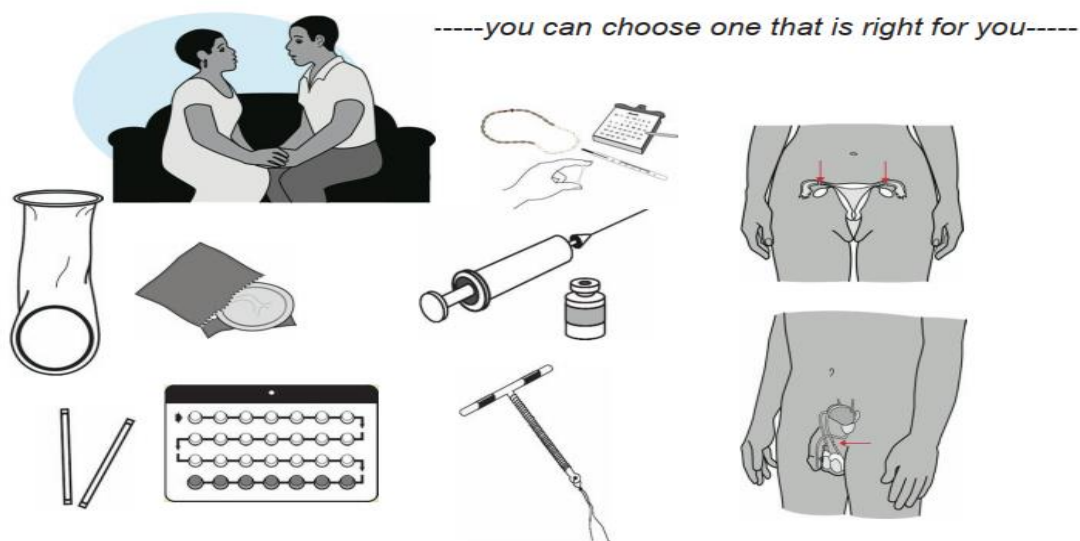


Nursing –Level III

Based on January, 2022, Curriculum Version I



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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BBT	Basal Body Temperature
BCC	Behavioral Change Communication
BTL	Bilateral Tubal Ligation
CAC	Comprehensive Abortion Care
CEDAW	Convention on Elimination of all forms of Discrimination against Women
COC	Combined Oral Contraceptives
DEVAW	Declaration for Elimination of Violence against Women
DHS	Demographic and Health Survey
DMPA	Deoxy Medroxy Progesteron Acetate
EC	Emergency Contraception
EMDHS	Mini-Demographic and Health Survey
FP	Family Planning
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSDP	Health Sector Development Program
HSTP	Health Sector Transformation Plan
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IUCD	Intrauterine Contraceptive Device
LAM	Lactational Amenorrhea Method
LARC	Long Acting Reversible Contraceptive
LMIS	Logistic Management Information System
LNG-IUS	Levonorgestrol Intrauterine system
MOH	Ministry of Health
PAC	Post Abortion Care
PFSA	P Pharmaceuticals Fund & Supply Agency
PID	Pelvic Inflammatory Disease
PLWHA	People Living With HIV/AIDS

POP	Progestin Only Pill
RH	Reproductive Health
SDM	Standard Days Method
SDGs	Sustainable Development Goals
STD	Sexually Transmitted Disease
STIs	Sexually Transmitted Infections
TT	Tetanus Toxoid
VDRL	Venereal Disease Research Laboratory
WHO	World Health Organization

Introduction Comprehensive Family Planning Services

The Government of Ethiopia committed itself to the achievement of Sustainable Development Goals (SDGs), and strongly believed FP is one of the key strategies to improving maternal health and bringing about development.

Family planning is the voluntary use of natural or modern methods of contraceptives by individuals or couples. This approach helps the users to have the number of children they want and when they want them and also assures the well-being of the children and the parents. Family planning service was introduced in Ethiopia in 1948. Although at the beginning the services were limited to only major cities, gradually the services expanded to the rural areas and are being used now by the rural communities

The provision of inadequate family planning services in Ethiopia has contributed and is still contributing to the high morbidity and mortality of mothers and children; unwanted and unplanned pregnancies; high risk abortion; HIV/AIDS and other sexually transmitted diseases; inadequate information and education about family planning. The Ethiopian population is rapidly increasing and causing incompatibility with the country's available natural resources. This situation, surely, is creating the inadequacy of farm land; deforestation; drought accompanied with famine and displacement; soil degradation and erosion; crowding of households; incompatible social service (health, education etc.) infrastructures and adverse impact on household income.

Module units

- Describing and Planning family planning services
- Promoting family planning services
- Providing family planning services
- Monitoring family planning services

Learning objectives of the Module

At the end of this session, the students will be able to:

- Describe and Plan family planning services
- Promote family planning services

- Provide family planning services
- Monitor family planning services

Module Learning Instructions:

1. Read the specific objectives of this Learning Guide.
2. Follow the instructions described below.
3. Read the information written in the information Sheets
4. Accomplish the Self-checks

Unit one: Describing and Plan family planning services

This learning unit is developed to provide the trainees the necessary information regarding the following content coverage and topics:

- Definition of family planning
- Basic component of comprehensive family planning
- Modern and traditional family planning methods
- Resource mapping
- Eligibility
- Calculating number of expected target group for family planning Practice
- Developing a plan of action to reach eligible

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

- Describe basic component of comprehensive family planning
- Describe modern and traditional family planning methods
- Conduct resource mapping
- Identify the eligible target group for family planning
- Calculate number of expected target group for family planning practice
- Develop a plan of action to reach eligible

1.1. Definition

Family planning is defined as the ability of individuals or couples to anticipate and attain their desired number of children, and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility.

Family planning is a means of promoting the health of women and families and part of a strategy to reduce high maternal, infant and child mortality. People should be offered the opportunity to determine the number and spacing of their own children. Information about FP should be made available, and should actively promote access to FP services for all individuals desiring them.

1.2. Basic component of comprehensive family planning

The following services and activities offered at different levels of the national health care delivery system

- EC/BCC
- Counseling
- Provision of contraceptives
- Testing and counseling for HIV
- Screening and treatment of STIs
- Prevention and management of infertility
- Screening for reproductive tract cancers

Modern and traditional family planning methods

Currently the different family planning methods used are categorized in to the following categorizations. Each type of contraceptive has its own effectiveness, advantage and disadvantage, mechanism of action, medical eligibility criteria, time of initiation and way of use.

1.1.1. Natural Contraceptives

Natural family planning refers to methods used to prevent or postpone pregnancy by giving attention to natural reproductive events related to fertility. All natural methods except for LAM require partners' cooperation. Couple must be committed to abstaining or using another method on fertile days. Couple/client must stay aware of body changes or keep track of days, according to rules of the specific method. Natural contraceptives methods do not have side effects or health risks. These methods include:

- Withdrawal method
- Fertility awareness method

- ✓ Calendar-based methods
 - Standard day method
 - Calendar/rhythm method
- ✓ Symptoms-based methods
 - Two day method
 - Basal body temperature method
 - ovulation method (also known as Billings method or cervical mucus method), and symptothermal method
 - Lactational amenorrhea method (LAM)

1.1.2. Artificial contraceptive Methods

These methods include:

I. Barrier methods

Barrier methods prevent pregnancy by blocking the sperm from reaching the egg. They cause very few side effects. Barrier methods are safe if a woman is breastfeeding. Most of these methods also protect against Sexually Transmitted Infections (STIs), including HIV. When a woman wants to become pregnant, she simply stops using the barrier method. The most common barrier methods are:

- Male and female condoms
- Spermicide
- Diaphragm
- Cervical cup

II. Oral Contraceptives (OCPs)

Oral contraceptive pills are contraceptives that are taken orally once daily to prevent pregnancy. Oral contraceptives contain either two or one female sex hormones. The hormones are synthetic estrogens and synthetic progesterone. These include:

- **Combined oral contraceptive pills (COCs):** contain both synthetic estrogen and progesterone like the natural female sex hormones.
- **Progestin only pills (POPs):** contain progestin only like the natural female sex hormone.

III. Injectables

The contraceptive injection, also known as ‘the shot’, contains progestogen or a combination of estrogen and progestogen. The injectables contraceptives depot medroxyprogesterone acetate (DMPA) and norethisterone enanthate (NET-EN) each contain a progestin like the natural hormone progesterone in a woman’s body. In contrast, monthly injectables contain both estrogen and progestin. DMPA, the most widely used progestin-only Injectable, is also known as Depo or Depo-Provera. In this learning you will learn progestin only injectables.

IV. Implants

Small plastic rods, each about the size of a matchstick, that release a progestin like the natural hormone progesterone in a woman’s body. A specifically trained provider performs a minor surgical procedure to place one or 2 rods under the skin on the inside of a woman’s upper arm. Do not contain estrogen, and so can be used throughout breastfeeding and by women who cannot use methods with estrogen. The Types of implants include:

- **Jadelle:** 2 rods containing levonorgestrel, highly effective for 5 years
- **Implanon NXT (Nexplanon):** 1 rod containing etonogestrel, labeled for up to 3 years of use (a recent study shows it may be highly effective for 5 years). Replaces Implanon; Implanon NXT can be seen on X-ray and has an improved insertion device.
- **Levoplant (Sino-Implant (II)),** 2 rods containing levonorgestrel. Labeled for up to 4 years of use.
- **Norplant,** which consisted of 6 capsules and was effective for 5–7 years, was discontinued in 2008 and is no longer available for insertion. A small number of women, however, may still need Norplant capsules removed.

V. Intra Uterine Contraceptive Device (IUCD)

A specifically trained health care provider inserts it into a woman’s uterus through her vagina and cervix. IUCD provides a long-term pregnancy protection and it is immediately reversible. The types of IUCD include:

- **Copper- bearing Intra uterine device:** is a small, flexible plastic frame with copper sleeves or wire around it. Shown to be very effective for up to 12 years
- **Levonorgestrel Intrauterine Device:** The Levonorgestrel intrauterine device (LNG-IUD) is a T-shaped plastic device that steadily releases a small amount of Levonorgestrel each day. (Levonorgestrel is a progestin hormone also used in some contraceptive

implants and oral contraceptive pills.) Also called the Levonorgestrel-releasing intrauterine system, LNG-IUS, or hormonal IUD. Very effective for 5 years. Works by preventing sperm from fertilizing an egg also cause the thickening of cervical mucus, which stops the sperm from entering the uterus. IUCDs' contraceptive effect is not abortifacient. In this learning guide you will learn about Copper-Bearing Intrauterine Device.

VI. Permanent family planning methods

Permanent FP methods, also called voluntary surgical contraception are among the most effective, popular and well-established contraceptive method options available for men and women who desire no more children. For individuals and couples desiring no more children, it provides the most effective protection against pregnancy. It offers the advantage over other contraceptive methods that it is a once-only procedure. The need for continued contraceptive supplies is eliminated. Globally, the permanent method of contraception is the most popular and commonly used method of contraception, but is one of the least utilized in Ethiopia. Following effective counseling and improving the availability and quality of service in permanent methods of contraception, it is possible to improve the acceptability of the methods in the community. The methods of permanent family planning are:

- **Bilateral Tubal Ligation:** is a permanent contraception method for female.
- **Vasectomy:** Is a permanent contraception method for male

1.4. Resource Mapping

- Resource mapping is a method of showing information regarding the occurrence, distribution, access to and use of resources; topography; human settlements; and activities of a community from the perspective of community members.
- Resource mapping is used to:
 - ✓ Identifying and examining relationships between a community's resources, topography, settlements, and activities
 - ✓ Enabling people to picture resources and features and to show graphically the significance attached to them
 - ✓ Identifying problems, possibilities, and opportunities

- Resource mapping tell you:
 - ✓ How people within a community view their environment
 - ✓ Community members' analysis of the natural resources found in their community and how they are used
- Key elements of resource mapping are local perceptions of resources and territories.
- To make resource mapping it takes 1.5 to 2 hours and no need supporting software
- A community resource map is usually spatially limited to the social, cultural, and economic domains of the local analysts who produce it so for larger geographical areas (such as a protected area or national park) and areas with several different administrations, producing a sufficient number of community specific sketch maps might be politically unrealistic.

1.5. Eligibility

Any person, male or female, who is sexually active and married, is eligible for FP services, including information, education, and counseling. Eligibility for specific choice of family planning is clearly stated under unit three of this module.

1.6. Calculating number of expected target group for family planning Practice

When you are planning family planning services in your community, the first step is to calculate the number eligible mothers for by using the base line data under the catchment of your facility or the conversion factors established by MOH family planning services. According to the findings of the surveys the percentage of women eligible for family planning services are 18.63% of the total population of Ethiopia.

1.7. Developing a plan of action to reach eligible

A work plan is a document developed by the manager and staff, which lists all planned activities, the date on which they will occur or by which they will be accomplished, the resources they will require, and the person who is responsible for carrying them out. Such a document is a valuable tool for efficient and effective programme implementation, and should be used regularly and consistently as a monitoring tool at all levels. Basically, there are two types of plans:

- (a) The strategic (long-term) plan
- (b) The annual (work) plan.

Short term plans/Plan of action should be developed and used at all levels of a programme or organization. They are particularly useful for nurses to deliver family planning services. The activities in work plans are based on the annual plan, which has been developed at your health facility.

Steps in organizing Family Planning services

Step 1: Conducting a needs assessment of existing services at facility

- It will help you identify existing problems and the people and materials available to provide

Step 2: Assess whether the health workers are trained to provide FP services and find out what materials are available in the health facility.

Step 3: Identifying problems related to FP

Steps 4: Developing a proposal

- Now you should develop a proposal to show how you are going to solve the problems you identified in your assessment.
- You may not be able to respond to all of the problems you have identified.
- Therefore you should prioritize the problems based on the importance of the problem and the resources you have or you could acquire.
- The proposal should have the problems identified.
- The proposal should also have what you want to achieve by addressing the identified problem. This is called **Objective**.
- The proposal should also have the different methods you use to tackle the problems. This is called **Strategy**.
- The following table will help you in how to write a proposal.

Step – 5: - Prepare Action Plan

Table1: Table shows how to prepare action plan

Problem	Action required	Responsible person	Time bound
Lack of health	Collecting health education	Health care	January 2023

education materials on contraceptives at the health facility	Materials request both orally and through formal letter that (i) the woreda health office Or (ii) the NGO working in the kebele (if any Or (iii) the health centre provides you with health education materials on contraceptives	professional	(E.C.)
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Self Check 1

Part I say “True” if the statement is correct or “False” if the statement is incorrect

1. Family planning is a means of promoting the health of women and families and part of a strategy to reduce high maternal, infant and child mortality.
2. Family planning is not a strategy to decrease the occurrence of unwanted pregnancy and abortions.
3. Family planning prevents the depletion of maternal nutritional reserves and reduces the risk of anemia from repeated pregnancies and birth.
4. Using a family planning can aggravate poverty.

Part II. choose the correct answer for the following alternatives

1. _____ is about making available family planning methods at an affordable price using private retailers.
 - A. Community-based distribution
 - B. Social marketing
 - C. Work-based services
 - D. Outreach family planning services.
2. Which contraceptive option is categorized under natural family planning method?
 - A. Male and Female Condoms
 - B. Injectable contraceptives
 - C. Lactational Amenorrhea Method (LAM)

D. Intra-Uterine Contraceptive Devices

Unit Two: Promoting family planning services

This learning unit is developed to provide the trainees the necessary information regarding the following content coverage and topics:

- Communicating with influential community representatives and voluntaries
- Undertaking community mobilization
- Implementing and sustaining family planning practice promotion and education

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

- Conduct communication with influential community representatives and voluntaries
- Undertake community mobilization
- Implement and sustain family planning practice promotion and education

2.1. [Communicating with influential community representatives and voluntaries](#)

Information Education Communication (IEC) combines strategies, approaches, and methods that enable individuals, families, groups, organizations, and communities to play an active role in achieving, protecting, and sustaining their own health. Embodied in IEC is the process of learning that empowers people to make decisions, modify behaviors, and change social conditions.

The Government of Ethiopia has initiated an innovative strategy; the health Development army (HDA), which aims to foster community ownership. The health development army provides the platform to promote family planning (FP) and reproductive health (RH) in the community. Partners working on FP and RH should work with HEW's and the primary health care unit staff to improve the knowledge of health development team leaders. Furthermore, FP

and RH issues should be recognized as priorities and be discussed on regular basis during community dialogues at the health development teams.

2.2. Undertaking community mobilization

Community mobilization a capacity-building process through which individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others. Community mobilization is the process of engaging communities to identify community priorities, resources, needs and solutions in such a way as to promote representative participation, good governance, accountability and peaceful change.

The community should be made aware of the overall benefits and availability of FP services. FP programs and services, including IEC/BCC activities, should respect the customs and traditions of the community. Community involvement is key to dispelling rumors and misconceptions, and thereby developing ownership of FP programs by the community for successful and sustainable outcome.

Challenges of Community Participation

- Less control
- Time and cost
- Differing priorities
- Stakeholders disagree
- Community skills and capacity
- Selection of community participants may be biased
- Contraceptive insecurity
- Need to plan for sustainability from beginning

2.3. Implementing and sustaining family planning practice promotion and education.

2.3.1. Social and Behavioral Change (SBC) for FP

Social and Behavioral change combines strategies, approaches, and methods that enable individuals, families, groups, organizations, and communities to play an active role in achieving,

protecting, and sustaining their own health. Accordingly, individual, community, organizational and socio economic level strategies are recommended to increase awareness and demand for family planning services.

Self-Check 2

Part I Give short answer for the following question

1. Define community mobilization
 2. List challenges in community participation in planning family service practice
- Implementation

Unit Three: Providing family planning services

This learning unit is developed to provide the trainees the necessary information regarding the following content coverage and topics:

- Family Planning counseling
- Provide short acting contraceptive methods and manage side effects
- Assist long acting Family Planning methods.
- Follow-up and Referral

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

- Family Planning counseling
- Provide short acting contraceptive methods and managed side effects
- Assist long acting Family Planning Methods.
- Follow-up and Referral

3.1. Family planning counseling

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

Family planning counseling is defined as a continuous process that you as the counselor provide to help clients and people in your village make and arrive at informed choices about the size of their family (i.e. the number of children they wish to have). Counseling can be conducted with:

- ✓ Individual levels
- ✓ Couples and
- ✓ family

3.1.1. Informed and Voluntary Decision Making and Informed Consent

The concept of informed and voluntary decision making applies broadly to any health care decision and assumes that individuals have both the right and the ability to make their own health

care decisions without pressure or coercion and with full information and understanding of the consequences of each option.

Informed consent is a medical, legal, and rights-based construct whereby clients agree to receive medical treatment, such as surgery (for an FP method or for another purpose) or to take part in a study. Informed consent is ideally given as a result of the client's informed choice. Unfortunately, there are many instances in which a client signs an informed consent form without adequate information and without feeling that he or she has had any choice in the matter.

General principles of counseling and counselor characteristics

These are the important principles and conditions necessary for effective counseling:

- Privacy — finds a quiet place to talk.
- Take sufficient time.
- Maintain confidentiality.
- Conduct the discussion in a helpful atmosphere.
- Keep it simple — use words people in your village will understand.
- First things first — do not cause confusion by giving too much information.
- Say it again — repeat the most important instructions again and again.
- Use available visual aids like posters and flip charts, etc.

Skills and characteristics of a counselor

The most important characteristics are:

- Respect the dignity of others.
- Respect the client's concerns and ideas.
- Be non-judgmental and open.
- Show that you are being an active listener.
- Be empathetic and caring.
- Be honest and sensitive.

3.1.2. Counseling Steps in Family Planning

The REDI framework:

- Emphasizes the client's right and responsibility for making decisions and carrying them out
- Provides guidelines to help the counselor and client consider the client's circumstances and social context
- Identifies the challenges a client may face in carrying out their decision
- Helps clients build skills to address those challenges

Step 1: Rapport Building

1. Greet client with respect
2. Make introductions (identify category of the client i.e., new, satisfied return, or dissatisfied return)
3. Assure confidentiality and privacy
4. Explain the need to discuss sensitive and personal issues

Step 2: Exploration

1. Explore in depth the client's reason for the visit (This information will help determine the client's counseling needs and the focus of the counseling Handout.)\
2. Explore client's future RH-related plans, current situation, and past experience
 - ✓ Explore client's reproductive history and goals, while explaining healthy timing and spacing of pregnancy (HTSP)
 - ✓ Explore client's social context, circumstances, and relationships
 - ✓ Explore issues related to sexuality
 - ✓ Explore client's history of STIs, including HIV
 - ✓ Explain STI risk and dual protection, and help the client perceive his or her risk for contracting and transmitting STIs

3. Focus your discussion on the method(s) of interest to client: discuss the client's preferred method, if any, or relevant FP options if no method is preferred, give information as needed, and correct misconceptions
4. Rule out pregnancy and explore factors related to monthly bleeding, any recent pregnancy and medical conditions

Step 3: Decision Making

1. Identify the decisions the client needs to confirm or make (for satisfied clients, check if client needs other services; if not, go to Phase 4, Step 5)
2. Explore relevant options for each decision
3. Help the client weigh the benefits, disadvantages, and consequences of each option (Provide information to fill any remaining knowledge gaps)
4. Encourage the client to make his or her own decision

Step 4: Implementing the Decision

1. Assist the client in making a concrete and specific plan for carrying out the decision(s) (obtaining and using the FP method chosen, risk reduction for STIs, dual protection, and so on)
2. Have the client develop skills to use his or her chosen method and condoms
3. Identify barriers that the client might face in implementing his or her decision
4. Develop strategies to overcome the barriers
5. Make a plan for follow-up and/or provide referrals as needed

3.2. Providing Short Acting Family Planning Methods

3.2.1. Natural Family Planning Methods

A. Withdrawal (Coitus interrupts) method

What Is Withdrawal?

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

How Effective?

Effectiveness depends on the user: Risk of pregnancy is greatest when the man does not withdraw his penis from the vagina before he ejaculates with every act of sex.

- One of the least effective methods, as commonly used.
- As commonly used, about 20 pregnancies per 100 women whose partners use withdrawal over the first year. This means that 80 of every 100 women whose partners use withdrawal will not become pregnant.
- When used correctly with every act of sex, about 4 pregnancies per 100 women whose partners use withdrawal over the first year.

Return of fertility after use of withdrawal is stopped: **No delay**

Protection against sexually transmitted infections: **None**

Advantage

- Always available
- Does not cost anything
- Requires no supplies and
- Has no side effects

Disadvantage

- It requires motivation, cooperation and self-control.
- It is least effective
- There is no protection against sexually transmitted infections.

Who can and can't use withdrawal method?

- All men can use withdrawal. No medical conditions prevent its use.
- Remember that there are some men who cannot consistently sense when ejaculation is about to occur and there are men who ejaculate prematurely.
- Always suggest that an additional or alternative family planning method is available. Explain ECP use in case a man ejaculates before withdrawing his penis from the vagina.

When can withdrawal method be initiated?

- The method can be initiated at any time.

Table 2: Table showing how to use withdrawal method

When the man feels close to ejaculating	He should withdraw his penis from the woman's vagina and ejaculate outside the vagina, keeping his semen away from her external genitalia.
If the man has ejaculated recently	Before sex he should urinate and wipe the tip of his penis to remove any semen remaining.

B. Fertility Awareness Method

What Are Fertility Awareness Methods?

- “Fertility awareness” means that a woman knows how to tell when the fertile time of her menstrual cycle starts and ends. (The fertile time is when she can become pregnant.)
- Sometimes called periodic abstinence or natural family planning.
- A woman can use several ways, alone or in combination, to tell when her fertile time begins and ends.
- **Calendar-based methods** involve keeping track of days of the menstrual cycle to identify the start and end of the fertile time. Examples: Standard Days Method, which avoids unprotected vaginal sex on days 8 through 19 of the menstrual cycle, and calendar rhythm method.
- **Symptoms-based methods** depend on observing signs of fertility.
 - ✓ **Cervical secretions:** When a woman sees or feels cervical secretions, she may be fertile. She may feel just a little vaginal wetness.
 - ✓ **Basal body temperature (BBT):** A woman's resting body temperature goes up slightly after the release of an egg (ovulation). She is not likely to become pregnant from 3 days after this temperature rise through the start of her next monthly bleeding. Her temperature stays higher until the beginning of her next monthly bleeding. Examples: Two Day Method, BBT method, ovulation method (also known as Billings method or cervical mucus method), and symptothermal method.
- Work primarily by helping a woman know when she could become pregnant. The couple prevents pregnancy by avoiding unprotected vaginal sex during these fertile days—usually by abstaining or by using condoms or a diaphragm. Some couples use spermicides or withdrawal, but these are among the least effective methods.

How Effective?

Effectiveness depends on the user: Risk of pregnancy is greatest when couples have sex on the fertile days without using another method.

- As commonly used, in the first year about 15 pregnancies per 100 women using periodic abstinence. This means that 85 of every 100 women relying on periodic abstinence will not become pregnant.
- Pregnancy rates with consistent and correct use vary for different types of fertility awareness methods (see table below).
- In general, abstaining during fertile times is more effective than using another method during fertile times.

Table 3: Compare the pregnancies that can occur if used consistently and correctly versus if used as commonly of different fertility awareness methods.

Method	Pregnancies per 100 Women Over the First Year of Use	
	Consistent and correct use	As commonly used
Calendar-based method		
Standard day method	5	12
Symptoms based method		
Two day method	4	14
Ovulation method	3	23
Symptothermal method	<1	2

Return of fertility after fertility awareness methods are stopped: **No delay**

Protection against sexually transmitted infections (STIs): **None**

Side Effects, Health Benefits, and Health Risks

Side Effects

None

Known Health Benefits

Help protect against:

- Risks of pregnancy

Known Health Risks

None

Advantage

- Have no side effects
- Do not require procedures and usually do not require supplies
- Help women learn about their bodies and fertility
- Allow some couples to adhere to their religious or cultural norms about contraception
- Can be used to identify fertile days by both women who want to become pregnant and women who want to avoid pregnancy

Disadvantage

- It has a high failure rate because it needs several days of abstinence and a lot of experience in using the method to be effective.
- Fewer "safe" days to have intercourse each month
- Training is essential
- No protection from STIs
- It is also difficult to use Two Day Method and Ovulation method in the case of vaginal infections, secretions may be misleading.
- If periods are not regular, calendar-based method may not be as effective
- False interpretation or indications in the case of fever, as this may mislead the result of BBT
- A special thermometer may be required to use BBT effectively

Correcting Misunderstandings

Fertility awareness methods:

- Can be effective if used consistently and correctly.
- Do not require literacy or advanced education.
- Do not harm men who abstain from sex.
- Do not work when a couple is mistaken about when the fertile time occurs, such as thinking it occurs during monthly bleeding.

Fertility awareness methods for women with HIV

- Women who are living with HIV or are on antiretroviral (ARV) therapy can safely use fertility awareness methods.

- Urge these women to use condoms along with fertility awareness methods. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.

Who can use calendar-based methods?

All women can use calendar-based methods. No medical conditions prevent the use of these methods, but some conditions can make them harder to use effectively and necessitate using *caution* or *delaying* their use.

- **Caution** means that additional or special counseling may be needed to ensure correct use of the method. E.g., menstrual cycles have just started or have become less frequent or stopped due to older age.
- **Delay** means that use of a particular fertility awareness method should be delayed until the condition is evaluated or corrected. Other temporary methods of contraception should be offered. E.g., recently gave birth or is breastfeeding, recently had an abortion or miscarriage, irregular vaginal bleeding, use of drugs that may delay ovulation (for example, certain antidepressants, thyroid medications, long-term use of certain antibiotics, or long-term use of any non steroidal anti-inflammatory drug, such as aspirin or ibuprofen)..

Who can use symptoms-based methods?

All women can use calendar-based methods. No medical conditions prevent the use of these methods, but some conditions can make them harder to use effectively and necessitate using *caution* or *delaying* their use.

- **Caution** is necessary in the following situations. E.g., recently had an abortion or miscarriage, menstrual cycles have just started or have become less frequent or stopped due to older age, a chronic condition that raises her body temperature (for BBT and symptothermal methods)
- **Delay** is necessary in the following situations. E.g., recently gave birth or is breastfeeding, an acute condition that raises her body temperature (for BBT and symptothermal methods), irregular vaginal bleeding, abnormal vaginal discharge, use of drugs that may affect cervical secretions (antihistamines), raise body temperature or delay ovulation (antibiotics).

Table 4: Depicts when to start using fertility awareness methods.

Women's situation	Calendar-Based Methods	Symptoms- Based Methods
Having	Any time of the month	Any time of the month

regular menstrual cycles	<ul style="list-style-type: none"> • No need to wait until the start of next monthly bleeding. 	<ul style="list-style-type: none"> • No need to wait until the start of next monthly bleeding.
No monthly bleeding	<ul style="list-style-type: none"> • Delay calendar-based methods until monthly bleeding returns. 	<ul style="list-style-type: none"> • Delay symptoms-based methods until monthly bleeding returns.
After childbirth (whether or not breastfeeding)	<ul style="list-style-type: none"> • Delay the Standard Days Method until she has had 4 menstrual cycles and the last one was 26–32 days long. 	<ul style="list-style-type: none"> • She can start symptoms-based methods once normal secretions have returned.
After miscarriage or abortion	<ul style="list-style-type: none"> • Delay the Standard Days Method until the start of her next monthly bleeding. 	<ul style="list-style-type: none"> • She can start symptoms based methods immediately with special counseling and support, if she has no infection-related secretions or bleeding due to injury to the genital tract.
Switching from a hormonal method	<ul style="list-style-type: none"> • Delay starting the Standard Days Method until the start of her next monthly bleeding. • If she is switching from injectables, delay the Standard Days Method at least until her repeat injection would have been given, and then start it at the beginning of her next monthly bleeding. 	<ul style="list-style-type: none"> • She can start symptoms based methods in the next menstrual cycle after stopping a hormonal method.
After taking emergency contraceptive pills	<ul style="list-style-type: none"> • Delay the Standard Days Method until the start of her next monthly bleeding. 	<p>She can start symptoms based methods once normal secretions have returned.</p>

How are calendar-based methods used?

Standard Days Method (SDM): It can be used if most of the cycles in a year are between 26 to 32 days long.

- A woman keeps track of the days of her menstrual cycle, counting the first day of monthly bleeding as day 1.
- Avoids unprotected sex or uses condoms or a diaphragm on days 8 – 19 that are considered fertile days for all users of the SDM.
- The couple can have unprotected sex on all the other days of the cycle—days 1 through 7 at the beginning of the cycle and from day 20 until her next monthly bleeding begin.
- The couple can use Cycle Beads, a color-coded string of beads that indicates fertile and non-fertile days of a cycle (see diagram below), or they can mark a calendar or use some other memory aid.

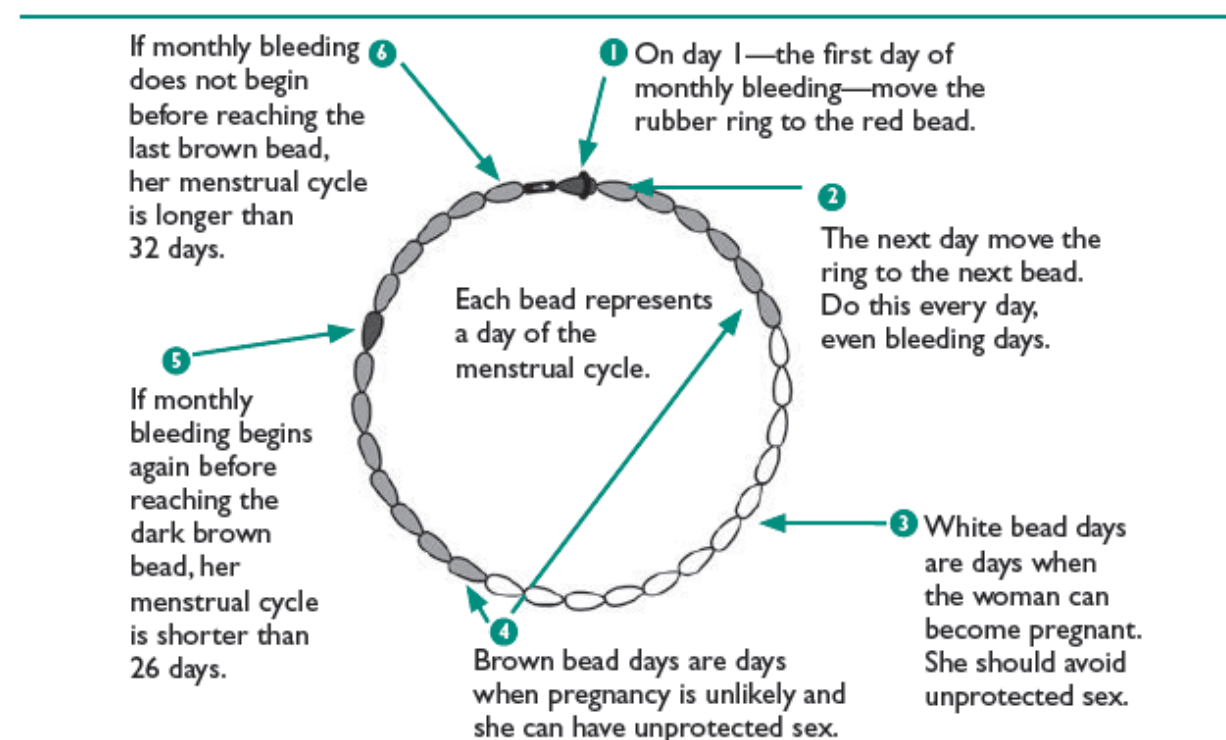


Figure 1: Displays different strategies for usage of standard days method.

Calendar Rhythm Method:

Before relying on this method, a woman records the number of days in each menstrual cycle for at least 6 months. The first day of monthly bleeding is always counted as day 1

- The woman estimates the fertile time by subtracting 18 from the length of her shortest recorded cycle. This tells her the estimated first day of her fertile time. Then she subtracts 11 days from the length of her longest recorded cycle. This tells her the estimated last day of her fertile time.
 - The couple avoids unprotected sex or uses condoms or a diaphragm during the fertile time.
 - She updates these calculations each month, always using the 6 most recent cycles.
 - Example: a woman has a length of menstrual cycle for 6 months as follows; 28,31,29,30,28 and 27
 - The shortest of her last 6 cycles is 27 days, $27 - 18 = 9$. She starts avoiding unprotected sex on day 9.
 - The longest of her last 6 cycles was 31 days, $31 - 11 = 20$. She can have unprotected sex again on day 21. Thus, she must avoid unprotected sex from day 9 through day 20 of her cycle.
-

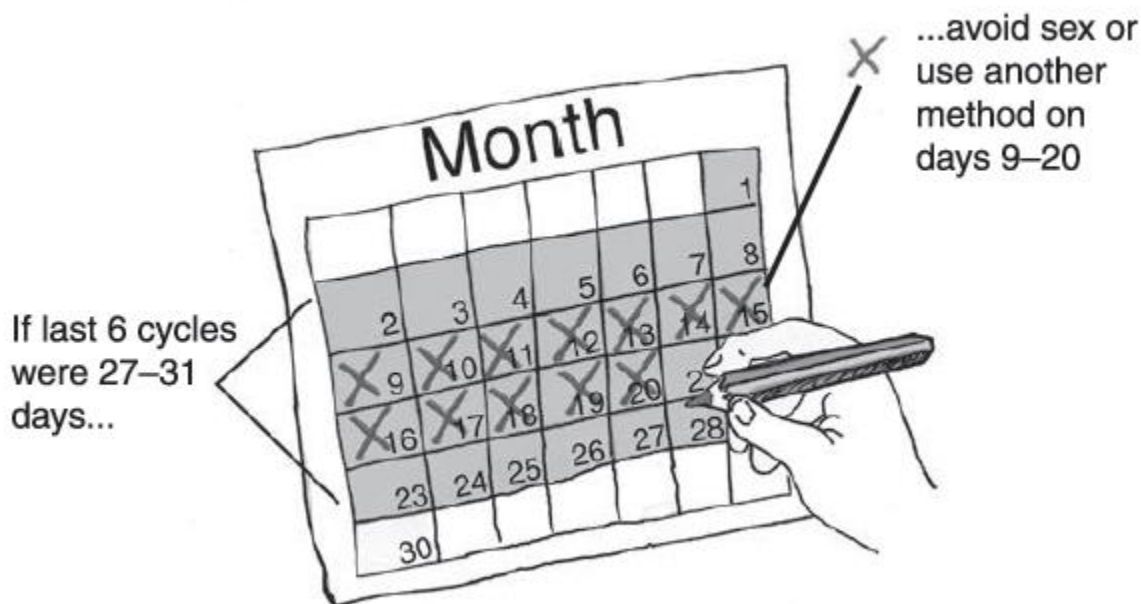


Figure 2: Way of identifying of fertility periods in calendar rhythm method.

How are symptoms-based methods used?

Two Day Method:

If the woman has a vaginal infection or another condition that changes cervical mucus, Two Day method will be difficult to use.

- The woman checks for cervical secretions every afternoon and/or evening, on fingers, underwear, or tissue paper or by sensation in or around the vagina.
- As soon as she notices any secretions of any type, color, or consistency, she considers herself fertile that day and the following day.



Figure 3: Identifying the nature of survival secretions to use two day method

- The couple avoids unprotected sex or uses condoms or a diaphragm on each day that she considers herself fertile and the following day.
- The couple can have unprotected sex again after the woman has had 2 dry days (days without secretions of any

Basal Body Temperature (BBT) Method:

If a woman has fever or other changes in body temperature, the BBT method will be difficult to use.

- The woman takes her body temperature at the same time each morning before she gets out of bed and before she eats anything. She records her temperature on a special graph.
- She watches for her temperature to rise slightly— 0.2° to 0.5°C (0.4° to 1.0°F)—around the time of ovulation (usually about midway through the menstrual cycle).
- The couple avoids vaginal sex, or uses condoms or a diaphragm from the first day of monthly bleeding until 3 days after the woman's temperature has risen above her regular temperature.
- When the woman's temperature has risen above her regular temperature and stayed higher for 3 full days, ovulation has occurred and the fertile period has passed.
- The couple can have unprotected sex on the 4th day and until her next monthly bleeding.

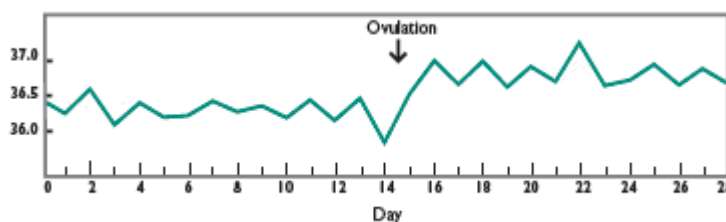


Figure 4: Basal Body Temperature (BBT) Method

Ovulation method (also known as Billings method or cervical mucus method):

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

- The woman checks every day for any cervical secretions on her finger, underwear, or tissue paper or by sensation in the vagina.
- Ovulation might occur early in the cycle, during the last days of monthly bleeding. Heavy bleeding could make mucus difficult to observe.
- Avoids unprotected sex on days of heavy bleeding that makes mucus difficult to observe
- Between the end of monthly bleeding and the start of secretions, the couple can have unprotected sex, but not on 2 days in a row. (Avoiding intercourse on the second day allows time for semen to disappear and for cervical mucus to be observed.)
- As soon as she notices any secretions, she considers herself fertile and avoids unprotected sex.
- She continues to check her cervical secretions each day. The secretions have a “peak day”—the last day that they are clear, slippery, stretchy, and wet. She will know this has passed when, on the next day, her secretions are sticky or dry, or she has no secretions at all. She continues to consider herself fertile for 3 days after that peak day and avoids unprotected sex. The couple can have unprotected sex on the 4th day after her peak day and until her next monthly bleeding begins.

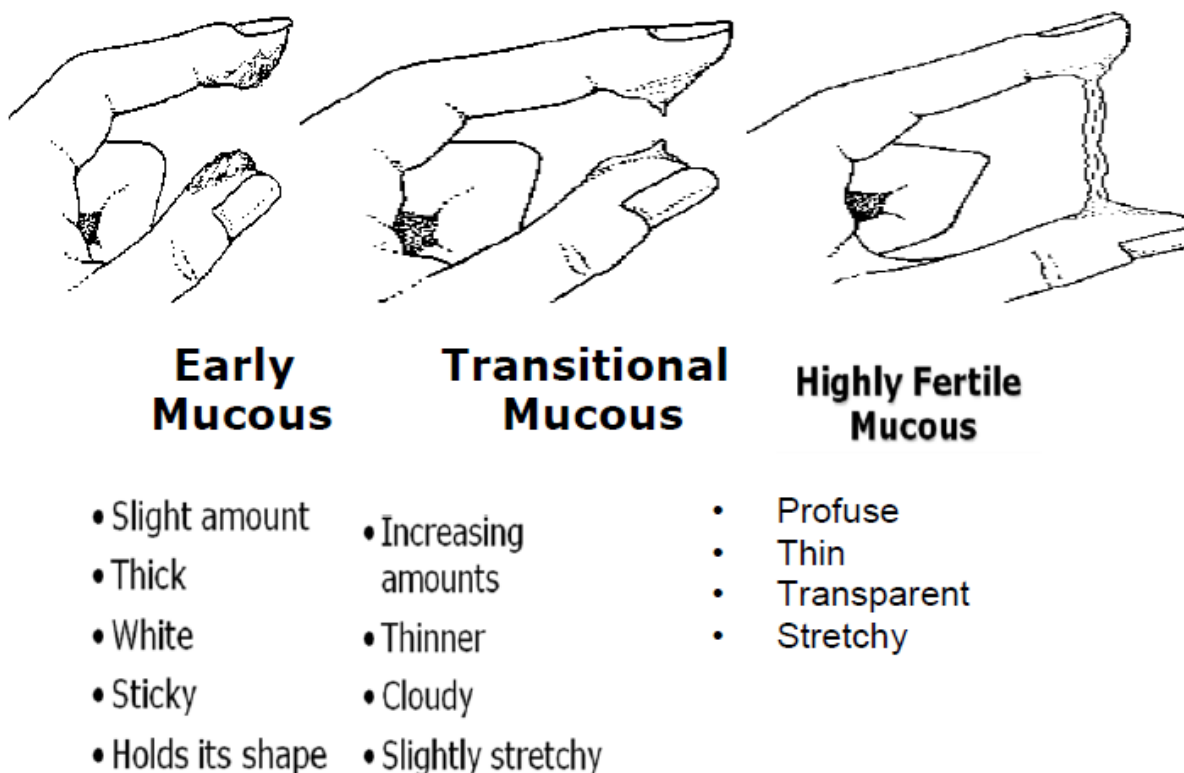


Figure 5: different types of cervical methods

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

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

C. Lactational Amenorrhea Method (LAM)

What Is the Lactational Amenorrhea Method?

- A temporary family planning method based on the natural effect of breastfeeding on fertility. (“Lactational” means related to breastfeeding. “Amenorrhea” means not having monthly bleeding.)

- The Lactational amenorrhea method (LAM) requires 3 conditions. All 3 must be met:
 1. The mother's monthly bleeding has not returned.
 2. The baby is fully or nearly fully breastfed and is fed often, day and night.
 3. The baby is less than 6 months old.
- "Fully breastfeeding" includes both exclusive breastfeeding (the infant receives no other liquid or food, not even water, in addition to breast milk) and almost-exclusive breastfeeding (the infant receives vitamins, water, juice, or other nutrients once in a while in addition to breast milk).
- "Nearly fully breastfeeding" means that the infant receives some liquid or food in addition to breast milk, but the majority of feedings (more than three-fourths of all feeds) are breast milk.
- Works primarily by preventing the release of eggs from the ovaries (ovulation). Frequent breastfeeding temporarily prevents the release of the natural hormones that cause ovulation. Suckling causes increased prolactin, which inhibits estrogen production and ovulation

How Effective?

Effectiveness depends on the user: Risk of pregnancy is greatest when a woman cannot fully or nearly fully breastfeed her infant.

- As commonly used, about 2 pregnancies per 100 women using LAM in the first 6 months after childbirth. This means that 98 of every 100 women relying on LAM will not become pregnant.
- When used correctly, less than 1 pregnancy per 100 women using LAM in the first 6 months after childbirth.

Return of fertility after LAM is stopped: Depends on how much the woman continues to breastfeed

Protection against sexually transmitted infections: None

Side Effects, Health Benefits, and Health Risks

Side Effects

None

Known Health Benefits

Helps protect against risks of pregnancy

Encourages the best breastfeeding patterns, with health benefits for both mother and baby

Known Health Risks

None

Advantages

- It is a natural family planning method
- It supports optimal breastfeeding, providing health benefits for the baby and the mother
- It has no direct cost for family planning or for feeding the baby
- Effectively prevents pregnancy for at least 6 months

Disadvantage

- Not a suitable method if the mother is working outside the home
- If the mother have HIV small chance to transmitter
- No protection against STIs including HIV
- Not effective after 6months

Correcting Misunderstandings

The Lactational amenorrhea method:

- Is highly effective when a woman meets all 3 LAM criteria.
- Is just as effective among fat or thin women.
- Can be used by women with normal nutrition. No special foods are required.
- Can be used for a full 6 months without the need for supplementary foods. Mother's milk alone can fully nourish a baby for the first 6 months of life. In fact, it is the ideal food for this time in a baby's life.
- Can be used for 6 months without worry that the woman will run out of milk. Milk will continue to be produced through 6 months and longer in response to the baby's suckling or the mother's expression of her milk.

Who can and cannot use LAM?

All breastfeeding women can safely use LAM, but a woman in the following circumstances may want to consider other contraceptive methods:

- Has HIV infection including AIDS.
- Is using certain medications during breastfeeding (including mood altering drugs, reserpine, ergotamine, anti-metabolites, cyclosporine, and high doses of corticosteroids, bromocriptine, radioactive drugs, lithium, and certain anticoagulants).

- The newborn has a condition that makes it difficult to breastfeed (including being small-for-date or premature and needing intensive neonatal care, unable to digest food normally, or having deformities of the mouth, jaw, or palate).

LAM for Women with HIV

- Women who are infected with HIV or who have AIDS can use LAM. Breastfeeding will not make their condition worse. There is a chance, however, that mothers with HIV will transmit HIV to their infants through breastfeeding. As breastfeeding is generally practiced, 10 to 20 of every 100 infants breastfed by mothers with HIV will become infected with HIV through breast milk.
- Women taking antiretroviral (ARV) medications can use LAM. In fact, ARV therapy during the first weeks of breastfeeding may reduce the risk of HIV transmission through breast milk.
- Replacement feeding poses no risk of HIV transmission. If—and only if— replacement feeding is acceptable, feasible, affordable, sustainable, and safe, it is recommended for the first 6 months after childbirth. If available replacement feeding cannot meet these 5 criteria, exclusive breastfeeding for the first 6 months is the safest way to feed the baby, and it is compatible with LAM.

When can LAM be initiated?

If the woman is within 6 months after childbirth:

- Start breastfeeding immediately (within one hour) or as soon as possible after the baby is born. In the first few days after childbirth, the yellowish fluid produced by the mother's breasts (colostrum) contains substances very important to the baby's health.
- Any time if she has been fully or nearly fully breastfeeding her baby since birth and her monthly bleeding has not returned.

Remember: A breastfeeding woman can use LAM to space her next birth and as a transition to another contraceptive method. She may start LAM at any time if she meets all the 3 above mentioned criteria required for using the method.

3.2.2. Barrier Methods

Condoms

➤ Male condoms

What are male condoms?

- Thin sheath usually made of rubber (latex) that is placed on an erect penis before intercourse. It is the only method of contraception that also provides protection from STIs, including HIV.
- Work by forming a barrier that keeps sperm out of the vagina, preventing pregnancy. Also keep infections in semen, on the penis, or in the vagina from infecting the other partner.

How effective are male condoms?

Effectiveness depends on the user: Risk of pregnancy or sexually transmitted infection (STI) is greatest when condoms are not used with every act of sex. Very few pregnancies or infections occur due to incorrect use, slips, or breaks.

Protection against pregnancy:

- As commonly used, about 13 pregnancies per 100 women whose partners use male condoms over the first year. This means that 87 of every 100 women whose partners use male condoms will not become pregnant.
- When used correctly with every act of sex, about 2 pregnancies per 100 women whose partners use male condoms over the first year.
- *Return of fertility after use of condoms is stopped:* No delay
- *Protection Against HIV and Other STIs:*

Protection against HIV and other STIs:

- Male condoms significantly reduce the risk of becoming infected with HIV when used correctly with every act of vaginal or anal sex.
- When used consistently and correctly, condom use prevents 80% to 95% of HIV transmission that would have occurred without condoms
- Condoms reduce the risk of becoming infected with many STIs when used consistently and correctly during vaginal or anal sex.
 - ✓ Protect best against STIs spread by discharge, such as HIV, gonorrhea, and chlamydia.
 - ✓ Also protect against STIs spread by skin-to-skin contact, such as herpes and human papillomavirus.

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)

Advantage

- Have no hormonal side effects
- Can be used as a regular, temporary or backup method
- Can be used without seeing a health care provider
- Are sold in many places and generally easy to obtain
- Help protect against both pregnancy and STIs, including HIV
- Can make sex last longer

Disadvantage

- Condom breaks, slips of the penis
- Difficulty putting on the condom
- Mild irritation in or around the vagina or penis or mild allergic reaction to condom (itching, redness, rash, and/or swelling of genitals, groin)
- Some people connect condoms with immoral sex, sex outside marriage, or sex with prostitutes, and do not want to use them.
- Some people are too embarrassed to buy condoms

Correcting Misunderstandings

Male condoms:

- Do not make men sterile, impotent, or weak.
- Do not decrease men's sex drive.
- Cannot get lost in the woman's body.
- Do not have holes that HIV can pass through.
- Are not laced with HIV.

- Do not cause illness in a woman. Exposure to semen or sperm is not needed for a woman's good health.
- Do not cause illness in men by making sperm "back up".
- Not only for use outside marriage. They are also used by married couples.
- Do not cause cancer and do not contain cancer-causing chemicals.

Who can use male condoms?

All men and women can safely use male condoms except those with severe allergy to latex rubber. Also, condoms can be used by:

- Men and women needing a temporary method while waiting for a regular one
- Couples needing a backup method
- Men and women who have intercourse infrequently
- Couples who need contraception immediately
- Couples in which either partner has more than one sexual partner, even if using another method

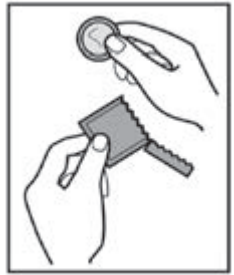
When to Start Using Male Condoms?





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

How to use a male condom

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

Table 5: The 5 basic steps of using a male condom

Basic steps	Important details	Picture
Use a new condom for each act of sex	<ul style="list-style-type: none">• Check the condom package. Do not use if torn or damaged. Avoid using a condom past the expiration date. Do so only if a newer condom is not available.• Tear open the package carefully. Do not use fingernails, teeth, or anything that can damage the condom	 A line drawing showing two hands. One hand is holding a small, rectangular condom package, and the other hand is tearing it open along the top edge. The package is shown at an angle, revealing its contents.

<p>Before any physical contact, place the condom on the tip of the erect penis with the rolled side out</p>	<ul style="list-style-type: none"> • For the most protection, put the condom on before the penis makes any genital, oral, or anal contact. 	
<p>Unroll the condom all the way to the base of the erect penis</p>	<ul style="list-style-type: none"> • The condom should unroll easily. Forcing it on could cause it to break during use. • If the condom does not unroll easily, it may be on backwards, damaged, or too old. Throw it away and use a new condom. • If the condom is on backwards and another one is not available, turn it over and unroll it onto the penis. 	
<p>Immediately after ejaculation, hold the rim of the condom in place and withdraw the penis while it is still erect</p>	<ul style="list-style-type: none"> • Withdraw the penis. • Slide the condom off, avoiding spilling semen. • If having sex again or switching from one sex act to another, use a new condom. 	
<p>Dispose of the used condom safely</p>	<ul style="list-style-type: none"> • Wrap the condom in its package and put it in the rubbish bin or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing. 	

➤ Female condoms

What Are Female Condoms?

- Sheaths, or linings, that fit loosely inside a woman's vagina, made of thin, transparent, soft film.
 - ✓ Have flexible rings at both ends
 - ✓ One ring at the closed end helps to insert the condom
 - ✓ The ring at the open end holds part of the condom outside the vagina

- Work by forming a barrier that keeps sperm out of the vagina, preventing pregnancy. Also helps to keep infections in semen, on the penis, or in the vagina from infecting the other partner.



Figure 6: Female Condoms

How Effective?

Effectiveness depends on the user: Risk of pregnancy or sexually transmitted infection (STI) is greatest when female condoms are not used with every act of sex. Few pregnancies or infections occur due to incorrect use, slips, or breaks.

Protection against pregnancy:

- As commonly used, about 21 pregnancies per 100 women using female condoms over the first year. This means that 79 of every 100 women using female condoms will not become pregnant.
- When used correctly with every act of sex, about 5 pregnancies per 100 women using female condoms over the first year.

Return of fertility after use of female condom is stopped: No delay

Protection against HIV and other STIs:

- Female condoms reduce the risk of infection with STIs, including HIV, when used correctly with every act of sex.

Side Effects, Health Benefits, and Health Risks

Side Effects

None

Known Health Benefits

Help protect against: Risks of pregnancy and STIs, including HIV

Known Health Risks

None

Advantage

- Women can initiate their use
- Have a soft, moist texture that feels more natural than male latex condoms during sex
- Help protect against both pregnancy and STIs, including HIV
- Outer ring provides added sexual stimulation for some women
- Can be used without seeing a health care provider
- Can be inserted ahead of time so do not interrupt sex
- Are not tight or constricting like male condoms
- Do not dull the sensation of sex like male condoms
- Do not have to be removed immediately after ejaculation

Disadvantage

- Condom slips of the vagina
- Difficulty insuring the female condom
- Inner ring uncomfortable or painful
- Makes squeaks or makes noise during sex
- Mild irritation in or around the vagina or penis (itching, redness or rash)

Correcting Misunderstandings

Female condoms:

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

Who can use female condoms?

Any women can use female condoms. No medical conditions prevent the use of this method.

When to start female condoms?

Anytime the client wants.

How are female condoms used?

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

a vagina with one hand and show how to insert the female condom with the other hand. Basic steps and important details are of using a female condom are as follows.

1. Use a new female condom for each act of intercourse

- Check the condom package. Do not use if torn or damaged. Avoid using a condom past its expiration date. Do so only if newer condoms are not available.
- If possible, wash your hands with mild soap and clean water before inserting the condom.

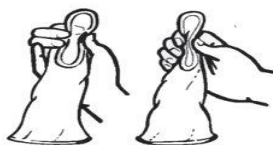
2. Before any physical contact, insert the condom into the vagina

- For the most protection, insert the condom before the penis comes in contact with the vagina. Can be inserted up to 8 hours before sex.
- Choose a position that is comfortable for insertion—squat, raise one leg, sit, or lie down



Figure 7: Way of inserting of female condom

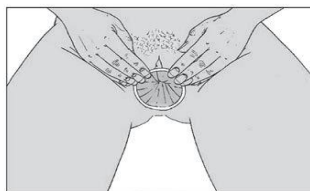
- Rub the sides of the female condom together to spread the lubricant evenly
- Grasp the ring at the closed end, and squeeze it so it becomes long and narrow



- With the other hand, separate the outer lips (labia) and locate the opening of the vagina.
- Gently push the inner ring into the vagina as far up as it will go. Insert a finger into the condom to push it into place. About 2 to 3 centimeters of the condom and the outer ring remain outside the vagina

3. Ensure that the penis enters the condom and stays inside the condom

- The man or woman should carefully guide the tip of his penis in to the condom. If his penis goes outside the condom, withdraw and try again.
- If the condom is accidentally pulled out of the vagina or pushed into it during sex, put the condom back in place (Figure 8)



4. After the man withdraws his penis, hold the outer ring of the condom, twist to seal in fluids, and gently pull it out of the vagina

- The female condom does not need to be removed immediately.
- Remove the condom before standing up, to avoid spilling semen.
- If the couple has sex again, they should use a new condom.
- Reuse of female condoms is not recommended

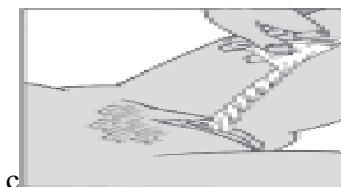


Figure 9: Removal of female condom after sex

5. Dispose of the used condom safely

- Wrap the condom in its package, and put it in the rubbish or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing.



Figure 10: Safe disposal of used female condom

Note: Male and female condoms should not be used together. This can cause friction that may lead to slipping or tearing of the condoms.

3.1.2. Spermicides

What Are Spermicides?

- Sperm-killing substances inserted deep in the vagina, near the cervix, before sex.
 - ✓ Nonoxynol-9 is most widely used.
 - ✓ Others include benzalkonium chloride, chlorhexidine, menfegol, octoxynol-9, and sodium docusate.

- Available in foaming tablets, melting or foaming suppositories, cans of pressurized foam, melting film, jelly, and cream.
 - ✓ Jellies, creams, and foam from cans can be used alone, with a diaphragm, or with condoms.
 - ✓ Films, suppositories, foaming tablets, or foaming suppositories can be used alone or with condoms.
- Work by causing the membrane of sperm cells to break, killing them or slowing their movement. This keeps sperm from meeting an egg.



Figure 11: Spermicide

How Effective?

Effectiveness depends on the user: Risk of pregnancy is greatest when spermicides are not used with every act of sex.

- One of the least effective family planning methods.
- As commonly used, about 21 pregnancies per 100 women using spermicides over the first year. This means that 79 of every 100 women using spermicides will not become pregnant.
- When used correctly with every act of sex, about 16 pregnancies per 100 women using spermicides over the first year.

Return of fertility after spermicides are stopped: No delay

Protection against sexually transmitted infections (STIs): None.

Frequent use of nonoxynol-9 may increase risk of HIV infection

Side Effects, Health Benefits, and Health Risks

Side Effects

Some users report the following:

- Irritation in or around the vagina or penis

Other possible physical changes:

- Vaginal lesions

Known Health Benefits

Help protect against risks of pregnancy

Known Health Risks

Uncommon:

- Urinary tract infection, especially when using spermicides 2 or more times a day

Rare:

- Frequent use of nonoxynol-9 may increase risk of HIV infection.

Advantage

- Are controlled by the woman
- Have no hormonal side effects
- Increase vaginal lubrication
- Can be used without seeing a health care provider
- Can be inserted ahead of time and so do not interrupt sex

Disadvantage

- Irritation in or around the vagina or penis. (she or her partner has itching, rash, or irritation that lasts for a day or more)
- Urinary tract infection (burning or pain with urination, frequent urination in small amounts, blood in the urine, back pain)
- Bacterial vaginosis (abnormal white or gray vaginal discharge with unpleasant odor)
- Candidiasis (abnormal white vaginal discharge that can be watery or thick chunky)

Correcting Misunderstandings

Spermicides:

- Do not reduce vaginal secretions or make women bleed during sex.
- Do not cause cervical cancer or birth defects.
- Do not protect against STIs.
- Do not change men's or women's sex drive or reduce sexual pleasure for most men.
- Do not stop women's monthly bleeding.

Who can use spermicides?

spermicides safe and suitable for nearly all women.

Who cannot use spermicides?

All women can safely use spermicides except those who:

- Are at high risk for HIV infection
- Have HIV infection
- Have AIDS

When to start using spermicides?

Anytime the client wants.

How are spermicides used?

Spermicides should be inserted before sex.

- **Foam or cream:** Any time less than one hour before sex.
- **Tablets, suppositories, jellies, film:** Between 10 minutes and one hour before sex.

The client checks the expiration date and washes hands with mild soap and clean water, if possible.

- **Applying the spermicide:**
 - ✓ **Foam or cream:** Shake cans of foam hard. Squeezes spermicide from the can or tube into a plastic applicator. Insert the applicator deep into the vagina, near the cervix, and pushes the plunger.
 - ✓ **Tablets, suppositories, jellies:** Inserts the spermicide deep into the vagina, near the cervix, with an applicator or with fingers.
 - ✓ **Film:** Folds film in half and inserts with dry fingers (or else the film will stick to the fingers and not the cervix).
- Before each act of vaginal sex additional spermicide should be inserted.
- Douching is not recommended because it will wash away the spermicide and also increase the risk of STIs. If the client must douche, she should wait for at least 6 hours after sex before doing so.

➤ Diaphragm

- A soft latex cup that covers the cervix. Plastic and silicone diaphragms may also be available.
- The rim contains a firm, flexible spring that keeps the diaphragm in place.
- Used with spermicidal cream, jelly, or foam to improve effectiveness.

- Most diaphragms come in different sizes and require fitting by a specifically trained provider. It does not require seeing a provider for fitting.
- Works by blocking sperm from entering the cervix; spermicide kills or disables sperm. Both keep sperm from meeting an egg.



Figure 12: The diaphragm

How Effective?

Effectiveness depends on the user: Risk of pregnancy is greatest when the diaphragm with spermicide is not used with every act of sex.

- As commonly used, about 17 pregnancies per 100 women using the diaphragm with spermicide over the first year. This means that 83 of every 100 women using the diaphragm will not become pregnant.
- When used correctly with every act of sex, about 16 pregnancies per 100 women using the diaphragm with spermicide over the first year.

Return of fertility after use of the diaphragm is stopped: No delay

Protection against STIs: May provide some protection against certain STIs but should not be relied on for STI prevention.

Side Effects, Health Benefits, and Health Risks

Side Effects

Some users report the following:

- Irritation in or around the vagina or penis

Other possible physical changes:

- Vaginal lesions

Known Health Benefits

Help protect against:

- Risks of pregnancy

May help protect against:

- Certain STIs (chlamydia, gonorrhea, pelvic inflammatory disease, trichomoniasis)
- Cervical pre cancer and cancer

Known Health Risks

Common to uncommon:

- Urinary tract infection

Uncommon:

- Bacterial vaginosis
- Candidiasis

Rare:

- Frequent use of nonoxynol-9 may increase risk of HIV infection

Extremely rare:

- Toxic shock syndrome

Advantage

- Is controlled by the woman
- Has no hormonal side effects
- Can be inserted ahead of time and so does not interrupt sex

Disadvantage

- Difficulty inserting or removing diaphragm
- Discomfort or pain with diaphragm use
- Irritation in or around the vagina or penis.

Correcting Misunderstandings

Diaphragms:

- Do not affect the feeling of sex. A few men report feeling the diaphragm during sex, but most do not.
- Cannot pass through the cervix. They cannot go into the uterus or otherwise get lost in the woman's body.
- Do not cause cervical cancer.

Who can use the diaphragm?

- Nearly all women can use the diaphragm safely and effectively.

Who cannot use the diaphragm?

Women who have the following conditions:

- Have had a baby or second-trimester abortion in the past 6 weeks
- Allergy to latex rubber
- Are at high risk for HIV infection
- Have HIV infection
- Have AIDS

When to start using the diaphragm?

Anytime the client wants, except within 6 weeks after full-term delivery or second-trimester spontaneous or induced abortion.

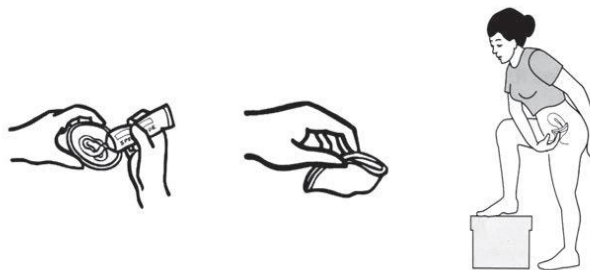
How is diaphragm used?

- A pelvic examination is needed before starting use. The provider determines the correct diaphragm size and checks that it fits properly and does not come out easily. With a properly fitted diaphragm, the client should not be able to feel anything inside her vagina, even when she walks or during sex.

IMPORTANT: Whenever possible, show the woman the location of the pubic bone and cervix with a model or picture. Explain that the diaphragm is inserted behind the pubic bone and covers cervix.

1. Squeeze a spoonful of spermicidal cream, jelly or foam into the diaphragm and around the rim.

- Wash hands with soap and clean water if possible.
- Check the diaphragm for holes, cracks, or tears by holding it up to the light.
- Check the expiration date of the spermicide and avoid using any beyond its expiration date.
- Insert the diaphragm less than 6 hours before having sex.



2. Press the rim together; push into the vagina as far as it goes

- Choose a position that is comfortable for insertion—squatting, raising one leg, sitting, or lying down.

3. Feel the diaphragm to make sure it covers the cervix

- Through the dome of the diaphragm, the cervix feels like the tip of the nose.
- If the diaphragm feels uncomfortable, take it out and insert it again.

4. Keep in place for at least 6 hours after sex

- Keep the diaphragm in place at least 6 hours after having sex but no longer than 24 hours.
- *Leaving the diaphragm in place for more than one day may increase the risk of toxic shock syndrome.* It can also cause a bad odor and vaginal discharge.
- For multiple sex acts, make sure that the diaphragm is in the correct position and also insert additional spermicides in front of the diaphragm before each act.

5. To remove, slide a finger under the rim of the diaphragm to pull it down and out

- Wash hands with mild soap and clean water, if possible.
- Insert a finger into the vagina until the rim of the diaphragm is felt.
- Gently slide a finger under the rim and pull the diaphragm down and out. Use care not to tear the diaphragm with a fingernail.
- Wash the diaphragm with soap and clean water and dry it after each use.

Tips for Users of Spermicides or the Diaphragm With

Spermicide

- Spermicides should be stored in a cool, dry place, if possible, out of the sun. Suppositories may melt in hot weather. If kept dry, foaming tablets are not as likely to melt in hot weather.
- The diaphragm should be stored in a cool, dry place, if possible.
- She needs a new diaphragm fitted if she has had a baby or a second trimester miscarriage or abortion.

a) Cervical cap

What Is the Cervical Cap?

- A soft, deep, latex or plastic rubber cup that snugly covers the cervix.
- Comes in different sizes; requires fitting by a specifically trained provider.

How Effective?

Effectiveness depends on the user: Risk of pregnancy is greatest when the cervical cap with spermicide is not used with every act of sex.

Women who have given birth:

- One of the least effective methods, as commonly used.
- As commonly used, about 32 pregnancies per 100 women using the cervical cap with spermicide over the first year. This means that 68 of every 100 women using the cervical cap will not become pregnant.
- When used correctly with every act of sex, about 26 pregnancies per 100 women using the cervical cap over the first year.

More effective among women who have not given birth:

- As commonly used, about 16 pregnancies per 100 women using the cervical cap with spermicide over the first year. This means that 84 of every 100 women using the cervical cap will not become pregnant.
- When used correctly with every act of sex, about 9 pregnancies per 100 women using the cervical cap over the first year.

Return of fertility after use of cervical cap is stopped: No delay

Protection against sexually transmitted infections: None

Side Effects, Health Benefits, and Health Risks

- Same as for diaphragms

Who can use the cervical cup?

- Nearly all women can use the diaphragm safely and effectively.

Who cannot use the cervical cup?

- Treated or going to be treated for cervical pre cancer or cervical cancer.
- Have had a baby or second-trimester abortion in the past 6 weeks
- Allergy to latex rubber
- Are at high risk for HIV infection
- Have HIV infection
- Have AIDS

How to use cervical cup

Providing the cervical cap is similar to providing diaphragms and helping diaphragm users.

Differences include:

Inserting

- Fill one-third of the cap with spermicidal cream, jelly, or foam.
- Press the rim of the cap around the cervix until it is completely covered, pressing gently on the dome to apply suction and seal the cap.
- Insert the cervical cap any time up to 42 hours before having sex.

Removing

- Leave the cervical cap in for at least 6 hours after her partner's last ejaculation, but not more than 48 hours from the time it was put in.
- Leaving the cap in place for more than 48 hours may increase the risk of toxic shock syndrome and can cause a bad odor and vaginal discharge.
- Tip the cap rim sideways to break the seal against the cervix, and then gently pull the cap down and out of the vagina

3.2.3. Providing Combined Oral Contraceptives

Oral contraceptive pills are contraceptives that are taken orally once daily to prevent pregnancy. Oral contraceptives contain either two or one female sex hormones. The hormones are synthetic estrogens and synthetic progesterone. These include:

I. Combined oral contraceptive pills (COCs):

Contain both synthetic estrogen and progesterone like the natural female sex hormones.

Progestin only pills (POPs): contain progestin only like the natural female sex hormone.

When to start

Table 6: 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 non hormonal method	Any time of the month <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 after giving birth	<ul style="list-style-type: none"> • 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.
Partially Breastfeeding Less than 6 weeks after giving birth	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

after giving birth	women having menstrual cycles.
Not breastfeeding Less than 4 weeks after giving birth	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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.

- | | |
|--|--|
| | <ul style="list-style-type: none">• All women will need to use a backup method for the first 7 days of taking pills. |
|--|--|



Figure13: Combined Oral Contraceptive

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, weight change, and possibly other side effects.

Explain about these side effects

- Side effects are not signs of illness.
- Most side effects usually become less or stop within the first few months of using COCs.
- 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 non hormonal pills? (Last 7 pills in 28-pill pack)

- Discard the missed non hormonal 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.

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 non-steroidal 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.

II. Providing Progestin-Only Pills

Progestin only pills (POPs): contain progestin only like the natural female sex hormone.

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

Table 7: Time to start POP

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • She can start POPs as advised for women having menstrual cycles.
Not breastfeeding Less than 4 weeks after giving birth	<ul style="list-style-type: none"> • She can start POPs at any time. No need for a backup method.
Not breastfeeding More than 4 weeks	<ul style="list-style-type: none"> • 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

after giving birth	<p>the first 2 days of taking pills.</p> <ul style="list-style-type: none"> • If her monthly bleeding has returned, she can start POPs as advised for women having menstrual cycles.
Switching from a hormonal method	<ul style="list-style-type: none"> • 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 non hormonal method	<p>Any time of the month</p> <ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 emergency contraceptive pills (ECPs)	<ul style="list-style-type: none"> • She can start POPs the day after she finishes taking the ECPs. There is no need to wait for her next monthly bleeding to start her pills. <ul style="list-style-type: none"> ✓ 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.

Managing Side Effects of Progestin Only Pills

Side Effects 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.

i. Emergency contraceptives

Emergency contraceptive are methods of contraception that can be used to prevent pregnancy following an unprotected act of sexual intercourse. The methods include:

Emergency contraceptive pills (ECPs): can be used up to five days following unprotected intercourse (120 hours).

A copper- bearing IUD: can also be used within seven days of unprotected intercourse as an emergency contraceptive.

3.2.3. Providing Progestin-Only Injectable

The contraceptive injection, also known as ‘the shot’, contains progestogen or a combination of estrogen and progestogen. The Injectable contraceptives depot medroxyprogesterone acetate (DMPA) and norethisterone enanthate (NET-EN) each contain a progestin like the natural hormone progesterone in a woman’s body. In contrast, monthly injectables contain both estrogen and progestin. DMPA, the most widely used progestin-only Injectable, is also known as Depo or Depo-Provera. In this learning you will learn 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.

Table 8: Shows **When to Start injectables**

Women's situation	When to start
Having menstrual cycles or switching from a nonhormonal method	Any time of the month <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Delay her first injection until at least 6 weeks after giving birth.

Partially breastfeeding More than 6 weeks after giving birth	<ul style="list-style-type: none"> • 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.
Not breastfeeding Less than 4 weeks after giving birth	<ul style="list-style-type: none"> • She can start injectables at any time. No need for a backup method.
Not breastfeeding More than 4 weeks after giving birth	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • She can start or restart injectables on the same day as taking the ECPs. <i>No need to wait for her next monthly bleeding to have the injection.</i> <ul style="list-style-type: none"> ✓ 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.

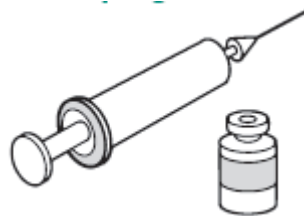
Explain about these side effects

- 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 Intramuscular 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.

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.

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.

a. Long acting contraceptive method

At this level you are expected to assist the provision of long acting contraceptive methods available in our country.

3.2.4. Providing Implants

When to Start

IMPORTANT: A woman can start using implants any time she wants if it is reasonably certain she is not pregnant. No tests or examinations are necessary before starting implants, although blood pressure measurement is desirable.

Table 9 appropriate time to start implants

Woman's situation	When to start
Having menstrual cycles or switching from a nonhormonal method	<p>Any time of the month</p> <ul style="list-style-type: none"> • 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 have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion. • If she is switching from an IUD, immediately
Switching from another hormonal method	<ul style="list-style-type: none"> • 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 a progestin-only or monthly injectable, she can have implants inserted 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	<ul style="list-style-type: none"> If her monthly bleeding has not returned, she can have implants inserted any time between giving birth and 6 months. No need for a backup method. If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles.
Fully or nearly fully breastfeeding More than 6 months after giving birth	<ul style="list-style-type: none"> If her monthly bleeding has not returned, she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion. If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles.
Partially breastfeeding If her monthly bleeding has not returned	<ul style="list-style-type: none"> She can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion.
Partially breastfeeding If her monthly bleeding has returned	<ul style="list-style-type: none"> If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles.
Not breastfeeding Less than 4 weeks after giving birth	<ul style="list-style-type: none"> She can have implants inserted at any time. No need for a backup method.
Not breastfeeding More than 4	<ul style="list-style-type: none"> If her monthly bleeding has not returned, she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion.

weeks after giving birth	<ul style="list-style-type: none"> If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles.
No monthly bleeding (not related to childbirth or breastfeeding)	<ul style="list-style-type: none"> She can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion.
After miscarriage or abortion	<ul style="list-style-type: none"> Immediately. If implants are inserted 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 have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion.
After taking emergency Contraceptive pills (ECPs)	<ul style="list-style-type: none"> Implants can be inserted on the same day as she takes the ECPs. <ul style="list-style-type: none"> ✓ She will need to use a backup method for the first 7 days. If she does not start immediately, but returns for an implant, she can start at any time if it is reasonably certain she is not pregnant.

Giving Advice on Side Effects

IMPORTANT: Thorough counseling about bleeding changes and other side effects must come before inserting implants. 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

- Changes in her bleeding pattern:
 - ✓ Irregular bleeding that lasts more than 8 days at a time over the first year.
 - ✓ Later, regular, infrequent, or no bleeding at all.
- Headaches, abdominal pain, 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.
- Most side effects usually become less or stop within the first year.
- Common, but some women do not have them.

- Client can come back for help if side effects bother her or if she has other concerns.

3.1.3. Providing the Intrauterine Device

When to Start

IMPORTANT: In many cases a woman can start the IUD any time if it is reasonably certain she is not pregnant. To be reasonably certain she is not pregnant, use the Pregnancy Checklist.

Table 10: Shows time to start IUCD.

Woman's situation	When to start
Having menstrual cycles	Any time of the month <ul style="list-style-type: none"> • If she is starting within 12 days after the start of her monthly bleeding, no need for a backup method. • If it is more than 12 days after the start of her monthly bleeding, she can have the IUD inserted any time if it is reasonably certain she is not pregnant. No need for a backup method.
Switching from another method	<ul style="list-style-type: none"> • 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. • If she is switching from an injectable, she can have the IUD inserted when the next injection would have been given. No need for a backup method.
Soon after childbirth (regardless of breastfeeding status)	<ul style="list-style-type: none"> • Any time within 48 hours after giving birth, including by caesarean delivery. (Provider needs specific training in postpartum insertion by hand or using a ring forceps.) • If it is more than 48 hours after giving birth, delay until 4 weeks or more after giving birth.
Fully or nearly fully breastfeeding Less than 6 months after giving birth	<ul style="list-style-type: none"> • If the IUD is not inserted within the first 48 hours and her monthly bleeding has not returned, she can have the IUD inserted any time between 4 weeks and 6 months after giving birth. No need for a backup method. • If her monthly bleeding has returned, she can have the IUD inserted as advised for women having menstrual cycles.

<p>Fully or nearly fully breastfeeding More than 6 months after giving birth</p>	<ul style="list-style-type: none"> • If her monthly bleeding has not returned, she can have the IUD inserted any time it is reasonably certain she is not pregnant. No need for a backup method. • If her monthly bleeding has returned, she can have the IUD inserted as advised for women having menstrual cycles.
<p>Partially breastfeeding or not breastfeeding More than 4 weeks after giving birth</p>	<ul style="list-style-type: none"> • If her monthly bleeding has not returned, she can have the IUD inserted <i>if it can be determined that she is not pregnant</i>. No need for a backup method. • If her monthly bleeding has returned, she can have the IUD inserted as advised for women having menstrual cycles.
<p>No monthly bleeding (not related to childbirth or breastfeeding)</p>	<ul style="list-style-type: none"> • Any time <i>if it can be determined that she is not pregnant</i>. No need for a backup method.
<p>After miscarriage or abortion</p>	<ul style="list-style-type: none"> • Immediately, if the IUD 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. • If it is more than 12 days after first- or second trimester miscarriage or abortion and no infection is present, she can have the IUD inserted any time if it is reasonably certain she is not pregnant. No need for a backup method. • If infection is present, treat or refer, and help the client choose another method. If she still wants the IUD, it can be inserted after the infection has completely cleared. • IUD insertion after second-trimester abortion or miscarriage requires specific training. If not specifically trained, delay insertion until at least weeks after miscarriage or abortion.
<p>For emergency contraception</p>	<ul style="list-style-type: none"> • Within 5 days after unprotected sex. • When the time of ovulation can be estimated, she can have an IUD inserted up to 5 days after ovulation. Sometimes this may be more than 5 days after unprotected sex.

After taking emergency contraceptive pills (ECPs)	<ul style="list-style-type: none">• The IUD can be inserted on the same day that she takes the ECPs (progestin-only, combined, or ulipristal acetate ECPs). No need for a backup method.• If she does not have it inserted immediately, but returns for an IUD, she can have it inserted any time <i>if it can be determined that she is not pregnant</i>.
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Giving Advice on Side Effects

IMPORTANT: Thorough counseling about bleeding changes must come before IUD insertion. 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

- Changes in her bleeding pattern:
 - ✓ Prolonged and heavy monthly bleeding
 - ✓ Irregular bleeding
 - ✓ More cramps and pain during monthly bleeding

Explain about these side effects

- Bleeding changes are not signs of illness.
- Usually become less after the first several months after insertion.
- Client can come back for help if problems bother her or if she has other concerns.

Self-Check 3

Directions: Answer all the questions listed below.

Part II say “True” if the statement is correct or “False” if the statement is incorrect

1. A woman 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.

Part II. Choose the correct answer for the following alternatives

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 complains?
 - 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. 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
- 4. 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
- 5. After child birth which contraceptive method should not give immediately? Progestin only injectables
 - A. Lactational amenorrhea
 - B. Progestin only pills implants
 - C. Male or female condoms Spermicides
- 6. 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
- 7. 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

Unit Four: Monitoring family planning services

This learning unit is developed to provide the trainees the necessary information regarding the following content coverage and topics:

- Collecting family planning services data
- Collecting, sustaining and updating RH events data
- Utilizing HMIIS standards for registration of FP related activities
- Reporting family planning activities to the concerned higher bodies
- Monitoring family planning practice
- Revising plan FP health services for the catchments

This unit will also assist you to attain the learning outcomes stated in the cover page.

Specifically, upon completion of this learning guide, you will be able to:

- Collect family planning services data
- Collect, sustain and update RH events data
- Utilize HMIIS standards for registration of FP related activities
- Report family planning activities to the concerned higher bodies
- Monitor family planning practice
- Revising plan FP health services for the catchments

4.1. Collecting, sustaining and updating family planning services data

The family planning service provision is one of the services, which need to be captured through the DHIS system. In this guideline, the major data that need to be captured in the DHIS and the tools used to collect clients information are described to help health care workers and health managers to follow FP services are well recorded and used for decision making. The major records are categorized as individual client's records, registers, and tally sheets.

4.1.2. Individual FP recording tools at Health Facilities

I. Integrated individual Folder

Any client who came to health facilities to receive FP service should visit medical record room and issued integrated individual folder that captures the basic demographic information of the client. The inside part of the folder contains a summary sheet to summarize summary of service provided for client at each visit and should be filled by service providers immediately after the service is provided.

II. Women's Card

All clients seeking FP services need to have a Women card. The card records their socio-demographic and health history including screening for family planning, past and current FP methods, the physical examination findings, and the client's current FP method. The follow-up section of the card records the history and physical examination findings at the time of the visit.

III. Appointment Card

It is a small card, which is used to remind clients who have next appointment. The card contains the client demographic information, appointment date and reason for appointment.

IV. Referral form

Referral form is used to transfer basic information from referring health facilities to accepting health facilities. The referral form is attached in which is based on the community-based health information system (CHIS) from HP to HC.

V. Family health Card [at health post level]

Any clients that visit health post should be issued a family health card. The card helps the HEW to capture all demographic information, FP provision and long-term FP removal. The HEW should keep all family health cards with appointments in a tickler box. Otherwise it should be put on the back on family folder.

VI. Registers

A. Family Planning Register

Family Planning Register is a longitudinal register that is used to capture HMIS data related to family planning services. The information required to complete the FP register is obtained from woman's card. The register should be kept in the Family Planning service room. The service provider will obtain complete information on individual clients from a woman's card and copy all the required information to the family planning register. This will help to compile and generate monthly family planning service statistics reports.

B. Long Acting Removal Register

The Long Acting Removal Register is used to record data for clients who have had long acting family planning methods and who have returned for removal. The family planning methods that are included for removal are implants (different types) and IUCD. Data is abstracted from women card and entered to the LAFP removal register by service providers.

Family Planning Register																							
Identification					Family Planning and contraceptive services																		
Personal information					Registration				Counselling and testing				VIA screening and test result				Clinical exam and contraceptive services provided				Follow-up and remark		
Serial No.	MRN	Name of Client	Age	Sex (M/F)	Reg. date (DD/MM/YY)	New acceptor at registration (✓)	Repeat acceptor at registration (0-48 hrs) (✓)	HIV Test offered (✓)	HIV Test performed (✓)	HIV Test Result (R or NR or I)	HIV specific counseling / methods offered (✓)	Positive and link to ART	VIA screening for women age 30-49 (✓)	VIA Test Result (Normal, PC or Ca)	VIA screening given for PC (✓)	TT status checked (✓)	Contraindication for IUCD (✓)	Visit No.	Visit date (DD/MM/YY)	Contraceptive provided	Appointment date	Remark/Name & signature	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
																		1					
																		2					
																		3					
																		4					
																		5					

Figure 14: Family planning register

4.2. Utilize HMIIS standards for registration of FP related activities

The HMIS captures much of its service and disease surveillance data from client/patient records that health professionals maintain for care and follow up. HMIS simply exploits this routinely established procedure and builds on its potential without itself imposing a totally separate requirement. Obviously there is a need for close integration between client/patient recording and HMIS reporting.

The recording instruments and processes to be reformed fall into four major areas:

1. **Client/patient encounter formats record** interactions between clients or patients and care providers and other technical or administrative health staff. The information recorded may

include medical history, clinical observations, diagnosis, treatment, laboratory, pharmacy, and financial data. The formats proposed here are based on current Federal Ministry of Health (FMOH) guidelines and regional practices.

2. **Intrafacility data flow** describes the way patient/client encounter formats follow an individual through the facility and how the medical information recorded by one practitioner can be consolidated so that it becomes available for other practitioners.

3. **HMIS reporting formats** contain the data required for the indicators used in performance improvement.

4. **HMIS data flow** moves data from facilities and administrative offices through the reporting chain from facility to regional and nation offices.

4.3. Report family planning activities to the concerned higher bodies

Report family planning activities is moving the data from facilities and administrative offices through the reporting chain from facility to regional and nation offices. **HMIS reporting formats** contain the data required for the indicators used in performance improvement. FP Tally, FP registers and other data tools serve as a reference to report the FP activities.

4.4. Monitor family planning practice

Monitoring

Monitoring is a process by which priority data and/or information is routinely collected, analyzed, used and disseminated to see progress towards the achievement of planned targets. This helps the managers take timely corrective actions in order to improve performance. It includes monitoring of inputs, outputs, outcomes and impacts of health programmes, including family planning.

At all levels, performance monitoring will be conducted regularly on a weekly, monthly, quarterly and annual basis, supplemented by semi-annual and annual review meetings. With regard to family planning, you need to know what has to be monitored and how — you can refer to national HMIS technical guidelines.

Common performance indicators for a family planning programme

Inputs (resources, activities)

- Total commodities (supplies, equipment, contraceptives) received.
- Training and technical assistance received by the staff.
- Supplies and contraceptives expended (subtract inventory from amount received).

- Number of educational materials received, by type.

Outputs (services, training, information, education and communication)

- Number of new clients, given by choice of contraceptive method.
- Number of providers trained.
- Number of households covered.
- Number of community meetings and number of people informed at meetings.
- Number of referrals for clinical methods.
- Number of contraceptives distributed, by contraceptive method.

Indicators of quality of care (Some of these indicators can only be measured through evaluation research, depending on the programmes Management Information System.)

- Providers' level of adherence to informed choice protocols.
- Method mix offered.
- Percentage of clients referred by other clients (an indicator of client satisfaction).
- Continuation rates in programme.
- Percentage of clients expressing satisfaction with the service.

Indicators of effectiveness:

- Indicators of knowledge of, attitudes towards, and practice of family planning in programme area.
- Indicators of impact
- Contraceptive prevalence rate (CPR) in area.
- Crude birth rate in area.
- Induced abortion rates in area (if available).
- Total Fertility Rates (TFR) in area.
- Infant mortality rate.
- Maternal mortality rate.
- Rate of high-risk births (women over 35 years with 5+ births).

[Self-check-4](#)

Choose the correct answer

1. The process by which priority data and/or information is routinely collected, analyzed, used and disseminated is called:
A. Evaluation B. monitoring C. Supervision D. Meeting

2. Which tool is important to capture FP data?
A. registers B appointment Card C. Tally Sheet D. all except B
3. One of the following is input variable Under FP service procedure
A. Training B. commodities. C. Educational materials D all

Test II: Short answer question

1. Discuss components of monitoring
2. List at least five family planning program indicators of effectiveness

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