

Family Planning
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Family Planning

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Family Planning

Definition

Family planning is a plan adopted by a couple that helps them to decide when, how often, and at what intervals they want to have children. Family planning allows couples to make a choice about methods based on accurate information and their own family planning goals.

Family Planning Depends on *Informed Choice*

- Ensuring that clients have clear, accurate, and complete information about contraceptive methods, benefits, risks, side effects, and costs to make their own family planning decisions.
- Giving access to a range of acceptable and affordable family planning methods from which to *choose*.

Benefits of Family Planning

Family planning has social, economic and health benefits for the individual, family, and society. By spacing pregnancies and reducing the number of pregnancies or preventing high risk or unwanted pregnancies, family planning offers the following benefits:

Benefits to the Mother

- Reduces the risk of maternal death.
- Decreases health risks associated with too many pregnancies too closely spaced for mothers who are either too young or too old.
- Promotes and protects maternal health through spacing the physical, mental, and nutritional status of the mother, giving a chance for health to be restored
- Decreases the incidence of high-risk pregnancies.
- Decreases the dangers of unsafe abortion sought for unwanted pregnancies.

Benefits to the Child

Through pregnancy spacing, family planning benefits the child by:

- Decreasing the rate of stillbirths, prenatal and infant mortality.
- Decreasing the rate of premature and low birth weight babies.
- Decreasing child morbidity due to infectious disease and malnutrition.
- Decreasing the rate of congenital abnormalities and mental retardation.
- Improving the child's the physical, mental, and intellectual growth, health and development, and academic achievement.
- Increasing the child's chance for sufficient breastfeeding, care and love.
- Reducing the risk of maternal death, which negatively impacts child health and survival.

Benefits to the Family

- Improves physical health and emotional well being of family members.

- Decreases parents' physical and mental burden and provides sufficient time for childcare.
- Decreases the family's economic burden, enabling the provision of good nutrition, health care, education, clothes, recreation and other family needs for a healthy environment.
- Enables the family to participate in social, educational, and economic activities.

Benefits to Society

- Improves the health and nutritional status of the community.
- Improves economic status and decreases poverty.
- Protects the environment by decreasing demand on natural resources.
- Decreases demand for public services such as housing, water, energy, education, health and social services.

Elements of Quality of Care

To achieve the health promotion goal of reproductive health services, high quality services are required to encourage utilization and continuity.

Table 1. Elements of Quality of Care

Elements	Health Center Inputs
Interpersonal Relations	<ul style="list-style-type: none"> • Providers skilled in counseling and communication • Clients treated with respect and honesty and understanding • Clients satisfied with staff courtesy, information, and care
Contraceptive Methods	<ul style="list-style-type: none"> • Wide variety available • Clients receive their method or choice or are referred to an accessible alternative site • Full range of RH services
Information and Counseling	<ul style="list-style-type: none"> • Accurate, complete, and unbiased overview of methods to make <i>free and informed choice</i>* possible • Method specific counseling including how to use; advantages and disadvantages; possible side effects; and when to return • Client understanding is tested repeating information
Technical Competence	<ul style="list-style-type: none"> • Family planning service protocols available • Staff are trained and supervised • Providers follow clinical procedures
Continuity of Service	<ul style="list-style-type: none"> • Follow-up system in place to track and contact defaulter • Clients informed about return visits • Resupply readily available or clients referred to a source • Facilities for removal or change available and accessible
Appropriateness & Acceptability of Services	<ul style="list-style-type: none"> • Clients satisfied with access • Privacy and confidentiality ensured • Physical premises clean and hygienic

**Free and informed choice* means that clients are making a decision without constraints or pressure; clients are making decisions based on complete, unbiased information. Clients select a method and decide whether or not or when to use family planning methods.

General Family Planning Counseling

Family planning decisions are made through counseling sessions between a trained provider and the client. Effective counseling helps clients make and carry out their own choices about reproductive health, including family planning.

Definitions

Counseling is a two-way process of communication through which one person helps another identify reproductive health needs and make the most appropriate decisions concerning those needs. This is characterized by an exchange of information and ideas, discussion and deliberation.

Counseling is equally important for continuing clients who experience side effects, have concerns about the effectiveness of their contraceptives, or wish to change methods.

Counseling Objectives

- To help clients arrive at an informed decision about their reproductive health goals.
- To help clients to select a contraceptive method with which they can be satisfied.
- To help clients use the method safely and effectively.

Characteristics of a Good Counselor

- Understands and respects clients' rights.
- Earns clients' trust.
- Understands the benefits and limitations of all contraceptive methods.
- Understands the cultural and emotional factors that affect a woman's decision to use a particular contraceptive method.
- Encourages clients to ask questions.
- Uses a non-judgmental approach that shows clients respect and kindness.
- Presents information in an unbiased, client-sensitive manner.
- Actively listens to clients' concerns.
- Understands the effect of non-verbal communication.
- Recognizes inability to sufficiently help a client and refers to someone who can.

Requirements for Counseling Area

To ensure confidentiality and comfort during counseling, the area must be:

- Private
- Clean and attractive
- Comfortable and safe
- Well ventilated
- Spacious
- Equipped with supportive educational material, models and contraceptives

Principles of Counseling

These principles of counseling help give a quick guide to providers.

Remember¹:

- Introduce yourself and greet clients with respect.
- Treat each client well.
- Listen to, learn from, and respond to each client.
- Adapt information to each client's personal situation.
- Avoid giving too much information at one time.
- Provide each client's preferred method if there are no absolute medical reasons against its use.
- Help each client understand and remember the instructions.

Counselor Approach and Attitude

- Greet clients politely and introduce yourself.
- Give clients your full attention as soon as you meet them.
- Explain that any information a client shares with you is confidential.
- Ask clients what the reason for their visit is and how you may help them.
- Listen attentively—demonstrate this through positive body language and non-verbal communication.
- Assist clients to talk about their needs and encourage them to ask questions.
- Explain that your questions to help them with their family planning needs.

Counseling Steps

To provide effective counseling, use the **GATHER** approach for family planning counseling:

- G** **GREET** clients
- A** **ASK** clients about themselves
- ASSESS** client knowledge and needs
- T** **TELL** clients about family planning methods
- H** **HELP** clients choose a method
- E** **EXPLAIN** how to use family planning methods
- R** **RETURN** visits

GATHER helps sequence the information needed by each client, and helps clients move through the steps of decision-making. Information needed to choose a method is different from those needed to use a method.

TELL

¹ Adapted from *The Essentials of Contraceptive Technology*. Johns Hopkins Population Information Program, 1998.

Present basic information to familiarize clients with available contraceptive options. Include brief information about:

- Characteristics of each method
- How each method works
- Effectiveness of each method

Information presented should fill the gap in client knowledge that was identified during client assessment. Clients can apply this information in determining which method appeals to them or appears to suit their needs,

HELP

Provide more detailed information to help clients choose a family planning method. The counselor and the client use this information to match client needs with an appropriate method.

EXPLAIN

- How to use the method.
- Possible side effects and warning signs and what to do if warning signs occur.
- During this step provide the client with written instructions or information.
- Ask client to repeat the explanation using her own words. If the client has omitted or misunderstood any information, the counselor should review the information with her.

RETURN

Give client information about when to return for:

- Follow-up
- Re-supply
- Danger signs
- Desire to switch to another method or to stop using the method
- Questions

Counseling Clients with Special Needs

Men

- Encourage men to support women's use of family planning methods and/or to use contraception themselves.
- Create a comfortable, male-oriented environment for men to access sexual and reproductive health information, since they usually have less information than women in this area and fewer opportunities to talk with health personnel.
- Emphasize to men that the family planning method that offers the most protection against HIV infection and other sexually transmitted infections is a male method—the condom.

Women Who Have Had a Pregnancy Loss

- Immediately following a pregnancy loss, the woman may not be thinking about resuming sexual activity, but will be in need of contraception with early return of her fertility (two weeks following a first trimester loss). Make an appointment for a follow-up visit within the first week following discharge from the hospital or clinic.

- The emotional state of a woman following a pregnancy loss may not make her receptive to contraceptive counseling. Give the woman a referral that she might use at a later date and offer condoms and/or spermicide.
- A woman who has become pregnant due to a contraceptive failure may be distrustful of contraception. Give the woman a referral that she might use at a later date and offer condoms and/or spermicide.

Adolescents

- During counseling, offer methods that will protect their health, such as condoms and spermicide. If privacy is a concern, Norplant or injectables may be offered.

IMPORTANT: Condoms should *always* be offered for additional protection against infection.

- Sexual activity among unmarried adolescents is unacceptable in Jordan. However, as a practitioner, adolescents may seek guidance about contraception. Unmarried adolescent sexual activity is usually spontaneous and infrequent; therefore counseling must be tailored to help adolescents be successful in protecting themselves from unwanted pregnancy and infections. Encourage the use of condoms for their dual protection and ease of access.
- Married adolescents may be under pressure to become pregnant shortly after marriage. Counseling must help the couple understand the implications of health risks to the young woman and the benefits of being physically and psychologically ready for pregnancy. Counsel on *all* available methods.

Counseling Process

There are three essential parts to effective counseling:

- 1) Initial Counseling
- 2) Method-Specific Counseling
- 3) Follow-up Counseling

An effective counseling session covers the following steps:

Initial Counseling

Objective: Help Clients Decide on a Method

- Greet clients respectfully.
- Ensure privacy.
- Obtain biographical information, such as name and address.
- Find out what each client knows about family planning in general.
- Provide information about family planning in general.
- Discuss each client's reproductive health needs and goals.
- Explain the difference between spacing and limiting, temporary and permanent methods.

- Find out what each client knows about specific methods.
- Explain a variety of methods.
- Discuss advantages and disadvantages of each method.
- Clarify any misconceptions. See Table 2 for guidance.
- Explore any attitudes or religious beliefs that either favor or rule out one or more methods.
- Do a client assessment to determine the following:
 - If client is pregnant (see “Attachment 1: Client Assessment for Pregnancy Before Contraceptive Use”).
 - If client has any conditions that rule out a particular method.
 - Whether additional assessment or treatment is required.
- Help clients choose appropriate methods according to their needs.
- When STI prevention or protection is indicated, use educational videos to show clients how to introduce condom use to their partners.

Method-Specific Counseling

Objective: Describe How to Use the Method

- Review client assessment data to see if there is a reason why a client should not use the desired method.
- State method effectiveness.
- Explain how to use the method.
- State when to start.
- Explain how to manage side effects and any changes expected in menstrual bleeding.
- Describe under what circumstances a client should return immediately for care.
- Ask clients to repeat instructions for use.
- Remind clients that they can return at any time for advice.
- Record information in client records.

Follow-up Counseling

Objective: Provide Proper Follow-up

- Discuss clients' satisfaction with method.
- Review any problems that may have occurred and management according to guidelines.
- Repeat usage instructions.
- Be prepared to change or stop a method upon client request or medical need.
- Refer as appropriate for complications and ensure there is a mechanism to document referral results.

Table 2. Rumors and Misinformation about Family Planning

Method	Rumor	Response
IUD	<ol style="list-style-type: none"> 1. The IUD will travel throughout the body. 2. The woman can become pregnant with the IUD and the baby will be born with it in its hand. 3. The IUD will give you infections. 	<ol style="list-style-type: none"> 1. The IUD is inserted into the uterus, which is like putting something into your pocket—there is only one opening out of the vagina. It cannot travel outside of the uterus. It may be expelled from the uterus, in which case it will come out through the vagina. On rare occasions during insertion, the IUD might be passed through the uterus, but can be retrieved by the provider. 2. The IUD is highly effective in preventing pregnancy, so it is not likely that the woman will become pregnant with the IUD in place. If the woman should become pregnant, the provider will remove the IUD to prevent uterine infection during the pregnancy. Therefore, it is very important to tell your provider immediately if you have any signs or symptoms of pregnancy. However, if the IUD is not removed, it will come out with the uterine contents after the baby is delivered. 3. The IUD will not give you infections. Your provider will be very careful to keep the insertion procedure free of organisms that would cause infection. Your provider will also ask you questions to see if you are at risk or have been exposed to sexually transmitted infections—this will make it inadvisable for you to use the IUD. Your provider will not insert an IUD if you already have a pelvic infection or if you are at risk of becoming infected.
Hormonal Pills	<ol style="list-style-type: none"> 1. Birth control pills will cause cancer. 2. Birth control pills accumulate in your belly and cause pain. 3. You need to take a “rest” from taking the pills. 	<ol style="list-style-type: none"> 1. Oral contraceptives have been shown to provide protection against ovarian and uterine cancers. 2. When oral contraceptive pills are swallowed, they dissolve in the fluids of your stomach and are absorbed (taken up) into the blood stream, making the changes in the hormones so that you cannot become pregnant. They do not stay as little pebbles in your belly and cause pain. 3. There is never a need to take a “rest” from the pills as long as you are satisfied with the method. Interrupting successful pill taking will put you at unnecessary risk of becoming pregnant. Oral contraceptives are very safe for long-term use.

Method	Rumor	Response
DMPA	<ol style="list-style-type: none"> 1. You will bleed heavily. 2. You will have no more menses and the blood will collect in your belly. 	<ol style="list-style-type: none"> 1. Very rarely, some women may experience heavier than normal menstrual bleeding during the first few months of use. It is not dangerous and will go away. If the bleeding is annoying, the provider can offer you medication such as anti-inflammatory agents, e.g., Ibuprofen or a 7-21 day course of combined oral contraceptives, if there is no contraindication to estrogen use. 2. It is to be expected that some women will no longer have their menstrual periods the longer they use DMPA, e.g., one year or more. This is not dangerous to your health and some women see it as an advantage. There is no need to stop taking DMPA for this reason. DMPA causes less and less of the lining in your uterus to develop, meaning that less and less blood is produced. Since the menstrual cycle hormones are no longer changing and causing menses, there is no uterine lining and blood to be released.
Norplant	<ol style="list-style-type: none"> 1. You will have more bleeding. 2. You will have heavy bleeding. 	<ol style="list-style-type: none"> 1. Irregular and prolonged bleeding is common especially in the first 3-6 months of use. It is not dangerous to your health and will improve with time. If the bleeding is persistent or annoying, your provider can offer anti-inflammatory agents or a 7-21 day course of combined oral contraceptives. 2. Heavy bleeding with Norplant is rare but can be managed with anti-inflammatory agents or oral contraceptives.
Condoms (male)	<ol style="list-style-type: none"> 1. Condoms will reduce the pleasurable sensations during sex. 2. Condoms break too often to be reliable. 	<ol style="list-style-type: none"> 1. Condoms can reduce the sensations for some men but applying a small amount of spermicide or lubricant to the head or the penis before putting on the condom might help. Also, for some men, the reduced sensations help them enjoy sex longer—which could also be a benefit for the woman. <i>The benefit of protection from STIs that condoms provide far outweighs the imperfections of the method.</i> 2. The main cause for condom breakage is insufficient lubrication. Generous use of water-based lubricants such as spermicides or vaginal lubricants will help reduce the risk of breakage. Taking more time in foreplay will help the woman produce more lubrication and can increase the pleasure for both the man and the women.

Method	Rumor	Response
Spermicide	1. Spermicide (creams, gels, and foams) is very messy.	1. For some women (and men), spermicides increase wetness to a degree that is not acceptable, especially when additional spermicide must be used with each act of intercourse. Using foam can reduce the wetness. However, the increased wetness can help reduce condom breakage.
LAM	1. You can still get pregnant even when you breastfeed.	1. The use of LAM requires a woman and her baby to have a certain pattern of breastfeeding. Absence of menstruation indicates that she is not fertile and won't get pregnant. In addition, for LAM to be effective, the baby must be less than 6 months old. When any one of these 3 criteria for LAM use changes, prevention of pregnancy can no longer be assured and another method of contraception must be used. Your provider will review the rules for LAM use with you and will check with you at each visit to see if it is still appropriate for you to continue using LAM.
Tubal Sterilization	<p>1. The woman will no longer have periods.</p> <p>2. Tubal sterilization will cause changes in the menstrual period; e.g. heavier bleeding spotting, and change in regularity or length.</p>	<p>1. Tubal sterilization only stops the egg from traveling to the uterus. It does not change hormones that would cause menses to stop.</p> <p>2. Studies have shown no increase in the risk of menstrual change and no changes in hormonal levels that would cause those symptoms.</p>

Contraceptive Methods

Method One: Combined Oral Contraceptive (COCs)

Definition

Combined oral contraceptives are preparations of synthetic estrogen and progesterone that are highly effective in preventing pregnancy.

Types of COCs

- Monophasic: a fixed concentration of estrogen and progesterone hormone through out the cycle.
- Multiphase: biphasic or triphasic variations of concentration of estrogen and/or progesterone throughout the cycle.

How it Works

COCs prevent pregnancy by stopping ovulation and thickening the cervical mucus making it difficult for sperm to pass through.

Effectiveness

COCs are very effective when correctly and consistently used: 1 pregnancy per 1,000 women in the first year when used perfectly. In typical use, 6-8 pregnancies per 100 women in the first year can be seen.

Who Should Use COCs?

COCs are appropriate for women of all ages, including women who:

- Require an easy, temporary method for spacing or limiting pregnancies.
- Have no problem remembering to take daily pills.
- Have or have not children.
- Are fat or thin.
- Do not smoke* (See “Who Should Not Use COCs” below).
- Blood pressure of 140/90 or less.
- Have just experienced a pregnancy loss including those having an abortion.

Who Should Not Use COCs?

Under the following conditions, COCs are not an appropriate contraceptive method:

- Pregnant women (see “Attachment 1: Client Assessment for Pregnancy”)
- Breastfeeding women of less than 6 months.
- Smokers over 35 years of age.*
- Women with diagnosed active liver disease.
- Women with diagnosed heart disease or cerebrovascular accident (stroke).
- Women with a history of or diagnosed breast cancer.

- Women with a history of or diagnosed blood clots in the vein (thromboembolic disorder).
- Women with blood pressure greater than 160/100.

Advantages

- Very effective when used correctly.
- Monthly periods are regular and lighter, with milder menstrual cramps.
- No rest period needed.
- Can be used by women who have and do not have children.
- Users can stop taking pills at any time.
- Fertility returns soon after stopping.
- Can be used as emergency contraceptive after unprotected sex.
- Users are less likely to develop iron deficiency anemia due to significantly reduced menstrual flow.
- Helps prevent endometrial and ovarian cancer.

Disadvantages

- Common side effects:
 - Nausea, most common in the first three months
 - Spotting or bleeding between menstrual periods
 - Mild headaches
 - Breast tenderness
 - Slight weight gain
 - Amenorrhea
- Difficult for some women to remember everyday.
- Not recommended for breastfeeding women (affects the quality and quantity of the milk)
- May cause mood changes including depression, less interest in sex.
- Does not protect against sexually transmitted infections (STIs).

Client Assessment

Screen clients for medical eligibility for COCs by asking the following questions. If she answers no to all of the questions, she can use COCs. If she answers yes, help her choose another effective method.

- Do you think you are pregnant?
- Do you smoke cigarettes and are you age 35 or older?
- Do you have high blood pressure?

Note: If yes, and blood pressure is below 140/90 give COCs. If BP is between 140 -159/90-99, provide COCs and check BP at next visit. If BP is 160/100 or higher, help her choose a method without estrogen.

- Are you breastfeeding a baby less than 6 months old?
- Do you have serious problems with your heart or blood vessels?
- Do you have or have you ever had breast cancer?
- Do you often get bad headaches with blurred vision?

- Are you taking medicine for seizures, rifampin or griseofluvin?
- Do you have vaginal bleeding that is unusual for you?
- Do you have gall bladder disease?
- Have you ever had jaundice?

Client Instructions

1. Hand the client a packet of the same pills that she will use. Show and tell the client to:
 - Start with combined monophasic preparations that contain 30-35 micrograms of estrogen (see Table 3).
 - Feel free to discuss the need to change the type of pill if there are side effects significant enough to make you want to stop taking the pills or making you want to consider changing the pills.
 - Review the instructions given. Provide the instructions clearly in a language appropriate to the background of the client.
 - Start taking pills:
 - Anytime (once the provider has determined that the woman is not pregnant)
 - Days 1-7 of the menstrual cycle (if the woman wishes to start the pills on a particular day that is beyond the seventh day of her menstrual cycle, she must use a back-up method for the next seven days.
 - Postpartum after six months if using LAM.
 - After 3-6 weeks postpartum, if not breastfeeding.
 - Immediately after pregnancy loss (or within the first seven days, since fertility can return within the first two weeks of a first trimester pregnancy loss).
 - Take one pill every day until the pill pack is finished.
 - If using a **21-day** pill pack, skip seven days before starting a new pill pack. Do not let more than seven days pass between the end of one packet to beginning the new packet.
 - If using a **28-day** pill pack, take the pill daily **without** skipping any days. Start the new packet the next day after you have taken the last pill from the old packet. In the 28-day pill packet, the last seven days do not contain hormones; they are reminder pills and are a different color from those taken from the first three rows. Since the last seven pills (in the pill packet) are not hormones, you will be protected if you forget to take one.
 - If you miss one or more pills in a row, you may have spotting or break-through bleeding. Missing pills puts you at risk of pregnancy.
 - If you miss **one pill**, take that pill as soon as you remember.
 - If you miss **two pills**, take two pills as soon as you remember and two pills the next day. Continue the rest of the pack as usual, and use a back-up method for the next seven days.
 - If you miss three pills in a row, you will probably have break-through bleeding. Whether you are bleeding or not, discard the packet of pills and begin a new packet of pills as you did when you first started the pills. Use a back-up method for at least seven days.

IMPORTANT: If you consistently miss pills, consider another contraceptive method.

- If you vomit or have severe diarrhea within one hour after taking your pill, take one pill from another packet.
 - If severe diarrhea continues for more than 24 hours, keep taking the pills **and** use a back-up method until you have taken a pill for seven days in a row **after** the diarrhea has stopped.
 - COCs do not protect against sexually transmitted infections (STIs); use condoms while taking COCs if you might be at risk of STIs.
2. Ask client to repeat key instructions. Correct any errors.
 3. Instruct the client to return if *any* of the following signs occur:
 - Severe pain in the abdomen, chest, legs, shortness of breath
 - Severe headaches, dizziness
 - Loss of vision, blurring
 - Jaundice (eyes or skin become yellow)
 4. Provide client with at least a three-month supply of COCs. Provide client with condoms and/or spermicide.
 5. Reassure client that she may change pills or try another method if she does not like these COCs. Reassure the client that the doctor is available to see her if she has any problems, questions, or needs advice.
 6. Plan for a return visit and give the client a definite return date.
 7. Document the visit in the client record.

Follow-up Visit

The client should be seen after the first cycle and then after three or six months. During the follow-up visit:

- Update the client's address and contact information.
- Assess the client's satisfaction with the method.
- Determine if the client has had any problems or side effects. If so, manage the problem or side effect and record management in her clinical record.
- Update the client's medical history and perform any indicated examinations, such as a blood pressure check.
- Provide appropriate counseling as required.
- Review the instructions for taking the pill with the client.
- Encourage the client to contact the clinic at any time if she has any questions or complaints.

Table 3. Interaction of Combined Contraceptives (COCs) with Other Drugs²

Commonly Used or Prescribed Drugs	Adverse Effects	Comments & Recommendations
Analgesics Acetaminophen (Tylenol, Paracetamol and others)	<ul style="list-style-type: none"> Possible decreased pain-relieving effect (increased drug excretion) 	Monitor pain-relieving response.
Antibiotics Griseofulvin and Rifampin <i>NO documented clinical effect or significance has been established for penicillins, tetracyclines, cephalosporins and other commonly used antibiotics.</i>	<ul style="list-style-type: none"> Decreased contraceptive effect with COCs, especially with low-dose COCs, 30-35 ug ethinyl estradiol (EE). 	Help client choose another method or use higher estrogen pill (50 ug EE) or backup method (e.g., condoms). Hormonal methods may be used and no backup method is routinely necessary with these antibiotics.
Antidepressants (Elavil, Norpramin, Tofranil and others)	<ul style="list-style-type: none"> Possible increased antidepressant effect. 	Use with caution. Low doses are probably safe.
Antihypertensives Methyldopa (Aldoclor, Aldomet and others)	<ul style="list-style-type: none"> Possible decreased antihypertensive effect. 	Use COCs with caution, monitor BP.
Antiseizure Drugs Barbiturates (Phenobarbital and others) Carbamazepine (Tegretol) Phenytoin (Dilatin) Primidone (Mysoline)	<ul style="list-style-type: none"> Decreased contraceptive effect with COCs, especially if lowest dose COC used. Possible increased phenytoin effect. 	Help client choose another method or use higher pill (50 ug EE) or backup method (e.g., condoms).
Beta Blockers (Corgard, Inderal, Lopressor, Tenormin)	<ul style="list-style-type: none"> Possible increased beta-blocker effect. 	Monitor cardiovascular status.
Bronchodilators Theophylline (Bronkotabs, Marax, Primatene, Quibron Tedral, Theor-Dur and others)	<ul style="list-style-type: none"> Increased theophylline effect. 	Monitor for symptoms of theophylline overdose.
Hypoglycemics: (Diabinese, Orinase, Tolbutamide, Tolinase)	<ul style="list-style-type: none"> Possible decreased hypoglycemic effect. 	Monitor blood glucose as for any diabetic patient.
Tranquilizers: Benzodiazepine (Ativan, Librium, Serax, Tranxene, Valium, Xanax and others)	<ul style="list-style-type: none"> Possible increased or decreased tranquilizer effects, including psychomotor impairment. 	Use with caution. Commonly prescribed dosages are unlikely to result in significant effects.

² Source: Blumenthal P., McIntosh N. eds. (1996), *Pocket Guide for Family Planning Service Providers*, Baltimore, JHPIEGO.

Table 4. COC Brands Available in Jordan

Name	Progestin	Estrogen
Lo-Femenal	Norgestrel 0.3 mg	Ethinyl Estradiol 0.03 mg
Lyndiol	Lynestrenol 2.5 mg	Mestranol 0.05 mg
Marvelon	Desogestrol 0.15 mg	Ethinyl Estradiol 0.03 mg
Microgynon	Levonorgestrel 0.15 mg	Ethinyl Estradiol 0.03 mg
Neogynon	Levonorgestrel 0.25 mg	Ethinyl Estradiol 0.05 mg
Nordette	Norgestrel 50 mcg	Ethinyl Estradiol 30 mcg
Nordirol	Norgestrel 250 mcg	Ethinyl Estradiol 50 mcg
Ovral	Norgestrel 0.5 mg	Ethinyl Estradiol 0.05 mg
Triordiol	Levonorgestrel 0.05 mg	Ethinyl Estradiol 0.03 mg
Ologyn	Norgestrel 0.25 mg	Ethinyl Estradiol 0.05 mg
Norlestrin	Norethindrone acetate 2.5 mg	Ethinyl Estradiol 5 mcg

COCs: Management of Side Effects and Other Problems

Symptoms/Situation	Assessment	Management
Spotting between periods, irregular bleeding	<p>Ask about:</p> <ul style="list-style-type: none"> • When the client started pills, • Symptoms of infection, • Vomiting or severe diarrhea, • Forgotten pills or irregular pill-taking • Taking Rifampicin or other medication that interferes with COCs. <p>Perform pelvic exam if history suggests infection.</p>	<p>If infection, treat according to clinical guidelines.</p> <p>If due to vomiting or diarrhea resulting in poor absorption of hormones, continue with pills but use a back-up method until 7 days after the last episode of vomiting or diarrhea.</p> <p>If drug interaction, encourage use of condoms and/or spermicide if drug use will be short term. If drug use will be long term, counsel for use of another method, e.g., DMPA.</p> <p>Review pill-taking guidelines with client and explore ways for the client to remind herself to take the pills at the same time daily.</p> <p>Reassure the client that symptoms, in the absence of any other causes, are not serious and will go away on their own with continued use.</p>
Nausea, breast tenderness, and moodiness	<p>Ask the client when she started using the pills.</p>	<p>Reassure the client that these symptoms are common during the first 3 months of COC use. Encourage the client to return if the symptoms worsen or extend beyond 6 months. Where feasible, change to a different formula pill may be required, if the client wishes to continue with COCs.</p>
Amenorrhea (no menstrual period)	<p>Ask about:</p> <ul style="list-style-type: none"> • Forgotten pills, irregular pill taking, missed more than 2 pills and has had unprotected sex. <p>Perform pelvic exam and pregnancy test if the client has missed pills and has had unprotected sex.</p>	<p>If the client may be pregnant or is pregnant, ask the client to stop the pills. Provide condoms and/or spermicides and refer for antenatal services.</p> <p>If not pregnant, menstrual periods will return in a few months; therefore, continue with the pills, if the client is satisfied with the method.</p> <p>Assure the client that the absence of menstrual period is not dangerous to her health.</p>
Taking medication that interferes with COCs.	<p>Ask the client what she is taking or has been prescribed to take.</p>	<p>If the client is or will be taking Rifampicin or Griseofulvin, use a back-up method while taking the medication and for 4-8 weeks after taking the last dose of medication, while continuing the COCs.</p> <p><i>There is no evidence that other antibiotics require a back-up method.</i></p> <p>If the client will be or is using anticonvulsant medication, e.g., Phenobarbital, primidone, carbamazepine, or ethosuximide, counsel for changing to DMPA or non-hormonal method.</p>

Contraceptive Methods

Method Two: Progestin-Only Pills (POPs)

Definition

Progestin only contraceptives are preparations of synthetic progesterone.

Types of POPs

Name	Progestin
Femulen	Ethinodiol Diacetate BP 500 mcg (28 tablets)
Ovrette	Norgestrel 0.075 mg (28 tablets)

How it Works

The contraceptive thickens the cervical mucus, making it difficult for sperm to pass through and stops ovulation in about 50% of menstrual cycles.

Effectiveness

For breastfeeding women, between 0.5 and 1 pregnancy in 100 women occurs in the first year of use. Method effectiveness is enhanced by breastfeeding. For all women, when POPs are used correctly and consistently, 5 pregnancies occur per 1000 women.

Note: Effectiveness increases if the pill is taken at the same time every day.

Who Should Use POPs?

POPs are appropriate for women who:

- Desire a safe, temporary method.
- Can remember a daily pill.
- Have or do not have children.
- Are breastfeeding (six weeks after childbirth or milk supply well established*).
- Are adolescents or over 40 years of age.
- Have just had abortion or miscarriage.
- Cannot use estrogen.

*Studies have shown that POPs have no negative effect on breastmilk production or infant growth, even when started in the first week postpartum.³

³ *Family Planning Methods and Practice: Africa*, 2nd ed (1999), U.S. Department of Health and Human Services, 352.

Who Should Not Use POPs?

Under the following conditions, POPs are not appropriate as a contraceptive method:

- During pregnancy (see “Attachment 1: Client Assessment for Pregnancy”).
- For women who have been breastfeeding fewer than six weeks.

Who Should Be Monitored More Closely By a Physician?

A physician should monitor women using POPs who also:

- Have a history of or diagnosed breast cancer.
- Have diagnosed liver disease.
- Have unexplained vaginal bleeding.

IMPORTANT: Women using Rifampicin, Griseofulvin, or anticonvulsants should be advised to use a back-up method or another method, since these drugs will reduce the effectiveness of the POPs.

Advantages

- Rapidly effective.
- Can be used by breastfeeding women.
- Easier to understand and remember than 21-day combined pills since pills are taken daily without a break.
- No estrogen side effects.
- May help prevent:
 - Endometrial and ovarian cancer
 - Pelvic Inflammatory disease
 - Benign breast disease

Disadvantages

- Changes in menstrual bleeding:
 - Irregular periods
 - Spotting or bleeding
 - Amenorrhea
- Less common side effects include headache and breast tenderness.
- Must be taken at the same time every day to be effective.
- Does not prevent ectopic pregnancy.
- Does not protect against STIs, including HIV.

Client Assessment

Screen client for POP medical eligibility by asking the following questions. If she answers no to all of the questions than she can use POPs. If she answers yes, see guidance or help her choose another effective method.

- a) Do you have or have you ever had breast cancer?
- b) Do you have jaundice (are her eyes or skin unusually yellow)?
- c) Are you breastfeeding a baby younger than six weeks?
- d) Do you have vaginal bleeding that is unusual for you?

- e) Are you taking medicine for seizures or any other medication?
- f) Do you think you are pregnant?

Client Instructions

Hand the client a packet of the pills that she will be taking. Show and tell the client the following:

- Start the first cycle of POPs:
 - Anytime (when the provider has determined that the client is not pregnant).
 - Within the first five days of the menstrual cycle, preferably the first day.
 - Postpartum:
 - After six months, if using LAM
 - After six weeks, if breastfeeding but not using LAM
 - Immediately or within six weeks if not breastfeeding
 - Immediately following pregnancy loss, or during the first week following the pregnancy loss.
- Take one pill every day **at the same time** until the cycle or packet is finished.
- Start a new cycle the day after you have taken the last pill from the old packet. There is never a break.
- If you miss one or more pills, you may have spotting, break-through bleeding, or risk pregnancy.
- If you miss one pill, take it as soon as you remember and continue taking one pill each day as usual.

IMPORTANT: If you are **more than three hours late in taking your pill**, take the pill as soon as you remember AND use a back-up method for the next two days at least.

- If you miss two or more pills in a row, start using your back-up method **immediately** and restart taking your pills right away (take two pills for two days). If your menses does not begin within four to six weeks, come to the clinic for an exam and pregnancy test.
- Keep track of your menses while taking POPs. If you have more than 45 days with no period, come to the clinic for an examination and pregnancy test.
- If you have diarrhea or vomiting or both, use your back-up method with the POPs until two days after the diarrhea or vomiting are over.
- Feel free to return to the clinic if you have any side effects, concerns, or questions. Common side effects during the first three cycles may include break-through bleeding, nausea, dizziness, breast tenderness, and headaches (mild).
- Return to the clinic immediately if you develop abdominal pain.
- POPs do not protect against STIs; use condoms along with POPs if you might be at risk of STIs, including HIV.
- Give the client an appointment for a follow-up visit in one month.

Follow-up Visit

- Update the client's address and contact information.
- Assess the client's satisfaction with the method.
- Determine if the client has had any problems or side effects. If so, manage the problem and record management in her clinical record.
- Update the medical history and any other examinations, as indicated.
- Provide appropriate counseling, as required.
- Review the pill, **Warning Signs** and the instructions for taking the pills with the client.
- Encourage the client to contact the clinic any time she has questions or complaints.
- Schedule the client for a visit in six months if she is satisfied with the method and experiences no side effects.

POPs: Management of Side Effects and Other Problems

Symptoms/Situation	Assessment	Management
<p>Amenorrhea (no menstrual periods), irregular bleeding/spotting (non-breastfeeding)</p>	<p>Ask if she has:</p> <ul style="list-style-type: none"> • Forgotten pills, irregular pill-taking, • Had regular periods then suddenly missed a period. • Symptoms of pregnancy, • Had exposure to STI. 	<p>If not pregnancy, reassure the client that irregular bleeding or absence of period can occur with POP use; it is not harmful. Review pill-taking guidelines.</p> <p>If due to other underlying causes, e.g., infection, treat according to clinic protocol.</p> <p>If suspected ectopic pregnancy, refer immediately for medical management.</p> <p>If pregnant, refer to antenatal services.</p>
<p>Severe Headache with blurred vision</p>	<p>Ask if:</p> <ul style="list-style-type: none"> • Headaches have become worse since POPs were started. • Headaches are associated with blurred vision, temporary loss of vision, seeing flashing lights or trouble speaking and moving. 	<p>Reassure client that although women with migraine headaches can safely use POPs, she may want to consider changing to another method without hormones.</p> <p>If symptoms include visual changes and trouble speaking and moving, refer immediately for medical management.</p>
<p>Taking medications that interfere with POPs</p>	<p>Ask the client what she is taking or has been prescribed to take.</p>	<p>If the client is or will be taking Rifampicin, use a back-up method while taking the medication and for 4-8 weeks after taking the last dose of medication, while continuing the POPs.</p> <p><i>There is no evidence that Griseofulvin or other antibiotics require a back-up method with POP use.</i></p> <p>If the client will be or is using anticonvulsant medication (e.g., Phenobarbital, primidone, carbamazepine, or ethosuximide), counsel for changing to DMPA or non-hormonal method.</p>

Contraceptive Methods

Method Three: Intrauterine Devices (IUDs)

Definition

The intrauterine device (IUD) is a small flexible plastic frame inserted in women's uterus through the vagina. The IUD can have copper wire or copper sleeves or hormones. All brands have one or two strings or threads tied to them to enable removal.

Types of IUDs

- Copper Bearing IUDs
- Inert: unmedicated plastic IUDs
- Hormone-releasing IUDs: steadily release small amounts of the hormone progesterone or levonorgestrel, synthetic progesterone.

How it Works

Although the exact mechanism of action is not known, IUDs are assumed to prevent the sperm and egg and from meeting. Hormonal IUDs cause thickening of the cervical mucus or changes in the endometrial lining making implantation difficult.

Effectiveness

Between 0.6 and 1.5 pregnancies occur per 100 women in the first year for copper IUDs. The rate varies with the type of IUD.

Who Should Use IUDs?

IUDs are appropriate for women who:

- Want a temporary method and do not like daily pills or using methods associated with sexual intercourse.
- Are of reproductive age.
- Are breastfeeding.
- Do not want or cannot use a hormonal method.

Who Should Not Use IUDs?

Under the following conditions, IUD is not an appropriate contraceptive method for:

- Women with PID currently or in last three months.
- Women at risk of having or have sexually transmitted infection, unless a condom is also used consistently.
- Women with a Sexually Transmitted Infection (STI) currently or in the last three months.
- Women with distorted uterine cavity.
- Women with genital tract cancer prior to treatment.
- Following septic pregnancy loss.

Advantages

- Long-term prevention from pregnancy (at least 10 years for copper devices, indefinitely for non-medicated, plastic devices).
- Very effective, little to remember.
- No interference with sex.
- No hormonal side effects.
- Immediate return of fertility after removal (reversible).
- Copper-bearing and inert IUDs have no effect on amount or quality of breastmilk.
- Can be used through menopause (one year amenorrhea after the last menstrual period).
- No interactions with any medicines.
- Can be inserted immediately postpartum or following a pregnancy loss in the absence of infection.

Disadvantages

- Side effects:
 - Menstrual changes (common in the first three months)
 - Longer and heavier menstrual periods
 - Spotting between periods
 - More cramps or pain during periods
- Does not protect against STIs.
- Some pain and bleeding or spotting may occur after insertion.
- Client requires access to health provider for removal.

When to Insert

- Any time during the menstrual cycle when:
 - Pregnancy has been ruled out.
 - Insertion is easier.
 - Minor bleeding caused by insertion is less likely to upset the woman.
 - Less pain.
- Within 48 hours after childbirth (the best time is within 10 minutes after delivery of the placenta).
- Four weeks after childbirth for copper devices, six weeks for others.
- After pregnancy loss (immediately, if no infection is present).
- Immediately after stopping another method.
- Anytime if the woman is an eligible candidate and is not pregnant.

Steps for IUD Counseling and Clinical Skills

Pre-Insertion Counseling

1. Greet client in a friendly and respectful manner.
2. Ask client about her reproductive goals.
3. Reaffirm that the client's contraceptive choice is the IUD.
4. If IUD counseling was not done, provide or arrange for counseling prior to performing procedures.
5. Interview client to rule out pregnancy following the pregnancy assessment guidance in Attachment 1.

6. Assess client's knowledge about the IUD's major side effects. Describe as necessary.
7. Be responsive to client's needs and concerns about the IUD, answer her questions.
8. Describe the insertion procedure and what to expect.

Pre-Insertion

1. Obtain or review brief reproductive health history.
2. Wash hands with soap and water.
3. Ask client if she had emptied her bladder.
4. Palpate abdomen and check for suprapubic or pelvic tenderness and adnexal abnormalities.
5. Tell client what is going to happen **before you do it** and encourage her to ask questions.
6. Put new examination (disposable) or HLD or sterile (reusable) gloves on both hands.
7. Perform speculum examination.
8. Collect specimens or vaginal and cervical secretions, if indicated.
9. Perform bimanual examination.
10. Perform rectovaginal examination, if indicated.
11. Remove gloves and dispose (single use) or immerse (reusable) in chlorine solution, according to Infection Prevention Guidelines.
12. Perform microscopic examination, if indicated (and if equipment is available).
13. Wash hands thoroughly with soap and water and dry with clean cloth or allow to air dry.
14. Load IUD through into the sterile package without contaminating the device.
15. The period of time between loading the IUD and insertion should **not** be more than **five** minutes.

IUD Insertion

1. Put examination (disposable) or HLD or sterile (reusable) gloves on both hands.
2. Insert vaginal speculum (and vaginal wall elevator if using single-valve speculum).
3. Swab cervix and vagina with antiseptic.
4. Gently grasp cervix with tenaculum.
5. Sound uterus (see "Attachment 2: IUD Insertion Techniques").
6. Set blue depth gauge on the loaded IUD inserter to the depth on the sound.
7. Insert the IUD using the withdrawal technique (see Attachment 2).
8. Cut strings and gently remove tenaculum and speculum.

Post-Insertion

1. Place used instruments in chlorine solution for decontamination.
2. Dispose of waste materials according to guidelines.
3. Remove reusable gloves and place them in chlorine solution.
4. Wash hands with soap and water.
5. Complete client record.

Post-Insertion Counseling

1. Teach client how and when to check for string.
2. Tell the client to:
 - Wash hands.
 - Sit in a squatting position.
 - Insert one or two fingers into the vagina until you feel the strings. Do not pull the strings or you can pull the IUD out of place.
 - Wash hands again.
3. Assure the client that she can have the IUD removed at any time.
4. Observe the client for at least 15 minutes before sending her home.
5. Provide the client with a written record of the date of IUD insertion and when it should be removed.
6. Remind the client she may return at any time if she experiences problems.
7. Return immediately to the clinic if the following **Warning Signs** occur:
 - Delayed menstrual period with symptoms of pregnancy (ectopic, intrauterine).
 - Abnormal vaginal bleeding, bleeding between periods.
 - Increasing or severe abdominal pain, and/or tenderness.
 - Fainting, not feeling well; fever and chills.
 - String missing or string seems shorter or longer.
 - Feel something hard in the vagina or at the cervix (part of the IUD).
 - Husband feels the IUD string during sex (come to clinic to have the string cut shorter).
 - Heavy, prolonged bleeding.
8. Give the client a return visit appointment four to six weeks (following first post-insertion menses) for check up and pelvic examination after insertion.
9. Remind the client that she must use condoms consistently if she might be at risk of STIs or HIV infection.

When to Remove the IUD

Remove the IUD in the following situations:

- Client wants the device removed.
- Client desires pregnancy.
- Acute PID.
- Perforated uterus.
- IUD out of place; partial expulsion.
- Abnormal, very heavy bleeding.
- Lifespan of copper or hormonal bearing IUD has expired.
- Woman has reached menopause (one year since last menstrual period).

Pre-Removal Counseling

1. Greet woman in friendly and respectful manner.
2. Ask client reason for removal and answer any question she may have.
3. Review client's present reproductive goals and other options for contraception.
4. Describe the removal procedure and what to expect.

Removal of IUD

1. Wash hands thoroughly with soap and water and dry with clean cloth.
2. Put new examination (disposable), high-level disinfected (HLD) or sterile (reusable) gloves on both hands.
3. Perform bimanual examination.
4. Insert vaginal speculum and look at length and position of strings.
5. Swab cervix and vagina with antiseptic.
6. Grasp strings close to cervix and pull gently but firmly to remove IUD.
7. For routine removals, take out the IUD during menses—it is easier then.
8. To avoid breaking the string, apply gentle, steady traction and remove the IUD slowly. If the IUD does not come out easily, refer to a specialist.

Post-Removal

1. Place used instrument in chlorine solution for decontamination.
2. Dispose of waste materials according to guideline.
3. Remove reusable gloves and place them in chlorine solution.
4. Wash hands with soap and water.
5. Record IUD removal in client record.

Post-Removal Counseling

1. Discuss what to do if client experiences any problems.
2. Counsel client regarding a new contraceptive method, if desired.
3. Assist client in obtaining a new contraceptive method or provide a back-up method. The new method can be started immediately in the absence of pregnancy or other precautions.

IUD: Management of Side Effects and Other Problems

Symptoms/Situation	Assessment	Management
<p>Irregular bleeding, prolonged or heavy bleeding</p>	<p>Ask client about:</p> <ul style="list-style-type: none"> • When IUD was inserted. • Number of bleeding days. • Number of pads more than usually used. • Abdominal pain, fever. • Possible risk of STI. <p>Perform pelvic exam if history suggested infection.</p>	<p>If history does not suggest infection and insertion was less than 3 months ago, reassure client that menstrual changes will diminish with time.</p> <p>Counsel client to eat iron-rich foods (dried fruit, dark leafy green vegetables, red meats). Offer iron supplements if indicated.</p> <p>If bleeding is annoying, offer client ibuprofen, or any other non-steroidal anti-inflammatory drug (NOT aspirin) to help reduce the bleeding.</p> <p>If client is unsatisfied with management and wants the device removed, counsel for another method, provide it immediately, and remove the IUD.</p> <p>If history and physical exam suggest pelvic infection, follow management for “Lower Abdominal Pain.”</p>
<p>Lower Abdominal Pain (suggesting pelvic infection)</p>	<p>Ask client about:</p> <ul style="list-style-type: none"> • Missed period. • Recent birth or pregnancy loss. • Pain or tenderness when abdomen is pressed. • Vaginal bleeding. • Foul-smelling vaginal discharge. <p>Take temperature (fever, 38.3°C).</p> <p>Perform pelvic exam looking for:</p> <ul style="list-style-type: none"> • Abnormal cervical or vaginal discharge. • Pain when cervix is moved during exam. • Adnexal tenderness (area of F. tubes and ovaries). • Recent sex partner with urethral discharge or treated for STI. 	<p>If the client shows one or more of these symptoms during the history or physical exam, refer to a provider who knows how to manage this complication.</p> <p>Management should include:</p> <ul style="list-style-type: none"> • Immediate treatment of gonorrhea, chlamydia, AND trichomonas (all at the same time). • Removal of the IUD (with counseling for another method and provision of condoms). • Follow-up appointment given for 48-72 hours after antibiotic treatment has started, evaluating improvement. If no improvement or development of an abscess, hospitalization is indicated. • If client improves after starting treatment, give follow-up appointment after client has completed all the medication. • Treat sex partner(s)/husband.

Symptoms/Situation	Assessment	Management
<p>Pregnancy (missed period; late, abnormally lighter period)</p>	<p>Ask client about:</p> <ul style="list-style-type: none"> • LMP (normal). • Current period, if different. • Presence of symptoms of pregnancy. <p>Note: Symptoms of ectopic pregnancy include missed period, nausea, breast tenderness; abnormal vaginal bleeding, abdominal pain or tenderness, anemia, fainting (suggesting shock).</p> <p>Do pregnancy test, if possible.</p> <p>Perform pelvic exam looking for uterine or adnexal enlargement.</p>	<p>If client is <13 weeks pregnant and IUD strings are visible:</p> <ul style="list-style-type: none"> • Explain that it is best to remove the IUD to avoid severe infection. • Explain that she will have a slightly increased risk of spontaneous abortion. • If client consents, remove IUD or refer for removal. • Counsel client to come to the clinic immediately if she has heavy bleeding, cramping, pain, fever, and/or abnormal vaginal discharge. <p>If the IUD strings cannot be seen and/or the pregnancy is beyond the first trimester:</p> <ul style="list-style-type: none"> • Explain to the client that she is at risk of serious infection that could be life threatening. • If the IUD cannot be removed, emphasize that the risk of spontaneous abortion AND infection is significantly increased. She must be observed closely by a physician and must come to the clinic immediately if she has heavy bleeding, cramping, pain, fever, and/or abnormal vaginal discharge. <p><i>If ectopic pregnancy is suspected, refer immediately to medical management for immediate surgery.</i></p>
<p>Cramping and pain, (in the absence of infection or pregnancy)</p>	<p>Ask client when the cramping occurs in relation to insertion; ask questions to determine presence of infection or pregnancy.</p>	<p>If immediately following insertion or associated with menses, give mild pain relievers, paracetamol every 4 hours, or ibuprofen 400 mg, every 4 hours, as needed.</p>

Contraceptive Methods

Method Four: DMPA Injectable Hormone (Depo-Provera)

Definition

Depot medroxy progesterone acetate (trade name: Depo-Provera) is a highly effective, reversible contraceptive method. It is a three-month injectable contraceptive that contains a synthetic progestin resembling the female hormone progesterone. Each dose contains 150 mg of depot-medroxyprogesterone acetate that is released slowly into the blood stream from the site of the intramuscular injection that provides the user with a safe and highly effective form of contraception.

Types of Depo-Provera

- Depo-Provera 150 mg every three months.

How it Works

The injectable prevents pregnancy by stopping ovulation and thickening the cervical mucus, making it difficult for sperm to pass through.

Effectiveness

Depo-Provera is very effective: 0.3 pregnancies per 100 (1 pregnancy in 333 women) women in first year of use when injections are regularly spaced three months apart.

Who Should Use Depo-Provera?

Depo-Provera is appropriate for women who:

- Desire convenient, long- term method and do not want a daily pill or a method associated with sexual intercourse
- Cannot tolerate estrogen or combined oral contraceptives
- Are of any reproductive age or parity and want highly effective reversible contraception.
- Breastfeed (six weeks after childbirth).
- Just gave birth or had a miscarriage
- Smoke cigarettes
- Have a history of ectopic pregnancy

Who Should Be Monitored More Closely By a Physician?

A physician should monitor and follow-up women who wish to use Depo-Provera who also have:

- A history of or diagnosed benign breast disease (not to be used when breast cancer is current)
- Serious liver disease
- Undiagnosed abnormal vaginal bleeding
- Amenorrhea not related to pregnancy or lactation

- Heart disease (Ischemic)
- Acute liver disease, e.g., viral hepatitis
- Diabetes with vascular disease or for more than 20 years
- Hypertension, severe (greater than 160/100)

Advantages

- Effective, long-acting, reversible method.
- Requires no preparation before intercourse.
- Convenient and confidential method.
- Helps prevent uterine fibroids.
- Reduces frequency of ovarian cysts.
- Protects against ectopic pregnancy.
- Reduces incidence of pelvic inflammatory disease.
- Relieves premenstrual tension.
- Less likely to develop anemia due to significantly reduced menstrual flow.
- Reduces symptoms of endometriosis.
- Reduces sickle cell crisis.
- Decreases the frequency of epileptic seizures in women with epilepsy.

Disadvantages

- Requires injections every three months.
- Slower return to fertility: occurs after approximately six to eight months.
- Does not protect against HIV and STIs.
- Changes menstrual pattern (light spotting or heavy bleeding at first or amenorrhea after the first year of use).
- May cause weight gain, breast tenderness, mood changes such as depression, loss of interest in sex.

When to Start Depo-Provera

- Depo-Provera can be started any time as long as back up method is given.
- Within the first seven days after menstrual bleeding has started (no back-up will be required).
- Immediately or six weeks postpartum, if not breastfeeding.
- After six months if the client is using LAM.
- Immediately following a pregnancy loss.
- Whenever you can be sure that the client is not pregnant (see “Attachment 1: Client Assessment for Pregnancy”).

How to Administer Depo-Provera

Prepare and administer Depo-Provera injection using the following procedure:

1. Wash hands.
2. Check vial for contents (dosage).
3. Gently shake Depo-Provera vial.
4. Open sterile package.
5. Attach a sterile or high-level disinfected (HLD) needle to syringe (21 or 23 gauge IM needle with 2 or 5 ml syringe).
6. Draw Depo-Provera into syringe.
7. Wipe site of injection with antiseptic.
8. Allow antiseptic to dry.
9. Administer 150 mg deep IM in deltoid (arm) or gluteal (hip) muscle. **Do not massage the injection site.**

Client Assessment and Counseling

1. Screen client for Depo-Provera medical eligibility by asking the following questions. If she answers “no” to all of the questions, she can use Depo-Provera. If she answers “yes”, seek guidance or help her choose another effective method.
 - a) Are you breastfeeding a baby less than six weeks old?
 - b) Do you have problems with your heart or blood vessels?
 - c) Do you have or have you ever had breast cancer?
 - d) Do you have cirrhosis of the liver, liver infection or tumor (Are her eyes unusually yellow)?
 - e) Do you think you are pregnant?
 - f) Do you have vaginal bleeding that is unusual for you?
2. Ask client what she knows about Depo-Provera, and correct any myths, rumors, or misinformation.
3. Explain how Depo-Provera works and its effectiveness in preventing pregnancy.
4. Explain the potential side effects of Depo-Provera:
 - Causes changes in menstrual bleeding pattern, such as irregular bleeding, menses, or spotting (60-70% of women); no periods (amenorrhea, 50-80% of women with Depo-Provera).
5. Explore with the client how irregular or increased bleeding may affect her daily life, and if delay in return of fertility will concern her; if problematic, she may need to consider another method.
6. Explain that she will return to fertility approximately six months after her last injection.
7. Explain that she will need an injection every three months
8. Ask the client if she has any questions and respond to them.
9. Record findings in the client record.
10. Client Instructions
 - Use a back-up method for one week after your first injection (not necessary if injection is given during the first seven days after the beginning of a normal menstrual period). Have back up method ready for client to select.
 - Return to the clinic every three months for the next injection (client may be up to two weeks late in returning and still be protected from pregnancy; if more

than two weeks late for injection, advise client that she should use a back-up contraceptive method).

- Remind client of menstrual changes that she may experience and possible weight gain.
- Remind client to inform other health care providers she is on Depo-Provera.
- Reassure client she may return at any time if she has questions or concerns.
- Discuss with client to return immediately if she has any of the following early

Warning Signs:

- Heavy vaginal bleeding
 - Excessive weight gain
 - Repeated, severe headaches (*if beginning or getting worse with DMPA use AND involving blurred vision, temporary loss of vision, seeing flashing lights or spots, or trouble speaking or moving*)
 - Severe abdominal pain
-
- Have client repeat important instructions back to you.
 - Give client time and date of next appointment.
 - Document the visit in client record.

Follow-up Visit

- Update client's address and contact information.
- Ask about any problems, complaints, or warning signs.
- Repeat the history checklist.
- Assess the client's satisfaction with method:
 - If client is satisfied with Depo-Provera method, no warning signs exist, and she wishes to continue, give Depo-Provera injection.
 - If client has developed any warning signs or wants to discontinue Depo-Provera, help her make an informed choice for other methods.

Depo-Provera: Management of Side Effects and Other Problems

Symptoms/Situation	Assessment	Management
Amenorrhea (no menstrual period)	Ask the client for the date of her last normal menstrual period; date of her last injection; when she started using the injection.	Reassure the client that: <ul style="list-style-type: none"> • Amenorrhea is normal among women using DMPA and is not dangerous to her health. • She is not pregnant nor is she sterile. It does not mean she will not be able to become pregnant when she stops. It may take up to 9 months for her periods to return after stopping DMPA. • Menstrual blood is not building up in her body.
Spotting or bleeding between monthly periods.	Ask the client if she has had any exposure to STI.	Reassure the client that spotting or bleeding between periods is common during the first months of DMPA use. It is not dangerous to her health and will improve over time. If irregular bleeding is caused by STI, she can continue with DMPA; treat the infection according to clinic protocols. Provide condoms, if the client is able to have her partner use them.
Heavy or prolonged bleeding (twice as long or as much as usual period)	Ask about exposure to STI or other possible causes for heavy bleeding.	If caused by STI, treat according to clinic protocols. If caused not related to DMPA and cause is not known, refer to medical management. Though rare, it can occur. However, if bleeding may be due to DMPA, and there are no precautions to estrogen use: <ul style="list-style-type: none"> • Offer anti-inflammatory drug such as Ibuprofen, not aspirin, or • Offer COC for 7-21 days (may require 2-3 cycles of COCs), or • If the previous injection was given more than 4 weeks ago, give another injection. Counsel client to eat foods that are rich in iron (dried fruit, dark leafy greens, beef, beets).

Contraceptive Methods

Method Five: Lactational Amenorrhea Method (LAM)

Definition

LAM is a modern, natural, temporary family planning method that encourages a state of infertility by suppressing ovulation through a sustained, high frequency pattern of breastfeeding.

How it Works

LAM stops ovulation (prevents the release of the egg from the ovary).

Effectiveness

LAM can be more than 98 percent effective in preventing pregnancy, when the following criteria are met:

1. The woman is fully or nearly fully breastfeeding, *and*
 - No more than four hours pass between any two daytime feeds.
 - No more than six hours pass between nighttime feeds.
 - Other foods or drink are not substituted for breastmilk.
2. The woman's menstrual period has not returned.
3. The baby is less than six months old (See "Attachment 3: Algorithm for LAM").

Advantages

- Available to all breastfeeding women and has no side effects.
- Immediately protective.
- No commodities or supplies are required.
- Breastfeeding has proven health benefits for mother and infant.
- Is a bridge to using other contraceptives.
- Consistent with religious and cultural practices.
- Can improve breastfeeding and weaning patterns.
- Allows breastfeeding mothers to postpone use of hormonal contraceptive until the infant is more mature.

Disadvantages

- Only effective until menses returns or up to six months (effectiveness after six months is not certain).
- Breastfeeding pattern may be difficult to maintain, especially for working women.
- Can be used only by breastfeeding women.
- Provides no protection against STIs and HIV.

Initiating LAM and Client Instructions

Support the mother in starting LAM as soon as possible after the infant is born. Early and frequent breastfeeding helps a woman produce enough milk for her infant's health and well-being.

Encourage breastfeeding often and on demand (8-10 times in each 24-hour period). Daytime feedings should not be spaced more than four hours apart and nighttime feedings should not be spaced more than six hours apart.

Explain to the mother that she should introduce other food and drinks when the infant is six months old. At that point, she should breastfeed first, and then give the other food and drink. Complementary contraceptives will need to be introduced just before introducing the infant to other foods.

Advise the mother to begin complementary contraceptives immediately if any of the following occurs:

- Her menstrual period returns.
- The infant feeds less frequently or begins taking other food and drink.
- The infant is six months old.
- She wants to change to another method (See Table 5).

Set up an appointment with the client for a return visit at two weeks postpartum, six to eight weeks postpartum, three months postpartum, and six months postpartum.

Follow-up Visit

1. Assess the client's satisfaction with LAM. Ask her if she has any questions or concerns.
2. Ask the client if she is having any difficulties with breastfeeding. If yes, manage according to guidelines or refer.
3. Ask the mother the three criteria questions:
 - Has your menstrual period returned?
 - Has the infant been feeding less frequently or started taking other food and/or drink? Is the infant sleeping through the night?
 - Is the infant 6 months old or beginning to sit up?
4. If the client is ready for a change of contraceptive method, counsel and initiate her on her chosen method and supply her with the method.
5. Offer and/or provide a back-up method (condom, spermicide, ECP).
6. Give an appointment for the next visit, depending on whether she is continuing with LAM or will be starting a new method.

Table 5. Contraceptive Options for Breastfeeding Women

First Choice	Second Choice	Third Choice
<ul style="list-style-type: none"> • Non-hormonal method 	<ul style="list-style-type: none"> • Progestin-only methods [After 6 weeks postpartum] 	<ul style="list-style-type: none"> • Combined estrogen/progestin methods [Use after 6 months postpartum or after weaning]
<ul style="list-style-type: none"> • LAM • Condom • Spermicides • IUD • Fertility Awareness Methods (CMM or Sympto-thermal)* • Voluntary Surgical Contraception 	<ul style="list-style-type: none"> • Minipills • DMPA • Norplant 	<ul style="list-style-type: none"> • Combined oral contraceptives

*Requires an identifiable pattern of signs of fertility.

Contraceptive Methods

Method Six: Condoms

Definition

A condom is a sheath or covering to fit over a man's erect penis.

Types of Condoms

Most condoms are coated with dry lubricant or with a spermicidal gel. They may be made of latex, plastic, or animal products. Different sizes, shapes, colors, and textures may be available.

IMPORTANT: Condoms made of animal products **DO NOT** protect against STIs, including HIV.

Effectiveness

Must be used correctly every time to be highly effective. Three pregnancies for 100 couples in the first year of near-perfect use. Fourteen pregnancies for 100 couples in the first year of typical use.

Who Should Use Condoms?

Condoms are an appropriate method of contraception for:

- Men who want to participate in family planning.
- Couples who want a temporary method, need a back-up method, or are just starting a new method.
- Couples at risk for STIs, including HIV.

Who Should Not Use Condoms

Condoms are not appropriate for:

- Men with severe allergy to latex.
- Men who desire a more long-term and effective method.
- Men who are not willing to be consistent users.
- Men who cannot consistently maintain an erection during condom use.

Advantages

- Prevention of STIs, including HIV/AIDS, and pelvic infections.
- Immediately effective, easily available, and economical.
- No side effects.
- No effect on breastmilk.
- Helps prevent ectopic pregnancies.
- Helps prevent premature ejaculation (last longer during sexual intercourse).
- Can be used by men of any age.

Disadvantages

- Effectiveness is dependent on correct use.
- Must be used with every act of sexual intercourse to be effective.
- May reduce sensitivity of penis during intercourse.
- Supply must be available when needed.
- Condoms (latex) weaken if oil-based lubricant is used.

IMPORTANT: Urge clients at risk of STIs including HIV and AIDS to keep using condoms despite any dissatisfaction. Help clients problem-solve their difficulties with the condom. Alternatively, make female condoms available for interested couples, if possible.

Initiation and Client Instructions

1. Ask if client has any questions or concerns and respond appropriately.
2. Ask client about prior experience with condoms. Check if the client knows how to use a condom. Ask the client to demonstrate by putting the condom on a penis model, banana, stick, or two fingers. Have the client repeat the demonstration, if necessary.
3. Show the client the condom and tell the client:
 - Condoms should be lubricated to prevent tears. Use water-based lubricants include spermicides, or glycerin
 - **Do not use** lubricants made from oil, such as cooking oil, baby oil, coconut oil, mineral oil, petroleum jelly (such as Vaseline), skin lotions, suntan lotions, cold creams, butter, cocoa butter or margarine.
 - **Remember**, generous lubrication prevents condom breakage during sexual intercourse.
4. To use condoms effectively:
 - Handle condoms carefully. Fingernails and rings can tear them.
 - Do not unroll condoms before use; this may weaken them and make them more difficult to put on. Before vaginal entry, place the condom on the tip of the penis and unroll it to the base of the penis.
 - After ejaculation, hold the rim of the condom at the base of the penis so it will not slip off as you remove your penis. Remove the penis from the vagina before completely losing your erection.
 - Take off the condom without spilling the semen on or near the vaginal opening.
 - Throw the condom away in a garbage, latrine, or burn or bury it. Do not leave it where children will find it and play with it.
 - **Do not use a condom more than once.**
5. If a condom breaks:
 - Immediately insert a spermicide, if available, into the vagina. Washing both the vagina and penis with soap and water may also reduce the risk of STIs.
 - Some clients may want to use emergency oral contraception to prevent pregnancy. Go with your partner to the clinic for ECP, if available.
6. Explain to clients that a new condom is required when the one they have:
 - Has torn or has damaged packaging.
 - Has a manufacturing date on the package that is more than five years past.
 - Is uneven or changed in color.

- Feels brittle, dried out, or very sticky.
- 7. Explain that condoms should be stored in a cool, dark place, if possible, since heat, light, and humidity will damage condoms.
- 8. Remind clients that they can return at any time for resupply or for answers to questions.
- 9. Urge clients to return to the clinic if they or their sex partner experience:
 - Symptoms of STI – sores on genitals, pain while urinating, or discharge (drip).
 - An allergic reaction to condoms (itching, rash, irritation).
- 10. Give each client a three-month supply or more (approximately 60 or more condoms) or ask the client how many are needed.
- 11. Provide spermicide or ECP as back-up and give the necessary instructions for use.

Follow-up Visit

- Ask clients if they are satisfied with the method or have questions.
- Ask clients if they are using the condoms with every act of sexual intercourse.
- Confirm clients' knowledge of how to put on and remove the condom by asking each client to demonstrate using a penis model, banana, fingers or a stick.
- If a client is satisfied with the method,
 - Give a generous resupply of condoms.
 - Remind the client to return if either partner has any symptoms of STI.
 - Offer spermicide for extra protection or ECP for emergency use, giving appropriate instructions.
 - Give a return visit at the client's convenience or need.

Condoms: Management of Side Effects and Other Problems

Symptoms/Situation	Assessment	Management
Breakage of condom	Ask client: <ul style="list-style-type: none"> • How he uses the condom, • Whether he uses lubricant; if he uses lubricant, what it is. 	<p>If not using lubricant, explain that lubrication will significantly reduce the risk of breaking. Suggest that the client allow more time for foreplay to encourage the woman to naturally lubricate and/or use a water-based lubricant or a spermicide before penile-vaginal contact.</p> <p>If the client is using lubricant, make sure it is not oil-based. Oil-base lubricants will cause the condom to break more quickly. Suggest water-based products or a spermicide that are water-based for lubrication and additional contraceptive protection.</p> <p>Encourage continued use of condoms if client is at risk of STI.</p>
Condom allergy (or allergy to the lubricant, itching or rash on genitals in contact with condom or lubricant.	Ask client what condom he has been using and/or lubricant his partner has been using. Inspect genitalia if complaining of itching and rash.	<p>Suggest that the client change the brand of condom and/or the brand of spermicide or lubricant. Explore availability of plastic condoms.</p> <p>If itching and/or rash continue, re-evaluate for possible infection.</p> <p>For clients at risk of STIs, urge continuation of condom use since it can help prevent STI transmission.</p>
Erectile difficulty with condom use	Ask the client to describe the circumstance when he has difficulty achieving or maintaining an erection while using condoms.	<p>Counsel the client to explore ways to make condom use with his partner more pleasant, less embarrassing, more creative.</p> <p>Suggest using a small amount of water-based lubricant on the penis and extra lubricant on the outside of the condom to help increase the sensation to maintain an erection.</p>
Reduced sensation		<p>Suggest using a small amount of water-based lubricant on the penis and extra lubricant on the outside of the condom to help increase the sensation to maintain an erection.</p>

Contraceptive Methods

Method Seven: Vaginal Spermicides

Definition

Spermicides are non-prescription preparations made of a carrier material or base such as foam, cream or gel, and a chemical agent that kills sperm.

Types of Spermicides

Spermicides include foaming tablets or suppositories, melting suppositories, foam, melting film, jelly, and cream.

How it Works

Spermicides kill sperm or make sperm unable to move toward the egg.

Effectiveness

- In perfect use, 6 pregnancies occurred per 100 women using spermicides in the first year.
- In typical use, 26 pregnancies occurred per 100 women using spermicides in the first year.
- Effectiveness is dependent on the woman using the method correctly **every time** she has sex, and on the type of spermicide used. The spermicide must be correctly placed in the vagina no more than one hour before intercourse.

Who Should Use Spermicides?

Spermicides are an appropriate method of contraception for couples who:

- Want additional contraceptive protection with use of male condoms.
- Need lubrication during intercourse due to hormonal changes (breastfeeding, perimenopausal women).
- Want an economical, over-the-counter contraceptive.

Who Should Not Use Spermicides or Be Monitored More Closely By a Physician?

Spermicides may not be appropriate under the following conditions:

- Couples who are allergic to the chemicals in spermicides.
- Women who are at risk of HIV and STIs.
- Women who need to use the method very frequently (more than every other day).

Advantages

- A safe, easy-to-use method that the woman can control.
- Helps prevent **some** STIs (e.g., conditions causing PID).
- Provides contraceptive protection only when needed.
- Has no hormonal side effects.
- Can be stopped any time.
- Can be used following pregnancy loss or postpartum.
- Provides lubrication.
- Use does not require a health care provider.

Disadvantages

- Common side effects include:
 - Irritation to woman or her partner if used several times per day.
 - Allergic reaction by woman or her partner.
 - Can cause more frequent occurrence of urinary tract infection.
- Requires following instructions correctly and consistently.
- May need to interrupt sex if not inserted before hand.
- Spermicides may be considered messy.
- Must time the insertion of spermicide into the vagina before having intercourse.

Initiation and Client Instructions

1. Show the client the particular spermicide she will be using.
2. Demonstrate insertion using a pelvic model.
3. Explain to the client to:
 - Wash her hands with soap and water.
 - Allow time for the suppository to melt or foam.
 - Foam: Shake the foam at least 20 times.
 - Fill the applicator by pressing it down on the nozzle of the container until the applicator is full.
 - Insert the applicator deeply into your vagina close to the cervix, then push the plunger to release the foam.
 - Cream or Jelly: Fill the applicator by attaching it to the mouth of the tube and squeezing the tube until the applicator is full.
 - Insert the applicator deeply into your vagina close to the cervix, then push the plunger to release the cream or jelly.
 - Suppository: Remove the wrapping and slide the suppository into your vagina.
 - Push it along the back wall of the vagina until it rests near the cervix.
 - Use spermicide every time you have sex and with each act of sexual intercourse.
 - After intercourse:
 - Do not douche. Wait for at least 6 hours, if you choose to douche.
 - Wash the applicator in warm soap and water and allow to air-dry.
4. Give the client an adequate supply of spermicide for the time until her follow-up visit. Schedule the follow-up visit at the client's convenience.
5. Encourage the client to return when she needs more spermicide.

Follow-up Visit

- Ask the client if she is satisfied with the method; if she has any questions or problems
- Ask the client whether she has symptoms of urinary tract infection. If symptoms are present, refer for management.
- Give resupply of spermicide, if she is satisfied with the method, or counsel and initiate her preferred method.

Vaginal Spermicides: Management of Side Effects and Other Problems

Symptoms/Situation	Assessment	Management
Allergic reaction (itching, burning of genitalia)	Ask client for: <ul style="list-style-type: none">• Signs of allergy (itching, burning, genital swelling since beginning to use spermicide),• Signs of infection (abnormal vaginal discharge, foul odor, itching of vulva). Perform speculum and bimanual exam if history suggested infection.	If history and/or pelvic do not indicate infection, suggest that the client use a different type of spermicidal product. If history and/or pelvic indicate infection, treat or refer for appropriate management.

Contraceptive Methods

Method Eight: Norplant Implants

Definitions

The Norplant implant system is a set of six small plastic capsules the size of a matchstick, containing progestin. The capsules are inserted under the skin of a woman's upper arm, slowly and steadily releasing hormones for at least five years.

How it Works

Norplant implants prevent pregnancy by:

- Inhibiting (stopping) ovulation.
- Thickening and decreasing the amount of cervical mucus, making it more difficult for sperm to penetrate.
- Thinning the uterine lining (endometrium).
- Disrupting normal functions of the corpus luteum.

Effectiveness

Norplant is very effective, with one pregnancy per 1,000 women using the method in the first year, and 1 in 62 women using the method over the five years.

Who Should Use Norplant?

Norplant is an appropriate contraceptive method for:

- Women breastfeeding (after six weeks; **does not interfere with milk production**)
- Women who do not want more children, but do not want or cannot access voluntary surgical contraceptive services.
- Women who can not use estrogen.
- Women who smoke.
- Women with high blood pressure, headaches, benign breast disease; heart disease; diabetes; sickle cell, pelvic inflammatory disease (PID), epilepsy, gallbladder disease.

Who Should Not Use Norplant or Be Monitored More Closely By a Physician?

Norplant may not be appropriate for:

- Pregnant women (see "Attachment 1: Client Assessment for Pregnancy")
- Women with unexplained vaginal bleeding
- Women with a history of or diagnosed current breast cancer
- Diagnosed acute and chronic liver disease

Advantages

- Highly effective.

- Effective after 24 hours of insertion.
- Reversible, long-term method with immediate return of fertility at removal.
- Not associated with sexual intercourse; requires no daily behavior.
- May help prevent endometrial cancer.
- May make sickle cell crises less frequent and less painful.
- Reduces or stops menstrual blood flow.

Disadvantages

- Possible side effects:
 - Menstrual changes: light spotting or bleeding between periods; prolonged bleeding (decreases after first few months); amenorrhea (considered an advantage by some women)
 - Headache, dizziness
 - Breast tenderness
 - Nausea
 - Nervousness
 - Acne and/or skin rash
 - Appetite change
 - Weight gain or loss
 - Hair loss or growth on face
- Requires removal by provider; may be difficult to remove.
- Minor surgical procedure required for insertion of capsules.
- Does not protect against STIs, including HIV.

When to Insert

- Anytime it is reasonably certain that the client is not pregnant.
- First seven days of menstrual period (no back-up is required).
- After day eight of the menstrual cycle, use back-up method for 48 hours after insertion.
- Immediately or six weeks postpartum, if not breastfeeding or partially breastfeeding.
- Six months postpartum, if breastfeeding full.
- Immediately or within seven days following a pregnancy loss.

IMPORTANT: Women choosing Norplant must have convenient access for insertion *and* removal.

Initiation and Client Instructions

1. Counsel client regarding this method and answer the client's questions.
2. Help client understand that she can have the implants removed at anytime she wants.
3. Explain the insertion procedure to client.
4. Follow infection prevention procedures.
5. Give local anesthetic at insertion site.
6. Insert the six capsules according to the manufacturer's instructions.
7. Close incision with adhesive bandage, cover with gauze.
8. Inform client that bruising and slight bleeding at insertion site is normal and common during the first few days after insertion.

9. Give the client the following instructions:
 - Keep the area dry for four days (take off gauze after two days, adhesive after five days).
 - You may experience soreness and/or swelling after anesthesia wears off.
 - Return to the clinic if pain continues without improvement after the first few days.
 - Return for removal when desired or when the five years is going to expire.
 - Return to the clinic immediately if you experience any of the following:
 - Symptoms of pregnancy (missed period after several regular cycles)
 - Abdominal (severe) pain, tenderness, fainting (ectopic pregnancy)
 - Infection at insertion site
 - Very heavy menstrual bleeding
 - Severe headaches
 - Skin and/or eyes becoming yellow (jaundice).
10. Give the client a card with the date of implant insertion and date for its removal.
11. Give the client a follow-up visit appointment within four weeks of insertion.

Follow-up Visit

- Assess the client's satisfaction with the method; ask questions regarding concerns, problems.
- Ask about the client's bleeding pattern.
- Encourage the client to return when problems arise, or when removal is desired or indicated.

Drug Interactions

Certain drugs may affect the effectiveness of Norplant. A back-up method must be used when the following drugs are prescribed:

- Rifampicin
- Barbiturates
- Phenytoin (anticonvulsant)
- Phenybutazone.

Norplant: Management of Side Effects and Other Problems

Symptoms/Situation	Assessment	Management
Amenorrhea (no menstrual periods)	Ask the client for the date of her last normal menstrual period; whether she has taken any medication that would interfere with Norplant without using a back-up method.	Reassure that client that she is not: <ul style="list-style-type: none"> • Pregnant. Absence of periods is not dangerous to her health. • Sterile. She will be able to become pregnant when capsules are removed. • Building up blood in her body. <p>If client is dissatisfied with amenorrhea, and wants the capsules removed, refer for removal and counsel for another method.</p>
Spotting or bleeding between periods	Ask about: <ul style="list-style-type: none"> • Exposure to STI. • Symptoms of pregnancy. 	Explain that irregular periods and prolonged bleeding are common and can be expected during the first 3-6 months of use. It is not harmful to the woman's health. <p>If caused by STI, treat according to clinic protocols.</p> <p>If suspected pregnancy, refer for removal of capsules and antenatal care.</p> <p>If spotting and bleeding is likely to be due to Norplant and is unacceptable and there are no precautions to the use of estrogen: <ul style="list-style-type: none"> • Offer anti-inflammatory drug such as Ibuprofen, not aspirin, or • Offer COC for 7-21 days (1 cycle). </p>
Heavy or prolonged bleeding	Ask about: <ul style="list-style-type: none"> • Exposure to STI. • Symptoms of pregnancy. 	Explain to the client that prolonged bleeding common and can be expected during the first 3-6 months of use, but heavy bleeding is rare. <ul style="list-style-type: none"> • Offer anti-inflammatory drug such as Ibuprofen (not aspirin); <i>or</i> • Offer COC for 7-21 days (may need to use a 50 mcg COC). • Check for anemia and treat or refer if anemic. • Give dietary counseling for increasing iron-rich foods.
Severe abdominal pain	Ask about: <ul style="list-style-type: none"> • Exposure to STI. • Symptoms of pregnancy 	Check or refer for evaluation of possible ovarian cyst or tumor, twisted ovarian follicle, or ectopic pregnancy. <p>If due to STI exposure, treat according to clinic protocol or refer for medical management.</p>

Contraceptive Methods

Method Nine: Fertility Awareness Methods (Cervical Mucous Method)

Definition

Fertility Awareness Methods (FAM) are methods for preventing or planning pregnancy by observing naturally occurring signs and symptoms of the fertile days and infertile days within the menstrual cycle.

Cervical Mucus Method (CMM) is a FAM based on identifying and interpreting cervical mucus secretions and vaginal sensations as they change before, during, and after ovulation.

Types of Fertility Awareness Methods

FAM includes CMM, calendar method, basal body temperature, and symptothermal methods. From this category of contraception, CMM is the method of choice.

How it Works

FAM in general and CMM in particular prevent pregnancy by avoiding sexual intercourse in the presence of signs and symptoms of ovulation (fertile days) and during menstrual bleeding, to avoid the possibility of sperm meeting an egg.

Effectiveness

For CMM, three pregnancies in 100 women with perfect use during the first year. Pregnancy rates may be higher in typical use. For CMM, as well as the other fertility awareness methods to be effective, **the couple** must be committed to following the rules of use, since it requires periodic abstinence.

Who Should Use CMM?

CMM is an appropriate contraceptive method for couples who:

- Are willing to work together in preventing unwanted pregnancy.
- Are concerned about side effects associated with scientific methods of contraception.
- Have religious beliefs or practices that prohibit “artificial” contraception.

Who Should Not Use CMM?

CMM is not appropriate for:

- Couples for whom prevention of pregnancy is critical.
- Couples for whom there is absence of male cooperation in following the rules.
- Those who are unable to identify and/or interpret and record signs of fertile and infertile days.

- Women not willing to touch their vaginal fluids/cervical mucus.
- Women in unstable relationships.
- Couples who are unable to abstain from sexual intercourse.

Advantages

- No hormonal or physical side effects
- Increased knowledge of woman's body and its function
- Increased self awareness and self-reliance
- No cost
- Involves men's active participation
- Can be used to achieve a desired pregnancy.

Disadvantages

- Requires a specially trained provider to teach the method.
- Couples usually need three months of practice to use CMM with frequent follow-up. The commitment and cooperation of **both** partners is crucial.
- Requires privacy to observe and note signs and symptoms of fertility.
- Does not prevent or protect against STI, HIV, and AIDS.

Initiation and Client Instructions

Instruct the Client to:

- Avoid sex during days of menstruation.
- Avoid sex during early infertile days of the menstrual cycle (days before ovulation)
- Have sex every other day when there is no cervical mucus or when not feeling any vaginal wetness (Semen changes the characteristic of mucus so it is necessary to check cervical mucus on days that semen is NOT in the vagina).
- The first day of cervical mucus or vaginal wetness begins the fertile phase; avoid sex until the end of the fertile phase.
- The last day of cervical mucus or vaginal wetness is called "peak" day. Continue to abstain for sexual intercourse for three days after the "peak" day.
- Resume sex on the third day of no cervical mucus or vaginal wetness until the next menstrual bleeding begins (See Table 6).

Follow-up Visit

1. Ask the client/couple if they are satisfied, have questions or problems.
2. Review instructions with the client/couple, correct and reinforce as necessary.
3. Remember:
 - Abstinence may be difficult, help the couple to discuss feeling and to come to solutions. Discuss alternative methods of pleasuring.

IMPORTANT: During fertile days, genital contact must be avoided.

- If the method's rules result in marital disputes, counsel the couple for use of another method.

Table 6. Summary of Cervical Mucus Method⁴

Phase of the Menstrual Cycle (Days)	How to Identify	Intercourse Allowed?
1-5: menstruation*	Bleeding *The menstrual cycle begins on the first day of menstrual bleeding.	No
6-9: Dry Days	Absence of cervical mucus or vaginal wetness.	Yes, on alternate nights only
10: Fertile Period Begins	Onset of sticky mucus secretion, gradually becoming slippery over the following days.	No
16: "Peak" Fertile Day	Last day on which slippery mucus, resembling raw egg white, is seen.	No
20: Fertile Period Ends	Evening of the 4 th day after the "peak" day.	Yes
21-29: Safe Period	From end of fertile period until the onset of the next menstrual bleeding.	Yes

⁴ *Family Planning Methods and Practice: Africa* (1999), 2nd ed., U.S. Department of Health and Human Services, Centers for Disease Control, 485.

Contraceptive Methods

Method Ten: Emergency Contraception (EC)

Definition

A method of preventing an unwanted pregnancy after unprotected intercourse or contraceptive accident has taken place.

IMPORTANT: Emergency contraception is **NOT** suitable or effective as an on-going method of contraception.

How it Works

ECPs cause temporary changes in the lining of the uterus (endometrium), making it unsuitable for implantation. If taken in the first half of the menstrual cycle, they also cause changes in the ovary, possibly delaying ovulation. If taken after ovulation, they alter the function of the corpus luteum.

Effectiveness

When used within 72 hours of unprotected intercourse, ECPs are at least 75% effective in preventing pregnancy (1 in 5 pregnancies in 100 women being treated in one cycle).

When to Use ECPs

- To prevent pregnancy after unprotected intercourse.
- After a contraceptive accident, such as a broken condom, an expelled IUD, or an error in using a contraceptive method.

SPECIAL NOTE: There are no absolute precautions against the use of ECPs unless pregnancy is suspected or has already been diagnosed. The advantages of using ECP outweigh the theoretical risks, even for women who would have one or more conditions making ongoing use of estrogen-containing contraceptives not recommended. Progestin-only pills are an alternative to ECPs containing estrogen.

Advantages

- Readily available and accessible
- Convenient
- A back-up to regular method
- Safe

Disadvantages

- Must be used within 72 hours of intercourse.
- Estrogen-containing pills may cause nausea (30-60%) and vomiting (12-20%), which may reduce effectiveness of the method.
- May cause headache, dizziness, and/or breast tenderness.
- May cause changes in amount, duration, and timing of the next menstrual period.

- Effect of high dose hormones on a developing embryo (if pregnancy does occur) is unknown, although no definite risk to the fetus has been seen.
- Pregnancy may still occur in up to 25% of cases.

How to Administer ECPs

Confirm that unprotected intercourse during a potentially fertile period (i.e., client is not within 5 days of completing menses) has occurred within the past 72 hours.

Instruct the client to:

- Take two tablets (each containing Ethinyl Estradiol 0.05 mg and DL-norgestrel 0.5 mg [Ovral]) immediately and take another two tablets 12 hours after taking the first dose for a total of four tablets (See Table 7 for COCs that can be used for EC).
- Take a prescribed oral anti-emetic (promethazine 25 mg, metoclopramid 5-10 mg) 30 minutes before each of the two doses of hormone.
- Expect to have a menstrual period within the next 21 days. If not, return to the clinic for examination and pregnancy testing.
- Do not have unprotected intercourse in the days or nights after ECP treatment.
- Use a back-up method until your next menstrual period or following the instructions for beginning a new method after ECP.

Note: A single course of ECPs is unlikely to have a significant effect on the quantity and quality of breastmilk. Some hormone will pass through the breastmilk, but it is not believed to have an adverse effect on the infant.

See Table 7 for guidance in starting routine contraception following EC.

Progestin-Only Pills for Emergency Contraception⁵

- EC can be provided by giving 0.75mg of levonorgestrel (20 yellow pills, Ovrette) within 72 hours after unprotected sex and a second dose (20 yellow pills, Ovrette) 12 hours after the first dose.
- The advantage of progestin-only pills for ECP use is that the side effects of nausea and vomiting are significantly less than with combined pills.
- Follow-up and post-ECP contraceptive options are the same as for ECP with combined pills.

- Provide a resupply of the client's regular contraceptive method or provide the new method.
- Counsel if ECPs need was for a method accident or error in contraceptive method use.
- Give appointment for follow-up visit in three to four weeks.

⁵ Source: Trussell, James. "The Emergency Contraception Website." ec.princeton.edu/questions.

REMEMBER: ECPs can be provided with instructions in advance of need. ECPs are most effective when taken within 24 hours of unprotected intercourse.

ECPs can delay ovulation resulting in an increased risk of pregnancy after treatment. Women should use contraception during the remainder of the cycle. The woman can use the following methods, outlined in Table 7 below:

Table 7. Guidelines for Contraception after EC Treatment⁶

Method	When to Begin
Condoms	Immediately after EC.
Spermicides	Immediately after EC.
COCs	Start a new packet at the beginning of the next menstrual period OR begin a new packet the day after ECPs have been completed.
DMPA	Within the first 7 days of beginning the next menstrual period.
IUD	Within the first 7 days of beginning the next menstrual period.
VSC	Anytime after beginning of the next menstrual period.
CMM	After onset of next menstrual period.
Implants	Within the first 7 days of beginning the next menstrual period.

Follow-up Visit

If the client has already adopted a contraceptive method for ongoing contraception and wants to continue the method, no further follow-up is needed unless the client has:

- Delayed menstrual period.
- Suspects she may be pregnant.
 - Record date of menses, perform pregnancy test if indicated.
 - If pregnant, refer for necessary services.

If client has not already adopted a contraceptive method, discuss contraceptive options, and provide the method. Give a follow-up appointment according to guidelines.

⁶ Source: Hatcher, R., MD, et al (1998). *Contraceptive Technology*, 17th ed. New York: Ardent Media Inc., 290.

Table 8a. Combined Oral Contraceptive Pills for Emergency Contraception

Trade Name	Formulation	Number of Pills to Take*
Ovral	0.05 mg Ethinyl Estradiol 0.05 mg Norgestrel	2
Lo-Ovral	0.03 mg Ethinyl Estradiol 0.03 mg Norgestrel	4
Nordette	0.03 mg Ethinyl Estradiol 0.15 mg Levonorgestrel	4
Levlen	0.03 mg Ethinyl Estradiol 0.15 mg Levonorgestrel	4
Triphasil	(yellow pills only) 0.03 mg Ethinyl Estradiol 0.125 mg Levonorgestrel	4
Trilevlen	(yellow pills only) 0.03 mg Ethinyl Estradiol 0.125 mg Levonorgestrel	4
Microgynon	0.03 mg Ethinyl Estradiol 0.15 mg Levonorgestrel	4
Lo-femenal	0.03 mg Ethinyl Estradiol 0.3 mg Norgestrel	4

*Take 2 doses 12 hours apart

Table 8b. Progestin-only Contraceptive Pills for Emergency Contraception

Trade Name	Formulation	Number of Pills to Take
Ovrette	Levonorgestrel 0.075 mg	20

*Take 2 doses 12 hours apart

Contraceptive Methods

Method Eleven: Voluntary Surgical Contraception: Female Tubal Occlusion

Definition

Tubal Occlusion is a permanent, surgical contraceptive method for a woman who is part of a couple that decides they want no more children.

Types of Voluntary Surgical Contraception (VSC)

Tubal Occlusion: tubal occlusion by clip, laparoscopy, mini-laparotomy under local anesthesia procedures.

How it Works

Tubal Occlusion closes off both Fallopian tubes, which allow the egg to pass from the ovaries. This keeps the egg from meeting with sperm. Menstruation and orgasm continue.

Effectiveness

Pregnancy rate runs 0.5 per 100 women in the first year after the procedure (1 in 200 women). 1.8 pregnancies per 100 women (1 in 55) within 10 years after the procedure. Postpartum sterilization is the most effective, at 0.05 pregnancies per 100 women (1 in 2,000 women).

Who Should Use VSC?

VSC is appropriate for:

- Men and women who do not want more children.
- Women who have medical conditions that make future pregnancies high risk or would worsen the condition, threatening the woman's life.

Who Should Not Use VSC?

Anyone who is not sure whether they will want more children should not use VSC.

Advantages

- Highly effective
- Permanent
- Nothing to remember
- One-time cost for long-term protection from pregnancy
- No activity associated with sex
- No hormonal side effects
- No effect on breastmilk
- Can be provided immediately following pregnancy loss or postpartum
- Helps protect against ovarian cancer

Disadvantages

- Post-procedure discomfort
- Bleeding or infection at site; damage to internal organs

- More involved surgical procedure
- Requires surgically skilled provider
- Reversal is difficult, expensive, and not available
- Offers no protection against STIs including HIV
- There is an anesthesia risk, if general is used (general anesthesia is not the preferred anesthetic for this procedure)

Initiation and Client Instructions – Tubal Occlusion/Tubectomy

Tubal Occlusion/Tubectomy

Can be performed:

- Immediately following pregnancy loss or within 48 hours.
- Immediately postpartum, if the client made an informed choice decision in advance of delivery.
- Six weeks or more postpartum.
- Upon discontinuing another method.
- When a woman decides she will never want more children.
- When a woman is reasonably certain she is not pregnant (see “Attachment 1: Client Assessment for Pregnancy”).

IMPORTANT: Female sterilization procedure should not be done between seven days and six weeks postpartum due to difficulty in accessing the tubes and increased risk of infection.⁷

Before the Procedure

Instruct the client to:

- Not eat or drink anything for eight hours before the surgery.
- Not take medication for 24 hours before surgery unless instructed otherwise.
- Bathe thoroughly the night before the procedure, especially the belly, genital area, and upper legs.
- Wear loose-fitting clothes.
- Not wear nail polish or jewelry to the clinic.
- Bring a friend or family member to help her go home after the procedure.

See Jordan Procedural Standards for Female Sterilization.

After the Procedure

1. Instruct the client to:

- Rest for two to three days and avoid heavy lifting for one week.
- Keep the incision clean and dry. Do not rub or irritate the incision for one week.
- Take paracetamol or another safe, pain-reliever as needed. **DO NOT** take aspirin or ibuprofen, which slows the clotting of blood.

⁷ Hatcher, R., MD, et al (1998). *Contraceptive Technology*, 17th ed. New York: Ardent Media Inc., 598.

- Not have sex for at least one week or until the pain is gone.
 - Return to the clinic at once if she has any of the following **Warning Signs**:
 - High fever (more than 38C), in the first four weeks.
 - Bleeding or pus from the wound.
 - Pain, heat, swelling, or redness at the incision that becomes worse or does not stop (sign of infection).
 - Abdominal pain, cramps, or tenderness that becomes worse or does not stop.
 - Diarrhea or fainting or extreme dizziness.
 - Return to the clinic **immediately** if she thinks she might be pregnant (has missed her period, has nausea and breast tenderness—first symptoms of pregnancy).
 - Return to the clinic immediately if you have the following **Warning Signs**:
 - Lower abdominal pain or tenderness on one side.
 - Abnormal or unusual vagina bleeding.
 - Faintness (indicating shock); signs of **ectopic** pregnancy.
2. Give the client a follow-up visit within seven days or at least within two weeks and to have stitches removed if, necessary.
 3. Answer any questions the client may have.

Follow-up Visit

- Ask the client if she has any questions, has had any problems.
- Check the incision site for complications and remove stitches if present.
- Offer the client condoms if she might be at risk for STI, including HIV.

Tubal Occlusion: Management of Other Problems

Symptoms- Situation	Assessment	Management
<p>Infection (pus, heat, redness, pain at the incision site)</p>	<p>Ask client when symptoms began.</p> <p>Take temperature (fever, >38.3C.)</p> <p>Inspect incision site for redness and/or pus at incision. Feel the abdomen for tenderness and/or enlargement (mass).</p>	<p>If infection, clean the site with soap and water or antiseptic solution.</p> <p>Refer for appropriate management or treat with oral antibiotics for 7 to 10 days.</p> <p>Give follow-up appointment upon completion of antibiotics.</p> <p>Instruct the client to return immediately if symptoms do not improve with 48-72 hours.</p>
<p>Pain</p>	<p>Inspect for signs of infection or abscess.</p>	<p>If infection, treat as above.</p> <p>If abscess, refer for medical management, which will include incision and drainage of abscess, followed by 7-10 days of antibiotic.</p> <p>If no infection or abscess, most likely post procedure discomfort. Suggest the client use paracetamol, not aspirin, for pain relief.</p>
<p>Missed period</p>	<p>Ask about:</p> <ul style="list-style-type: none"> • LMP: was it normal? • Symptoms of pregnancy; abnormal spotting since missed period, cramps, pain, feeling faint. <p>Perform pelvic exam to assess for uterine or adnexal enlargement.</p>	<p>Refer immediately for medical management, which will include immediate surgery, if ectopic pregnancy is diagnosed.</p>

Contraception Following Pregnancy Loss

Definitions

The provision of contraception is the second element in a comprehensive approach to protecting reproductive health by providing contraceptives to women or couples immediately following a pregnancy loss. Contraception following pregnancy loss gives the woman's body a chance to recuperate. Recuperation allows the woman to begin a subsequent pregnancy in optimal health for good health outcomes—for herself and her infant.

Elements of care following pregnancy loss include:

- Management of incomplete pregnancy loss to prevent death and illness.
- Immediate provision of contraception.
- Referral to other needed health services.

Considerations

- All women experiencing pregnancy loss need information about fertility and contraception.
- Fertility may return within two weeks in first trimester pregnancy loss, putting a client at risk of an untimely pregnancy before her next menstrual period.
- Several contraceptive methods can be safely used immediately after pregnancy loss or at a time in the future, at the client's preference.
- The client has a right to choose, refuse, or delay contraception.
- A client is more likely to successfully use contraception if she receives counseling and her preferred method **BEFORE** being discharged from the hospital.⁸

Guidelines for Contraceptive Counseling Following Pregnancy Loss (see also Table 9)

In all cases, provide STI prevention counseling; offer condoms for protection against STIs and HIV with methods, if acceptable to the client. See also Table 9.

Note: Following second trimester pregnancy loss, tubal sterilization may be more difficult to perform immediately. IUDs have a higher expulsion rate with immediate insertion following pregnancy loss.

⁸ Adapted from *Talking with Clients About Family Planning: A Guide For Health Care Providers* (1995), New York: AVSC International.

Initiation and Client Instructions

- Following management of incomplete pregnancy loss and/or related complications, provide post pregnancy loss care.
- When the client is stable or before preparing for discharge, counsel client regarding:
 - Return of fertility within two weeks, and
 - Benefits of delaying subsequent pregnancy and use of family planning method.
- Explore client's knowledge and experience with family planning.
- Present appropriate, available methods based on absence or presence of infection and/or hemorrhage.
- Assist the woman or couple to select a method and provide it.
- Provide method instructions to the client according to RH standard.
- Accept the client's decision to refuse or defer family planning use.
- Review the following **Warning Signs** for care following pregnancy loss and advise the client to return to the clinic immediately if she experiences any of the following:
 - Fever
 - Chills
 - Muscle aches
 - Tiredness
 - Abdominal pain, cramping, or backache
 - Prolonged or heavy bleeding
 - Foul-smelling vaginal discharge
 - Delay of six weeks or more in resuming menstrual period⁹
- Give the client a follow-up appointment for four weeks after pregnancy loss care.

Follow-up Visit

1. Review the client history.
2. Explore with the client her recovery course, presence of warning signs, satisfaction with method, if provided before discharge.
 - If satisfied, provide resupply if needed and review instructions for use.
 - If not satisfied, or if the client did not choose a method before discharge, provide counseling about method options and initiate the client's preferred method.

⁹ *Family Planning Methods and Practice: Africa*, 2nd ed (1999). U.S. Department of Health and Human Services, Centers for Disease Control, 547-558.

Table 9. Selecting a Family Planning Method Following Pregnancy Loss

Method	Considerations
Oral Contraceptives	<ul style="list-style-type: none"> ○ Can be used immediately. Good for women who may have had genital tract trauma or infection. ○ Good option for women who have experienced hemorrhage.
DMPA	<ul style="list-style-type: none"> ○ Can be used immediately. Good for women who may have had genital tract trauma or infection. ○ Good option for women who have experienced hemorrhage.
Condoms	<ul style="list-style-type: none"> ○ Can be used immediately. Good for women who may have had genital tract trauma or infection. ○ Good option for women who have experienced hemorrhage.
Spermicides	<ul style="list-style-type: none"> ○ Can be used immediately. Good for women who may have had genital tract trauma or infection. ○ Good option for women who have experienced hemorrhage.
Implants	<ul style="list-style-type: none"> ○ Can be used immediately. Good for women who may have had genital tract trauma or infection ○ Good option for women who have experienced hemorrhage.
IUD	<ul style="list-style-type: none"> ○ Can be used immediately in the absence of infection. ○ Avoid with women who have experienced hemorrhage.
Tubal Sterilization	<ul style="list-style-type: none"> ○ Can be provided immediately if the woman is sure she never wants more children. If concerned about potential for regret, offer long-term or temporary method until the client has a chance to reconsider or be certain of her decision. ○ Avoid with women who have experienced hemorrhage.

Attachment 1

Client Assessment for Pregnancy Before Contraceptive Use¹⁰

How to be Reasonably Sure a Client is not Pregnant

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 any one of the following:
 - Has not had intercourse since her last menses.
 - Has been correctly and consistently using a reliable contraceptive method.
 - Is within the first seven days after the start of her menses (days 1-7).
 - Is within four weeks postpartum (for non-breastfeeding women).
 - Is within the first seven days following pregnancy loss.
 - Is fully breastfeeding, less than six months postpartum and has had menstrual bleeding.
2. When a woman is more than six months postpartum, you can still be reasonably sure she is not pregnant if these three conditions apply:
 - She has kept her breastfeeding frequency high.
 - She has still had no menstrual bleeding (amenorrheic).
 - She has no clinical signs or symptoms of pregnancy.

A pelvic examination is seldom necessary, except to rule out pregnancy of greater than 6 weeks, measured from the last menstrual period (LMP).

Pregnancy testing is unnecessary except in cases where:

- It is difficult to confirm pregnancy (i.e., six weeks or fewer from the LMP).
- 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 (i.e., detects <50 mIU/ml of hCG) may be helpful, if readily available and affordable. If pregnancy testing is not available, counsel the client to use a temporary contraceptive method or abstain from intercourse until her menses is finished or pregnancy is confirmed.

¹⁰ Source: Blumenthal, P., McIntosh, N. (1996-98), *Pocket Guide for Family Planning Service Providers*, 2nd ed., JHPIEGO.

Attachment 2 IUD Insertion Technique

I. Passing a Uterine Sound

Sounding the uterus is recommended for all IUDs inserted by the “withdrawal” technique to ensure fundal placement.

Objectives of Sounding the Uterus

1. To check the position of the uterus and obstructions in the cervical canal.
2. To measure the direction of the cervical canal and uterine cavity, so that the inserter can be shaped appropriately to follow the canal.
3. To measure the length from external cervical os to the uterine fundus so that the blue depth gauge on the insertion tube (Tuck 380A IUD) can be set correctly, for placement in the uterine fundus.

Procedure

Use a gentle, no-touch (aseptic) technique throughout the procedure.

IMPORTANT: Before attempting to sound the uterus, a screening speculum and bimanual exam should be performed to rule out the possibility of vaginal and cervical infection and to determine the size of the uterus.

Step 1:

- Put on high-level disinfected (HLD) or sterile gloves.

Step 2:

- Insert the speculum. Thoroughly clean the cervix with an antiseptic e.g., Chlorhexidine Gluconate (Hibiclens, Hibiscrub, Hibitane or Savlon (concentrations of Savlon may vary) or iodophors (povidone iodine, Betadine, Wesodyne).

Step 3:

- Apply the HLD or sterile tenaculum at the 10 o'clock and 2 o'clock positions on the cervix. Slowly close the tenaculum **one notch at a time**, and no further than necessary.

Note: All persons learning to do IUD insertions should use the tenaculum. Very experienced clinicians may find a tenaculum is only needed when the fundus is sharply flexed.

- Gently pull either the anteverted or retroverted uterus toward you with constant smooth traction on the tenaculum in a downward and outward direction.

Step 4:

- Gently pass the sterile tip of the uterine sound into the cervical canal while maintaining traction with the tenaculum. If there is an obstruction at the level of the os, use a smaller sound, if available.
- Insert the sound carefully and gently into the uterine cavity while pulling steadily downward and outward on the tenaculum. Be careful to not touch the vaginal walls during passage of the sound to the cervical os. From the bimanual exam, you should know the general direction of the uterus, so direct the sound gently toward where you expect the fundus to be. Gentle traction on the tenaculum may enable the sound to pass more easily.
- If the client begins to show symptoms of fainting, or pallor with slow heart rate, **STOP**.

Step 5:

- When a slight resistance is felt, the tip of the uterine sound has reached the fundus. Do not remove the tenaculum, but leave it attached to the cervix.

Step 6:

- Remove the sound and determine the length of the uterus by noting the mucus and/or blood on the sound. The average uterus will sound to a depth of 6-8 cm. Do not attempt to insert an IUD into a uterus that measures 6.0 cm or less in depth.

Step 7:

- Set the depth gauge to the level on the sound. If the uterus sounds to a depth of 10 cm or more, the sound may have perforated the uterus, or the uterus may be enlarged due to tumors or pregnancy. **DO NOT** insert an IUD.

If perforation is suspected, observe the client in the clinic carefully:

- For the first hour, keep the woman at rest and check the pulse and blood pressure every 5 to 20 minutes.
- If the woman remains stable after one hour, check the hematocrit/hemoglobin, if possible, allow her to walk; check vital signs as needed, and observe for several more hours.
- If she has no signs or symptoms, she can be sent home, but should avoid intercourse for two weeks. Help her make an informed choice for a different contraceptive.
- If there is a rapid pulse and falling blood pressure, or new pain or increasing pain around the uterus, hospitalization for further management is necessary.

II. IUD Insertion using the Withdrawal Technique

Procedure

Step 1

Load the IUD into the inserter barrel without breaking its sterility.

Step 2

Insert the IUD into the uterus to the set depth of the gauge (based on “sounding”) or until resistance is felt.

Step 3

Hold the inserter rod at fundus while retracting (drawing back) the outer barrel over the inserter rod.

Step 4

Release the IUD, withdrawing the insertion tube no more than 1 cm while the solid rod is held stable (this movement releases the arms of the device).

Step 5

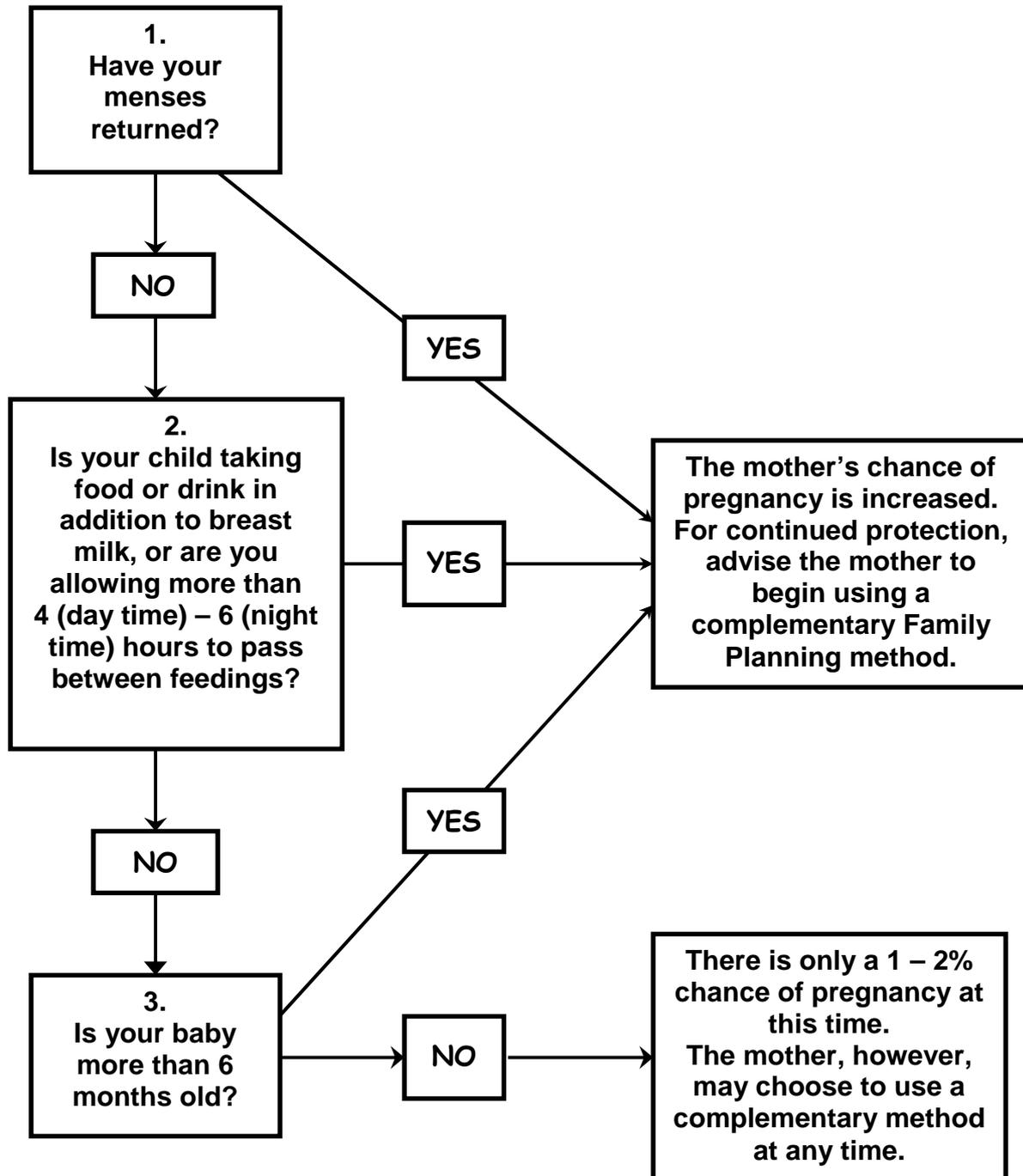
Withdraw the rod inserter while holding the insertion tube stationary.

Step 6

Withdraw the insertion tube from the cervix.

Attachment 3 Algorithm for Lactational Amenorrhea¹¹

Ask the mother (or advise her to ask herself) these three questions:



¹¹ *Pocket Guide for Family Planning Service Providers*, 2nd ed (1996), JHPIEGO, 84.

Attachment 4 Health in Jordan¹²

Indicator	Value
Estimated Population	5.1 million
Crude Birth rate/1,000 population	28
Crude Death rate/1,000 population	5
Infant Mortality rate/1,000 live births	28
Child mortality rate (1-4 years)/1,000	4.5
Maternal mortality rate/100.000 live births	41.4
Population Growth Rate	3%
Life expectancy at birth: female	71 years
Life expectancy at birth: male	69 years
Family size	6 children

¹² Source: *Annual Statistical Book, 2000*. Prepared by Information Center.

Attachment 5

Progress In Reproductive Health Indicators for Jordan¹³

Indicator	1990	1997	2000
Women (15-49) with no education	24%	9%	
Median age at first marriage	19.6	21.5	
Median age at first birth	21.2	23.2	
Teen age pregnancy and mother hood	7%	6%	
Median birth interval (months)	24	25.6	
Births occurred before 24 months of previous child	50%	44%	
Contraceptive prevalence rate (all methods)	40%	53%	56%
Contraceptive prevalence (modern methods)	27%	38%	39%
Unmet need for family planning services	22%	14%	
Total demand for family planning services satisfied	66%	80%	
Unwanted pregnancies	32%	37%	
Antenatal care by physician or nurse/midwife	80%	96%	
Timing of ANC visit (median) months	3	2.2	
Median number of ANC visits	7.5	8	
Pregnant women receiving 4+ visits	67%	86%	
Tetanus toxoid vaccination one/2 or more doses	22/20	24/16	
Medical assistance during delivery	87%	97%	
Delivery in health facility	78%	93%	
Infant mortality rate/1000 live births	37	29	28
Under five mortality rate/1000 live births	42.4	34	
Child mortality rate (1-4years)/1000 live births	5.8	5.1	4.5
Maternal mortality rate/100.000 live births	60	41.4	

¹³ Sources: Jordan Population and Family Health Surveys: 1997, 2000, Demographic and Health Surveys, Department of Statistics, Amman, Jordan and Macro International Inc., Calverton, Maryland. Jordan Annual Fertility Survey 2000, Department of Statistics in collaboration with the International Programs Center, U.S. Census Bureau.

Family Planning Checklists

1. General Counseling
2. Counseling Following Pregnancy Loss
3. Combined Oral Contraceptives (COCs)
4. Progestin-Only Pills (POPs)
5. Intrauterine Device (IUDs)
6. DMPA Injectable Hormone (Depo-Provera)
7. Lactational Amenorrhea Method (LAM)
8. Condom
9. Vaginal Spermicides
10. Norplant Implant
11. Fertility Awareness Method-Cervical Mucus Method (CMM)
12. Emergency Contraceptive Pills (ECP)
13. Voluntary Surgical Sterilization: Tubal Occlusion (Female)

Performance Checklist 1: General Counseling

Instructions: For each of the tasks listed below, place a check in the “Yes” or “No” box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter NA (“not applicable”) in the “Comments” column. Use the “Comments” column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	ACHIEVED?		COMMENTS
	YES	NO	
All Clients			
1. Greets client with respect: <ul style="list-style-type: none"> • Introduces self. • Shows respect for client. • Gives full attention without distractions. • Assures client of privacy and confidentiality. 			
2. Provides a private space for client.			
3. Makes clients from special needs groups feel welcome, e.g., adolescents, men, following pregnancy loss.			
4. Informs client of family planning services available at the facility.			
All New Clients			
1. Confirms with patient purpose of visit: to explain various methods of birth spacing and help her determine which might be best for her.			
2. Asks patient about her objectives and desires in birth spacing.			
3. Asks patient about her past history and experiences with birth control and her fears and concerns.			
4. Asks client about medical and surgical problems/history.			
5. Interviews client to determine pregnancy status.			

Task	ACHIEVED?		COMMENTS
	YES	NO	
6. Asks client if she is currently breastfeeding.			
7. Explores with client her/his risk of exposure to STIs.			
8. Explains the benefits of family planning for client, children, family, community, and society at large.			
9. Explains the basic elements of each family planning method: <ul style="list-style-type: none"> • Uses language appropriate to the understanding of the patient. • Uses demonstration chart or samples of pills, IUD, condoms, etc. • Periodically confirms that the patient understands information – does not overwhelm client with too much information; watches for non-verbal communication and asks client to clarify her feelings. 			
10. Briefly explains the various methods (description, how it works, effectiveness, advantages, disadvantages, side effects, and risks.			
11. Briefly demonstrates how to use each method or where it is located in/on the body.			
12. Encourages client to handle each method and ask questions.			
13. Clarifies rumors or misinformation about family planning or specific methods.			
14. Asks patient if she is interested in a specific method.			

Task	ACHIEVED?		COMMENTS
	YES	NO	
15. If specific method selected, gives complete explanation of this method: <ul style="list-style-type: none"> • How it works. • Contraindications for use of this method. • Other beneficial effects of this method. • Specific use of this method. 			
16. Asks for and answers questions, and clarifies misconceptions.			
17. Schedule follow-up visit appropriate to method selected (or, if patient uncertain, for further counseling and discussion).			
All Follow-up Visit Clients			
1. Asks client about satisfaction with method.			
2. Asks client about problems or questions with method.			
3. Reviews user instructions for method.			
4. Offers condoms for STI protection.			
5. Gives re-supply of family planning method.			
6. Schedules follow-up visit appropriate to method selected (or, if patient uncertain, for further counseling and discussion).			
Physical Assessment			
1. Conducts physical assessment or refers for further care if appropriate.			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 2: Counseling Following Pregnancy Loss

Instructions: For each of the tasks listed below, place a check in the “Yes” or “No” box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A (“not applicable”) in the “Comments” column. Use the “Comments” column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	ACHIEVED?		COMMENTS
	YES	NO	
All Clients			
1. Provides appropriate emotional support to client experiencing pregnancy loss.			
2. Before discharge, counsels client regarding (a) return of fertility within 2 weeks of first trimester loss, (b) benefits of delaying subsequent pregnancy.			
3. Explores client’s knowledge and/or experience with family planning methods.			
4. Explains characteristics of each available method to client.			
5. Accepts a woman’s right or decision to refuse FP or to postpone using FP until a later time.			
6. Assists client in selecting a method.			
7. Provides client’s selected method, including instructions.			
8. Reviews side effects for client’s selected method.			
9. Assesses client for risk of STIs and offers condoms.			
10. Asks client to repeat instructions and encourages client’s questions.			
11. Gives follow-up appointment according to the standard for client’s selected method.			

Task	ACHIEVED?		COMMENTS
	YES	NO	
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 3: Combined Oral Contraceptives (COCs)

Instructions: For each of the tasks listed below, place a check in the “Yes” or “No” box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A (“not applicable”) in the “Comments” column. Use the “Comments” column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	ACHIEVED?		COMMENTS
	YES	NO	
All Clients			
1. Interviews client to determine pregnancy status			
2. Interviews client to determine medical eligibility for method			
3. Hands the client a packet of the same pills she will use.			
4. Tells client the possible side effects of COCs.			
5. Shows and tells client how and when to start the pills: <ul style="list-style-type: none"> • During first 7 days of menstrual cycle. • 6 months postpartum, if using LAM. • 3 weeks postpartum, if not breastfeeding. • Immediately following pregnancy loss or during first week following pregnancy loss. • Anytime she is not pregnant. 			
6. Instructs client to take one pill every day until the packet is finished.			
7. If using a 21-day packet, tells client to wait 7 days after taking the last pill before starting the new packet.			

Task	ACHIEVED?		COMMENTS
	YES	NO	
8. If using a 28-day packet, tells client to take the pills daily without stopping or skipping any days. Start the new packet the next day after taking the last pill from the old packet.			
9. Forgotten pills (1 pill) – Tells client to take the forgotten pill as soon as she remembers.			
10. Forgotten pills (2 pills) - Tells client to take 2 pills as soon as she remembers and 2 pills the next day, continuing the rest of the packet as usual.			
11. Tells client to use a back-up method (condom, spermicides) for 7 days if more than one pill is forgotten.			
12. Forgotten pills (3 pills in a row) – Tells client to throw away the packet, begin new packet of pills, as when first starting the pills, and use a back-up method for at least 7 days; she may have bleeding.			
13. Counsels client to consider another method if forgetting pills becomes recurrent.			
14. Vomiting: Tells client if she has vomiting or diarrhea within 1 hour of taking pills, to take 1 pill from another packet.			
15. Severe diarrhea or severe vomiting: Tells client to continue taking pills and to use a backup method until she has taken a pill for 7 days in a row AFTER diarrhea or vomiting has stopped.			

Task	ACHIEVED?		COMMENTS
	YES	NO	
16. Counsels client that COCs do not protect against STI and encourages use of condoms while taking COCs, if she might be at risk of STIs.			
17. Counsels client to always tell other health care providers that she is taking COCs to avoid possible drug interaction with prescriptions.			
18. Gives client a 3-month supply of COCs.			
19. Tells client about problems that require care and to return if any problems arise.			
20. Asks client repeat instructions and encourages client's questions.			
21. Gives client a follow-up visit appointment within 3 months.			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 4: Progestin-Only Pills (POPs)

Instructions: For each of the tasks listed below, place a check in the “Yes” or “No” box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A (“not applicable”) in the “Comments” column. Use the “Comments” column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	ACHIEVED?		COMMENTS
	YES	NO	
All Clients			
1. Interviews client to determine pregnancy status.			
2. Interviews client to determine medical eligibility for method.			
3. Hands the client a packet of the same pills that she will use.			
4. Tells client the possible side effects of POPs.			
5. Shows and tells client how and when to start the pills: <ul style="list-style-type: none"> • During first 7 days of menstrual cycle. • 6 months postpartum, if using LAM. • 6 weeks postpartum if breastfeeding but not using LAM. • Immediately or within 6 weeks postpartum, if not breastfeeding. • Immediately following pregnancy loss. 			
6. Tells the client to take one pill every day at the same time until the packet is finished.			
7. Tells client to start a new packet the day after taking the last pill in the old packet. There is never a break.			

Task	ACHIEVED?		COMMENTS
	YES	NO	
8. Forgotten pills (1 pill) – Tells client take pill as soon as remembered and continue taking one pill each day, using a back-up method for the next 2 days; she may have spotting.			
9. Informs client that taking the pill more than 3 hours later than the regular time can put her at risk of pregnancy; use a back-up method for the next 2 days.			
10. Forgotten pills (2 or more pills in a row): Tells client to start using a back-up method immediately ; restart taking pills right away (take 2 pills for 2 days). If menses does not come in 4-6 weeks, come to the clinic for exam and pregnancy test.			
11. Tells client to keep track of menses when taking POPs; if more than 45 days late, come to clinic for examination and pregnancy test.			
12. Diarrhea/vomiting : Tells client to use a back-up method with the POPs until 2 days after the diarrhea or vomiting are over.			
13. Counsels client that POPs do not protect against STI and encourages use of condoms while taking POPs, if she might be at risk of STIs.			
14. Counsels client to always tell other health care providers that she is taking POPs to avoid possible drug interaction with prescriptions.			
15. Give client a 3-month supply of POPs.			
16. Tells client to return if any problems arise.			

Task	ACHIEVED?		COMMENTS
	YES	NO	
17. Has client repeat instructions and encourages client's questions.			
18. Gives client a follow-up visit appointment within 3 months.			
Recordkeeping			
1. Records visit information in client record.			

Performance Checklist 5: Intrauterine Devices (IUDs)

Instructions: For each of the tasks listed below, place a check in the “Yes” or “No” box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A (“not applicable”) in the “Comments” column. Use the “Comments” column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		COMMENTS
	YES	NO	
All Clients			
1. Confirms that patient has received adequate counseling about family planning methods, and that she has selected the IUD as best for her situation.			
2. Confirms that patient does not have contraindications: <ul style="list-style-type: none"> • Pregnancy (using pregnancy questionnaire or pregnancy test). • Recent or high risk for STI or PID. • Cancer of cervix, uterus or ovaries, or hydatid mole. • Pregnancy-related infection (infected abortion or delivery). • Endometriosis (persistently painful menstrual periods). • Unexplained vaginal bleeding. • Anemia • Postnatal anemia (48 hours and up to 4 weeks). 			
2. Interviews client to determine medical eligibility for method.			
3. Shows the client the IUD that will be inserted.			
4. Tells the client possible side effects of IUD use.			
5. Reconfirms that client is not at risk for STIs.			

Task	Achieved?		COMMENTS
	YES	NO	
6. Tells the client the device can be inserted: <ul style="list-style-type: none"> • During the menstrual cycle. • 4 weeks after childbirth (copper T IUD), 6 weeks (other IUD). • Immediately following pregnancy loss. • Immediately after stopping another FP method. • Anytime she is not pregnant. 			
7. Explains to client the insertion procedure and answers questions.			
Insertion Technique			
1. Inserts the IUD using aseptic technique and following recommended insertion steps.			
2. Asks patient to empty her bladder.			
3. Positions woman appropriately on examination table with feet in stirrups.			
4. Drapes woman appropriately.			
5. Positions light for good illumination of cervix.			
6. Opens IUD insertion instrument package.			
7. Puts gloves on both hands.			
8. Performs pelvic examination, Pap and specimen collection as appropriate, and bimanual examination for uterine size and position according to protocol.			
9. Removes and disposes of gloves.			
10. Wears sterile gloves.			

Task	Achieved?		COMMENTS
	YES	NO	
11. Using sterile, no-touch technique, bends IUD arms into inserter tube through package, and opens package.			
12. Inserts sterile vaginal speculum.			
13. Swabs vagina and cervix with appropriate antiseptic solution twice.			
14. Grasps anterior os of cervix with tenaculum.			
15. Sounds uterus with appropriate instrument.			
16. Sets depth gauge of IUD inserter according to measured uterine depth and confirms that gauge is in same plane as the IUD arms.			
17. Inserts IUD slowly and gently into uterus without touching speculum or vaginal walls. Stops if any significant resistance is felt.			
18. Holds white rod in one position and release IUD arms by pulling inserter tube toward you, NOT by pushing on white rod.			
19. Once IUD arms are released, gently pushes inserter tube into uterus until slight resistance is felt – to seat IUD at top of uterus.			
20. Remove inserter tube and white rod, and cut strings to 3-4 cm. with scissors.			
21. Removes tenaculum and apply pressure with cotton ball on ring forceps if any significant bleeding.			

Task	Achieved?		COMMENTS
	YES	NO	
22. Removes speculum – places all instruments in disinfectant solution.			
23. Observes the client for at least 15 minutes.			
24. Teaches client how to check for IUD strings.			
25. Assures client she can have the IUD removed whenever she wants it to be removed.			
26. Gives client a card with date for IUD removal.			
27. Instructs client to return to the clinic if she has the following: <ul style="list-style-type: none"> • Delayed menstrual period bleeding between periods, or symptoms of pregnancy. • Abnormal, foul-smelling vaginal discharge. • Severe abdominal pain, pain with intercourse. • Strings missing, shorter or longer; cannot palpate IUD strings in vagina. 			
28. Has client repeat instructions and encourages client's questions.			
29. Gives client a follow-up visit within 6 weeks of insertion.			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 6: DMPA Injectable Hormone (Depo-Provera)

Instructions: For each of the tasks listed below, place a check in the “Yes” or “No” box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A (“not applicable”) in the “Comments” column. Use the “Comments” column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		COMMENTS
	YES	NO	
All Clients			
1. Interviews client to determine pregnancy status.			
2. Interviews client to determine medical eligibility for method.			
3. Shows client the vial of injectable hormone she will use.			
4. Tells client possible side effects of DMPA.			
5. Explores how irregular or increased bleeding or absence of menses will affect client's daily life.			
6. Tells the client she can receive DMPA: <ul style="list-style-type: none"> • During the first 7 days of menses. • Immediately or within 6 weeks postpartum if not breastfeeding. • 6 months postpartum, if using LAM. • 6 weeks postpartum if breastfeeding but not using LAM. • Immediately following pregnancy loss. • Anytime she is not pregnant. 			

Task	Achieved?		COMMENTS
	YES	NO	
7. Tells the client she will not need a back-up method when receiving the first injection during the first 7 days of her menstrual cycle.			
8. Tells the client she will need to use a back-up method for 2 weeks when receiving the first injection after the 7 th day of her menstrual cycle.			
9. Tells client to return to clinic every 3 months for reinjection (may be up to 2 weeks late and return for reinjection), and to use a back-up method for one week.			
10. Give the client the injection of DMPA into the deltoid or the gluteus maximus muscle using aseptic technique and not massaging the injection site.			
11. Counsels client that DMPA does not protect against STI and encourages use of condoms while taking DMPA, if she might be at risk of STIs.			
12. Tells client to return if she has any of the following: <ul style="list-style-type: none"> • Heavy vaginal bleeding. • Severe headache with blurred vision. • Severe abdominal pain. 			
13. Has client repeat instructions and encourages client's questions.			
14. Gives client an appointment for Follow-up visit within 3 months			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 7: Lactational Amenorrhea Method (LAM)

Instructions: For each of the tasks listed below, place a check in the “Yes” or “No” box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A (“not applicable”) in the “Comments” column. Use the “Comments” column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		COMMENTS
	YES	NO	
All Clients			
1. Supports the client in starting LAM as soon as possible after birth of infant.			
2. Explains the criteria for LAM use: <ul style="list-style-type: none"> • Menses have not returned. • Infant is breastfeeding fully day and night, taking not other food or drink. • Infant is less than 6 months old. 			
3. Encourages woman to breastfeed often and on demand day and night.			
4. Tells the woman not to introduce any other food or drink before 6 months postpartum.			
5. Instructs client to use a back-up method or come to the clinic immediately if any one of the criteria changes.			
6. Instructs client how to handle difficulties that might interfere with breastfeeding; encourages client to return for help.			
7. Gives client back-up method.			
8. Has client repeat instructions and encourages client's questions.			
All Follow-up Visit Clients			

Task	Achieved?		COMMENTS
	YES	NO	
1. At follow-up visit, asks client: <ul style="list-style-type: none"> • Have menses returned? • Is the infant still breastfeeding fully day and night, not taking other food or drink? • Is infant 6 months old yet? 			
2. If criteria for use is still present, support client to continue LAM.			
3. If criteria for use are not present, or client wants to change the method, counsels client to use a complementary method of FP that does not interfere with breastfeeding.			
4. Give client follow-up visit appointment or encourage her to return whenever she feels the need.			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 8: Condoms (Male)

Instructions: For each of the tasks listed below, place a check in the “Yes” or “No” box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A (“not applicable”) in the “Comments” column. Use the “Comments” column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		COMMENTS
	YES	NO	
All Clients			
1. Shows client the condom he will use.			
2. Praises client for choosing a method that protects against pregnancy and STIs.			
3. Demonstrates while telling client how to put on and remove the condom.			
4. Instructs client to: <ul style="list-style-type: none"> • Use water-based lubricant to prevent breakage. • Roll condom onto the penis all the way to the base. • Hold the rim of the condom at the base of the penis so it will not slip off when removing the penis from the vagina after ejaculation, before completely losing his erection. • Throw the condom away in the garbage, burn or bury it. Do not leave where children will find and play with it. 			
5. Tells client to encourage his partner/wife to use a spermicide while he uses condoms.			
6. Instructs client that if condom breaks, to immediately insert a spermicide into the vagina and bring his partner/wife to clinic for ECPs within 72 hours—the sooner the better.			

Task	Achieved?		COMMENTS
	YES	NO	
7. Advises client never to re-use condoms.			
8. Encourages client to return to clinic for resupply of condoms.			
9. Offers client a spermicide or ECPs as back-up, with necessary instructions for use.			
10. Gives client 3-month supply (~40 or more) of condoms.			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 9: Vaginal Spermicides

Instructions: For each of the tasks listed below, place a check in the “Yes” or “No” box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A (“not applicable”) in the “Comments” column. Use the “Comments” column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		COMMENTS
	YES	NO	
All Clients			
1. Interviews client to determine medical eligibility for the method			
2. Shows client the spermicide she will use.			
3. Demonstrates insertion using a pelvic model.			
4. Instructs client to: <ul style="list-style-type: none"> • Wash hands with soap and water before and after insertion spermicide. • If using suppositories, allow time for it to melt before having sexual contact. 			
5. Foam: Tells client to shake foam at least 20 times; fill the applicator from the container; insert the applicator deeply into the vagina close to the cervix, then push the plunger to release the foam.			
6. Cream or Jelly: Tells client to fill the applicator from the tube, insert the applicator deeply into the vagina until it is near the cervix; push plunger to release the cream or jelly.			
7. Suppository: Tells client to remove the wrapping and slide the suppository into the vagina, pushing it along the back wall of the vagina until it rest near the cervix.			

Task	Achieved?		COMMENTS
	YES	NO	
8. Instructs client to use the spermicide every time she has sex and with each act of sexual intercourse.			
9. Advises client not to douche or rinse vagina after sex; if she must, wait at least 6 hours.			
10. Tells client to wash applicator with warm soap and water and allow to air-dry.			
11. Gives client adequate supply of spermicide for time until the next visit; encourages client to return when she needs more.			
12. Has client repeat instructions and encourages client's questions.			
13. Schedules a follow-up visit at the client's convenience.			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 10: Norplant Implants

Instructions: For each of the tasks listed below, place a check in the “Yes” or “No” box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A (“not applicable”) in the “Comments” column. Use the “Comments” column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		COMMENTS
	YES	NO	
All Clients			
1. Interviews client to determine pregnancy status			
2. Interviews client to determine medical eligibility for method			
3. Shows client the Norplant implants and where in her arm it will be placed.			
4. Tells client possible side effects of Norplant use.			
5. Explains the procedure for insertion to client.			
6. Assures client that the implants can be removed whenever she wants.			
7. Tells client the implants can be inserted: <ul style="list-style-type: none"> • During the first 7 days of the menstrual cycle. • 6 weeks postpartum, if not breastfeeding. • 6 months postpartum, if breastfeeding and using LAM. • Immediately or within 7 days following pregnancy loss. • Anytime she is not pregnant (must use back-up). 			
Insertion Technique			
1. Inserts Norplant implants using sterile technique.			

Task	Achieved?		COMMENTS
	YES	NO	
2. Tells client there may be bruising and slight bleeding at the insertion site during the first few days; this is normal.			
3. Instructs client to keep the area dry for 4 days (remove gauze after 2 days, adhesive after 5 day). <ul style="list-style-type: none"> • May have soreness and/or swelling after anesthesia wears off. 			
4. Tells client to return to clinic immediately if she experiences any of the following: <ul style="list-style-type: none"> • Symptoms of pregnancy. • Abdominal pain (severe). • very heavy menstrual bleeding. • Severe headache. • Yellow skin and/or eyes (jaundice). 			
5. Counsels client that Norplant does not protect against STI and encourages use of condoms while taking Norplant, if she might be at risk of STIs.			
6. Counsels client to always tell other health care providers that she is taking Norplant to avoid drug interaction with possible prescriptions.			
7. Has client repeat instructions and encourages client's questions.			
8. Give client a card with date for Norplant removal.			
9. Give client a follow-up visit within 4 weeks of insertion.			
Recordkeeping			
1. Records visit information in the client record.			

Performance Checklist 11: Fertility Awareness Method-Cervical Mucus Method (CMM)

Instructions: For each of the tasks listed below, place a check in the “Yes” or “No” box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A (“not applicable”) in the “Comments” column. Use the “Comments” column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		COMMENTS
	YES	NO	
All Clients			
1. Displays graphic of woman’s reproductive system including anatomy, menstrual cycle, and process of conception; shows fertile days.			
2. Explores the presence or absence of partner support for this method with client.			
3. Using a graphic, explains reproductive physiology covering woman’s reproductive system, anatomy, menstrual cycle, process of conception.			
4. Explains to the client the pattern of fertile and infertile days.			
5. Explains rules of CMM: <ul style="list-style-type: none"> • Avoid sex during menstrual days. • Avoid sex during early infertile days before ovulation. • Have sex every other day when there is no cervical mucus or vaginal wetness. • Avoid sex from the first day of cervical mucus or vaginal wetness (beginning of the fertile phase) until the end of the fertile phase. • The last day of cervical mucus or vaginal wetness is the “peak” day. Continue abstaining from sex for 3 days after the “peak” day. 			

Task	Achieved?		COMMENTS
	YES	NO	
<ul style="list-style-type: none"> Resume sex on the 3rd day of no cervical mucus or vaginal wetness until the next menstrual bleeding begins. 			
6. Encourages client/couple to ask questions.			
7. Asks client/couple to repeat instructions.			
8. Gives client a chart to record CMM changes over 2 cycles and advises client to abstain during the learning period.			
9. Reminds client/couple that CMM does not protect against STI; a condom must be used if they might be at risk of infection.			
10. Gives client/couple follow-up visit in 6 weeks.			
Recordkeeping			
1. Records visit information.			

Performance Checklist 12: Emergency Contraceptive Pills (ECPs)

Instructions: For each of the tasks listed below, place a check in the “Yes” or “No” box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A (“not applicable”) in the “Comments” column. Use the “Comments” column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		COMMENTS
	YES	NO	
All Clients			
1. Explains to client how ECPs are used, how it works, and how to adopt regular contraception.			
2. Gives client 2 pills of Ovral* for 2 doses within 12 of each other. <i>*Use chart to give the correct number of pills for the combined contraceptive pills available for EC use.</i>			
3. Offers client anti-nausea medication to take before taking the hormones.			
4. Gives client instructions for follow-up visit as follows: <ul style="list-style-type: none"> • Return to clinic in 4 weeks, • Avoid unprotected sexual intercourse after ECP use; use condoms or spermicides. 			
5. Counsels client for selection of an ongoing family planning method.			
6. Gives client new or resupplies client’s regular family planning method.			
7. Gives condoms and/or spermicides immediately ; or within first 7 days of cycle COC, POP, DMPA, IUD, or Norplant implant.			

Task	Achieved?		COMMENTS
	YES	NO	
8. Asks client to repeat instructions and encourages client's questions.			
9. Instructs client to return to clinic immediately when symptoms such as delayed menstrual period, suspected pregnancy occur.			
10. Reminds client that condoms are the only protection against STIs; she should use them if she may be at risk of infection.			
11. Gives client follow-up appointment within 4 weeks of ECP treatment.			
Recordkeeping			
1. Records visit information in the client record.			

Checklist 13: Voluntary Surgical Sterilization: Tubal Occlusion

Instructions: For each of the tasks listed below, place a check in the “Yes” or “No” box, as appropriate, to indicate whether or not the task was achieved. If a particular task is not applicable, enter N/A (“not applicable”) in the “Comments” column. Use the “Comments” column to note details about why a particular task was not achieved or other information that may be useful in identifying or resolving inappropriate practices.

Task	Achieved?		COMMENTS
	YES	NO	
All Clients			
1. Interviews client to determine pregnancy status			
2. Interviews client to determine medical eligibility for method			
3. Gives client instructions for preparing herself for procedure.			
4. Refer client to the specialist and ask her to come for follow-up visit one week after the procedure.			
5. After procedure, instructs the client on the following: <ul style="list-style-type: none"> • Rest 2-3 days, avoid heavy lifting for 1 week. • Keep incision clean and dry for 1 week. • Take paracetamol for pain relief (not aspirin or ibuprofen). • Avoid sex for at least 1 week or use a back-up method for family planning. 			

Task	Achieved?		COMMENTS
	YES	NO	
6. Advises client to return to the clinic if any of the following symptoms occur: <ul style="list-style-type: none"> • High fever in the first 4 weeks. • Bleeding or pus from the wound. • Pain, heat, swelling, or redness at the incision that becomes worse or does not stop. • Abdominal pain, cramps, or tenderness that becomes worse or does not stop. • Diarrhea, or fainting or extreme dizziness. 			
7. Instructs client to return to clinic immediately if she thinks she might be pregnant (missed period, nausea, breast tenderness).			
8. Reminds client that tubal sterilization does not prevent STIs; encourage client to use condoms if she may be at risk.			
9. Asks client to repeat instructions and encourages client's questions.			
10. Gives client condoms, if she wants them.			
11. Gives client follow-up visit appointment for 7-14 days after the procedure.			
Recordkeeping			
1. Records visit information in the client record.			