Logo	Name of institution

Promote and Provide Family Planning Service

NTQF Level III

Learning Guide # 3

Unit of Competence	**Promote and Provide Family Planning Service**
Module Title:	**promoting and Providing Family Planning**
LG Code:	**HLT MDW3 M07 LO03-03**
TTLM Code:	**HLT MDW3 TTLM 0919v1**

LO 3: Provide short acting contraceptive method and manage side effects

Instruction Sheet	Learning Guide # 3

This learning guide is developed to provide you the necessary information regarding the following **content coverage** and topics:

Short acting contraceptive methods

Managing side-effects of short acting contraceptives

Managing complications of short acting contraceptives

Family planning service linked with other RH services

Postpartum and Post-Abortion Family Planning

Infertility

This guide will also assist you to attain the learning outcome stated in the cover page. Specifically, **upon completion of this Learning Guide, you will be able to**:

- Provide short acting contraceptive method
- Manage Side-effects of hormonal method of contraceptives
- Identify and manage Complications of hormonal method of contraceptive
- Link family planning service with other RH services

Learning Instructions:

1. Read the specific objectives of this Learning Guide.
2. Follow the instructions described below 3 to 6.
3. Read the information written in the information “Sheet 1, Sheet 2, Sheet 3, Sheet 4, Sheet 5 and Sheet 6 respectively.

4. Accomplish the “Self-check 1, Self-check 2, Self-check 3, Self-check 4, Self-check 5, and Self-check 6 in **page 17, 26, 33, 44, 51 and 56 respectively**.

Information sheet 1	Provide short acting contraceptive method

1.1. Providing Combined Oral Contraceptives

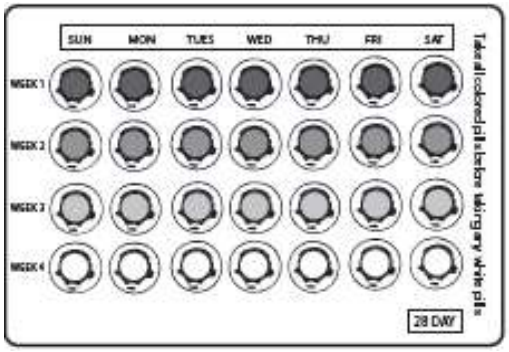
When to start

IMPORTANT: A woman can start using COCs any time she wants if it is reasonably certain she is not pregnant.

Women's situation	When to start
Having menstrual cycles or switching from a nonhormonal method	**Any time of the month** • If she is starting within 5 days after the start of her monthly bleeding, no need for a backup method. • If it is more than 5 days after the start of her monthly bleeding, she can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills. • If she is switching from an IUD, she can start COCs immediately
Switching from a hormonal method	• Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. • If she is switching from injectables, she can begin taking COCs when the repeat injection would have been given. No need for a backup method.
Fully or nearly fully breastfeeding Less than 6 months after giving birth	• Give her COCs and tell her to start taking them 6 months after giving birth or when breast milk is no longer the baby's main food— whichever comes first.
Fully or nearly fully Breastfeeding More than 6 months	• If her monthly bleeding has not returned, she can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills.

after giving birth	• If her monthly bleeding has returned, she can start COCs as advised for women having menstrual cycles.
Partially Breastfeeding Less than 6 weeks after giving birth	• Give her COCs and tell her to start taking them 6 weeks after giving birth. • Also give her a backup method to use until 6 weeks since giving birth if her monthly bleeding returns before this time.
Partially Breastfeeding more than 6 weeks after giving birth	• If her monthly bleeding has not returned, she can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills. • If her monthly bleeding has returned, she can start COCs as advised for women having menstrual cycles.
Not breastfeeding Less than 4 weeks after giving birth	• She can start COCs at any time on days 21–28 after giving birth. Give her pills any time to start during these 7 days. No need for a backup method.
Not breastfeeding More than 4 weeks after giving birth	• If her monthly bleeding has not returned, she can start COCs any time it is reasonably certain she is not pregnant.† She will need a backup method for the first 7 days of taking pills. • If her monthly bleeding has returned, she can start COCs as advised for women having menstrual cycles.
No monthly bleeding (not related to childbirth or breastfeeding)	• She can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills.
After miscarriage or abortion	• Immediately. If she is starting within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method. • If it is more than 7 days after first- or second trimester miscarriage or

	abortion, she can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills.
After taking emergency contraceptive pills (ECPs)	• She can start COCs the day after she finishes taking the ECPs. There is no need to wait for her next monthly bleeding to start her pills. • A new COC user should begin a new pill pack. • A continuing user who needed ECPs due to pill taking errors can continue where she left off with her current pack. • All women will need to use a backup method for the first 7 days of taking pills.



Giving Advice on Side Effects

IMPORTANT: Counseling about bleeding changes may be the most important help a woman needs to keep using the method without concern.

Describe the most common side effects

- In the first few months, bleeding at unexpected times (irregular bleeding). Then lighter, shorter, and more regular monthly bleeding.
- Headaches, breast tenderness, w eight change, and possibly other side effects.

Explain about these side effects

- Side effects are not signs of illness.
- Most side effects usually become less or stop within the first few months of using COCs.

- Common, but some women do not have them.

Explain what to do in case of side effects

- Keep taking COCs. Skipping pills risks pregnancy and can make some side effects worse.
- Take each pill at the same time every day to help reduce irregular bleeding and also help with remembering.
- Take pills with food or at bedtime to help avoid nausea. The client can come back for help if side effects bother her or if she has other concerns.

Explaining How to Use

1. Give pills

- Give up to 1 year's supply (13 packs) depending on the woman's preference and planned use.

2. Explain pill pack

- Show which kind of pack—21 pills or 28 pills. With 28-pill packs, point out that the last 7 pills are a different color and do not contain hormones.
- Show how to take the first pill from the pack and then how to follow the directions or arrows on the pack to take the rest of the pills.

3. Give key instruction

- **Take one pill each day**— until the pack is empty.
- Discuss cues for taking a pill every day. Linking pill-taking to a daily activity—such as cleaning her teeth—may help her remember.
- Taking pills at the same time each day helps to remember them. It also may help reduce some side effects.

4. Explain starting next pack

- 28-pill packs: When she finishes one pack, she should take the first pill from the next pack on the very next day.
- 21-pill packs: After she takes the last pill from one pack, she should wait 7 days—no more— and then take the first pill from the next pack.
- It is very important to start the next pack on time. Starting a pack late risks pregnancy.

5. Provide backup method and explain use

- Sometimes she may need to use a backup method, such as when she misses pills.
- Backup methods include abstinence, male or female condoms, spermicides, and withdrawal.Tell her that spermicides and withdrawal are the least effective contraceptive methods.Give her condoms, if possible.
- If she misses 3 or more hormonal pills, she can consider ECPs.

Managing Missed Pills

Key message: Take a missed hormonal pill as soon as possible.

- Keep taking pills as usual, one each day. (She may take 2 pills at the same time or on the same day.)

Missed 1 or 2 pills? Started new pack 1 or 2 days late?

- Take a hormonal pill as soon as possible.

- Little or no risk of pregnancy.

Missed pills 3 or more days in a row in the first or second week?

Started new pack 3 or more days late?

- Take a hormonal pill as soon as possible.
- Use a backup method for the next 7 days.
- Also, if she had sex in the past 5 days, she can consider ECPs.

Missed 3 or more pills in the third week?

- Take a hormonal pill as soon as possible.
- Finish all hormonal pills in the pack. Throw away the 7 non hormonal pills in a 28-pill pack.
- Start a new pack the next day.
- Use a backup method for the next 7 days.
- Also, if she had sex in the past 5 days, she can consider ECPs.

Missed any nonhormonal pills? (Last 7 pills in 28-pill pack)

- Discard the missed nonhormonal pill(s).
- Keep taking COCs, one each day. Start the new pack as usual.

Severe vomiting or diarrhea

- If she vomits within 2 hours after taking a pill, she should take another pill from her pack as soon as possible, then keep taking pills as usual.
- If she has vomiting or diarrhea for more than 2 days, follow instructions for 3 or more missed pills, above.

Planning the Next Visit

1. Encourage her to come back for more pills before she uses up her supply of pills.
2. An annual visit is recommended.
3. Some women can benefit from contact after 3 months of COC use. This offers an opportunity to answer any questions, help with any problems, and check on correct use.

1.2. Providing Progestin-Only Pills

IMPORTANT: A woman can start using POPs any time she wants if it is reasonably certain she is not pregnant.

Fully or nearly fully breastfeeding Less than 6 months after giving birth	• If her monthly bleeding has not returned, she can start POPs any time between giving birth and 6 months. No need for a backup method. • If her monthly bleeding has returned, she can start POPs as advised for women having menstrual cycles.
Fully or nearly fully breastfeeding More than 6 months after giving birth	• If her monthly bleeding has not returned, she can start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking pills. • If her monthly bleeding has returned, she can start POPs as advised for women having menstrual cycles.
Partially breastfeeding If her monthly bleeding has not returned	• She can start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking pills.
Partially breastfeeding If her monthly bleeding has returned	• She can start POPs as advised for women having menstrual cycles.
Not breastfeeding Less than 4 weeks after giving birth	• She can start POPs at any time. No need for a backup method.
Not breastfeeding More than 4 weeks after giving birth	• If her monthly bleeding has not returned, she can start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking pills.

	• If her monthly bleeding has returned, she can start POPs as advised for women having menstrual cycles.
Switching from a hormonal method	• Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. • If she is switching from injectables, she can begin taking POPs when the repeat injection would have been given. No need for a backup method.
Having menstrual cycles or switching from a nonhormonal method	**Any time of the month** • If she is starting within 5 days after the start of her monthly bleeding, no need for a backup method. • If it is more than 5 days after the start of her monthly bleeding, she can start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking pills. • If she is switching from an IUD, she can start POPs immediately.
No monthly bleeding (not related to childbirth or breastfeeding)	• She can start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking pills.
After miscarriage or abortion	• Immediately. If she is starting within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method. If it is more than 7 days after first- or second trimester miscarriage or abortion, she can start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking pills.
After taking	• She can start POPs the day after she finishes taking the ECPs.

emergency contraceptive pills (ECPs)	There is no need to wait for her next monthly bleeding to start her pills. ✓ A new POP user should begin a new pill pack. ✓ A continuing user who needed ECPs due to pill-taking errors can continue where she left off with her current pack. • All women will need to use a backup method for the first 2 days of taking pills.

Giving Advice on Side Effects

Describe the most common side effects

- Breastfeeding women normally do not have monthly bleeding for several months after giving birth. POPs lengthen this period of time.
- Women who are not breastfeeding may have frequent or irregular bleeding for the first several months, followed by regular bleeding or continued irregular bleeding.
- Headaches, dizziness, breast tenderness, and possibly other side effects.

Explain about these side effects

- Side effects are not signs of illness. Lack of bleeding does not mean pregnancy.
- Usually become less or stop within the first few months of using POPs. Bleeding changes, however, usually persist.
- Common, but some women do not have them.

Explain what to do in case of side effects

- Keep taking POPs. Skipping pills risks pregnancy.
- Try taking pills with food or at bedtime to help avoid nausea.
- The client can come back for help if side effects bother her or if she has other concerns.

Explaining How to Use

1. **Give pills**

- Give as many packs as possible—even as much as a year's supply (11 packs of 35 pills each or 13 packs of 28 pills each).

2. **Explain pill pack**

- Show which kind of pack—28 pills or 35 pills.
- Explain that all pills in POP packs are the same color and all are active pills, containing a hormone that prevents pregnancy.
- Show how to take the first pill from the pack and then how to follow the directions or arrows on the pack to take the rest of the pills.

3. **Give key instruction**

- **Take one pill each day**— until the pack is empty.
- Women who are not breastfeeding should take a pill at the same time each day. Taking a pill more than 3 hours late makes it less effective.
- Discuss cues for taking a pill every day. Linking pill-taking to a daily activity—such as cleaning her teeth— may help her remember.

4. **Explain starting next pack**

- When she finishes one pack, she should take the first pill from the next pack on the very next day.
- It is very important to start the next pack on time. Starting a pack late risks pregnancy.

5. **Provide backup method and explain use**

- Sometimes she may need to use a backup method, such as when she misses pills or is late taking a pill.

6. **Explain that effectiveness decreases when breastfeeding stops**

- Without the additional protection of breastfeeding itself, POPs are not as effective as most other hormonal methods.

- When she stops breastfeeding, she can continue taking POPs if she is satisfied with the method, or she is welcome to come back for another method.

Managing Missed Pills

- **Key message: Take a missed pill as soon as possible.**
- Keep taking pills as usual, one each day. (She may take 2 pills at the same time or on the same day.)

Do you have monthly bleeding regularly?

- If yes, she also should use a backup method for the next 2 days.
- Also, if she had sex in the past 5 days, she can consider taking ECPs.

Severe vomiting or diarrhea

- If she vomits within 2 hours after taking a pill, she should take another pill from her pack as soon as possible, then keep taking pills as usual.
- If she has vomiting or diarrhea for more than 2 days, follow instructions for 3 or more missed pills, above.

Planning the Next Visit

1. Encourage her to come back for more pills before she uses up her supply of pills.
2. Contacting women after the first 3 months of POP use is recommended. This offers an opportunity to answer any questions, help with any problems, and check on correct use.

1.3. Providing Progestin-Only Injectables

When to Start

IMPORTANT: A woman can start injectables any time she wants if it is reasonably certain she is not pregnant.

Women's situation	When to start

Having menstrual cycles or switching from a nonhormonal method	**Any time of the month** • If she is starting within 7 days after the start of her monthly bleeding, no need for a backup method. • If it is more than 7 days after the start of her monthly bleeding, she can start injectables any time it is reasonably certain she is not pregnant. She will need a backup method* for the first 7 days after the injection. • If she is switching from an IUD, she can start injectables immediately.
Switching from a hormonal method	• Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method.
Fully or nearly fully breastfeeding Less than 6 months after giving birth	• If she gave birth less than 6 weeks ago, delay her first injection until at least 6 weeks after giving birth. • If her monthly bleeding has not returned, she can start injectables any time between 6 weeks and 6 months. No need for a backup method. • If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles.
Fully or nearly fully breastfeeding More than 6 months after giving birth	• If her monthly bleeding has not returned, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection. • If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles.
Partially breastfeeding Less than 6 weeks after giving birth	• Delay her first injection until at least 6 weeks after giving birth.
Partially breastfeeding More	• If her monthly bleeding has not returned, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a Backup

than 6 weeks after giving birth	method for the first 7 days after the injection. • If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles.
Not breastfeeding Less than 4 weeks after giving birth	• She can start injectables at any time. No need for a backup method.
Not breastfeeding More than 4 weeks after giving birth	• If her monthly bleeding has not returned, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection. • If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles.
No monthly bleeding (not related to childbirth or breastfeeding)	• She can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.
After miscarriage or abortion	• Immediately. If she is starting within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method. • If it is more than 7 days after first- or second trimester miscarriage or abortion, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.
After taking emergency contraceptive pills (ECPs)	• She can start or restart injectables on the same day as taking the ECPs. *No need to wait for her next monthly bleeding to have the injection.* ✓ She will need to use a backup method for the first 7 days after the injection. ✓ If she does not start immediately but returns for injectables, she can start at any time if it is reasonably certain she is not pregnant.

Giving Advice on Side Effects

IMPORTANT: Counseling about bleeding changes may be the most important help a woman needs to keep using the method without concern.

Describe the most common side effects

- For the first several months, irregular bleeding, prolonged bleeding, frequent bleeding. Later, no monthly bleeding.
- Weight gain (about 1–2 kg per year), headaches, dizziness, and possibly other side effects.

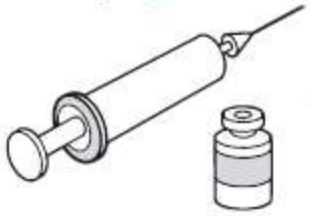
Explain about these side effects

- Side effects are not signs of illness.
- Common, but some women do not have them.
- The client can come back for help if side effects bother her.

Giving Intermusclar Injection with a Conventional Syringe

1. **Obtain one dose of injectable, needle, and syringe**

- DMPA: 150 mg for injections into the muscle (intramuscular injection). NET-EN: 200 mg for injections into the muscle.
- For each injection use a prefilled single-use syringe and needle from a new, sealed package (within expiration date and not damaged), if available.
- If a single-dose prefilled syringe is not available, use single-dose vials. Check expiration date. If using an open multi dose vial, check that the vial is not leaking.
  - ✓ DMPA: A 2 ml syringe and a 21–23 gauge intramuscular needle.
  - ✓ NET-EN: A 2 or 5 ml syringe and a 19-gauge intramuscular needle. A narrower needle (21–23 gauge) also can be used.



2. Wash

- Wash hands with soap and water, if possible. Let your hands dry in the air.
- If injection site is dirty, wash it with soap and water.
- No need to wipe site with antiseptic.

If using a prefilled syringe, skip to step 5.

3. Prepare vial

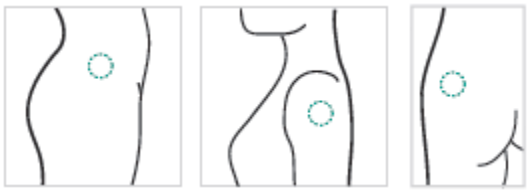
- DMPA: Gently shake the vial.
- NET-EN: Shaking the vial is not necessary.
- No need to wipe top of vial with antiseptic.
- If vial is cold, warm to skin temperature before giving the injection.

4. Fill syringe

- Pierce top of vial with sterile needle and fill syringe with proper dose.

5. Inject formula

- Insert sterile needle deep into the hip (ventrogluteal muscle), the upper arm (deltoid muscle), or the buttocks (gluteal muscle, upper outer portion), whichever the woman prefers. Inject the contents of the syringe. Do not massage injection site.



6. Dispose of disposable syringes and needles safely

- Do not recap, bend, or break needles before disposal.
- Place in a puncture-proof sharps container.
- Do not reuse disposable syringes and needles.

Supporting the User Give specific instructions

- Tell her not to massage the injection site.
- Tell the client the name of the injection.
- Agree on a date for her next injection and give her a paper with the date written on it.

Planning the Next Injection

1. Agree on a date for her next injection in 3 months (13 weeks) for DMPA, or in 2 months (8 weeks) for NET-EN. Discuss how to remember the date, perhaps tying it to a holiday or other event or circling a date on a calendar.
2. Ask her to try to come on time. With DMPA she may come up to 4 weeks after the scheduled injection date and still get an injection. With NET-EN she may come up to 2 weeks after the scheduled injection date and still get an injection. No need for tests, evaluation, or a backup method. With either DMPA or NET-EN, she can come up to 2 weeks before the scheduled injection date.
3. She should come back no matter how late she is for her next injection. If more than 4 weeks late for DMPA or 2 weeks late for NET-EN, she should abstain from sex or use condoms, spermicides, or withdrawal until she can get an injection. Also, if she has had sex in the past 5 days without using another contraceptive method, she can consider emergency contraceptive pills.

Self-check 1	Written test

Directions: Answer all the questions listed below.

Part II say "True" if the statement is correct or "False" if the statement is incorrect (2 point each 6x2= 12%).

1. A women who takes COCs of 21-pill packs, she takes the last pill from one pack, should not wait for 7 days and then take the first pill from the next pack.
2. Pills in POP packs are the same color and all are active pills, containing a hormone that prevents pregnancy.
3. POPs are as effective as most other hormonal methods, without the additional protection of breastfeeding itself.
4. Women who are not breastfeeding if taking a pill more than 3 hours late makes it less effective.
5. When we prepare for NET-EN injection shaking the vial is not necessary.
6. A women come late up to 4 for DMPA and up to 2 weeks for NET_EN, need for tests, evaluation, or a backup method.

Part II. Choose the correct answer for the following alternatives (each 2 point 5x2=10%)

1. If a women is fully or nearly fully Breastfeeding when she should start COCs?
   A. Before six weeks
   B. After six weeks
   C. Before six months
   D. After six months
2. A women having menstrual cycles should start POPs within _____ days?
   A. 4
   B. 5
   C. 6

D. 7

3. When we give progestin only injectable, which women need a backup method?
   A. Fully or nearly fully breastfeeding Less than 6 months after giving birth
   B. More than 7 days after the start of her monthly bleeding
   C. Not breastfeeding Less than 4 weeks after giving birth
   D. Switching from a hormonal method

4. Next injection for next injection for DMPA and NET-EN should be with in _____ and ____ respectively.
   A. 3 month and 2 month
   B. 2 month and 3 month
   C. 4 month and 3 month
   D. 3 month and 4 month

Note: **Satisfactory rating - 10 points** **Unsatisfactory - below 10 points**

Answer sheet for True or False

1. _____
2. _____

Answer Sheet for Multiple choose Questions

1. _____
2. _____
3. _____
4. _____

Score= _____

Rating = _____

Name: _____ Date: _____

Information sheet 2	Managing side-effects of short acting contraceptives

2.1. Managing Side Effects of Combined Oral Contraceptives

May or may not be due to the method.

- Problems with side effects affect women's satisfaction and use of COCs. They deserve the provider's attention. If the client reports side effects or problems, listen to her concerns, give her advice, and support, and, if appropriate, treat. Make sure she understands the advice and agrees.
- 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.

Irregular bleeding (bleeding at unexpected times that bothers the client)

- Reassure her that many women using COCs experience irregular bleeding. It is not harmful and usually becomes less or stops after the first few months of use.
- Other possible causes of irregular bleeding include:
  - ✓ Missed pills
  - ✓ Taking pills at different times each day
  - ✓ Vomiting or diarrhea
  - ✓ Taking anticonvulsants, rifampicin, or rifabutin
- To reduce irregular bleeding:
  - ✓ Urge her to take a pill each day and at the same time each day.
  - ✓ Teach her to make up for missed pills properly.

- ✓ For modest short-term relief, she can try 800 mg ibuprofen 3 times daily after meals for 5 days or other nonsteroidal anti-inflammatory drug (NSAID), beginning when irregular bleeding starts.
- ✓ If she has been taking the pills for more than a few months and NSAIDs do not help, give her a different COC formulation, if available. Ask her to try the new pills for at least 3 months.

- If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.

No monthly bleeding

- Reassure her that some women using COCs stop having monthly bleeding, and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not pregnant or infertile. Blood is not building up inside her. (Some women are happy to be free from monthly bleeding, and for some women this may help prevent anemia.)

Ordinary headaches (nonmigrainous)

- Try the following (one at a time):
  - ✓ Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.
- Any headaches that get worse or occur more often during COC use should be evaluated.

Nausea or dizziness

- For nausea, suggest taking COCs at bedtime or with food. If symptoms continue:
- Consider locally available remedies.

Breast tenderness

- Recommend that she wear a supportive bra (including during strenuous activity and sleep).
- Try hot or cold compresses.

- Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.
- Consider locally available remedies.

Weight change

- Review diet and counsel as needed.

Mood changes or changes in sex drive

- Some women have changes in mood during the hormone-free week (the 7 days when a woman does not take hormonal pills).
- 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.
- Clients who have serious mood changes such as major depression should be referred for care.

Acne

- Acne usually improves with COC use. It may worsen for a few women.
- If she has been taking pills for more than a few months and acne persists, give her a different COC formulation, if available. Ask her to try the new pills for at least 3 months.
- Consider locally available remedies.

2.2. Managing Side Effects of Progestin Only Pills

May or may not be due to the method.

- Problems with side effects affect women's satisfaction and use of POPs. They deserve the provider's attention. If the client reports side effects or problems, listen to her concerns, give her advice and support, and, if appropriate, treat. Make sure she understands the advice and agrees.

- Encourage her to keep taking a pill every day even if she has side effects. Missing pills can risk pregnancy.
- Many side effects will subside after a few months of use. For a woman whose side effects persist, give her a different POP formulation, if available, for at least 3 months.
- Offer to help the client choose another method—now, if she wishes, or if problems cannot be overcome.

No monthly bleeding

- Breastfeeding women:
  - ✓ Reassure her that this is normal during breastfeeding. It is not harmful.
- Women not breastfeeding:
  - ✓ Reassure her that some women using POPs stop having monthly bleeding, and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not pregnant or infertile. Blood is not building up inside her. (Some women are happy to be free from monthly bleeding.)

Irregular bleeding (bleeding at unexpected times that bothers the client)

- Reassure her that many women using POPs experience irregular bleeding—whether breastfeeding or not. (Breastfeeding itself also can cause irregular bleeding.) It is not harmful and sometimes becomes less or stops after the first several months of use. Some women have irregular bleeding the entire time they are taking POPs.
- Other possible causes of irregular bleeding include:
  - ✓ Vomiting or diarrhea
  - ✓ Taking anticonvulsants or rifampicin
- To reduce irregular bleeding:
  - ✓ Teach her to make up for missed pills properly.

- ✓ For modest short-term relief she can try 800 mg ibuprofen 3 times daily after meals for 5 days, or other nonsteroidal anti-inflammatory drug (NSAID), beginning when irregular bleeding starts.
- ✓ If she has been taking the pills for more than a few months and NSAIDs do not help, give her a different POP formulation, if available. Ask her to try the new pills for at least 3 months.

- If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.

Heavy or prolonged bleeding (twice as much as usual as or longer than 8 days)

- Reassure her that some women using POPs experience heavy or prolonged bleeding. It is generally not harmful and usually becomes less or stops after a few months.
- For modest short-term relief she can try NSAIDs, beginning when heavy bleeding starts.
- To help prevent anemia, suggest she take iron tablets and tell her it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).
- If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.

Ordinary headaches (nonmigrainous)

- Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.
- Any headaches that get worse or occur more often during POP use should be evaluated.

Mood changes or changes in sex drive

- 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.
- Some women experience depression in the year after giving birth. This is not related to POPs. Clients who have serious mood changes such as major depression should be referred for care.
- Consider locally available remedies.

Breast tenderness

- Breastfeeding women:
  - ✓ It may due to cracked nipples, sore breast or infection give appropriate treatment
- Women not breastfeeding:
  - ✓ Recommend that she wear a supportive bra (including during strenuous activity and sleep).
  - ✓ Try hot or cold compresses.
  - ✓ Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.
  - ✓ Consider locally available remedies.

Nausea or dizziness

- For nausea, suggest taking POPs at bedtime or with food.
- If symptoms continue, consider locally available remedies.

2.3. Managing Side Effects of Progestin only Injectable

May or may not be due to the method.

- Problems with side effects affect women's satisfaction and use of injectables. They deserve the provider's attention. If the client reports side effects, listen to her concerns, give her advice and support, and, if appropriate, treat. Make sure she understands the advice and agrees.

- Offer to help the client choose another method—now, if she wishes, or if problems cannot be overcome.

No monthly bleeding

- Reassure her that most women using progestin-only injectables stop having monthly bleeding over time, and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not infertile. Blood is not building up inside her. (Some women are happy to be free from monthly bleeding.)

Irregular bleeding (bleeding at unexpected times that bothers the client)

- Reassure her that many women using progestin-only injectables experience irregular bleeding. It is not harmful and usually becomes less or stops after the first few months of use.
- For modest short-term relief, she can take 500 mg mefenamic acid 2 times daily after meals for 5 days or 40 mg of valdecoxib daily for 5 days, beginning when irregular bleeding starts.
- If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.

Weight gain

- Review diet and counsel as needed.

Abdominal bloating and discomfort

- Consider locally available remedies.

Heavy or prolonged bleeding (twice as much as usual as or longer than 8 days)

- Reassure her that some women using progestin-only injectables experience heavy or prolonged bleeding. It is not harmful and usually becomes less or stops after a few months.
- For modest short-term relief she can try (one at a time), beginning when heavy bleeding starts:
  - ✓ 500 mg of mefenamic acid twice daily after meals for 5 days
  - ✓ 40 mg of valdecoxib daily for 5 days
  - ✓ 50 µg of ethinyl estradiol daily for 21 days
- If bleeding becomes a health threat or if the woman wants, help her choose another method. In the meantime, she can use one of the treatments listed above to help reduce bleeding.
- To help prevent anemia, suggest she take iron tablets and tell her it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).
- If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.

Ordinary headaches (nonmigrainous)

- Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.
- Any headaches that get worse or occur more often during use of injectables should be evaluated.

Mood changes or changes in sex drive

- Ask about changes in her life that could affect her mood or sex drive, including changes in her relationship with her partner. Give support as appropriate.

- Clients who have serious mood changes such as major depression should be referred for care. Consider locally available remedies.

Dizziness

- Consider locally available remedies.

Self-check 2	Written test

Directions: Answer all the questions listed below.

Part II say "True" if the statement is correct or "False" if the statement is incorrect (2 point each 3x2= 6%).

1. Problems with side effects affect women's satisfaction and use of COCs.
2. Acne usually worsens with COC use.
3. Irregular bleeding due to progestin only injectable is not harmful and usually becomes less or stops after the first few months of use.

Part II. Choose the correct answer for the following alternatives (each 2 point 3x2=6%)

1. Suggest taking COCs at bedtime or with food is used to manage which side effect of COC?
   A. Ordinary headaches (nonmigrainous)
   B. Nausea or dizziness
   C. Breast tenderness
   D. Mood changes or changes in sex drive
2. A women using progestin only pills complaining about breast tenderness. Which is NOT the appropriate intervention to manage her complain?
   A. Recommend that she wear a supportive bra
   B. Suggest taking COCs at bedtime or with food
   C. Try hot or cold compresses.
   D. Suggest aspirin, ibuprofen, paracetamol , or other pain reliever.
3. A women using progestin only injectable complaining about no monthly bleeding on the repeat injection. Which is the appropriate action you do for the client?

A. Suggest aspirin, ibuprofen, paracetamol (325–1000 mg), or other pain reliever.
B. help her choose another method like intra uterine contraceptive device
C. Suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.
D. Reassure her that most women using progestin-only injectables stop having monthly bleeding over time, and this is not harmful.

Note: **Satisfactory rating - 6 points** **Unsatisfactory - below 6 points**

Answer sheet for True or False

1. _____
2. _____
3. _____

Answer Sheet for Multiple choose Questions

1. _____
2. _____
5. _____

Score= _____

Rating = _____

Name: _____ Date: _____

Information sheet 3	Managing complications of short acting contraceptives

3.1. Managing Complications of Combined oral contraceptives

New Problems That May Require Switching Methods

May or may not be due to the method.

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

- Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate.
- She can continue using COCs while her condition is being evaluated.
- If bleeding is caused by sexually transmitted infection or pelvic inflammatory disease, she can continue using COCs during treatment.

Starting treatment with anticonvulsants, rifampicin, or rifabutin

- Barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, and rifabutin may make COCs less effective. If using these medications long-term, she may want a different method, such as a progestin-only injectable, implant, a copper bearing IUD, or an LNG-IUD.
- If using these medications short-term, she can use a backup method along with COCs for greater protection from pregnancy.

Migraine headaches

Identifying Migraine headaches

- For women who want a hormonal method or are using one. If a woman reports having very bad headaches, ask her these questions to tell the difference between a migraine headache and an ordinary headache. If she answers “yes” to any 2 of these questions, she probably suffers from migraine headaches. Continue to Identifying Migraine Auras, below.

1. **Do your headaches make you feel sick to your stomach?**
2. **When you have a headache, do light and noise bother you a lot more than when you do not have a headache?**
3. **Do you have headaches that stop you from working or carrying out your usual activities for one day or more?**

Identifying Migraine Auras

- Ask this question to identify the most common migraine aura. If a woman answers "yes," she probably suffers from migraine auras.
  1. **Have you ever had a bright light in your eyes lasting 5 to 60 minutes, loss of clear vision usually to one side, and then a headache?** If her headaches are not migraines and she does not have aura, she can start or continue hormonal methods if she is otherwise medically eligible. Any later changes in her headaches should be evaluated.
- Regardless of her age, a woman who develops migraine headaches, with or without aura, or whose migraine headaches become worse while using COCs should stop using COCs.
- Help her choose a method without estrogen.

Circumstances that will keep her from walking for one week or more

- If she is having major surgery, or her leg is in a cast, or for other reasons she will be unable to move about for several weeks, she should:
  - ✓ Tell her doctors that she is using COCs.
  - ✓ Stop taking COCs and use a backup method during this period.
  - ✓ Restart COCs 2 weeks after she can move about again.

Certain serious health conditions (suspected heart or serious 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 gallbladder disease).

- The table below lists signs and symptoms of some serious health conditions. These conditions occur rarely to extremely rarely among users of the method. Still, it is important to recognize possible signs of these conditions and to take action or refer for care if a client reports them. In some cases clients who develop one of these conditions may need to choose another contraceptive method.

Condition	Description	Signs and symptoms
Heart attack	Occurs when the blood supply to the heart is blocked, usually due to a build-up of cholesterol and other substances in the coronary arteries	Chest discomfort or uncomfortable pressure; fullness, squeezing, or pain in the center of the chest that lasts longer than a few minutes or that comes and goes; spreading pain or numbness in one or both arms, back, jaw, or stomach; shortness of breath; cold sweats; nausea.
Liver disease	Infection with hepatitis inflames the liver; cirrhosis scars tissue, which blocks blood flow through the liver	Yellow eyes or skin (jaundice) and abdominal swelling, tenderness, or pain, especially in the upper abdomen.
Deep vein thrombosis	A blood clot that develops in the deep veins of the body, generally in the legs	Persistent, severe pain in one leg, sometimes with swelling or red skin.
Stroke	When arteries to the brain become blocked or burst, preventing normal blood flow and leading to the death of brain tissue	Numbness or weakness of the face, arm or leg, especially on one side of the body; confusion or trouble speaking or understanding; trouble seeing in one or both eyes; trouble walking, dizziness, loss of balance or coordination; severe headache with no other known cause. Signs and symptoms develop suddenly.
Pulmonary	A blood clot that travels through	Sudden shortness of breath, which may worsen

embolism	the bloodstream to the lungs	with a deep breath, cough that may bring up blood, fast heart rate, and a light-headed feeling.

- Tell her to stop taking COCs.
- Give her a backup method to use until the condition is evaluated.
- Refer for diagnosis and care if not already under care.

Suspected pregnancy

- Assess for pregnancy.
- Tell her to stop taking COCs if pregnancy is confirmed.
- There are no known risks to a fetus conceived while a woman is taking

3.2. Managing Complications of Combined oral contraceptives

New Problems That May Require Switching Methods

May or may not be due to the method.

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

- Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate.
- She can continue using POPs while her condition is being evaluated.
- If bleeding is caused by a sexually transmitted infection or pelvic inflammatory disease, she can continue using POPs during treatment.

Starting treatment with anticonvulsants, rifampicin, or rifabutin

- Barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, rifabutin, and ritonavir may make POPs less effective. If using these medications long-term, she may want a different method, such as progestin-only injectables or a copper-bearing IUD or LNG-IUD.

- If using these medications short-term, she can use a backup method along with POPs.

Migraine headaches

- A woman who has migraine headaches with or without aura can safely start POPs.
- If she develops migraine headaches without aura while taking POPs, she can continue to use POPs if she wishes.
- If she develops migraine aura while using POPs, stop POPs. Help her choose a method without hormones.

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

- Tell her to stop taking POPs.
- Give her a backup method to use until the condition is evaluated.
- Refer for diagnosis and care if not already under care.

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

- A woman who has one of these conditions can safely start POPs. If, however, the condition develops after she starts using POPs, she should stop. Help her choose a method without hormones.
- Refer for diagnosis and care if not already under care.

Suspected pregnancy

- Assess for pregnancy, including ectopic pregnancy.
- Tell her to stop taking POPs if pregnancy is confirmed.
- There are no known risks to a fetus conceived while a woman is taking POPs

3.3. Managing complications of Progestin only Injectables

New Problems That May Require Switching Methods

May or may not be due to the method.

Migraine headaches

- If she has migraine headaches without aura, she can continue to use the method if she wishes.
- If she has migraine aura, do not give the injection. Help her choose a method without hormones.

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

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

Certain serious health conditions (suspected blocked or narrowed arteries, serious liver disease, severe high blood pressure, blood clots in deep veins of legs or lungs, stroke, breast cancer, or damage to arteries, vision, kidneys, or nervous system caused by diabetes).

- Do not give next injection.
- Give her a backup method to use until the condition is evaluated.
- Refer for diagnosis and care if not already under care.

Suspected pregnancy

- Assess for pregnancy.

- Stop injections if pregnancy is confirmed.
- There are no known risks to a fetus conceived while a woman is using injectables

Self-check 3	Written test

Directions: Answer all the questions listed below.

Part II say "True" if the statement is correct or "False" if the statement is incorrect (2 point each 2x2= 4%).

1. A women who has Heart disease due to blocked or narrowed arteries (ischemic heart disease) can safely start POPs.
2. In case of unexplained vaginal bleeding, she can continue using POPs progestin-only injectables while her condition is being evaluated.

Part II. Choose the correct answer for the following alternatives (each 2 point 2x2=4%)

1. What results if a women using COCs starting treatment with anticonvulsants, rifampicin, or rifabutin for long term
   A. Migraine headache
   B. Less effect
   C. Heart attack
   D. Liver disease
2. A woman who has migraine headaches with or without aura can safely start ___.
   A. Combined oral contraceptives
   B. Progestin only pills
   C. Progestin only pills
   D. All

Note: **Satisfactory rating - 4 points** **Unsatisfactory - below 4 points**

Answer sheet for True or False

1. _____
2. _____

Answer Sheet for Multiple choose Questions

1. _____
2. _____

Score= _____

Rating = _____

Name: _____ Date: _____

Information sheet 4	Family planning service linked with other RH services

4.1. Men

Important Supporters, Important Clients

Providers can give support and services to men both as supporters of women and as clients.

Encourage Couples to Talk

Couples who discuss family planning— or without a provider's help—are more likely to make plans that they can carry out. Providers can:

- Coach men and women on how to talk with their partners about sex, family planning, and STIs.
- Encourage joint decision-making about sexual and reproductive health matters.

- Invite and encourage women to bring their partners to the clinic for joint counseling, decision-making, and care.
- Encourage the man to understand and support his partner to choose the contraceptive method she prefers.
- Encourage the man to consider taking more responsibility for family planning—for example, by using condoms or vasectomy.
- Suggest to female clients that they tell their partners about health services for men. Give informational materials to take home, if available.

Provide Accurate Information

To inform men's decisions and opinions, they need correct information and correction of misperceptions. Topics important to men include:

- Family planning methods, both for men and for women, including safety and effectiveness
- STIs including HIV—how they are and are not transmitted, signs and symptoms, testing, and treatment
- The benefits of waiting until the youngest child is 2 years old before a woman becomes pregnant again
- Male and female sexual and reproductive anatomy and function

Offer Services or Refer

Important services that many men want include:

- Male condoms and vasectomy services
- Information and counseling about other contraceptive methods, particularly methods that must have male cooperation, such as fertility awareness-based methods and female condoms
- Counseling and help for sexual problems
- STI/HIV counseling, testing, and treatment
- Infertility counseling
- 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 nonjudgmental counseling.

4.2. Women Near Menopause

A woman has reached menopause when her ovaries stop releasing eggs (ovulating). Because bleeding does not come every month as menopause approaches, a woman is considered no longer fertile once she has gone 12 months in a row without having any bleeding.

Menopause usually occurs between the ages of 45 and 55. About half of women reach menopause by age 50. By age 55 some 96% of women have reached menopause.
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.

Special Considerations about Method Choice

When helping women near menopause choose a method, consider:

Combined hormonal methods

- Women age 35 and older who smoke—regardless of how much— should not use COCs.
- Women age 35 or older should not use COCs if they have migraine headaches (whether with migraine aura or not).

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

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

Emergency contraceptive pills

- Can be used by women of any age, including those who cannot usehormonal 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, diaphragms, spermicides, cervical caps, and withdrawal

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

Intrauterine device (copper-bearing IUDs and LNG-IUDs)

- 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.

When a Woman Can Stop Using Family Planning

It is recommended to continue using a family planning method until 12 months with no bleeding have passed. No longer needs contraception once she has had no bleeding for 12 months in a row. *Copper-bearing IUDs* can be left in place until after menopause. The IUD should be removed 12 months after a woman's last monthly bleeding.

Relieving Symptoms of Menopause

Women experience physical effects before, during, and after menopause: hot flashes, excess sweating, difficulty holding urine, vaginal dryness that can make sex painful, and difficulty sleeping.

Providers can suggest ways to reduce some of these symptoms:

- Deep breathing from the diaphragm may make a hot flash go away faster. A woman can also try eating foods containing soy or taking 800 international units per day of vitamin E.
- Eat foods rich in calcium (such as dairy products, beans, fish) and engage in moderate physical activity to help slow the loss of bone density that comes with menopause.
- Vaginal lubricants or moisturizers can be used if vaginal dryness persists and causes irritation. During sex, use a commercially available vaginal lubricant, water, or saliva as a lubricant if vaginal dryness is a problem.

4.3. Clients with Disabilities

Health care providers should treat people with disabilities in the same way that they should treat people without disabilities: with respect. People with disabilities are at increased risk of being infected with HIV and other STIs. Many have been sterilized against their will, forced to have abortions, or forced into unwanted marriages, and many have experienced gender-based violence.

To counsel clients with disabilities, health care providers need to consider their preferences and the nature of their disability. For example, barrier methods may be difficult for some people with a physical disability, and women with an intellectual disability may have trouble remembering to take a pill each day or dealing with changes in monthly bleeding.

Like all clients, people with disabilities need sexual and reproductive health education to make informed choices. People with intellectual disabilities have the same rights as other people to make their own decisions about contraception, including sterilization. They may need special support to do so. For a client with an intellectual disability who is unable to communicate her or his preferences clearly, someone whom the client trusts should participate and help to make an informed choice that is as consistent as possible with the client's preference. Especially for the choice of sterilization, health care systems should ensure that a process of supported decision-making is available.

To care for people with disabilities, programs should make it known in the community that they serve people with disabilities without discrimination. Facilities should be made physically accessible—for example, with ramps for wheelchairs and large bathrooms with grab bars. Outreach programs should make a special effort to identify and reach people in the community who have limited mobility. Print materials should have simple graphics, large print, and Braille, if possible, and information should be available in audio formats, such as CD or cassette tape, as well as in print. Providers may need especially to demonstrate actions as well as describing them, to speak slowly, and to pause often and check comprehension.

4.4. Sexually Transmitted Infections, Including HIV

Family planning providers can help their clients in various ways to prevent STIs, including infection with the human immunodeficiency virus (HIV).

What Are Sexually Transmitted Infections?

STIs are caused by bacteria, viruses, and parasites spread through sexual contact. Infections can be found in body fluids such as semen, on the skin of the genitals and areas around them, and some also in the mouth, throat, and rectum. Some STIs cause no symptoms. Others can cause discomfort or pain. If not treated, some can cause pelvic inflammatory disease, infertility, chronic pelvic pain, and cervical cancer. Some STIs can also greatly increase the chance of becoming infected with HIV.

STIs spread in a community because an infected person has sex with an uninfected person. The more sexual partners a person has, the greater his or her risk of either becoming infected with STIs or transmitting STIs.

Who Is at Risk?

Sexual behavior that can increase exposure to STIs includes:

- Sex with a partner who has STI symptoms
- Sex with a partner who has recently been diagnosed with or treated for an STI
- Sex with more than one partner—the more partners, the more risk

- Sex with a partner who has sex with others and does not always use condoms
- Sex without a condom with almost any new partner in a community where many people have STIs

What Causes STIs?

Several types of organisms cause STIs. Those caused by organisms such as bacteria generally can be cured. STIs caused by viruses generally cannot be cured, although they can be treated to relieve symptoms

STI	Type	Sexual transmission	Nonsexual transmission	curable
Chancroid	Bacteria	Vaginal, anal, and oral sex	None	Yes
Chlamydia	Bacteria	Vaginal and anal sex Rarely, from genitals to mouth	From mother to child during pregnancy	Yes
Gonorrhea	Bacteria	Vaginal and anal sex, or contact between mouth and genitals	From mother to child during delivery	Yes
Hepatitis B	Viral	Vaginal and anal sex, or from penis to mouth	In blood, from mother to child during delivery or in breast milk	No
Herpes	Viral	Genital or oral contact with an ulcer, including vaginal and anal sex; also genital contact in area without ulcer	From mother to child during pregnancy or delivery	No
HIV	Viral	Vaginal and anal sex Very rarely, oral sex	In blood, from mother to child during pregnancy or delivery or in breast milk	No
Human papilloma virus	Viral	Skin-to-skin and genital contact or contact between mouth and genitals	From mother to child during delivery	No

Syphilis	Bacteria	Genital or oral contact with an ulcer, including vaginal and anal sex	From mother to child during pregnancy or delivery	Yes
Trichomoniasis	Parasite	Vaginal, anal, and oral sex	From mother to child during delivery	Yes

Common signs and symptoms that may suggest an STI include:

Symtoms	**Possible cause**
Discharge from the penis—pus, clear or yellow-green drip	Commonly: Chlamydia, gonorrhea Sometimes: Trichomoniasis
Abnormal vaginal discharge or pain during sex	Chlamydia, gonorrhea, pelvic inflammatory disease
Lower abdominal pain or pain during sex	Chlamydia, gonorrhea, pelvic inflammatory disease
Swollen and/or painful testicles	Chlamydia, gonorrhea
Itching or tingling in the genital area	Commonly: Trichomoniasis Sometimes: Herpes
Blisters or sores on the genitals, anus, surrounding areas, or mouth	Herpes, syphilis, chancroid
Warts on the genitals, anus, or surrounding areas	Human papillomavirus
Unusual cervical discharge— changes from normal vaginal discharge in color, consistency, amount, and/or odor	Most commonly: Bacterial vaginosis, candidiasis Commonly: Trichomoniasis Sometimes: Chlamydia, gonorrhea

Avoiding Sexually Transmitted Infections

Family planning providers can talk to clients about how they can protect themselves both from STIs, including HIV, and pregnancy (dual protection).

Choosing a Dual Protection Strategy

Every family planning client needs to think about preventing STIs, including HIV—even people who assume they face no risk. A provider can discuss what situations place a person at increased risk of STIs, including HIV and clients can think about whether

these risky situations come up in their own lives. If so, they can consider 5 dual protection strategies.

One person might use different strategies in different situations; one couple might use different strategies at different times. The best strategy is the one that a person is able to practice effectively in the situation that she or he is facing. (Dual protection does not necessarily mean just using condoms along with another family planning method.)

Strategy 1: Use a male or female condom correctly with every act of sex.

- One method helps protect against pregnancy and STIs, including HIV.

Strategy 2: Use condoms consistently and correctly plus another family planning method.

- Adds extra protection from pregnancy in case a condom is not used or is used incorrectly.
- May be a good choice for women who want to be sure to avoid pregnancy but cannot always count on their partners to use condoms.

Strategy 3: If both partners know they are not infected, use any family planning method to prevent pregnancy and stay in a mutually faithful relationship.

- Many family planning clients are in this group and thus are protected from STIs, including HIV.
- Depends on communication and trust between partners. Other strategies, which do not involve using contraceptives, include:

Strategy 4: Engage only in safer sexual intimacy that avoids intercourse or otherwise prevents semen and vaginal fluids from coming in contact with each other's genitals.

- This strategy will not prevent syphilis, genital herpes, or infection with human papillomavirus. These spread through skin-to-skin contact.
- Depends on communication, trust, and self-control.
- If this is a person's first-choice strategy, it is best to have condoms on hand in case the couple does have sex.

Strategy 5: Delay or avoid sexual activity (either avoiding sex any time that it might be risky or abstaining for a longer time).

- If this is a person's first-choice strategy, it is best to have condoms on hand in case the couple does have sex.
- This strategy is always available in case a condom is not at hand.

People at high risk of exposure to HIV can take PrEP—preexposure prophylaxis—to prevent HIV infection. PrEP consists of some of the same ARV drugs also used to treat infection. Hormonal contraceptives and PrEP can be taken at the same time. The effectiveness of the contraception and of PrEP are not affected. Condom use while taking PrEP will help prevent both HIV and other STIs.

Contraceptives for Clients with STIs, Including HIV

People with STIs and people with HIV, whether or not they are taking antiretroviral (ARV) therapy, can start and continue to use most contraceptive methods safely. There are a few limitations, however. See the table below.

Special Family Planning Considerations for Clients with STIs, including HIV

Method	Has STIs	Has HIV
Intrauterine device (copperbearing IUD or LNG-IUD)	Do not insert an IUD in a woman who is at very high individual risk for gonorrhea and chlamydia, or who currently has gonorrhea, chlamydia, purulent cervicitis, or PID. (A current IUD user who becomes infected with gonorrhea or chlamydia or develops PID can safely continue using an IUD during and after treatment.)	A woman with HIV clinical disease that is mild or with no symptoms, including a woman on ARV therapy, can have an IUD inserted. Generally, a woman should not have an IUD inserted if she has HIV clinical disease that is severe or advanced (WHO Stages 3 or 4). A woman using an IUD who becomes infected with HIV or whose HIV clinical disease becomes severe or advanced (WHO Stages 3 or 4) can safely continue using the IUD. A woman using an IUD can keep the IUD in place when she starts ARV therapy.
Female sterilization	If client has gonorrhea, chlamydia, purulent cervicitis, or PID, delay sterilization until the condition is treated and	Women with HIV, including women on ARV therapy, can safely undergo female sterilization. The procedure may need to be delayed if she currently has an HIV-related illness.

	cured.	
Vasectomy	If client has scrotal skin infection, active STI, or swollen, tender tip of penis, sperm ducts, or testicles, delay sterilization until the condition is treated and cured.	Men who are living with HIV, including men on ARV therapy, can safely undergo vasectomy. The procedure may need to be delayed if he currently has an HIV-related illness.
Spermicides (including when used with diaphragm or cervical cap)	Can safely use spermicides.	Should not use spermicides if at high risk of HIV. Generally, should not use spermicides if she has HIV infection.
Progestin-only pills, injectables, and implants	Can safely use progestin-only methods	Can safely use progestin only methods..

Self-check 4	**Written test**

Directions: Answer all the questions listed below.

Part II say "True" if the statement is correct or "False" if the statement is incorrect (1 point each 5x1= 5%).

1. Providers can give support and services to men both as supporters of women and as clients.
2. DMPA decreases bone mineral density slightly there for women near menopause are not allowed to use DMPA.
3. Dual protection does not necessarily mean just using condoms along with another family planning method.)
4. A current IUD user who becomes infected with gonorrhea or chlamydia or develops PID can safely continue using an IUD during and after treatment.)

5. A woman using an IUD should be removed if infected with HIV or whose HIV clinical disease becomes severe or advanced (WHO Stages 3 or 4).

Part II. Choose the correct answer for the following alternatives (each 2 point 2x2=4%)

1. Which method is more difficult to use for a women near a menopause?
   A. Progestin only methods
   B. Intrauterine devise
   C. Fertility awareness method
   D. Female sterilization and vasectomy
2. Which method is difficult to use for a women with an intellectual disability
   A. Oral contraceptives (Pills)
   B. injectables
   C. Implants
   D. Intrauterine device

Part III. Give short and correct answer for the following essay item questions (5 point)

1. List and discuss the types of dual Protection Strategy

Note: **Satisfactory rating - 7 points** **Unsatisfactory - below 7 points**

Answer sheet for True or False

1. _____
2. _____
3. _____
4. _____
5. _____

Answer Sheet for Multiple choose Questions

1. _____
2. _____

Answer sheet for essay item question

Score= _____

Rating = _____

Name: _____ Date: _____

Information sheet 5	Postpartum and Post-Abortion Family Planning

5.1. Post-partum Family Planning

Help pregnant women and new mothers decide how they will avoid pregnancy after childbirth. Ideally, family planning counseling should start during antenatal care.

- Waiting until her baby is at least 2 years old before a woman tries to become pregnant again is best for the baby and good for the mother, too.
- A woman who is not fully or nearly fully breastfeeding is able to become pregnant as soon as 4 to 6 weeks after childbirth.
- A woman who is fully or nearly fully breastfeeding is able to become pregnant as soon as 6 months postpartum.
- For maximum protection, a woman should not wait until the return of monthly bleeding to start a contraceptive method.
- Mothers and newborns should receive routine postnatal care. Four routine postpartum contacts are recommended:
  1. In the facility for the first 24 hours or at home within the first 24 hours
  2. On day 3
  3. In days 7 through 14
  4. At 6 weeks
- Coordinate family planning visits with an infant's immunization schedule.
- Optimal breastfeeding offers triple value: important improvements in child survival and health, better health for mothers, and temporary contraception (Lactational Amenorrhea Method). Still, any breastfeeding is better than none (except if a woman has HIV).

Guidelines for breast feeding

1. **Begin breastfeeding the newborn as soon as possible— within 1 hour after delivery**

- This stimulates uterine contractions that may help prevent heavy bleeding.
- It helps the infant to establish suckling early, which stimulates milk production.
- Colostrum, the yellowish milk produced in the first days after childbirth, provides important nutrients for the child and transfers immunities from mother to child.

2. Fully or nearly fully breastfeed for 6 months

- Mother's milk alone can fully nourish a baby for the first 6 months of life.
- Avoids the risks of feeding the baby contaminated liquids or foods.
- Full breastfeeding provides contraceptive benefits for the first 6 months as long as monthly bleeding has not returned.

3. At 6 months, add other foods to breastfeeding

- After 6 months babies need a variety of foods in addition to breast milk.
- At each feeding breastfeed before giving other foods.
- Breastfeeding can and should continue through the child's second year or longer.

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 partner's pregnancy	
Male or female condoms Spermicides	Immediately	
Progestin-only pills Implants	Immediately	
Copper-bearing IUD Levonorgestrel IUD	Within 48 hours. Otherwise wait 4 weeks.	
Female sterilization	Within 7 days. Otherwise wait 6 weeks.	
Diaphragm	Can be fitted 6 weeks after childbirth	
Fertility awareness methods	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 injectables	6 weeks after childbirth	Immediately if not breastfeeding 6 weeks after childbirth if partially breastfeeding
Combined oral contraceptives Monthly injectables Combined patch Combined vaginal	6 months after childbirth	21 days after childbirth if not breastfeeding§ 6 weeks after childbirth if partially breastfeeding

ring		

5.2. Post abortion Family Planning

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

Help Women Obtain Family Planning

Counsel with Compassion

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

- Try to understand what she has been through
- Treat her with respect and avoid judgment and criticism
- Ensure privacy and confidentiality
- Ask if she wants someone she trusts to be present during counseling

Provide Important Information

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

- Fertility returns quickly—within 2 weeks after a first-trimester abortion or miscarriage and within 4 weeks after a second-trimester abortion or miscarriage. Therefore, she needs protection from pregnancy almost immediately.
- She can choose among many different family planning methods that she can start at once. Methods that women should not use immediately after giving birth pose no special risks after treatment for abortion complications.

- She can wait before choosing a contraceptive for ongoing use, but she should consider using 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, and also 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. Waiting at least 6 months may reduce the chances of low birth weight, premature birth, and maternal anemia. A woman receiving post abortion care may need other reproductive health services. In particular, a provider can help her consider if she might have been exposed to sexually transmitted infections.

When to Start Contraceptive Methods

- Combined oral contraceptives, progestin-only pills, progestin-only injectables, monthly injectables, implants, male condoms, female condoms, and withdrawal can be started immediately in every case, even if the woman has injury to the genital tract or has a possible or confirmed infection.
- IUDs, female sterilization, and fertility awareness methods can be started once infection is ruled out or resolved.
- IUDs, spermicides, diaphragms, cervical caps, female sterilization, and fertility awareness methods can be started once any injury to the genital tract has healed.

Special considerations:

- *IUD* 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.

- *Spermicides, diaphragms,* and *cervical caps* can be used immediately, even in cases of uncomplicated uterine perforation.
- The *diaphragm* must be refitted after uncomplicated first-trimester miscarriage or abortion. After uncomplicated second-trimester miscarriage or abortion, use should be delayed 6 weeks for the uterus to return to normal size, and then the diaphragm should be refitted.
- *Fertility awareness methods:* A woman can start symptoms-based methods once she has no infection-related secretions or bleeding due to injury to the genital tract. She can start calendar-based methods with her next monthly bleeding, if she is not having bleeding due to injury to the genital tract.

Self-check 5	**Written test**

Directions: Answer all the questions listed below.

Part II say "True" if the statement is correct or "False" if the statement is incorrect (2 point each 3x2= 6%).

1. After child birth a woman should wait until the return of monthly bleeding to start a contraceptive method.
2. Fertility returns quickly—within 2 weeks after a first-trimester abortion or miscarriage and within 4 weeks after a second-trimester abortion or miscarriage.
3. Methods that women should not use immediately after giving birth pose no special risks after treatment for abortion complications.

Part II. Choose the correct answer for the following alternatives (each 2 point 3x2=6%)

1. After child birth which contraceptive method should not give immediately?
   A. Progestin only injectables
   B. Lactational amenorrhea
   C. Progestin only pills implants
   D. Male or female condoms Spermicides

2. To reduce the chances of low birth weight, premature birth, and maternal anemia after abortion if she wants to become pregnant again soon, encourage her to wait at least _____
   A. 3 month
   B. 6 months
   C. 1 year
   D. 2 year

3. After treatment of abortion which method can be started once infection is ruled out or resolved?
   A. Intra uterine device
   B. Combined oral contraceptives
   C. Progestin-only injectables
   D. Male condoms, female condoms

Note: **Satisfactory rating - 6 points** **Unsatisfactory - below 6 points**

Answer sheet for True or False

1. _____
2. _____
3. _____

Answer Sheet for Multiple choose Questions

1. _____
2. _____
3. _____

Score= _____

Rating = _____

Name: _____ Date: _____

Information sheet 6	Infertility

What Is Infertility?

Involuntary infertility is a disease of the reproductive system: the inability to become pregnant when desired. Involuntary childlessness is the inability to give birth to desired children, whether due to inability to achieve pregnancy or due to stillbirth or miscarriage. These conditions occur in couples who have never had children (primary infertility) and, more often, in couples who have had children previously (secondary infertility).

Infertility is “defined by the failure to establish a clinical pregnancy after 12 months of regular unprotected sexual intercourse” between a man and a woman. (On average, 85% of women would be pregnant by then.)

Worldwide, infertility affects about 12% of couples who are seeking to have a child—about 2% who have never had children and about 10% who have had children previously. There are differences among regions.

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

What Causes Infertility?

Globally, infertility has many causes, which vary depending on the setting. Although often the woman is blamed, the cause of infertility can be in either the man or the woman or in both.

Medically, causes of infertility range from the effects of sexually transmitted infections (STIs) in one or both partners to hormonal imbalances and defects of the uterus in women and low sperm count, low sperm motility, and malformed sperm in men. Lifestyle factors include smoking, alcohol, and drug abuse as well as obesity and nutritional deficiencies. Exposures to chemicals in the environment that disrupt the endocrine system as well as other environmental and stress-related factors are suspected as well.

A large WHO study in the late 1970s found that STIs were a major cause of infertility in developing countries. It is not known how much STIs contribute to infertility now.

However, the evidence is clear that, if left untreated, gonorrhea and chlamydia can infect the fallopian tubes, the uterus, and the ovaries in women. This is known as pelvic inflammatory disease (PID). Clinical PID is painful, but sometimes PID has no symptoms and goes unnoticed (silent PID). Gonorrhea and chlamydia can scar women's fallopian tubes, blocking eggs from traveling down the tubes to meet sperm. Similarly, untreated gonorrhea and chlamydia in men can cause scarring and blockage in the sperm duct (epididymis) and urethra.

Other factors or conditions that can reduce fertility or cause infertility include:

- Other reproductive tract infections, including genital tuberculosis (TB) in both men and women
- HIV
- Medical procedures that introduce infection into a woman's upper reproductive tract or uterus, including postpartum and post abortion infections
- Mumps that develop after puberty in men
- Certain disorders of the reproductive tract, such as endometriosis, polycystic ovaries, and fibroids (myomas)

- Anatomical, endocrine, genetic, or immune system problems in both men and women
- Surgical interventions that adversely affect reproductive tissues or organs
- Cancer treatments that affect reproductive health and the capacity to reproduce
- Aging in both women and men

Preventing Involuntary Infertility

Involuntary infertility often can be prevented. Providers can:

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

Contraceptives Do Not Cause Infertility

- With most modern contraceptive methods, there is no significant delay in the time to desired pregnancy after contraception is stopped. On average, pregnancy occurs after 3 to 6 months of unprotected sex. There is great variation around this average, however, related to the age and the health status of the individuals in the couple. When counseling couples who stop contraception and want to have a child, aging

and other factors affecting the fertility of the woman and the man need to be considered.

- The return of fertility after injectable contraceptives are stopped usually takes longer than with most other methods. In time, however, a woman is as fertile as before using the method, taking aging into account.
- Among women with current gonorrhea or chlamydia, IUD insertion slightly increases the risk of pelvic inflammatory disease in the first 20 days after insertion. However, research has not found that former IUD users are more likely to be infertile than other women.

Counseling Clients with Fertility Problems

- Counsel both partners together, if possible. A man may blame his partner for infertility when he himself may be responsible for the inability of the woman to become pregnant or to maintain a pregnancy.
- Explain that a man is just as likely to have fertility problems as a woman. In more than 40% of couples with fertility problems, it is because of semen or sperm abnormalities, or other health problems of the male partner. In 20% of couples with fertility problems, both male and female factors reduce fertility. Sometimes it is not possible to find the cause of the problem,
- Recommend that the couple attempt pregnancy with unprotected sex for at least 12 months before they suspect infertility. Provide educational materials and guidance on risks to fertility.
- The most fertile time of a woman's cycle is several days before and at the time of ovulation (when an ovary releases an egg). Fertility awareness methods can help couples identify the most fertile time of each cycle. Provide educational material about these methods and/or refer the couple to a fertility care provider or specialist.
- If, after one year, following the suggestions above has not resulted in a pregnancy or live birth, refer both partners to a qualified fertility care provider for evaluation and assessment, if available. Referral to a fertility care provider or specialist may be particularly helpful in the following situations: the couple is affected by HIV or

suspected genital TB; the woman is age 35 or older; she has polycystic ovary syndrome or has been diagnosed with endometriosis; the woman or the man suspects they had an STI and it was not treated; either had been treated for a cancer or had surgery that may have affected the reproductive tissues or organs.

- The couple also may want to consider adoption or other alternatives to having children or more children of their own, such as taking in nieces and nephews.

Self-check 6	**Written test**

Directions: Answer all the questions listed below.

Part II say "True" if the statement is correct or "False" if the statement is incorrect (2 point each 6x2= 12%).

1. Secondary infertility is occur in couples who have never had children.
2. With most modern contraceptive methods, there is no significant delay in the time to desire pregnancy after contraception is stopped.
3. The most fertile time of a woman's cycle is at the time of ovulation and several days after ovulation.
4. The return of fertility after injectable contraceptives are stopped usually takes longer than with most other methods.
5. Among women with current gonorrhea or chlamydia, IUD insertion slightly increases the risk of pelvic inflammatory disease in the first 20 days after insertion.
6. Man is just as likely to have fertility problems as a woman.

Note: **Satisfactory rating - 6 points** **Unsatisfactory - below 6 points**

Answer sheet for True or False

1. _____
2. _____
3. _____
4. _____

5. _____
6. _____

Score= _____

Rating = _____

Name: _____ Date: _____

Prepared By

No	Name	Educational Back grand	LEVEL	Region	College	Email	Phone Number
1	Masresha Leta	Midwifery	A	Harari	Harar HSC	masreshaleta3@gmail.com	0911947787
2	Gosaye T/haymanot Zewde	Midwifery	A	Harari	Harar HSC	Zewegosa@yahoo.com	0913227450
3	Amare Kiros	Midwifery	A	BGRS	Pawi HSC	amarekiros9@gmail.com	0920843010
4	Jalele Mosisa	Midwifery	B	oromia	Nekemte HSC	jalemosis2018@gmail.com	0939316415
5	Serkalem Fetene	Midwifery	A	oromia	Mettu HSC	serkefetene@gmail.com	0912022476
6	Balela Kadir	Midwifery	B	oromia	Nagelle HSC	balela.kedirbedu@gmail.com	0916633542
7	Sadeya Mohamed	Midwifery	A	Somali	Jigjiga HSC	yanaan261@gamil.com	0915076012