This may increase sensation and help maintain an erection.</li> </ul>

**j) How to store condoms:**

These tips will help keep condoms from breaking or leaking.

1. Store condoms in cool, dark place. Heat, light and humidity can damage condoms. Keep them away from rats.
2. Take care when handling condoms. Fingernails can tear them.
3. Do not unroll condoms before using them as unrolling will weaken them, and an unrolled condom is difficult to put on.

**k) Myths and Facts related to condoms:**

**Myth 1:** The condom breaks very easily.

**Fact:** Now condoms are very strong. They rarely break especially if care is taken to use them correctly.

**Myth 2:** The condom will decrease sexual pleasure.

**Fact:** Condoms are made of extremely thin rubber. Although sex with a condom does not feel exactly like sex without it, it is just as enjoyable for most people. The security of knowing the woman will not get pregnant while using a condom can actually improve the couple's sexual pleasure.

**Myth 3:** Condoms usually cause allergy.

**Fact:** Allergy to condoms is very rarely seen.

**Myth 4:** Condoms are harmful if used continuously for many years.

**Fact:** They are extremely safe and protect both partners from STIs including HIV/AIDS. They protect women from pelvic inflammatory disease (PID) and cancer of cervix. So, regular use of condom is recommended.

### 3.3.2 Female Condom (FC)

Female Condom is a strong, loose-fitting polyurethane sheath that is 17 centimeters long (about 6.5 inches) with a flexible ring at each end.

#### a) How to Use Female Condom

1. While holding the sheath at the closed end, grasp the flexible inner ring and squeeze it with the thumb and second or middle finger so it becomes long and narrow.
2. With the other hand, separate the outer lips of the vagina.
3. Gently insert the inner ring into the vagina. Feel the inner ring go up and move into place.
4. Place the index finger on the inside of the condom, and push the inner ring up as far as it will go. The outer ring should remain on the outside of the vagina.
5. The female condom is now in place and ready for use with your partner. Now gently guide your partner's penis into the sheath's opening with your hand to make sure that it enters properly – be sure that the penis is not entering on the side, between the sheath and the vaginal wall. It has special advantages in that it does not require an erect penis to insert the female condom into the vagina.
6. To remove the condom, twist the outer ring and gently pull the condom out. It need not be removed immediately after ejaculation.
7. Wrap the condom in the package or in tissue, and throw it in the garbage.

- FC comes pre-lubricated with a non-spermicidal, silicone-based lubricant that is needed for ease of insertion and for easy movement during intercourse.
- Lubrication reduces noise during sexual intercourse and makes sex smoother.
- Additional lubricant, either oil-based or water-based, can be used.

#### b) Effectiveness

The pregnancies rate per 100 women in the first year of use as commonly used is 21. If used correctly and consistently there are 5 pregnancies per 100 women.

#### c) Advantages

- Female controlled
- It can be inserted up to eight hours in advance so it will not interrupt sexual spontaneity.
- It is not tight or constricting.
- Its larger size makes the female condom easier for ejaculation.
- There are no serious side effects associated with use of the female condom; less than 10% of users report mild irritations.



- It does not require a prescription or the intervention of a health care provider.
- No medical condition limits use.
- More comfortable to men, less decrease in sensation than male latex condoms. As a result, sensitivity of male partner is not substantially reduced. It also offers ease of use by men with erectile dysfunction.
- Offers greater protection as it covers both internal and external genitalia.
- Stronger (polyurethane is 40% more stronger than latex), and therefore there is less frequent breakage (1% compared to 4% for male condoms)
- Longer shelf-life even under unfavourable storage conditions.
- CSWs found that the female condom allowed them to continue their job without interruption.

**d)           Disadvantages**

- Difficulties in insertion and removal. Some participants noted difficulties associated with insertion and removal of the female condom, discomfort, messiness and inconvenience associated with use and movement of device during use.
- More expensive than male condoms.

## Unit 3.4 Copper Bearing Intra Uterine Contraceptive Device (IUCD)

### Learning Objectives

At the end of the session, the participants should be able to:

- Describe the effectiveness and mechanism of action for copper-bearing IUCD.
- List advantages and disadvantages of copper-bearing IUCD.
- List client screening guidelines for IUCD
- Describe key steps in the insertion and removal of IUCD
- Explain the process of follow-up.
- Describe the key steps for management of common problems of copper-bearing IUCD.

### 3.4.1 Introduction

IUCDs are effective, long-lasting, convenient (as the client does not have to remember anything once this is inserted), immediately reversible method of contraception. If used correctly and consistently effectiveness is on par with injectables, implants and voluntary male and female sterilization.

### 3.4.2 Mechanism of Action

Copper-bearing IUCD work mainly by preventing the sperm and egg from meeting. The IUCD makes it hard for sperm to move through the woman's reproductive tract, which reduces the ability of sperm to fertilize an egg, or it prevents the egg from implanting in the wall of the uterus.

### 3.4.3 Side Effects, Health Benefits, Health Risks and Complications

#### Side Effects

Some users report the following 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

#### Known Health Benefits

Helps protect against Risks of pregnancy. May help protect against cancer of the lining of the uterus (endometrial cancer)

## **Known Health Risks**

### **Uncommon:**

May contribute to anemia if a 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 gonorrhea at the time of IUCD insertion.

### **Rare Complications:**

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.

## **3.4.4 Advantages**

- A single decision leads to effective long-term prevention of pregnancy.
- Long-lasting. The most widely used IUCD — CuT-380A, lasts at least for 10 years.
- Very effective and also convenient, as the client does not have to remember anything once this is inserted.
- No interference with sex.
- No hormonal side effects of copper-bearing IUCD
- Immediately reversible. When women have their IUCD removed, they can become pregnant as quickly as women who have not used IUCD.
- Copper-bearing IUCD have no effect on quality or quantity of breast milk.
- Can be inserted immediately after childbirth or after induced abortion (if there is no evidence of infection.)
- Can be used through menopause (one year or so after the last menstrual cycle).
- Does not interfere with any medication.
- Helps prevent ectopic pregnancy (less risk of ectopic pregnancy than in women not using any contraceptive method)

## **3.4.5 Disadvantages**

- Menstrual changes common in early months, but this is reduced after 3 months'
- Longer and heavy menstrual periods
- Bleeding or spotting between periods
- More cramps or pain during period.
- Some uncommon side effects: -Severe cramps and pain beyond first 3-5 days of insertion -Heavy menstrual bleeding or bleeding between periods, possibly contributing to anaemia. This is more likely with inert IUCD than with copper-bearing or hormonal IUCD-Rare possibility of perforation if not inserted properly

- Does not protect against sexually transmitted diseases (STDs) including HIV/AIDS. This is not a good method for women with recent STDs or with multiple sex partners (or who has a partner with multiple sex partners).
- Medical procedure, including pelvic examination is needed to insert IUCD. Occasionally, a woman faints during the insertion procedure.
- Some pain and bleeding or spotting may occur immediately after IUCD insertion, which disappears in a day or two.
- Client cannot stop IUCD use on her own. A trained health care provider must remove the IUCD from her.
- The IUCD may come out of the uterus possibly without the woman knowing about it (more common when the IUCD is inserted soon after childbirth).
- Does not protect against ectopic pregnancy.
- The woman should check the position of IUCD strings from time to time. To do this, she must put her fingers into her vagina, which some women may not want to do.

### **3.4.6 Client Screening Guidelines for IUCD**

IUCD can be given to all women except in the following conditions

1. Pregnancy ( suspected or confirmed)
2. Nulliparity
3. Immediate post septic abortion
4. Unexplained vaginal bleeding (suspicious for serious condition) before evaluation
5. Benign or malignant trophoblastic disease
6. Cervical cancer , Endometrial cancer or ovarian cancer
7. Uterine fibroids with distortion of uterine cavity
8. Current Pelvic Inflammatory Disease
9. Increased risk of OR Current STI ( purulent cervicitis, chlamydia or gonorrhoea) or AIDS
10. Known Pelvic Tuberculosis

**Source:** WHO Medical Eligibility Criteria for Contraceptive Use, 2004, category 3 and 4

### **3.4.7 Women can begin using IUCD**

- Without STI testing
- Without an HIV test
- Without any blood tests or other routine laboratory tests
- Without cervical cancer screening
- Without a breast examination

### 3.4.8 When to start an IUCD

**Table 6: When to start an IUCD**

<b>The Scenario</b>	<b>When to start</b>
Having menstrual cycle	<p><b>Any time during the menstrual cycle</b></p> <ul style="list-style-type: none"> <li>• If she is starting within 12 days after the start of her monthly bleeding, no need for a backup method.</li> <li>• 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. No need for a backup method.</li> </ul> <p><b>During menstruation, possible advantages: -</b></p> <ul style="list-style-type: none"> <li>• Pregnancy is ruled out</li> <li>• Insertion may be easy</li> <li>• Any minor bleeding caused by insertion is less likely to upset the client</li> <li>• Insertion may cause less pain</li> </ul> <p><b>Possible disadvantages during menstruation: -</b></p> <ul style="list-style-type: none"> <li>• Pain from pelvic infection may be confused with pain of menstrual period. IUCD should not be inserted if the woman has a pelvic infection.</li> <li>• May also be harder to identify other signs of infection</li> </ul>
Switching from another method	<ul style="list-style-type: none"> <li>• Immediately, if she has been using the 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.</li> <li>• If she is switching from injectables, she can have the IUCD inserted when the next injection would have been given. No need for a backup method.</li> </ul>
Breast feeding	<ul style="list-style-type: none"> <li>• If her menstruation has not returned. She can have IUCD inserted after 6 weeks of delivery or more, when it is reasonably certain that she is not pregnant. No need for a back up method.</li> <li>• If her menstruation has returned, she can have the IUCD inserted as advised for woman having menstrual bleeding.</li> </ul>
After miscarriage or abortion	<ul style="list-style-type: none"> <li>• Immediately, if the IUCD is inserted within 12 days after first- or second-trimester abortion or miscarriage and if no infection is present. No need for a backup method.</li> <li>• 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. No need for a backup method.</li> </ul>

	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul>
No monthly bleeding (not related to child birth or breastfeeding)	Any time if it can be determined that she is not pregnant. No need for a backup method.
For Emergency Contraception	Within 5 days after unprotected intercourse.
After taking emergency contraceptive pills	The IUCD can be inserted on the same day that she takes the ECPs. No need for a backup method.

**Source:**

- Family Planning – A global Handbook for providers, A WHO family planning cornerstone, 2007.
- Contraceptive Updates, Reference manual for Doctors, Oct.2007, MOHFW, Govt. of India.

### 3.4.9 Key steps in procedure

- The provider follows proper infection prevention procedures. Generally, the health care provider will insert a new, pre-sterilized IUCD that is individually packed.
- The **‘No-Touch’ technique** is preferred. This includes:
  - Loading the IUCD in the inserter while both parts are still in the sterile package
  - Cleaning the cervix 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 uterine sound and IUCD inserter only once through the cervical canal.
- The woman is asked to tell the provider if she feels discomfort or pain at any time during the procedure. Ibuprofen may be given 30 minutes before insertion to reduce cramping and pain.
- The health care provider conducts a careful pelvic examination (speculum and bimanual) and checks the position of the uterus to make sure that the woman can use an IUCD safely and effectively.
- The provider carefully cleans the cervix and vagina several times with an antiseptic solution such as iodine.
- Working slowly and gently, the provider inserts the IUCD, following the manufacturers’ instructions.

- After the insertion, the provider asks the client how she feels. If she feels dizzy when sitting, suggests that she lie down quietly for 5 or 10 minutes. Any cramping probably will not last long.
- An IUCD can be inserted just after delivery of the placenta up to 48 hours after childbirth. It can be inserted both after vaginal delivery or caesarean delivery.

*Important: For postpartum insertion, only providers who have special training should insert IUCD after childbirth. Proper insertion technique is important to reduce the risk of expulsion.*

### **3.4.10 Explaining how to use the IUCD**

1. Plan with the client for **Post- Insertion Follow- Up visit in 3 to 6 weeks** – for example, after a menstrual period - for check up and pelvic examination, to make sure that her IUCD is still in place and that no infection has developed. The visit can be at any time convenient to the client when she is not menstruating. After this one return visit, no further routine visits are required.
2. **Make sure she knows:**
  - Exactly what kind of IUCD she has and how it looks like
  - When to have IUCD removed or replaced (for TCU-380A IUCD, 10 years after insertion).
  - Discuss how to remember the year to return. If she wants a new IUCD, it can be inserted as soon as the old IUCD is removed.
  - When she visits health care providers, she should tell them that she has an IUCD.

*Important: Provide the client with a written record of the month and year of IUCD insertion and the month and year of when it should be removed.*

3. **Give specific instructions:**
  - About the common side effects.
  - How and when to check the IUCD

#### **When to Check:**

- Once a week during the first month after insertion
- After noticing any possible symptoms of serious problems.
- After a menstrual period, from time to time. IUCD are more likely to be dislodged with menstrual blood.

#### **How to Check:**

- Wash her hands
- Sit in the squatting position
- Insert 1 or 2 fingers in her vagina as far as she can until she feels the strings. She should return to the health care provider if she thinks the IUCD might be out of place.
- Wash hands again

**Important:**

- She should not pull the strings, as the IUCD may be dislodged.
- After postpartum insertion, the strings do not always come down through the cervix.

**4. ‘Come back anytime’ Reasons to return to a health care provider:**

- Missed menstrual cycle
- If she thinks that she might have been exposed to STIs or has HIV/AIDS.
- Strings missing or strings seen shorter or longer
- Something harder in her vagina at the cervix. It may be part of the IUCD.
- Increasing or severe pain in the lower abdomen, especially if there is also fever and/or bleeding between menstrual periods.
- Heavy or prolonged bleeding
- IUCD has reached the end of its effectiveness
- She wants the IUCD to be removed for any reason.
- She has questions.
- She wants to opt for another family planning method.

**3.4.11 Post-Insertion Follow-Up Visit (3 to 6 Weeks)**

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 Any Problems)
3. 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
4. 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:
  - A sexually transmitted infection or pelvic inflammatory disease
  - The IUCD has partially or completely come out

**3.4.12 Managing any problems**

If the client reports common side effects of IUCD, such as menstrual changes:

- Do not dismiss the woman’s concerns or take them lightly.
- If the woman is worried but wants to continue the method, reassure and counsel her about side effects
- If the woman is not satisfied after treatment and counselling, ask her if she wants the IUCD removed. If so, remove the IUCD or refer for removal even



if her problems with the IUCD would not harm her health. If she wants a new method, help her choose one.

## **Managing Problems reported as Side Effects or Complications**

### **1. Heavy or Prolonged Bleeding (Twice as much as usual or more than 8 days)**

- Reassure her that many IUCD users 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):
  - Tranexamic acid (1500 mg) 3 times daily for 3 days, then 1000 mg once daily for 2 days, beginning when heavy bleeding starts.
  - 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.
- Provide iron tablets and tell to eat foods containing iron
- If problem persists for long period consider underlying conditions unrelated to method use.

### **2. Irregular Bleeding (bleeding at unexpected times)-**

- Reassure her (same as above).
- For modest short-term relief Advice NSAIDs e.g. ibuprofen (400 mg) or indomethacin (25 mg) 2 times daily after meals for 5 days,
- If irregular bleeding continues – rule out underlying conditions unrelated to method use.

### **3. Cramping and pain**

- Common in the first 3 to 6 months of IUCD use, particularly during monthly bleeding. Generally, not harmful and usually decreases over time.
- Suggest NSAID like ibuprofen (200–400 mg), paracetamol (325–1000 mg)
- If cramping continues - Evaluate for underlying health conditions and treat.
- 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.

### **4. Possible anemia**

- Pay special attention to IUCD users with signs and symptoms of anaemia
- Provide iron tablets and iron rich food.

### **5. Partner can feel IUCD strings during sex**

Explain that this happens sometimes when strings are cut too short. Describe available options:

- Strings can be cut even shorter. Her partner will not feel the strings, but she will no longer be able to check her IUCD strings.

- If she wants to be able to check her IUCD strings, Remove and insert a new IUCD.

**6. Severe pain in lower abdomen (suspected pelvic inflammatory disease [PID])**

- First rule out ectopic pregnancy, assess for PID by P/A and P/V examination.
- Look for the following S/S-
  - 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
  - Direct abdominal tenderness or rebound abdominal tenderness
- Treat PID
  - All the suspected cases based on the above mentioned S/S should be treated.
  - Treat for gonorrhea, chlamydia, and anaerobic bacterial infections- all 3.
  - Counsel the client about condom use.
  - No need to remove the IUCD. If she wants it to be removed, take it out after starting antibiotic treatment and advice other method.
- Treat the sex partner

**7. Severe pain in lower abdomen (Suspected ectopic pregnancy)**

Look for the following S/S to rule out 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 the client does not have these S/S assess for pelvic inflammatory disease

**8. Suspected uterine puncturing (perforation)**

If at the time of insertion or sounding –

- Stop the procedure immediately (and remove the IUCD if inserted).
- Observe the client in the clinic carefully for the first hour, bed rest and check vital signs (blood pressure, pulse, respiration, and temperature) every 5 to 10 minutes.
- If the condition remains stable after one hour, and no signs or symptoms of intra- abdominal bleed, 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, evaluate at the time of removing such IUCD IUCD partially

## **9. Partial expulsion of IUCD**

Remove and discuss with the client whether she wants another IUCD or a different method help her accordingly.

## **10. 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

Check for the strings in the folds of the cervical canal with forceps.

If strings cannot be located either they have gone up into the uterus or the IUCD has been expelled unnoticed. Rule out pregnancy and advice for x-ray or ultrasound. Give her a backup method to use in the meantime, in case the IUCD came out.

## **11. Pregnancy**

If IUCD user is found to be pregnant

- Exclude ectopic pregnancy
- Explain that she is at risk of preterm delivery or miscarriage, including infected (septic) miscarriage during the first or second trimester, which can be life threatening.
- Early removal of the IUCD reduces these risks, although the procedure itself involves a small risk of miscarriage.
- If she doesn't want to continue for pregnancy- Inform her about MTP.
- If she continues the pregnancy: –
  - If she agrees to remove IUCD, gently remove it.
  - 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, she should return promptly 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

### **3.4.13 Removing the IUCD**

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.

### **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.

### **Possible reasons for removal**

- Client's request
- Any side effects that make client want her IUCD
- Any medical reason e.g. Pregnancy, Acute PID, Perforation of uterus
- IUCD has come out of place (partial expulsion)
- When the effective lifespan is finished
- When the woman reaches menopause (at least 1 year after her last period)

### **Important Points**

- 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 she 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 Managing Any Problems). See if she would rather try to manage the problem or to have the IUCD removed immediately.

## Unit 3.5 Natural Methods

Natural Methods for prevention of pregnancy are mainly of two types. These are Lactational Amenorrhoea Method (LAM) and Standard days Method (SDM).

### Learning Objectives

At the end of the session, the participants should be able to:

- Describe effectiveness and mechanism of Natural Methods (LAM and SDM).
- List advantages and disadvantages of Natural Methods.
- List client screening guidelines for Natural Methods.
- Key considerations in Natural Methods.

### 3.5.1 Lactational Amenorrhoea Method (LAM)

Lactational Amenorrhoea Method (LAM) is the use of breastfeeding as a temporary family planning method. Effectively prevents pregnancy at least 6 months and maybe longer if a woman keeps breastfeeding often, day and night. The only conditions that limit use of LAM are conditions that make breastfeeding difficult or that rule out breastfeeding.

#### a) Mechanism of Action and Effectiveness

LAM stops ovulation (release of eggs from ovaries) because breastfeeding changes the rate of release of natural hormones.

Effective as commonly used: 2 pregnancies per 100 women in the first 6 months after childbirth.

Very effective when used correctly and consistently: 0.5 pregnancies per 100 women in the first 6 months after childbirth.

#### b) Advantages of LAM

- Effectively prevents pregnancy at least 6 months and maybe longer if a woman keeps breastfeeding often, day and encourages the best breastfeeding patterns.
- Can be used immediately after childbirth
- No need for any precaution at the time of sexual intercourse
- No direct cost for family planning or for feeding the baby.
- No supplies or procedure required to prevent pregnancy.
- No hormonal side effects.
- Counselling on LAM encourages starting a follow on method at the proper time.
- Breastfeeding practices required by LAM have other health benefits for mother and baby:
  - Provides the healthiest food for the baby

- Protects the baby from life-threatening diarrhoea.
- Helps protect the baby from diseases like measles and pneumonia by passing the mother's immunities to the baby
- Helps develop close bondage between mother and baby.

**c) Disadvantages**

- Effectiveness after 6 months is not certain.
- Frequent breastfeeding may be inconvenient or difficult for some women, especially working mothers.
- No protection against STIs including HIV.
- If the mother has HIV, there is a small chance that breast milk will pass HIV to the baby.

**d) Client Screening Guidelines for LAM**

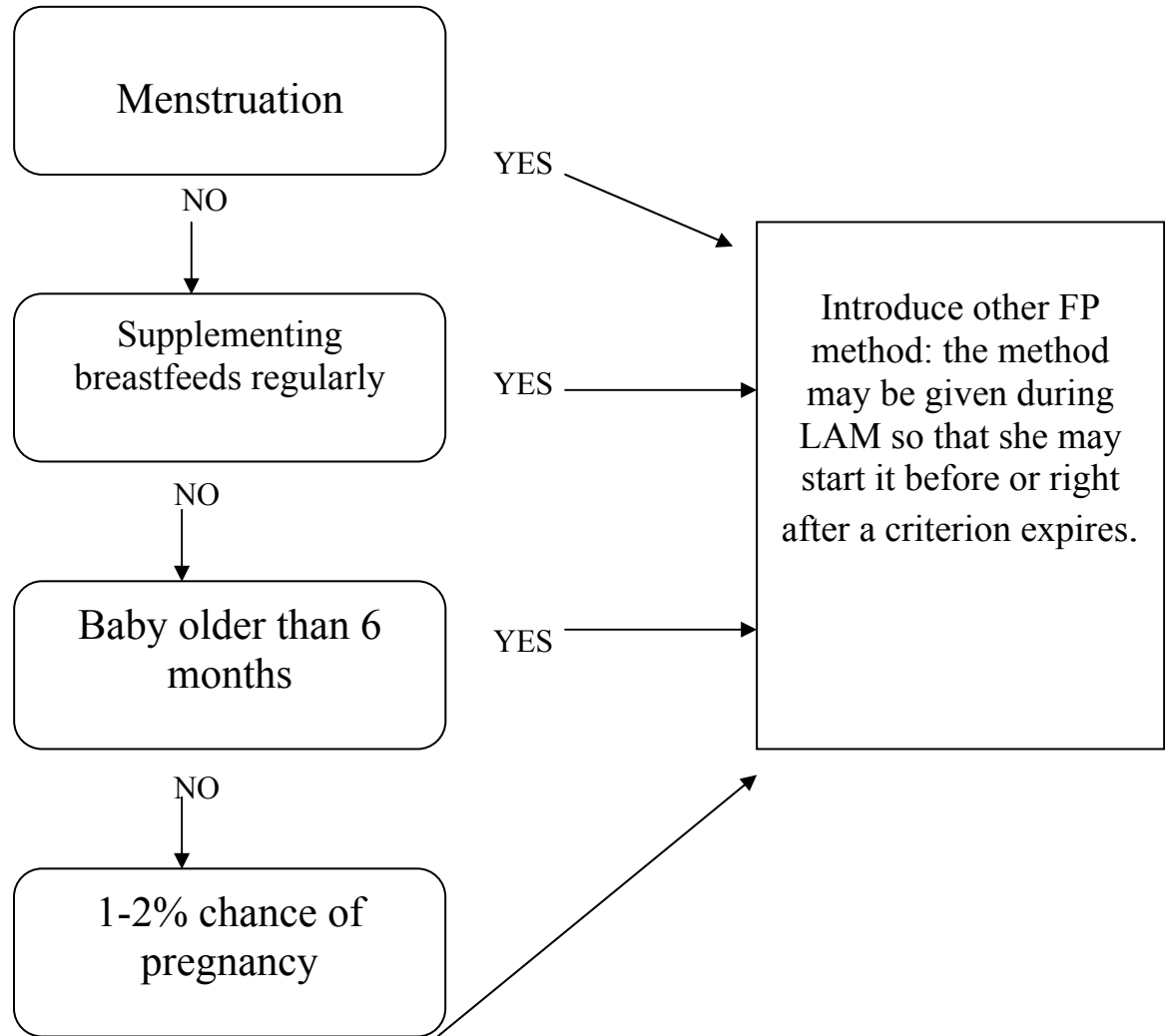
LAM requires 3 conditions. All 3 must be met:

- The baby is less than 6 months old
- After last childbirth mother's menstrual period has not returned
- The baby is fully or nearly breastfed and is fed often, day and night i.e. at least 8-10 times a day, at least once in 4 hours, and at least once at night (night feeding regularly not more than 6 hours apart), and at least 85% of her baby's feeding should be from breastfed milk.

*A woman must switch to another method as soon as any of the 3 LAM criteria no longer applies (see the algorithm below).*

**Table 7: The Lactational Amenorrhea Method (LAM)**

**The Lactational Amenorrhea Method (LAM) is presented as an algorithm**



**When response changes to YES....**

*Source: Labbok M, Cooney K, Coly S. Guidelines: Breastfeeding, Family planning and the Lactational Amenorrhea Method- LAM. Washington DC: Institute for Reproductive Health, 1994.*

### 3.5.2 The Standard Days Method (SDM)

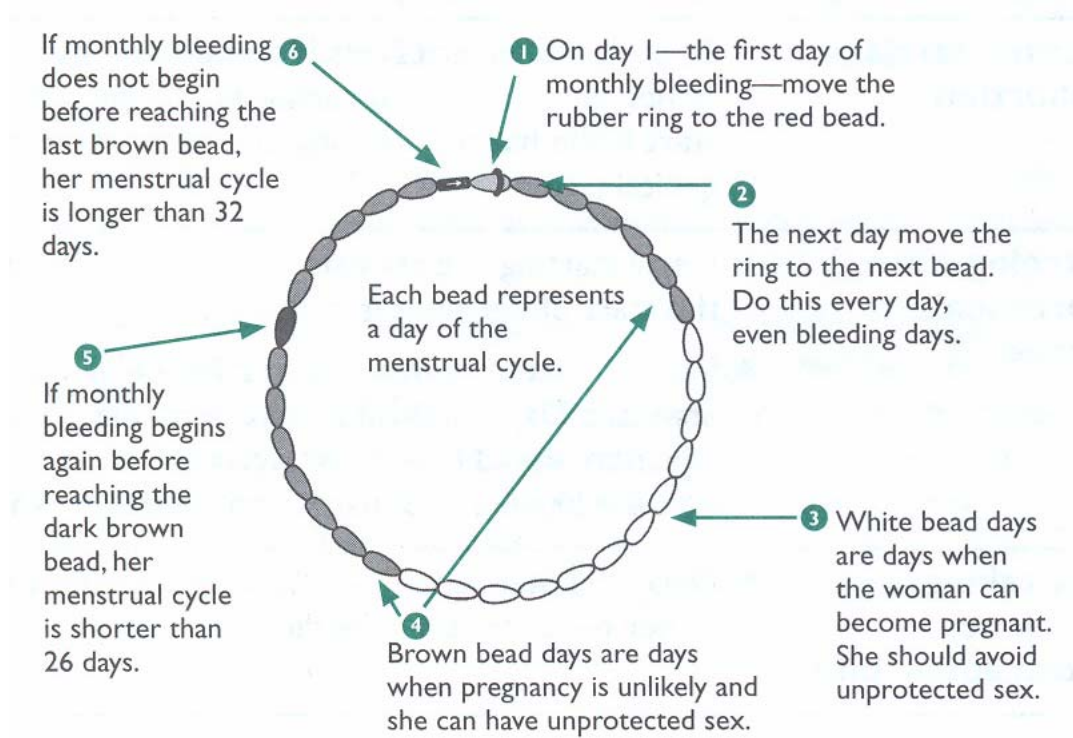
- Natural family planning method
- Useful for women with menstrual cycles ranging between 26 and 32 days
- Advice on avoiding unprotected sexual intercourse from day 8 to 19 of menstrual cycle.

#### a) How to use SDM

- For easy and correct use of SDM a device called **Cycle Beads**- a string of colour coded beads is given to client (see the diagram below).
- On the first day of menstrual period, start moving the rubber ring onto the first red bead. Simultaneously, mark the day on calendar provided with the cyclebeads.
- Each day, move the rubber ring onto the next bead, moving in the direction of the arrow.
- All white beads mark the days when she is likely to get pregnant. Advise to avoid sexual intercourse or use condoms on the days when the rubber ring is on any of these white beads.
- All brown beads mark the days when the woman is not likely to get pregnant if she has unprotected intercourse.
- The dark brown bead helps her to know if cycle is less than 26 days long. If her period starts before she moves the ring to the dark brown bead, her cycle is shorter than 26 days.
- If her period does not start by the day she moves the ring to the last brown bead, her cycle is longer than 32 days.



**Fig 2: Cycle beads for SDM**



**b) Return to health care provider or facility if**

- You are not happy with the method.
- You think you are pregnant.
- You want information about or want to start using another family planning method.
- You think there is any chance you may have been exposed to HIV infection or any other sexually transmitted infection (STI).

## Unit 3.6 Permanent Methods

### Learning Objectives

At the end of the session, the participants should be able to:

- Describe the effectiveness and mechanism prevention of pregnancy in
- Male sterilization.
- List advantages and disadvantages of male sterilization.
- List key issues for medical eligibility of vasectomy.
- Describe key steps in vasectomy.

### 3.6.1 Male Sterilization (Vasectomy)

- Vasectomy, especially no-scalpel vasectomy (NSV), is one of the safest, permanent and most effective contraceptive methods
- Simple, minor surgical procedure that takes 5-15 minutes to perform, after 5-10 minutes of pre-operative preparation and administration of local anaesthesia.

#### a) Mechanism of Action and Effectiveness

A small opening is made in the man's scrotum and the vas deferens on either side is closed off. This keeps sperms out of the semen. The man can still have erections and ejaculate semen, but his semen no longer makes a woman pregnant because it has no sperm in it.

It is a very effective and permanent method, which is commonly used, with 0.15 pregnancies per 100 men in the first year after the procedure. For this method to be effective, correct use is essential. Correct use means using condoms or another effective family planning method consistently for at least the first 3 months or until the sperm completely disappears from the semen.

#### b) Advantages

- Very effective
- Permanent. A small, quick procedure leads to lifelong, safe and very effective family planning.
- Nothing to remember except to use condoms or another family planning method for at least 3 months.
- Does not affect the man's ability to have sex.
- Increased sexual enjoyment because no need to worry about pregnancy.
- No supplies to get, no repeated clinic visits required.
- No apparent long-term health risks.
- Compared to voluntary female sterilization, vasectomy is:-Probably slightly more effective-Slightly safer-Easier to perform-If there is a charge, often less expensive-Can be tested for effectiveness at any time.

- Even if pregnancy occurs it is less likely to be ectopic than if there is a pregnancy in a woman who has been sterilized.

**c) Disadvantages**

- Common minor short-term complications of surgery:
  - Usually uncomfortable for 2 or 3 days.
  - Pain in scrotum, swelling and bruising
  - Brief feeling of faintness after the procedure
- Uncommon complications of surgery:
  - Bleeding or infection at the incision site or inside the incision.
  - Blood clots in the scrotum.
- Requires minor surgery by a trained provider.
- Not immediately effective. The couple must use another contraceptive method for at least the first 3 months after the surgery, or until sperms are cleared from semen. ?During this period, the man should resume sexual activity, but he or his partner will need to use additional contraceptive protection.? Semen analysis, where available, can confirm contraceptive effectiveness after the 3–month waiting period.
- Reversal surgery is difficult, expensive, and not available in settings that are poor in resource. Success cannot be guaranteed. Men who may want to have more children in the future should choose a different method.
- No protection against STIs including HIV.

**d) Eligibility of Providers for Performing Male Sterilization**

**Table 8: Eligibility of providers performing male Sterilization**

<b>Service</b>	<b>Basic Qualification Requirement of Provider</b>
Conventional vasectomy	Trained MBBS doctor
No-scalpel vasectomy (NSV)	Trained MBBS doctor

The state has a district-wise panel of doctors for performing sterilization operations in government institutions and government-accredited private/NGO centres based on the above criteria. Only those doctors whose names appear in the panel are entitled to carry out sterilization operations in government and/or government-accredited institutions. The panel is updated quarterly.

## e) **Medical eligibility**

Most men can have a vasectomy in routine settings.

- **DELAY** the vasectomy and refer the client to treatment if he has:
  - Active sexually transmitted infection
  - Inflamed (swollen and tender) tip of penis, ducts or testicles
  - Scrotal skin infection or mass in the scrotum
  - Acute systemic infection or significant gastroenteritis
  - Filariasis or elephantitis

If he has any of the following, refer him to a centre with experienced staff and equipment that can handle potential problems:

- Hernia in the groin (provider if able, can perform vasectomy at the same time as repairing hernia. If this is not possible, the hernia should be repaired first)
- Undescended testicles on both sides
- Current AIDS-related illness
- Coagulation disorders

If he has any of the following, use **CAUTION**:

- previous scrotal surgery or injury
- Large varicocele or hydrocoele (swollen veins or membranes in the spermatic cord or testes, causing swollen scrotum)
- Undescended testicles on one side only (vasectomy is performed on the normal side only. Then if any sperm remains in the semen after 3 months, vasectomy must be performed on the other side too.
- If he has diabetes.
- Young Age
- Depressive illness

## f) **Requirements for a safe procedure**

### 1. **Counselling:**

- It should be provided only to men who have decided on their own that they do not want children any more.
- Clients should be counselled about other available methods of contraception before deciding on sterilization.

### 2. **Client assessment:**

- **Medical history**
- **Physical examination**-including genital examination; the penis, scrotum and the inguinal region should be inspected visually; and the scrotum should be palpated.
- **Laboratory tests**- Reserved for specific cases in which a condition that would make it necessary to make extra preparation is suspected.

3. **Informed consent:** The form should be signed after confirming that the client has made an informed choice.
4. **Infection prevention:** Proper aseptic technique is essential. Shaving or clipping the hair at the operation site is no longer recommended.
5. **Anaesthesia:** Both, conventional and no scalpel vasectomy are done under local anaesthesia. General anaesthesia may be necessary when there are scrotal abnormalities (such as large varicocele, large hydrocoele or chryptorchidism).
6. **Instructions to the client:** After the procedure, the man should-
  - Put a cold compresses on the scrotum for 4 hours to lessen swelling
  - Rest for 2 days. He should not do any heavy work or vigorous exercise for a few days.
  - Keep the incision clean and dry for 2-3 days. He can use a towel to wipe his body clean but should not soak in water.
  - Wear snug underwear or pants for 2-3 days to help support the scrotum.
  - Take paracetamol or another pain-relief medication as needed. He should not take aspirin or ibuprofen, which slow blood clotting.
  - Use condoms or another effective family planning method for 3 months after the procedure.
  - He can have sex within 2-3 days after the procedure. Vasectomy does not affect man's ability to have sex.
- 7 Return to the clinic for a **follow-up** and for any of these reasons:

A health worker should visit all clients who undergo a vasectomy within 48 hours. First follow-up: seven days after the surgery for removal of stitches (in cases of conventional vasectomy), to have the wound examined and to have his questions answered.

**Second follow-up:** the client should undergo semen analysis after three months.

Emergency follow-up: this can be done at any time after the surgery if:

- His wife misses her menstrual period or thinks she is pregnant.
- He has questions or problems of any kind.
- If he has high fever (greater than 38°C) in the first 4 weeks and especially in the first week, or
- If he has bleeding or pus from the wound, or
- If he has pain, heat, swelling, or redness at an incision that becomes worse or does not stop (signs of infection)
- If the clinic cannot be reached quickly, he should go to another doctor or health care provider at once.

### **3.6.2 Female Sterilization (Tubectomy)**

Female sterilization is one of the safest operative procedures that involves permanently blocking the fallopian tubes to prevent fertilization.

#### **a) Effectiveness**

In female sterilization, both fallopian tubes of a woman which carry eggs from the ovaries to the uterus are blocked or cut off. With the tubes blocked, the woman's eggs cannot meet the man's sperm. The woman continues to have menstrual periods.

In the first year after the procedure: 0.5 pregnancies per 100 women. Within 10 years of the procedure: 1.8 pregnancies per 100 women. Effectiveness depends partly on how the tubes are blocked. Postpartum tubal ligation is one of the most effective female sterilization techniques. In the first year after the procedure there are 0.05 pregnancies per 100 women and within 10 years after the procedure, 0.75 pregnancies per 100 women.

#### **b) Advantages:**

- Very effective method of contraception
- Permanent. A single procedure leads to lifelong, safe, and very effective family planning.
- Nothing to remember (as in many other methods), no supplies needed, and no repeated clinic visits required.
- No interference with sex. Does not affect the woman's ability to have sex.
- No effect on breast feeding.
- No known side effect or health risks
- Minilaparotomy can be performed just after a woman gives birth.
- Helps protect against ovarian cancer.

#### **c) Disadvantages**

- Usually painful at first, but pain recedes after a day or two.
- Uncommon complications of surgery:
  - Infection or bleeding at the incision
  - Internal infection or bleeding
  - Injury to internal organs
  - Anaesthesia risk
- In the rare cases that pregnancy occurs, it is likely to be ectopic than in a woman who used no contraception.
- Requires physical examination and minor surgery by a specially trained provider.

**d) Eligibility of Providers for Performing Female Sterilization**

**Table 9: Eligibility of Providers for Performing Female Sterilization**

<b>Service</b>	<b>Basic Qualification Requirement of Provider</b>
Minilap services	Trained MBBS doctor
Laparoscopic sterilization	DGO, MD (Obst. & Gynae.), MS (Surgey) (Trained in Laparoscopic sterilization)

The states constitute a district-wise panel of doctors for performing sterilization operations in government institutions and accredited private/NGO centres based on the above criteria. Only those doctors whose names appear on the panel are entitled to carry out sterilization operations in the government and/or government-accredited institutions. The panel is updated quarterly.

**e) Medical eligibility for female sterilization**

In general, most women who want sterilization can have safe and effective procedures in routine settings. With proper counselling and informed consent, sterilization can be used in any circumstances by women who:

- Just gave birth (within 7 days)
- Are breastfeeding

Also, women with the following conditions can have sterilization in a routine setting in any circumstances:

- Mild pre-eclampsia
- Past ectopic pregnancy
- Benign ovarian tumours
- Irregular or heavy vaginal bleeding patterns, painful menstruation
- Vaginitis without purulent cervicitis
- Varicose veins
- HIV positive or high-risk of HIV or other STIs
- Malaria
- Non-pelvic tuberculosis
- Caesarean delivery (surgical delivery) at same time.

**In the following conditions, use the instructions below:**

**1. Gynaecological / obstetrical conditions:**

If the woman has any of the following, **DELAY** female sterilization and treat as appropriate or refer: **Pregnancy**

- Postpartum or second trimester abortion (7 - 42 days)
- Serious postpartum or post-abortion complications
- Unexplained vaginal bleeding that suggests a serious condition
- Severe pre-eclampsia, eclampsia
- Pelvic inflammatory disease within past 3 months
- Current STI
- Pelvic cancers
- Malignant trophoblast disease

If she has any of the following, **REFER** her to a centre with experienced staff and equipment that can handle potential problems:

- Fixed uterus due to previous surgery or infection
- Endometriosis
- Hernia (umbilical or abdominal wall)
- Postpartum uterine rupture or perforation or postabortion uterine perforation

If she has any of the following, use **CAUTION**:

- Past PID since last pregnancy
- Current breast cancer
- Uterine fibroid

**2. Cardiovascular conditions**

If she has the following, **DELAY** female sterilization:

- Acute heart disease due to blocked arteries
- Deep vein thrombosis or pulmonary embolism

If she has the following, **REFER** her to a centre with experienced staff and equipment that can handle potential problems:

- Moderate or severe high blood pressure (160/100 or higher)
- Vascular disease including diabetes-related
- Complicated vulvular disease

If she has any of the following, use **CAUTION**:

- Mild high blood pressure (140/90 – 155/99 mm)
- History of high blood pressure where blood pressure can be evaluated, or adequately controlled high blood pressure where blood pressure can be evaluated
- Past stroke or heart disease due to blocked arteries.
- Vulvular heart disease without complications.



### **3. Chronic disease conditions:**

If she has any of the following, **DELAY** female sterilization:

- Gall bladder disease with symptoms
- Active viral hepatitis
- Severe iron deficiency anaemia (haemoglobin below 7g/dl)
- Acute lung disease (bronchitis or pneumonia)
- Systemic infection or severe gastroenteritis
- Abdominal skin infection
- Abdominal surgery for emergency or infection at time sterilization is desired, or major surgery with prolonged immobilization.

If she has any of the following, **REFER** her to a centre with experienced staff and equipment that can handle potential problems:

- Severe cirrhosis of liver
- Diabetes for more than 20 years
- Hyperthyroid
- Coagulation disorders
- Chronic lung disease
- Pelvic tuberculosis

If she has any of the following, use **CAUTION**:

- Epilepsy Or taking medicines for seizure
- Taking antibiotics or griseofulvin
- Diabetes with vascular disease
- Hypothyroid
- Mild cirrhosis of liver, liver tumours or schistosomiasis with liver fibrosis
- Sickle cell disease
- Inherited anaemia
- Kidney disease
- Diaphragmatic hernia
- Severe lack of nutrition
- Obese (Is she extremely overweight?)
- Elective abdominal surgery at time sterilization is desired. Be sure to 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.

### **f) Requirements for a safe procedure**

#### **Counselling:**

Clients should be counselled about all available methods of contraception before deciding on sterilization. It should be provided only to women who have decided on their own that they do not want children any more.

#### **Client assessment:**

- **History** (medical and obstetrics and gynaecological history)

- **Physical examination** (vital signs, heart, lungs, abdomen, and pelvic and speculum examination).
- **Laboratory tests:** To screen for anaemia and to rule out current pregnancy.

Criteria to minimize the chances of pregnancy, one should perform the procedure:

- Within 7 days of the menstrual period
- Within 7 days of abortion
- Within 7 days of term delivery
- In women using reliable method of contraception e.g. IUCD, Injectable hormonal method.

**Informed consent:** The form should be signed after confirming that the client has made an informed choice.

**Infection prevention:** Proper aseptic technique is essential. Shaving or clipping the hair is no longer recommended.

**Anaesthesia:** Three choices of anaesthesia regimen—local, general, or regional. Factors to be considered in the choice of anaesthesia include the type of surgical technique, the skill of surgeon, the availability of appropriate drugs, and the safety and conformity of the client, and the ability of the surgeon to manage complications, should they occur.

**Explaining self-care** for minilaparotomy or laparoscopy

- Before the procedure, the woman should:
  - Not eat or drink anything for 8 hours before surgery;
  - Not take any medication for 24 hours before surgery (unless the doctor performing the procedure tells her to do so);
  - Bathe thoroughly the night before the procedure, especially her belly, genital area, and upper thighs;
  - Wear a clean, loose fitting clothing to the health facility if possible;
  - If possible, bring a relative to help her go home.
- After the procedure, the woman should:
  - Rest for 2 or 3 days and avoid heavy lifting for a week;
  - Keep the incision clean and dry for 2-3 days;
  - Be careful not to rub or irritate the incision for 1 week;
  - Take paracetamol or another safe, locally available pain-relief medicine as needed. She should not take aspirin or ibuprofen which slow blood clotting.
  - Not have sexual intercourse for at least one week. If pain lasts for more than one week, do not have sex until all pain is gone.

**Specific reasons to see a doctor or nurse**

A woman should return to the clinic for any of these reasons:

- For a follow-up, if possible, within 7 days or at least 2 weeks and to have stitches removed, if necessary. Follow-up can also be done at home or at any other suitable facility.

- She has questions or problems of any kind.
- Return at once if she has: -High fever (more than 38 degrees C) in the first weeks and especially in the first week or -Pus or bleeding from the wound, or -Pain, heat, swelling, or redness of the wound that becomes worse or does not stop (signs of infection), or
- Abdominal pain, cramping, or tenderness that becomes worse or does not stop, or -Diarrhoea, or -Fainting or extreme dizziness

If the clinic cannot be reached quickly, she should go to another doctor at once.

- She thinks that she might be pregnant. First symptoms of pregnancy are:-Missed periods
- Nausea, and
- Breast tenderness

She should come to the clinic at once if she also has any one of the signs of possible ectopic pregnancy:

- Lower abdominal pain or tenderness on one side-Abnormal or unusual vaginal bleeding,
- Faintness (indicating shock)

Pregnancies among users of voluntary sterilization are few. But when pregnancy occurs, it is more likely to be ectopic than average pregnancy. Ectopic pregnancy is life-threatening. It requires immediate treatment.

Two methods can be used to prevent failures:

- The incidence of unintended pregnancy can be decreased by scheduling this procedure within the first 7-10 days of the start of a menstrual cycle.
- The fallopian tubes can be identified properly by tracing it to the fimbrial end prior to occlusion.

Meticulous attention should be paid to technique, whichever method is used.

Follow-up within 7 days or at least 2 weeks is strongly recommended to check the site of the incision looks for any sign of complications and removes any stitches.

## Unit 3.7 Emergency Contraceptive Methods

### Learning Objectives

At the end of the session, the participants should be able to:

- Explain the situations in which EC can be used.
- Learn various methods of Emergency Contraception

#### 3.7.1 Introduction

Emergency contraception refers to back – up methods for contraceptive emergencies which woman can use within the first few days after unprotected intercourse to prevent an unwanted pregnancy.

**It should be used only in the emergency situations described below:**

1. Sex was forced (rape) or coerced
2. Any unprotected sex
3. 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 2 weeks late for her repeat progestin-only injection or more than 7 days late for her repeat monthly injection

To summarize, emergency contraception can be used in all those circumstances in which a woman has reason for concern that she may become pregnant.

#### 3.7.2 Methods of Emergency Contraception

##### A) Levonorgestrel only EC pills (A dedicated product)

Available as Over The Counter Drug. Brand names:

1. E pill
2. ECee2
3. Norlevo 0.75 mg
4. Pill 72
5. Pregnon
6. Preventol
7. I Pill

**Dosage:** One pill of LNG 0.75 mg to be taken as soon as possible after unprotected coitus (within 72 hours), followed by another pill 12 hours later.

## **B) High Doses of Oral Contraceptive Pills as Emergency method**

Pills (containing 30 or 35 microgram oestrogen): 4 tablets as soon as possible (within 72 hours of unprotected coitus), followed by another 4 pills 12 hours later.

Make certain that the client does not want to become pregnant, but that she understands that there is still a chance of pregnancy even after using ECPs. Explain that the ECPs will not cause any harm to the foetus if it fails to prevent pregnancy.

## **C) IUCD as an emergency contraception**

- IUCD can be effectively used as an emergency method of contraception within 5 days of first act of unprotected intercourse.
- -Eligibility criteria are the same as when IUCD is used for regular contraception but special care should be taken in the case of sexual assault cases as presence of STIs increases the risk for PID.
- -Follow- up of all the woman after the first menstrual period is critical to make sure that the client is not pregnant and that IUCD is in situ.

*Note: Emergency contraception should not be used in place of other family planning methods.*

# MODULE 4

## Family Planning for Special Groups

Unit 4.1      Serving Special Groups

# About the Module

While providing Family Planning method, provider should keep in mind special consideration for different groups of clients. In this module reproductive needs of diverse groups and appropriate choice and strategy to meet this will be discussed.

## Unit 4.1 Serving Special Groups

### Learning Objectives

At the end of the session, the participants should be able to:

- List various methods which can be used by diverse groups of clients.

#### 4.1.1 After Delivery

A woman should not wait until the return of monthly bleeding to start a contraceptive method, but instead she should start as soon as guidance allows in the table given below:

**Table 10: Earliest time that a woman can start a family planning method after childbirth**

Family Planning Method	Fully or nearly fully breastfeeding	Partially Breastfeeding or not breastfeeding
Lactational Amenorrhea Method	Immediately	(Not applicable)
Vasectomy	Immediately or during partners' pregnancy*	
Male or Female condom	Immediately or when intercourse is resumed	
Copper-bearing IUCD	Immediately after delivery (Post Placental insertion ,only by trained providers) or after 6 weeks	
Female sterilization	Within 7 days, otherwise wait 6 weeks	
Fertility awareness methods/SDM	Start when normal secretions have returned (for symptoms-based methods) or she has had 3 regular menstrual cycles (for calendar-based methods). This will be later for breastfeeding women than for women who are not breastfeeding.	
Progestin-only pills	6 weeks after childbirth **	- Immediately if not breastfeeding **
Progestin-only Injectables		- 6 weeks after childbirth if partially breastfeeding.
Implants		
Combined oral contraceptives	6 months after childbirth **	21 days after childbirth if not breastfeeding **
Injectables		

- \* If a man has a vasectomy during the first 6 months of his partner’s pregnancy, it will be effective by the time she delivers her baby.
- \*\* Earlier use if not usually recommended unless other, more appropriate methods are not available or not acceptable.

#### 4.1.2 Family Planning in Post abortion Care

- Counsel with Compassion
- .To make decisions about her health and fertility, she needs to know:
- Fertility returns quickly—within 2 weeks after a first-trimester abortion or miscarriage and within 4 weeks after a second-trimester abortion or miscarriage.
- She can choose among many different family planning methods that she can start at once (see next page). Methods that women should not use immediately after giving birth pose no special risks after treatment for abortion complications.
- She can wait before choosing a contraceptive for ongoing use, but she should consider using 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. If she wants to become pregnant again soon, encourage her to wait.

*\*Backup methods include abstinence, male or female condoms and withdrawal.*

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

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

##### **Special considerations:**

- IUCD insertion immediately after a second-trimester abortion requires a specifically trained provider.
- Female sterilization must be decided upon in advance, and not while a woman is sedated, under stress, or in pain. Counsel carefully and be sure to mention available reversible methods).
- Fertility awareness methods: A woman can start symptoms-based methods once she has no infection-related secretions or bleeding due to injury to the genital tract.



### 4.1.3 Adolescents

- All Contraceptives Are Safe for Young People
- Male and female condoms (provides triple protection which many young people need)
- Hormonal contraceptives (oral contraceptives, injectables)
- Emergency contraceptive pills (ECPs)
- Copper Bearing Intrauterine device
- Fertility awareness methods/ Standard days Method
- Withdrawal
- Female sterilization and vasectomy (Provide with great CAUTION)

### 4.1.4 Male Participation in Family Planning:

- Providers can give support and services to men both as supporters of women and as clients.
- Important services that many men want include:
  - Condoms, vasectomy, and counselling about other methods
  - Counselling and help for sexual problems STI/HIV counselling, testing, and treatment
  - Infertility counselling
  - Screening for penile, testicular, and prostate cancer
- Like women, men of all ages, married or unmarried, have their own sexual and reproductive health needs. They deserve good-quality services and respectful, supportive, and non-judgemental counselling.

### 4.1.5 Women near Menopause

- It is recommended to use a family planning method for 12 months after last bleeding
- To prevent pregnancy until it is clear that she is no longer fertile, an older woman can use any method, if she has no medical condition that limits its use. By itself, age does not restrict a woman from using any contraceptive method.

#### I) Special Considerations about Method of choice

When helping women near menopause choose a method, consider:

**Combined hormonal methods (combined oral contraceptives [COC], monthly injectables:**

- Women age 35 and older who smoke—regardless of how much—should not use COC,
- Women age 35 and older who smoke 15 or more cigarettes a day should not use monthly injectables.

- Women age 35 or older should not use COC, monthly injectables, if they have migraine headaches (whether with aura or not).

### **Progestin-only methods (progestin-only pills, progestin-only injectables)**

- A good choice for women who cannot use methods with estrogen. During use, DMPA decreases bone mineral density slightly. It is not known whether this decrease in bone density increases the risk of bone fracture later, after menopause.

### **Emergency contraceptive pills**

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

### **Female sterilization and vasectomy**

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

### **Male and female condoms and withdrawal**

- Protect older women well, considering women's reduced fertility in the years before menopause.
- Affordable and convenient for women who may have occasional sex.

### **Copper Bearing Intrauterine device**

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

### **Fertility awareness methods**

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

## **II) When a Woman Can Stop Using Family Planning**

Because bleeding does not come every month in the time before menopause, it is difficult for a woman whose bleeding seems to have stopped to know when to stop using contraception. Thus, it is recommended to use a family planning method for 12 months after last bleeding in case bleeding occurs again.

Hormonal methods affect bleeding, and so it may be difficult to know if a woman using them has reached menopause. After stopping a hormonal method, she can use a nonhormonal method. She no longer needs contraception once she has had no bleeding for 12 months in a row.

Copper-bearing IUCD can be left in place until after menopause. They should be removed within 12 months after a woman's last monthly bleeding.

#### 4.1.6 Contraceptives for Clients with STIs, HIV, and AIDS

Advice should be given on choosing a **Triple Protection Strategy**- (i. e. protection against pregnancy, STIs and HIV) - The strategy is mainly to use a male or female condom correctly and consistently with every act of sex despite of using another method of contraception for extra protection. See the table given below for special consideration regarding various family planning methods for them.

**Table 11: Special family planning considerations for clients with STIs, HIV, AIDS, or on Antiretroviral Therapy**

Method	Has STIs	Has HIV or AIDS	On anti-retroviral (ARV) Therapy
Intrauterine device (Copper -bearing or hormonal IUCD)	Do not insert an IUCD in a woman who is at very high individual risk for gonorrhea and Chlamydia, or who currently has gonorrhea, Chlamydia, purulent cervicitis, or PID (a current IUCD user who becomes infected with gonorrhea or Chlamydia or develops PID can safely continue using an IUCD during and after treatment)	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  (a woman who develops AIDS while using an IUCD can safely continue using the IUCD).	Do not insert an IUCD if client is not clinically well.
Female sterilization	If client has gonorrhea, Chlamydia, purulent cervicitis, or PID, delay sterilization until the condition is treated and cured.	Woman who are infected with HIV, have AIDS or are on antiretroviral therapy can safely undergo female sterilization. Special arrangements are needed to perform female sterilization on a woman with AIDS. Delay the procedure if she is currently ill with AIDS-related illness.	
Vasectomy	If client has scrotal skin infection, active STI, swollen, tender tip of penis, sperm ducts, or testicles, delay sterilization until the condition is treated and cured	Men who are infected with HIV, have AIDS, or are on antiretroviral 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.	

Source:

- *Family Planning – A global Handbook for providers, A WHO family planning cornerstone, 2007.*
- *Contraceptive Updates, Reference manual for Doctors, Oct. 2007, MOHFW, Govt. of India.*

## Annexure- 1

### Pregnancy Checklist

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

N O		Y E S
	1. Did you have a baby less than 6 months age, are you fully or nearly-fully breastfeeding, and had no monthly bleeding since then?	
	2. Have you abstained from sexual intercourse since your last monthly bleeding or delivery?	
	3. Have you had a baby in the last 4 weeks?	
	4. Did your last monthly bleeding start within the past 7 days (or within the past 12 days if the client is planning to use an IUCD)?	
	5. Have you had a miscarriage or abortion in the last 7 days (or within the past 12 days if the client is planning to use an IUCD)?	
	6. Have you been using a reliable contraceptive method consistently and correctly?	

If a client answered “no” to all questions, pregnancy cannot be ruled out. The client should wait for her next monthly bleeding or use a pregnancy test.

If the client answered “yes” to at least one of the questions, and she has no signs or symptoms of pregnancy, you can give her the method she has chosen.

## Annexure- 2

### Contraceptive Effectiveness

#### Rates of unintended Pregnancies per 100 Women

Family Planning method	First year Pregnancy Rates		Key
	Consistent & Correct use	As commonly used	
Vasectomy	0.1	0.15	0-0.9 Very effective
Female Sterilization	0.5	0.5	
Copper-bearing IUCD	0.6	0.8	
LAM (for 6 months)	0.9	2	1-9 Effective
Progestin-only injectables	0.3	3	
Combined OCP	0.3	8	10-25 Moderately effective
Progestin-only oral pills	0.3	8	
Male condom	2	15	
Standard days method	5		
Female condom	5	21	26-32 Less Effective
No method	85	85	

*a. Rates largely from the United States Source: Trussell J. Contraceptive efficacy. In: Hatcher R et al, editors, Contraceptive technology. 19<sup>th</sup> revised e. 2007.*

## References

1. Family Planning – A global Handbook for providers, A WHO family planning cornerstone, 2007.
2. Contraceptive Updates, Reference manual for Doctors, Oct.2007, MOHFW, Govt. of India.
3. Contraceptive Updates, Facilitator's Guide, Oct.2007, MOHFW, Govt. of India.
4. IUCD Reference Manual for Medical Officers, July 2007, Family Planning Division, MOHFW, Govt. of India.
5. Alternative Methodology of Training in IUCD, Facilitator's Guide (Draft) Family Planning Division, MOHFW, Govt. of India.
6. Quality Assurance Manual for Sterilization Services, Oct. 2006, Research Studies and Standard Division, MOHFW, Govt. of India.
7. Standards for female and Male Sterilization, Oct. 2006, Research Studies and Standard Division, MOHFW, Govt. of India.
8. D.C.Dutta, Textbooks of Obstetrics, VI edition, 2004, New Central Book Agency(P) Ltd.
9. K. Park, Park's Textbook of Preventive and Social Medicine, 19<sup>th</sup> edition, Bhanot Publication.