GOSS

MINISTRY OF HEALTH

Technical Guidelines (TG) for Family Planning Services in Southern Sudan

September 2006

Foreword

With 9.7 million people, Southern Sudan has one of the youngest populations in the world, and is expected to grow by three million over the next six years as refugees and displaced persons return to their homes. This rapid increase in population due to migration, coupled with a fertility rate of 6.7 (UNFPA, Sudan Country Office Annual Report, 2005), is likely to place new and difficult demands on all Southern Sudan's institutions, Health, Education agriculture, and economy. Health in general and reproductive health in particular has been adversely affected by over 20 years of civil conflict and the accompanying social instability. Most of the region's social services infrastructure and overall quality of life have been eroded over these years. Consequently, the major health indicators for Southern Sudan rank among the poorest in the world. The maternal mortality ratio is 1,700 per 100,000 live births, the fifth highest in the world. The under-five population is estimated to be chronically malnourished and to have a mortality rate of 250 per 1,000 with an infant mortality rate of 150 per 1,000. Antenatal care coverage is estimated to be approximately 16 percent. The contraceptive prevalence rate (CPR) is reported to be less than one percent (New Sudan Centre for Statistics and Evaluation, 2002, Juba, Southern Sudan).

Health is an integral part of and essential component of reconstruction. As a result of the years of conflict, access to health care services especially reproductive health and family planning services has been nearly non-existent. One of the key goals of the Government of Southern Sudan (GOSS) is to strengthen core health sector systems capacities wherever possible and to establish new ones as necessary. Family planning provides an important way to reduce maternal mortality and morbidity and to strengthen the health and economic development of women and families. Before the internal

conflicts began in Southern Sudan, many communities had well known norms of birth spacing, so this concept is not new for the people of that region.

The *Family Planning Technical Guidelines for Service Providers in Southern Sudan* builds on the Maternal and Reproductive Health Policy of the Government of Southern Sudan (GOSS), providing national standards for high quality services. These guidelines will be the foundation to reinstate quality professional service provision for family planning. They are designed to assist family planning service providers in giving comprehensive quality care for clients and how to integrate family planning into other reproductive health services using the most up to date WHO medical eligibility criteria for contraceptive services. The guidelines will provide direction to all reproductive health service providers working in both the public and private sectors, at all levels and types of health care delivery points, including tertiary referral teaching hospitals, secondary referral hospitals, Primary Health Care Centres (PHCC), and Primary Health Care Unit (PHCU). Private sector facilities include those implemented by NGOs, faith-based organizations, individual private clinics, and semi private/government facilities.

We expect that with quality services available, more couples will make informed decisions about family planning and seek services, leading to improved health outcomes for women, children, and families.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
BBT	Basal Body Temperature
BMI	Body Mass Index
BP	Blood Pressure
BS/FP	Birth Spacing/Family Planning
BTL	Bilateral Tubal Ligation
CHW	Community Health Worker
CI	Cervical Intraepithelial Neoplasm
COC	Combined Oral Contraceptive
CPA	Comprehensive Peace Agreement
CPR	Contraceptive Prevalence Rate
CVA	Cerebrovascular Accident
CVD	Cardiovascular Disease
DMPA	Depot Medroxyprogesterone Acetate
DVT	Deep Venous Thrombosis
ECP	Emergency Contraceptive Pill
FP	Family Planning
FC	Female Condom
Kms	Kilometres
TG	Technical Guidelines
NGO	Non Governmental Organization
FBO	Faith Based Organization

GOSS	Government of Southern Sudan
HIV	Human Immunodeficiency Virus
HBC	Home Based Care
IDPs	Internally Displaced Persons
IHD	Ischemic Heart Disease
IUCD	Intrauterine Contraceptive Device
IMR	Infant Mortality Rate
LAM	Lactational Amenorrhea Method
MCHW	Maternal Child Health Worker
MEC	Medical Eligibility Criteria
MMR	Maternal Mortality Ratio
MOH	Ministry Of Health
MTCT	Mother to Child Transmission
NFP	Natural Family Planning
NGO	Non Governmental Organization
OC	Oral Contraceptive
PE	Pulmonary Embolism
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
PEP	Post Exposure Prophylaxis
PID	Pelvic Inflammatory Disease
PMTCT	Prevention of Mother to Child Transmission
POP	Progesterone Only Pills
RH	Reproductive Health
RHS	Reproductive Health Services

SBE	Sub-acute bacterial endocarditis
SDP	Service Delivery Point
SDM	Standard Days Method
STI	Sexually Transmitted Disease
Sq	Square
SSA	Sub-Saharan Africa
TB	Tuberculosis
TBA	Traditional Birth Attendant
TL	Tubal Ligation
VCT	Voluntary Counselling and Testing
VIA	Visual Inspection with Acetic Acid
VILI	Visual Inspection with Lugols Iodine
VS	Voluntary Sterilization
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

Introduction and Background

Southern Sudan covers a geographical area of approximately 640,000 square kilometres and has an estimated population of about 10 million.

For various reasons including the impact of protracted civil wars over the past four decades, health indicators (especially reproductive health) are very poor. The maternal mortality ratio is estimated at 1,700/100,000 live births. IMR is 150/1,000, and the under five mortality is 250/1,000. The contraceptive prevalence rate (CPR) is less than one percent (New Sudan Centre for Statistics and Evaluation, 2002, Juba, South Sudan).

The overall infrastructure remains poor, weak or underdeveloped. The national health infrastructure lacks facilities, sufficient equipment and adequate human resources. The health care delivery system in Southern Sudan has been operating on an emergency basis. Reproductive health (RH) services have suffered most, especially the family planning (FP) component.

Historically, it was well recognized in Southern Sudan that family planning has the potential to reduce the high maternal mortality and morbidity rates. Traditionally, many communities knew about and practiced birth spacing. Men and women abstained from trying to have another baby until their child began walking and could be sent out to do errands. During this time the child was also breast fed. These norms, however, have been disrupted by the wars that have displaced people, communities and families, and which made it difficult to practice the hitherto accepted traditional family planning/birth spacing methods.

There is evidence to demonstrate that healthy timing and spacing of pregnancies (HTSP) is an effective intervention that promotes the best health outcomes for mothers and infants through the practice of recommended pregnancy spacing. The best evidence to date suggests that after a live birth, it is recommended that a mother waits at least 24 months before trying to become pregnant again. It is also recommended that after a miscarriage or an induced abortion, couples should wait at least six months before attempting to get pregnant again. Adolescents are recommended to use an effective FP method of their choice *continuously* until they are 18 years of age before trying to become pregnant.

Objectives of the Technical Guidelines (TG)

- The guidelines are designed to assist family planning service providers in providing high quality client-sensitive comprehensive care for those seeking professional services for family planning.
- The guidelines will provide the basis for integrating family planning into other RH services and vice versa. The guidelines integrate the most up to date World Health Organization (WHO) medical eligibility criteria for contraceptive services.
- The TG for FP services is intended to provide a solid foundation upon which service providers can provide and improve family planning/birth spacing in South Sudan. The TG is based on the Maternal and Reproductive Health Policy of the Government of South Sudan (GOSS).

Target Users of the TG for FP Services

- All public RH service providers at all health care delivery levels, including the community level, namely:

- ⇨ Tertiary referral teaching hospitals, secondary referral hospitals, primary health care centre (PHCC), Primary Health Care Unit (PHCU).
- ⇨ Service managers and supervisors at all the different levels of health care service delivery system.

- All private sector providers:
  - ⇨ NGO run facilities.
  - ⇨ Faith-based run facilities.
  - ⇨ Individual private clinics.
  - ⇨ Semi private/Government facilities.

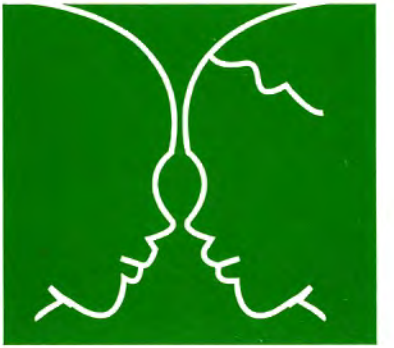
Comprehensive Peace Agreement (CPA) Implications:

- The expected population influx into the region from the South Sudanese diaspora will present challenges in providing reproductive health service (RHS) delivery and especially FP.
- The majority of the people who return will be internally displaced persons (IDPs) and refugees.
- A comprehensive population census, demographic health survey and health facility assessments will help guide future planning.
- The area of human resource development for the provision of comprehensive health services will have a bearing on service delivery, especially PHC delivery and Birth Spacing/Family Planning (BS/FP).
- The emergence of the HIV/AIDS pandemic in the last two decades, especially in Sub-Saharan Africa (SSA) will also have an impact on all health services. Though current data show a low incidence of the disease, HIV/AIDS will more than likely increase in this region.

Bearing in mind the above challenges, providing high quality services and FP will require:

- That all players recognize and embrace the challenges with the Ministry of Health (MoH) taking the lead
- The adoption of sound and evidence-based knowledge and principles of practice
- The integration and ensuring the availability of the most-up-to date information.

The FP/BS guidelines are intended to provide a solid foundation upon which service providers can provide and improve FP services. The availability of these guidelines will assist in providing services that follow national standards for quality services. By establishing quality services, more couples will be equipped to make informed decisions about FP services leading to improved health outcomes for women, children, families and the community.



CHAPTER 1

The Scope of Family Planning Service Delivery

Family Planning is a key intervention for improving the health of women, men, children and families. This is also an important component of RH and is recognized as a human right. All individuals, including those who are displaced as a result of war, have the right to access, choose, and reap the benefits of scientific progress in the selection of family planning methods. Applying a rights-based approach, consideration must include an individual client's sexual and reproductive health care needs. All the relevant information and facts must be available to the client so that she/he can make an informed choice in what FP method to use.

Many factors contribute to the gap between access to and use of services. These include: logistics; lack of adequate and relevant information; religious, socio-cultural, behavioural barriers; ability to meet the contraceptive needs and wishes of individuals and couples; and how services are organized. Successful delivery of FP services requires proper understanding of the population being served and proper coordination of all the activities that are involved with the supply chain.

The content of this chapter is best suited for service managers and supervisors to facilitate the following important activities:

1. Human resource allocation and preparation.
2. Service organization.
3. Facilitative/supportive supervision.

Counselling

Counselling is an important prerequisite for the initiation and continuation of a family planning method.

Service providers should be competent in counselling for all methods of family planning available, including natural and traditional family planning methods. There should be no special incentive or coercion

to adopt family planning or any particular method of contraception. In addition, the providers should be able to communicate with clients with respect, safeguarding confidentiality. It is critically important for all providers to be able to manage inter-personal communication skills, which allow them to convey all the information that the client and her partner/husband need to select a contraceptive of their choice. The provider also needs to be knowledgeable on all methods of contraception including traditional methods of BS/FP. Similarly, health providers should be able to rule out pregnancy among women seeking FP services through the use of simple checklists like *"how to be reasonably sure a woman is not pregnant"* in order to increase access to FP services. This will assist in safely initiating FP methods for clients at all levels of service delivery (See Appendix 1).

Family planning and HIV/AIDS service providers must always keep in mind that some of the clients seeking FP services also have HIV/AIDS service needs, and vice versa. Hence, both FP and voluntary counselling and testing (VCT) counsellors must be equipped with adequate counselling skills appropriate to both service needs. In particular, they should be prepared to counsel clients about sex and sexuality, childbearing and prevention of mother-to-child-transmission (MTCT) of HIV.

Provision of Contraceptives

Providers who work on FP should be competent enough to provide contraceptives to clients in accordance with the approved method-specific guidelines. By taking a "cafeteria" approach, they can provide clients with a wide range of methods from which to choose.

Follow-ups and Referral System

All clients who choose a family planning method must be informed of the method limitations and encouraged to visit a service delivery point (SDP) should they have any concerns or needs. Providers should follow the established referral system.

Record Keeping

All providers of FP should maintain proper records on each client and the distribution of contraceptives. NGOs and the private sector should also follow the MoH record keeping and service provision guidelines.

Supportive Supervision

Supportive supervision is an essential component of program evaluation. Supervision ensures that guidelines are being followed and needs of clients are being met. Facilitative/supportive supervision should be encouraged. Feedback mechanisms will ensure an enabling work environment that is both mutually supportive to the client and the provider. Supervision activities should extend to private sector facilities.

Logistics

Maintenance of a logistics system will help SDPs in avoiding both under-stocking and overstocking. In order to maintain quality, the SDPs must adhere to proper storage and handling of contraceptive commodities for the stipulated shelf life.

Cost Considerations

The service provider must at all time keep in mind that provision of FP services involves both financial and opportunity costs. The cost to the client includes the time taken off work to visit the SDP, as well as the

direct cost of services, including cost of the contraceptive commodity and the actual professional services. In addition to these direct costs at the SDP, there is also the cost to the national program related to procurement of commodities and consumable supplies, logistics, supervision and monitoring. Thus we cannot provide FP services without considering the client's financial circumstances. The client should know in advance what the ongoing expenses are likely to be. It should be explained that some methods may be a higher cost at the onset, e.g., IUCD and implants, however because the duration of their effectiveness is long, the unit cost per year is low. On the other hand, a less expensive method that has a shorter duration of effectiveness and therefore requires more frequent visits to the SDP (e.g., pills, injectables, and condoms) will end up having a higher yearly unit cost. If cost will impose a major hardship, then an alternative contraceptive or a means of obtaining the desired contraceptive that is less expensive should be offered. In this regard, the service provider should be prepared to discuss with the client the cost-effectiveness of the various available contraceptive methods.

Categories of Family Planning Service Providers

Different cadres of service providers can be involved in the provision of FP advice, information, and services provided they have received the necessary training and technical instruction. Similarly, FP services can be provided in varied settings: at different levels of the health care system (tertiary, secondary, primary and community levels), and within facilities operated by different providers (public, mission, private), provided they conform to the basic requirement for the provision of the particular FP method. For example, whereas condoms, spermicides and oral contraceptives can be provided anywhere, special conditions must be met before surgical methods can be provided in a health facility. The TG specifies these conditions for each method.

Many of the clients receiving VCT, antiretroviral therapy (ART) and home-based care (HBC) services also have a need for FP advice and services. A range of FP services can be provided within HIV/AIDS programs depending on the available facilities, and provider's knowledge and skills in FP counselling and methods.

Table 1.1 shows the range of FP methods that each category of service providers working in South Sudan may provide. The service providers are grouped into two main categories, clinician and non-clinician, depending on their basic training.

Table 1.1: Provision of FP by different categories of service providers

Provider Category	Condom Spermicide	Diaphragm Cervical Cap	LAM	Pill (COC, POP)	Injectable	IUCD	Implant	NFP	Tubal Ligation (TL)/ Voluntary Sterilization (VS)
Clinician (● : Can provide full services)									
Medical Doctor	●	●	●	●	●	●	●	●	●
Nurse Midwife	●	●	●	●	●	●	●	●	Can be trained
Clinical Officer	●	●	●	●	●	●	●	●	
Non-clinician (**C**: Counsel; **P**: Provide/Sell; **R**: Refer)									
Pharmacy	C, P	C, P, R	C, R	C, P	C, P, R	C, R	C, R	C, R	C, R
CBD, TBA, CHW, Peer Educator, Maternal Child Health Worker (MCHW)	C, P	C,R	C, R	C, P, R	C, R	C, R	C, R	C, R	C, R

Source: ESD Project, 2006

Linkage of Family Planning and STIs/HIV/AIDS Services

Rationale

Family planning service providers have the opportunity to discuss matters related to sex and sexual practices during counselling about FP methods. As such they should play a leading role in risk assessment, screening, diagnosis and treatment of STIs including HIV/AIDS, as well as providing clients with the information and skills needed to assess and reduce their risk of acquiring these infections.

All clients visiting FP clinics have a need for HIV/AIDS service of one type or another. They need to be assessed for HIV risk and status; they need counselling on dual protection (against pregnancy and STIs/HIV); and they need appropriate referral, e.g., to VCT centres and other treatment centres.

There are several reasons why FP and STIs/HIV/AIDS services should be linked:

- Both cater to similar clientele, women and men of reproductive age who are sexually active.
- The same providers can be oriented with minimal inputs to serve in both areas.
- FP programs are good entry points for most of the STIs/HIV/AIDS services, and vice versa. Thus, providers in both areas need to be able to assess the relevant needs of clients and to direct them accordingly.
- Integrated services ensure that hard-to-reach clients don't miss critical opportunities for a wider range of services at the point of contact. This is particularly important for men and youth.
- Integrated services can overcome the stigma of stand-alone HIV/AIDS, since FP services tend to receive more support from men.

- Integration provides an opportunity to assess and monitor the effects of FP methods on HIV/AIDS and vice versa.

Integration of FP and VCT Services

Women with HIV infection, like other women, may wish to plan a pregnancy, limit the size of their family, or avoid pregnancy. Health professionals should be able to provide these reproductive choices through counselling and provision of appropriate contraception at the time of HIV diagnosis and during follow-up. The MoH should review and formulate a policy that looks at the various levels of RH service delivery and ensure that guidelines include integrating FP into VCT and vice versa.

Where possible, FP services should be provided at the VCT site, otherwise, VCT clients should be referred for FP services. Where possible, HIV/AIDS services, especially VCT, should be provided at FP SDPs, otherwise, FP clients with HIV/AIDS needs should be referred accordingly.

Service providers including counsellors should emphasize "dual protection" as a strategy to prevent both STIs/HIV transmission and unintended pregnancy through the use of condoms alone, the use of condoms combined with other methods (dual method use), or through practicing abstinence. Counsellors need to explain to HIV positive clients the risk of mother-to-child transmission (MTCT) as well as benefits of family planning. Both men and women should be encouraged to use FP services to make informed decisions about contraceptive measures appropriate to their HIV status. FP service providers should maintain confidentiality of HIV test results and treat all FP and HIV clients with respect.

Integration of FP in VCT Services

The MoH has approved a strategy that identifies four levels of integrating of FP into VCT services, each contingent on resources available at the particular type of facility. All centres can assess risk unintended pregnancy and sexually transmitted infection, provide information and counselling on contraceptive methods, and refer clients for methods that are not available at the VCT centres.

The levels differ, however, in the methods that are provided on site:

Level I	(Community Level):	Condoms and pills.
Level II	(PHCU):	Condoms, pills, and injectables.
Level III	(PHCC):	Condoms, pills, injectables, and intrauterine devices.
Level IV	(Hospital):	A full range of contraceptive methods.

Integration of VCT into FP Services

There are two levels at which VCT can be integrated in FP services, depending on resources available and level of provider training:

Level I (PHCC):	Level II
• Risk assessment for STIs and HIV • IEC on VCT and availability of VCT centres • Referral to post-test clubs and other appropriate services	• All VCT services in Level I • Pre-and post-test counselling and testing

The Key Role of FP in PMTC

Family planning is among the core interventions for PMTCT. FP service providers should ensure that safe and effective contraception is accessible to HIV-positive women in order to help them determine future childbearing patterns, including the prevention of HIV-infected births. *The National Guidelines on Prevention of Mother-to-Child Transmission* should outline a variety of FP methods that may be used by HIV-infected women in order to avoid unplanned pregnancies. The service provider should refer to the particular section in the *Family Planning Guidelines for Service Providers* for eligibility criteria in the use of different methods by such clients.

Method Effectiveness and Safety

The ideal contraceptive would be 100 percent effective; totally safe without any limitations; affordable and available to everyone; instantly reversible; easy to use without interfering with intercourse in any way; and its use totally dependent on the client without the need to consult health providers. It is unlikely such a method will be found, hence, the two most important considerations for clients choosing a method are effectiveness and safety.

Service providers should be prepared to respond to the clients' questions regarding the effectiveness of various contraceptive methods. Appendix 2 gives estimates of the effectiveness of various contraceptive methods, based on research data, i.e., when the method is used consistently and correctly (method-effectiveness), as well as effectiveness for typical use (user-effectiveness) when the method may not always be used consistently and correctly. In practice, the effectiveness of a method largely depends on the way it is used, which in turn depends on the kind of counselling and information clients receive from service providers.

No contraceptive can be said to be 100 percent safe as defined above.

In fact, there are a variety of risks, depending on the method. First, there are the risks associated with method use, particularly in the presence of certain medical conditions. For example, how often might the method be associated with various complications (hospitalization, loss of fertility, infection, etc.)? Secondly, there are potential risks in terms of inconvenience. Does the method interfere with sexual intercourse; make it less pleasant, or even unpleasant? Is there great expense involved or lost time from work? Finally, there are risks associated with pregnancy should the method fail. How often does pregnancy occur? What are the dangers of pregnancy to the woman, etc.? Appendix 3 shows medical conditions that expose a woman to increased risk as a result of unintended pregnancy. Women with these conditions should be counselled to choose contraceptive methods that are known to be effective in preventing pregnancy.

Return to Fertility

The use of contraceptive methods, with the exception of male and female surgical contraception, does not result in an irreversible change in fertility. Return to fertility is prompt with all methods, with the exception of DMPA and NET-EN. The median delay in return to fertility with DMPA and NET-EN is 10 and 6 months respectively, from the date of the last injection, regardless of the duration of their use. Male and female surgical contraception should be regarded as permanent, and all individuals and couples considering these methods should be counselled accordingly. No other methods result in permanent fertility.

Drug Interaction and Hormonal Contraception

Both components of the combined oral contraceptives (COCs), oestrogen and progestin, are metabolized in the liver. Some drugs, through effects on the liver enzymes, increase or reduce the metabolism of these hormones and thereby interfere with their

contraceptive efficacy. Similarly, some anti-epileptics, anti-TB drugs, anti-fungals and certain ARVs, as shown in Table 1.2 can affect the efficacy of hormonal contraceptives. contraceptive efficacy. Similarly, some anti-epileptics, anti-TB drugs, anti-fungals and certain ARVs, as shown in Table 1.2 can affect the efficacy of hormonal contraceptives.

Table 1.2: Drugs that May Reduce Efficacy of Hormonal Contraceptives

Condition	Drugs Known to Reduce Efficacy of Hormonal Contraceptives
Epilepsy	Phenytoin, Carbamazepine, Barbiturates, Primidone, Topiramate and Oxcarbazepine
Fungal Infection	Griseofulvin
Tuberculosis	Rifampicin
AIDS	Nevirapine, Ritonavir, Nelfinavir, Lopinavir with Ritonavir

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

The WHO Medical Eligibility Criteria (MEC) and Their Application to Southern Sudan

The WHO Scientific Working Group, after periodic review of the latest scientific information on safety of contraceptive methods, makes recommendations on criteria for their use in different situations. WHO groups medical conditions into four categories as follows:

1. Conditions with no restriction on the use of the contraceptive method.

2. Conditions where advantages of the method generally outweigh the theoretical or proven risks. The method can generally be used, but careful follow-up may be required.
3. Conditions where theoretical or proven risks usually outweigh the advantages of the method. Use of method is not usually recommended unless other more appropriate methods are not available or not acceptable.
4. Conditions which present an unacceptable health risk if the contraceptive method is used. Method should not be used.

However, considering that FP services will be provided in diverse settings with differing resource availability and level of provider training and skills, the eligibility criteria have been adapted to the local situation. Simplified WHO categories for situations when clinical judgment is limited are defined as follows:

"Use the method" (for WHO categories 1 and 2) and
"Do not use the method" (for WHO categories 3 and 4).

In this Technical Guidelines for FP services in Southern Sudan, the conditions listed under "Who can use the method" correspond to WHO's category 1, i.e., conditions with no restriction on the use of the contraceptive method. The conditions listed under "Use with care" would fall under WHO category 2, conditions where advantages of using the FP method generally outweigh the theoretical or proven risks to the client. In this case the method can generally be used, but careful follow-up may be required. However, as stated earlier, in the Southern Sudan context this approach is not applicable and some level of clinical judgment is required for provision of a contraceptive method to clients with category 2 conditions. Some category 2 conditions also require evaluation prior to initiation of the method.

Table 1.4 shows an adaptation of the WHO MEC categories for use in the Southern Sudan setting. Table 1.5 gives an example of a woman

with uncomplicated diabetes who chooses to use oral contraceptive pills. Whereas a clinician will generally provide the method to such a client, it is expected that the CBD agent will instead refer the client, providing the pill to such a client only after a clinician has assessed her. Table 1:6 gives the WHO MEC categories and provider actions for female and male surgical contraception.

Table 1.3: Categories of Medical Eligibility Criteria for Temporary Methods

WHO Category	Where clinical judgment is possible	Where clinical judgment is not possible or is limited
1	♦ Method can be used under any circumstances	♦ Method can be used under any circumstances ♦ Use the method
2	♦ Generally use the method with care	♦ Use the method with care or refer
3	♦ Method should not be used unless a clinician makes a clinical judgment that the method can be used by the client safely	♦ Do not use the method
4	♦ Method should not be used ♦ The condition represents an unacceptable health risk if method is used	♦ Do not use the method

Adapted from: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Table 1.4: Example of Actions by Service Providers in Relation to MEC Category 2 Conditions

Situation	Clinical judgment possible	Clinical judgment not possible or is limited (e.g., CBD)
Woman with uncomplicated diabetes chooses COC pill	♦Generally provide ♦Advise follow-up	♦Refer for assessment before initiating method ♦Re-supply clients that have been assessed ♦Advise follow-up

Adapted from: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Table 1.5: WHO Category for Female and Male Surgical Contraception

WHO Category	Definition
Accept	♦No medical reason prevents performing the procedure in a routine setting.
Caution	♦The procedure can be performed in a routine setting but with **extra preparation and precautions.**
Delay	♦**Delay the procedure.** Condition must be treated and resolved before the procedure can be performed. Provide temporary methods in meantime.
Refer (Special)	♦Refer client to a centre where an experienced surgeon and staff can perform the procedure. Setting should be equipped for general anaesthesia and other medical support. Provide temporary methods in meantime.

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

CHAPTER 2

Quality of Care For Family Planning Services

Quality of Care

Service providers at all levels, whether public, mission or private, must at all times seek to provide quality services. Deficient quality reduces the benefit to clients and contributes to waste of scarce health resources.

To provide good quality care, service providers should:

- Inform clients about the methods available: how they work, the advantages, limitations, side effects, how to use them, re-supply and the importance of follow-up.
- Avoid long waiting times for clients.
- Maintain clean SDPs with well-organized client flow; at the minimum, services should be provided during normal working hours.
- Maintain an adequate supply of contraceptives.
- Provide individualized care.
- Maintain privacy and treat all clients with respect and dignity.
- Service providers should be trained and given regular technical updates.

Service managers should:

- Establish an effective supervision system.
- Ensure regular support supervision of clinical services.
- Facilitate services for special groups with special needs such as adolescents, displaced persons, postpartum women, among others.

Successful FP programs require well-trained staff, who exhibit:

- Care, sensitivity and thoroughness in informing the client about the FP method and allowing the client to make an informed choice.

- Adequate knowledge, positive attitudes and proper skills for providing family planning services.
- Knowledge of and ability to recognize real or potential problems.
- Capability to make good clinical judgments and to take appropriate clinical action in response to problems, including knowing when and where to refer clients.

Values and Attitudes

It is important to recognize that as health service providers, our beliefs and attitudes can affect the way we interact with clients. Everyone has a right to her or his own beliefs. However, health care providers have a professional obligation to provide care in a respectful and non-judgmental manner. The health provider should be competent in the counselling process and remember basic counselling skills, using the counselling process and good communication skills. Every interaction between health care staff and clients, from the moment they enter the health care setting until they leave, affects their:

- Willingness to trust and to share personal information and concerns.
- Ability to listen and retain important information.
- Capacity to make decisions that accurately reflect their situation, needs and concerns.
- Commitment to adopt new positive health-related behaviours.

Counselling

Counselling is a vital part of reproductive health care. It supports clients to:

- Arrive at an informed choice of reproductive options.
- Select a contraceptive method with which they are satisfied.
- Use the chosen method safely, continuously and effectively.

Who Should Provide Counselling?

Information and counselling will commonly come from more than one source. This includes all service providers trained in FP counselling who must therefore be knowledgeable about all available contraceptive methods.

Essentials of a Good Counsellor

A good counsellor:

- Understands and respects the client's rights.
- Earns the client's trust.
- Understands the benefits and limitations of all contraceptive methods.
- Understands the cultural and emotional factors that affect a client's (or a couple's) decision to use a particular contraceptive method.
- Encourages the client to ask questions.
- Uses a non-judgmental approach which shows respect and kindness to the client.
- Presents information in an unbiased client-sensitive manner.
- Actively listens to the client's concerns.
- Understands the effect of non-verbal communication.
- Recognizes when she/he cannot sufficiently help a client and refers the client to someone who can.

To be effective, counselling must be based on the establishment of trust and respect between the client and counsellor. In serving clients it is important to remember that they have:

- The right to decide whether or not to practice family planning.
- The freedom to choose which method to use.
- The right to privacy and confidentiality.

- The right to refuse any type of examination.
- The freedom to choose where to seek services.

Also, while many contraceptive methods are highly effective, method failure can occur. Clients should be informed of the failure rate of the different contraceptive options in order for her/him/couple to make an informed choice. In case of method failure, the client should be counselled, informed about the options available and referred for appropriate services.

The Counselling Process

In discussing contraceptive options with clients, service providers should briefly review all available methods, even if a client knows which method she/he wants.

Service providers should be aware of a number of factors about each client that may be important, depending on the method in question. These are:

- Reproductive goals of the women or couple (spacing or timing of births).
- Personal factors including the time, travel costs, pain or discomfort likely to be experienced.
- Accessibility and availability of other products which are necessary to use the method effectively.
- The need for protection against STIs and HIV.

Steps in Family Planning Counselling

The provision of counselling should be part of every interaction with the client. Counselling can be divided into three phases:

1. Initial counselling	At reception (all methods are described and the client is helped to choose the method appropriate for him/her).
2. Method -Specific counselling	Prior to and immediately following service provision (the client is given instructions on how to use the method and the benefits and limitations of the method. The client is informed on the follow-up schedule.
3. Follow-up counselling	During the return visit, use of the method, satisfaction and any problem that may have occurred are discussed.

Within the context of HIV/AIDS, family planning counselling should address the following concerns:

- Whether or not the FP method protects against STIs, including HIV.
- Reassurance of safety of the FP method when used by an HIV positive person.
- Interactions/contra-indications between contraceptive methods and some drugs used in treatment of HIV/AIDS, including ARVs, as well as anti-TB and anti-fungal drugs.

Client Assessment

Objectives of Client Assessment

- The primary objectives of assessing clients prior to providing family planning services are to determine:
- That the client is not pregnant.
- Whether many conditions requiring additional care exist for a particular method.
- Whether there are any special problems that require further assessment, treatment, regular follow-up or referral.

- Whether there are needs for HIV/AIDS services, i.e., whether to provide these or to arrange for appropriate referral.

Client Assessment Process

This usually can be accomplished by asking a few key questions by a skilled provider. Unless specific problems are suspected, the safe provision of most contraceptive methods, except IUCDs and voluntary surgical contraception, does not require performing a physical or pelvic examination.

Where resources are limited, requiring medical evaluation and/or laboratory testing (e.g., blood sugar and haemoglobin) before providing modern contraceptive methods are not justifiable. Where demand for family planning services is high, medical requirements are not essential to the provision of specific contraceptives and may act as a major barrier to contraceptive choice and access to services. To enable clients to obtain the contraceptive method of their choice, only procedures that are essential and mandatory for all clients in all settings should be required.

With the exception of male and female condom (as well as diaphragm and cervical cap to a lesser degree), no contraceptive method provides protection against STIs (including HIV and hepatitis B). All clients should be made aware of the risks of STI transmission.

How to Be Reasonably Sure a Woman is Not Pregnant (See Appendix 1.)

You can be reasonably sure a client is not pregnant if she has no signs or symptoms of pregnancy (e.g., breast tenderness or nausea) and:

- Has not had intercourse since her last menstrual period; or

- Has been correctly and consistently using another reliable contraceptive method; or
- Is within the first 7 days after the start of her menses (days 1-7);
- Is within 4 weeks post-partum (for non-breastfeeding women);
- Is within the first 7 days post-abortion; or
- Is fully breast-feeding, less than 6 months post-partum and has no menstrual bleeding.

Pelvic examination is seldom necessary, except to rule out pregnancy of more than 6 weeks, measured from last menstrual period (LMP).

Pregnancy testing is not essential except in cases where:

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

In these situations a sensitive urine pregnancy test or ultrasound scan may be helpful, if readily available and affordable. If pregnancy testing is not available, counsel the client to use barrier methods or abstain from intercourse until her menses occur or pregnancy is confirmed.

Client Screening for STIs and HIV

Family planning service providers have a responsibility to assess the risk of STIs and HIV/AIDS in all clients seeking FP services. In most cases, effective screening does not require the use of complicated clinical or laboratory investigations. It is essential that service providers:

- Be knowledgeable about high-risk sexual practices and behaviours.

- Be aware of the signs and symptoms of common STIs.
- Be aware of the common STIs in the client population they serve and carefully evaluate clients in whom STIs are suspected based on their medical history or physical examination findings.
- Be familiar with the current protocols for treatment of common STIs.
- Know where to refer clients who require a higher level of care.

Questions for STIs Screening History

- Do you have a vaginal discharge that is especially unusual for you?
- In the previous year, have you had a genital tract problem, such as an unusual vaginal discharge, ulcers or skin lesions in your genital area?
- Has your sex partner been treated for a genital tract problem, such as discharge from the penis or swollen groin glands, in the last three months?Do y
- Do you know or think your sex partner has other sex partners?
- Are you or your partner in a profession that puts you at a high risk (e.g., commercial sex worker, long distance truck driver)?
- Have you had more than one sex partner in the last two months?
- Do you think that you might have a STI?

Note:

- All persons at risk for getting infected with STIs (see above) are also at risk of getting infected with HIV. HIV/AIDS is largely a sexually transmitted disease.
- A person with a history of blood transfusion should be encouraged to take an HIV test.

- A person who does not look sick can still be infected with HIV and pass it on to others.

Special Population

Medical eligibility criteria address contraceptive use by clients with specific medical conditions and needs. In addition, contraceptive provision to clients with special needs requires further consideration. Individuals with a physical disability represent such a group. Decisions on appropriate contraception must take into account the nature of the disability, the expressed desires of the individual, the nature of the disability, and the nature of the method. Decisions must be based on informed choice. Similar considerations should be given to individuals with a mental disability or with a serious psychiatric disease. Where the nature of the condition does not allow for informed choice, contraceptives should be provided only after full discussion with all parties including guardian or care-givers. The reproductive rights of the individual must be considered in any such decisions.

Adolescents

Adolescents are defined as persons aged 10-19 while youths are defined by WHO as persons aged 10-24 years. Among the strategic actions identified globally for promotion of adolescent and youth health is to safeguard their reproductive rights, including their right to appropriate and relevant information and services. Denial of reproductive health services to young people negatively affects their general well-being.

Adolescents lack knowledge about what services are available and how to access them. Adolescents give high priority to confidentiality. This may be more important than seeking treatment. They are put off if the services are far away or are expensive. They will not use services if they have to interact with "unfriendly" staff or those with poorly

trained staff.

In order to improve the utilization of health services by adolescents, efforts must be made to address factors that affect accessibility and quality of care, such as provider attitudes, privacy, confidentiality and working hours of service. Service providers should adopt positive attitudes when dealing with adolescents and youth, and should ensure their easy access to the range of services they need, including family planning information, counselling and services. Adolescents, in need for contraceptive services can safely use most of the temporary methods included in these guidelines.

Adolescent friendly health services require:

- Health care providers who are technically competent; have good interpersonal and communication skills; are motivated and supported; are non-judgmental and considerate; treat all clients with equal respect; provide information and support to enable each adolescent to make her/his correct free choices.
- Health facilities that provide a safe environment at a convenient location; have convenient working hours; offer privacy and avoid stigma; provide information and education material.
- Effective health services for adolescents that are guided by evidence-based protocols and guidelines; have supplies and basic services necessary to deliver the essential health care package; have a process of quality improvement to create and maintain a culture of supportive staff.
- Adolescent involvement so they are well informed about services and their rights; are involved in service assessment and provision.
- Community involvement and dialogue to encourage parental and community support.
- Community based, outreach and peer-to-peer services to increase coverage and accessibility for adolescents.

Returning Refugees and Internally Displaced Persons

During return and reintegration into their home communities, women and girls are exposed to increased reproductive health risks. If the destinations of returning migrant populations do not provide adequate reproductive healthcare services, this can result in high rates of unwanted pregnancy, unsafe abortion, and preventable death and injury as a result of pregnancy and childbirth as well as heightened exposure to sexual violence.

There are many challenges to the provision of RH services in post-conflict settings. Planning for the provision must take into consideration the comparability of services within the camp versus those of the host community or community of origin, and what this means for returning population. The challenges of transferring standards of reproductive health services and care to local NGOs and/or service providers in the area of return are coupled with the complications of ensuring that women can maintain access to family planning methods (condoms, the pill, IUDs, etc.). Gender based violence is a cause and consequence of displacement that remains a continued threat as women and girls make their way home. HIV/AIDS is a primary concern for any RH program working in a sexually active population with little to no knowledge of the disease, polygamous relationships, no condoms or acceptance of them, now facing a large-scale return of people from high-prevalence countries.

A community-based approach which provides services equally to returning refugees and displaced persons, as well as those that remained during the conflict has the advantage of reducing the vulnerability of entire communities and helping to eliminate feelings of resentment and divisions.

The most cost-effective and efficient way to increase RH/FP access to the population of Southern Sudan, considering the low level of infrastructure and human capacity, will be to focus on developing strong primary health care services and integration of RH system in primary health care system. Community based activities are an essential component to its sustainability such as community based contraceptive distribution. There is also a need to increase community awareness about the benefits of FP focusing including timing and spacing.

Gender Based Violence

- Implement awareness-raising through BCC to both advocate for legal mechanisms to protect women and to change the shroud of silence and shame that surrounds the issue.
- Ensure established protocols for the medical management of rape survivors.

Family Planning

- Develop a roster of all relevant healthcare workers in the regions where refugees and internally displaced people are likely to be resettled and ensure that they are all provided with training on reproductive health, especially safe motherhood.
- Planning for the provision must take into consideration the comparability of services within the camp versus those of the host community or community of origin, and what this means for returning populations. The challenges of transferring standards of reproductive health services and care to local NGOs and/or service providers in the area of return are coupled with the complications of ensuring that women can maintain access to family planning methods (condoms, the pill, IUDs, etc.).

- Link all family planning programs with all sectors of reproductive health and primary health care.
- A security plan must be developed by the MOH in collaboration with local NGOs, and international agencies working in the area to ensure constant and sustainable FP supply provision.
- Improve quality of FP services by ensuring an expanded method mix.
- Provide counseling for couple or women on FP methods suitable for suitable for their lifestyle and situation.
- Provide FP counseling during post abortion care services.
- Establish resources and facilities to train village health workers.
- Include men's involvement in safe motherhood in programming design.

STIs/AIDS

- HIV/AIDS information and education programs should stress the need for people with HIV/AIDS to be integrated within the community, as well as how to prevent and manage HIV/AIDS
- Integrate access to counseling and other services at the village level HIV/AIDS programs with other RH/FP and PHC services.
- An increased focus on men and boys should be incorporated so that they may become effective behavior change and prevention agents.
- Returnees can also play an important role in educating the staying population about HIV/AIDS as they often have potentially higher levels of knowledge about the disease from their time living in refugee camps or other settings.
- Improve staff capacity to diagnose and treat STIs using the syndromic approach
- Ensure a continuous supply of essential drugs for treating STIs

Services for Clients Based on Their HIV Status

Knowledge about and guidance on "dual protection" practices, with emphasis on abstinence or the consistent and correct use of condoms are important information for the client as the most effective means of protection against HIV. In this regard appropriate counselling messages depend on the HIV status of the client or couple, as suggested in Table 1:3.

Table 2.1: Key Counselling Messages Based on Clients' HIV Status

HIV Status of Couple	Key Counselling Messages and Emphases
Concordant HIV-negative	"Effective contraception" "Be faithful"
Discordant(one partner HIV-positive	"Effective contraception" "Use of condoms" "Get treatment medical care and
Concordant HIV-positive	"Effective contraception" "Be faithful" Use condoms to avoid re-infection with new HIV variants" Get medical care and support

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Both VCT and FP counsellors must be equipped to counsel clients about sex and sexuality, childbearing and prevention of MTCT HIV. The possibility or reality of a positive HIV test makes VCT counselling emotionally charged. Hence, counsellors need to be equipped to address clients' feelings and emotions about HIV.

Infection Prevention

Infection prevention prevents disease carrying agents from being transmitted from where the agents live (reservoir) to human beings and hence cause disease. In FP every effort should be made to break the disease transmission cycle during the process of providing the services. Infection prevention requires that standard precaution procedures are followed. There are two primary objectives in RH infection prevention:

- To prevent major postoperative infections when providing clinical contraceptive methods (e.g., IUCDs, injectables, implants, and male and female voluntary sterilization);
- To prevent the transmission of serious diseases such as hepatitis B and AIDS not only to clients but also to service providers and staff, including cleaning and housekeeping personnel.

In the following sections, the recommended infection prevention practices are based on the following principles:

Consider every person	(Client or staff) potentially infectious.
Wash hands	The most practical procedure for preventing cross-contamination (person to person). Where there is no running/tap water, a bucket with a tap or a pouring container will serve equally well. Antiseptic rubs can also be prepared from locally available materials (See Appendix 4).
Wear gloves	Before touching anything wet, such as broken skin, mucous membranes, blood or other bloody fluids (secretions or excretions), or soiled instruments and other items.

Use safe work practices,	Such as not recapping or bending needles, safely passing sharp instruments and properly disposing of medical waste.
Isolate patients	Only if secretions (air borne) or excretions (urine or faeces) cannot be contained.
Process instruments for re-use:	The providers should be familiar with the steps of processing instruments for reuse namely: decontamination, cleaning, high level disinfection by use of boiling or steaming methods and chemicals, sterilization and storage.
Safe waste disposal:	All waste that is from the health facility including any sharp instruments, body tissues and disposable supplies.
Post exposure HIV prophylaxis.	

Hand Washing

- Wash hands before and after examining every client (direct contact).
- Wash hands after removing gloves because the gloves may have holes in them.
- Wash hands after exposure to blood or any other body fluids (secretions and excretions), even if gloves were worn. Supplies needed for hand washing are running water which must be clean, soap, and a clean dry towel.
- Remove all jewellery from both hands.

Experience has shown that the most effective way to increase hand washing is to have senior health workers or other respected

individuals (role models) consistently wash their hands and encourage others to do the same.

The Supervisor should work with facility management to ensure provision of soap, detergents and continued supply of clean water.

Gloves

Wear gloves:

- All health providers should perfect the techniques of wearing gloves.
- When performing a procedure in the clinic or operating room.
- When handling soiled instruments, gloves and other items.
- When disposing of contaminated waste items (cotton, gauze or dressing).

A separate pair of gloves must be used for each client to avoid cross-contamination.

Who are Likely to Get Needle Stick Injuries?

- **Needles in theatre most often stick surgeons** by the surgeons accidentally sticking themselves during suturing.
- **Needles in hospitals most often stick nurses** by nurses accidentally sticking themselves while handling hypodermic needles and syringes or being accidentally stuck by surgeons.
- **Cleaning staff** are most often stuck by needles when processing soiled instruments.
- **Housekeeping staff** are most often stuck by needles when disposing of waste material.

How to Handle Hypodermic Needles, Scissors and Other Sharp Items

Operating Room

Use a kidney dish (safe zone) to carry and pass sharp items (e.g., pass suture needles on a needle holder).

- Do not leave sharp instruments in places other than safe zones.
- Warn others before passing them sharp items.

Safety Tips When Using Hypodermic Needles and Syringes

- Use each needle and syringe only once.
- Do not disassemble needle and syringe after use.
- Do not recap, bend or break needles prior to disposal.
- Decontaminate needle and syringe prior to disposal.
- Dispose of needle and syringe in a puncture-proof container.
- Make hypodermic needles unusable by burning them.

Note

Where recapping is necessary, use the "one-handed" (none touch) recap method:

- First, place the cap on a hard, flat surface; then remove hand.
- Next, with one hand, hold the syringe and use the needle to "scoop up" the cap.
- Finally, when the cap covers the needle completely, hold the needle at the base near the hub and use the other hand to secure the cap on the needle.

How to Withdraw Medication from a Sterile Multidose Vial

- Wipe the top of the vial with a cotton swab soaked in 60-90 percent alcohol or other locally available disinfectant. Allow it to dry.
- If using a new disposable needle and syringe, open the sterile pack.
- If using a sterile or high-level disinfected needle and syringe, remove from covered container using dry sterile or high-level disinfected forceps.

  Never use a syringe for more than one injection. Studies have shown that changing only the needle, not the syringe, between clients can result in transmission of hepatitis B virus and HIV/AIDS.

- Attach needle to syringe by holding the hub (base) of the needle and the barrel of the syringe.
- Turn the vial containing the drug upside down and draw the fluid into syringe using the same needle you will use for the injection.
- Withdraw needle from the vial.

Do not leave a needle inserted in the rubber stopper of a multiple-dose vial. This practice is dangerous because it provides a direct route for bacteria to enter the drug vial and contaminate the fluid between each use.

Post Exposure Prophylaxis

Refer to the National AIDS Control Council protocols for Southern Sudan for details on post exposure prophylaxis.

Waste Disposal

The purpose of waste disposal is:

- To prevent the spread of infection to clinic personnel who handle the waste.
- To prevent the spread of infection to the environment and local community.
- To protect those who handle waste from accidental injury.Prevent cross infection in the health facility.

Medical waste may be non-contaminated or contaminated. Non-contaminated waste (e.g., paper from office boxes) poses no infectious risks and can be disposed of according to local guidelines. Proper handling of contaminated wastes (blood or And can be disposed of according to local guidelines. Proper handling of contaminated wastes (blood or body fluid contaminated items) is required to minimize the spread of infection to clinic personnel and to the local community. Proper handling means:

- Wearing utility gloves.
- Transporting solid contaminated wastes to the disposal site in covered containers.
- Disposing of all sharp items in puncture-resistant containers
- Carefully pouring liquid waste down a utility drain or pit latrine.
- Burning or burying contaminated solid waste.
- Decontaminating utility gloves and any containers used.
- Washing hands.

Prevention of STIs, including HIV/AIDS and Hepatitis B

- Service providers should ensure clients receive information on modes of transmission, especially the risk of contracting STIs and HIV/AIDS through high-risk sexual behaviour.

- Service providers should ensure clients receive information on modes of transmission, especially the risk of contracting STIs and HIV/AIDS through high-risk sexual behaviour.
- Service providers should encourage the use of condoms and other barrier methods for clients who are at risk of acquiring STIs even when they are using other methods of family planning.
- Trained FP service providers at the SDP can offer STI treatment using the syndromic treatment approach.
- Service providers offering treatment should follow contact-tracing guidelines.
- Community health workers and TBAs should be trained to recognize STIs, ophthalmia neonatorum and refer.
- All clients should be educated about:
  - ⇨ High-risk sexual behaviours.
  - ⇨ The protective benefits of male and female condoms and the limitations.
  - ⇨ The need to have the sex partner(s) evaluated and treated if a client is found to have an STI.
  - ⇨ The importance of knowing one's HIV status and information on where VCT services may be obtained. Service providers should encourage the use of condoms and other barrier methods for clients who are at risk of acquiring STIs even when they are using other methods of family planning.
- Trained FP service providers at the SDP can offer STI treatment using the syndromic treatment approach.
- Service providers offering treatment should follow contact-tracing guidelines.
- Community health workers and TBAs should be trained to recognize STIs, ophthalmia neonatorum and refer.
- All clients should be educated about:
  - ⇨ High-risk sexual behaviours.
  - ⇨ The protective benefits of male and female condoms and the limitations.

- The need to have the sex partner(s) evaluated and treated if a client is found to have an STI.
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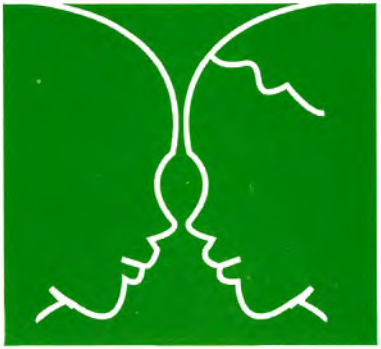
- The importance of knowing one's HIV status and information on where VCT services may be obtained.

Notes



CHAPTER 3

Lactational Amenorrhea Method (LAM)

Lactational Amenorrhea Method (LAM)

Q What is LAM?

LAM is a temporary method of family planning based on the lack of ovulation resulting from exclusive breastfeeding. It is used during the first 6 months postpartum only when fertility is low and the infant is fed solely on breast milk. LAM is an effective method. The pregnancy rate is about 2 percent for those who exclusively use this method in the first 6 months. When used correctly (i.e., all LAM criteria are met), the pregnancy rate is 0.5 percent (See Appendix 2).

LAM is defined by three criteria:

1. The woman's menstrual periods have not resumed, AND
2. The baby is exclusively or nearly exclusively breastfed, AND
3. The baby is less than 6 months old.

When any one of these 3 criteria is no longer met, another FP method must be introduced in a timely manner to accomplish healthy timing and spacing of pregnancy.

Advantages

Contraceptive Benefits:	*Other Benefits:*
• Protection against pregnancy as long as all three LAM criteria are met • Does not interfere with sexual activity	• Breastfeeding provides passive immunization for the child • Decreases exposure of infants to pathogens in water or other milk • Best source of nutrition for infants • Affordable no direct cost for family planning • Counselling for LAM encourages starting a follow-on method at the proper time

Limitations

- Effective only as long as all 3 LAM criteria are met. However, there are a number of reasons that can make a woman choose not to breastfeed:
  - ⇨ Breastfeeding can transmit HIV from mother to her baby
  - ⇨ A woman may not breastfeed because she is taking certain drugs (e.g., mood altering drugs, reserpine, ergotamine, antimetabolites, cyclosporine, cortisone, bromocryptine, radioactive drugs, lithium, or certain anticoagulants)
  - ⇨ Exclusive breastfeeding may be inconvenient or difficult for some women, especially working mothers.
- Does not protect against STIs including Hepatitis B, HIV/AIDS and therefore may be used with a barrier method to protect individuals from these diseases.

Who Can Use LAM

Women whose babies are less than 6 months old, who are exclusively breastfeeding, and who are amenorrhoeic.

Note:

Counsel woman in advance about future contraceptive options and to initiate another method as soon as:

- Supplementary feeding begins (or baby starts to skip his/her regular meals, e.g., sleeps through the night).
- Menstruation begins, or
- Baby is about to turn 6 months old.

Who Should Not Use LAM

- Women who are not breastfeeding at all or not exclusively for the first 6 months postpartum.
- Women with resumed menses.
- Where the baby is more than 6 months old.
- Couples who want highly effective protection against pregnancy; or where the woman has conditions that make pregnancy dangerous (See Appendix 3).

Who Can Provide	Where It Can Be Provided
All trained providers including community health workers.	Any appropriate site with qualified providers.

CHAPTER 4

Natural Family Planning (NFP)

Natural Family Planning (NFP)

Q What Is Natural Family Planning?

Natural family planning, also called fertility awareness, and periodic abstinence, is the practice of abstaining from intercourse during the fertile time. The fertile period is recognized through various ways such as checking physiological cervical mucus changes (Billings or cervical mucus method), measuring changes in body temperature (Basal body temperature method BBT), a combination of these two (Sympto-thermal method), changes in the feel of the cervix, calendar, calendar calculation, or a combination of several of these for more accurate identification of the fertile time.

Couples who choose to use fertility awareness methods usually need personal guidance from a trained counsellor, usually over several months. During this time the couple must use another method or avoid intercourse. Once trained, a woman or couple can begin using fertility awareness-based techniques at any time.

NFP methods are only somewhat effective. A 20 percent pregnancy rate occurs in the first year for typical users of most NFP methods; this can reduce to 1- 9 percent with the consistent and correct use of the method.

Types of Natural Family Planning

Cervical Mucus or Billings Ovulation Method

In this method, the woman identifies the fertile time by the increasing amounts of cervical mucus. She may feel wetness at the opening of her vagina or see mucus on her finger, underpants or tissue paper. The mucus has a peak day, when it is most slippery, stretchy, and wet. The

woman is instructed that as soon as she notices any mucus, the couple should avoid sex, use a barrier method or use withdrawal, until 4 days after the peak day.

Basal Body Temperature (BBT)

In this method, the woman is taught how to take her body temperature either orally, rectally or vaginally, at the same time each morning before getting out of bed. The temperature readings are recorded on a special graph paper. The woman's temperature rises by 0.2°C-0.5°C, around the time of ovulation (about midway through the menstrual cycle for many women). The couple is instructed to abstain from sex, use a barrier method or withdrawal from the first day of menstrual bleeding until the woman's temperature has risen above her regular readings and stays up for a full 3 days, thereby ensuring that ovulation has occurred and passed. After this period, the couple can have unprotected sex (over the next 10 to 12 days) until her next menstrual bleeding begins.

Cervical Mucus + BBT (Sympto-thermal Method)

Quite often users of fertility awareness methods identify fertile and infertile days by combining BBT and cervical mucus observations and often, other signs and symptoms of ovulation, such as abdominal pain, cervical changes and breast tenderness. The couple starts avoiding sex or uses a barrier method or withdrawal from the first day of menstrual bleeding, until the fourth day after the peak cervical mucus and the third full day after the rise of the BBT. If one of these events happens without the other, the couple waits for the other event before having unprotected sex.

Calendar or Rhythm Method

The calendar method is used to identify start and end of the fertile time.

Before starting to use the calendar method, however, a woman must record the length of her menstrual cycles for at least 6 months. The first day of the menstrual bleeding is always counted as day 1.

- To estimate the first day of the fertile time, subtract 18 days from the length of the shortest recorded cycle.
- To estimate the last day of the fertile time, subtract 11 days from the length of the longest recorded cycle.

The couple avoids sexual intercourse, uses a barrier method or withdrawal during the fertile time. The calendar method may require 16 days or more in a row of avoiding sex or using withdrawal or a barrier method in each cycle, especially for women with irregular menstrual cycles. This much abstinence may be too restrictive for some couples.

The Standard Days Method (SDM)

This natural method of family planning was developed though scientific analysis of the fertile time in the woman's menstrual cycle. To prevent pregnancy, the couple abstains from sex, uses a barrier method or withdrawal on days 8 to 19 of the cycle- a formula based on computer analysis of thousands of menstrual cycles. Studies on its efficacy show that SDM is more than 95 percent effective with correct use and more than 88 percent with typical use, among women who have regular cycles of 26 32 days length. This is similar to the efficacy of most other user-dependent methods. The use of SDM is facilitated by the CycleBeads, a colour-coded string of beads that represent the days of the cycle. It helps the woman track her cycle days, know which days she is fertile, and to monitor the length of her cycle.

The SDM is less effective for women who have cycles outside the 26-32 days range. Breastfeeding women or those who are using or recently have used contraceptive injectables need to wait a few cycles before they can use SDM.

Advantages

Contraceptive Benefit	*Other Benefits*
• No physical side effects.	• Free. • No need for prescriptions by a medical person. • Improved knowledge of the reproductive system and possible close relationship between couples.

Limitations

- Low effectiveness.
- Requires daily record keeping.
- Long period of training required before use of the method.
- Requires varying periods of sexual abstinence during fertile phase.
- Requires active cooperation of both partners.

Who Can Use NFP Method

- All clients of reproductive age.
- Women with regular menstrual cycles.
- Couples willing to abstain from intercourse or use condoms for more than one week during each cycle.
- Couples who are able to maintain effective events records.

Who Should Not Use NFP Method

- Women with irregular or not well established cycles (e.g., around menarche and peri-menopausal periods)
- Women who dislike touching their genital area
- Women whose partners will not cooperate
- Couples who want highly effective protection against pregnancy; where the woman has conditions that can be made worse by pregnancy (See Appendix 3)

Who Can Provide	Where It Can Be Provided
Trained health professionals and lay persons.	At any appropriate site with a qualified service provider.

Withdrawal (Coitus Interruptus) Methods

Q What is Coitus Interruptus?

Coitus interruptus is one of the traditional methods of birth control. A couple using this method may have intercourse in any way acceptable to them until ejaculation is about to occur, at which point the male withdraws his penis from the vagina and external genitalia of the female, in order to prevent sperm from entering woman's reproductive tract.

The advantage of the withdrawal method over others is that it requires no devices, involves no chemicals, is available at no cost and it can be used any time. However, it has one strong disadvantage: the method demands consistent self-control on the part of the male partner, which may be lacking at times. In addition, there is the possibility that pre-ejaculatory fluid containing sperm may flow out during the excitement phase, before the penis is withdrawn. The failure rate of withdrawal ranges from 4 10 pregnancies per 100 women per year (when used conscientiously) to 14-23 pregnancies per 100 women per year among actual users.

Lack of ejaculatory control (or premature ejaculation) is a contraindication to the use of the withdrawal method of birth control.

Notes

CHAPTER 5

Hormonal Contraceptive Methods

Q What are hormonal contraceptive methods?

These are methods containing synthetic hormones (e.g., oestrogen, progestin, or a combination of both hormones), which primarily work through prevention of ovulation or by making the cervical mucus too thick for sperm penetration. They are very effective contraceptive methods but vary in terms of limitations associated with their use. Oestrogen-containing methods are not advisable in women who are breastfeeding because they can suppress lactation. On the other hand, progestin-only methods do not suppress lactation and are ideal for the breastfeeding mother. It is generally recommended that initiation of progestin-only contraceptives be delayed up to 6 weeks postpartum, because there is inadequate knowledge on the effects on infants of these hormones, which are secreted in breast milk.

Oestrogen-containing methods are not advisable for women who have risk factors for cardiovascular disease (CVD), but these women may use progestin-only methods if careful monitoring and care are available. Some progestin-only contraceptives may increase the risk of thrombosis, although this increase is substantially less than with the combined oral contraceptive pill.

Hormonal methods do not protect against STIs, including Hepatitis B and HIV. Therefore, individuals at risk should use a barrier method for dual protection against pregnancy and STIs.

Methods commonly available in Southern Sudan:	Methods not available in Southern Sudan:
• Combined oral contraceptive pill (COC). • Progestin-only contraceptive pill (POP). • Progestin-only injectable contraceptives (DMPA, NET-EN).	• Combined injectable contraceptives (Cyclofe, Cycloprovera, Mesigyna, Norgynon). • Combined vaginal contraceptives. • Combined contraceptive (skin) patch. • Progestin-only contraceptive implants (Norplant, Jadelle)- these are not available in the whole of Southern Sudan.

The guidelines that follow relate only to the methods that are likely to be available in Southern Sudan:

Combined Oral Contraceptive Pills (COCS)

Q What are combined oral contraceptive pills?

Combined oral contraceptives (COCs/OCs) are pills containing synthetic oestrogens and progestins similar to the natural hormones in a woman's body. These are the contraceptives commonly referred to as "The Pill". The pill has to be taken daily to prevent pregnancy.

Over the years the doses of hormone in the pill have decreased to lower and safer levels, with a consequent decrease in occurrence of side effects. High-dose COCs are now defined as those containing 50

micrograms or more of oestrogen, while low-dose pills contain less than 50 micrograms of oestrogen. The most common available COCs in South Sudan contain 30-35 micrograms.

COCs are highly effective (See Appendix 2); they primarily prevent pregnancy by:

- Suppressing ovulation
- Thickening the cervical mucus, thereby preventing penetration of the sperm
- Possibly changing the endometrial lining, making implantation less likely

Types of COCs

Pills come in packets of 21 or 28 tablets. In the 28-pill packet only the first 21 are active pills (they contain hormones); the remaining 7 are not active and usually contain iron.

The low-dose pill comes in three types:

- Monophasic: each active pill contains the same amount of oestrogen and progestin. Examples are Microgynon, Femiplan, Nordette, and Marvelon.
- Biphasic: the active pills in the packet contain two different dose-combinations of oestrogen and progestin. For example in a cycle of 21 active pills, 10 may contain one combination while 11 contain another. Examples are Biphasic, Ovanon, and Normovlar.
- Triphasic: the active pills contain three different dose combinations of oestrogen and progestin. Out of a cycle of 21 active pills, 6 may contain one combination, 5 another combination, while 10 pills contain other combinations of the same two hormones. Examples are Logynon and Trinordial.

In Southern Sudan, Microgynon is the most common labelling for low-dose pill, especially in the few facilities that provide FP services.

Advantages

Contraceptive Benefits	*Other Benefits*
• Highly effective. • Effective immediately (when started within the first 7 days of the menstrual cycle). • Easy to use. • Can be provided by a trained non-clinical service provider. • Pelvic exam is not essential to initiate use.	• Reduces menstrual flow (lighter, shorter periods). • Decreases dysmenorrhoea (painful periods). • Improves and prevents anaemia. • Protects against ovarian and endometrial cancer. • Decreases benign breast

Over the years, the doses of hormone in the pill have decreased to lower and safer levels, with a consequent decrease in occurrence of 50 micrograms or more of oestrogen, while low-dose pills contain less than 50 micrograms of oestrogen. The most common available COCs in South Sudan contain 30-35 micrograms.

COCs are highly effective (See Appendix 2); they primarily prevent pregnancy by:

- Suppressing ovulation.
- Thickening the cervical mucus, thereby preventing penetration of the sperm.
- Possibly changing the endometrial lining, making implantation less likely.

Limitations

Use may be associated with minor and major side effects.

Minor side effects (but may cause serious concerns to women)

- Nausea (common in first 3 months).

- Spotting or bleeding in between menstrual periods, especially if a woman forgets to take her pills or takes them late (common in first 3 moths).
- Mild headaches.
- Breast tenderness.
- Slight weight gain.
- Amenorrhea (however, some women see amenorrhea as an advantage).

Major side effects (serious side effects and complications though rare, are possible)

- Major side effects include myocardial infarction, stroke, and venous thrombosis/embolism.
- Their effectiveness may be lowered when certain drugs are taken concurrently, e.g., certain anti-tuberculosis, anti-epileptic, and anti-retroviral drugs).
- Effectiveness may also be lowered in the presence of gastroenteritis, vomiting and diarrhoea.
- The combined pills offer no protection against STIs, including Hepatitis B and HIV/AIDS, and therefore, individuals at risk should use a barrier method to ensure protection against STIs/HIV/AIDS.
- COCs must be taken daily to be effective.

Who Can Use Combined Oral Contraceptive Pills (Category 1)

- Sexually active women of reproductive age.
- Women with established menses (Note: ovulation can occur and pregnancy take place before a woman has experienced her first menstruation).

- Women of any parity, including those that are nulliparous.
- Women who want highly effective protection against pregnancy.
- Breastfeeding mothers more than 6 months postpartum.
- Women who feel they can follow a daily routine of pill taking.
- Post-abortion clients (should begin within 7 days of abortion for immediate effectiveness).
- Women with anaemia form heavy menstrual bleeding.
- Women with severe menstrual pains.
- Women with a history of ectopic pregnancy.

Proceed with care in the following situations (Category 2):

Table 5.1: Combined Oral Contraceptive Pills (Category 2)

CONDITION	SUGGESTED ACTION (Where clinical judgement is possible	SUGGESTED ACTION (Where clinical judgement is not possible or is limited, e.g., CHW)
Women over 40 years old	♦Use the method	♦Initiate method and refer for assessment ♦Re-supply to continuing clients ♦Where referral is not possible assist client to select alternative methods

CONDITION	SUGGESTED ACTION (Where clinical judgement is possible	SUGGESTED ACTION (Where clinical judgement is not possible or is limited, e.g., CHW)
Women with unexplained vaginal bleeding	♦Evaluate bleeding, including VIA (visual inspection with acetic acid), VILI (visual inspection with lugol's iodine) and Pap smear (which ever is most appropriate in a given setting) before initiating use	♦Refer for evaluation before initiating use (CBD should not initiate or re-supply)
Women with migraine without aura and age< 35 years	♦Requires careful assessment to determine severity ♦Initiate method and Follow-up closely (Note: do not initiate in women >35 or those with aura at any age)	♦Refer for clinic assessment and follow up
Women who suffer from obesity (equal or > 30kg/m^2 BMI)	♦Use the methods, but counsel about risk and symptoms of thrombosis ♦Advice follow-up	♦Refer for assessment/ Counseling (CBD should not initiate, but may re-supply after method is initiated at the clinic

CONDITION	SUGGESTED ACTION (Where clinical judgement is possible	SUGGESTED ACTION (Where clinical judgement is not possible or is limited, e.g., CHW)
Women with gallbladder disease, asymptomatic or treated by cholecystectoy	♦Use the method, follow-up and discontinue if symptoms develop ***(Note: women under medical treatment should not use COCs; assist to choose another method***	♦May re-supply in between clinic visits, especially where cholecystectomy has been performed
Women with breast lumps	♦Evaluate the lump and confirm diagnosis before initiating method ♦Women with benign breast disease can use COC	♦Refer women with breast lump for evaluation
Women with sickle cell disease	♦Women with sickle cell disease may use COC after initial clinical assessment and advice on regular follow up	♦May re-supply in between clinic visits
Women who smoke and are <35 years	♦Initiate method use and recommend follow-up ♦Discontinue if symptoms or signs of cardiovascular disease (CVD) appear (categories 3 & 4)	♦Non-clinical providers should initiate but may re-supply in between clinics visit

CONDITION	SUGGESTED ACTION (Where clinical judgement is possible	SUGGESTED ACTION (Where clinical judgement is not possible or is limited, e.g., CHW)
Uncomplicated diabetes (no vascular diseases or diabetes of less than 20 years duration)	♦Generally use the method and recommend follow-up	♦Refer ♦Re-supply in between clinic visits
Women with superficial venous thrombosis	♦Evaluate to rule out DVT (deep vein thrombosis) before initiating method	♦Refer for evaluation ♦Re-supply after clinic visits

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Who Should Not Use COCs (Categories 3 & 4)

- Breastfeeding mothers up to 6 months postpartum.
- Women with a history of blood clotting disorder; women who have undergone major surgery with prolonged immobilization; those who are or are known to have thrombogenic mutations, which increase risk for blood clotting disorders.
- Women with current or history of ischaemic heart disease or complicated valvular heart diseaseWomen with active liver disease (viral hepatitis, mild to severe cirrhosis, benign or malignant tumours).
- Women with a history of hypertension (where blood pressure [BP] cannot be measured).
- Women with adequately controlled BP (where BP can be measured).

- Women with moderate to severe hypertension (BP 140-159/90-99 or equal to or more than 160/100) or hypertension complicated by vascular disease.
- Women with diabetes mellitus complicated by vascular disease.
- Women with a history of or with current breast cancer.
- Women with symptomatic gall bladder disease including those on medical treatment (who have not undergone cholecystectomy).
- Women receiving treatment with drugs that affect liver enzymes: Rifampicin (TB), phenytoin, carbamazepine (epilepsy), and certain ARV drugs (HIV).

Who Can Provide COCs

Clinical Providers:	Non-clinical Providers:
• Medical doctors • Nurses/midwifes • Clinical officers • Medical Assistants	• Trained community workers and community-based distributors CHW/TBA/ MCHW) • Trained pharmacists/pharmaceutical technologists, EPI promoters and safe motherhood motivators

Note:

Non-clinical providers can:

- Initiate use of COCs using the approved MoH checklist. They should not initiate supply to clients with chronic medical conditions.

- Supply no more than three cycles before evaluation by a clinical provider.

After review by a clinical provider, non-clinical providers may re-supply up to three cycles per visit. They should ensure that the client will keep drugs in safe custody and return all unused pills to the provider if she changes to another method. All clients, however, should be encouraged to attend a clinic for any problems or concerns. Providers should ensure that any unused pills returned by clients are destroyed to avoid re-issue to other clients.

What to do in the case of a "missed pill"

This guidance refers to combined oral contraceptive pills containing less than 20 μg of ethinylestradiol.

Table 5.2: What to do in case of a "missed pill"

Missed pill (COC)	Recommendations
Missed 1 or 2 active pills	♦Take the missed pill as soon as possible ♦Take the next pill at the usual time, which may mean taking 2 pills on the same day or even at the same time ♦Continue taking pill as usual, one each day ♦No need of back-up protection method
Missed 3 or more active pills during the first week of the pill pack (Days 1-7)	♦Must take active pills for 7 days in a row to get back to full protection, so: ♦Take the first missed pill as soon as remembered ♦Take the next pill at the usual time, which may mean taking 2 pills on the same day or even at the same time ♦Abstain from sex or use back-up method for the next 7 days until you have taken the active pills for 7 days in a row
Missed 3 or more active pills during the second week of the pill pack (Days 8-14)	♦Take the first missed pill as soon as possible ♦Take the next pill at the usual time, which may mean taking 2 pills on th same time ♦Continue taking the pills as usual, one each day ♦No need for back-up protection
Missed 3 or more active pills during the third week of the pill pack (Days15-21)	♦Finish only the active pills in the pack ♦throw away the reminder pills and start a new pack the next day ♦No need of back-up

Missed pill (COC)	Recommendations
Missed 1 or more inactive pills (Day 22-28)	♦Discard the inactive pills and go straight to the next pack ♦Continue taking the pills as usual, one each day ♦No need of back-up protection

Source: Selected Practice Recommendations for Contraceptive Use, Second Edition. Department of Reproductive Health and Research, Family and Community Health, WHO, Geneva, 2004

Note:

- Contraceptive pills preferably should be taken at about the same time each day.
- A woman who misses taking the pill more than two days consecutively needs counselling; including assistance to consider another method that she can practice more effectively. It may be helpful to discuss with her emergency contraception if the pregnancy was not planned.

Table 5.3: Management of Common Side Effects

Side Effects	Management
Nausea and dizziness	♦Assess for pregnancy; counsel about side effects, advice to take pills with meals
Spotting	♦Assess for pregnancy; counsel about side effects, asses for other illness ♦Encourage to take pills at the same time each day ♦If spotting persists and the woman does not want to tolerate it, switch to higher oestrogen (50mcg) pills or select alternative method
Amenorrhea	♦Assess for pregnancy; if negative, counsel that this is one of the side effects of COC use

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland

Where COCs Can Be Provided

- Hospitals.
- Primary Health Care Centres.
- Primary Health Care Unit.
- VCT Centres.
- Outreach (including CHW/TBAs/MCHW) and mobile services.
- Pharmacies.
- Private clinics.

Progestin-only Pills (POPS)

Q What are progestin-only pills?

As the name suggests, the POPs contain progestin only; they do not contain oestrogen. Therefore, they do not cause many of the side effects associated with COC use. Progestins do not suppress production of breast milk, which makes then an ideal contraceptive method for breastfeeding women (See Appendix 2 for method effectiveness).

POPs must be taken at the same time every day (+/- 2 hours to avoid pregnancy and minimize side effects). They prevent pregnancy by:

- Thickening the cervical mucus, thereby preventing sperm to pass through it.
- Suppressing ovulation in about 50 percent of cycles possibly by changing the endometrial lining.

Types of POPs

The brands commonly available in the public sector and the pharmacies include: Mircrolut, Micronor, Microval, and Ovrette.

Advantages

Contraceptive Benefits	*Other Benefits*
• Effective • Immediate return to fertility on discontinuation • Pelvic exam is not required to	• Does not affect breastfeeding • Lighter and shorter periods • Decreased breast tenderness • Does not increase blood clotting • Decreases dysmenorrhoea • Protects against endometrial cancer

Limitations

- Slightly lower level of contraceptive protection than COCs.
- Requires strict daily pill taking, preferably at the same time.
- Side effects include spotting or bleeding between periods (more common), amenorrhea (less common), possibly headaches and breast tenderness (although less common than with COCs).
- Effectiveness may be lowered when certain drugs are taken concurrently (e.g., anti-tuberculosis and anti-epileptic drugs) as well as ARV.
- Does not protect against STIs including Hepatitis B and HIV/AIDS and, therefore, individuals at risk should use a barrier method to ensure protection against STIs/HIV/AIDS.

Who Can Use POPs (Category 1)

- Women of reproductive age.
- Women of any parity, including nulliparous women.
- Women immediately postpartum if they are not going to breastfeed.
- Breastfeeding mothers after 6 months postpartum.

- Heavy smokers of any age.
- Women who cannot use COCs, due to oestrogen-related contraindications.
- Post-abortion clients.
- Women with hypertension (BP<160/100).
- Women with sickle cell disease.

Proceed with care (Category 2):

Table 5.4: Progestin-only Pills (Category 2)

CONDITION	SUGGESTED ACTION (Where clinical judgment is possible)	SUGGESTED ACTION (Where clinical judgment is not possible or is limited, e.g., CHW)
Women with a history of past ectopic pregnancy	♦Method can be used ♦Advise clients to report at the clinic without delay if she develops any symptoms suggestive of ectopic pregnancy	♦Can initiate method but refer for evaluation any client with abdominal pain
Women receiving treatment for HIV (ARV therapy) and who are clinically well on this therapy	♦Method can be initiated ♦Establish the drugs she is using and counsel regarding drug interactions as necessary	♦Refer for evaluation ♦CHW should not initiate but can re-supply in between clinic visits
Migraine with aura at any age	♦Method can be initiated ♦Ensure /motivate regular follow-up at clinic ♦Discontinue method use if symptoms get worse	♦CHW should not initiate or re-supply

CONDITION	SUGGESTED ACTION (Where clinical judgment is possible)	SUGGESTED ACTION (Where clinical judgment is not possible or is limited, e.g., CHW)
Women with history of DVT and pulmonary embolism or in prolonged post-operative immobilization; women known to have thrombogenic mutations	♦Method can be initiated ♦Ensure/ motivate regular follow-up at clinic	♦CHW should not initiate or re-supply
Women with gall bladder disease: asymptomatic, medically treated or after cholecystectomy	♦Method can be initiated ♦Ensure regular follow-up at clinic	♦CHW should not initiate or re-supply in between clinic visits
Cirrhosis (mild) of liver	♦Method can be initiated ♦Ensure/motivate regular follow-up at clinic	♦CHW should not initiate but can re-supply in between clinic visits
Women with multiple risk factors for cardiovascular disease: current and history of ischaemic heart disease and stroke (CVA)	♦May initiate method use ♦Careful evaluation in consultation with responsible clinical ♦Ensure regular follow-up at clinic	♦CHW should not initiate or re-supply

CONDITION	SUGGESTED ACTION (Where clinical judgment is possible)	SUGGESTED ACTION (Where clinical judgment is not possible or is limited, e.g., CHW)
Women with undiagnosed breast lumps	♦Evaluate before providing method ♦Women with benign breast disease can use POPs	♦Refer evaluation for breast lump
Women with irregular, heavy or unexplained vaginal bleeding	♦Initiate method Client should be evaluated (including VIA/VILI and Pap smear, which ever is most appropriate in a given setting)	♦Refer evaluation before initiating method
Women with diabetes (including those with vascular complications) and hypertension (BP higher than 160/100)	♦May initiate method use followed by careful evaluation in consultation with responsible clinician ♦Ensure regular follow-up at clinic	♦Refer for evaluation ♦CHW should not initiate or re-supply

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Who Should Not Use (Categories 3 & 4)

- Breastfeeding women less than 6 weeks postpartum.
- Women who have breast cancer or a history of breast cancer.
- Women with active liver disease (viral hepatitis, severe cirrhosis) or liver tumour (benign and malignant).
- Women with current Deep Venous Thrombosis (DVT) or pulmonary embolism (PE).
- Women who take drugs which affect liver enzymes (for TB, epilepsy).

Note:

- All clients with relevant medical conditions should have regular follow-up and treatment of the medical condition while on POPs.
- Pregnancies among consistent users of POPs are few, especially during breastfeeding. When pregnancy occurs, however, as many as 1 in every 10 are ectopic pregnancies. Ectopic pregnancy is a life-threatening condition that requires immediate treatment.
- For women who have had an ectopic pregnancy, POPs **will not** effectively prevent another extra-uterine pregnancy since they do not consistently suppress ovulation.
- For women who have had problems with ovarian cysts, POPs **will not** protect against the development of the future ovarian cysts.
- Inconsistent or incorrect use of pills is a major reason for unintended pregnancy. It is important to motivate clients to **ensure that POPs are taken at approximately the same time each day.** It is deemed necessary to use POP for at least two days (48 hours) before it can provide contraceptive protection.

Table 5.5: Management of Common Side Effects

Side Effects	Management
Spotting	Assess for pregnancy, if no other cause, reassure; if causes identified, manage or refer to appropriate level
Amenorrhea	Assess for pregnancy; - If pregnant, stop use of POPs and refer to ante-natal care (ANC); -If not pregnant, reassure and continue POPs
Headache or dizziness	Determine cause; -If no cause, counsel; -If severe and no cause, help client select alternative method ; -Refer if persistent
Abnormal suspicious vaginal bleeding	Client should be evaluated (refer as necessary), including VIA/VILI and Pap smear; refer as necessary for management
Mood changes or nervousness	Counsel; if it worsens, help client select alternative methods

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

When to Initiate Use of POPs

- If the woman is breastfeeding and has not resumed her menses: any time between 6 weeks and 6 months after childbirth.
- After childbirth and not breastfeeding: any time within the first 4 weeks.
- After miscarriage/abortion: With in the first 7 days method can be initiated without need for backup protection. After 7 days, condom should be used as a backup method for 2 days.

- Having menstrual cycles: any time if reasonably sure that the woman is not pregnant. If initiated within 5 days after menstrual cycle, no backup method needed. Otherwise, backup method (condom) should be used for the next 2 days.

Who Can Provide POPs

Clinical Providers:	**Non-clinical Providers:**
• Medical doctors • Nurses/midwives • Medical assistants • Clinical officers	• Trained pharmacists/pharmaceutical technicians/technologists • Trained community health workers

Table 5.6: Management of "missed pill"

Missed POP	Suggested Action
Woman who is having her menstrual cycles (including those who are breastfeeding) AND Missed 1 or more pills by more than 3 hours.	♦Take 1 pill as soon as possible ♦Continue taking the pills as usual, one each day ♦Abstain from sexual intercourse or use back-up method (e.g., condom) for the next 2 days
Woman who is breastfeeding and is amenorrhoeic misses 1 or more pills by more than 3 hours.	♦Take 1 pill as soon as possible ♦Continue taking the pills as usual, one each day ♦If she is less than 6 months postpartum, no additional contraceptive protection is needed.

Source: Selected Practice Recommendations for Contraceptive Use, Second Edition. Department of Reproductive Health and Research, Family and Community Health, WHO, Geneva, 2004

Note:

Non-clinical providers (pharmacists and community health workers) can:

- Initiate use of POPs using the approved checklist. They should not initiate supply to clients with chronic medical conditions.
- Supply no more than three cycles before evaluation by a clinical provider.

After review by a clinical provider, non-clinical providers may re-supply up to three cycles per visit. They should ensure that the client will keep the drugs in safe custody and return all unused pills to the provider if she changes to another method. All clients, however, should be encouraged to attend a clinic for any problems or concerns. Providers should recommend that any unused pills returned by clients are destroyed to avoid re-issue to other clients.

Where POPs Can Be Provided

All Service Delivery Points

- Hospitals.
- Primary Health Care Centres.
- Primary Health Care Units.
- VCT Centres.
- Outreach/mobile services.
- Private Health Facilities.
- Private Clinics.
- Pharmacies.

Emergency Contraceptive Pills (ECP)

Q What is emergency contraception?

Emergency contraception prevents pregnancy following unprotected intercourse. Emergency contraceptive pills (ECPs) must be taken within 72 hours of intercourse. However, the sooner they are taken, the more effective they are. If taken when the woman is already pregnant, they have no effect on pregnancy. ECPs do not cause abortion. It should be emphasized that emergency contraception should not be used on a regular basis (from month to month) because it is less effective than other methods.

Emergency contraceptive pills seem to prevent on average 85 percent of pregnancies that would otherwise have occurred. The average chance of pregnancy resulting from one act of unprotected intercourse in the second or third week of the menstrual cycle is estimated at 8 percent; after emergency oral contraception it is 1-2 percent. The sooner ECPs are used, the better for preventing pregnancy. ECPs prevent pregnancy through:

- Preventing ovulation.
- nhibiting transport of the egg and/or sperm through the fallopian tubes.

Types of Dosage

Combined Oral Contraceptives

50-microgram oestrogen pills (e.g., Eugynon): two tablets to be taken as soon as possible but within 72 hours of unprotected intercourse. Repeat same dose in 12 hours. Requires a total of four 50-mcg pills.

Or

30-microgram oestrogen pills (e.g., Microgynon): Four tablets to be taken as soon as possible, but within 72 hours of unprotected intercourse. Repeat same dose in 12 hours. Requires a total of eight 30-mcg pills.

Progestin-only Oral Contraceptive

One 750 mcg Levonorgestrel pill (e.g., Postinor-2) to be taken as soon as possible, but within 72 hours of unprotected intercourse. Repeat same does in 12 hours.

Or

Two 750-mcg Levonorgestrel pills to be taken as a single dose as soon as possible, but within72 hours of unprotected intercourse.

Or

Regular progestin-only pill (POP) may be used: 20 tablets taken within 72 hours of unprotected intercourse and repeated in 12 hours.

Advantages

Provides emergency protection (prevents pregnancy) in about 85 percent of those at risk.

Limitations

- Reasonably effective only within 72 hours of unprotected intercourse.
- Not to be used as a regular method.
- Does not protect against STIs, including HIV/AIDS.
- May cause nausea.

Who Can Use Emergency Contraception

Emergency contraception should not be used in place of regular family planning methods. It should be emphasized that ECP contains a much higher dose of hormones compared to regular hormonal contraceptive methods. Therefore, it should be used only in an emergency, for example:

- A woman has had coerced sexual intercourse, such as rape.
- A condom has broken.
- An IUCD has come out of place.
- A woman has run out of oral contraceptives, has missed two or more POPs, or is more than a few weeks late for a DMPA injection and has had unprotected intercourse.
- Sexual intercourse took place without contraception, and the woman wants to avoid pregnancy.

Who Should Not Use Emergency Contraception

- ECP is not to be used as a regular method. Recurrent demand for ECP is an indication that the woman requires further counselling on other contraceptives options.
- ECP should not be given to women who are known to be pregnant. However, in the event it is accidentally given after pregnancy has been established, there is no known harm to the woman, the course of her pregnancy, or to the foetus.

The success of emergency contraception depends on knowledge of its availability/efficacy prior to an unprotected, unplanned act. The method is only effective if potential users are aware of the method by prior information and counselling.

Table 5.7: Management of Common Side effects

Side Effects	Management
Nausea and vomiting	♦Women should be counselled of possible occurrence of nausea at the time of ECP supply. ♦For women using the combined pill or POP for ECP, an anti-emetic may be used before the pills are taken. ♦If she again vomits, give the dose vaginally (place the needed dose high up in the vagina).

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Who Can Provide	Where It Can Be Provided
All trained service providers, clinical and non-clinical.	At any site with a qualified provider.

Note:

Counsel client regarding subsequent regular contraception options
Provide or refer for treatment or prophylaxis against STIs and HIV, including Post-Exposure Prophylaxis (PEP), especially in case of rape or violence

Injectable Contraceptives

Q What are injectable contraceptives?

The most available injectable contraceptives are the **three-monthly** Depo Provera (DMPA) and the **two-monthly** Noristerat (see below). Both contain only progestin and therefore do not have oestrogen-associated side effects. In addition, since progestin does not suppress production of breast milk, these injectables can be used by breastfeeding women after six weeks postpartum (See Appendix 2 for effectiveness). Less commonly available is the monthly injectable which contains oestrogen in addition to progestin, hence referred to as combined injectable contraceptives.

Progestin-only injectables prevent pregnancy by:

- Suppressing ovulation.
- Thickening cervical mucus so as to prevent sperm passing through it.
- Thinning the endometrium to interfere with implantation.

Types

- Depot-medroxyprogesterone acetate (DMPA): **Depo-Provera**, Megestron, given every three months but can be given up to four weeks (28 days) earlier or two weeks later (14 days).
- Norethisterone enanthate (NETEN): **Noristerat,** given every two months but can be given up to two weeks (14 days) earlier or one week later (7 days).
- Monthly injectable (rarely available): Cylofen, Cyloprovera, Mesigyna, Norgynon. Note: These contain oestrogen in addition to progestin and are given once every 30 days, but could be given up to three days earlier or later.

Note:

The guidelines below relate only to progestin-only injectables.

Advantages

Contraceptive Benefits	*Other Benefits*
• Highly effective. • Pelvic exam is not required to initiate use. • No oestrogen, therefore does not have the cardiac and blood clotting effects, which are associated (though rarely) with oestrogen-containing pills and injectables. • Long-acting method.	• Reduces menstrual flow (long term) and is therefore beneficial for women with or at risk of iron deficiency anaemia. • Decreases sickle cell crises. • Protects against endometrial cancer and possibly ovarian cancer. • Helps prevent ectopic

Limitations

- Return of fertility may be delayed for about four months or more after discontinuation.
- Common side effects include menstrual changes, such as light spotting/bleeding, heavy bleeding and eventually amenorrhea (normal, especially after one year of use).
- Other side effects may include headache, breast tenderness, mood swings and nausea (less common than with oestrogen-containing contraceptives).
- Does not protect against STIs including Hepatitis B and HIV; individuals at risk should, in addition, use condoms.

Who Can Use Injectables (Category 1)

- Women of reproductive age (15-49 years).
- Women of any parity including nulliparous with established menses).
- Women who want highly effective, long-term protectionagainst pregnancy.
- Breastfeeding mother after 6 weeks postpartum.
- Immediate postpartum if not breastfeeding.
- Women with fibroids or endometrial cancer.
- Women who cannot remember to take the pill every day.
- Post-abortion clients.
- Women with obesity, anaemia, sickle cell disease, thyroid disease, uncomplicated diabetes, hypertension (moderate to severe), valvular heart disease.
- Women with STIs, PID, TB, HIV, and AIDS doing well on treatment with ARVs (ARVs that do not compromise effectiveness of the method).

Proceed with Care (Category 2)

Table 5.8: Injectable Contraceptives (Category 2)

CONDITION	SUGGESTED ACTION (Where clinical judgment is possible)	SUGGESTED ACTION (Where clinical judgment is limited or not possible, e.g., PHCU)
Women aged < 18 years and > 45 years	♦ The method can be used in these age groups with careful consideration and counselling on other methods available ♦ Quite frequently, the benefits of using the method outweighs risks	♦ Method can be provided; when in doubt, refer

CONDITION	SUGGESTED ACTION (Where clinical judgment is possible)	SUGGESTED ACTION (Where clinical judgment is limited or not possible, e.g., PHCU)
Women with heavy or irregular vaginal bleeding	♦Investigate (including VIA and Pap smear, which ever is most appropriate in a given setting) before initiating method	♦Do not initiate method ♦Refer for evaluation and management
Women with CIN or cervical cancer awaiting treatment	♦May initiate the method pending definitive treatment *(Note: treatment may render woman sterile)*	♦Do not initiate method; refer ♦Do not initiate method before evaluation of the breast lump; refer
Women with undiagnosed breast lumps	♦Evaluate prior to initiation ♦Method can be used if lumps are benign (Category 1)	Initiate method and refer for evaluation Do not initiate method; refer
Women with migraine without aura	♦Initiate method ♦Arrange follow-up	
History of DVT or pulmonary embolism; known thrombogenic mutations and hyperlipidaemias; major surgery with prolonged immobilization	♦May initiate method ♦Arrange follow-up	♦Refer for evaluation

CONDITION	SUGGESTED ACTION (Where clinical judgment is possible)	SUGGESTED ACTION (Where clinical judgment is limited or not possible, e.g., PHCU)
Women under treatment with Rifampicin, certain anticonvulsants, and certain ARVs	♦May initiate method ♦Arrange follow-up	♦Refer for evaluation ♦Refer for evaluation
Women with history of hypertension or adequately controlled BP	♦May initiate the method ♦Ensure regular follow-up at clinic	
Women with AIDS but doing well on ARVs	♦May initiate the method ♦Ensure/motivate regular follow-up at clinic	♦Refer for evaluation
Women with gall bladder disease, symptomatic or asymptomatic	♦May initiate the method ♦Ensure/motivate regular follow-up at clinic	♦Refer for evaluation
Women with uncomplicated diabetes	♦May initiate the method ♦Ensure/motivate regular follow-up at clinic	♦Refer for evaluation
Women with mild cirrhosis of liver	♦May initiate the method ♦Ensure/motivate regular follow-up at clinic	♦Refer for evaluation

CONDITION	SUGGESTED ACTION (Where clinical judgment is possible)	SUGGESTED ACTION (Where clinical judgment is limited or not possible, e.g.,
Women at risk of STIs	♦May initiate the method ♦Ensure/motivate regular follow-up at clinic	♦Refer for evaluation

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Who Should Not Use (Categories 3 & 4)

- Breastfeeding women less than 6 weeks postpartum.
- Women with active liver disease and severe cirrhosis.
- Women with benign or malignant liver tumours.
- Women with unexplained abnormal vaginal bleeding (before evaluation).
- Women who have breast cancer or a history of breast cancer.
- Women with multiple risk factors for arterial cardiovascular diseas (various combinations of older age, smoking, diabetes and hypertension).
- Women with current or history of ischaemic heart disease.
- Women with diabetes mellitus complicated by vascular disease and women with vascular disease.
- Women with stroke or history of CVA.
- Women with current DVT or pulmonary embolism (PE).

Giving the Injection

- Refer to instructions for infection prevention (IP) (Refer to Infection Prevention Guidelines for Southern Sudan).

DO NOT REUSE DISPOSABLE SYRINGE AND NEEDLES.

Who can provide	Where they can be provided
• Medical doctors • Clinical officers • Nurses/midwives • MCHW	• Hospitals • Primary Health Care Centres • Primary Health Care Units • Outreach/mobile services • Private health facilities

Table 5.9: Management of Common Side Effects

Side Effects	Management
Spotting or light bleeding between monthly periods	Spotting or light bleeding is common during use of injectable contraceptives, particularly with the first injection cycle. It is not harmful. In women with persistent spotting or bleeding, and in women with bleeding after a period of amenorrhea, assess for pregnancy or incomplete abortion, as well as excluding gynaecological problems when clinically warranted such as infections, uterine fibroids, cervical polyps, and treat according to the cause or refer. ♦ If pregnant, stop the injectable, counsel, reassure, and refer accordingly. ♦ If STI or pelvic inflammatory disease (PID) is diagnosed, she can continue the method while receiving treatment; counsel on abstinence or condom use.

Side Effects	Management
Cont. Spotting or light bleeding between monthly periods	♦If above conditions are excluded and the client finds the bleeding unacceptable, discontinue the injectable; help her choose another method.
Bleeding heavy or prolonged (lasting more than 8 days or twice as much as her usual menstrual period)	♦Explain that heavy or prolonged bleeding is common in the first injection cycle. ♦If heavy or prolonged bleeding persists, evaluate as above. ♦If a gynaecologic problem is identified, treat or refer for care. ♦If the bleeding becomes a threat to the health of the woman, or is not acceptable to her, discontinue the injectable; help her choose another method. ♦To prevent anaemia, provide haematinics and advice on diet. ♦If no cause of the bleeding is obvious and it is < 8 weeks from the last dose (injection), one or more of the following approaches may be tried: ⇨NSAIDs (non-steroidal anti-inflammatory drugs) such as Ibuprofen and Mefanemic acid can also be used (Ibuprofen 400-800 mg tds for 7-14 days). ⇨COC: one active pill daily up to 1-3 cycles (or 50-mcg pill where bleeding is continuing). ⇨Ethinyl oestradiol cypronate: 5mg IM or combined injectable contraceptive; however, these approaches may be of short-term or no benefit at all.

Table 5.10: Switching from another Method

SWITCHING FROM	WHEN FIRST INJECTION CAN BE GIVEN
Cont. Bleeding heavy or prolonged (lasting more than 8 days or twice as much as her usual menstrual period)	♦ If client presents when it is 8 weeks or more from the last dose, give another dose of injectable contraceptive and set a new return date based on the current injection. This schedule may speed up the development of amenorrhea and, thus, stop the bleeding
Amenorrhea	♦ By the end of the first year on injectables, amenorrhea develops in a majority of clients. Normally amenorrhea does not require any medical treatment. Counselling and reassurance are sufficient. If suspicious, assess for pregnancy, and manage as above. If client is bothered by lack of menses despite reassurance, discontinue injectable. Support her in choosing another method.
Headache or dizziness	If mild, treat with analgesics and reassure. Check blood pressure; if normal and headaches persist, discontinue injectable and refer for evaluation. Support her to choose another method.
Another hormonal method (e.g., pill or another injectable)	♦ Give immediately if client has been using her hormonal method consistently and correctly, or if it is reasonably certain she is not pregnant. **No need to wait for her next menstrual period.** ♦ If previous method was another injectable, start the new injectable when the repeat injection would have been given. No additional contraceptive protection is needed.

SWITCHING FROM	WHEN FIRST INJECTION CAN BE GIVEN
Non-hormonal method (other than IUCD)	♦ Give immediately, if reasonably certain she is not pregnant. **No need to wait for her next menstrual period** ⇨ If she is within 7 days of the start of her menstrual bleeding, additional contraception is needed. ⇨ If it has been more than 7 days since menstrual bleeding started, she will need to abstain from sex or use additional contraceptive protection for the next 7 days.
IUCD (including hormone-bearing IUCD)	♦ Can give within 7 days after the start of menstrual bleeding. No additional contraceptive protection is needed. IUCD can be removed at the same time. ♦ Can also be given at any other time, if it is reasonably certain she is not pregnant: ⇨ If she has been sexually active in this menstrual cycle, and it has been more than 7 days since the menstrual bleeding started, it is recommended that the IUCD should remain in position to be removed at that time of her next menstrual period. ⇨ If she has not been sexually active in the menstrual cycle and it has been more than 7 days since menstrual bleeding started she will need protection for the next 7 days, if the IUCD is removed at that time. Otherwise she should retain it for removal at the time of her next menstrual period. ⇨ If she is amenorrhoeic or has irregular bleeding, she can have the injection as advised for other amenorrhoeic women.

SWITCHING FROM	WHEN FIRST INJECTION CAN BE GIVEN
Switching between DMPA and NET-EN	♦Using DMPA and NET-EN interchangeably is not recommended. ♦If it becomes necessary to switch from one to the other, the switch should be made at the time the repeat injection would have been given.

Source: Selected Practice Recommendations for Contraceptive Use, Second Edition. Department of Reproductive Health and Research, Family and Community Health, WHO, Geneva, 2004

Table 5.11: Missed Appointment

CLIENT ARRIVES	SUGGESTED ACTION
Too early for her next injection	♦The repeat injection for both DMPA and NET-EN can be given up to 2 weeks early.
Late for her injection, up to 2 weeks	♦The repeat injection for both DMPA and NET-EN can be given up to 2 weeks late without requiring additional contraceptive protection.
Late for her injection, more than 2 weeks	♦If she is more than 2 weeks late for a DMPA or NET-EN repeat injection, she can have the injection, if it is reasonably certain she is not pregnant. *(Note: DMPA users may develop amenorrhea without pregnancy).* ♦She will need to abstain from sex or use additional contraceptive protection for the next 7 days. Client should be made aware of her options and help her make the decision that suits her. ♦She may wish to consider the use of emergency contraception if appropriate.

Source: Selected Practice Recommendations for Contraceptive Use, Second Edition. Department of Reproductive Health and Research, Family and Community Health, WHO, Geneva, 2004

Note:

All clients should be encouraged to come back to the clinic no matter how late for injection they are.

Contraceptive Implants
(Not available in Southern Sudan for now)

What are contraceptive implants?

Contraceptive implants are small hormone bearing capsules or rods which when inserted under the skin of a woman's upper arm release hormone slowly over a long period, to prevent pregnancy. They are also called "sub-dermal implants." They contain only a progestin hormone, do not contain oestrogen, and are therefore free from the side effects associated with oestrogen containing methods.

Implants prevent pregnancy by:

- Making cervical mucus so thick that sperm cannot pass through it.
- Suppressing ovulation in many cycles.
- Making the endometrium too thin for implantation to take place.

Table 5.12: Types of Contraceptive Implants

Device	Design	Hormone	Duration of Effectiveness
Norplant	6 capsules	Levonorgestrel	5-7 years (depending on client's weight)
Jadelle	2 rods	Levonorgestrel	5 years
Implanon	1 rod	Etonogestres	3 years

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Note:

Effectiveness of Norplant and Jadelle is reduced when a client's body weight exceeds 70kg and 80kg respectively.

Advantages

Contraceptive Benefits	*Other Benefits*
• Highly effective • Effective within 24 hours after insertion • Immediate return to fertility • Offer continuous, long-term protection	• Reduces menstrual flow in some clients • Protects against endometrial cancer • Helps prevent ectopic pregnancy (but does not eliminate risk altogether) • Does not affect breastfeeding • Protects against iron deficiency anaemia • May make sickle cell crises less frequent and less painful

Limitations

- Must only be inserted and removed by trained providers.
- Requires a minor surgical procedure with appropriate infection prevention practices for insertion and removal.
- Common side effects include menstrual changes, such as light spotting or bleeding between periods and amenorrhea.
- Less common side effects include prolong bleeding, headache, dizziness, nausea and breast tenderness.
- Removal services must be available at sites where insertion is done.
- Does not protect against STIs, including Hepatitis B and HIV; individuals at risk should, in addition, use condoms.

Who Can Use Contraceptive Implants (Category 1)

- Women of reproductive age.
- Women of any parity, including nulliparious with established menses.
- Women who want highly effective, long-term protection against pregnancy.
- Women with sickle cell.
- Breastfeeding mother after 6 weeks postpartum or immediate postpartum if not breastfeeding.
- Women who have achieved desired family size but do not want a permanent method.
- Women who prefer not to use or have contraindications to contraceptives that contain oestrogen or have developed oestrogen-related complications while take COCs.
- Postpartum clients (after first 6 weeks).
- Women with STIs, PID, HIV, and/or AIDS, including those who take ART (ART that do not compromise effectiveness of the method).

- Women with moderate hypertension (BP<160/100) and those with history of hypertension during pregnancy.
- Women with valvular heart disease.
- Women having major and minor surgery without prolonged immobilization or without varicose veins.
- Women with non-migraine headache or depressive disorders.
- Women with endometriosis, severe dysmenorrhoea, benign ovarian tumours, fibroids.
- Women with benign breast tumours, endometrial and ovarian cancer.
- Women with goitre.

Proceed with care in the following situations (Category 2):

Table 5.13: Contraceptive Implants (Category 2)

Condition	Suggested Action
Woman with multiple risk factors for cardiovascular disease	The only conditions that would dictate non-use of method are current ischaemic heart disease or current deep venous thrombosis (DVT) or PE; otherwise, implants can be used by women with severe hypertension and diabetes
History of hypertension, BP cannot be measured	Implants can be used but need follow-up where BP can be checked
Severe hypertension (=/>160/100); or with vasculopathy	Implants can be used but need follow-up to monitor onset of complications which necessitate discontinuation of method, e.g., onset of IHD (ischaemic heart disease) or CVA
History of DVT or major surgery with prolonged immobilization; known thrombogenic mutations	Implants can be used but need follow-up to monitor onset of complications which necessitate discontinuation of method, e.g., onset of DVT (deep vein thrombosis) or PE (pulmonary embolism)
Women with migraine without aura	Implants can be used but need follow-up; discontinue if she reports aura
Women having irregular, prolonged or heavy bleeding	Evaluate to exclude serious underlying condition; women with cervical cancer and continue using the method until definitive treatment is provided

Condition	Suggested Action
Women diagnosed with CIN (cervical intraepithelial neoplasm) or cervical cancer	Women with cervical cancer can continue suing the method until treatment is provided
Women with undiagnosed breast lump	Evaluate before insertion. Women with benign tumours can use implants, but not those with breast cancer (Category 4)
Diabetes without or with vascular complications	Implants can be used but need follow-up to monitor onset of serious cardiovascular complications which necessitate discontinuation of method
Gall bladder disease	Implants can be used
Mild cirrhosis symptomatic or asymptomatic	Implants can be used; monitor progress and discontinue if cirrhosis becomes severe (Category 3)
Treatment with Griseofulvin and certain ARVs	♦ Implants can be used; counsel regarding drug interaction effect on contraceptive effectiveness ♦ If client is worried, help choose alternative method

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Who Should Not Use Contraceptive Implants (Categories 3&4)

- Breastfeeding women less than 6 weeks postpartum.
- Women who have active liver disease (viral hepatitis, severe cirrhosis, liver tumours).
- Women who have undiagnosed abnormal vaginal bleeding (before evaluation).
- Women who have breast cancer or women with a history of breast cancer.
- Women who cannot tolerate menstrual changes.
- Women who currently have DVT, ischaemic heart disease or stroke
- Women with migraine with aura.
- Women receiving treatment with Rifampicin (for TB) and certain anticonvulsants (for epilepsy).

Specific Instructions after Insertion

- Keep insertion area dry for 4-5 days.
- Can remove gauze bandage after 1-2 days, but leave in place the adhesive plaster for 5 days.
- Return to clinic if capsules (or rods) come out or if soreness in the arm lasts more than a few days.

Table 5.14: When can a woman start using an implant?

Situation	Suggested Action
Woman is having her menstrual cycles	♦ Insert implant within 7 days after the start of her menstrual bleeding. No additional contraceptive protection is needed. ♦ Insert implant any other time, if it is reasonably certain that she is not pregnant. If it has been more than 7 days since menstrual bleeding started, she will need additional contraceptive protection for the next 7 days.
Woman is amenorrhoeaic	♦ Insert implant any time, it is reasonably certain that she is not pregnant ♦ She will need additional contraceptive protection for the next 7 days
Woman is breastfeeding	♦ Between 6 weeks and 6 months postpartum and she is amenorreahic, insert implant any time. If she is fully or nearly fully breastfeeding (see LAM) no additional contraceptive protection is needed. ♦ More than 6 weeks postpartum and her menstrual cycles have returned, she can have the implant inserted as advised for other women having menstrual cycles. ♦ For women less than 6 weeks postpartum and previously and primarily breastfeeding, use of implant is not recommended unless other more appropriate methods are not available or not acceptable.
Woman is switching from an IUCD (including hormonal)	♦ Implant can be inserted within 7 days after the start of menstrual bleeding. No additional contraceptive protection is needed. The IUCD can be removed at that time.

Table 5.15: Management of Common Side Effects

Side Effects	Management
Cont. Woman is switching from an IUCD (including hormonal)	♦ Implant can also be inserted at any time, if it reasonably certain she is not pregnant. If she has been sexually active in this menstrual cycle, and it has been more than 7 days since the menstrual bleeding started, it is recommended that the IUCD should remain in position to be removed at the time of her next menstrual period. ♦ If she has *not* been sexually active in this menstrual cycle and it has been more than 7 days since menstrual bleeding started, she will need protection for the next 7 days, if the IUCD is removed at that time. Otherwise she should retain it for removal at the time of her next menstrual period. ♦ If she is amenorreahic or has irregular bleeding, she can have the implant inserted as advised for other amenorrhoeic women.
Amenorrhea	♦ Reassure that this is normal while using implants. ♦ Amenorrhea does not require any medical treatment. Counselling is sufficient. ♦ If suspicious, assess for pregnancy. If pregnant, remove the implants. If not pregnant, reassure and continue method.
Spotting	♦ Spotting or light bleeding is common during implant use, particularly in the first year, and is not harmful. ♦ In woman with persistent spotting or bleeding, or woman with bleeding after a period of

Situation	Suggested Action
Cont. Spotting	amenorrhea, exclude gynaecologic problems when clinically warranted. If a gynaecologic problem is identified, treat the condition or refer for care. ♦ If STI or PID is diagnosed, she can continue using implants while receiving treatment and be counselled on condom use. ♦ If no gynaecologic problems are found, and she desires treatment, non-hormonal (NSAIDs) and hormonal (COCs or EE, ethinyl estradiol) options are available.
Spotting or light bleeding	♦ If she does not desire treatment or the treatment is not effective, and she finds the bleeding unacceptable, the implants should be removed. Help her choose another method.
Heavy or prolonged bleeding (more than 8 days or twice as much as her usual menstrual period)	♦ Exclude gynaecologic problems when clinically warranted. Treat the condition or refer for care after counselling. ♦ If gynaecologic problem is found, and she desires treatment, non hormonal and hormonal options are available (see above). ♦ If she does not desire treatment or treatment is not effective, and the bleeding becomes a threat to her health or is unacceptable to her, the implants should be removed. Help her choose another method.

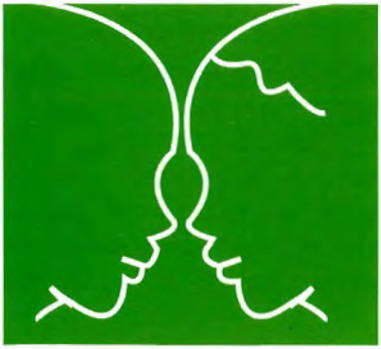
Situation	Suggested Action
Implant expulsion	♦Assess for other causes. Reassure if mild. If severe, remove implants and refer. ♦Assist client to select another method.
Recurrent and persistent headaches especially with blurred vision	♦If one Norplant capsule is expelled, open a new package and insert one capsule. If more than one is expelled, remove all capsules and insert a new set in the other arm or in the reverse direction in the same arm, or help the client select alternative method.

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Who can provide?	Where they can be provided
• Specially trained provider • Medical doctor • Clinical officer • Nurse/midwife	• Hospitals • Primary Health Care Centres • Primary Health Care Units • Private Clinics

Note:

- The facility must follow appropriate infection prevention measures.
- Sites that offer insertion must provide removal facilities, including counselling and other alternative methods



CHAPTER 6

Barrier Methods of Contraception

Q What are barrier methods?

Barrier methods, as the name suggests, create a barrier that prevents the sperm from gaining access to the upper female reproductive tract, thus preventing it from meeting the egg. The common ones are male and female condoms, spermicides, diaphragm and cervical cap. Whereas condoms, diaphragm and cervical cap are mechanical barriers, spermicides create a chemical barrier that interferes with movement of the sperm and its ability to fertilize the egg.

The effectiveness of barrier methods is largely dependent on the way they are used. For example, condoms are only moderately effective if used incorrectly or inconsistently (pregnancy rate about 14 percent), but much more effective when used consistently and correctly (3 percent pregnancy rate) (See Appendix 2).

Barrier methods (condoms) help prevent both pregnancy and some STIs including HIV. For example, used correctly, both male and female condoms keep sperm and any disease organisms in semen out of the vagina; at the same time, they stop any disease organisms in the vagina from entering the male urethra. Another advantage of barrier methods is that, with the exception of the male condom, all the others are woman-controlled methods that would allow the woman to use the method, if empowered to make the decision.

Unlike latex rubber, there is no known allergy to polyurethane, the material used to make female condoms.

Male Condom

Q What is the male condom?

THe male condom is a sheath, or covering, made to fit a man's erect penis. Most condoms are made of thin latex rubber. Some are coated with a dry lubricant or with spermicide. Condoms come in different sizes, shapes, colours and texture. As stated above, condoms help prevent both pregnancy and some STIs including HIV.

Advantages

Contraceptive benefits	*Other benefits*
• Fairly effective if used properly. • Immediately effective. • Offer contraception only when needed (no daily intake). • Easy to obtain, can be used without seeing a health care provider. • Safe.	• Highly effective protection against STIs/HIV/AIDS with consistent and proper use. • May prevent premature ejaculation. • Can be used by almost every man. • Easy to use with a little practice. • No health risk associated with the method.

Limitations

- A new condom must be worn for each act of sexual intercourse.
- Have a higher failure rate if used inconsistently and/or incorrectly (use with spermicides does not increase condom efficacy).
- May reduce sensitivity.
- May cause itching for a few people who are allergic to latex.

Note:

Male condoms should not be used with non-water-soluble lubricants or jellies, such as petroleum products and oils, as these lead to rapid degeneration and may reduce their effectiveness in preventing pregnancy and protection against STIs/HIV/AIDS.

Who Can Use Condoms

- Men who wish to participate actively in family planning.
- Couples needing a backup method (e.g., for missed pills).
- Couples who have sex infrequently and who do not need continual protection.
- Couples needing temporary methods while awaiting another method
- Couples who want protection from STIs/HIV
- Those who are not using another method
- Those who are using another method for pregnancy prevention but are at risk of acquiring STIs/HIV (e.g., those with more than one partner)
- Post-abortion clients before initiating more appropriate methods or any client who needs more time to make a decision about a contraceptive method

Who Should Not Use Condoms

Couples who want highly effective protection against pregnancy, e.g., where the woman has conditions that make pregnancy dangerous, and therefore needs to consider a more reliable method (See Appendix 3). If she is also at risk of STIs, she should use a condom in addition to the more reliable method.

Table 6.1: Management of Common Side Effects

Side Effects	Management
Allergy/irritation	In case of latex, advise to use another method. Rule out infection. If the lubricant is a cause of irritation, suggest using water lubricant. ***NOTE:*** *Clients at risk of STIs/HIV should be counselled to continue to iuse condoms despite discomfort as long as they are at risk. If irritation is unacceptable to the client, assist in choosing another method. Rule out infection*

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Table 6.2: List of providers matched with the service sites where FP services can be provided

Who can provide	Where it can be provided
• All service providers • Medical doctors • Nurses/midwives • Clinical officers • Trained community workers/CBDs • Pharmacists/pharmaceutic als technologists	All service-delivery points: • Hospitals • Primary Health care centres • Primary Health care units • Outreach/mobiles services • Pharmacies • Private clinics • Retail outlets • Through condom dispensers at most any convenient point

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Disposal of used condoms

Clients should be advised on proper ways of using condom (male and female) as well as how to dispose of the used ones.
In the case of male condom:

- After ejaculation the man should hold the rim of the condom at the base of the penis so it will not slip off when he is pulling his penis out of the vagina, before completely losing his erection.
- The condom is taken off the penis without spilling the semen on/around the vaginal opening.
- The used condom can be thrown into a pit latrine, burned or buried. It should not be left where children will find it and play with it.
- Condoms must not be reused.

Female Condom (FC)

Q What is the female condom?

The female condom is a strong, soft, transparent polyurethane sheath inserted in the vagina before sexual intercourse, providing protection against both pregnancy and STIs. It forms a barrier between the penis and the vagina, cervix and external genitalia. It is stronger than latex, odourless, causes no allergic reactions, and, unlike latex, may be used with both oil-based and water-based lubricants.

Advantages

Contraceptive Benefits	*Other Benefits*
• Fairly effective if used properly. • Immediately effective. • Effectiveness of FC is similar to male condom and to the other vaginal methods.	• Highly effective protection against STIs/HIV/AIDS with consistent and proper use. • Protects against PID. • Woman controlled method. • Can be used by almost every woman. • No need to see health care provider before using . • Easy to use with a little practice. • No health risk associated with the method. • Unlike latex rubber, there is no known allergy to polyurethane, the material used to make female condoms.

Limitations

- Requires insertion before sexual intercourse
- Could be expensive for single use only

Who Can Use The Female Condom?

- All women of reproductive age.
- Women of all parity, including nulliparous.
- Women needing to rule out possible pregnancy before proceeding with another method.
- Women needing a back-up method.
- Women needing temporary methods of contraception.
- Post-abortion clients before initiating more appropriate methods.
- Women with sickle cell, diabetes, hypertension.
- Breastfeeding women.

Who Should Not Use

Couples who want highly effective protection against pregnancy; where the woman has conditions that make pregnancy dangerous (See Appendix 3).

Dispose of Used Condoms

In the case of female condom:

- At the end of intercourse the woman should hold the outside rim of the female condom and carefully pull out the device without spilling semen.
- The used condom can be thrown into a pit latrine, burned or buried. It should not be left where children will find it and play with it.
- Female condoms must not be reused.

Diaphragm, Cervical Cap and Spermicide

Advantages

Contraceptive Benefits	*Other Benefits*
• Effective immediately. • Does not affect breastfeeding.	• Woman-controlled method. • Can be used by almost every woman. • Easy to use with a little practice. • No serious health risk. associated with the methods • Protect against. STIs/HIV/AIDS; however, this protection is not com plete.

Limitations

- The diaphragm and cervical cap require an initial fitting by a trained provider.
- Efficacy is improved if diaphragm is used together with spermicide.
- Water and soap are needed to wash the diaphragm. All of these methods have to be inserted before sexual intercourse; spermicides must be inserted before each sexual act.

- Spermicides may cause irritation to the woman or her partner, especially if used several times a day. In addition, if used often, spermicides may increase the woman's risk of acquiring HIV when exposed to infection.
- Local allergic reactions may occur, though rare.
- The diaphragm may increase risk of urinary tract infections.
- Spermicide requires insertion of a finger or an inserter into the vagina, which may be a problem for some women.

Who Can Use a Diaphragm/Cervical Cap and Spermicide

- All women of reproductive age.
- Women of any parity, including nulliparous.
- Women needing to rule out possible pregnancy before proceeding with another method.
- Women needing a back-up method.
- Women needing temporary methods of contraception.
- Post-abortion clients before initiating more appropriate methods.
- Women with contraindications to some other methods, e.g., women with advanced diabetes, hypertension.
- Breastfeeding women.

Proceed with care in the following situations:

Table 6.3: Diaphragm/Cervical Cap and Spermicide Special Care

Situation	Suggested Action
Women with recurrent history of urinary tract infection	Do urinalysis and treat appropriately. Requires careful follow- up. Continued use of the diaphragm is usually not reccommended for a woman with chronic or reccurent urinary tract infection that does not respond well to treatment
Women who have repeated intercourse over several hours	Advice to apply more spermicide with each act of intercourse until no more intercourse is expected Look out for possible vaginal irritation . Counsel about increased risk of HIV acquisition with frequent use of spermicide. Help to choose another form of protection

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Who Should Not Use

- Women who desire highly effective protection against pregnancy; those who have conditions that make pregnancy particularly dangerous (See Appendix 3).
- Women who dislike touching their genitals or are unable to feel their own cervix or posterior fornix (for diaphragm and cervical cap).

- Women with vaginitis.
- Couples (or either partner) who are allergic to spermicide or the material from which the device is made.
- Women with vaginal abnormalities or poor vaginal muscle tone.
- Women who have had toxic shock syndrome should not use diaphragm or cervical cap.
- Women who recently gave birth or had second trimester abortion (spontaneous or induced) should wait 6 to 12 weeks for diaphragm or cervical cap to be fitted.
- Women at increased risk of STIs including HIV should not use Nonoxynol-9 spermicides.

Table 6.4: Diaphragm/Cervical Cap and Spermicide: Who can provide and where it is provided

Who can provide	Where it can be provided
Diaphragm and cervical cap: Doctors Nurses/midwifes Clinical officers	Diaphragm and cervical cap can be provided at all SDP where there is a provider trained in fitting them
Spermicide: All trained providers including CBD workers	Spermicide can be provided at any appropriate site

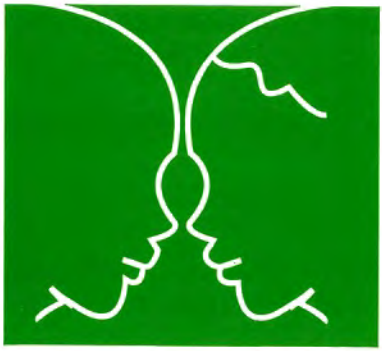
Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Table: 6.5: Management of Common side Effects

Side Effects	Management
Allergic reaction to spermicide or material from which diaphgram or cervical cap is made	Assess for infection, advice to use another method
Discomfort with diaphragm	Assess for appropriate size or choose another method

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland

NOTES



CHAPTER 7

Intrauterine Contraceptive Device (IUCD)

Intrauterine ContraceptiveDevice (IUCD)

Q What is an intrauterine contraceptive device?

The IUCD is a small flexible device inserted into the uterine cavity by a trained service provider. The most widely used are the copper-bearing IUCDs, which are made of plastic with copper sleeves on the arms and copper wire wound around the stem. The copper T 380A is the most widely available IUCD in the region. It is the device that is considered with regard to the eligibility criteria, given in this section.

IUCDs do not suppress milk production in breastfeeding women. They do not cause PID (pelvic inflammatory disease). On the other hand, if the client already has an STI at the time of insertion or the service provider inserts the IUCD without maintaining sterility, there is a small increased risk of pelvic infection in the first three weeks after insertion.

The copper IUCD prevents pregnancy primarily by preventing sperm from fertilizing the egg. By changing the environment in the uterine cavity, the IUCD makes it difficult for the egg and sperm to meet. **The IUCD does not cause abortion.**

Hormone-release IUCDs are less widely available. These are made of plastic and steadily release small amounts of the hormone progesterone or another progestin such as Levonorgestrel. It is this hormone that is responsible for prevention of pregnancy by the IUCD. The hormone-releasing IUCD is a mechanism for long-term administration of a contraceptive hormone as is the case of contraceptive implants.

Almost all brands of IUCDs have one or two strings, or threads, tied to the lower end. The strings hang through the opening of the cervix into the vagina, which enable the user to check that the device is still in place by touching the strings.

Table 7.1: IUCD Brands and Duration of Effectiveness

Device	Duration of Effectiveness
Copper T 380A	Up to 12 years
NOVA T	5 years
Multiload-MLCu-375	5 years
MUltiload-MLCu-250	3 years
Copper 220	3 years
Gynefix	8 years
Hormone releasing IUCDs: e.g., Mirena (LNG-IUCD), Progestasert (Progesterone IUCD)	5 years

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Prophylactic antibiotics are generally not recommended for Cu-IUCD insertion. However, where the risk for cervical gonococci and Chlamydia infections is high and facilities for STI screening are inadequate, such prophylaxis may be considered. In any case, such clients should be counselled to watch for symptoms of PID, especially during the first month of insertion.

Advantages

Contraceptive Benefits	*Other Benefits*
• Highly effective. • Immediate effectiveness. • Long-term protection. • Immediate return of fertility upon removal.	• Does not interfere with intercourse. • Can be used by women who are breastfeeding. • Help prevent ectopic pregnancy.

Limitations

- Require appropriate infection prevention practices during insertion and removal.
- May increase menstrual bleeding and cramping during the first few months of use.
- Does not protect against all ectopic pregnancies.
- Does not protect against STIs/HIV/AIDS.
- May be expelled or translocated.
- Perforation of the uterus may occur if provider is unskilled.

Who Can Use the IUCD (Category 1)

- Women of reproductive age.
- Parous women of any parity.
- Women who want long-term, highly effective protection against pregnancy.
- Women who are 4 weeks or more postpartum.
- Women following first trimester abortion or ectopic pregnancy
- Women who have delivered by caesarean section.
- Women with irregular menstrual cycles without heavy bleeding.

- Women with cervical ectropion (erosion), and those with uterine fibroids without distortion of uterine cavity.
- Women with past history of PID who have subsequently conceived.
- Women with non-pelvic TB.
- Women with multiple risk factors for CVD.
- Women with diabetes with or without complications.
- Women with breast disease and those with benign ovarian tumours.
- Women with liver and gall bladder disease.

Proceed with care in the following situations (Category 2):

Table 7.2: IUCD (Category 2)

Condition	Suggested Action
Women aged <20 years nulliparous Women	Generally provide after counselling on range of methods availlable. There is concern both about the increased risk of IUCD expulsion due to nulliparity and therisk of STIs due to sexual behaviour in Younger age groups. Reccommend / motivate follow-up.
Postpartum less than 48 hours (or immediately after expulsion of placenta)	Generally provide. Requires provider trained in postpartum IUCD insertion. Ensure there is no sepsis (category 4) and watch during follow-up for expulsion.
Following second trimester abortion (where there is no sepsis)	Generally provide. Requires provider trained in insertion, if provider not trained specific situation insertion, delay four weeks for uterus to return to normal size. Follow- up needed because of higher chance of expulsion compared with after first trimester abortion.
Past PID without subsequent pregnancy	Generally provide, but needs careful counselling regarding STI risk. Careful follow-up is needed.

Condition	Suggested Action
Increased risk of STIs including HIV or is HIV infected, as well as those with AIDS but doing well on ARVs	Counsel client that IUCDs do not protect against STIs including HIV. Generally provide. Careful follow- up needed.
Women having heavy and/or prolonged vaginal bleeding (may be regular or irregular)	Unusually heavy bleeding should raise the suspicion of a serious underlying condition; hence she needs investigation (including VIA and Pap smear) to rule out pathology before initiating IUCD use. For continuing client, she can continue with pending diagnosis.
Women with endometriosis or severe dysmenorrhoea	Use of CU-IUCD may intensify dysmenorrhoea, including that associated with endometriosis. Generally provide method. Careful follow up as needed. Provide analgesics.
Anaemias iron deficiency anaemia, sickle cell disease, Thalassaemia	There is concern about an increased risk of blood loss with CU-IUCD. Generally provide method. Careful follow- up needed. Advise haematinics.
Women with valvular heart disease (complicated by pulmonary hypertension, risk of arterial fibrillation and those with history of SBE (sub-acute bacterial endocarditis)	Generally provide method, but give prophylactic antibiotics at the time of insertion to prevent endocarditis. Needs careful counselling, follow-up and referral.

Condition	Suggested Action
Women whose partners are at increased risk of STIs	Counsel client on dual method use.

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Who Should Not Use (Categories 3 & 4)

- Postpartum women after 48 hours and before end of 4 weeks.
- Women with puerperal sepsis or immediately after post-septic abortion.
- Women with unexplained vaginal bleeding before evaluation.
- Women with trophoblastic disease, benign or malignant.
- Women with pelvic cancer (cervical, endometrial and ovarian cancers).
- Women with fibroids distorting the uterine cavity.
- Women with anatomical abnormalities of the uterus and cervix which interferes with insertion and retention of IUCD.
- Women with current PID or current purulent cervicitis.
- Women who have high individual likelihood of exposure to gonorrhoea and/or Chlamydia.
- Women known to have pelvic TB.

Table 7.3: IUCD: Who can provide and where it can be provided

Who can provide	Where it can be provided
Medical doctors	IUCDs should be provided within facilities that follow appropriate infection prevention measures.
Clinical officers	Hospitals.
Trained nurses/midwives	Primary Health Care Centres, Primary Health Care Units, Private Clinics.

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Table 7.4: Management of Common Problems Associated with IUCD Use

PROBLEM	MANAGEMENT
Spotting or light bleeding between menstrual periods	Clients should be counselled that spotting or light bleeding is common during the first 3 to 6 months of Cu-IUCD use. It is not harmful and usually decreases over time. If she desires treatment, a short course of NSAIDs may be given during the days of bleeding. In women with persistent spotting and bleeding, exclude gynaecologic problems when clinically warranted. If a gynaecologic problem is identified, treat the condition or refer for care. If no gynaecologic problems are found, and she finds the bleeding unacceptable, remove the IUCD and help her choose another method.

PROBLEM	MANAGEMENT
Heavier or prolonged menstrual bleeding than with normal menstrual periods	Heavier or prolonged menstrual bleeding is common during the first 3 to 6 months of Cu-IUCD use. Usually this is not harmful, and bleeding usually becomes light over time. During the days of menstrual bleeding NSAIDs or Tranexamic acid (a haemostatic agent) can be given. ***Aspirin should NOT be used.*** Exclude gynaecologic problems when clinically warranted. If a gynaecologic problem is identified, treat the condition or refer for care. If the bleeding continues to be very heavy or prolonged, especially if there are clinical signs of anaemia, or if she finds the bleeding unacceptable, remove the IUCD and help her choose another method. To prevent anaemia, provide an iron supplement and/or encourage foods containing iron.
Cu-IUCD user is found to be pregnant	Exclude ectopic pregnancy. Explain that she is at risk of second trimester miscarriage, Pre-term delivery, and/or infection if the IUCD is left in place. The removal of the device reduces these risks, although the procedure itself entails a small risk of miscarriage.

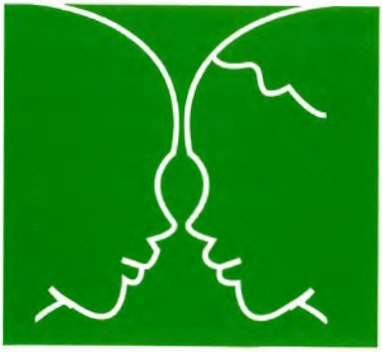
PROBLEM	MANAGEMENT
Cont. Cu-IUCD user is found to be pregnant	If IUCD cannot be removed and she wishes to continue the pregnancy, make clear to her the increased risks of miscarriage, pre-term delivery and infection. Advise her to seek care promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge, fever. If she does not wish to continue the pregnancy, counsel accordingly. ***If IUCD strings are visible or can be retrieved safely from the cervical canal:*** Advise her that it is best to remove the IUCD. Removing the device can improve pregnancy outcome if the IUCD strings are visible or can be retrieved safely from the cervical canal, and that the risk of miscarriage, pre-term delivery and infection is substantial if the IUCD is left in place. If the IUCD is to be removed, remove it by pulling on the strings gently. Explain that she should return promptly if she has heavy bleeding, cramping, pain,abnormal vaginal discharge, or fever. If she chooses to keep the IUCD, advise her to seek care promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever.

PROBLEM	MANAGEMENT
Cont. Cu-IUCD user is found to be pregnant	***The lucid strings are not visible and cannot be safely retrieved:*** Where ultrasound is available, determine the location of the IUCD. If the IUCD is not located, this may suggest that an expulsion of the IUCD has occurred. If ultrasound is not possible or if the IUCD is determined by ultrasound to be inside the uterus, make clear the risks and advise her to seek care promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever.
Abdominal cramps, pain and severe dysmenorrhoea	All women should be counselled on potential changes in menstrual cycle before IUCD insertion. Examination should rule out partial expulsion of the IUCD, ectopic pregnancy or PID (see below). Treat dysmenorrhoea with analgesics. If persistent, rule out pelvic pathology (refer as necessary).
A woman using Cu-IUCD is diagnosed with PID	Treat the PID using appropriate antibiotics. There is no need for removal of Cu-IUCD if she wishes to continue its use. If she does not want to keep the IUCD, remove it after antibiotic treatment has been started.

PROBLEM	MANAGEMENT
Cont. A woman using Cu-IUCD is diagnosed with PID	If the IUCD is removed, help her to choose another contraceptive method. If the infection does not improve, generally the course would be to remove IUCD and continue antibiotics. If the IUCD is not removed, antibiotics should also be continued. In both circumstances, her health should be closely monitored.

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Notes



CHAPTER 8

Voluntary Surgical Contraception (Permanent Contraception)

Introduction

Voluntary surgical contraception (VSC) includes female and male sterilization procedures that are intended to provide permanent contraception. As such, special care must be taken to assure that every client makes a voluntary, informed choice for the method. Particular attention must be given to counselling in the case of youth clients, nulliparous women, men who have not yet been a father, and clients with mental health problems, including depression conditions. All clients must be carefully counselled about intended permanence of the sterilization and the availability of alternative, long-term, highly effective methods.

There is no medical condition that would absolutely restrict a person's eligibility for sterilization although some conditions and circumstances will require that certain precautions are taken, including those where the recommendation is C (Caution), D (Delay), or S (Special). For some of these conditions and circumstances, the theoretical or proven risks may outweigh the advantages of undergoing VSC, particularly female VSC. Where the risk of VSC outweighs the benefits, long-term highly effective contraceptive methods are a preferable alternative.

Definitions of Conditions

A. Accept: There is no medical reason to deny sterilization to a person with this condition.

C. Caution: The procedure is normally conducted in a routine setting, but with extra preparation and precautions.

D. Delay: The procedure is delayed until the condition is evaluated and/or corrected. Alternative temporary methods of contraception should be provided in the meantime.

S. Special: The procedure should be undertaken in a setting with an experienced surgeon and staff; equipment needed to provide general anaesthesia; and other back up medical support. For these conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen are also needed. Alternatively, temporary methods of contraception should be provided, if referral is required or there is any other delay.

Note:

In outreach programs, all appropriate infection prevention practices, counselling, and follow-up should be arranged as per procedures done at static sites. No more than 30 procedures should be performed in one operating theatre or by one surgeon in a day.

No incentive is to be given to clients to accept any form of contraception or to providers to recruit clients and perform the surgical procedure. The client is free to change her/his mind anytime prior to accepting the procedure.

Informed consent must be obtained and a standard consent form signed by the client for the procedure. Partner's consent is not mandatory but counselling should be provided to and consent obtained from both partners, if possible (See Appendix 5).

Female Voluntary Surgical Contraception

Q What Is Female Voluntary Surgical Contraception?

Female voluntary surgical contraception, also referred to as female sterilization or bilateral tubal ligation (BTL), is a minor surgical operation, which involves the tying and cutting of the fallopian tubes in order to prevent the egg released by the ovary from being fertilized by sperm, and reaching the uterine cavity. It is generally a safe procedure, and when performed by a trained provider, few women experience side effects or complications. Overall rates of complications are in the range of 0.4-2.0 percent. It is a highly effective method of contraception, failing in less than 1 percent of women in the first year after surgery (See Appendix 2).Tubal ligation can be performed under conscious sedation and local anaesthesia. Tubal ligation is a permanent FP method (reversal cannot be assured). Hence, thorough, careful counselling is needed before decision, making. The client in all cases must sign a consent form before the procedure is undertaken. In the case of mentally challenged clients, a signature of parent/guardian must be obtained (See Appendix 5).

Types

- Minilaparotomy (postpartum or interval).
- aparoscopic tubal ligation interval tubal ligation (not available in Southern Sudan).

- At caesarean section or other abdominal surgery.

Advantages

Contraceptive Benefits	*Other Benefits*
• Highly effective. • Immediately effective. • No change in sexual function. does not interfere with intercourse. • Permanent. • Few known side effects . • Good choice for client if pregnancy would be a serious health risk. • Does not affect breastfeeding.	• Decreases risk of ovarian cancer.

Limitations

- Generally irreversible, success of reversal surgery cannot be guaranteed.
- Minimum risks and side effects of anaesthesia.
- Risks associated with surgical procedures.
- Usually painful for a few days after the procedure.
- In rare cases when pregnancy occurs, it is more likely to be ectopic
- Not provided at all SDPs.
- Can only be offered by a trained provider.
- Does not protect against STIs/HIV/AIDS.

Who Can Use Bilateral Tubal Ligation (Category A)

- Women of reproductive age.
- Women who are certain they have achieved the desired family size.
- Clients in whom pregnancy would pose a serious health risk.
- Women who understand and voluntarily follow an informed consent procedure. In certain situations, the procedure may be performed on mentally challenged persons with the consent of a responsible parent/guardian/husband.

Who Should Not Use

- Clients who are uncertain of their desire for future fertility.
- Clients who cannot withstand surgery.
- Clients who do not give voluntary informed consent.

Table 8.1: Classification of Medical Conditions According to Precautionary Measures Needed for Female Sterilization

CAUTION	DELAY	SPECIAL
Procedure can be conducted in a routine setting, but with extra preparation and precautions Obesity Hypertension adequately controlled; moderated BP less than 160/100	Delay procedure until condition is evaluated and/or corrected. Provide alternative temporary contraception. Postpartum 7 to 42 days Severe pre-eclampsia/ eclampsia Prolonged rupture of membranes	Procedure requires experienced surgical team, equipment for general anaesthesia and other medical support. Provide alternative temporary contraception if referral is required or there is any other delay.

CAUTION	DELAY	SPECIAL
History of ischaemic heart disease History of stroke Uncomplicated valvular heart disease Epilepsy or depressive disorders Uterine fibroids Diabetes Cirrhosis-mild Liver tumours Anaemias Previous abdominal or pelvic surgery Kidney disease Severe nutritional deficiencies	Puerperal sepsis-intrapartum or Puerperal Severe antepartum and postpartum haemorrhage Traumatic delivery with severe trauma to the genital tract Post-abortion sepsis or fever Severe post-abortion haemorrhage Severe trauma to genital tract at time of abortion, including uterine perforation Current DVT or PE Current ischaemic heart disease Unexplained vaginal bleeding before diagnosis Current PID or purulent cervicitis Current gall bladder disease Active viral hepatitis Severe anaemia Local infection - abdominal skin Acute respiratory disease	Fixed uterus due to previous surgery, PID or endometriosis Known pelvic TB Uterine rupture or perforation Multiple factors for CVD BP 160/100 or higher Hypertension complicated by vascular disease Complicated valvular heart disease Diabetes with vascular complications Severe cirrhosis Coagulation disorders Chronic respiratory disease AIDS

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Proceed with caution or delay in the following situations:

Table 8.2: Female Sterilization Special Caution or Delay

CONDITION	SUGGESTED ACTION
Young age Woman with no living children	CAUTION: Due to high risk of regret, counsel very carefully about the permanency of the procedure and the availability of alternative long-term highly effective methods. Allow additional time if need be to assure informed decision.
For women undergoing postpartum sterilization: Prolonged rupture of membranes Puerperal sepsis Severe ante partum haemorrhage or postpartum haemorrhage Severe trauma to genital tract at delivery.	DELAY: Procedure to permit treatment with antibiotics. Wait till 3 months after deliver. If woman is exclusively breastfeeding, she does not require additional contraceptive protection; if not advise another methods.
Post-abortion: Post-abortion sepsis or fever Severe post-abortion haemorrhage Severe trauma to genital tract including uterine perforation	DELAY: Procedure to permit treatment with antibiotics. Wait till 3 months after abortion. Women who have had uterine perforation need specialized care (SPECIAL). Advise alternative contraception in the meantime.

CONDITION	SUGGESTED ACTION
Current PID	DELAY: Procedure to permit treatment with antibiotics until complete healing has occurred.
Women with previous PID without subsequent pregnancy and those with fixed uterus due to any cause	CAUTION & SPECIAL: Possibility of pelvic adhesions making surgery difficult. Avoid use of laparoscopic method.
Women with endometrial, ovarian or cervical cancer	DELAY: Treatment of these conditions may render her sterile.
Women with heart disease, respiratory disorders, hypertension, diabetes, obesity	DELAY & REFER (SPECIAL) For careful assessment by a doctor (specialist). CAUTION: avoid use of laparoscopic method.
Women with any lingering chronic ailment: gall bladder disease, active viral hepatitis, severe anaemia, current AIDS-related illness	DELAY & REFER (SPECIAL) for careful assessment by a doctor (specialist)

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Note:

Ectopic pregnancy: Pregnancy following BLT is rare, but when it occurs, it is more likely to be an ectopic than uterine pregnancy. Ectopic pregnancy is life threatening and requires immediate treatment. Following the procedure the client should be counselled that if ever she suspects a pregnancy, she should seek help right away.

Who Can Provide	**Where It Can Be Provided**
Trained providers (doctors, medical assistants)	Any health facility with minor theatre, appropriate equipment and ability to observe infection prevention measures, and has drugs and equipment to handle emergencies

Table 8.3: Management of Common Side Effects

Side Effects	Management
Pain at incision site	Determine presence of infection and treat; if no infection, reassure and provide analgesics.
Wound infection, fever	If skin infection, clean, dress and treat with antibiotics; if abscess, incise and drain.
Haematoma	Apply warm, moist packs on site, observe for a few days; if increasing, evacuate.
More injuries, e.g., bladder or bowel	Refer for competent care in a hospital.

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Male Voluntary Surgical Contraception: Vasectomy

Q What Is Male Voluntary Surgical Contraception (Vasectomy)?

Male VSC or vasectomy is the surgical process of cutting the vas deferens in order to stop the sperm from mixing with semen, so that the semen is ejaculated without sperm. The operation is performed under a local anaesthetic.

Vasectomy is not synonymous with castration and does not affect sexual ability. It is one of the most effective methods of contraception; it has a failure rate of less than 1 percent in most studies. Vasectomy **does not become** effective immediately. It is important that clients use condoms or another FP method for 3 months after the operation to be completely safe.

Thorough and careful counselling is needed before decision making to avoid future regret. The procedure must be considered permanent since reversal surgery cannot be assured.

Types

- Scalpel and non-scalpel vasectomy techniques.

Advantages

Contraceptive Benefits

- Highly effective.
- No change in sexual function; does not interfere with sexual intercourse.
- Permanent.

Limitations

- Irreversible, success of reversal surgery cannot be guaranteed.
- Minimal risks and side effects of local anaesthesia.
- Risks associated with surgical procedures.
- Does not protect against STIs/HIV/AIDS.
- Can only be offered by a trained provider.
- Delayed effectiveness once the procedure has been performed.

Note:

- Informed consent must be obtained and standard consent form signed by the client for the procedure (See Appendix 5).
- In outreach programs, all appropriate infection prevention measures, counselling, and follow-up should be arranged as per procedures from a static site. No more than 30 procedures should be performed in one operating theatre or by one surgeon in a day.
- No incentives should be given to clients to accept VSC or to providers to recruit clients and perform the surgical procedure.
- The client is free to change his mind anytime prior to the procedure.

Who Can Use Vasectomy

- Men of reproductive age.
- Men who have achieved desired family size.
- Men who understand and voluntarily give informed consent for the procedure.

Table 8.4: Classification of Medical Conditions According to Precautionary Measures Needed for Male Sterilization

CAUTION	DELAY	SPECIA
Procedure can be conducted in a routine setting, but with extra preparation and precautions: Young age Depression disorders Diabetes Previous scrotal injury Large varcocele Large hydrocele Cryptoorchidism	Delay procedure until condition is evaluated and/or corrected; provide alternative temporary contraception: Local skin infection Active STI, balanitis, epididymitis or orchitis Systemic infection or gastroenteritis Filariasis; elephantiasis Intra-scrotal mass	Procedure requires experienced surgical team, equipment for general anaesthetic, and other medical support; provide alternative temporary contraception if referral is required or there is any other delay: Coagulation disorders AIDS Inguinal hernia

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva Switzeland

Proceed with caution or delay in the following situations:

Table 8.5: Male Sterilization Special Caution or Delay

CONDITION	CARE
Single men; men with no living children; men below 18 years of age	CAUTION: Counsel very carefully and allow additional time if needed to make informed decision.

CONDITION	CARE
Diabetes mellitus	CAUTION: Diabetics are more likely to get postoperative wound infections. Follow-up and treat with antibiotics if any signs of infection are present.
Any local infection, including active STI, orchitis, balanitis or epididymitis	DELAY: Treat before procedure.
Any systemic infection or gastroenteritis	DELAY: Until treated and resolved.
Cryptorchidism	SPECIAL: May require an extensive surgery to locate the vas.
Coagulation disorders	SPECIAL: There is an increased risk of postoperative haematoma and this, in turn, may lead to increased risk of infection. Additional follow-up and interventions may be required.
Intra-scrotal mass	DELAY. This may, indicate an underlying disease. Evaluate as needed before the procedure.
AIDS	SPECIAL: Can be done if AIDS-related illnesses are not manifesting themselves at a time of procedure.

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Who Should not Use

- Clients who are uncertain of their desire for future fertility
- Clients who do not give voluntary informed consent

Who Can Provide	Where it Can Be Provided
Trained providers (doctor, medical assistant, clinical officer, nurse midwife)	Vasectomy can be undertaken at any facility with a minor theatre, appropriate equipment and ability to provide infection prevention measures, and where drugs and equipment to handle emergencies are available.

Appendix 1

How to be Reasonably Sure a Client is Not Pregnant

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

Table A1: How to be reasonably sure a client is not pregnant

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

If the client answered "No" to *all of the questions*, pregnancy cannot be ruled out. Client should await menses or use a pregnancy test.	If the client answered "Yes" to *at least one of the questions* and she is free of signs or symptoms of pregnancy, provide client with desired method.

Source: Family Health International (www.fhi.org).

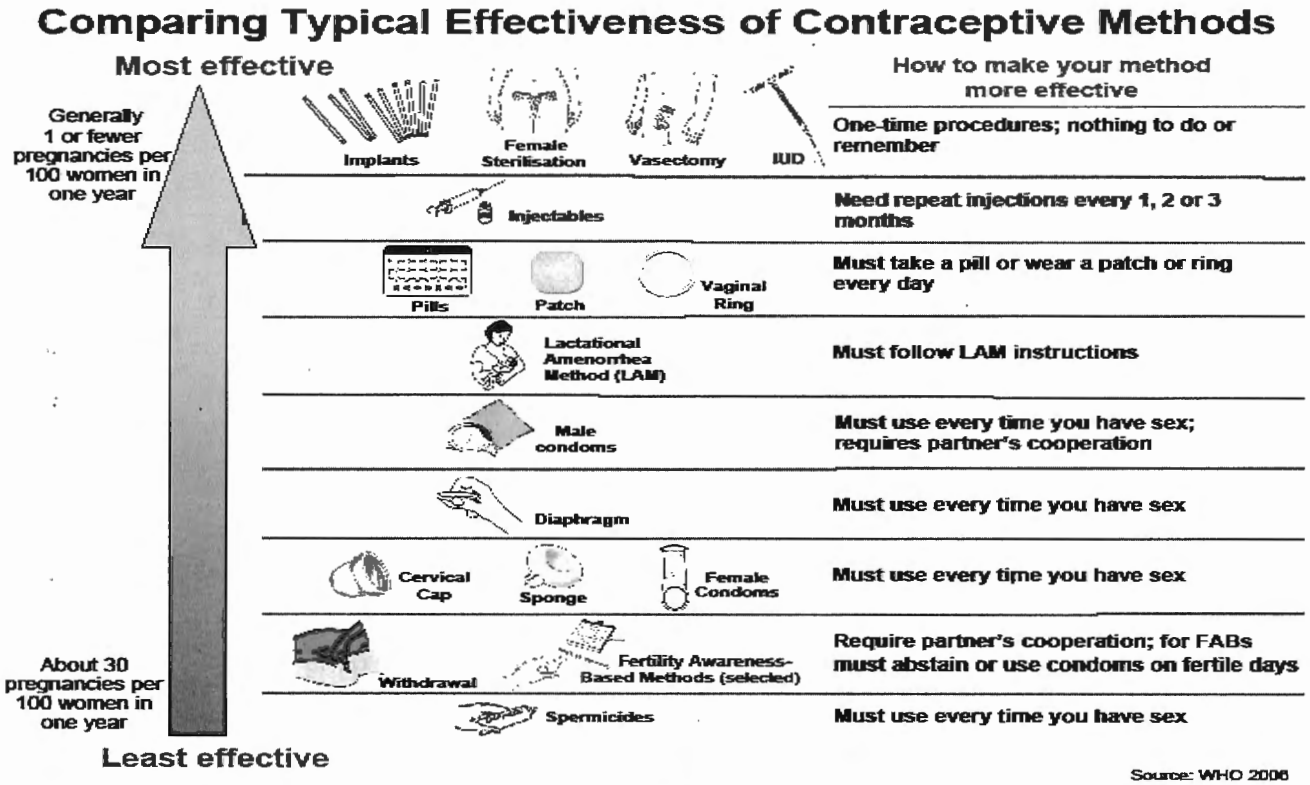
Appendix 2

Table A2: Effectiveness of family planning methods pregnancy rates per 100 women during first year of use

Method	Pregnancy Rates as Commonly Used	Pregnancy Rates Used Correctly and Consistently
No method	85	85
Vasectomy	0.15	0.1
Tubal occlusion	0.5	0.5
Progestin only implants	0.1	0.1
Progestin only injectables, e.g., DMPA	0.3-1	0.3
Intrauterine devices	0.8	0.6
Progestin only pills (during breastfeeding	1	0.5
Combined oral contraceptives	6-8	0.1
Lactational amenorrhea method	2	0.52
Male condoms	14	3
Female condoms	21	5
Spermicides	26	6
Withdrawal (coitus interruptus)	18-23	4-10
Diaphragm with spermicides	20	6
Natural family planning	20	1-9

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland.

Appendix 2: Chart A2



Appendix 3

Table A3: Conditions that expose a woman to increased risk as a result of unintended pregnancy

Breast cancer
Complicated valvular heart disease
Diabetes: Insulin dependent; with nephropathy or vascular disease; or 20 years duration
Endometrial or ovarian cancer
High Blood (Systolic >160mm Hg or diastolic >100 Mm Hg)
HIV/AIDS
Ischaemic heart disease
Malignant gestational trophoblastic disease
Malignant liver tumours
Schistosomiasis with fibrosis of the liver
Severe decompensated cirrhosis
Sickle cell disease
Sexually transmitted diseases
Stroke
Thrombogenic mutations
Tuberculosis

Source: WHO. 2004. Medical eligibility for contraceptive use, Third Edition. Geneva, Switzerland

Appendix 4

Antiseptic Handrub Solution

A nonirritating, antiseptic handrub can be made by adding either glycerin, proplyene glycol or sorbitol to alcohol (2 mL in 100 mL of 6090% ethyl or isopropyl alcohol solution) (Larson 1990; Pierce 1990). Use 5 mL (about one teaspoonful) for each application and continue rubbing the solution over the hands until they are dry (1530 seconds).

Note:

Glycerin is often sold in cosmetic departments because it is used as a hand softener.

Source: Tietjen, Linda, et al. 2003. Infection Prevention Guidelines for Healthcare Facilities with Limited Resources. JHPIEGO. Baltimore, Maryland.

Appendix 5

Informed and Voluntary Consent Form for Surgical Contraception

I_____, the undersigned, wish to be sterilized by the following procedure:

I understand the following:
There are temporary methods that I can use instead of sterilization for family planning.
Sterilization is a surgical procedure, the details of which my doctor/nurse midwife has explained to me.
The operation procedure carries certain risks, complications and side effects, which my doctor/nurse midwife has explained to me.
The sterilization procedure will permanently prevent future pregnancies.
The sterilization procedure is considered permanent and probably cannot be reversed.
I know that I can change my mind and decide against the procedure at any time before the procedure is done, and I will continue to be provided with medical services from my doctor /nurse/midwife.

_____	_____
Client's Name (Print)	Doctor's Name (Print)
_____	_____
Client Signature	Doctor's Signature
_____	_____
Date	Date

_____

Witness's Name (Print) - Can be another service provider

_____

Witness's Signature

_____

Date

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