Evidence-Based Guidelines in Family Planning for Health Workers

Essential policies and standards of practice for Family Planning services in Vanuatu

Third Edition, 2015

Ministry of Health

RMNCAH UN JOINT PROGRAMME

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Preface

By Hon. Jerome LUDVAUNE, Minister of Health

I am pleased to present the Third Edition of the Evidence Based Guidelines in Family Planning for Health Workers in Vanuatu. The people of Vanuatu live in the islands. Some parts of the islands are easily accessed by road, air and sea, others are more difficult and most women who live in the hardest rural areas are badly missing out from receiving Family Planning services. Even in urban areas, many women are not well informed of Family Planning services. I ask the Ministry of Health to continue to take the lead in ensuring that necessary steps exist to meet the Family Planning needs of the population of Vanuatu. Many young families would have wanted to make the right choice in planning their family size, still they do not have access to information to make that choice. The Family Planning guideline is such a comprehensive document and captures the essential policies and standards of practice for Family Planning in Vanuatu.

Family Planning plays a key role in helping people and especially women benefiting from socio-economic opportunities. It helps women to make the right choices of having lesser children, going for higher education and becoming leaders in the country, it empowers women to participate in economic building of the country, it helps women contributing to decision making at all levels of the society. As the Minister of Health, I call on the Health Workers to think well on this and take time to read the guideline and help to reach out to our young women throughout the country make a small difference in their lives.
The small choice they make will contribute to a major change in the work of Family Planning in the country in the next five years and beyond.

Honourable Jerome LUDVAUNE (MP)
Minister of Health

Acknowledgements

This revised, third edition of Vanuatu's *Evidence-Based Guidelines in Family Planning for Health Workers* has been prepared by the Vanuatu Reproductive Health Consultant, Mr Chris Hagarty, in accordance with the UNDP MAF Program Work plan.

Special thanks and acknowledgement for their technical review and input are extended to Ms Apisai Tokon, National Reproductive Health Coordinator (Ministry of Health), Dr Rufina Latu (WHO), Dr Pulane Tlebere (UNFPA) and the members of the national RMNCAH Committee. Thanks also to Mr Pioni Willie, MAF Program Coordinator (UNDP) for his assistance in supporting the completion of the document.

The printing of the guideline is made possible by RMNCAH UN Joint Presence support under DFAT. The guideline will be used to further develop training packages for Trainer's Guide and Participants Manual. To this end I would like to also thank the support of UNDP and RMNCAH UN Joint Presence for recognizing and assisting to realize such a document which will be used to provide training in Family Planning for Health Workers throughout Vanuatu.

As always I remind the Health Workers of the Ministry of Health to always remember that a lot of time and resources have been put into the development of the guideline and bringing it to its present state. It is the Ministry of Health onus to make sure that the guideline is fully utilised and for health workers and the target population to benefit from it.

George Taleo
Director-General
Ministry of Health

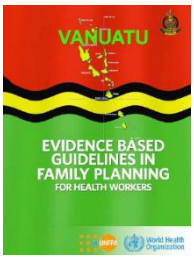
Background

A Guide for service providers, managers and supervisors.
This revised, third edition of Vanuatu's *Evidence-Based Guidelines in Family Planning for Health Workers* has been developed as a comprehensive reference for all Family Planning service providers, managers and supervisors, however it is understood that not all users will need to consult the entire document on a regular basis. Rather the Guidelines have been structured (and colour-coded) into three sections to facilitate quick navigation and reference to whichever aspect of Family Planning service delivery is required.

1	Family Planning information and approaches for community engagement
2	Family Planning service development and management for national program managers and clinical supervisors
3	Family Planning information for service providers, including types of contraceptive methods

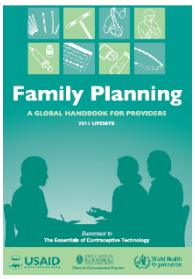
It is recommended that service providers are familiar with each section of the Guidelines, as their role necessitates delivery of Family Planning services, as well as community engagement and the need to be aware of expectations of supervisory support.

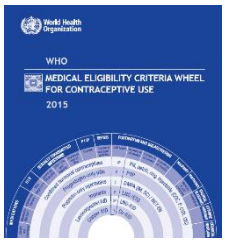
While some users may find the information presented repetitive, this is necessary to ensure those referencing only a single chapter of the document - perhaps to review a particular Family Planning method - will not miss important information.



About the Guidelines.
The revised *Evidence-Based Guidelines in Family Planning for Health Workers* draw heavily on relevant content from previous editions, with updates from various sources as appropriate for the ever-changing Family Planning service delivery environment, and in accordance with improved knowledge and capacity of service providers across the country.

Throughout this document, unless otherwise indicated, all diagrams, pictures and illustrations have been sourced from the 2006 Second Edition of the *Evidence-Based Guidelines in Family Planning for Health Workers*[1]. In order to enhance understanding and learning of health workers and supervisors delivering and overseeing Family Planning services, this new edition presents many more illustrations and diagrams which have been referenced throughout, most notably sourced from the *Family Planning: A Global Handbook for Providers: 2011 Update*[2].





Other resources which should be consulted as companions to this document include Vanuatu's *Health Worker's Manual: Standard Treatment Guidelines*[3] (particularly for more detail regarding infection control and ordering of pharmaceutical supplies for clinics), the *Standard Guidelines for Emergency Obstetrics and Neonatal Care: A Health Worker's Guide* (new edition to be released in 2015), and WHO's *Medical Eligibility Criteria for Contraceptive Use*[4], *Medical Eligibility Criteria Wheel for Contraceptive Use*[5] and *Four Cornerstones of Family Planning Guidance* documents.

[1] Government of Vanuatu, UNFPA & WHO, 2006; *Evidence-Based Guidelines in Family Planning for Health Workers: Essential policies and standards of practice for Family Planning services in Vanuatu: Second Edition*; Port Vila; Government of Vanuatu.
[2] WHO, John Hopkins Bloomberg School of Public Health & USAID, 2011; *Family Planning: A Global Handbook for Providers: 2011 Update.*
[3] Ministry of Health, 2013; *Health Worker's Manual: Standard Treatment Guidelines; September 2013, 3rd Edition*; Port Vila; Republic of Vanuatu Ministry of Health.
[4] WHO, 2014; *Medical eligibility criteria for contraceptive use: Fifth edition 2015*; Geneva, World Health Organization.
[5] WHO, 2015; *WHO medical eligibility criteria wheel for contraceptive use: 2015 update*; Geneva; World Health Organization.

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BBT	Basal Body Temperature
BCC	Behaviour Change Communication
CMS	Central Medical Stores
COC	Combined Oral Contraceptive
DMPA	Depot medroxyprogesterone acetate (injectable contraceptive)
ECP	Emergency Contraceptive Pill
HIV	Human Immunodeficiency Virus
HIS	Health Information System
HVS	High Vaginal Swab
IEC	Information, Education and Communication
IUCD	Intrauterine Contraceptive Device
LAM	Lactational Amenorrhoea Method
PID	Pelvic Inflammatory Disease
POP	Progestin-Only (contraceptive) Pill
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually transmitted infection
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
VCNE	Vanuatu College of Nursing Education
VFHA	Vanuatu Family Health Association
VNSO	Vanuatu National Statistics Office
VWC	Vanuatu Women's Centre
WHO	World Health Organization

Section 1: Family Planning information and approaches for community engagement

1. Introduction

1.1. What is Family Planning?

Family Planning is the means by which individuals and couples can **freely and responsibly** decide the:

- ***Number*** of children they want.
- ***Spacing*** between births.
- ***Timing*** of each child.

Family Planning is also helps individuals and couples to prepare for, and achieve a successful pregnancy and childbirth.

1.2. What do Family Planning Services Provide?

Information to plan families;

Family Planning information, education and communication (IEC) programs promote understanding of basic reproductive health and available contraceptive methods, and provide information for avoiding high risk pregnancy.

Every chance should be taken to inform women and men about Family Planning. For example, at antenatal, postnatal, maternal and child health, and outpatient clinics, at schools, at youth and women's group meetings, and when appropriate during general discussions.

Means to plan families;

Different types of contraceptives are available for individuals and couples to choose the best method for them at that time.

With modern Family Planning methods, serious side-effects are rare. On the other hand, unplanned and poorly spaced pregnancies can be very dangerous. Vanuatu experiences about six maternal deaths and approximately 120 infant deaths* each year. Some of these may be avoided if more pregnancies were planned.

** based on an IMR of 15/1,000 live births and approximately 8,000 births/year*

Access to other sexual and reproductive health services;

Family Planning services also provide basic management of common gynaecological and related conditions.

1.3. Who Needs Family Planning?

All women and men of reproductive or childbearing age (that is, the age at which they are able to have a baby) who want to avoid pregnancy, including:

- A woman who does not want to interrupt her studies or her work by having a baby.
- A woman, man or couple who are not ready and/or able to take on the responsibility of a child.
- A family who cannot financially support a (or another) child.
- A family with little land to divide up between their children.

Particular target groups for Family Planning **information education and communication (IEC)** are:

- All women and men of reproductive age (usually said to be age 15-49 years).
- All young people (including those younger than 15 years) to ensure they have the information to make informed choices about sex and pregnancy.

- National and community leaders, whose position and influence can help to create environments and processes which enable information about Family Planning to be available.

1.4. Family Planning is important for families, individuals and Vanuatu.

By enabling individuals and couples to make their own decisions about the **number, spacing and timing** of pregnancies, Family Planning plays an important role in helping people to benefit from educational, economic or social opportunities, and especially to improve their health and wellbeing.

Table 1.1: Benefits of Family Planning for families, individuals and the wider population of Vanuatu.

<table>
<tr><th colspan="2">Family Planning supports FAMILY health and welfare</th></tr>
<tr><th>Avoiding unplanned and high risk pregnancy</th><th>Reducing physical and emotional burden on parents</th></tr>
<tr><td>Family Planning enables women to avoid high risk pregnancies. These include:
• Pregnancy before age 18 or after 35 increases health risks to both mother and child.
• Risk of death for young children is increased by about 50% if the space between births is less than 2 years.
• Having >4 children increases risk of problems during pregnancy and childbirth for mother and child.
• Pregnancy and childbirth in mothers with certain medical problems can be dangerous.
Family Planning can prevent high risk pregnancy, and therefore illness, disability and death (mothers/children).</td><td>Supporting a large family is hard work, and can take a physical and emotional toll which impacts on the health and well-being of parents.
Family Planning can help individuals and parents to decide on the number, spacing and timing of their children so that they can provide for, and look after them.</td></tr>
<tr><th>Avoiding disease from overcrowding</th><th>Making the most of income and opportunities</th></tr>
<tr><td>Additional children can contribute to overcrowded households, which can facilitate the spread of disease such as tuberculosis (TB).
Family Planning can help individuals and couples to choose the number of children they would like to have based on their living conditions, environment and household resources.</td><td>Family Planning helps individuals and couples to choose the number, spacing and timing of their children in accordance with their personal and financial situation.
Living expenses, such as clothes, school fees, phones and credit, food, cooking fuel and transport impact on households. Family Planning helps individuals and couples to choose how many children they want depending on what they can afford.
In this way, Family Planning also helps:
• To provide children with opportunities for good education and employment.
• Reduce financial pressures on parents through a better standard of living, and more time for parenting and companionship.</td></tr>
<tr><th colspan="2">Family Planning improves well-being of INDIVIDUALS</th></tr>
<tr><td colspan="2">By supporting individuals and couples to decide on the number, spacing and timing of their children, Family Planning can help them to develop their full potential.
For example, a well-spaced, manageable number of children may enable a mother and/or father:
• To secure and maintain paid employment, which will provide income for themselves and their family.
• To study in higher education, which will help them to get a better job in the future.
• To participate in activities outside of work (important for health and well-being), such as church, sport, social activities.</td></tr>
<tr><th colspan="2">Family Planning improves development opportunities for the POPULATION</th></tr>
<tr><td colspan="2">Family Planning can help Vanuatu's population to grow more slowly. Currently, Vanuatu's population is growing too fast, and in 25 years there will be nearly twice as many people as there are today! Fast population growth increases pressure on availability of food, fresh water, land, housing, jobs and government services (such as education and health).
Family Planning will contribute to national development by reducing the number of children being born (that is, preventing unplanned and unwanted pregnancies), which will enable:
• Vanuatu to grow richer from steady economic development. This provides the government with the time it needs to plan for services and resources, rather than having to struggle to provide the basic needs of a fast growing population.
• The government to provide enough education, health services and generate jobs for all its people, rather than have to try to control increasing social problems such as overcrowding and crime.</td></tr>
</table>

1.5. Family Planning and Sexual and Reproductive Health and Rights.

Access to Family Planning is recognised by the Government of Vanuatu as an essential element to improved health and well-being of the nation. Providing women and men with the opportunity to choose the **number, spacing and timing** of their children is considered one of the key elements of the Government's commitment to Sexual and Reproductive Health and Rights (SRHR) for all.

Every individual or couple has the right to choose Family Planning, and to obtain and use contraceptives. In respecting this right there are two important issues to consider:

- That the individual/couple's choice to use or not to use Family Panning is respected.
- That the individual and couple should not be forced to use any Family Planning method against their will.

This right extends to all; a single or unmarried person/couple also have the right to access Family Planning advice and commodities. Health workers should treat these clients with respect, patience and understanding. Their attendance at a clinic shows that they want to behave responsibly, and in respect of their rights, they should be given whatever advice and help they need to prevent unwanted pregnancies.

A Note on Rights-Based Family Planning:

Most religious and cultural groups agree that Family Planning helps the lives of individuals and families, however some of these groups do not support all Family Planning methods.

A rights-based approach to health and social welfare directs any health worker to provide accurate and comprehensive family planning advice to any individual or couple who request this, regardless of the health worker's own views or beliefs.

SRHR encompasses more than simply Family Planning; it includes aspects of social and reproductive health:

- Advance gender equality and empowerment of women.
- Eliminate violence against women (also referred to as gender-based violence).
- Eliminate discrimination.
- Achieve full, equal participation of women in civil, cultural, economic, political and social life.
- Enable women to control their fertility.

Addressing these requires action from actors outside the health system, however health provider can play a leading role in at least 2 of the 5 elements of SRHR. Controlling fertility (Family Planning) is the main focus of these Evidence-Based Guidelines, but the health sector is also well placed to support elimination and response to violence against women/gender-based violence, including sexual violence.

1.6. Violence Against Women.

Providers of Family Planning services are likely to see women who have experienced violence, such as:

- Physical violence: hitting, slapping, kicking and beating.
- Emotional or psychological violence: controlling behaviour, intimidation, humiliation, isolating a woman from family and friends, and restricting her access to resources.
- Sexual violence: including unwanted sexual contact or attention, coercive sex and forced sex (rape).

Violence against women is present across all provinces of Vanuatu, in both urban and rural communities. In a comprehensive household survey conducted by the Vanuatu Women's Centre (VWC) in 2010-11[6], 60% of women reported to have suffered from physical and/or sexual violence from their intimate partner (44% in the preceding 12 months) and 48% of women reported to have been physically and/or sexually assaulted by someone other than their intimate partner. 41% of women's first sexual experience was forced and/or unwanted.

Women experiencing violence have special health needs, particularly relating to sexual and reproductive health. Violence can cause injury, unwanted pregnancy, sexually transmitted infections (STIs - including HIV), decreased sexual desire, pain during sex and chronic pelvic pain. For some women, violence may start or become worse

[6] VWC, 2011; *Vanuatu National Survey on Women's Lives and Family Relationships*; Port Vila, VWC and VNSO.

during pregnancy, placing her foetus at risk as well. Furthermore, fear of violence can deprive a woman of her right to make her own choice about whether to use Family Planning or what method to use.

Therefore, providers of Family Planning services are likely to see abused women among their usual clientele, and may be the first health care workers to notice if a woman has experienced violence or abuse. They will need to provide counselling, guidance, support, referral or even acute treatment.

Table 1.2: Appropriate health sector response to violence against women/gender based violence.

<table>
<tr><th colspan="2">Health Worker response to violence</th></tr>
<tr><th>Help women feel welcome, safe, and free to talk</th><th>Ask women about abuse when violence is suspected</th></tr>
<tr><td>Help women feel comfortable speaking freely about any personal issue, including violence - assure and ensure confidentiality.

Provide opportunity to discuss violence; ask about:
• Partner's attitudes toward her using Family Planning; whether she foresees problems with using Family Planning.
• If there is anything else she would like to discuss.</td><td>Health providers should ask women about violence only when abuse is suspected. Be alert to symptoms, injuries, or signs that suggest violence; this might include depression, anxiety, chronic headaches, pelvic pain or vague stomach pains.

Another sign may be that a client's story about how an injury occurred does not fit the type of injury she has.

Suspect violence with any injury during pregnancy, especially to the abdomen or breasts.

When asking about violence:
• Explain you are asking because you want to help.
• Use comfortable language for you and client.
• Ask questions in a confidential space where no one else (especially partner) can hear.
• Explain that her symptoms may be due to stress. Ask:
▪ 'Domestic violence is a common problem in our community, can I ask you about this?'
▪ 'Do you and your partner tend to fight a lot? Have you ever gotten hurt?'
▪ 'Does your partner ever want sex when you do not? What happens in such situations?'
▪ 'Are you afraid of your partner?'</td></tr>
<tr><th>Counsel in a non-judging, supportive manner</th><th>Assess client's immediate danger; develop safety plan and refer her to community resources</th></tr>
<tr><td>Counselling is important for women experiencing violence. This should be tailored to a woman's particular circumstances; she may be at different stages of willingness to accept help. Counselling is not for finding out for sure if the client is experiencing violence, but rather to address the issue with compassion and caring.

If she does not want to talk about the violence, assure her that you are available whenever she needs you. Provide her with options and resources should she ever want them.

If she wants to talk about her experience of violence:
• Ensure confidentiality.
• Tell only those who need to know (such as security staff), after seeking client's permission.
• Listen, offer support and avoid making judgments. Respect her right to make her own choices.
• Relieve feelings of shame and self-blame: 'No one ever deserves to be hit/abused', 'It's not your fault'.
• Explain that 'domestic violence is a common problem in our community - You are not alone. Help is available'.
• Explain that 'abuse tends to continue. It can become worse unless something is done'.</td><td>If client faces immediate danger, help her consider a course of action. If danger not immediate, develop a longer-term plan.

Assess present situation: 'Is your partner at the health facility now?', 'Are you or your children in danger now?', 'Do you feel safe to go home?', 'Is there a friend or relative who can help you at home?'

Help her protect herself and her children if the violence recurs; 'Keep a bag packed with important documents and a change of clothes so you can leave quickly if need be'. Suggest that she have a signal to let children know when to seek help from neighbours.

Make (and keep up-to-date) a list of resources available and contact information to help victims of abuse (police, counselling services, Vanuatu Women's Centre) to receive emotional, legal and perhaps even financial support. Give a copy of the list to the client.</td></tr>
</table>

Provide appropriate care	Document the woman's condition
Tailor care and counselling to a woman's circumstances. Treat any injuries or see that she gets treatment. Evaluate risk of pregnancy; provide emergency contraception if appropriate/wanted. Offer emergency contraceptive pills for future use (see Chapter 12). Offer a contraceptive method that can be used without a partner's knowledge, such as an injectable. Discuss whether woman could safely propose condom use, without risking further violence. In cases of rape, refer to staff trained in response: • Collect samples to be used as evidence (such as torn or stained clothing - blood, semen - hair). • Provide or refer for HIV and STI testing and treatment. Some women may need such services repeatedly. • Consider post-exposure prophylaxis for HIV, and presumptive treatment for gonorrhoea, chlamydia, syphilis, and other common STIs.	Carefully document the woman's symptoms or injuries, the cause of injuries, and her history of abuse. Clearly record the identity of the alleged abuser, his relationship to the victim, and any other details about him. These notes could be helpful for future medical follow-up and/or legal action.

2. Family Planning Communication

2.1. Family Planning Behaviour Change Communication.

It is important for health professionals to inform, educate, communicate and counsel their clients individually, in couples and in groups, to change their behaviour towards accepting and using Family Planning for the good of themselves and families.

Behaviour Change Communication (BCC) is the interactive process (and communication tools) through which Family Planning messages are promoted to individuals, couples and communities. BCC uses different ways to deliver important, consistent messages about Family Planning which can be well heard and understood by different target groups.

For example, young people might be more receptive to information about Family Planning from social media on their mobile phones (such as Facebook and Twitter), whereas older women in rural areas may hear and understand Family Planning messages better when delivered by a female health worker. Also, for effective, sustainable Family Planning behaviour change in Vanuatu, men must not be excluded from BCC, as they play an important role in decisions which affect a couple's reproductive health.

Community and social mobilisation is the process of engaging with target groups, communities and key decision-makers (e.g. community and religious leaders) to lead the activities which will promote understanding of Family Planning and access to services. Identifying appropriate target groups, and working with them to determine how they will best receive and understand Family Planning messages is the key to effective BCC. Supporting communities and target groups to develop and participate in the activities which promote Family Planning knowledge and behaviour change will ensure these are acceptable and appropriate for them.

Effective communication and social mobilisation therefore requires service providers to understand all key messages relating to Family Planning, and to have the confidence and skills to communicate these through different methods which suit the target audience.

Good BCC uses a variety of different methods and approaches to deliver the same (consistent), factual information to all target groups. It should aim not only to provide that information, but to encourage target audiences to discuss and communicate those messages with their peers. This will foster understanding and acceptance of the larger group/community, which in turn generates sustained attitudinal and behaviour change to accept and use Family Planning.

Key Family Planning Messages:
- What is Family Planning? (Chapter 1)
- Why is Family Planning Important? (Chapter 1)
- Who needs Family Planning? (Chapter 1)
- What types of Family Planning methods are available? (Chapters ?-?)
- Where/when are Family Planning services available in your area? (local knowledge of Health Worker)

Working to change the attitudes and behaviour of individuals and couples is one important aspect of BCC. But in order for behaviour change to be successful, BCC must create an **enabling environment**, in which Family Planning is accepted (by everyone, including community leaders) and in which people are encouraged and supported to use Family Planning.

Behaviour change takes time. Family Planning professionals must work to **communicate** Key Family Planning Messages to individuals, couples and communities while at the same time, working with them and leaders through **community and social mobilisation** to foster an **enabling environment** for Family Planning.

Targeted IEC resources exist to assist Family Planning providers to communicate key messages to target groups at meetings, group discussions and other community events. These brochures, flipcharts and technical resources are available from Reproductive Health Supervisors and the National Reproductive Health Unit. It is the responsibility of service providers to ensure they have a reliable stock on-hand.

Communication.

Service providers must know key messages for promoting Family Planning knowledge and services at the community level, and know how to present this information for specific target groups.

Activities aim to generate change in 3 main ways:
- Change in receiver's knowledge (e.g. availability of long-acting contraceptive implants, such as Jadelle).
- Change in receiver's attitude (e.g. a man is no longer suspicious about his wife using contraceptives).
- Change in receiver's actions or behaviour (e.g. a couple go to Family Planning clinic together).

Communication is helped through targeted IEC resources available from the national level. Family Planning providers should communicate with their supervisors or National Reproductive Health Unit to ensure a reliable stock of IEC resources.

Skills: Family Planning professionals need to have the confidence and skills to communicate key messages effectively to a range of audiences.

Community and Social Mobilisation.

Information alone does not change attitudes or behaviour. Change also influenced by attitudes and behaviours of those around them (their partner, family, community and leaders), and the environment around them.

An **enabling and supportive environment** for Family Planning ensures an individual is aware of the services and methods available. It supports and encourages one to access Family Planning when they need to, without fear of recrimination or stigma.

An enabling environment is influenced by Health Workers communicating with communities and leaders to promote knowledge and understanding of Family Planning, and through engaging with target groups and leaders to identify and plan the best ways of getting the key messages understood, and encouraging them to lead the communication of those messages.

Skills: Family Planning professionals need to have the confidence and skills to facilitate and support community/target group engagement and action.

Table 2.1: The Behaviour Change Continuum for Family Planning

Client	BCC Strategies
Client is unaware of Family Planning methods	The health professional needs to raise awareness of Family Planning methods through face to face communication or by using IEC materials or both. There is a need to personalize information on risks and benefits.
Client is aware but is reluctant, not sure	The health professional first needs to identify the reasons for client's concern or reluctance to change and then explain benefits of behaviour change. The health professional must motivate and encourage the client to make a specific plan.
Client is motivated to change	Health professional needs to provide logistical information, e.g. where to get more information on Family Planning methods, where to obtain the methods etc. Similarly, health professional should use community groups or well-known individuals/leaders to counsel and motivate the client.
Client tries new behaviour	This is a critical stage. Health professional to provide further information, encourage continual use of the Family Planning method by emphasizing benefit, reduce barriers through problem solving, build skills of the client through trials and create social support within the community
Client sustains new behaviour	The work is not finished. Health professional needs to remind the client of the benefits of new behaviour and assure him/her of his/her ability to sustain and to create and use social support

Most importantly, Family Planning professionals must be patient; changing attitudes and behaviours takes time. People are often afraid of the unknown, or of being criticized for doing something different from the rest of society, therefore many in the community will regard new Family Planning methods with little interest, and sometimes with suspicion. Being patient, showing respect and providing clear, accurate information and descriptions about Family Planning will yield positive attitudinal change over time, and working with individuals and groups at the community level to plan and deliver awareness activities will help to promote acceptance of the ideas and messages being presented

Opportunities for Community Engagement.

The following activities provide ideal opportunities for engagement and promotion of Family Planning.

- Antenatal Clinics: postpartum period and postnatal clinics.
- Child Health Clinics and visits.
- STI clinics.
- NGO and church-based clinics.
- Public Health Program community visits.

2.2. Family Planning Education and Awareness.

Community and small group education presentations are important for increasing awareness, knowledge and interest in Family Planning, and for correcting rumours and wrong ideas (see next section).

Preparing for an education and awareness presentation.
Preparation is an essential part to ensuring community education and awareness sessions are well-delivered and relevant to the specific target groups.

The following table provides a summary of the three steps health workers should work through when preparing for Family Planning education and awareness presentations.

Table 2.2: Three steps for preparing Family Planning education and awareness presentations.

1: Conduct a Community needs assessment.	2: Make necessary arrangements for the presentation.	3: Prepare the presentation.
This will help to find out which: • Topics need to be covered. • Target groups exists and current level of knowledge. • Target groups to aim your presentation at.	• Seek permission from appropriate leaders (community/group). • With leaders and audience, decide on place and time. • Inform target group/s. • Set-up venue; make sure people can see and hear you.	• Decide topics to cover during presentation - determined by current level of knowledge (Step 1). • Decide on one or a series of presentations (based on Step 1). • Develop a presentation plan; follow headings given in the lesson plan guideline (below).
REMINDER: • Always involve participants in preparation and delivery of presentation - an important part of community and social mobilisation; it will improve effectiveness of activity, and reduce the workload on the health worker. • Keep presentation short and simple (do not talk too much). It may be better to arrange a series of talks and cover one or two topics at each. • Use visual aids and other health education methods (e.g. role plays, songs, demonstrations), because seeing and doing things help people to remember. • Allow time at the end of the presentation for questions and feedback. Use your skills as a Family Planning Counsellor (see Section 2.3) to facilitate the discussion; ask open questions, give supportive of comments and answers.		

Table 2.3: Structure of Family Planning education and awareness presentations.

Opening	Content of the Presentation	Ending
• Warmly welcoming everyone. • Introduce yourself. • Say a prayer (if appropriate). • If small group, ask each participant to introduce and say something interesting about themselves (e.g. what was something unusual you did last week?). • Create a friendly atmosphere by showing personal interest in them or commenting on common experiences.	• Introduce your topic/s and what you are going to talk about. • Explain the consultation process with community/target groups to develop the presentation so that it is meaningful to the audience. • Follow the lesson plan, use visual aids and involve the group in discussions/demonstrations. • Allow time for questions, discussion and feedback.	• Summarise the key information. • Thank participants for their attention, discussion and ideas. • Arrange a follow-up talk, if necessary. • Close with a prayer (if appropriate).

Topics to be covered in a Family Planning education and awareness presentation.

Whether Family Planning presenters decide to do one presentation, or a series of shorter ones, the following topics should be considered and included (depending on the knowledge level identified during the needs assessment (see Step 1 of Table 2.2).

- What is Family Planning? (Chapter 1).
- Who needs Family Planning? (Chapter 1).
- Why is Family Planning important? (Chapter 1).
- 'Facts For Life' messages (see green box).
- Reproductive health (Chapter 3).
  Use simple words and visual aids to explain: how female/male reproductive systems work; menstrual cycle; how babies are made.
- Types of Family Planning methods (Chapters 10-22).
  Use visual aids and show samples. For each method, provide information on: what they are; how they work; how to use/get them; their advantages/disadvantages.

'Facts for Life' Messages for Family Planning.

Maternal Age: Becoming pregnant before the age of 18, or after the age of 35, increases the health risks for both mother and child.

Birth Spacing: The risk of death for young children is increased by about 50% if the space between births is less than two years.

Family Size: Having more than four children increases the health risks of pregnancy and childbirth.

Choice: Family Planning provides individuals and couples with a choice of when to begin having children, how many to have, how far apart to have them and when to stop.

2.3. Family Planning Counselling.

What is Family Planning Counselling?

Counselling is a two-way communication process between a health worker and client/s. Individuals and couples are supported to ask questions about Family Planning, and to receive accurate, tailored information to assist their Reproductive Health and Family Planning decisions about the number, timing and spacing of their children. If they wish to access Family Planning, counselling helps them to select the best contraceptive method, and to learn how best to use it.

Why is Family Planning Counselling important?

Counselling is an important part of Behaviour Change Communication (BCC), as the health worker has the undivided attention of an individual and couple with which to demonstrate/promote Family Planning methods:

- **Acceptance of Family Planning:** In a friendly, non-judging, confidential setting, a Family Planning counsellor encourages discussion to address concerns and correct misinformation which they may have heard. This encourages individuals and couples to accept and use Family Planning.
- **Appropriate choice of contraceptive method:** Family Planning counselling assists individuals/couples to make informed decisions about appropriate Family Planning methods to meet their needs.
- **Effective use of contraceptive method:** Family Planning counselling helps individuals to learn how to correctly and consistently use their chosen contraceptive; this ensures its effective use.
- **Longer continuation:** Through informed decision making about the Family Planning method and its use (including managing side effects), individuals are more likely to continue use in the long term.
- **Efficient use of staff time:** Even though effective Family Planning counselling takes time, the result is worthwhile because it encourages sustained, correct use of contraceptives.

Family Planning rights

Section 1.5 details Family Planning rights in Vanuatu; it is the basic right of every individual or couple to choose Family Planning, and to obtain and use contraceptives. In respect of this right, it is important to note that:

- An individual or couple's choice to use or not to use Family Panning is respected.
- An individual and couple should not be forced to use any Family Planning method against their will.

This right extends to all; a single or unmarried person or couple each have the right to access Family Planning advice and commodities.

IMPORTANT: There is no law in Vanuatu that requires the husband, wife or parent/guardian of any client to give consent for Family Planning; a health worker cannot be subject to retribution from a client's spouse or parent for supplying Family Planning to the client

Where possible, health workers should attempt to counsel couples together, or encourage clients to discuss the matter with their spouse at home, however the decision is ultimately up to the individual.

For sterilisation cases, written consent of a husband and wife is usually needed. But if the client is single, his/her consent alone may be sufficient for sterilisation on social and/or medical grounds (see Chapters 18 and 19).

Family Planning Counsellors.
All health workers in direct contact with clients should therefore be trained and equipped to deliver effective Family Planning counselling. They should have:

- A good understanding of, and respect for clients' rights.
- A sensitive, friendly and non-judging approach which fosters openness and trust in the client/s.
- An understanding of how to facilitate discussion (including use of open questions to encourage discussion).
- An excellent knowledge and understanding of all available Family Planning methods.
- An appreciation of cultural and psychological reasons which influence Family Planning decisions.
- The ability to recognise when he/she cannot adequately help a client and so refer them to another facility (e.g. If the client expresses a desire for sterilization).

An appropriate setting for Family Planning Counselling.
Family Planning counselling does not require special equipment, only a setting which:

- Is quiet, private and has good air flow.
- Is set-up to facilitate good communication between the counsellor and client/s; chairs should face each other, and no desk between them.
- Has suitable visual aids and/or IEC materials (e.g. posters, flip charts) to facilitate explanations that the client understands/remembers.

Six elements of effective Family Planning Counselling
Effective Family Planning counselling includes the six 'GATHER' elements (see Table 2.4):

G - Greet Clients
A - Ask clients about themselves
T - Tell clients about FP (Initial Counselling)
H - Help clients choose a method
E - Explain how to use a method (Method Specific Counselling)
R - Return for follow-up (Follow-up Counselling)

Rumours and misconceptions (wrong ideas).
During counselling and community awareness activities, it is common to hear people ask questions which demonstrate they have misconceptions (wrong ideas) about Family Planning and particular methods.

Taking time to correct these rumours and wrong ideas can be a powerful way to change attitudes and behaviours relating to Family Planning. It is important that service providers can do this without making individual feel foolish. If a client or community member expresses a misconception or wrong idea, it is important to listen to what they say before responding.
Respond with a positive statement first. DO NOT say, 'No, that's wrong!', or 'No, that's not true'.
Start with, 'Yes, that is a common understanding amongst people in Vanuatu, but actually, the way this method works is to…' or 'Yes, I have heard lots of people say this, however…'
This is a much better approach as it acknowledges and respects the person's opinion, but still provides an opportunity to correct the wrong idea.

Table 2.5 presents common misconceptions (wrong ideas), and information for correcting these.

Table 2.4: GATHER – The Six Elements of Effective Counselling.

G	**Greet clients**
	Give clients your full attention; be polite, greet them, introduce yourself and offer them seats. Ask them how you can help/why have they come? Make sure there is as much privacy as possible. Assure clients that you will not tell other people what they say. Explain what will happen during the visit, including any physical examination and laboratory tests.
A	**Ask clients about themselves**
	Ask clients about themselves, and why have they come? What are their experiences so far regarding the reproductive health matter that concerns them? Help clients talk about their feelings, and their Family Planning needs, fears and concerns. Explain that you have to ask some questions to help them with their Family Planning needs. Keep questions open, and encourage them to lead the discussion – follow wherever the discussion goes. Listen carefully and actively to what they are telling you. Express your understanding, without judgement. They may tell you 'stories' that they have heard. Use pauses in the discussion to correct any misconceptions. Always bring the conversation back to where they left it.
T	**Tell clients about available Family Planning methods**
	For first-time Family Planning Counselling; client needs to know about available methods. How much they need to know depends on which methods interest them and what they know already – ask them. Use IEC, visual aids and samples to describe available methods. Spend more time on the method(s) which interest them. Discuss: how the method works; advantages/disadvantages of the method; possible side-effects. Briefly describe other methods which they may like to use in future.
H	**Help clients choose a Family Planning method**
	Assure the client that the choice of method to use is completely their own. Ask clients if there is a method they would like to use. Some may know what they want; others may need help in choosing. Ask questions and listen attentively. Help match client's family plans, situation and preferences with method. Help client to consider consequences/result of each choice. Ask client to consider what their partner may want. For health and/or social reasons, some methods are not safe for some clients. When a method is not safe, explain why clearly. Then help them to consider another method (see Chapter 9).
E	**Explain how to use a method**
	Method Specific Counselling; give a full, detailed explanation on how to use the chosen method – use IEC resources and repeat this as often as required. Provide written instructions or information about the method. Ask clients to repeat your instructions to make sure they have understood and remember how to use the method. Inform clients about possible side-effects and danger signs. Give clear instructions on how to manage these. Arrange signing of informed consent (if appropriate – e.g. For tubal ligation). Tell clients when to come back for their follow-up visit, or earlier if side effects or danger signs.
R	**Return for follow-up visit**
	Follow-up Counselling; Ask client if they are satisfied and still using the method. Ask questions to determine if they are using method correctly - if necessary repeat the instructions of how to use the method. Ask questions to determine if they are having side-effects. Go through the possible side-effects one at a time to check if the client has any of them. Reassure and suggest ways of managing side-effects. Refer for medical follow-up if necessary. If needed, help client to select another method. Remember changing methods is normal; they may have tried it first and don't like it, or their situation may have changed. If client has decided they would like a child, help them to stop their method. Remind clients of the importance of antenatal care and where and when it is available. Remind client to return as soon as their child is born to discuss Family Planning options.

Table 2.5: Common rumours, wrong ideas and the facts about Family Planning.

✗	**Rumour:** It is against the wishes of the church.
✓	**Fact:** The churches in Vanuatu agree that Family Planning should be used to promote good family health. Some churches do place restrictions on some specific Family Planning methods.
✗	**Rumour:** Family Planning is an idea from overseas and not Vanuatu custom.
✓	**Fact:** Many modern Family Planning methods have come from overseas. However, traditional methods for child spacing have been used in Vanuatu for a long time. In the past, after the birth of one child, many couples did not have sexual intercourse until the child was weaned, and custom or leaf medicine is still used for contraception.
✗	**Rumour:** Taking the pill while pregnant will cause deformity in the unborn baby and/or prevent a woman from being able to have children in the future.
✓	**Fact:** This is not true. Even if a woman takes the pill while she is unknowingly pregnant, it will not cause any harm to an unborn child or her own reproductive health.
✗	**Rumour:** IUCDs and the pill cause cancer
✓	**Fact:** There is no relationship between IUCDs and cancer, and studies show that the pill protects against ovarian and uterine cancers.
✗	**Rumour:** The pill causes infertility
✓	**Fact:** The pill does not cause infertility. There are many causes of infertility, some affecting the male and others the female partner. The most common causes are: blocked Fallopian tubes or poor sperm production (from damage during past Sexually Transmitted Infections (STIs).
✗	**Rumour:** The pill causes weight gain
✓	**Fact:** Some women using the pill will lose weight while others may gain weight (no more than 2 Kg). Weight gain is due to increased appetite. Weight gain can be reduced and/or prevented through dietary management.
✗	**Rumour:** With the pill, periods become light and some 'rabis blad' stays inside the body and can cause harm.
✓	**Fact:** Periods are usually lighter with the pill because ovulation is blocked. This means that during the menstrual cycle the lining of the uterus does not become very thick; there is less blood during 'sik mun' (period). Blood does not collect in the uterus when periods are light or absent. The blood is normal, and not 'rabis blad'. See Chapter 3 for explanation of what happens during menstrual cycle.
✗	**Rumour:** Men can feel IUCDs during sexual intercourse.
✓	**Fact:** If an IUCD is in the proper position (i.e. in the uterus) it is impossible for a man to feel it. This might be possible if the threads are too long; these could be shortened by a health worker (but not cut too short and bristly).
✗	**Rumour:** Women can feel the IUCD in their uterus or it may fall out if they do hard work.
✓	**Fact:** Hard work does not cause IUCDs to fall out. Nor is there any evidence of uterine discomfort from an IUCD during hard work. IUCD discomfort or expulsion is unusual, but if it can occur during periods; women should check the threads of their IUCD after their period.
✗	**Rumour:** Selling condoms in shops encourages people to 'slip olbaot' (be promiscuous).
✓	**Fact:** In Vanuatu, many single people have sex with more than one partner even when condoms are not available. Making condoms easy to get doesn't encourage 'slip olbaot', but can protect against pregnancy, HIV and STIs.
✗	**Rumour:** During sex a condom may fall off and become lost inside a woman's body.
✓	**Fact:** If a condom is used correctly, it will not fall off the penis; it must be put on the erect penis (down to its base). After ejaculation, the still-erect penis should be taken out of the vagina while holding onto the rim of the condom at the base of the penis. A condom will only fall off if used incorrectly. If this happens, it is easy to remove it by gently feeling for the condom inside the vagina. In penile-vaginal sex, a condom cannot go up into a woman's 'bel'.
✗	**Rumour:** After a vasectomy, a man is like a castrated pig or bull. He will lose his strength and be unable to have an erection or ejaculation.
✓	**Fact:** Castration is NOT the same as vasectomy. In castration, the testicles are removed and this makes animals quiet. With vasectomy, the testicles are NOT removed but continue to produce the male sex hormone, testosterone. Because testosterone is still being produced the man will still look, behave and be as sexually active as before. In vasectomy, the tubes (vas deferens) of the testicles are blocked so that the sperm cannot get into the semen. However, the same amount of semen is produced and ejaculated as before.
✗	**Rumour:** After Tubal Ligation, a woman will stop having periods and becomes weak.
✓	**Fact:** Women still have periods after Tubal Ligation and they do NOT become weak. The hormones which control the menstrual cycle come from the brain and the ovaries. The hormones controlling menstrual cycle are still produced as before...

3. Overview of Reproduction

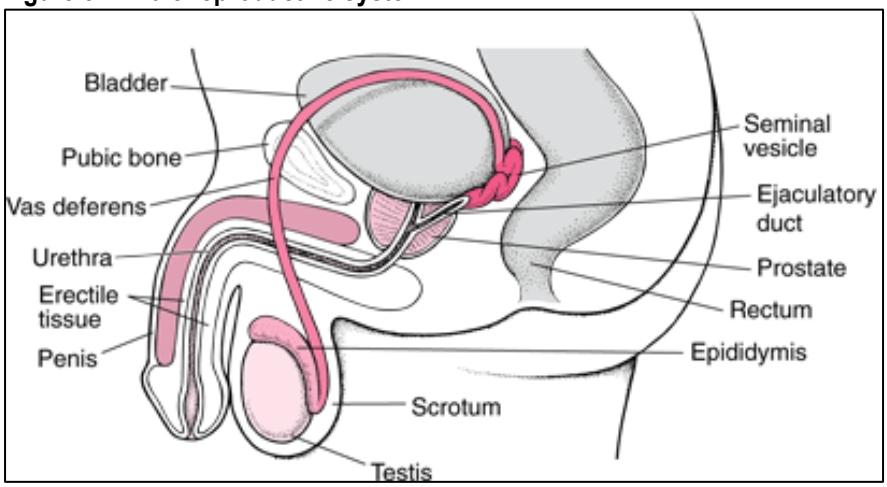
3.1. Male Reproductive System.

The male reproductive organs consist of the penis, urethra, testicles, vas deferens, the epididymis and the seminal vesicles. ***The Penis*** has two main parts:

- The **shaft** is the section which becomes hard during erection.
- The **glans** is the rounded head; the most sensitive part of the penis to touch.
  The glans is covered by the **foreskin** (the foreskin is what gets removed during circumcision).

The Urethra is the pipe/tube inside the penis which connects with the **bladder**. A man passes urine and ejaculates semen through the urethra.

Figure 3.1: Male reproductive system[7].



The Testicles or Testes (2) hang in the skin sack called the **scrotum**. The scrotum holds the testicles outside the body (keeping them cooler for sperm production). It is common for one testicle to hang lower than the other. The testes have two functions:

- To produce **sperm**; starting from the time a boy reaches puberty until his death. Sperm are the tiny male sex cells that fertilise a woman's egg to make a baby.
- To produce the male hormone, **testosterone**; this creates male characteristics, such as hair growth.

The Epididymis is a long, coiled tube attached to each testis. The epididymis collects and houses the sperm as it matures, before it moves along the **vas deferens**. *The* ***Vas Deferens*** are the tubes joining each testicle to the **seminal vesicles**. ***The Seminal Vesicles*** are where sperm and a fluid called semen are mixed together and stored. The semen, sperm and some fluid from the prostate gland are released together at ejaculation.

3.2. Female Reproductive System.

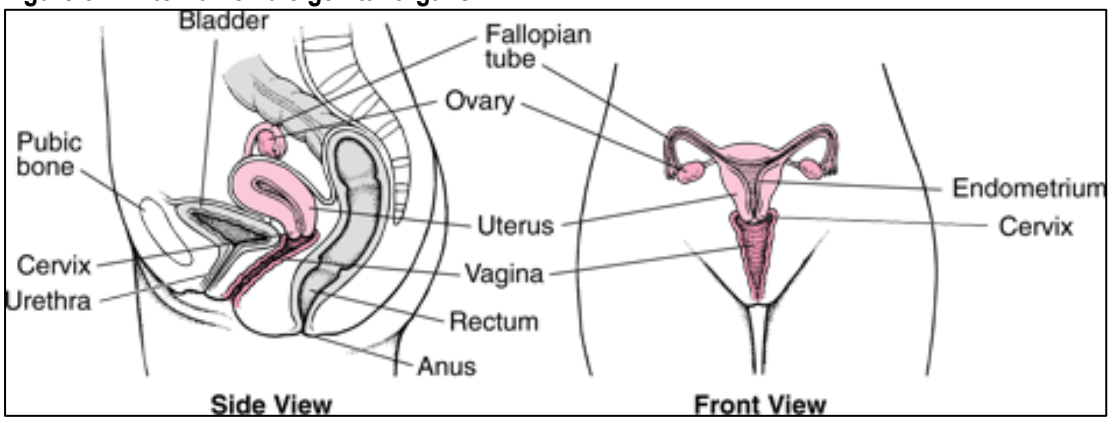
The female reproductive organs consist of the: ovaries, uterus, vagina and vulva.

The Ovaries have two functions:

- To store and release eggs. A girl is born with all the eggs she will ever produce in her two ovaries. One egg ripens and is released from one ovary about every 28 days; the process called **ovulation**. This begins when she reaches puberty (age 9-18) and continues until she reaches menopause (age 45- 50).
- To produce female hormones: **oestrogen** and **progesterone;** produced when instructed by the hypothalamus and pituitary glands (in the brain). Oestrogen and progesterone influence female characteristics and functions related to menstruation and pregnancy.

[7] Source: www.merckmanuals.com/.../mens_health_issues/...; accessed 20th February 2015.

Figure 3.2: Internal female genital organs[8].



The Uterus is an organ about the size of a fist.

The Fallopian Tubes are needle-width tubes protruding from each side of the uterus, ending in fine, finger-like fringes which wrap around the ovaries. These 'fingers' guide the egg from the ovary into the Fallopian tube.

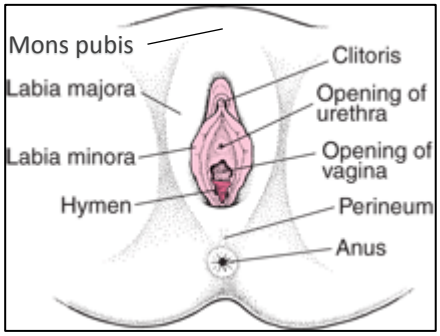
The Cervix is the opening (or mouth) at the lower end of the uterus. Every 28 days, the cervix opens a little to allow the menstrual flow to pass out. It opens very wide during labour to allow the baby to be born.

The Vagina is a stretchy canal between the uterus and the outside of the body. This is where male sperm are left during sex. This is also the birth canal through which a baby is born and menstrual fluid leaves the body.

The Vulva[9] consists of:

- The **mons pubis**, a cushion of fat on the symphysis pubis.
- Two folds of skin. A hairy outer fold (**labia majora**) and a thinner, hairless inner fold (**labia minora**). These protect the openings of the vagina, **urethra** and the **clitoris**.
- The urethra is a small tube through which urine is passed.
- The clitoris feels like a small bean inside the inner lips of the vulva. It is very sensitive.

Figure 3.2: External female genital organs (Vulva).



3.3. Menstruation.

All women menstruate unless they are pregnant, breastfeeding, very underweight, ill, taking certain medicines or have some problem with their reproductive system. Menstruation is not an illness. It is a normal part of the female reproductive cycle. During menstruation girls and women can continue doing all the things they do at any other time: attending school, active sports, running, cooking, visiting friends and so on.

A woman usually begins to menstruate between ages 9-18. Her first menstrual cycle is called **menarche** (*meh-nark-ee*). She continues to menstruate approximately every month until she reaches age 45-50. The time when a woman stops menstruating is called **menopause**.

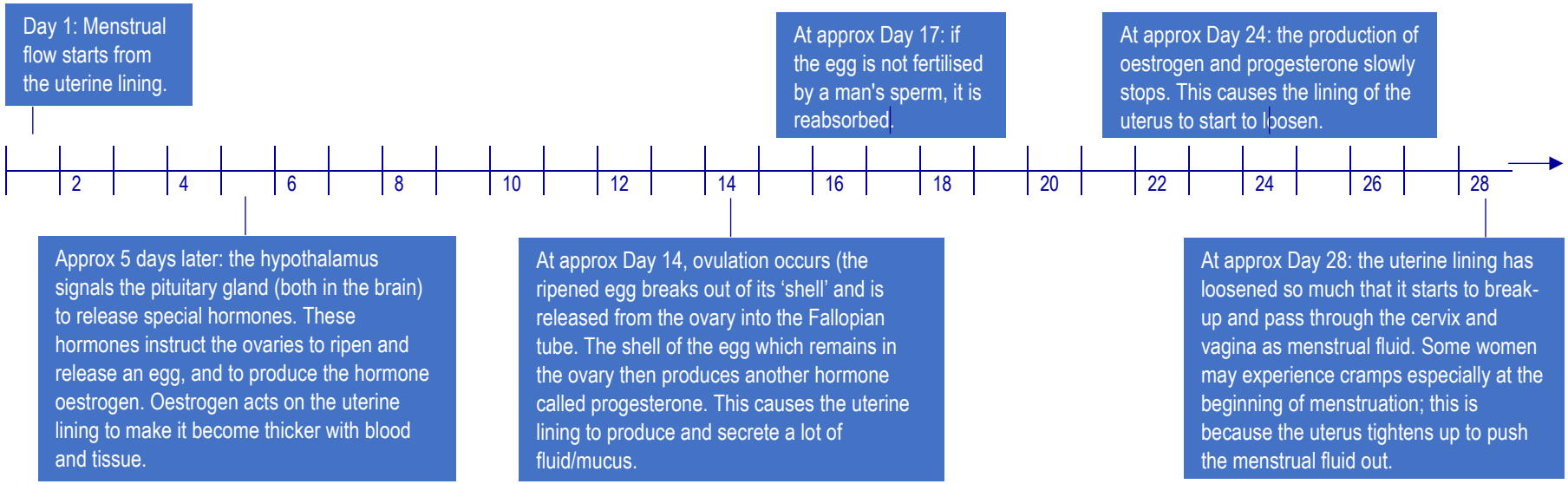
Menstruation (also called 'periods' or *'sik mun'*) comes every 21-40 days (average = 28 days). Some women are regular (they menstruate after the same period each month), and some are irregular. Menstruation may last from 2-7 days. Heavy or long periods can cause anaemia.

[8] Source: www.merckmanuals.com/.../womens_health_issues/...; accessed 20th February 2015.
[9] Diagram adapted from: www.merckmanuals.com/.../womens_health_issues/...; accessed 20th February 2015.

The menstrual cycle.
Normal menstruation depends on events happening in 4 places in the body: the hypothalamus and pituitary gland (in the brain), the ovaries and the uterus. Figure 5.3 below outlines the average timing and events which make up the menstrual cycle.

Menstrual fluid is a mixture of tissue, mucous and a small amount of blood. It is not 'dirty' or 'unclean'. It is the same as the blood which would come out when a finger or leg is cut. When it comes out it is bright red. Like all blood it turns brown in the air.

Figure 3.3: Menstrual cycle events and timeline.



3.4. Conception.

When a man and woman have sex, the man releases thousands of sperm into the woman's vagina. These sperm are very small. They can swim quickly up through the cervix, into the uterus and Fallopian tubes.

If a woman has ovulated in the last 2-3 days, there is a strong chance that she will get pregnant. If a sperm meets the egg in the Fallopian tube or the uterus, the sperm will fertilise the egg. This means that the sperm enters the egg and the 2 join together. Many sperms are needed to break-down the coat surrounding the egg but it only takes one sperm to fertilise the egg.

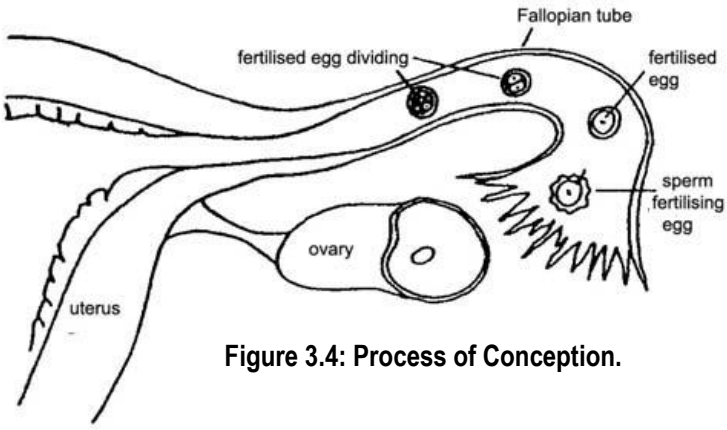


Figure 3.4: Process of Conception.

The fertilised egg implants into the thickened uterine wall. Ovulation stops and the foetus is supported (provided with oxygen and nutrients) through the uterine wall via the **placenta** and **umbilical cord**. This continues for about nine months until the baby is fully developed and ready to be born.

Section 2:
Family Planning service development and management for national program managers and clinical supervisors

4. Organisation and Management of Family Planning Services

This chapter provides an overview of the organisation and management of Family Planning services to help managers, supervisors and service providers clarify their role within the wider Family Planning program.

4.1. Family Planning policy and services in Vanuatu.

Through its *Health Sector Strategy 2010-16*, and the *National Reproductive Health Policy 2008*, the Vanuatu Ministry of Health prioritises reduction of maternal and child health mortality and morbidity[10], and endorses an approach which promotes delivery of quality Family Planning services, and the establishment and maintenance of a secure, uninterrupted supply of contraceptives[11].

To help guide decisions relating to Reproductive Health/Family Planning policy development and service provision, the National Reproductive Health Unit within the Ministry of Health should clearly define:

- Policy on who should be targeted for, and who should access Family Planning services.
- Guidelines on Family Planning service provision, stating what services and contraceptive methods should be provided, who should deliver these and mechanisms for coordination between various providers.

Specific Reproductive Health/Family Planning policies and guidelines for Vanuatu have been developed through consultation within the Ministry of Health and with other Government and non-government parties supporting or delivering Family Planning. Agreed guidelines are defined under the relevant sections of this Manual.

[10] Government of Vanuatu, 2010; *Health Sector Strategy 2010-2016: Moving Health Forward*; Port Vila; Government of Vanuatu.
[11] Ministry of Health, 2009; *Reproductive Health Policy 2008: Reproductive Health Strategy 2008-2010*; Port Vila, Government of Vanuatu.

4.2. Assessing Community Needs for Family Planning Services.

Effective uptake of Family Planning services will be impacted by decisions on service provision at the national, provincial or health facility levels. These should always be based on community needs, acceptability, affordability and accessibility, and with consideration of available reproductive health data. These can be assessed directly or indirectly through community studies.

The **direct** way is to conduct structured surveys, and to ask people (ensuring an appropriate mix which reflects all key target groups).

Two or more of the following will contribute to an **indirect** assessment of Family Planning need:

- Reviewing data for: unwanted or unplanned pregnancies; sickness and death among mothers and children.
- Comparing experiences with other similar communities.
- Reviewing clinic Family Planning Records (see Section 7.2)
- Listening carefully to clients during Family Planning counselling.

4.3. Organisation of Family Planning Services in Vanuatu.

Family Planning services should be provided by appropriately trained staff who can provide good quality, safe care. Where trained staff are not (or not always) available, an efficient, effective referral system should be established to enable clients who need Family Planning services to access these without delay.

Family Planning services should be provided to suit the needs of the client, **not** the provider.

- ***Clinic-based Family Planning services:*** Should be available at all times during normal clinic operating hours, including during Reproductive Health and routine outpatient (*'sik man'*) clinics. Depending on demand, service providers may also offer an additional, specific Family Planning clinic.
- ***Community-based Family Planning services:*** In isolated, rural areas, integrated family health outreach services should be established, travelling from Hospitals and Health Centres to Dispensaries and Aid Posts to deliver Reproductive Health, Family Planning, antenatal and postnatal services. These may engage with peer educators and community-based condom distributors.

Family Planning service providers and referral.
A minimum range of Family Planning services are provided from all formal health facilities (Dispensaries, Health Centres and Hospitals) and some non-government facilities in Vanuatu (see Table 4.1). At a minimum, this will include counselling, providing correct information about contraceptives or handling simple complaints or side-effects. Depending on staffing (numbers and capacity) at some lower-level facilities, clients may require referral to the nearest higher-level facility for management of more serious problems/complaints, or to seek services offered only at higher-level facilities, such as IUCD insertion and sterilisation.

Village Health Workers operating from community-owned Aid Posts provide basic awareness and counselling for Family Planning, and referral to higher-level health facilities for Family Planning services.

Clients who are referred to other health facilities for Family Planning services should be provided with a referral letter describing the reason for their referral, and their Family Planning Record card (see Section 7.2).

After the referral has taken place, the client should be provided with a letter of response from the higher-level facility (that is, the facility to which the client was referred), describing the services provided, including the diagnosis, management and any follow-up required. They should also be given their updated Family Planning Record card, and asked to return these documents to their original, local health facility.

4.4. Family Planning Responsibilities of Service Providers.

Family Planning clients are not patients; they are not sick; they do not usually need medicines or special laboratory tests. Instead, they simply need information, advice and contraceptives. Effective delivery of a national Family Planning program requires action from individuals at a number of levels. Table 4.2 provides a detailed summary of these responsibilities.

Table 4.1: Facilities/Organisations Providing Family Planning Services and Commodities in Vanuatu.

Facility Type	Usual provider	Methods Provided
Government Facilities		
Referral Hospitals: Provide specialist services; located in Port Vila and Luganville. Contain 100-120 beds and staffed by a team of specialist doctors, nurse practitioners, midwives, registered nurses and nurse aides. ***Provincial Hospitals:*** Located in Lenakel (Tanna), Norsup (Malekula) and Lolowai (Ambae), these offer a comprehensive range of hospital services. Staffed by a medical officer, nurse practitioner(s), one or more midwives, registered nurses and nurse aides.	Midwife, doctor, nurse practitioner, registered nurse.	Contraceptive pills (incl. emergency pill). Depo-Provera. Condoms: female and male. IUCDs. Implants. Sterilization. Vasectomy. Fertility Awareness Methods.
Health Centres: Provide in- and out-patient services (such as medical and dental treatment) and houses a maternity ward for	Midwife, nurse practitioner,	Contraceptive pills (incl. emergency pill). Depo-Provera. Condoms: female and male.

Facility Type	Usual provider	Methods Provided
Government Facilities		
population of 3,000-5,000. Usually staffed by a nurse practitioner, midwife and 1-2 registered nurses, nurse aides and/or microscopists.	registered nurse.	IUCDs. Implants. Fertility Awareness Methods.
Dispensaries: Provide limited health services, including referral to populations of approx. 2,000. Staffed by a registered nurse and/or nurse aide. Usually has a treatment and delivery room.	Registered nurse.	Contraceptive pills (incl. emergency pill). Depo-Provera. Condoms: female and male. Implants. Fertility Awareness Methods.
MCH Mobile and Reproductive Health Outreach Clinics: These provided by Hospital and Health Centre teams conducting outreach visits to Dispensaries, Aid Posts or other community.	Midwife, nurse practitioner, registered nurse.	Contraceptive pills. Depo-Provera. Condoms: female and male. IUCDs. Implants. Fertility Awareness Methods.
Non-Government Facilities		
Aid Posts: Community owned/operated facilities providing basic health care and referral services to communities. Usually 1 consultation room with cupboard to store medical supplies. Staffed by a Village Health Worker.	Village Health Worker	Condoms: female and male. Fertility Awareness Methods.
Vanuatu Family Health Association (VFHA): IPPF member organisation with clinics located in Port Vila and Luganville. Provide comprehensive Family Planning information and services.	Midwife, Family Planning nurse	Contraceptive pills (incl. emergency pill). Depo-Provera. Condoms: female and male. IUCDs. Implants. Fertility Awareness Methods.
Wan Smol Bag: Local organisation targeting young people, with clinics located in Port Vila and Luganville, and outreach services to North Pentecost.	Reproductive health nurse	Contraceptive pills (incl. emergency pill). Depo-Provera. Condoms: female and male. Implants. Fertility Awareness Methods.
Secondary School Clinics: Located in some rural schools, and managed by the school.	Reproductive health nurse	Contraceptive pills. Condoms: female and male. Fertility Awareness Methods.
Community-Based Condom Distributors: Trained volunteers supported by MOH or non-government organisations to provide information and condoms.	Community-Based Distributors	Condoms: male.
Private Medical Clinics:	Doctor	Contraceptive pills (incl. emergency pill).

Facility Type	Usual provider	Methods Provided
Government Facilities		
Located in Port Vila and Luganville		Depo-Provera. Condoms: female and male. Implants.
Private pharmacies: Located in Port Vila and Luganville	Pharmacist	Contraceptive pills (incl. emergency pill). Condoms: female and male.
Retail Stores:	Store keeper	Condoms: male.

Table 4.2: Family Planning Responsibilities of Service Providers at Various Levels.

Individual/ organisation	Main Family Planning responsibilities	Training	Data collection, monitoring and reporting	Reproductive Health Commodities Security
National Level				
National Reproductive Health Coordinator (MOH)	Technical and program coordination and resource for government and non-government agencies. Provide technical oversight through engagement with national coordinating mechanisms (such as RMNCAH Committee). Develop, maintain and update policies related to Family Planning. Identify and establish program priorities based on community needs and data analysis. Work with National Health Promotion Unit to develop and roll-out communication strategy and associated outputs (e.g. IEC). Provide remote and on-site technical and coordination assistance to provincial field staff as required (see Section 4.5). Develop, monitor and revise program tools (Family Planning Record cards, guidelines) to support and improve quality of services Identify external funding to support program activities and innovation.	Engage with VCNE to ensure cohesion of guidelines with nursing, midwifery and nurse practitioner curricula. Engage with Village Health Worker Program to ensure cohesion of guidelines with Pre- and In-Service Training for Village Health Workers. Develop/review/update training modules for in-service training of Family Planning staff. Deliver and support refresher training for national and provincial staff. Identify capacity building opportunities in Vanuatu and overseas, and liaise with MOH senior managers and VCNE to select appropriate candidates.	Monitor and evaluate program activities through the HIS, supervisory visits and discreet surveys. Conduct and/or participate in Family Planning research. Complete 6-monthly national program reports for MOH.	Monitor and ensure supplies of valid commodities at national and sub-national levels. Monitor CMS and provincial stocks of commodities and equipment. Conduct periodic stocktakes and forecasting. Oversee and support CMS in its procurement of supplies and equipment. Monitor and modify commodities distribution processes from the national – provincial – health facility level.
Provincial Level				
Reproductive Health Supervisor (MOH)	Coordinator and technical resource for Family Planning services (both government and NGO) at provincial level.	Based on issues identified during supervisory visits, deliver on-the-job training to personnel.	Collation, analysis and reporting of	Coordinate supply of Family Planning Record cards and HIS forms to facilities.

Individual/ organisation	Main Family Planning responsibilities	Training	Data collection, monitoring and reporting	Reproductive Health Commodities Security
	Supervise and support provincial reproductive health teams (see Section 4.5). Oversee and monitor distribution of IEC and messages to health facilities and the community. Conduct supervisory visits to all facilities to monitor activity, and submit reports to provincial/national levels (see Section 4.5). Provide supervisory feedback and guidance for improved performance of staff. Conduct and support community education activities in accordance with Communications Strategy.	Work with VCNE and other providers to support refresher training for midwives and reproductive health nurses. Work with Village Health Worker Program to support Family Planning components of Village Health Worker In-Service Training.	provincial monitoring data to national level. Conduct supervisory visits to all facilities to monitor activity, and submit reports to provincial and national levels.	Monitor provincial pharmacy and health facility stocks of commodities and equipment. Conduct periodic joint stocktakes and forecasting. Coordinate supply of commodities and equipment from provincial pharmacies to health facilities.
Health Facility Level				
Nurse Practitioners, Midwives, Reproductive Health Nurses (MOH)	Maintain up-to-date knowledge and skills in Family Planning. Promote Family Planning at community level through awareness and health education activities. Coordinate and distribute IEC and messages to health facilities and the community. Provide all appropriate Family Planning services, incl. counselling, prescribing of contraceptives, following-up of defaulters and referral. Conduct outreach Family Planning clinics along with scheduled visiting Reproductive Health, antenatal and postnatal services. Liaise with and provide technical support to non-government agencies engaged in Family Planning (e.g. women's groups). Liaise with national and provincial-level Reproductive Health staff to establish community Family Planning needs. ***Nurse Practitioners only:*** Coordinate and supervise all facility- and community-based Family Planning activities (see Section 4.5).	Based on issues identified through data collection and review, deliver on-the-job training to other staff.	Establish population catchment data: total population, target groups, number of Family Planning users, user rates. Conduct analysis and monitoring of data and report this as required.	Monitor and record health facility stocks of contraceptives and Family Planning equipment, and support ordering from provincial pharmacy.
Nurse Aides (MOH)	Maintain up-to-date knowledge and skills in Family Planning. Promote Family Planning at community level through awareness and health education activities. Distribute IEC and messages to the community.		Support collection of population catchment data: total population, target groups, number of	Monitor and record health facility stocks of contraceptives and Family Planning equipment, and

Individual/ organisation	Main Family Planning responsibilities	Training	Data collection, monitoring and reporting	Reproductive Health Commodities Security
	Help organise/support outreach Family Planning clinics to facilities. Provide condoms as appropriate. Liaise with and provide technical support to non-government agencies engaged in Family Planning (e.g. women's groups). Support national and provincial-level Reproductive Health staff to establish community Family Planning needs.		Family Planning users, user rates.	support ordering from provincial pharmacy.
Village Health Worker	Maintain up-to-date knowledge and skills in Family Planning. Promote Family Planning at community level through awareness and health education activities. Distribute IEC and messages to the community. Provide all appropriate Family Planning services, incl. counselling, provision of condoms, following-up of defaulters and referral. Help organise/support outreach Family Planning clinics to Aid Posts. Liaise with and provide technical support to non-government agencies engaged in Family Planning (e.g. women's groups). Support national and provincial-level Reproductive Health staff to establish community Family Planning needs.		Collection of number of Family Planning users and monitor over time.	Monitor and record Aid Post stocks of Family Planning Record cards, condoms and IEC materials and support ordering from provincial pharmacy/ Reproductive Health Supervisor.
Peer Educators and Community-Based Condom Distributors	To promote safe sex and healthy sexual and reproductive behaviour amongst young people. To encourage young people to utilise reproductive health services. To encourage young people to access Family Planning through counselling on available contraceptive methods. To provide condoms for dual protection (prevent unwanted pregnancies and STIs) To refer clients to the appropriate facility for further advice, other contraceptives and/or Family Planning issues.			
Non-government organisations, including VFHA and Wan Smol Bag and some Faith-based organisations.	To provide Family Planning services which align with Ministry of Health policies and directives, and which complement those of the Ministry. Provide all appropriate Family Planning services, incl. counselling, prescribing of contraceptives, following-up of defaulters and referral. Conduct outreach Family Planning clinics to communities as per organisational mandate. Promote Family Planning at community level through awareness and health education activities. Coordinate and distribute IEC and messages to target groups and the community. Provide condoms as appropriate.			

Individual/ organisation	Main Family Planning responsibilities	Training	Data collection, monitoring and reporting	Reproductive Health Commodities Security
Stores, retail pharmacies and other commercial outlets	Condom sales through stores and other outlets (e.g. nightclubs). ***Retail pharmacies only:*** Sale of other contraceptives (e.g. contraceptive pills).			

4.5. Supervision of Family Planning Services.

Supervision for Family Planning services is delivered by personnel from the national and provincial levels, and should reach all health facilities and their catchment areas. The main functions of supervisory visits include:

- Observing and providing support and feedback to health workers to improve quality of service delivery.
- Identifying common issues requiring additional refresher training, and to deliver same.
- Monitoring service provision, facilities, equipment and commodities, and addressing or reporting issues for immediate attention.
- Collection of service data, such as population catchment information, number of Family Planning users, user rates etc. (see Chapter 7) for analysis and reporting, and to help identify local Family Planning needs.
- Delivering community awareness activities to promote Family Planning services.

The Role of a Supervisor.

A good supervisor is a problem-solver who motivates and supports their staff to improve the service quality. She/he is not simply a 'fault-finder' who criticises their staff, but someone who recognises both the strengths and weaknesses of staff, and builds upon the strengths of some to address weaknesses in others.

A good supervisor with a positive and supportive attitude will create an environment in which staff are happy to see their supervisor, and to be willing to discuss difficulties and issues they have experienced. Fostering good relationships between a supervisor and their staff will yield improved quality of Family Planning services.

Supervisors at every level have certain basic functions and responsibilities:

- To prepare (and communicate to all facilities) a schedule of supervisory visits outlining the visit date.
- To maintain regular contact with health staff through supervisory visits; to motivate and encourage staff, provide feedback, solve problems and provide guidance, assistance and support when needed.
- To work with staff to set individual performance objectives. These activities and target completion dates should be worked out and agreed with staff themselves, so that they know what is expected of them.
- To utilise structured supervisory checklists to ensure complete supervision and support, and to provide a systematic record for reporting. These also assist for comparison during subsequent visits.

How to motivate staff.

Supervisors can influence and motivate staff to improve service quality. Listening, being respectful and supportive, and encouraging staff to make decisions will influence their motivation.

- Praise senior staff for good performance and encourage them to do likewise to their staff.
- Point out good performance and help staff to see the value of their work.
- Ensure all staff receive a supervisor's attention during visits.
- Encourage and support staff to use initiative to solve problems, and provide friendly guidance.
- Offer staff opportunities to take responsibility and demonstrate leadership.
- Provide staff with opportunities for professional and personal development, including skills refresher training.

Providing Effective Supervision.

Effective supervision can be achieved through:

- Sharing and reminding staff about the Reproductive Health program's overall goals and objectives so that they can contribute to decision-making on activities.
- Respecting staff and their ideas; listening to, and encouraging their decision-making. Ensuring staff know that their hard work and commitment is recognised and depended upon is essential.
- Being willing to hear and incorporate the views of staff who may be affected by a decision.
- Conducting regular supervisory visits in accordance with communicated schedules, and encouraging staff to make suggestions about issues to be covered within training and support activities.

5. Family Planning Clinic Organisation and Management

In Vanuatu, Family Planning services are provided free-of-charge at all Government facilities. The Health Committees Act 2006 allows some clinics and Aid Posts to establish standard consultation fees to assist with maintenance and management (fees must not be prohibitive, and waived if client unable to pay). Fees are charged by private doctors, and NGOs such as Wan Smol Bag and Vanuatu Family Health Association may provide services for free, or charge a small fee to help meet the costs of running their service.

5.1. Essential Elements of an Effective Family Planning Clinic?

Table 5.1: Five essential elements of an effective Family Planning clinic.

Element	Details
Well trained and adequate numbers of staff	It may be preferable in some parts of Vanuatu for female clients to visit a female health worker, and likewise for males. Current staffing levels may not support this, so clinic staff must be creative to ensure their services are acceptable. E.g., a male health worker may arrange for a midwife to attend the Family Planning clinic to encourage women to visit, or a female health worker could train a community leader or Village Health Worker to educate men about Family Planning, provide condoms and recommend referral to health facilities where a male health worker is present. In Hospitals and Health Centres, the most appropriate person to provide Family Planning services is the midwife or Reproductive Health nurse, however other staff should be prepared to provide Family Planning when requested.
A spacious, clean, private environment	Family Planning clinics should have a clean, sheltered waiting area with chairs or benches. There should be a separate consultation room to counsel and examine clients; this room should be private such that the people in the waiting area cannot hear or see the consultation. This may not always be possible, especially during outreach, however efforts should be made to ensure privacy. Clients must feel that their consultation will remain private, or they may not be willing to request the services/assistance/contraceptives they need, and they may not return for follow-up.
Suitable furniture and functional, safe equipment	• Examination bed with sheets. • Table/desk (1) and chairs (at least 2). • Cupboard for supplies (this must be lockable if the room cannot be locked). • Instrument table. • Portable spot-light. • Hand-washing facilities (sink, bucket, basin). • Pan with cover for clean instruments. • Bucket for used instruments. • Waste bin. • Adult weighing scales. • Sphygmomanometer and stethoscope. • Vaginal speculum. • Light source (e.g. torch). • IUCD insertion tray containing: ▪ Vaginal speculum. ▪ Uterine sound instrument. ▪ Cervical tenaculum/Vulsellum forceps. ▪ Sponge-holding forceps. ▪ Scissors: curved/long handle. ▪ Small bowl for antiseptic solution. ▪ Kidney dish for instruments.
Adequate supplies (see also Chapter 6)	The following supplies and commodities to be in stock, and with a valid expiry period: • Contraceptives: ▪ Combined oral contraceptive (COC) pills. ▪ Progestogen-only-pills (POP). ▪ Progestogen-only injectables. ▪ Emergency contraceptive pills. ▪ Condoms: female and male. ▪ IUCDs (Copper-T 380A/200B). ▪ Implants (Jadelle). • Antibiotics for vaginal/pelvic infections. • Family Planning health education material: poster, leaflets, flip-chart etc. • For vaginal examination and IUCD insertion: ▪ Cotton wool/gauze. ▪ Antiseptic solution. ▪ Examination gloves. • For cervical vaginal swabs (if lab facilities): ▪ Glass microscope slides. ▪ Wooden spatula. ▪ Fixative swabs. • Stationery: ▪ Family Planning Record cards. ▪ Record book/worksheet/log book ▪ Monthly HIS Activity Report Form. ▪ Family Planning folder/tickler filing box. ▪ A calendar.
Appropriate operating hours	Family Planning services should first-and-foremost be provided to suit the needs of the client; they should be available whenever needed. Services should be available at all times during normal clinic operating hours, including during Reproductive Health and routine outpatient ('sik man') clinics. Depending on demand, service providers may also offer an additional, specific Family Planning clinic.

6. Reproductive Health Commodities Security

Reproductive Health Commodity Security (RHCS) is the title given to the systems and processes of ensuring reproductive health commodities (such as contraceptives and equipment and resources needed to apply these) are available to individuals and couples when they need them.

Effective services require continuous supply of contraceptives and other commodities. Table 6.1 outlines the action required from providers at the different operative levels to ensure RHCS.

Table 6.1: RHCS responsibilities at all levels.

RCHS Responsibilities at the National, Provincial and Health Facility levels.	
National Level: Ministry of Health has established list of contraceptive commodities available in Vanuatu: • Combined oral contraceptive (COC) pills. • Progestogen-only-pills (POP). • Progestogen-only injectables. • Emergency contraceptive pills. • Condoms: female and male. • IUCDs (Copper-T 380A/200B). • Implants (Jadelle). CMS is responsible for ensuring suitable supplies of these commodities are available in the country.	***Health Facility Level:*** Each health facility is responsible for ordering its supplies of reproductive health commodities, based on usage. Facility managers submit completed Essential Medicines Order Form to Provincial Pharmacy every 2 months in accordance with the processes outlined in the Health Worker's Manual[12]. RHCS is assured through a 2-month supply of commodities being available in each facility at any given time (see below). Facility staff responsible for ensuring commodities are securely stored, and managed to enable regular review of quantities and expiry dates. On receiving new supplies: • Count contents to check if supplies matched order. • Update stock records for each item (in the column marked, 'Givmaot risivim'). • Check expiry date of new supplies, mark date on boxes and (if the expiry date is later than your old stock) store them behind your old stock.
Provincial Level: Provincial Pharmacies responsible for compiling request orders from health facilities, and ordering supplies from CMS to meet provincial need. Provincial Pharmacies package-up the commodities ready for distribution to health facilities.	

Calculating Stock Orders for Reproductive Health Commodities: Health Centres and Dispensaries

1. You must have accurate records of previous orders and stock received! Keep a file with copies of previous orders and what you received.
2. Count full containers/packages of reproductive health commodities in units specified.
3. Work out how much was used since last order:
   Last stock check + Amount received – This stock check = Amount used since last order
4. Now work out how much to order:
   2 x Amount used since last order – This stock check = Amount you need to order

Note: The Provincial pharmacy will check this calculation and change it to be correct so if you do not understand the calculation – just do an ACCURATE stock check and pharmacy can work it out!

Stock Orders for Reproductive Health Commodities: Aid Posts

In 2012, the system changed for Aid Posts and there is a maximum quantity that can be ordered for each item listed on the order form.

Aid Posts must place an order every two months according to the Order Schedule.

[12] Ministry of Health, 2013 op cit.

Section 3: Family Planning information for service providers, including types of contraceptive methods

7. Family Planning Data

7.1. Family Planning Information/Statistics.

It is essential to understand reproductive health and family planning needs at the national and provincial levels in order to ensure that these are being met. Understanding whether Family Planning programs are meeting the need is a 3-step process:

1. Identify target population for Family Planning (baseline).
2. Determine how many people are using services and commodities.
3. Determine Family Planning user rate – an indicator of service-delivery reach and gaps.

Step1: Establishing the Target Population.
Health facilities must establish the ***Total Population*** in its catchment area; this is either an estimate (see Table 7.1), or health staff will be required to do a house-to-house count. The latter is more time consuming, but preferred because it can provide information about the number of children in a house, their age and gender, and about how many families are in each village, which is important information for all public health programs (not only Reproductive Health). Collecting this information helps us with our Total Population count, but also to understand and investigate if, which and why certain people, groups and communities might not be accessing services.

It is important to remember that the population is always changing, so reviewing the Total Population count should be undertaken at least once a year. It can also be useful to document this process by developing maps of communities and households (this makes it particularly easier when it comes to updating information later).

Once the total population has been established, it should be easy to determine the **Target Population** for Family Planning (commodities and information). In Vanuatu, this will be women and men of reproductive age (usually 15-49 years).

Table 7.1: Number and Percentage (of Total Population) of Women and Men of Reproductive Age By Urban and Rural Residence. Data sourced from 2009 National Census[13].

Women and men of reproductive age (15-49) by urban and rural	Females			Males		
	Total	Urban	Rural	Total	Urban	Rural
Number of reproductive age	58,154	16,494	41,660	57,312	17,114	40,198
% of total population (234,023)	24.8%	7.0%	17.8%	24.5%	7.3%	17.2%

Estimating Target Population:
Target Population = Total Population x % of total population (see Table 7.1)

Table 7.2: Examples of Calculations for Estimating Target Population of Rural and Urban Clinics.

Setting	Total Catchment	Females of repro age	Males of repro age
Rural Dispensary	150	150 x 17.8% = 27	150 x 17.2% = 26
Rural Health Centre	320	320 x 17.8% = 57	320 x 17.2% = 55
Urban Dispensary	1,200	1,200 x 7.0% = 84	1,200 x 7.3% = 88

[13] VNSO, 2009; *2009 National Population and Housing Census: Basic Tables Report, Volume 1*; Port Vila, VNSO.

Step 2: Determining Users of Family Planning and Reproductive Health Commodities.
Keeping records of client contacts will assist health facilities to determine the number of new and repeat users of services and commodities. At the end of every week/month, health facilities should tally-up the number of users of services and commodities (being careful not to count the same client twice).

Step 3: Determining User Rates of Family Planning Services and Commodities.
At the end of every quarter/year, clinics can determine if their services are meeting the needs of their target population, based on their Target Population data (Step 1) and the number of users (Step 2):

Family Planning User Rate = Number of users / Target Population x 100.

Table 7.3: Examples of Calculations for Family Planning User Rates for Rural and Urban Clinics.

Setting	Total Catchment	Females of repro age			Males of repro age		
		Target	Users	Rate (%)	Target	Users	Rate (%)
Rural Dispensary	150	27	7	7/27x100 = 25.9	26	3	3/26x100 = 11.5
Rural Health Centre	320	57	12	12/57x100 = 21.1	55	6	6/55x100 = 10.9
Urban Dispensary	1,200	84	24	24/84x100 = 28.6	88	14	14/88x100 = 15.9

Data collection throughout the year (perhaps quarterly) and at the end of the year can assist clinics to assess their progress in meeting Family Planning need. This can also be used to assess progress in each province, and nationally.

7.2. Family Planning Records.

Keeping a Family Planning Record for each client helps service providers remain up-to-date with a client's history and needs, and thereby contributes to improved service quality. Keeping accurate client records also prevents clients from repeated examinations and assessments which they may find unpleasant or uncomfortable, even if subsequent visits are conducted by a different health worker.

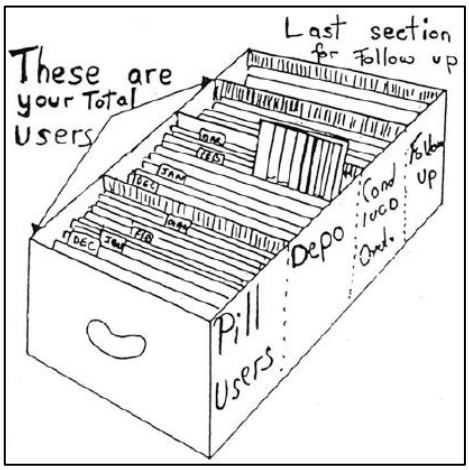
Table 7.4: What information goes in the Family Planning Record?

Details of the Client Assessment (see Chapter 8)	First Visit
• Personal/social history. • Family History. • Medical and surgical history. • Obstetric history. • Contraceptive history. • Gynaecological history. • Sexual History (including STIs). • Results of a physical examination. • Results of laboratory tests. • Family Planning method of recommended/provided, and any specific information provided to the client.	• Client provided with Family Planning Record card. • Front of card completed with information (see opposite). Back of card with notes from subsequent visits. **Follow-up Visit** • Notes from subsequent visits added to back of Family Planning Record card. Includes: ▪ Date of visit. ▪ Any problems experienced since last visit. ▪ Weight, blood-pressure and date of her last menstrual period. ▪ Services provided during visit, including changed method, demonstrations, education or advice. ▪ Date for follow-up appointment (use the follow-up checklist for the specific method being used).

Efficient and Confidential Storage of Family Planning Record. Health facilities should have a folder, drawer, shelf or Tickler Filing box (see picture) for storage of Family Planning Record Cards. These are stored in a secure location for access by staff only.

Storage units should have dividers to separate the cards of clients using different methods, such as pills, condoms, IUCDs, injectables or implants. Cards can be placed in different sections, making it easier to schedule and monitor follow-up visits.

Defaulters' cards may be kept at the back for reference should they return later in the year.



7.3. Family Planning Reporting.

Reporting of Family Planning services within health facilities is done through the Monthly Activity Reports, for submission to the Provincial HIS Officer. Completing the Family Planning section requires:

- Family Planning Record Cards.
- Family Planning record book/worksheet/log book (record of client names, age, visit date).

The Monthly Activity Report requires information to be completed for **each** of the Family Planning methods used during the month. Table 5.4 describes the data fields to be completed, and how to obtain the required data.

Table 7.5: Definitions and Instructions for Monthly Family Planning Reporting.

Reporting Category	Definition	Instructions for accessing information from Family Planning Record cards.
Number of Users Last Month ***(No. blong ol users last manis)***	Someone who was using the recommended Family Planning method last month.	• This is the same as the Total Users recorded at the end of the previous month. There is no need to count anything just use the figures from last month's report or as on the worksheet/log book.
Number of New Users ***(Niu Users tis manis)***	Someone who started using Family Planning method this month, and who was not using it last month.	• For pills, look in the section of the folder/box one month ahead: e.g. If it is May, look under June to find the cards of May's new users. • For other methods: look under the specific sections to find the new users.
Number of Defaulters ***(Defaulters tis manis)***	Someone who was scheduled to attend their follow-up appointment this month, but who did not present to the clinic, or someone who came to the clinic, but has stopped using the most recently recommended/supplied Family Planning method.	• For pills, count the cards still remaining in the section for that contraceptive, for that month. • For IUCDs, these are the women who had an IUCD removed this month but did not have another one inserted. • For condoms, it is not easy to count defaulters. You may remove cards of those who should have returned for more supplies that month but did not, or it may be more practical to wait for 3 months after their missed appointment before counting them as a defaulter.
Total Number of Users ***(Family Planning users tis manis)***	All those in the catchment area who have been using that particular Family Planning method this month.	Total Number of Users (for that method) = (Users Last Month + New Users) - Defaulters
Note: The current Monthly Activity Report form specifically asks for information on the Progestin-Only Pill (Microlut), the Combined Oral Contraceptive pill (Microgynon), IUCD, Depo-Provera injection, male and female condoms, tubal ligation (female sterilization) and vasectomy. Information on contraceptive implants (Jadelle) must be provided in the space entitled, *'Narafala family planning method'*, until revised forms are made available.		

8. Client Assessment

Conducting a systematic client assessment and accurately recording the findings is important for the long-term health outcomes of the client (see Section 7.2). An assessment will provide health workers with:

- A baseline assessment of the client's health (to be compared with follow-up visits).
- A record of the client's relevant medical history, which will assist with providing Family Planning advice.
- To determine contraindications for contraceptive methods.
- To determine if complications have resulted from any previous use of a contraceptive method.
- To identify issues for treatment or referral.

Any person requesting Family Planning should be assessed for the most suitable contraceptive method. Depending on client need, this should include one or more of the following:

- A history: personal, social, medical, surgical and obstetric history (see Table 8.1): updated each visit. Oral injectable and implant contraceptives, and condoms can usually be safely prescribed after an assessment.
- Physical examination: including breast, abdominal and pelvic examination (see Section 8.6): pelvic examinations not needed for most Family Planning methods; only female sterilization, and IUCD insertion.
- Simple laboratory tests: urine test, haemoglobin, VDRL/RPR/TPHA (for syphilis), vaginal swabs: conducted only where indicated and as appropriate.

Client assessments should be undertaken by all Family Planning service providers:

- During a new client's first visit.
- Once a year for continuing users of Family Planning.
- Whenever indicated during client follow-up visits, such as if a client is experiencing complications or side effects, and/or if they wish to change to a new Family Planning method.

8.1. Conducting an initial Client Assessment.

A detailed Client Assessment should be undertaken at the first visit (see Table 8.1):

- Greet client warmly. Introduce yourself. Explain that your discussion will be kept confidential/private. Ask how you can help her/him.
- Explain the need for an Assessment before starting a contraceptive.
- Discuss contraceptive methods so that the client can make an informed choice (see Chapter 9)
- Start Client Assessment.

Table 8.1: History taking for an initial Client Assessment.

Personal/social History	Family History	Medical and Surgical History
• Name. • Age. • Address/contact details. • Smoking history.	Has anyone in your close family (parents, brothers, sisters) ever had: • High blood pressure. • Diabetes. • Heart disease/stroke. • Cancer.	Have you ever had any: • Serious diseases (heart, liver, blood, diabetes)? • Admissions to hospital and/or any operations? • Allergic reactions to medicines? Are you taking any medicines now? If so, list these.
Obstetric History	**Contraceptive History**	**Gynaecological History**
How many pregnancies have you had? How many children have you got? Ask details of previous pregnancies • e.g. live birth, stillbirth, premature delivery, abortion, ectopic preg'y. Date of last delivery. Are you breastfeeding now?	Are you using any Family Planning method now? • If YES: what, are you happy with it? Have used a contraceptive before? • If YES: which method? • Why did you stop using it?	Menstrual History: • How long do periods normally last? • Are periods regular? • Do you bleed between periods? • Do you have severe pain with your periods?

	Do you wish to space your pregnancies or stop having children?	• When was your last normal menstrual period (LMP)?
Sexual History		**Sexually Transmitted infections**
This should be approached with care; it is not always necessary. • Having regular sex with anyone now? • Is it satisfactory, if not why not? • How often do you have sex? • How many partners have you had? • How many do you currently have?	If using a Family Planning method: • Has your Family Planning method affected sexual intercourse for you and/or your partner? • Are you worried about getting STIs or HIV?	Any signs or symptoms of an STI? • e.g. vaginal discharge, pain on intercourse? • Have you had a STI or Pelvic Inflammatory Disease (PID) in the past?

Conduct a Physical Examination.
The client should be comfortable and there should be privacy.

- Explain clearly what you are going to do, and why this is important. Answer questions and reassure.
- Ask client to empty her bladder before the examination.

Physical examination (**inspection, palpation, percussion and auscultation**) should include assessment of the following, to identify common medical conditions which may prohibit use of some contraceptive methods:

Table 8.2: What to Assess During a Physical Examination, and Why.

Health Workers to Examine:	Conditions to look for:	Impact on choice of Family Planning method:
Weight and height	Underweight/overweight	Overweight may affect use of COC
Blood pressure (BP)	High BP (greater than 140/90)	Not suitable for COC; caution with POP
Pulse	Irregular/weak beat	May impact on COC and injectables
Conjunctiva	Yellowness/paleness	Caution with COC, POP, injectables and IUCD.
Skin	Infections/rashes, etc.	May signify immune-suppression (query diabetes, HIV, drug-interactions).
Mouth/teeth	Severe infection	
Thyroid gland	Enlargement/nodules	No significant impact
Heart	Irregular heart beat/murmur (evidence of valve disease)	Should not use COC
Lungs	Congestion/infection	May impact on COC
Abdomen	Masses/tenderness/liver enlargement	May signify cancer or other mass; impact on contraceptives containing oestrogen
Breasts	Masses/tenderness	
External & internal genitalia	Infections/abnormalities	Treat infections or use alternative methods
Legs and feet	Swelling or tenderness of feet/veins	May signify diabetes or cardiovascular conditions

Conduct a breast, abdominal and/or pelvic examination where indicated (see Section 8.6). Note: Pelvic examinations not needed for most Family Planning methods; only female sterilization or IUCD insertion.

If issues identified through history and examination, additional tests may be required to help diagnose problems such as diabetes or anaemia, which may impact on choice of Family Planning method (see Table 8.2). For most Family Planning cases, only basic tests (such as urine test) are indicated and can be performed in the examination area (see Table 8.3).

8.2. Follow-up Client Assessment.

It is important to complete some form of client assessment when they return for a follow-up visit; what is assessed depends on the client's history update. The client assessment will enable the health worker to:

- Check if the client is satisfied with their Family Planning method.
- Discuss any side-effects or problems and answer questions.

- Update information obtained at the first visit (baseline), and/or the previous visit.
- Give the client more contraceptive supplies (if required).
- Identify any recently-developed medical conditions and provide treatment, advice and/or referral.

Table 8.3: Information About Additional Tests for Family Planning (where indicated).

Test Type	Test for	Additional information
Urine testing:	Glucose and protein (high levels may be sign of diabetes and/or kidney disease).	**Equipment required:** Clean container for urine specimen. Reagent/test papers (Dipsticks) –stored correctly and discarded if expired. **Impact for family Planning:** ***Diabetes:*** IUCDs used with caution due to increased risk of infections. If diabetic > 20 years, and/or if eye, vascular, nerve or kidney damage, most methods to be used only with extreme caution and monitoring. ***Kidney disease:*** Contraceptive use possibly with clinical monitoring.
Blood test	Haemoglobin (Hb) (test for anaemia if clinically suspected).	IUCDs not the best method for women who are high risk for anaemia, particularly if cause is heavy bleeding during periods.
Cervical/ High Vaginal Swab (HVS)	To isolate organism causing clinically-identified infection (in order that the correct treatment can be given). **To be conducted if:** Suprapubic tenderness, vaginal discharge, discomfort during sex, partner diagnosed with an STI, any sign of infection, history of PID. Client requests an IUCD, or has come for her routine IUCD check-up.	**Equipment needed:** Clean water for hand-washing. Gloves. Examination table and light. Swabs/slides/medium **Procedure:** See Pelvic/Speculum Examination for initial steps (Section 8.3.3) Inspect cervix and the characteristics of any discharge. Remove swab from packaging. Take discharge around the cervix (HVS) With 2nd swab, sweep inside the cervical os (endocervical specimen). As appropriate, smear, fix or insert swabs into special medium. Remove speculum and clean client. Give advice on the findings and treatment. Arrange for contact tracing; follow-up to check on condition of patient, swab results and, if possible, repeat swabs. Label specimen(s) with client's name/address; send to lab immediately.

Update the Patient History.
Update history taken at the initial and subsequent visits (see Table 8.1). Update:

- ***Personal/social History.***
- ***Medical and Surgical History:*** has there been any change to the client's medical history since last visit; any hospital visits, surgery, changes to medication etc.? Any STIs since last visit?
- ***Obstetric History:*** any pregnancies since last visit (relevant for Family Planning defaulters).
- ***Gynaecological History:*** any changes to menstrual cycle since last visit. Particularly relevant for oral contraceptives (bleeding between periods) or IUCD (heavy, painful bleeding during or between periods)
- ***Contraceptive History:*** any specific problems related to their use of contraceptives;
  - check if contraceptive is being used properly.
  - Pill-taking history (when last taken, when does she starts a new packet, timing of pills etc.).
  - IUCD issues (last time client felt strings, any abdominal discomfort or vaginal discharge).
  - Condoms (ask client to demonstrate use of a condom with a penis model).

Conduct an examination and any special tests (if required).

- As per the initial visit, conduct a basic physical examination (Table 8.2).
- At least once/year (or as indicated), conduct breast and abdominal examinations (see below).
- When required (for IUCD or sterilisation), conduct a pelvic examination (see below).
- Conduct special tests for urine, haemoglobin and/or take a cervical/high vaginal swab (if required – see Table 8.3).

At the end of each visit, always give the client an appointment for their next visit.
Remind them to return earlier whenever they wish.

8.3. Client Examination Techniques.

8.3.1. Breast Examination

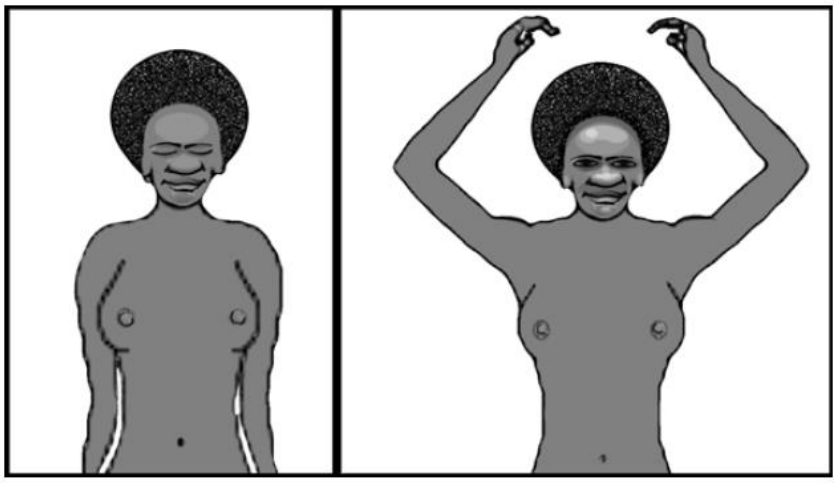
Why to conduct a Breast Examination.

- To find any breast lesion suggestive of cancer:
  No contraceptives containing oestrogen should be used.
- To identify problems (e.g. mastitis, cracked nipples) for which the client may need treatment or referral.
- To teach clients to do breast self-examination for early identification and treatment of cancer.

When should a Breast Examination be conducted?

- Initial/first Family Planning visit.
- Once every year.
- Whenever a client has identified an issue of concern through self-examination.
- At any clinic visit where an issue is identified.

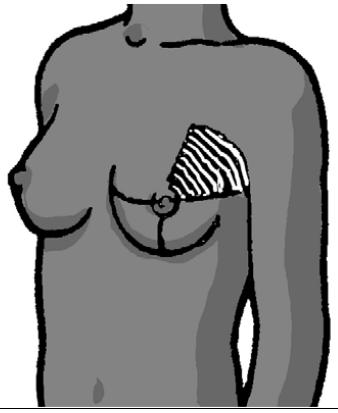
Table 8.4: Breast Examination Procedure.

Breast Examination Procedure	
Step 1	**Prepare the Client for examination.** • Explain to the client that you will examine each breast, including the tail of the breast under the arm, while she is in two positions: sitting and lying with her aim over her head. • Explain that you will teach her how to do a full breast self-examination; she will to do it herself every month after her menstrual period. • Wash and dry your hands. • Respect client's modesty. Close and lock doors, draw curtains. Ask her to undress to the waist and give her a sheet to cover herself below the waist.
Step 2	**Look/observe (client sitting up).** • With the client's arms at her side, look at the breasts for: masses, swelling, dimples or discoloured areas of skin. • Ask the client to raise her arms over her head, and look closely again. • Dimples may suggest cancer under the skin. • Ask client to put her hands on her hips and press against her hips to tighten the muscles underneath the breasts. Look again for dimples or differences between the two breasts.  • Look at the nipples for ulcers, rashes, discharge or other abnormalities. • If only one nipple is inverted ask if: ▪ the inversion is new ▪ the inverted nipple can be everted for breastfeeding. Recent inversion on one side only and/or one which is not reversible, is suspicious of an underlying cancer.

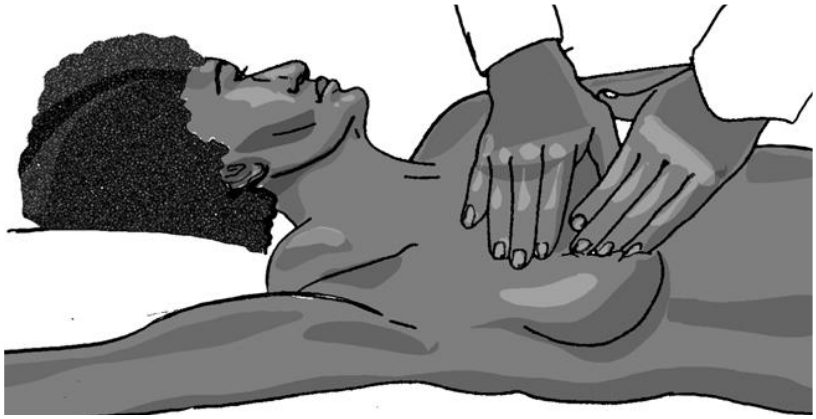
Step 3

Palpate (client lying down)

- Ask the client to lie down, and raise her arm over her head on the side you are examining. This will spread out the breast tissue and make it easier to find any masses.
- Think of the breast as divided into 4 quadrants, with the tail going up into the axilla (underarm area).

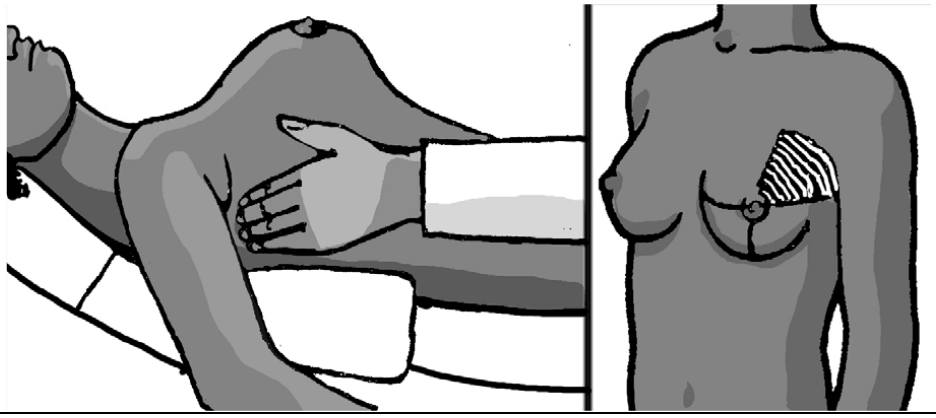


- Examination of the breast must include the tail and lymph nodes which drain the breast. Both are found in the axilla. Important because most breast cancers occur in the upper, outer quadrant.
- Use the pads of your middle 3 fingers to gently press and 'roll' the breast against the underlying chest wall. Follow spiral or parallel lines to make sure all the breast tissue and lymph nodes are palpated.



- While palpating breast, note lumps and/or tenderness. Breasts tenderness may be normal just before a period.
- If a lump, gently press the breast and look for dimpling of the skin. Compare lump with the normal breast tissue. Remember, normal breast tissue:
  - may feel slightly lumpy due to parts of the breast gland(s) or small cysts in the breast tissue.
  - usually feels the same in both breasts.
  - is not stuck to the skin overlying the breast or to the muscle underlying the breast.
  - swells and becomes tender just before a period.
- Gently palpate the areola and nipple for lumps. Note any abnormal discharge.

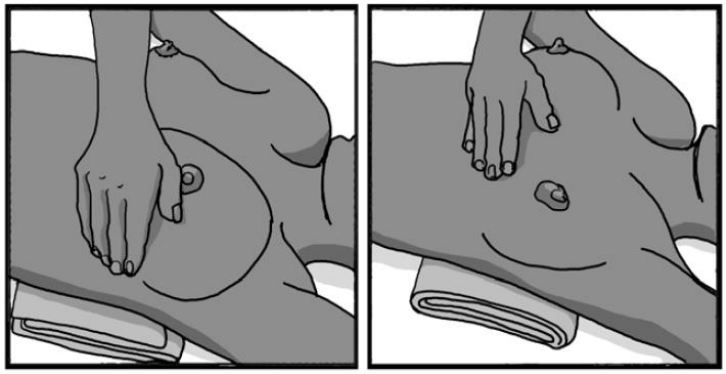
- Gently palpate the axilla and at base of the neck for enlarged or tender lymph nodes.

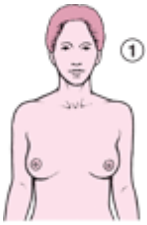
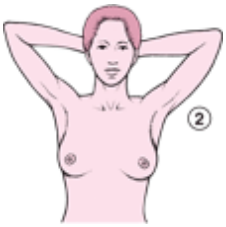
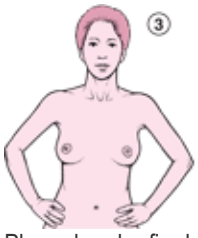


Step 4

Teach self-examination of breasts.

- While you examine each breast, tell the client about each step you do so she understands what you are doing.
- After examining both breasts, ask the client to repeat the same procedure on herself.
- Watch to see that she:
  - keeps the arm outstretched (above her head) on the side she is examining.
  - uses the pads of her middle 3 fingers to examine.
  - covers all the breast, including the tail of the breast.
- After she has examined both breasts lying down she should repeat the procedure while sitting or standing. This is especially important for women with large breasts.



	 [14]While standing in front of a mirror, look at the breasts. The breasts normally differ slightly in size. Look for changes in the size difference between the breasts and changes in the nipple, such as turning inward (an inverted nipple) or a discharge. Look for puckering or dimpling  Watching closely in the mirror, clasp the hands behind the head and press them against the head. This makes it easier to see small changes caused by cancer. Look for changes in the shape and contour of the breasts, especially in the lower part of the breasts.  Place hands firmly on hips and bend slightly toward the mirror, pressing the shoulders and elbows forward. Again, look for changes in the shape and contour of each breast. • Remind the client to examine her breasts every month after her period, and to come to the clinic if she ever notices any abnormalities or changes.
Step 5	**Refer as required.** • Refer any woman with new lumps or abnormalities to a Vila Central Hospital or Northern Provincial Hospital (Santo) for a surgical assessment.

8.3.2. Abdominal Examination.

Why to conduct an Abdominal Examination.

- To detect problems/abnormalities which may impact on which contraceptive method to use. For example:
  - enlargement or tenderness of the liver (suggestive of liver or gall bladder disease).
  - enlargement of the uterus (suggestive of pregnancy or a tumour).
  - tenderness of the suprapubic area (suggestive of PID).
- To detect problems which may require treatment and/or referral. For example, a painless abdominal mass may be found which may need further investigation.

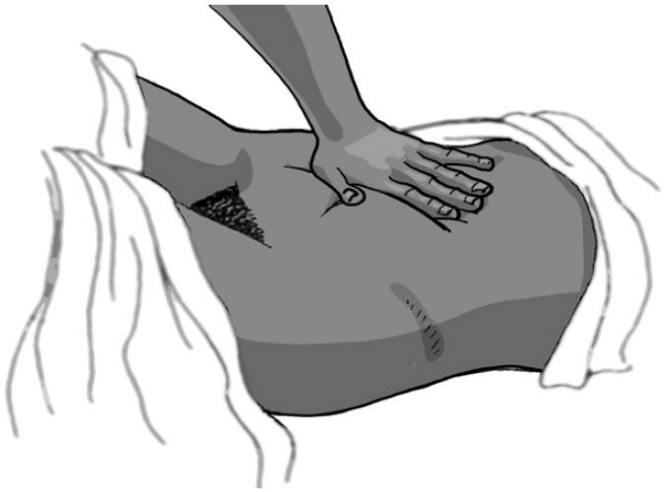
When should an Abdominal Examination be conducted?

- Initial/first Family Planning visit.
- Once every year.
- When a client is wishing to change her Family Planning method.
- Whenever a client has identified an issue of concern.
- At any clinic visit where an issue is identified.

Table 8.5: Abdominal Examination Procedure.

Abdominal Examination Procedure	
Step 1	**Prepare the Client for examination.** • In a calm, reassuring voice, explain briefly to the client what you are going to do. • Ask client to empty her bladder before the examination. • Respect clients' modesty. Close and lock doors, draw curtains and cover areas not directly being examined. • Ask the client to lie down flat on a bed, and to rest her hands by her side and to breathe slowly and deeply. • Ask the client to expose the whole abdominal area (from the xiphoid process to the symphysis pubis) and to relax her abdominal muscles as much as possible. • Ask the client to show, with her own finger(s), any painful areas. These should be examined last of all.

[14] Diagram source: www.merckmanuals.com/.../womens_health_issues/...; accessed 2nd March 2015.

Step 2	**Inspect/observe the abdomen.** Look for: • Scars. • skin infections - redness? pus-filled bumps? open sores? • any fullness or swelling suggestive of masses. • normal movement of the abdomen.
Step 3	**Palpate the abdomen.** Mentally divide abdomen into four parts or quadrants: right upper, right lower, left upper and left lower. • Lightly palpate each quadrant. If any area is tender to touch palpate the other areas first and the tender area last • With four fingers held close together, palpate each quadrant again more firmly. Press downward on the abdominal cavity, moving it forward and backward to find masses and tenderness, including 'rebound tenderness' (pain upon removal of hands).  • If abnormalities, record exact site, size, the way it feels, if it is mobile or fixed and if there is any tenderness. • If client has suprapubic tenderness it is difficult to know whether the problem lies in the uterus, ovaries, bladder or colon. In such cases bimanual pelvic examination should be done (see below). • If it is impossible to do a bimanual examination, but the woman has a history of constant lower abdominal pain with/without abnormal vaginal discharge and fever, PID may be suspected (see Table 8.6, Step 4))
Step 4	**Percuss the Abdomen** • This may help confirm the presence of masses, organ enlargement and ascites.
Step 5	**Listen to the Abdomen (Auscultation)** • In clients with severe abdominal pain and those with suspected bowel obstruction it is especially important to listen to the bowel sounds (Normal - Tinkling - Reduced - None).
Step 6	**Reassure, Treat and/or Refer** • As appropriate, clients should be reassured, treated and/or referred depending on the findings of the examination.

8.3.3. Pelvic Examination.

Why to conduct a Pelvic Examination.

- To detect pelvic abnormalities which may impact on which contraceptive method to use.
- To detect an abnormality that may have occurred by chance while using a contraceptive or as a complication of using it.
- To look for possible causes in women with infertility.
- To ensure normal recovery in postpartum or post-abortion clients.

When should a Pelvic Examination be conducted?

Pelvic examinations are not needed for most Family Planning methods. They are invasive, and should be conducted only:

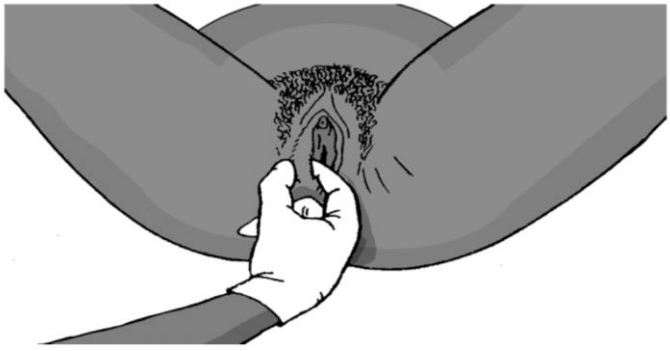
- If a client wishes to have an IUCD inserted, or wishes to undergo sterilization.
- If an Abdominal Examination identifies an abnormality which requires further investigation.
- If the client presents with a complaint of infertility.
- If the client presents with symptoms or history of recent, complicated pregnancy or abortion.
- If the client presents with complaints/symptoms, that cause of which cannot be otherwise identified.

Before conducting a pelvic examination, an appropriate client history must be taken.

Equipment required.

- Clean water for hand-washing.
- Gloves.
- Examination table or mat and light.
- Vaginal specula.
- Sponge forceps and gauze.
- Glass slides/swabs.
- Bowl with antiseptic solution.

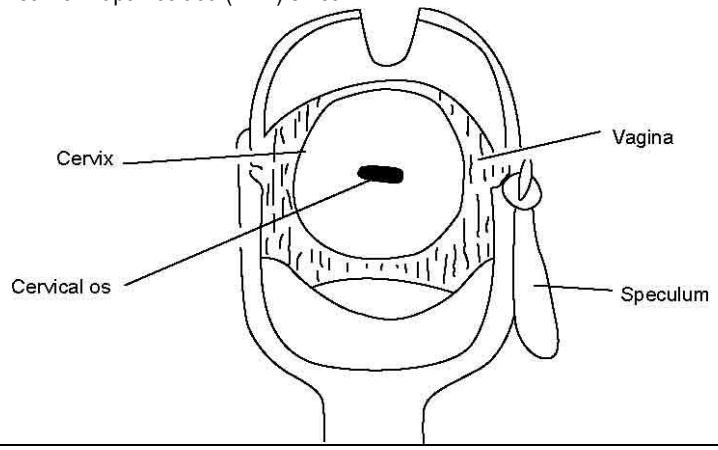
Table 8.6: Pelvic Examination Procedure.

Pelvic Examination Procedure	
Step 1	**Prepare the Client for examination.** • In a calm, reassuring voice, explain briefly to the client what you are going to do. • Gather the equipment needed for the examination and tests. • Ask client to empty her bladder before the examination. • Respect clients' modesty. Close and lock doors, draw curtains and cover areas not directly being examined. • Ask the client to lie down and take slow, deep breaths. As she breathes out, she should relax her muscles. • Wash your hands and put on clean gloves. • In postpartum clients, check abdominal muscle tone. Ask client to lift head or legs and feel how well the abdominal muscles tighten. Explain the use of postnatal exercises to strengthen weak stomach muscles. • Ask client to bend knees up towards her chest and then to let them fall open widely and relax her hips. Now explain again, in simple words what you will do. Reassure her that you will be gentle.
Step 2	**Inspect the external genitalia.** • For clients with possible STIs; look for bumps, ulcers, lice, swollen lymph nodes, and other evidence of STIs. • Also done to exclude abnormalities in the vulval area.  • Carefully look at external genitalia. Use one gloved hand to part the labial folds and look for abnormalities: ▪ visible scabies, lice or nits in the pubic hair. ▪ swollen or tender inguinal lymph nodes. ▪ ulcers (note if hard, soft, tender, painless). ▪ signs of bleeding, vaginal discharge (note colour, smell, amount). ▪ abrasions, irritation, tears, old perineal scars. ▪ enlarged Bartholin's glands. ▪ genital warts or other growths.

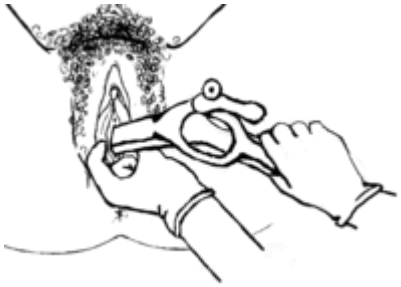
Step 3

Speculum Examination

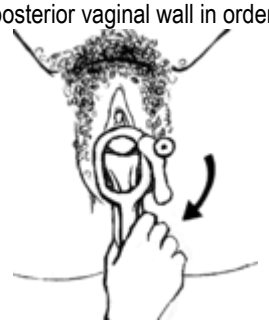
- To check the vagina and cervix for infection, tears, growths or other abnormalities.
- To assess complaints of vaginal discharge.
- Done prior to IUCD insertion - to rule out contraindications.
- For IUCD follow-up visits - to confirm presence of the strings.
- Done to obtain specimens for laboratory tests:
  - vaginal wet smear for saline prep (Trichomoniasis, Candida infection or anaerobic/nonspecific vaginitis).
  - endocervical culture or Gram Stain (Gonorrhoea).
  - cervical smear for Papanicolaou (PAP) smear.



- Explain to the client what you are doing.
- Prepare all equipment needed before inserting the speculum.
- Select a speculum of the right size (small, medium or large).
- Lubricate speculum (e.g. with K-Y gel) before insertion if vagina is dry (use only water if are taking smears).
- Ask client if she is ready to start. When she is ready, gently open the lips of her genitals with one hand so that you can see the opening of her vagina. Make sure to explain everything you are doing.
- Hold the speculum with your other hand, and turn the handle to one side. Slide the closed bills over your fingers holding the client's genitals, and insert into the vagina at a 45 degree angle downward or posteriorly[15].



- Gently slide bills downwards into the vagina. Keep bills held diagonally and slight pressure exerted towards the posterior vaginal wall in order to avoid the more sensitive anterior wall and urethra.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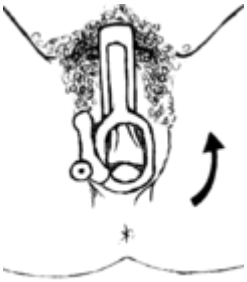


[15] Speculum diagrams source; en.hesperian.org/hhg…; accessed 2nd March 2015.

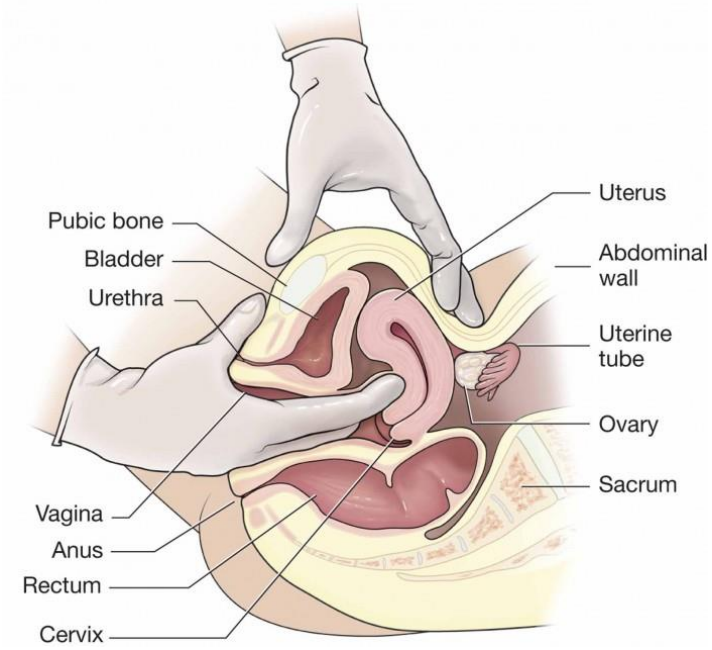
- As you insert speculum, turn it so the handle is down keeping pressure there posteriorly. Take care not to pull pubic hair or pinch labia. The handle should rest against the skin between the vagina and the anus.
  Note: If the client is on a bed or a flat table and the speculum handle will not fit facing down, you can insert it with the handle pointing up.

- Open bills by pushing the thumb-rest with your thumb. When you see the cervix between the bills, tighten the screw on the thumb-rest to keep the speculum open.
  Note: If you open speculum but do not see cervix, close speculum and remove it partway. Then try again. Cervix may be off to one side. This is normal - sometimes the cervix will come into view more clearly if the woman coughs or pushes down as if she is passing stool while the speculum is open inside her.
- Under good light, look carefully at the cervix.
- Obtain any specimens.
- After loosening the speculum's screws, take it out slowly with the blades closed. While taking it out, gently turn it to the right and left to carefully check the vaginal mucosa.
- Ask the client to bear down, and look for any vaginal wall bulging suggestive of a cystocele, or rectocele (best seen using a Sims speculum).

Step 4

Bimanual Examination[16]

- To determine the size and shape of the uterus and ovaries, and to check for abnormal masses.
- Part of IUCD insertion - rule out contraindications, identify position of uterus and its angle with the cervix.
- To investigate abnormal vaginal discharge or lower abdominal pain, and to locate cause (e.g. PID, or ectopic pregnancy).



[16] Diagram source: http://biology-forums.com...; accessed 2nd March, 2015.

	• Explain to the client what you are doing. • Lie the client on a bed or mat, with knees up and separated. • Separate the labia with two fingers noting any lesions. With the palm facing up, gently pass the gloved index and middle fingers into the vaginal opening. Gently palpate the urethra against the symphysis pubis. • Examine the Bartholin's glands, by palpating, at the lower end of each labia majora, with the thumb on the outside and the two fingers inside the vagina. • With two gloved fingers in the vagina and thumb in your palm, identify the cervix. Note its position, size, consistency, and any tenderness. • To feel uterus, pass both examining fingers into the anterior fornix above the cervix and sweep the abdominal hand forward over the abdomen, puffing the uterine fundus forward between the hands as far as possible. Determine the position, size, consistency and any tenderness or abnormality of the uterus. • A retroverted uterus may not be felt; put the examining fingers in the posterior fornix and repeat the process. • Feel the right adnexa by placing both fingers in the right fornix and the abdominal hand in the area of the right iliac fossa. Bring hands together and move them centrally towards the pubic bone. The vaginal fingers will best define ovaries as they slip between the fingers. Note excessive pain or masses. Repeat procedure on left side. • Withdraw your fingers from the vagina and ask the client to return to the sitting position. • Explain the results of the examination and answer any questions from the client.

9. Selecting the most appropriate contraceptive method

There are many different types of Family Planning methods which are used throughout the world. The following chapters focuses on one Family Planning method each. Table 9.1 summarise the information presented.

Table 9.1: Information presented for each contraceptive method.

What a health worker must know about each method	What to say, do and check at first visit
• What it is. • How it stops pregnancy. • How effective it is. • Side effects, health benefits, risks and/or complications • When (for whom) it should/should not be used. • Its use in women with HIV. • Medical eligibility criteria for its use. • Advice on providing the method (including explanations, support, managing problems). • Questions and answers regarding its use.	• Screening history (including examination/tests). • Method Specific Counselling. • Obtain consent. • Supply the commodity. • Plan for follow-up.
	What to say, do and check at follow-up visit
	• Update history. • Examination/tests. • Manage problems. • Supply the commodity. • Plan for follow-up.

Table 9.2: Important Facts about Family Planning Methods.

Important Facts about Family Planning Methods	
1	NOT every Family Planning method is suitable for every individual or couple.
2	Good counselling and client assessment can help to select most suitable method for the client/s (see Section 2.3). Some people may try 2-3 different methods before they find one that suits them best. People may need to use different methods at different times, e.g. people who have sex infrequently and need protection against STIs may prefer condoms; people who have sex regularly may prefer pills or IUCD.
3	Using any Family Planning method is safer than becoming pregnant. There are about six maternal deaths every year in Vanuatu, but there are no deaths related to using Family Planning.
4	Some people experience side-effects from some Family Planning methods; these can be serious (rare) or mild. It is important to explain common side-effects of particular methods to new clients (see Chapters 10-22), so that they will know what to do. Clients may change methods if they experience uncomfortable or serious side-effects.
5	Family Planning users should be encouraged to come for regular check-ups and to discuss any problems or concerns at any time.

6	Always treat clients with kindness and respect. Everything that is discussed and done during Family Planning visits should be confidential. Health workers must NOT discuss anything about the visit with anyone else (including the client's partner) without first asking permission from the client.
7	There is a small chance that any Family Planning method may fail to work; no method is 100% effective. With some methods, such as condoms and natural Family Planning, failure can depend on how well it is used.
8	There are many rumours about Family Planning. Many of these are incorrect (*'giaman toktok nomo'*). Clients and the public should be given correct information on Family Planning so that their decisions can be based on the true facts and not on rumours (see Table 2.5 above, and Questions and Answers in each of the following chapters).
9	There are two main groups of contraceptives: • Reversible or temporary methods, such as condoms, pills, injectables, implants and IUCD; these best for clients who want to delay/space pregnancy. They can use these Family Planning methods until they are ready to get pregnant, and then they can simply stop using the method. • Irreversible or permanent methods, namely female sterilization and vasectomy; for clients who have decided that she/he/they do not want any more children. Note: reversible methods can be used on an ongoing basis by clients who do not want any more children but do not want to, or cannot be sterilised.
10	Contraception must not be started if pregnancy is suspected.

9.1. Medical Eligibility Criteria for Family Planning Methods.

As with many medical conditions, treatments and medications, Family Planning methods and commodities can both impact on, and/or be impacted by existing medical conditions or the use of some medications. Chapters 10-22 of these Guidelines describe in detail the various methods and commodities available in Vanuatu, and within each chapter, a table outlining the medical eligibility criteria for the particular method. Service providers should be well aware of these medical eligibility criteria before prescribing any Family Planning method, and should consult these Guidelines regularly to refresh their knowledge, or when a client is requesting/changing to a new method.

A useful resource to have on-hand in the clinic is the WHO Medical Eligibility Criteria Wheel for Contraceptive Use[17]. This helpful resource assists a provider to ask appropriate questions as part of their initial client assessment to determine existing medical conditions and/or medications being taken, and enables them to plot these conditions on a useful wheel, which indicates appropriate methods and precautions for that client.

9.2. Family Planning for women with HIV and AIDS.

While the prevalence of HIV in Vanuatu remains low at this time, it is important for providers of Family Planning services to be aware of the implications of HIV and AIDS on the use of some contraceptive commodities and methods, should someone infected with HIV present to their clinic. Most methods are safe for women infected with HIV, or suffering from AIDS, including Combined Oral Contraceptives, Progestin-Only Pills and Injectables, Emergency Contraceptive Pills, Implants, IUCDs, sterilization and fertility awareness methods.

Caution needs to be exercised with the use of Combined Oral Contraceptives and Progestin-Only Pills if the client is taking ritonavir with antiretroviral therapy (see Medical Eligibility Criteria section for each of these methods. IUCDs should be used only if the HIV-infected client is clinically well and taking antiretroviral therapy, and there is no need to remove an IUCD should a woman become infected with HIV after having had the device inserted.

[17] WHO, 2015; *WHO medical eligibility criteria wheel for contraceptive use: 2015 update*; Geneva; World Health Organization.

The most important message associated with HIV, AIDS and Family Planning is that most contraceptive methods do not prevent transmission of HIV (or other STIs) during sex. Therefore, all Family Planning clients infected with HIV must be urged to use condoms (either male or female condoms) along with their preferred contraceptive method.

The use of Lactational Amenhorroea Method of contraception is safe for women infected with HIV in the first 6 months of her baby's life, however there are implications for the prevention of mother-to-child transmission of HIV which must be considered when using this method (see the Lactational Amenhorroea Method for Women With HIV text box in Chapter 22).

10. Combined Oral Contraceptives (COCs)

- Pills that contain low doses of two hormones — a progestin and an oestrogen — like the natural hormones progesterone and oestrogen in a woman's body.
- Combined oral contraceptives (COCs) are also called 'the Pill', low-dose combined pills, OCPs, and OCs.
- Work primarily by preventing the release of eggs from the ovaries (ovulation).

Why some women say they like COCs
- Are controlled by the woman.
- Can be stopped at any time without a provider's help.
- Do not interfere with sex.

In Vanuatu, the most commonly available COC is:
- Microgynon 30 ED (ethinylestradiol and levonorgestrel tablets).

How Effective?
Effectiveness depends on the user: Risk of pregnancy is greatest when a woman starts a new pill pack 3 or more days late, or misses 3 or more pills near the beginning or end of a pill pack.
- With common usage: about 8 pregnancies per 100 women using COCs over the first year. This means that 92 of every 100 women using COCs will not become pregnant.
- If no pill-taking mistakes: <1 pregnancy/100 women using COCs over the first year (3/1,000 women).

Return of fertility after COCs are stopped: No delay.
Protection against sexually transmitted infections (STIs): No protection; use condoms to prevent STIs.

Correcting Misunderstandings *(see also Questions and Answers about COCs).*
Combined oral contraceptives:
- Do not build up in a woman's body. Women do not need a 'rest' from taking COCs.
- Must be taken every day, whether or not a woman has sex that day.
- Do not make women infertile.
- Do not cause birth defects or multiple births.
- Do not change women's sexual behaviour.
- Do not collect in the stomach. Instead, the pill dissolves each day.
- Do not disrupt an existing pregnancy.

Side Effects, Health Benefits and Health Risks

Side Effects

(see Managing Any Problems, below

Some users report the following:

- Changes in bleeding patterns including:
  - Lighter bleeding and fewer days of bleeding
- Headaches
- Dizziness
- Nausea
- Breast tenderness
- Weight change
- Mood changes
- Acne (can improve or worsen)
- Blood pressure increases (declines quickly after stopping use of COCs).

Known Health Benefits.

Help protect against:

- Unplanned pregnancy
- Cancer of the lining of the uterus (endometrial cancer)
- Cancer of the ovary
- Pelvic inflammatory disease
- Ovarian cysts (possible)
- Iron-deficiency anaemia (possible)

Reduces:

- Menstrual cramps
- Menstrual bleeding problems
- Symptoms of polycystic ovarian syndrome (irregular bleeding, acne, excess hair on face or body)
- Symptoms of endometriosis (pelvic pain, irregular bleeding)

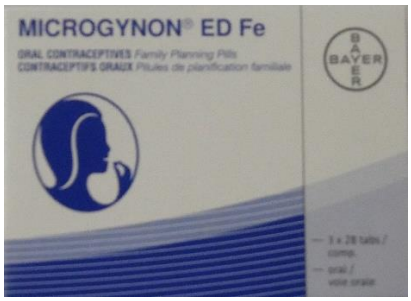
Known Health Risks.

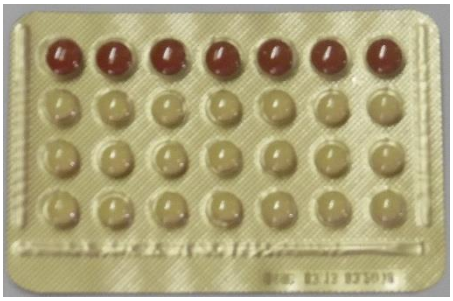
Very rare:

- Blood clot in deep veins of legs or lungs (deep vein thrombosis or pulmonary embolism)

Extremely rare:

- Stroke
- Heart attack





Microgynon 30 ED (ethinylestradiol and levonorgestrel tablets) is the most widely available COC in Vanuatu.

Medical Eligibility Criteria for

Combined Oral Contraceptives

Ask the client the questions below about known medical conditions. Examinations/tests not necessary. If she answers 'no' to all of the questions, then she can start COCs. If she answers 'yes' to a question, follow the instructions. In some cases she can still start COCs.

1. Are you breastfeeding a baby less than six months old?

❑ NO ❑ YES

- If fully or nearly fully breastfeeding: Give COCs and advise to start taking 6 months after giving birth or when breast milk is no longer the baby's main food - whichever comes first.
- If partially breastfeeding: Start COCs as soon as 6 weeks after childbirth. *(see When to Start below)*

2. Have you had a baby in the last three weeks and you are not breastfeeding?

❑ NO ❑ YES

Give COCs now and tell her to start taking them 3 weeks after childbirth. (If there is an additional risk that she might develop a blood clot in a deep vein, start at 6 weeks instead (risk factors include previous deep vein clot, thrombophilia, caesarean delivery, blood transfusion at delivery, postpartum haemorrhage, pre-eclampsia, obesity (>30 kg/m^2), smoking.)

3. Do you smoke cigarettes?

❑ NO ❑ YES

If she is 35 years of age or older and smokes, do not provide COCs. Urge her to stop smoking and help her choose another method.

4. Do you have cirrhosis of the liver, a liver infection, or liver tumour? (Are her eyes or skin unusually yellow? [signs of jaundice]) Have you ever had jaundice when using COCs?

❑ NO ❑ YES

If she reports serious active liver disease (jaundice, active hepatitis, severe cirrhosis, liver tumour) or ever had jaundice while using COCs, do not provide COCs. Help her choose a method without hormones (she can use monthly injectables if she has had jaundice only with past COC use).

5. Do you have high blood pressure?

❑ NO ❑ YES

If you cannot check blood pressure and she reports a history of (or is being treated for) high blood pressure, do not provide COCs. Refer for blood pressure check and help her choose a method without oestrogen. Check blood pressure if possible:

- If her blood pressure is <140/90 mm Hg, provide COCs.
- If her systolic blood pressure is >140 mm Hg or diastolic blood pressure is >90, do not provide COCs. Help her choose a method without oestrogen, but not progestin-only injectables if systolic blood pressure >160 or diastolic pressure >100.

Note: one blood pressure reading of 140–159/90–99 mm Hg is not enough to diagnose high blood pressure. Give her a backup method[18] until she can return for another blood pressure check, or select another method. If blood pressure at next check is <140/90, she can use COCs.

6. Have you had diabetes for more than 20 years or damage to your arteries, vision, kidneys, or nervous system caused by diabetes?

❑ NO ❑ YES

Do not provide COCs. Choose a method without oestrogen but not progestin-only injectables.

7. Do you have gallbladder disease now or take medication for gallbladder disease?

❑ NO ❑ YES

Do not provide COCs. Choose another method.

8. Have you ever had a stroke, blood clot in your legs or lungs, heart attack, or other serious heart problems?

❑ NO ❑ YES

If history of heart attack/disease due to blocked or narrowed arteries, or stroke, do not provide COCs. Choose a method without oestrogen, but not progestin-only injectables. If history of a current blood clot in the deep veins of the legs or lungs, Choose a method without hormones.

9. Do you have, or have you ever had breast cancer?

❑ NO ❑ YES

Do not provide COCs. Help her choose a method without hormones.

10. Do you sometimes see a bright area of lost vision in the eye before a very bad headache (migraine aura)? Do you get throbbing, severe head pain, often on one side of the head, that can last a few hours to several days and can cause nausea or vomiting (migraine headaches)? Such headaches are often made worse by light, noise, or moving about.

❑ NO ❑ YES

Do not provide COCs if: she has migraine aura at any age; she has migraine headaches without aura and is age 35 or older. Choose a method without oestrogen. If under 35 and has migraine headaches without aura, she can use COCs.

11. Are you taking medications for seizures? Are you taking rifampicin or rifabutin for tuberculosis or other illness?

❑ NO ❑ YES

If she is taking barbiturates, carbamazepine, lamotrigine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, rifabutin, or ritonavir, do not provide COCs. Choose another method but not progestin-only pills. If she is taking lamotrigine, help her choose a method without oestrogen.

12. Are you planning major surgery that will keep you from walking for one week or more?

[12] *Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.*

❑ NO ❑ YES She can start COCs two weeks after surgery – until then, use a backup method.
13. Do you have several conditions that could increase your chances of heart disease (coronary artery disease) or stroke, such as older age, smoking, high blood pressure, or diabetes? ❑ NO ❑ YES Do not use COCs. Choose a method without oestrogen but not progestin-only injectables.
Also, women should not use COCs if they report having thrombogenic mutations or lupus with positive (or unknown) antiphospholipid antibodies. Be sure to explain the health benefits and risks and the side effects of the method that the client will use.

Providing Combined Oral Contraceptives

When to Start

IMPORTANT: A woman can start using COCs any time if it is reasonably certain she is not pregnant (use Annex 1: Pregnancy Checklist). A client can be given COCs at any time and told when to start taking them.

Woman's Situation	When to Start
Having menstrual cycles or switching from a non-hormonal method	**Any time of the month** • Starting within 5 days of start of period: backup method not required. • Starting >5 days after start of period: start COCs any time it is reasonably certain she is not pregnant. Will need a backup method for first 7 days of taking pills. • If switching from an IUCD, start COCs immediately (see Chapter 15).
Switching from a hormonal method	• Immediately, if using hormonal method consistently and correctly or if reasonably certain she is not pregnant. Backup method not required. • If she is switching from injectables, she can begin taking COCs when the repeat injection would have been given. No need for a backup method.
Fully or nearly fully breastfeeding	
Less than six months after giving birth	• Give her COCs and tell her to start taking them six months after giving birth or when breast milk is no longer the baby's main food–whichever comes first.
More than six months after giving birth	• If period has not returned, start COCs any time it is reasonably certain she is not pregnant. Will need a backup method for the first 7 days of taking pills. • If period has returned, she can start COCs as advised for women having menstrual cycles (see previous page).
Partially breastfeeding	
Less than six weeks after giving birth	• Give her COCs to start taking 6 weeks after giving birth. • Give backup method to use until 6 weeks after giving birth if her monthly bleeding returns before this time.
More than six weeks after giving birth	• If period has not returned, start COCs any time it is reasonably certain she is not pregnant[19]. She will need a backup method[20] for first 7 days of taking pills. • If period has returned, start COCs as advised for women having menstrual cycles (see previous page).
Not breastfeeding	
Less than four weeks after giving birth	• Start COCs at any time on days 21–28 after giving birth. No need for a backup method (if additional risk for deep vein clot, wait until 6 weeks - see Question 2 of Medical Eligibility Criteria for COCs).
More than four weeks after giving birth	• If period has not returned, start COCs any time it is reasonably certain she is not pregnant[21]. Will need backup method for the first 7 days of taking pills.

[19] *Where a visit six weeks after childbirth is routinely recommended and other opportunities to obtain contraception limited, some providers and programs may give COCs at the six-week visit, without further evidence that the woman is not pregnant, if her monthly bleeding has not yet returned.*

[20] *Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.*

[21] *As per [18].*

	• If period has returned, she can start COCs as advised for women having menstrual cycles.
No monthly bleeding (not related to childbirth or breastfeeding)	• She can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills.
After miscarriage or abortion	• Immediately. If she is starting within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method. • If it is more than 7 days after first- or second trimester miscarriage or abortion, start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills.
After taking emergency contraceptive pills (ECPs)	• Start COCs the next day after finishing ECPs. Backup method for first 7 days. – A new COC user should begin a new pill pack. – A continuing user who needed ECPs due to pill-taking errors can continue where she left off with her current pack.

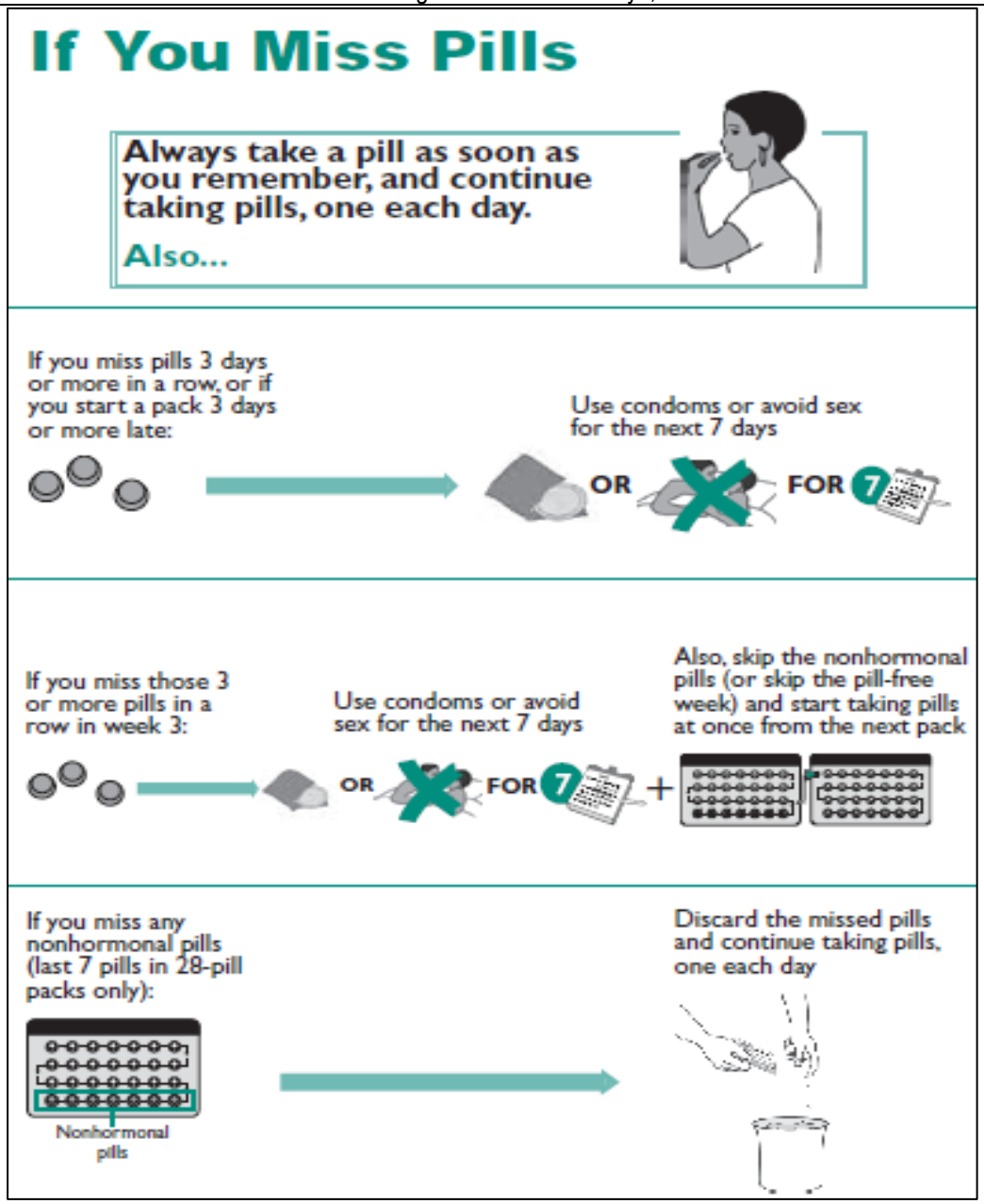
Giving Advice on Side Effects	
IMPORTANT: Counselling about bleeding changes and other side effects is an important part of providing the method – it may be the most important help a woman needs to keep using the method.	
Describe the most common side effects	• In the first few months, bleeding at unexpected times (irregular bleeding). Then lighter, shorter, and more regular monthly bleeding. • Headaches, breast tenderness, weight change, and other side effects.
Explain about these side effects	• Side effects are not signs of illness – they are common. • Side effects usually reduce/stop within the first few months of using COCs.
Explain what to do in case of side effects	• Keep taking COCs. Skipping pills risks unplanned pregnancy. • Take pills with food or at bedtime to help avoid nausea. • The client can come back for help if side effects bother her.

Explaining How to Use	
1. Give Pills	• Give as many packs as possible.
2. Explain pill pack	• Show which kind of pack; point out that the last 7 pills are a different colour and do not contain hormones. • Show how to take the first pill and then follow the arrows for the rest.
3. Give key instruction	• **Take one pill each day** – until the pack is empty. • Discuss cues for taking a pill every day. Linking pill-taking to a daily activity– such as cleaning her teeth or mealtime - may help her remember.
4. Explain starting next pack	• When one pack is finished, next day take the first pill from the next pack. • Client must start the next pack on time to prevent unplanned pregnancy.
5. Provide backup method and explain use	• Sometimes client may need backup method, such as when she misses pills. • Backup methods include abstinence, male or female condoms, spermicides, and withdrawal. Give condoms.

Supporting the User	
Managing Missed Pills: COC users should know what to do if they forget to take pills. **If a woman misses one or more pills, she should follow the instructions below.** Use the information box below to help explain to the client.	
Making Up Missed Pills With 30–35 µg Oestrogen[22]	
Key Message	• **Take a missed hormonal pill as soon as possible.** • Keep taking pills as usual, one each day (take 2 pills together to catch-up).
Missed 1 or 2 pills? **Started new pack 1 or 2 days late?**	• Take a hormonal pill as soon as possible. • Little or no risk of pregnancy.

[22] *For pills with 20 µg of oestrogen or less, women missing one pill should follow the same guidance as for missing one or two 30–35 µg pills. Women missing two or more pills should follow the same guidance as for missing three or more 30–35 µg pills.*

Missed pills 3 or more days in a row in the first or second week? **Started new pack 3 or more days late?**	• Take a hormonal pill as soon as possible. • Use a backup method for the next 7 days. • Also, if she had sex in the past 5 days, can consider ECPs (see Emergency Contraceptive Pills, Chapter 12).
Missed 3 or more pills in the third week?	• Take a hormonal pill as soon as possible. • Finish all hormonal pills in the pack. Throw away the 7 non-hormonal pills. • Start a new pack the next day. • Use a backup method for the next 7 days. • If sex in the past 5 days, can consider ECPs (see Chapter 12).
Missed any non-hormonal pills?	• Discard the missed non-hormonal pill(s). • Keep taking COCs, one each day. Start the new pack as usual.
Severe vomiting or diarrhoea	• If vomiting within 2 hours of taking a pill, take another pill from as soon as possible, then keep taking pills as usual. • If vomiting/diarrhoea for >2 days, follow instructions for >3 missed pills above.



Source: WHO, John Hopkins Bloomberg School of Public Health & USAID, 2011; *Family Planning: A Global Handbook for Providers: 2011 Update;* p. 373.

Helping Continuing Users - Managing Any Problems.

Problems reported as side effects or problems with use.
May or may not be due to the method.

- Side effects can influence satisfaction with COCs. If client reports side effects, listen to her concerns, give her advice, and, if appropriate, treat.
- Encourage pill-taking every day, even if side effects, to prevent unplanned pregnancy.
- Many side effects will subside after a few months of use, or choose another method.

Ordinary headaches (non-migrainous)

- Aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.
- If headaches during the hormone-free 7 days, consider extended use (see Extended and Continuous Use of Combined Oral Contraceptives text box below).
- Any headaches that get worse or occur more often during COC use should be evaluated.

Nausea or dizziness

- For nausea, suggest taking COCs at bedtime or with food.
- Consider locally available remedies for symptoms
- Consider extended use if her nausea comes after she starts a new pill pack (see Extended and Continuous Use of Combined Oral Contraceptives text box below).

Breast tenderness

- Recommend client wear a supportive bra (including during strenuous activity and sleep).
- Try hot or cold compresses or consider locally available remedies.
- Aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.

Mood changes or changes in sex drive

- If mood during the hormone-free 7 days, consider extended use (see Extended and Continuous Use of Combined Oral Contraceptives text box below).
- Clients who have serious mood changes such as major depression should be referred for care.

Acne

- If taking pills for more than a few months and acne persists, choose another method.

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

Unexplained vaginal bleeding (suggests condition not related to method) **or heavy or prolonged bleeding**

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

Starting treatment with anticonvulsants, rifampicin, rifabutin, or ritonavir

- Barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, rifabutin, and ritonavir may make COCs less effective. If using these medications long-term, choose different method.
- If using these medications short-term, use backup method for prevention of unplanned pregnancy.

Migraine headaches

- Regardless of her age, a woman who develops migraine headaches, with or without aura, or whose migraine headaches become worse while using COCs should stop using COCs.
- Help her choose a method without oestrogen.
-

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

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

Certain serious health conditions (suspected heart or serious liver disease, high blood pressure, blood clots in deep veins, stroke, breast cancer, damage to arteries, vision, kidneys, or nervous system caused by diabetes, or gall bladder disease).

- Stop taking COCs. Use backup method until the condition is evaluated.
- Refer for diagnosis and care if not already under care.

Suspected pregnancy

- Assess for pregnancy.
- Stop taking COCs if pregnancy is confirmed - no risks to foetus conceived while a woman is taking COCs (see Questions and Answers about COPs, Q5).

Questions and Answers about Combined Oral Contraceptives.

1. **Should a woman take a 'rest' from COCs after taking them for a long time?**
   No. A 'rest' is not helpful – this can lead to unplanned pregnancy. COCs can safely be used for many years without having to stop taking them periodically.

2. **If taking COCs for a long time, will a woman be protected from pregnancy after she stops?**
   No. A woman is protected only as long as she takes her pills regularly.

3. **How long does it take to become pregnant after stopping COCs?**

COCs do not delay the return of a woman's fertility after she stops taking them. Bleeding patterns return after stopping COCs. Some women may have to wait a few months before their usual bleeding pattern returns.

Extended and Continuous Use of Combined Oral Contraceptives

Extended use of COCs is when a woman takes hormonal pills for 12 weeks without a break, followed by one week of non-hormonal pills (or no pills). Continuous use means taking hormonal pills without any breaks at all. These variations can be used under advice from health workers.

Benefits of Extended and Continuous Use

- Women have vaginal bleeding only 4 times a year or not at all.
- Reduces frequency of headaches, premenstrual syndrome, mood changes, and heavy or painful bleeding during the week without hormonal pills.

Disadvantages of Extended and Continuous Use

- Irregular bleeding for up to 6 months–especially new COC users.

Extended Use Instructions

- Skip the last week of pills (without hormones) in 3 packs in a row. No backup method is needed during this time.
- Take all 4 weeks of pills in the 4th pack. Expect some bleeding during this 4th week.
- Start new pack the day after taking the last pill in the 4th pack.

Continuous Use Instructions

Take one hormonal pill every day for as long as client wishes to use COCs. If irregular bleeding occurs, stop taking pills for 3 or 4 days and then start taking hormonal pills continuously again.

4. **Do COCs cause abortion?**
   No. COCs do not disrupt an existing pregnancy - they should not be used to cause an abortion.

5. **Do COCs cause birth defects? Will the foetus be harmed if a woman accidentally takes COCs while she is pregnant?**
   No. COCs will not cause birth defects and will not otherwise harm the foetus if a woman becomes pregnant while taking COCs or accidentally starts to take COCs when she is already pregnant.

6. **Do COCs cause women to gain or lose a lot of weight?**
   No. Most women do not gain or lose weight due to COCs. Weight changes naturally as life circumstances change and as people age. Because these changes in weight are so common, many women think that COCs cause these gains or losses in weight.

7. **Do COCs change women's mood or sex drive?**
   Generally, no. Some women using COCs report these complaints, but majority of COC users do not report any such changes. COCs do not affect women's sexual behaviour.

8. **Must a woman have a pelvic examination before she can start COCs or at follow-up visits?**
   No. Instead, asking the right questions usually can help to make reasonably certain that a woman is not pregnant (see Annex 1: Pregnancy Checklist).

9. **Can women with varicose veins use COCs?**
   Yes. COCs are safe for women with varicose veins. Varicose veins are enlarged blood vessels close to the surface of the skin. A woman who has or has had deep vein thrombosis should not use COCs.

10. Can a woman safely take COCs throughout her life?
Yes. There is no minimum or maximum age for safe use of COCs.

11. Can women who smoke use COCs safely?
Women <35 who smoke can use low-dose COCs. Women >35 who smoke should choose a method without oestrogen. Older smokers can take the progestin-only pill if they prefer. Smoking should be discouraged.

12. What if a client wants to use COCs but it is not reasonably certain that she is not pregnant?
If pregnancy tests are not available, a woman can be given COCs to take home with instructions to begin their use within 5 days after the start of her next period. She should use a backup method until then.

13. Can COCs be used as emergency contraceptive pills (ECPs) after unprotected sex?
Yes. As soon as possible, but no more than 5 days after unprotected sex, a woman can take COCs as ECPs (see Emergency Contraceptive Pills, Chapter 12). Progestin-only pills, however, are more effective and cause fewer side effects such as nausea and stomach upset.

14. Is it important for a woman to take her COCs at the same time each day?
Yes, for 2 reasons. Some side effects may be reduced by taking the pill at the same time each day. Also, taking a pill at the same time each day can help women remember to take their pills more consistently.

11. Progestin-Only Pills

This chapter focuses on progestin-only pills for breastfeeding women. Women who are not breastfeeding also can use progestin-only pills. Guidance that differs for women who are not breastfeeding is noted.

What Are Progestin-Only Pills?
- Pills that contain low doses of a progestin like the natural hormone progesterone in a woman's body.
- Do not contain oestrogen, and so can be used by women who are breastfeeding, or who cannot use methods with oestrogen.
- Progestin-only pills (POPs) are also called 'minipills' and progestin-only oral contraceptives.
  - Work primarily by thickening cervical mucus (to block sperm from meeting an egg), and disrupting the menstrual cycle, including preventing the release of eggs from the ovaries (ovulation).

In Vanuatu, the most commonly available formulation of Progestin-Only Pills is:
- Microlut (Levonorgestrel 30 µg tablets)

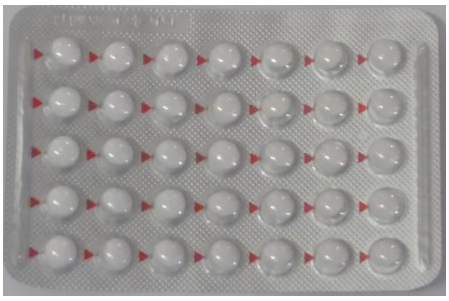
How Effective?
Effectiveness depends on the user: For women who have monthly bleeding, risk of pregnancy is greatest if pills are taken late or missed completely.

Why some women say they like Progestin-Only Pills.
- Can be used while breastfeeding.
- Can be stopped at any time without a provider's help.
- Do not interfere with sex.
- Are controlled by the woman.

Breastfeeding women:
- About 1 /100 women using POPs over the first year. This means that 99 of every 100 women will not become pregnant.
- When pills are taken every day, less than 1 pregnancy per 100 women using POPs over the first year (3 per 1,000 women).

Less effective for women not breastfeeding:
- As commonly used, about 3 to 10 pregnancies per 100 women using POPs over the first year. This means that 90-97 of every 100 women will not become pregnant.
- If no pill-taking mistakes: <1 pregnancy/100 women using POPs over the first year (9/1,000 women).

Return of fertility after POPs are stopped: No delay.
Protection against sexually transmitted infections (STIs): No protection; use condoms to prevent STIs.



Microlut (Levonorgestrel 30 µg tablets) is the most widely available POP in Vanuatu.

Correcting Misunderstandings about POPs *(see also Questions and Answers about POPs).*

- Do not cause a breastfeeding woman's milk to dry up.
- Must be taken every day, whether or not a woman has sex that day.
- Do not make women infertile.
- Do not cause diarrhoea in breastfeeding babies.
- Reduce the risk of ectopic pregnancy.

Side Effects, Health Benefits and Health Risks.

Side Effects *(see Managing Any Problems, below)*

Some users report the following:

- Changes in bleeding patterns including:
  - For breastfeeding women, longer delay in return of monthly bleeding after childbirth (lengthened postpartum amenorrhea)
  - Lighter bleeding and fewer days of bleeding
  - Frequent bleeding
  - Irregular bleeding
  - Infrequent bleeding
  - Prolonged bleeding
  - No monthly bleeding
- Headaches
- Dizziness
- Mood changes
- Breast tenderness
- Abdominal pain
- Nausea
- For women not breastfeeding, enlarged ovarian follicles

Known Health Benefits.

Help protect against:

- Risks of pregnancy

Known Health Risks.

None.

Medical Eligibility Criteria for

Progestin-Only Pills

Ask the client the questions below about known medical conditions. Examinations/tests not necessary. If she answers 'no' to all of the questions, then she can start POPs. If she answers 'yes' to a question, follow the instructions. In some cases she can still start POPs.

1. Are you breastfeeding a baby less than 6 weeks old?

❑ NO ❑ YES

Start taking POPs as soon as 6 weeks after childbirth. Give her POPs now and tell her when to start taking them (see When to Start below).

2. Do you have severe cirrhosis of the liver, a liver infection, or liver tumour? (Are her eyes or skin unusually yellow? [signs of jaundice])

❑ NO ❑ YES If she reports serious active liver disease (jaundice, severe cirrhosis, liver tumour), do not provide POPs. Help her choose a method without hormones.
3. Do you have a serious problem now with a blood clot in your legs or lungs? ❑ NO ❑ YES If she reports a current blood clot (not superficial clots), and she is not on anticoagulant therapy, do not provide POPs. Help her choose a method without hormones.
4. Are you taking medication for seizures? Are you taking rifampicin or rifabutin for tuberculosis or other illness? ❑ NO ❑ YES If taking barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, rifabutin, or ritonavir, do not use POPs. Choose another method (not COCs).
5. Do you have or have you ever had breast cancer? ❑ NO ❑ YES Do not provide POPs. Help her choose a method without hormones.
Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable, when relevant to the client.

Providing Progestin-Only Pills

When to Start

IMPORTANT: A woman can start using POPs any time if it is reasonably certain she is not pregnant (use Annex 1: Pregnancy Checklist). A client can be given POPs at any time and told when to start taking them.

Woman's Situation	When to Start
Fully or nearly fully breastfeeding	
Less than 6 months after giving birth	• If she gave birth <6 weeks ago, give her POPs and tell her to start taking them 6 weeks after giving birth. • If period has not returned, start POPs any time between 6 weeks and 6 months. No need for a backup method. • If period has returned, start POPs as advised for women having menstrual cycles (below).
More than 6 months after giving birth	• If period has not returned, start POPs any time it is reasonably certain she is not pregnant. She will need a backup method[23] for the first 2 days (if you cannot be reasonably certain, start taking POPs during her next period). • If her monthly bleeding has returned, she can start POPs as advised for women having menstrual cycles (below).
Partially breastfeeding	
Less than 6 weeks after giving birth	• Start taking POPs 6 weeks after giving birth. • Backup method until 6 weeks since giving birth if her period returns before this time.
More than 6 weeks after giving birth	• If period has not returned, start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days (if you cannot be reasonably certain, start taking POPs during her next period). • If her monthly bleeding has returned, she can start POPs as advised for women having menstrual cycles (see next page).
Not breastfeeding	
Less than 4 weeks after giving birth	• Start POPs at any time. No need for a backup method.
More than 4 weeks after giving birth	• If period has not returned, start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days (if you cannot be reasonably certain, start taking POPs during her next period).

[23] *Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.*

	• If her monthly bleeding has returned, she can start POPs as advised for women having menstrual cycles (see next page).
Switching from a hormonal method	• Immediately, if using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. • If switching from injectables, begin taking POPs when the repeat injection would have been given. No need for a backup method.
Having menstrual cycles or switching from a non-hormonal method	**Any time of the month** • If starting within 5 days after the start of period, no need for a backup method. • If >5 days after the start of period, start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days (if you cannot be reasonably certain, start taking POPs during her next period). • If switching from an IUCD, start POPs immediately (see Chapter 15, IUCD).
No monthly bleeding (not related to childbirth or breastfeeding)	• Start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking pills.
After miscarriage or abortion	• Immediately. If she is starting within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method. • If >7 days after first- or second trimester miscarriage or abortion, start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days (if you cannot be reasonably certain, start taking POPs during her next period).
After taking emergency contraceptive pills (ECPs)	Start POPs the day after finishing ECPs. Backup method for first 2 days - A new POP user should begin a new pill pack. - A continuing user who needed ECPs due to pill-taking errors can continue where she left off with her current pack.

Giving Advice on Side Effects	
IMPORTANT: Counselling about bleeding changes and other side effects is an important part of providing the method – it may be the most important help a woman needs to keep using the method.	
Describe the most common side effects	• Breastfeeding women normally do not have monthly bleeding for several months after giving birth. POPs lengthen this period of time. • Women not breastfeeding may have frequent or irregular bleeding for the first several months, followed by regular bleeding or continued irregular bleeding. • Headaches, dizziness, breast tenderness, and possibly other side effects.
Explain about these side effects	• Side effects are not signs of illness – they are common. • Usually become less or stop within the first few months of using POPs. Bleeding changes, however, usually persist.
Explain what to do in case of side effects	• Keep taking POPs to prevent unplanned pregnancy. • Try taking pills with food or at bedtime to help avoid nausea. • The client can come back for help if side effects bother her.

Explaining How to Use	
1. Give Pills	• Give as many packs as possible.
2. Explain pill pack	• Show which kind of pack - 28 pills or 35 pills. • Explain that all pills in POP packs are the same colour and all are active pills, containing a hormone that prevents pregnancy. • Show how to take the first pill from the pack and then how to follow the directions or arrows on the pack to take the rest of the pills.
3. Give key instruction	• **Take one pill each day** – until the pack is empty. • Link pill-taking to a daily activity to remember, e.g. cleaning teeth or meal time.

4. Explain starting next pack	• When one pack is finished, take the first pill from the next pack the following day.
5. Provide backup method and explain use	• A backup method may be required if pills are missed. • Backup methods include abstinence, male or female condoms, spermicides, and withdrawal. Spermicides and withdrawal are the least effective contraceptive methods. Give her condoms.
6. Explain that effectiveness decreases when breastfeeding stops	• Without additional protection from breastfeeding itself, POPs are not as effective as most other hormonal methods. • When breastfeeding ends, continue taking POPs if satisfied with the method, or change to another method.

Supporting the User	
Managing Missed Pills: POP users should know what to do if they forget to take pills. **If a woman is 3 or more hours late taking a pill (12 or more hours late taking a POP containing desogestrel 75 mg), or if she misses a pill completely, she should follow the instructions below.** For breastfeeding women, whether missing a pill places her at risk of pregnancy depends on whether or not her monthly bleeding has returned.	
Making Up Missed Progestin-Only Pills	
Key Message	• **Take a missed pill as soon as possible.** • Keep taking pills as usual, one each day (take 2 pills together to catch-up).
Do you have monthly bleeding regularly?	• If yes, she also should use a backup method for the next 2 days. • If she had sex in the past 5 days, can consider taking ECPs (see Chapter 12).
Severe vomiting or diarrhoea	• If vomiting within 2 hours of taking a pill, take another pill from as soon as possible, then keep taking pills as usual. • If her vomiting or diarrhoea continues, follow the instructions for making up missed pills above.

Helping Continuing Users - Managing Any Problems.

Problems reported as side effects or problems with use.

May or may not be due to the method.

- Side effects can influence satisfaction with POPs. If client reports side effects, listen to her concerns, give her advice, and, if appropriate, treat.
- Encourage pill-taking every day, even if side effects, to prevent unplanned pregnancy.
- Many side effects will subside after a few months of use, or choose another method.

No monthly bleeding

- Breastfeeding women; reassure that this is normal. It is not harmful.
- Women not breastfeeding; reassure that some POP users stop having monthly bleeding, and this is not harmful. The woman is not infertile. Blood is not building up inside her.

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

- Reassure that some POP users experience irregular bleeding–whether breastfeeding or not - breastfeeding itself also can cause irregular bleeding. It is not harmful and sometimes becomes less or stops after the first several months of use. Some women have irregular bleeding the entire time they are taking POPs.
- Other possible causes of irregular bleeding include vomiting or diarrhoea and taking anticonvulsants or rifampicin (see Starting treatment with anticonvulsants or rifampicin, above)
- To reduce irregular bleeding: make up for missed pills, including after vomiting or diarrhoea (see Managing Missed Pills, above).
- Short-term relief; 800 mg ibuprofen 3 times daily with meals for 5 days, once irregular bleeding starts.
- If irregular bleeding continues or starts after several months of normal or no monthly bleeding, consider underlying conditions unrelated to method use (see Unexplained vaginal bleeding, below).

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

- Reassure that some POP users experience heavy or prolonged bleeding. It is generally not harmful and usually becomes less or stops after a few months.
- Short-term relief; anti-inflammatories once irregular bleeding starts.
- If irregular bleeding continues or starts after several months of normal or no monthly bleeding, consider underlying conditions unrelated to method use (see Unexplained vaginal bleeding, below).
- To help prevent anaemia, take iron tablets and eat foods containing iron (meat and poultry, especially beef and chicken liver, fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).

Ordinary headaches (non-migrainous)

- Aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.

Breast tenderness

- Recommend client wear a supportive bra (including during strenuous activity and sleep).
- Try hot or cold compresses or consider locally available remedies.
- Aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.

Severe pain in lower abdomen

- Abdominal pain may be due to various problems, such as enlarged ovarian follicles or cysts.
  - A woman can continue to use POPs during evaluation and treatment.
  - No need to treat enlarged ovarian follicles or cysts unless they grow abnormally large, twist, or burst. Reassure that they usually disappear on their own; ask client to return in 6 weeks for review.
  - Be alert for signs or symptoms of ectopic pregnancy (abdominal pain or tenderness, abnormal vaginal bleeding or no monthly bleeding, light-headedness or dizziness, fainting). This is rare and not caused by POPs, but it can be life-threatening (see Managing Ectopic Pregnancy text box, Chapter 18).
- If ectopic pregnancy is suspected, refer at once for immediate diagnosis and care.

Nausea or dizziness

- For nausea, suggest taking POPs at bedtime or with food. Consider locally available remedies.

New Problems That May Require Switching Methods

May or may not be due to the method.

Unexplained vaginal bleeding (suggests condition not related to method) **or heavy or prolonged bleeding**

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

Starting treatment with anticonvulsants, rifampicin, rifabutin, or ritonavir

- Barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, rifabutin, and ritonavir may make POPs less effective. If using these medications long-term, choose different method.
- If using these medications short-term, use backup method for prevention of unplanned pregnancy.

Migraine headaches

- If she has migraine headaches without aura, she can continue to use POPs if she wishes.
- If she has migraine aura, stop POPs. Help her choose a method without hormones.

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

- Stop taking POPs. Backup method to use until the condition is evaluated.
- Refer for diagnosis and care if not already under care.

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

- A woman who has one of these conditions can safely start POPs. If condition develops after starting POPs, she should stop. Choose a method without hormones.
- Refer for diagnosis and care if not already under care.

Suspected pregnancy

- Assess for pregnancy, including ectopic pregnancy.
- Stop taking POPs if pregnancy is confirmed.
- No risk to foetus conceived while a woman is taking POPs (see Question and Answers about POPs, Q3).

Questions and Answers about Progestin-Only Pills.

1. **Can a woman who is breastfeeding safely use POPs?**
   Yes. This is a good choice for a breastfeeding mother who wants to use pills. POPs are safe for both mother and baby, starting as early as 6 weeks after giving birth. They do not affect milk production.

2. **What should a woman do when she stops breastfeeding her baby? Can she continue taking POPs?**
   POPs can continue, but she is less protected from pregnancy than when breastfeeding. She can switch to another method if she wishes.

3. **Do POPs cause birth defects? Will the foetus be harmed if a woman accidentally takes POPs while she is pregnant?**
   No. POPs do not cause birth defects and will not otherwise harm the foetus if a woman becomes pregnant while taking POPs or accidentally takes POPs when she is already pregnant.

4. **How long does it take to become pregnant after stopping POPs?**
   POPs do not delay the return of a woman's fertility after she stops taking them. Bleeding patterns return straight away or a few months after stopping POPs.

5. **If a woman does not have monthly bleeding while taking POPs, does this mean that she is pregnant?**
   Probably not, especially if she is breastfeeding. If she has been taking her pills every day, she is probably not pregnant and can keep taking her pills. A pregnancy test can confirm this.

6. **Must the POP be taken every day?**
   Yes. All of the pills in the pack contain the hormone that prevents pregnancy.

7. **Is it important for a woman to take her COCs at the same time each day?**
   Yes, for 2 reasons. Some side effects may be reduced by taking the pill at the same time each day. Also, taking a pill at the same time each day can help women remember to take their pills more consistently.

8. **Can POPs be used as emergency contraceptive pills (ECPs) after unprotected sex?**
   Yes. As soon as possible, but no more than 5 days after unprotected sex (see Chapter 12).

9. **Do POPs change women's mood or sex drive?**
   Generally, no. Some women using POPs report these complaints, but majority of POP users do not report any such changes. POPs do not affect women's sexual behaviour.

10. **What should be done if a POP user has an ovarian cyst?**
    Most cysts are not true cysts but fluid-filled structures in the ovary (follicles) that grow beyond the usual size in a normal menstrual cycle. They may cause abdominal pain, but they only require treatment if they grow abnormally large, twist, or burst. Follicles usually go away without treatment.

11. **Do POPs increase the risk of ectopic pregnancy?**

No. POPs reduce the risk of ectopic pregnancy. On the uncommon occasions that POPs fail and pregnancy occurs, 5 to 10 of every 100 of these pregnancies are ectopic. Thus, most pregnancies after POPs fail are not ectopic. Ectopic pregnancy can be life-threatening; providers should know that ectopic pregnancy is possible if POPs fail.

12. Emergency Contraceptive Pills

- Pills that contain a progestin alone, or a progestin and an oestrogen together–hormones like the natural hormones progesterone and oestrogen in a woman's body.
- Emergency contraceptive pills (ECPs) are sometimes called 'morning after' pills or post-coital contraceptives.
- Work by preventing or delaying the release of eggs from the ovaries (ovulation). They do not work if a woman is already pregnant (see Question and Answers about ECPs, Q1).

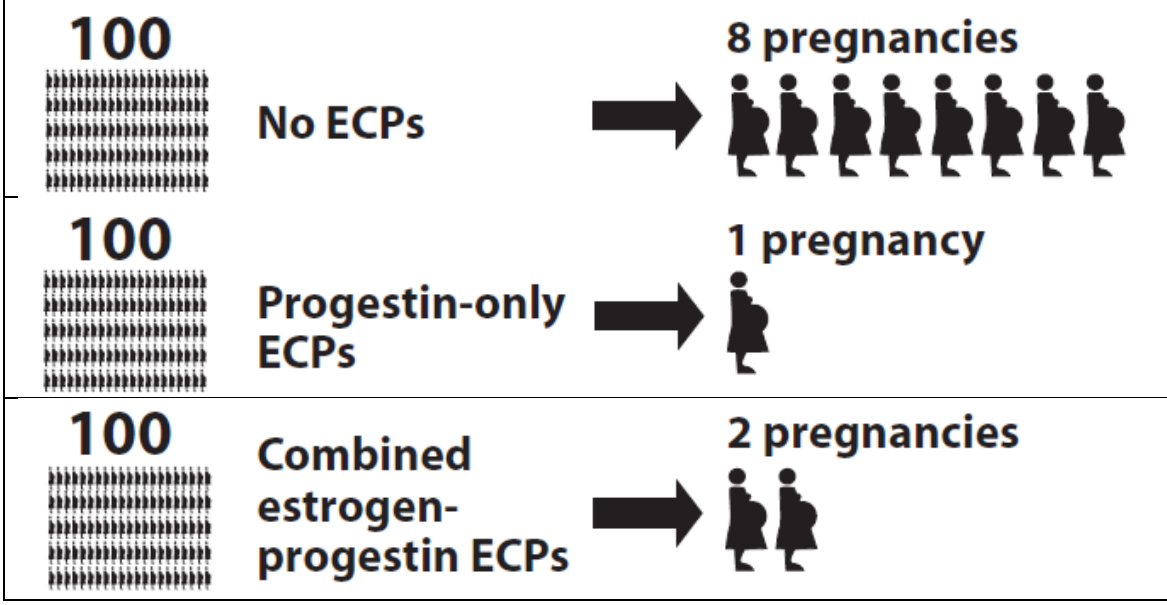
In Vanuatu, the most commonly available formulations of Emergency Contraceptive Pill are:
- Levonorgestrel-Richter (2 x 0.75mg tablets).
- Postinior (Levonorgestrel 1.5mg tablet).

When to Take Them?
- As soon as possible after unprotected sex. The sooner the better to prevent pregnancy.
- Can prevent pregnancy when taken any time up to 5 days after unprotected sex.

How Effective?
If 100 women each had sex once during the second or third week of the menstrual cycle without using contraception, 8 would likely become pregnant, however:
- If all 100 women used progestin-only ECPs, one would likely become pregnant.
- If all 100 women used oestrogen and progestin ECPs, 2 would likely become pregnant.

Effectiveness of Emergency Contraceptive Pills (ECPs)

If 100 women **each** had unprotected sex once during the second or third week of the menstrual cycle...



Source: Adapted from WHO, John Hopkins Bloomberg School of Public Health & USAID, 2011; *Family Planning: A Global Handbook for Providers: 2011 Update;* p. 46.

Levonorgestrel-Richter
(2 x 0.75mg tablets)

Return of fertility after taking ECPs: No delay. A woman can become pregnant immediately after taking ECPs. Taking ECPs prevents pregnancy only from acts of sex that took place in the 5 days before. They will not protect a woman from pregnancy from acts of sex after she takes ECPs—not even on the next day. To stay protected from pregnancy, women must begin to use another contraceptive method at once (see Planning Ongoing Contraception, below).

Protection against sexually transmitted infections (STIs): No protection; use condoms to prevent STIs.

Why some women say they like Emergency Contraceptive Pills.

- Offer a second chance at preventing pregnancy.
- Are controlled by the woman.
- Reduce seeking out abortion in the case of contraceptive errors or if contraception is not used.
- Can have on hand in case an emergency arises.

Side Effects, Health Benefits and Health Risks.

Side Effects *(see Managing Any Problems, below)*

- Changes in bleeding patterns including:
  - Slight irregular bleeding for 1–2 days after taking ECPs.
  - Monthly bleeding that starts earlier or later than expected.

In the week after taking ECPs:

- Nausea*
- Abdominal pain
- Fatigue
- Headaches
- Breast tenderness
- Dizziness
- Vomiting*

Known Health Benefits.

Help protect against:

- Risks of pregnancy

Known Health Risks.

None.

* *Women using progestin-only ECP formulations are much less likely to experience nausea and vomiting than women using oestrogen and progestin ECP formulations.*

Correcting Misunderstandings *(see also Questions and Answers about ECPs).*

Emergency Contraceptive Pills:

- Do not cause abortion.
- Do not cause birth defects if pregnancy occurs.
- Are not dangerous to a woman's health.
- Do not promote sexual risk-taking.
- Do not make women infertile.

Medical Eligibility Criteria for

Emergency Contraceptive Pills

All women can use ECPs safely and effectively, including women who cannot use ongoing hormonal contraceptive methods.

Because of the short-term nature of their use, there are no medical conditions that make ECPs unsafe for any woman.

Providing Emergency Contraceptive Pills

ECPs may be needed in many different situations. Women are more likely to use ECPs when needed if they already have them, and having them on hand enables women to take them as soon as possible after unprotected sex (so give a supply in advance).

When to Use

- Any time within 5 days after unprotected sex. The sooner after unprotected sex that ECPs are taken, the more effective they are.

ECPs Appropriate in Many Situations

ECPs can be used any time a woman is worried that she might become pregnant. For example, after:

- Sex was forced (rape) or coerced.
- Any unprotected sex.
- Contraceptive mistakes, such as:
  - Condom was used incorrectly, slipped, or broke.
  - Couple incorrectly used a fertility awareness method.
  - Man failed to withdraw, as intended, before ejaculation.
  - Woman has missed 3 or more COCs or has started a new pack 3 or more days late.

Dosing Information

Pill type	Total dosage to provide
Levonorgestrel only dedicated product	• 1.5 mg of levonorgestrel in a single dose.

Giving Emergency Contraceptive Pills	
1. Give Pills	• She can take them at once. • If she is using a 2-dose regimen, tell her to take the next dose in 12 hours.
2. Describe the most common side effects	• Nausea, abdominal pain, possibly others. • Slight bleeding or change in timing of monthly bleeding. • Side effects are not signs of illness.
3. Explain what to do about side effects	• Nausea; routine use of anti-nausea medications is not recommended. • Vomiting: if vomiting <2 hours after taking ECPs, take another dose. If vomiting continues, she can take the repeat dose by placing the pills high in her vagina. If vomiting >2 hours after taking ECPs, no need for extra pills.
4. Give more ECPs and help her start an ongoing method	• If possible, give more ECPs to take home in case she needs them. • See Planning Ongoing Contraception, below.

When to Start Contraception After ECP Use	
Method	**When to Start**
Combined oral contraceptives, progestin-only pills	Begin day after taking ECPs. No need to wait for next period. • Oral contraceptives: – New users should begin a new pill pack. – A continuing user who needed ECPs due to error can resume use as before. • Must use a backup method[24] for the first 7 days of using their method.
Progestin-only injectables	• Start progestin-only injectables on the same day as the ECPs, or if preferred, within 7 days after the start of period. Use a backup method for the first 7 days after injection.
Implants	• After period has returned. Use backup method, starting the day after ECPs.
Intrauterine contraceptive device (copper-bearing IUCDs)	• IUCD can be used for emergency contraception; a good option for a woman who wants IUCD as her long-term method (see Chapter 15, IUCD). • If she decides to use an IUCD after taking ECPs, the IUCD can be inserted on the same day she takes the ECPs. No need for a backup method.
Fertility awareness methods	• Standard Days Method: With the start of her next monthly bleeding. • Symptoms-based methods: Once normal secretions have returned. • Use backup method until she can begin the method of her choice.

[24] *Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.*

Helping Users - Managing Any Problems.

Problems reported as Side Effects or Method Failure.
May or may not be due to the method.

Slight irregular bleeding

- Irregular bleeding due to ECPs will stop without treatment.
- Assure the woman that this is not a sign of illness or pregnancy.

Change in timing of next monthly bleeding or suspected pregnancy.

- Monthly bleeding may start earlier or later than expected. This is not a sign of illness or pregnancy.
- If next monthly bleeding is >1 week later than expected after taking ECPs, assess for pregnancy. There are no risks to a foetus conceived if ECPs fail (see Questions and Answers about ECPs, Q2).

Questions and Answers about Emergency Contraceptive Pills.

1. **Do ECPs disrupt an existing pregnancy?**
   No. ECPs do not work if a woman is already pregnant. When taken before a woman has ovulated, ECPs prevent the release of an egg from the ovary or delay its release by 5 to 7 days. By then, any sperm in the woman's reproductive tract will have died, since sperm can survive there for only about 5 days.

2. **Do ECPs cause birth defects? Will the foetus be harmed if a woman accidentally takes ECPs while she is pregnant?**
   No. Good evidence shows that ECPs will not cause birth defects and will not otherwise harm the foetus if a woman is already pregnant when she takes ECPs or if ECPs fail to prevent pregnancy.

3. **How long do ECPs protect a woman from pregnancy?**
   A women who takes ECPs can become pregnant the next time she has unprotected sex without contraception. Another contraceptive method must commence at once to prevent unplanned pregnancy.

4. **What oral contraceptive pills can be used as ECPs?**
   Many COCs and POPs can be used as ECPs. Any pills containing the hormones used for emergency contraception - levonorgestrel, norgestrel, norethindrone, and these progestins together with oestrogen (ethinyl estradiol) - can be used.

5. **Is it safe to take 40 or 50 progestin-only pills as ECPs?**
   Yes. Progestin-only pills contain very small amounts of hormone. Thus, it is necessary to take many pills in order to receive the total ECP dose needed. In contrast, the ECP dosage with combined (0estrogen-progestin) oral contraceptives is generally only 2 to 5 pills in each of 2 doses 12 hours apart. Women should not take 40 or 50 combined (oestrogen-progestin) oral contraceptive pills as ECPs.

6. **If ECPs failed to prevent pregnancy, does a woman have a greater chance of that pregnancy being an ectopic pregnancy?**
   No. ECPs do not increase the risk of ectopic pregnancy.

7. **Should women use ECPs as a regular method of contraception?**
   No. Nearly all other contraceptive methods are more effective in preventing pregnancy. A woman who uses ECPs regularly for contraception is more likely to have an unintended pregnancy than a woman who uses another contraceptive regularly.

8. **If a woman buys ECPs over the counter, can she use them correctly?**
   Yes. Taking ECPs is simple, and medical supervision is not needed.

13. Progestin-Only Injectables

The injectable contraceptives depot medroxyprogesterone acetate (DMPA) contains a progestin like the natural hormone progesterone in a woman's body. These:

- Do not contain oestrogen; can be used throughout breastfeeding.
- Are given by intramuscular injection. The hormone is then released slowly into the bloodstream.
- Work primarily by preventing the release of eggs from the ovaries (ovulation).

In Vanuatu, the most commonly available formulation of Progestin-Only Injectables is:

- Depo-Provera (DMPA), medroxyprogesterone acetate 150 mg aqueous injection (commonly known as 'Depo' or 'the shot').

Why some women say they like Progestin-Only Injectables.

- Do not require daily action.
- Do not interfere with sex.
- Are private: No one else can tell that a woman is using contraception.
- Cause no monthly bleeding (for many women).

How Effective?

Effectiveness depends on getting injections regularly: Unplanned pregnancy results from missed injection.

- As commonly used, about 3 pregnancies per 100 women using progestin-only injectables over the first year. This means that 97 of every 100 women using injectables will not become pregnant.
- When women have injections on time, less than 1 pregnancy per 100 women using progestin-only injectables over the first year (3 per 1,000 women).

Return of fertility after injections are stopped: About 4 months after stopping DMPA (see Questions and Answers for Progestin-Only Injectables, Q7).

Protection against sexually transmitted infections (STIs): No protection; use condoms to prevent STIs.

Side Effects, Health Benefits and Health Risks.

Side Effects *(see Managing Any Problems, below).*

Some users report the following:

- First 3 months: (irregular/prolonged bleeding
- At one year: (no/ infrequent/irregular monthly bleeding)
- Weight gain (see Questions and Answers, Q4)
- Headaches
- Dizziness
- Abdominal bloating and discomfort
- Mood changes
- Less sex drive
- Loss of bone density (see Questions and Answers, Q10)

Known Health Risks.

None.

Known Health Benefits.

DMPA: Helps protect against:

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

May help protect against:

- Symptomatic pelvic inflammatory disease
- Iron-deficiency anaemia.

Reduces:

- Sickle cell crises among women with sickle cell anaemia
- Symptoms of endometriosis (pelvic pain, irregular bleeding).

NET-EN: Helps protect against:

- Risks of pregnancy
- Iron-deficiency anaemia.

Correcting Misunderstandings *(see also Questions and Answers about Progestin-Only Injectables).*
Progestin-Only Injectables:

- Can stop monthly bleeding, but this is not harmful. Blood is not building up inside the woman.
- Do not disrupt an existing pregnancy.
- Do not make women infertile.

Medical Eligibility Criteria for

Progestin-Only Injectables

Ask the client the questions below about known medical conditions. Examinations/tests not necessary. If she answers 'no' to all of the questions, then she can start Progestin-Only Injectables. If she answers 'yes' to a question, follow the instructions. In some cases she can still start Progestin-Only Injectables.

1. Are you breastfeeding a baby less than 6 weeks old?

❑ NO ❑ YES

Start taking Progestin-Only Injectables 6 weeks after childbirth (see When to Start below).

2. Do you have severe cirrhosis of the liver, a liver infection, or liver tumour? (Are her eyes or skin unusually yellow? [signs of jaundice])

❑ NO ❑ YES

If serious active liver disease (jaundice, severe cirrhosis, liver tumour), do not provide Progestin-Only Injectables. Choose a method without hormones.

3. Do you have high blood pressure?

❑ NO ❑ YES

If you cannot check blood pressure and she reports having high blood pressure in the past, provide Progestin-Only Injectables. Check her blood pressure if possible:

- If she is currently being treated for high blood pressure and it is adequately controlled, or her blood pressure is below 160/100 mm Hg, provide Progestin-Only Injectables.
- If systolic blood pressure is 160 mm Hg or higher or diastolic blood pressure 100 or higher, do not provide Progestin-Only Injectables. Help her choose another method without oestrogen.

4. Have you had diabetes for more than 20 years or damage to your arteries, vision, kidneys, or nervous system caused by diabetes?

❑ NO ❑ YES

Do not provide Progestin-Only Injectables. Choose another method without oestrogen.

5. Have you ever had a stroke, blood clot in your legs or lungs, heart attack, or other serious heart problems?

❑ NO ❑ YES

If history of heart attack, heart disease due to blocked or narrowed arteries, or stroke, do not provide Progestin-Only Injectables. Choose another method without oestrogen. If a blood clot in deep veins of leg or lungs and not on anticoagulant therapy, choose a method without hormones.

6. Do you have vaginal bleeding that is unusual for you?

❑ NO ❑ YES

If unexplained vaginal bleeding suggesting pregnancy or an underlying medical condition, Progestin-Only Injectables could make diagnosis and monitoring of treatment difficult. Choose a method to use while being evaluated/treated (not implants or IUCD).

7. Do you have or have you ever had breast cancer?

❑ NO ❑ YES

Do not provide Progestin-Only Injectables. Choose a method without hormones.

8. Do you have several conditions that could increase your chances of heart disease (coronary artery disease) or stroke, such as high blood pressure and diabetes?

❑ NO ❑ YES

Do not provide Progestin-Only Injectables. Choose a method without oestrogen.

Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable, when relevant to the client.

Providing Progestin-Only Injectables
When to Start

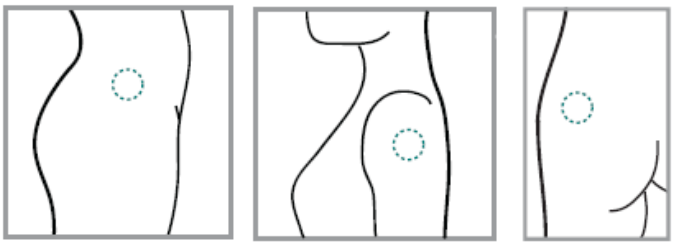
IMPORTANT: A woman can start using Progestin-Only Injectables any time she wants if it is reasonably certain she is not pregnant (use Annex 1: Pregnancy Checklist)

Woman's Situation	When to Start
Having menstrual cycles or switching from a non-hormonal method	• If starting within 7 days of start of period, no need for a backup method. • If >7 days after start of period, start Progestin-Only Injectables any time. Use a backup method[25] for 7 days after the injection. • If switching from IUCD, start Progestin-Only Injectables immediately (see Chapter 15).
Switching from a hormonal method	• Immediately, if it is otherwise reasonably certain she is not pregnant. No need for a backup method.
Fully or nearly fully breastfeeding	
Less than 6 months after giving birth	• Delay first injection until at least 6 weeks after giving birth. • If period has not returned, start injectables any time between 6 weeks and 6 months. No need for a backup method. • If period has returned, start injectables as advised for women having menstrual cycles (see previous page).
More than 6 months after giving birth	• If period has not returned, start injectables any time it is reasonably certain she is not pregnant. Use a backup method[26] for first 7 days after injection. • If period has returned, start injectables as advised for women having menstrual cycles (see above).
Partially breastfeeding	
Less than 6 weeks after giving birth	• Delay first injection until at least 6 weeks after giving birth (see Questions and Answers about Progestin-Only Injectables, Q8).
More than 6 weeks after giving birth	• If period has not returned, start injectables any time it is reasonably certain she is not pregnant. Use a backup method for first 7 days after injection. • If period has returned, start injectables as advised for women having menstrual cycles (see above).
Not breastfeeding	
Less than 4 weeks after giving birth	• Start injectables at any time. No need for a backup method.
More than 4 weeks after giving birth	• If period has not returned, start injectables any time it is reasonably certain she is not pregnant. Use a backup method for first 7 days after injection. • If period has returned, start injectables as advised for women having menstrual cycles (see above).
No monthly bleeding (not related to childbirth or breastfeeding)	• Start injectables any time it is reasonably certain she is not pregnant. Use a backup method for first 7 days after injection.
After miscarriage or abortion	• Immediately. If she is starting within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method. • If >7 days after first- or second trimester miscarriage or abortion, start injectables any time it is reasonably certain she is not pregnant. Use a backup method for the first 7 days after the injection.
After taking ECPs	• Start injectables same day as the ECPs, or within 7 days after the start of period. Use a backup method for the first 7 days after injection.

[25] *Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.*

[26] *As per [21].*

Giving Advice on Side Effects	
IMPORTANT: Counselling about bleeding changes and other side effects is an important part of providing the method – it may be the most important help a woman needs to keep using the method.	
Describe the most common side effects	• First several months; irregular/prolonged/frequent bleeding, then no period. • Weight gain (about 1–2 kg per year), headaches, and dizziness.
Explain about these side effects	• Side effects are not signs of illness – they are common.

Giving the Injection	
1. Obtain one dose of injectable, needle and syringe	• DMPA: 150 mg for injections into the muscle (intramuscular injection). • Use single-dose vials. Check expiration date. • DMPA: A 2 ml syringe and a 21–23 gauge intramuscular needle.
2. Wash	• Wash hands with soap and water. • If injection site dirty, wash with soap and water. Do not wipe with antiseptic.
3. Prepare vial	• DMPA: Gently shake the vial. • No need to wipe top of vial with antiseptic. • If vial is cold, warm to skin temperature before giving the injection.
4. Fill syringe	• Pierce top of vial with sterile needle and fill syringe with proper dose.
5. Inject formula	• Insert needle deep into the hip (ventrogluteal muscle), upper arm (deltoid muscle), or buttocks (gluteal muscle, upper outer portion). Inject contents. • Do not massage injection site. 
6. Dispose of disposable syringes and needles safely	• Do not recap, bend or break needles; place in sharps container. • Do not reuse disposable syringes and needles. They are meant to be destroyed after a single use.

Supporting the User	
Give specific instructions	• Must not massage injection site. • Agree on a date for her next injection.

Helping Continuing Users - Managing Any Problems.

Problems reported as side effects.

May or may not be due to the method.

- Side effects affect women's satisfaction and use of injectables. They deserve the provider's attention. If the client reports side effects or problems, listen to her concerns, give her advice, and, if appropriate, treat.

No monthly bleeding

- Reassure that Progestin-Only Injectables users stop having monthly bleeding over time, and this is not harmful. If this bothers her, choose another method.

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

- Reassure that Progestin-Only Injectables users experience irregular bleeding. It is not harmful and sometimes becomes less or stops after the first several months of use.

- Short-term relief; take 500 mg mefenamic acid 2 times daily after meals for 5 days or 40 mg of valdecoxib daily for 5 days, beginning when irregular bleeding starts.
- If irregular bleeding continues or starts after several months of normal or no monthly bleeding, consider underlying conditions unrelated to method use (see Unexplained vaginal bleeding, below).

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

- Reassure her that some women using Progestin-Only Injectables experience heavy or prolonged bleeding. It is not harmful and usually becomes less or stops after a few months.
- Short-term relief:
  - 500 mg of mefenamic acid twice daily after meals for 5 days.
  - 40 mg of valdecoxib daily for 5 days.
  - 50 µg of ethinyl oestradiol daily for 21 days, beginning when heavy bleeding starts.
- If bleeding becomes a health threat or if the woman wants, choose another method.
- To help prevent anaemia, take iron tablets and eat foods containing iron (meat and poultry, especially beef and chicken liver, fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).
- If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, consider underlying conditions unrelated to method use (see Unexplained vaginal bleeding, below).

Ordinary headaches (non-migrainous)

- Aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.

New Problems That May Require Switching Methods

May or may not be due to the method.

Migraine headaches

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

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

- Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate.
- If no apparent cause, stop Injectable to assist diagnosis. Use another method (not implants or IUCD)
- If bleeding is caused by STI or pelvic inflammatory disease, continue using Progestin-Only Injectables.

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

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

Suspected pregnancy

- Assess for pregnancy - stop injections if pregnancy is confirmed.
- No risk to foetus conceived while using injectables (see Question and Answers about Progestin-Only Injectables, Q11).

Questions and Answers about Progestin-Only Injectables.

1. **Can women who could get STIs use Progestin-Only Injectables?**
   Yes. Women at risk for STIs can use Progestin-Only Injectables; they should be encouraged to use condoms correctly every time they have sex.

2. **If a woman does not have monthly bleeding while using Progestin-Only Injectables, does this mean that she is pregnant?**

Probably not, especially if she is breastfeeding. Eventually most women using Progestin-Only Injectables will not have monthly bleeding.

3. **Can a woman who is breastfeeding safely use Progestin-Only Injectables?**
   Yes. Progestin-Only Injectables are safe for both the mother and the baby starting as early as 6 weeks after childbirth. They do not affect milk production.

4. **Does DMPA cause abortion?**
   No. Injectables should not be used to try to cause an abortion.

5. **Do Progestin-Only Injectables make a woman infertile?**
   No. There may be a delay in regaining fertility after stopping Progestin-Only Injectables, but in time the woman will be able to become pregnant as before.

6. **How long does it take to become pregnant after stopping DMPA?**
   Women who stop using DMPA wait about 4 months before becoming pregnant.

7. **Does DMPA cause cancer?**
   DMPA does not cause cancer; it helps protect against cancer of the lining of the uterus (endometrial cancer).

8. **How does DMPA affect bone density?**
   DMPA use decreases bone density, but does not lead to broken bones. When DMPA use stops, bone density increases again for women of reproductive age.

9. **Do Progestin-Only Injectables cause birth defects? Will the foetus be harmed if a woman accidentally uses Progestin-Only Injectables while she is pregnant?**
   No. Progestin-Only Injectables will not cause birth defects and will not otherwise harm the foetus if a woman becomes pregnant while using Progestin-Only Injectables.

10. **What if a woman returns for her next injection late?**
    Give a woman her next DMPA injection if she is up to 4 weeks late, without the need for further evidence that she is not pregnant. Some women return even later for their repeat injection, however. Whether a woman is late for reinjection or not, her next injection of DMPA should be planned for 3 months later, as usual.

14. Implants

- Small plastic rods or capsules that release a progestin (like the natural hormone progesterone) into body.
- A trained provider performs minor surgical procedure to place implants under the skin on upper arm.
- These do not contain oestrogen; can be used whilst breastfeeding.
- Work primarily by:
  - Thickening cervical mucus (this blocks sperm from meeting an egg).
  - Disrupting the menstrual cycle, including preventing the release of eggs from the ovaries (ovulation).

In Vanuatu, the most commonly available implants are:

- Jadelle (levonorgestrel-releasing implant 75 mg): 2 rods, effective for 5 years).

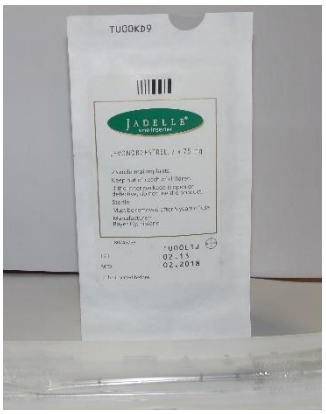
Why some women say they like Implants.

- Do not require the user to do anything once they are inserted.
- Prevent pregnancy very effectively.
- Are long-lasting.
- Do not interfere with sex.

How Effective?

One of the most effective and long-lasting methods:

- Less than 1 pregnancy per 100 women using implants over the first year (5 per 10,000 women). This means that 9,995 of every 10,000 women using implants will not become pregnant.
  - A small risk of pregnancy remains beyond the first year of use and continues as long as the woman is using implants (over 5 years of Jadelle use: About 1 pregnancy per 100 women).
  - Jadelle implants start to lose effectiveness sooner for women weighing >80 kg. Users may want to replace implants every 4 years (see Questions and Answers about Implants, Q9).



Jadelle with applicator

Return of fertility after POPs are stopped: No delay.

Protection against sexually transmitted infections (STIs): No protection; use condoms to prevent STIs.

Side Effects, Health Benefits and Health Risks and Complications.

Side Effects *(see Managing Any Problems)*

- Changes in bleeding patterns including:
  - Lighter bleeding and fewer days of bleeding
  - Irregular/infrequent bleeding
  - No monthly bleeding (usually first several months only)
- Headaches
- Abdominal pain
- Acne (can improve or worsen)
- Weight change
- Breast tenderness
- Dizziness
- Mood changes
- Nausea
- Enlarged ovarian follicles

Known Health Benefits.

Help protect against:

- Risks of pregnancy
- Symptomatic pelvic inflammatory disease

May help protect against:

- Iron-deficiency anaemia

Known Health Risks.

None.

Complications

Uncommon:

- Infection at insertion site (most occur in first 2 months)
- Difficult removal (rare if skilled provider)

Rare:

- Expulsion of implant (usually in first 4 months after insertion)

Correcting Misunderstandings *(see also Questions and Answers about Implants).*

- Stop working once they are removed; hormones do not remain in a woman's body.
- Can stop monthly bleeding, but this is not harmful.
- Do not make women infertile.
- Do not move to other parts of the body.
- Substantially reduce the risk of ectopic pregnancy.

Medical Eligibility Criteria for

Implants

Ask the client the questions below about known medical conditions. Examinations/tests not necessary. If she answers 'no' to all of the questions, then she can start COCs. If she answers 'yes' to a question, follow the instructions. In some cases she can still start COCs.

1. Are you breastfeeding a baby less than 6 weeks old?

❑ NO ❑ YES

She can start using implants as soon as 6 weeks after childbirth (see When to Start below).

2. Do you have severe cirrhosis of the liver, a liver infection, or liver tumour? (Are her eyes or skin unusually yellow? [signs of jaundice])

❑ NO ❑ YES

If serious active liver disease (jaundice, severe cirrhosis, liver tumour), do not provide implants. Choose a method without hormones.
3. Do you have a serious problem now with a blood clot in your legs or lungs? ❑ NO ❑ YES If a current deep blood clot, and not on anticoagulant therapy, do not provide implants. Choose a method without hormones.
4. Do you have vaginal bleeding that is unusual for you? ❑ NO ❑ YES If unexplained vaginal bleeding that suggests pregnancy or medical condition, implants make diagnosis and treatment more difficult. Choose a method to use while being evaluated/treated (not Progestin-Only Injectables or IUCD).
5. Do you have or have you ever had breast cancer? ❑ NO ❑ YES Do not provide implants. Choose a method without hormones.
Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable, when relevant to the client.

Providing Implants

When to Start

IMPORTANT: A woman can start using implants any time she wants if it is reasonably certain she is not pregnant (use Annex 1: Pregnancy Checklist).

Woman's Situation	When to Start
Having menstrual cycles or switching from a non-hormonal method	**Any time of the month** • If starting within 7 days after the start of period, no need for backup method. • If >7 days after the start period, start implants any time it is reasonably certain she is not pregnant. She will need a backup method[27] for the first 7 days. • If switching from an IUCD, start implants immediately (see Chapter 17).
Switching from a hormonal method	• Immediately, if certain she is not pregnant. No need for backup method. • If switching from injectables, insert implants when the repeat injection due. No need for a backup method.
Fully or nearly fully breastfeeding	
Less than 6 months after giving birth	• If birth >6 weeks ago, delay insertion until 6 weeks after birth (see Questions and Answers about Implants, Q8). • If period has not returned, insert implants any time between 6 weeks and 6 months. No need for a backup method. • If period has returned, insert implants as advised for women having menstrual cycles (see above).
More than 6 months after giving birth	• If period has not returned, insert implants any time it is reasonably certain she is not pregnant. Use backup method for first 7 days after insertion. • If period has returned, insert implants as advised for women having menstrual cycles (see above).
Partially breastfeeding	
Less than 6 weeks after giving birth	• Delay insertion until at least 6 weeks after giving birth (see Questions and Answers about Implants, Q8).
More than 6 weeks after giving birth	• If period has not returned, insert implants any time it is reasonably certain she is not pregnant. Use backup method for first 7 days after insertion. • If period has returned, insert implants as advised for women having menstrual cycles (see above).
Not breastfeeding	

[27] *Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.*

Less than 4 weeks after giving birth	• She can have implants at any time. No need for a backup method.
More than 4 weeks after giving birth	• If period has not returned, insert implants any time it is reasonably certain she is not pregnant. Use backup method for first 7 days. • If period has returned, insert implants as advised for women having menstrual cycles (see above).
No monthly bleeding (not related to childbirth or breastfeeding)	• She can have insertions any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion.
After miscarriage or abortion	• Immediately. If implants are inserted within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method. • If >7 days after first- or second-trimester miscarriage or abortion, insert implants any time it is reasonably certain she is not pregnant. Use backup method for the first 7 days after insertion.
After taking ECPs	• Insert implants within 7 days after the start of period or any other time it is reasonably certain she is not pregnant. Use backup method day after taking ECPs, until implants are inserted.

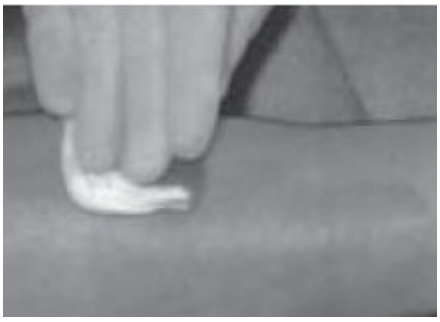
Giving Advice on Side Effects	
IMPORTANT: Counselling about bleeding changes and other side effects is an important part of providing the method – it may be the most important help a woman needs to keep using the method.	
Describe the most common side effects	• Changes in her bleeding pattern: – Irregular bleeding that lasts more than 8 days at a time over the first year. – Regular, infrequent, or no bleeding at all later. • Headaches, abdominal pain, breast tenderness.
Explain about these side effects	• Side effects are not signs of illness – they are common. • Side effects usually reduce/stop within the first year.

Inserting Implants.

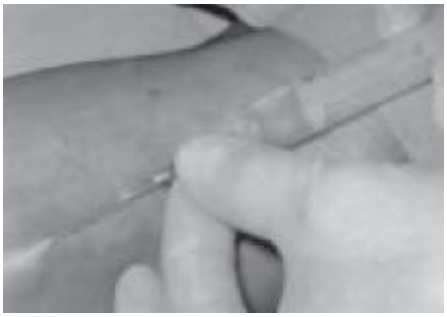
Explaining the Insertion Procedure for Jadelle and Norplant[28]

A woman who has chosen implants needs to know what will happen during insertion. The following description can help explain the procedure to her. Learning to insert and remove implants requires training and practice under direct supervision. Therefore, this description is a summary and not detailed instructions.

Inserting implants usually takes only a few minutes but can sometimes take longer, depending on the skill of the provider. Related complications are rare and also depend on the skill of the provider.

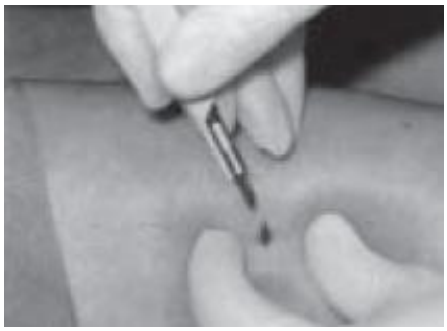


1. The provider uses proper infection-prevention procedures.

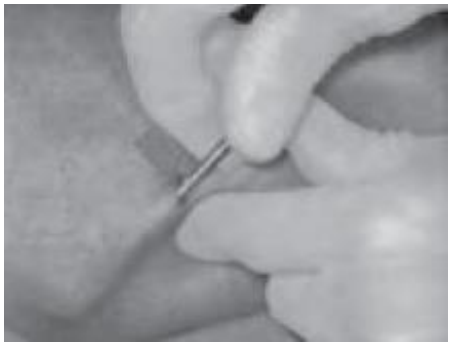


[28] All images sourced from: WHO et al., 2011 op cit.

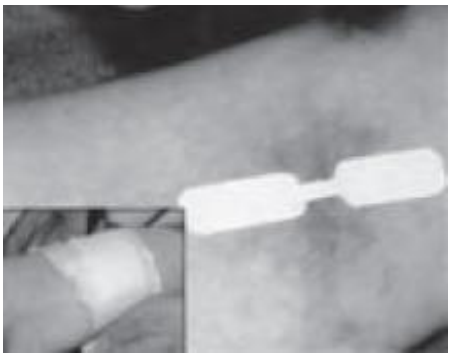
2. The woman receives an injection of local anaesthetic under the skin of her arm to prevent pain while the implants are being inserted. This injection may sting. She stays fully awake throughout the procedure.



3. The provider makes a small incision in the skin on the inside of the upper arm.



4. The provider inserts the implants just under the skin. The woman may feel some pressure or tugging.



5. After all implants are inserted, the provider closes the incision with an adhesive bandage. Stitches are not needed. The incision is covered with a dry cloth and the arm is wrapped with gauze.

Removing Implants.

IMPORTANT: Providers must not refuse or delay when a woman requests implants to be removed, whatever her reason (personal or medical). A woman must not be pressured or forced to continue using implants.

Explaining the Removal Procedure[29]

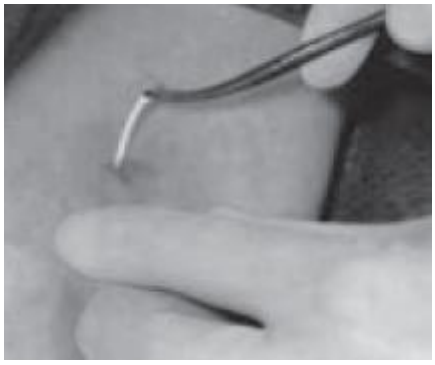
A woman needs to know what will happen during removal. The following description can help explain the procedure to her. The same removal procedure is used for all types of implants.

1. The provider uses proper infection-prevention procedures.

2. The woman receives an injection of local anaesthetic under the skin of her arm to prevent pain during implant removal. This injection may sting. She stays fully awake throughout the procedure.

3. The health care provider makes a small incision in the skin on the inside of the upper arm, near the site of insertion.

[29] All images sourced from: WHO et al., 2011 op cit.

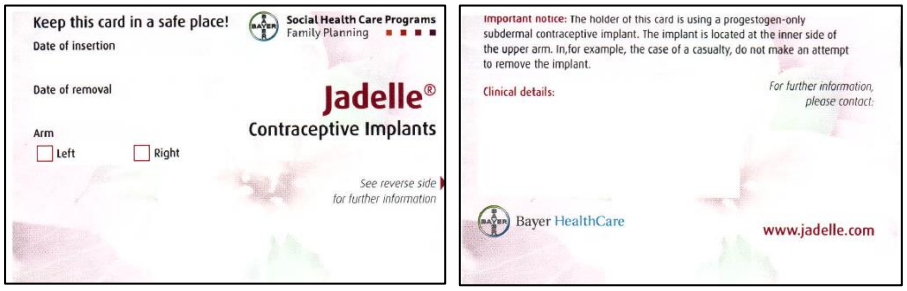


4. The provider uses an instrument to pull out each implant. A woman may feel tugging, slight pain, or soreness during the procedure and for a few days after.

5. The provider closes the incision with an adhesive bandage. Stitches are not needed. An elastic bandage may be placed over the adhesive bandage to apply gentle pressure for 2 or 3 days and keep down swelling.

If a woman wants new implants, they are placed above or below the site of the previous implants or in the other arm.

Supporting the User	
Giving Specific Instructions	
Keep arm dry	• Keep the insertion area dry for 4 days. Take off elastic bandage or gauze after 2 days and the adhesive bandage after 5 days.
Expect soreness, bruising	• After the anaesthetic wears off, arm may be sore for a few days (may be swelling/bruising at insertion site which will go away without treatment).
Length of pregnancy protection	• Discuss how to remember the date to return. • Provide information in writing on a reminder card (provided with the implant) – The type of implant she has. – Date of insertion. – Month and year when implants will need to be removed or replaced. – Where to go if she has problems or questions with her implants.
Have implants removed before they lose effectiveness	• Return before implants lose effectiveness (for removal or replacement).



Jadelle return date reminder card (front and back)

Helping Continuing Users - Managing Any Problems.

Problems reported as side effects or problems with use.

May or may not be due to the method.

- Problems with side effects affect women's satisfaction and use of implants. They deserve the provider's attention. If the client reports side effects or problems, listen to her concerns, give her advice, and, if appropriate, treat.
- Offer to help the client choose another method - now, if she wishes, or if problems cannot be overcome.

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

- Reassure that implant users experience irregular bleeding. It is not harmful and sometimes becomes less or stops after the first several months of use.
- Short-term relief; take 800 mg ibuprofen or 500 mg mefenamic acid 3 times daily after meals for 5 days or 40 mg of valdecoxib daily for 5 days, beginning when irregular bleeding starts.
- If these drugs do not help her, try:
  – Combined oral contraceptives with the progestin levonorgestrel. Ask her to take one pill daily for 21 days.
  – 50 µg ethinyl estradiol daily for 21 days.
- If irregular bleeding continues or starts after several months after normal or no monthly bleeding, consider underlying conditions unrelated to method use (see Unexplained vaginal bleeding, below).

No monthly bleeding

- Reassure that some implant users stop having monthly bleeding over time, and this is not harmful. If this bothers her, choose another method.

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

- Reassure her that some women using implants experience heavy or prolonged bleeding. It is not harmful and usually becomes less or stops after a few months.
- Short-term relief, try any of the treatments for irregular bleeding, above. COCs with 50 µg of ethinyl estradiol may work better than lower-dose pills.
- To help prevent anaemia, take iron tablets and eat foods containing iron (meat and poultry, especially beef and chicken liver, fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).
- If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, consider underlying conditions unrelated to method use (see Unexplained vaginal bleeding, below).

Ordinary headaches (non-migrainous)

- Aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.

Mild abdominal pain

- Aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.

Acne

- Consider switching to COCs. Many women's acne improves with COC use.

Breast tenderness

- Wear a supportive bra (including during strenuous activity and sleep).
- Try hot or cold compresses or consider locally available remedies.
- Aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.

Pain after insertion or removal

- For pain after insertion, check that the bandage or gauze on her arm is not too tight.
- Put a new bandage on the arm and advise her to avoid pressing on the site for a few days.
- Aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.

Infection at the insertion site (redness, heat, pain, pus)

- Do not remove implants.
- Clean the infected area with soap and water or antiseptic.
- Give oral antibiotics for 7 to 10 days.
- Return after taking all antibiotics if the infection does not clear - remove the implants or refer for removal.
- Expulsion or partial expulsion often follows infection. Ask client to return if implant coming out.

Abscess (pocket of pus under the skin due to infection)

- Clean the area with antiseptic.
- Cut open (incise) and drain the abscess. Treat the wound.
- Give oral antibiotics for 7 to 10 days.

- Return after taking all antibiotics if heat, redness, pain, or drainage of the wound. If infection is present, remove the implants or refer for removal.

Expulsion (when one or more implants begins to come out of the arm)

- Rare. Usually occurs within a few months of insertion or with infection.
- If no infection, replace expelled implant through a new incision near the other implants.

Severe pain in lower abdomen

- Abdominal pain may be due to various problems, such as enlarged ovarian follicles or cysts.
  - A woman can continue to use implants during evaluation.
  - No need to treat enlarged ovarian follicles or cysts unless they grow abnormally large, twist, or burst. Reassure that they usually disappear on their own; ask client to return in 6 weeks for review.
- Be alert for signs or symptoms of ectopic pregnancy (abdominal pain or tenderness, abnormal vaginal bleeding or no monthly bleeding, light-headedness or dizziness, fainting). This is rare and not caused by implants, but it can be life-threatening (see Questions and Answers about Implants, Q7).
- If ectopic pregnancy is suspected, refer at once for immediate diagnosis and care.

New Problems That May Require Switching Methods

May or may not be due to the method.

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

- Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate.
- If no apparent cause, stop implants to assist diagnosis. Use another method (not Progestin-Only Injectables or IUCD)
- If bleeding is caused by STI or pelvic inflammatory disease, continue using implants during treatment.

Migraine headaches

- If she has migraine headaches without aura, she can continue to use implants if she wishes.
- If she has migraine aura, remove the implants. Help her choose a method without hormones.

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

- Remove the implants or refer for removal.
- Use backup method to use until the condition is evaluated.
- Refer for diagnosis and care if not already under care.

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

- If one of these conditions, can safely start implants. If condition develops while she is using implants:
  - Remove the implants or refer for removal.
  - Choose a method without hormones.
  - Refer for diagnosis and care if not already under care.

Suspected pregnancy

- Assess for pregnancy, including ectopic pregnancy.
- Remove the implants or refer for removal if she intends to carry the pregnancy to term.
- No risk to foetus conceived while using implants (see Question and Answers about Implants, Q5).

Questions and Answers about Implants.

1. **Do users of implants require follow-up visits?**
   No. Routine periodic visits are not required, but women are welcome to return at any time with questions.

2. **Can implants be left permanently in a woman's arm?**

Leaving the implants in place beyond their effective lifespan is not recommended. The implants themselves are not dangerous, but as the hormone levels in the implants drop, they become less and less effective.

3. **Do implants cause cancer?**
   No. There is no increased risk of any cancer with use of implants.

4. **How long does it take to become pregnant after the implants are removed?**
   Implants do not delay the return of a woman's fertility after they are removed. Some women may have to wait a few months before their usual bleeding pattern returns.

5. **Do implants cause birth defects? Will the foetus be harmed if a woman accidentally becomes pregnant with implants in place?**
   No. Implants will not cause birth defects and will not otherwise harm the foetus if a woman becomes pregnant while using implants.

6. **Can implants move around within a woman's body or come out of her arm?**
   Implants do not move around in a woman's body. The implants remain where they are inserted until they are removed.

7. **Do implants increase the risk of ectopic pregnancy?**
   No. Implants greatly reduce the risk of ectopic pregnancy.

8. **Should heavy women avoid implants?**
   No. These women should know, however, that they need to have Jadelle implants replaced sooner to maintain a high level of protection from pregnancy.

9. **What should be done if an implant user has an ovarian cyst?**
   The great majority of cysts are not true cysts but actually fluid-filled structures in the ovary (follicles) that continue to grow beyond the usual size in a normal menstrual cycle. They may cause some mild abdominal pain, but they only require treatment if they grow abnormally large, twist, or burst. These follicles usually go away without treatment.

10. **Can a woman work soon after having implants inserted?**
    Yes, a woman can do her usual work immediately after leaving the clinic as long as she does not bump the insertion site or get it wet.

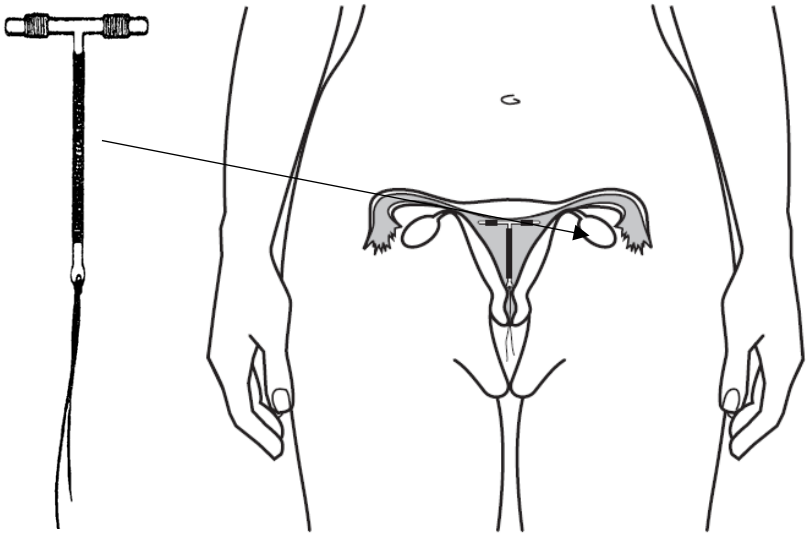
11. **Must a woman have a pelvic examination before she can have implants inserted?**
    No. Asking the right questions can help a provider be reasonably certain she is not pregnant (see Annex 1: Pregnancy Checklist). No condition that can be detected by a pelvic examination rules out use of implants.

15. Copper-Bearing Intrauterine Contraceptive Device.

- The copper-bearing intrauterine contraceptive device (IUCD) is a small, flexible plastic frame with copper sleeves or wire around it. It is inserted it into a woman's uterus through her vagina and cervix.
- IUCDs have one or two strings (threads); these hang through the cervix into the vagina.
- Works primarily by causing a chemical change that damages sperm and egg before they can meet.

In Vanuatu, the most commonly available IUCD is:

- Copper T (TCu-380A).



How Effective?

One of the most effective and long-lasting methods:

- Less than 1 pregnancy per 100 women using an IUCD over the first year (6 to 8 per 1,000 women). This means that 992 to 994 of every 1,000 women using IUCDs will not become pregnant.
- A small risk of pregnancy remains beyond the first year of use and continues as long as the woman is using the IUCD.
  - Over 10 years of IUCD use: About 2 pregnancies per 100 women

Return of fertility after POPs are stopped: No delay.
Protection against sexually transmitted infections (STIs): No protection; use condoms to prevent STIs.

Why some women say they like IUCDs.

- Prevents pregnancy very effectively
- Is long-lasting
- Has no further costs after the IUCD is inserted
- Does not require the user to do anything once the IUCD is inserted

Correcting Misunderstandings *(see also Questions and Answers about IUCDs).*
IUCDs:

- Rarely lead to PID.
- Do not increase the risk of contracting STIs, including HIV.
- Do not increase the risk of miscarriage when a woman becomes pregnant after the IUCD is removed.
- Do not make women infertile.
- Do not cause birth defects.
- Do not cause cancer.
- Do not move to the heart or brain.
- Do not cause discomfort or pain for the woman during sex.
- Substantially reduce the risk of ectopic pregnancy.

Side Effects, Health Benefits, Health Risks and Complications

Side Effects

(see Managing Any Problems, below)

- Changes in bleeding patterns (especially in the first 3-6 months) including:
  - Prolonged and heavy monthly bleeding
  - Irregular bleeding
  - More cramps and pain during monthly bleeding

Known Health Benefits.

Helps protect against:

- Risks of pregnancy

May help protect against:

- Cancer of the lining of the uterus (endometrial cancer)

Known Health Risks.

Uncommon:

- May contribute to anaemia if already low iron blood stores before insertion and if IUCD causes heavier monthly bleeding

Rare:

- PID may occur if chlamydia or gonorrhoea at the time of IUCD insertion

Complications.

Rare:

- Puncturing (perforation) of wall of uterus by IUCD or an instrument used for insertion. Usually heals without treatment.
- Miscarriage, preterm birth, or infection in rare case that the woman becomes pregnant with IUCD

Medical Eligibility Criteria for

Copper-Bearing IUCDs

Ask the client the questions below about known medical conditions. If she answers 'no' to all of the questions, then she can have an IUCD inserted If she answers 'yes' to a question, follow the instructions. In some cases she can still have an IUCD inserted.

1. Did you give birth more than 48 hours ago but less than 4 weeks ago?

❑ NO ❑ YES

Delay inserting an IUCD until 4 or more weeks after childbirth (see When to Start).

2. Do you have an infection following childbirth or abortion?

❑ NO ❑ YES

If infection of the reproductive organs during the first 6 weeks after childbirth (puerperal sepsis) or abortion-related infection in the uterus (septic abortion), do not insert the IUCD. Treat or refer. Choose another method or offer a backup method[30]. After treatment, re-evaluate for IUCD use.

3. Do you have vaginal bleeding that is unusual for you?

❑ NO ❑ YES

If unexplained vaginal bleeding that suggests pregnancy or medical condition, IUCD could make diagnosis and monitoring of treatment difficult. Choose a method to use while being evaluated/ treated (not Progestin-Only Injectables or implants). After treatment, re-evaluate for IUCD use.

4. Do you have any female conditions or problems (gynaecologic or obstetric conditions or problems), such as genital cancer or pelvic tuberculosis? If so, what problems?

❑ NO ❑ YES

Known cervical, endometrial, or ovarian cancer; gestational trophoblast disease; pelvic tuberculosis: Do not insert IUCD. Treat or refer for care. Choose another method.

5. Do you have AIDS?

❑ NO ❑ YES

Do not insert an IUCD unless client is clinically well on antiretroviral therapy. If infected with HIV but does not have AIDS, can use IUCD. If a woman who has an IUCD in place develops AIDS, she can keep the IUCD.

6. Assess whether she is at very high individual risk for gonorrhoea or chlamydia.

Women who have a very high individual likelihood of exposure to gonorrhoea or chlamydia should not have an IUCD inserted (see Assessing Women for Risk of STI, below).

[30] *Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.*

7. Assess whether the client might be pregnant.
Ask client questions in the pregnancy checklist (Annex 1). If she answers 'yes' to any question, she can have an IUCD inserted (see also When to Start, below).

Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable, when relevant to the client.

Assessing Women for Risk of STIs

A woman who has gonorrhoea or chlamydia now should not have an IUCD inserted, as these increase risk of PID. These STIs may be difficult to diagnose clinically, however, and reliable laboratory tests are often unavailable. Without clinical signs or symptoms, or laboratory testing, a woman's behaviour or situation might provide the only indication of risk of infection. If this risk is high, she generally should not have an IUCD inserted.

Note: In contrast, if a current IUCD user's situation changes and she finds herself at very high individual risk for gonorrhoea or chlamydia, she can keep using her IUCD.

Note: Local STI prevalence rates are not a basis for judging individual risk.

There is no universal set of questions that will determine an individual's risk for gonorrhoea and chlamydia. Instead of asking questions, providers can discuss with the client the personal behaviours and the situations in their community that are most likely to expose women to STIs.

Steps to take:

1. Tell client that a woman who faces a high individual risk of some STIs usually should not have an IUCD inserted.
2. Ask client to consider her own risk and to think about whether she might have an STI.

   Note: If reliable testing for gonorrhoea and chlamydia is available, a woman who tests negative can have an IUCD inserted. A woman who tests positive can have an IUCD inserted as soon as she finishes treatment.

   Client does not have to tell provider about her or her partner's behaviour. Providers can explain situations that may place a woman at high risk, and the client can indicate if such situations occurred recently.

   Possibly risky situations include:

   - A sexual partner has STI symptoms such as pus coming from his penis, pain or burning during urination, or an open sore in the genital area.
   - She or a sexual partner was diagnosed with an STI recently.
   - She has had more than one sexual partner recently.
   - She has a sexual partner who has had other partners recently.

   All of these situations pose less risk if a woman or her partner uses condoms consistently and correctly.

3. Ask if client thinks she is a good candidate for an IUCD or would like to consider other contraceptive methods. If, after considering her individual risk, she thinks she is a good candidate, and she is eligible, provide her with an IUCD. If she wants to consider other methods or if you have strong reason to believe that the client is at very high individual risk of infection, help her choose another method.

Screening Questions for Pelvic Examination Before IUCD Insertion
When performing pelvic examination, asking yourself the questions below helps you check for signs of conditions that would rule out IUCD insertion. If the answer to all of the questions is 'no', then the client can have an IUCD inserted. If the answer to any question is 'yes', do not insert an IUCD.
For questions 1 - 5, if the answer is 'yes', refer for diagnosis and treatment as appropriate. Choose another method and counsel for condom use if risk of STIs. Give condoms. If STI or PID is confirmed and client still wants IUCD, it may be inserted as soon as treatment finishes, if not at risk for reinfection before insertion.

1. Is there any type of ulcer on the vulva, vagina, or cervix?
❑ NO ❑ YES
Possible STI.

2. Does the client feel pain in her lower abdomen when you move the cervix?
❑ NO ❑ YES
Possible PID.

3. Is there tenderness in the uterus, ovaries, or fallopian tubes (adnexal tenderness)?
❑ NO ❑ YES
Possible PID.

4. Is there a purulent cervical discharge? ❑ NO ❑ YES Possible STI or PID.
5. Does the cervix bleed easily when touched? ❑ NO ❑ YES Possible STI or cervical cancer.
6. Is there an anatomical abnormality of the uterine cavity that will prevent correct IUCD insertion? ❑ NO ❑ YES If an anatomical abnormality distorts the uterine cavity, proper IUCD placement may not be possible. Choose another method.
7. Were you unable to determine the size and/or position of the uterus? ❑ NO ❑ YES Determining the size and position of the uterus before IUCD insertion is essential to ensure high placement of the IUCD and to minimize risk of perforation. If size and position cannot be determined, do not insert an IUCD. Choose another method.

Providing IUCDs

When to Start

IMPORTANT: In many cases a woman can start the IUCD any time it is reasonably certain she is not pregnant. To be reasonably certain she is not pregnant, use Annex 1: Pregnancy Checklist.

Woman's Situation	When to Start
Having menstrual cycles	**Any time of the month** • If starting within 12 days after the start of period, no need for backup method. • If >12 days after the start of period, can have IUCD inserted any time it is reasonably certain she is not pregnant. No need for a backup method.
Switching from another method	• Immediately, if she has been using the method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method[31]. • If switching from injectables, can have IUCD inserted when the next injection would have been given. No need for a backup method.
Soon after childbirth	• Within 48 hours after giving birth, including by caesarean delivery. Fewest expulsions when done just after delivery of placenta • If >48 hours after giving birth, delay until 4 weeks or more after giving birth.
Fully or nearly fully breastfeeding	
Less than 6 months after giving birth	• If period has not returned, can have IUCD inserted any time between 4 weeks and 6 months after giving birth. No need for a backup method. • If period has returned, can have IUCD inserted as advised for women having menstrual cycles (see above).
More than 6 months after giving birth	• If period has not returned, can have IUCD inserted any time it is reasonably certain she is not pregnant. No need for a backup method. • If period has returned, can have IUCD inserted as advised for women having menstrual cycles (see above).
Partially breastfeeding or not breastfeeding	
Less than 4 weeks after giving birth	• If period has not returned, can have IUCD inserted *if it can be determined that she is not pregnant*. No need for a backup method. • If period has returned, can have IUCD inserted as advised for women having menstrual cycles (see above).

[31] *Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.*

No monthly bleeding (not related to childbirth or breastfeeding)	• Any time *if it can be determined that she is not pregnant*. No need for a backup method.
After miscarriage or abortion	• Immediately, if IUCD inserted within 12 days after first- or second-trimester abortion or miscarriage and no infection. No need for backup method. • If >12 days after first- or second-trimester miscarriage or abortion and no infection, can have IUCD inserted any time it is reasonably certain she is not pregnant. No need for a backup method. • If infection is present, treat or refer and choose another method. If client still wants the IUCD, it can be inserted after the infection has completely cleared. • IUCD insertion after second-trimester abortion or miscarriage requires specific training.
For emergency contraception	• Within 5 days after unprotected sex. • When the time of ovulation can be estimated, can have IUCD inserted up to 5 days after ovulation (this may be more than 5 days after unprotected sex).
After taking ECPs	• IUCD can be inserted on the same day that she takes the ECPs. No need for a backup method.

Preventing Infection at IUCD Insertion

Proper insertion technique can help prevent many problems, such as infection, expulsion, and perforation.

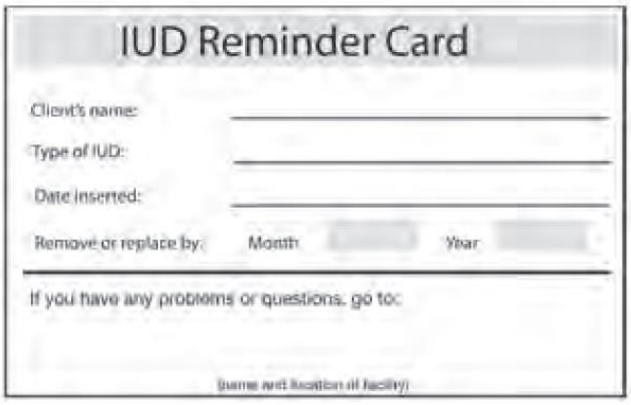
- Follow proper infection-prevention procedures.
- Use high-level disinfected or sterile instruments.
- Use a new, pre-sterilized IUCD that is packaged with its inserter.
- The 'no-touch' insertion technique is best; don't let the loaded IUCD or uterine sound touch any unsterile surfaces (e.g. hands, speculum, vagina, table top).
  - Load IUCD into the inserter while it is still in the sterile package, to avoid touching the IUCD directly.
  - Clean cervix thoroughly with antiseptic before IUCD insertion.
  - Be careful not to touch the vaginal wall or speculum blades with the uterine sound or loaded IUCD inserter.
  - Passing both the uterine sound and the loaded IUCD inserter only once each through the cervical canal.

Giving Advice on Side Effects	
IMPORTANT: Thorough counselling about bleeding changes must come before IUCD insertion. Counselling about bleeding changes may be the most important help a woman needs to keep using the method.	
Describe the most common side effects	• Changes in her bleeding pattern: – Irregular, prolonged and heavy monthly bleeding. – More cramps and pain during monthly bleeding.
Explain about these side effects	• Bleeding changes are not signs of illness. • Usually become less after the first several months after insertion.

Inserting the IUCD	
Talk with the client before the procedure	• Explain the insertion procedure (see below). • Show the speculum, tenaculum, the IUCD and inserter in the package. • Tell client she will experience some discomfort/cramping during procedure. • Ask her to tell you any time that she feels discomfort or pain. • Ibuprofen (200–400 mg), paracetamol (325–1000 mg) may be given 30 minutes before insertion to help reduce pain. Do not give aspirin.
Talk with the client during the procedure	• Tell client what is happening, step by step, and reassure her. • Alert her before a step that may cause pain or might startle her. • Ask from time to time if she is feeling pain.

Explaining the Insertion Procedure
A client needs to know what will happen during IUCD insertion. Learning IUCD insertion requires training and practice under direct supervision; therefore the following provides a summary description only. 1. Pelvic examination to assess eligibility (see Screening Questions for Pelvic Examination before IUCD Insertion, above). Provider first does bimanual examination and then inserts a speculum into the vagina to inspect the cervix. 2. Provider cleans the cervix and vagina with appropriate antiseptic. 3. Provider slowly inserts tenaculum through the speculum and closes the tenaculum just enough to gently hold the cervix and uterus steady. 4. Provider slowly and gently passes the uterine sound through the cervix to measure the depth and position of the uterus. 5. Provider loads IUCD into inserter while both are still in the unopened sterile package. 6. Provider slowly and gently inserts the IUCD and removes the inserter. 7. Provider cuts the strings on the IUCD, leaving about 3 cm hanging out of the cervix. 8. After insertion, the woman rests on the examination table until she feels ready to get dressed.

Supporting the User	
Giving Specific Instructions	
Expect cramping and pain	• Expect some cramping and pain for a few days after insertion. • Ibuprofen (200–400 mg), paracetamol (325–1000 mg) as needed. • Expect some bleeding or spotting immediately after insertion up to 6 months.
She can check the strings	• Client can check her IUCD strings from any time, especially in the first few months and after period, to confirm IUCD is still in place (see Questions and Answers about IUCDs, Q10).
Length of pregnancy protection	• Discuss how to remember the date to return. • Give information in writing on a reminder card, and explain: – The type of IUCD she has. – Date of IUCD insertion. – Month and year when IUCD will need to be removed or replaced.
Follow-up visit	• A follow-up visit after her first monthly bleeding or 3 to 6 weeks after IUCD insertion is recommended.


IUD Reminder Card

Client's name: _____

Type of IUD: _____

Date inserted: _____

Remove or replace by: Month _____ Year _____

If you have any problems or questions, go to:

(name and location of facility)

Helping Continuing Users.

Removing the Intrauterine Device.

IMPORTANT: Providers must not refuse or delay when a woman asks to have her IUCD removed, whatever her reason, whether personal or medical. Client must not be pressured or forced to continue using the IUCD.

If a woman is finding side effects difficult to tolerate, first discuss the problems she is having (see Managing Any Problems, below). See if she would rather try to manage the problem or to have the IUCD removed immediately (removal of IUCD can be done any time of the month).

Explaining the Removal Procedure

Before removing the IUCD, explain what will happen during removal:

1. Provider inserts a speculum to see the cervix and IUCD strings and carefully cleans the cervix and vagina with an antiseptic solution, such as iodine.
2. Client to relax; advise her to say if she feels pain during the procedure.
3. Using narrow forceps, provider pulls IUCD strings slowly and gently until the IUCD comes completely out of the cervix.

Switching from an IUCD to Another Method

These guidelines ensure that the client is protected from pregnancy without interruption when switching from a copper-bearing IUCD or a hormonal IUCD to another method (see also When to Start for each method).

Switching to	When to Start
Combined oral contraceptives (COCs), progestin-only pills (POPs), progestin-only injectables, or implants	• If starting during the first 7 days of period (first 5 days for COCs and POPs), start hormonal method now and remove IUCD. No need for a backup method. • If starting after first 7 days of period (after first 5 days for COCs and POPs) and client has had sex since last period, start hormonal method now. Keep IUCD in place until her next period. • If starting after the first 7 days of period (after the first 5 days for COCs and POPs) and she has not had sex since her last period, the IUCD can stay in place and be removed during her next period, or IUCD can be removed and she can use a backup method[32] for the next 7 days (2 days for POPs).
Male or female condoms, or withdrawal	• Immediately the next time she has sex after the IUCD is removed.
Fertility awareness methods	• Immediately after the IUCD is removed.
Female sterilization	• If starting during the first 7 days of period, remove IUCD and perform the female sterilization procedure. No need for a backup method. • If starting after first 7 days of period, perform the sterilization procedure. • IUCD can be kept in place until her follow-up visit or her next period. If a follow-up visit is not possible, remove IUCD at the time of sterilization. No need for a backup method.
Vasectomy	• Any time • The woman can keep the IUCD for 3 months after her partner's vasectomy to keep preventing pregnancy until the vasectomy is fully effective.

Managing Any Problems.

Problems reported as side effects or problems with use.

May or may not be due to the method.

- Problems with side effects affect women's satisfaction and use of IUCDs. If client reports problems, listen to her concerns, give her advice, and, if appropriate, treat.
- Offer to help client choose another method - now, if she wishes, or if problems cannot be overcome.

[32] *Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.*

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

- Reassure her that some women using IUCDs experience heavy or prolonged bleeding. It is not harmful and usually becomes less or stops after a few months.
- For short-term relief, try:
  - Tranexamic acid (1500 mg) 3 times daily for 3 days, then 1000 mg once daily for 2 days, beginning when heavy bleeding starts.
  - Nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen (400 mg) or indomethacin (25 mg) 2 times daily after meals for 5 days, beginning when heavy bleeding starts.
- To help prevent anaemia, take iron tablets and eat foods containing iron (meat and poultry, especially beef and chicken liver, fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).
- If heavy or prolonged bleeding continues or starts after several months of normal bleeding or long after the IUCD was inserted, or if you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use (see Unexplained vaginal bleeding, below).

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

- Reassure her that many women using IUCDs experience irregular bleeding. It is not harmful and usually becomes less or stops after the first several months of use.
- For short-term relief she can try NSAIDs such as ibuprofen (400 mg) or indomethacin (25 mg) 2 times daily after meals for 5 days, beginning when irregular bleeding starts.
- If irregular bleeding continues or starts after several months of normal bleeding, consider underlying conditions unrelated to method use (see unexplained vaginal bleeding, below).

Cramping and pain

- Expect some cramping and pain for the first day or two after IUCD insertion.
- Explain this is common in the first 3 to 6 months of IUCD use, particularly during monthly bleeding. Generally, this is not harmful and usually decreases over time.
- Aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg).
- If cramping continues and occurs outside of monthly bleeding, evaluate for underlying health conditions and treat or refer.
- If no underlying condition is found and cramping is severe, discuss removing the IUCD.
  - If the removed IUCD looks distorted, or if difficulties during removal suggest that the IUCD was out of proper position, explain to the client that she can have a new IUCD that may cause less cramping.

Possible anaemia

- IUCD may contribute to anaemia if a woman already has low iron blood stores before insertion and the IUCD causes heavier monthly bleeding.
- Pay special attention to IUCD users with any of the following signs and symptoms:
  - Inside of eyelids or underneath fingernails looks pale, pale skin, fatigue or weakness, dizziness, irritability, headache, ringing in the ears, sore tongue, and brittle nails.
  - If blood testing is available, haemoglobin less than 9 g/dl or haematocrit less than 30.
- Provide iron tablets and advise foods containing iron (meat and poultry, especially beef and chicken liver, fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).

Partner can feel IUCD strings during sex

- Explain that this happens sometimes when strings are cut too short.
- If partner finds the strings bothersome, describe available options:
  - Strings can be cut even shorter so they are not coming out of the cervical canal. Her partner will not feel the strings, but the woman will no longer be able to check her IUCD strings.
  - If the woman wants to be able to check her IUCD strings, the IUCD can be removed and a new one inserted (to avoid discomfort, the strings should be cut so that 3 cm hang out of the cervix).

Severe pain in lower abdomen (suspect pelvic inflammatory disease – PID)

- Some common signs and symptoms of PID often occur with other abdominal conditions, such as ectopic pregnancy. If ectopic pregnancy is ruled out, assess for PID.

- Abdominal and pelvic examinations (see Chapter 8) for signs that would indicate PID.
- If a pelvic examination is not possible, and she has a combination of the following signs and symptoms in addition to lower abdominal pain, suspect PID:
  - Unusual vaginal discharge.
  - Fever or chills.
  - Pain during sex or urination.
  - Bleeding after sex or between monthly bleeding.
  - Nausea and vomiting.
  - A tender pelvic mass.
  - Pain when the abdomen is gently pressed (direct abdominal tenderness) or when gently pressed and then suddenly released (rebound abdominal tenderness).
- Treat PID or immediately refer for treatment:
  - Because of the serious consequences of PID, health care providers should treat (as soon as possible) all suspected cases, based on the signs and symptoms above.
  - Treat for gonorrhoea, chlamydia, and anaerobic bacterial infections. Provide condoms and counsel use.
  - There is no need to remove IUCD.

Severe pain in lower abdomen (suspect ectopic pregnancy)

- Be alert for additional signs or symptoms of ectopic pregnancy, which is rare and not caused by the IUCD, but it can be life-threatening (see Questions and Answers about IUCD, Q11).
- In early stages of ectopic pregnancy, symptoms may be absent or mild, but they will become severe. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy:
  - Unusual abdominal pain or tenderness
  - Abnormal vaginal bleeding or no monthly bleeding
  - Light-headedness, dizziness or fainting
- Refer if ectopic pregnancy or other serious health condition is suspected.
- If client does not have these additional symptoms or signs, assess for PID (see above).

Suspected uterine puncturing (perforation)

- If puncturing suspected at time of insertion or sounding of uterus, stop procedure immediately (and remove IUCD if inserted). Observe the client in the clinic carefully:
  - For first hour, keep client at bed rest and check vital signs (blood pressure, pulse, respiration, and temperature) every 5 to 10 minutes.
  - If stable after one hour, check for signs of intra-abdominal bleeding, such as low haematocrit or haemoglobin and vital signs. Observe for several hours. If no signs or symptoms, send home, but advise to avoid sex for 2 weeks. Choose another method.
  - If rapid pulse and falling blood pressure, or new/increasing pain around the uterus, refer her to a higher level of care.
  - If uterine perforation is suspected within 6 weeks after insertion or if it is suspected later and is causing symptoms, refer for evaluation and removal of IUCDs.

IUCD partially comes out (partial expulsion)

- If IUCD partially comes out, remove it. If client wants another IUCD, insert at any time it is reasonably certain she is not pregnant or choose another method.

IUCD completely comes out (complete expulsion)

- If IUCD came out, and client wants another, insert at any time it is reasonably certain she is not pregnant.
- If complete expulsion is suspected and the client does not know whether the IUCD came out, refer for x-ray to assess whether IUCD has moved to abdominal cavity. Use backup method to use in the meantime.

Missing strings (suggesting possible pregnancy, uterine perforation, or expulsion)

- Ask the client:
  - Whether and when she saw the IUCD come out.
  - When she last felt the strings.
  - When she had her last monthly bleeding.
  - If she has any symptoms of pregnancy.
  - If she has used a backup method since she noticed the strings were missing.
- Always start with minor and safe procedures and be gentle. Check for the strings in the folds of the cervical canal with forceps. About half of missing IUCD strings can be found in the cervical canal.
- If strings cannot be located in the cervical canal, either they have gone up into the uterus or the IUCD has been expelled unnoticed. Rule out pregnancy before attempting more invasive procedures. Refer for evaluation. Give her a backup method to use in the meantime, in case the IUCD came out.

New Problems That May Require Switching Methods

May or may not be due to the method.

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

- Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate.
- Continue using IUCD while her condition is being evaluated; if bleeding caused by STI or PID, she can continue using the IUCD during treatment.

Suspected pregnancy

- Assess for pregnancy, including ectopic pregnancy.
- Remove IUCD (or refer for same).
- Explain that she should return at once if she develops any signs of miscarriage or septic miscarriage (vaginal bleeding, cramping, pain, abnormal vaginal discharge, or fever).
- If she chooses to keep the IUCD, her pregnancy should be followed closely by a nurse or doctor. She should see a nurse or doctor at once if she develops any signs of septic miscarriage.

Questions and Answers about IUCDs.

1. **Does the IUCD cause pelvic inflammatory disease (PID)?**
   By itself, the IUCD does not cause PID. Gonorrhoea and chlamydia are the primary direct causes of PID. IUCD insertion when a woman has gonorrhoea or chlamydia may lead to PID, however. This does not happen often. When it does, it is most likely to occur in the first 20 days after IUCD insertion.

2. **Can young women and older women use IUCDs?**
   Yes. There is no minimum or maximum age limit. An IUCD should be removed after menopause has occurred– within 12 months after her last monthly bleeding.

3. **If a current IUCD user has an STI or has become at very high individual risk of becoming infected with an STI, should her IUCD be removed?**
   No. If a woman develops a new STI after her IUCD has been inserted, she is not especially at risk of developing PID because of the IUCD. She can continue to use the IUCD while she is being treated for the STI. Removing the IUCD has no benefit and may leave her at risk of unwanted pregnancy. Counsel her on condom use and other strategies to avoid STIs in the future.

4. **Does the IUCD make a woman infertile?**
   No. A woman can become pregnant once the IUCD is removed just as quickly as a woman who has never used an IUCD.

5. **Can a woman who has never had a baby use an IUCD?**
   Yes. A woman who has not had children generally can use an IUCD, but she should be advised that the IUCD may come out because her uterus may be smaller than the uterus of a woman who has given birth.

6. **Can the IUCD travel from the woman's uterus to other parts of her body, such as her heart or her brain?**
   The IUCD never travels to the heart, brain, or any other part of the body outside the abdomen. The IUCD normally stays within the uterus like a seed within a shell.

7. **Should a woman have a "rest period" after using her IUCD for several years or after the IUCD reaches its recommended time for removal?**
   No. This is not necessary, and it could be harmful. Removing the old IUCD and immediately inserting a new IUCD poses less risk of infection than 2 separate procedures. Also, a woman could become pregnant during a 'rest period' before her new IUCD is inserted.

8. **Should antibiotics be routinely given before IUCD insertion?**
   No, usually not. When appropriate questions to screen for STI risk are used and IUCD insertion is done with proper infection-prevention procedures, there is little risk of infection.

9. **Must an IUCD be inserted only during a woman's monthly bleeding?**
   No. For a woman having menstrual cycles, an IUCD can be inserted at any time during her menstrual cycle if it is reasonably certain that the woman is not pregnant. Inserting the IUCD during her monthly bleeding may be a good time because she is not likely to be pregnant, and insertion may be easier.

10. **Should a woman be denied an IUCD because she does not want to check her IUCD strings?**
    No. A woman should not be denied an IUCD because she is unwilling to check the strings. The importance of checking the IUCD strings has been overemphasized. It is uncommon for an IUCD to come out, and it is rare for it to come out without the woman noticing.

11. **Do IUCDs increase the risk of ectopic pregnancy?**
    No. IUCDs greatly reduce the risk of ectopic pregnancy.

16. Male Condoms

- Sheaths, or coverings (mostly made from thin latex rubber), that fit over a man's erect penis.
- Also called 'rubbers', 'raincoats', 'skins' and prophylactics; known by many different brand names.
- Work by forming a barrier that keeps sperm out of the vagina, preventing pregnancy. Also keep infections (in semen, on the penis, or in the vagina) from infecting the other partner.

In Vanuatu, available in stores, clinics, pharmacies and from some community-based condom distributors.

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

Protection against pregnancy:
- As commonly used, about 15 pregnancies per 100 women whose partners use male condoms in one year. This means that 85 of every 100 women whose partners use male condoms will not become pregnant.
- When used correctly with every act of sex, about 2 pregnancies per 100 women whose partners use male condoms over the first year.

Return of fertility after use of condoms is stopped: No delay

Protection against HIV and other STIs:
- When used consistently and correctly, condom use prevents 80% to 95% of HIV transmission that would have occurred without condoms (see Question and Answers about Male Condoms, Q2).
- Reduce risk of infection with STIs when used consistently and correctly.
  - Protect best against STIs spread by discharge, such as HIV, gonorrhoea, and chlamydia.
  - Also protect against STIs spread by skin-to-skin contact, such as herpes and human papilloma virus.

Why some women and men say they like condoms.
- Have no hormonal side effects.
- Can be used as a temporary or backup method.
- Can be used without seeing a health care provider.
- Are sold in many places and generally easy to obtain
- Help protect against both pregnancy and STIs, including HIV

Side Effects, Health Benefits and Health Risks.

Side Effects
None.

Known Health Risks.
- Severe allergic reaction (among people with latex allergy – extremely rare)

Known Health Benefits.
Help protect against unplanned pregnancy and STIs, including HIV

May help protect against conditions caused by STIs:
- Recurring pelvic inflammatory disease and chronic pelvic pain
- Cervical cancer

Bringing Up Condom Use

Some women find it hard to discuss or persuade their partners to use condoms. Men give different reasons for not using condoms, but these often based on rumours/misunderstanding. Facts can help a woman respond to her partner's objections.

Talking First Can Help. Talk to partner about using condoms before beginning to have sex increases likelihood of condom use. A woman can any of the following to encourage condom use:
- Emphasizing use of condoms for pregnancy prevention rather than STI protection.
- Appealing to concern for each other, e.g. 'Many people in the community have chlamydia, so we need to be careful'.
- Taking an uncompromising stance, e.g. 'I cannot have sex with you unless you use a condom'.
- For pregnant women, discussing risks of STIs for health of the baby; stressing that condoms protect the baby.

Medical Eligibility Criteria for

Male Condoms

All men and women can safely use male condoms except those with severe allergic reaction to latex rubber. For more information on latex allergy, see sections on mild irritation or reaction to condom (below).

Providing Male Condoms

When to Start

Any time the client wants.

Explaining How to Use

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

Explain the 5 Basic Steps of Using a Male Condom

Basic Steps	Important Details	
1. Use a new condom for each act of sex	• Check condom package. Do not use if torn or damaged. Avoid using a condom past the expiry date - do so only if a newer condom not available. • Tear open the package carefully. Do not use fingernails, teeth, or anything that can damage the condom.	
2. Before any physical contact, place the condom on the tip of the erect penis with the rolled side out	• For the most protection, put the condom on before the penis makes any genital, oral or anal contact.	
3. Unroll the condom all the way to the base of the erect penis	• The condom should unroll easily. Forcing it on could cause it to break during use. • If condom does not unroll easily, it may be on backwards, damaged, or too old. Throw it away and use a new condom. • If the condom is on backwards and another one is not available, turn it over and unroll it onto the penis.	
4. Immediately after ejaculation, hold the rim of the condom in place and withdraw the penis while it is still erect	• Withdraw the penis. • Slide the condom off, avoiding spilling semen. • If having sex again or switching from one sex act to another, use a new condom.	
5. Dispose of the used condom safely	• Wrap the condom in its package and put in the rubbish or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing.	

Supporting the User	
Ensure client understands correct use	• Ask client to explain 5 basic steps of using a condom by putting it on a model or other object and then taking it off. When counselling, use the graphics above to demonstrate correct use.
Give clients condoms to use until they can return	• Give plenty of condoms and, if available, a water or silicone-based lubricant. Oil-based lubricants should not be used with latex condoms. See text box. • Tell clients where they can buy condoms, if needed.
Explain importance of using a condom with every act of sex	• Just one unprotected act of sex can lead to pregnancy or an STI (or both). • If condom not used for one act of sex, try to use one the next time. A mistake once or twice does not mean that it is pointless to use condoms in the future.
Explain about ECPs	• Explain ECP use in case of errors in condom use - including not using a condom - to help prevent pregnancy (see Chapter 12). Give ECPs.
Discuss ways to talk about using condoms	• Discuss skills and techniques for negotiating condom use with partners (see Bringing Up Condom Use, above).

What condom users should NOT do

Some practices can increase the risk that the condom will break and should be avoided.

- Do not unroll the condom first and then try to put it on the penis.
- Do not use lubricants with an oil base because they damage latex (see text box below).
- Do not use a condom if the colour is uneven or changed.
- Do not use a condom that feels brittle, dried out, or very sticky.
- Do not reuse condoms.
- Do not use the same condom when switching between different penetrative sex acts, such as from anal to vaginal sex. This can transfer bacteria that can cause infection.

Lubricants for Latex Condoms

Lubrication helps avoid condom breakage. There are 3 ways to provide lubrication - natural vaginal secretions, adding a lubricant, or using condoms packaged with lubricant on them.

Glycerine or silicone lubricants can be used with latex condoms. So can clean water and saliva.

Put lubricants on the outside of the condom, in the vagina, or in the anus, but not on the penis, as this can make the condom slip off. A drop or two of lubricant on the inside of the condom before it is unrolled can help increase the sensation of sex for some men (too much can make the condom slip off).

Do not use oil-based lubricant with latex condoms. Also, do not use oils (cooking, baby, coconut, mineral), petroleum jelly, lotions, cold creams, butter, cocoa butter, and margarine.

Helping Continuing Users - Managing Any Problems.

Problems with use.

May or may not be due to the method.

- Problems with condoms affect clients' satisfaction and use of the method. They deserve the provider's attention. If the client reports any problems, listen to the client's concerns and give advice.

Condom breaks, slips off the penis, or is not used

- ECPs can help prevent pregnancy in such cases (see Chapter 12). If a man notices a break or slip, he should tell his partner so that she can use ECPs if she wants.
- Little can be done to reduce the risk of STIs if a condom breaks, slips, or is not used. If client presents with signs or symptoms of STIs after having unprotected sex, assess or refer.
- If a client reports breaks or slips:
  - Check client's technique for opening the condom package and putting the condom on, using a model or other item. Correct any errors.
  - Assess if lubricants are used (must be water-based). Too much lubricant can cause condom to slip off.

Difficulty putting on the condom

- Ask clients to show how they put the condom on, using a model or other item. Correct any errors.

Difficulty persuading partner to use condoms or not able to use a condom every time

- Discuss ways to talk about condoms with partner (see Bringing Up Condom Use, above).
- Consider combining condoms with another contraceptive method (if no risk of STIs).
- If client or partner at risk for STIs, encourage condom use while working out problems.

Mild irritation in or around the vagina or penis or mild allergic reaction to condom (itching, redness, rash, and/or swelling of genitals, groin, or thighs during or after condom use)

- Try another brand of condom. A person may be more sensitive to one brand of condoms than to others.
- Suggest putting lubricant or water on the condom to reduce rubbing that may cause irritation.
- If symptoms persist, assess or refer for possible vaginal infection or STI.
  - If no infection and irritation continues or recurs, the client may have an allergy to latex.
  - If not at risk of STIs, including HIV, choose another method.
  - If client/partner at risk for STIs, suggest female condoms or plastic male condoms (if available). Stop using latex condoms if symptoms become severe (see next section).

New Problems That May Require Switching Methods

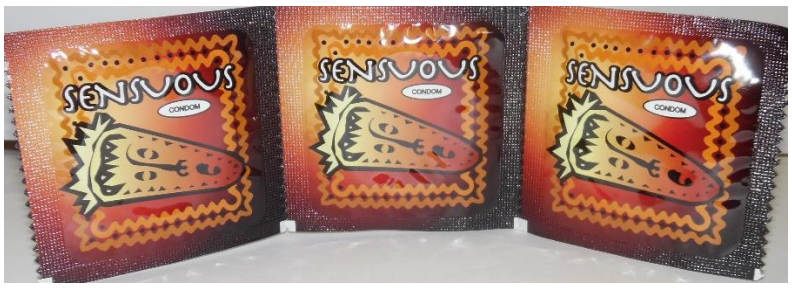
May or may not be due to the method.

Female partner is using miconazole or econazole (for treatment of vaginal infections)

- A woman should not rely on latex condoms during vaginal (topical) use of miconazole or econazole. They can damage latex (oral treatment will not harm condoms).
- Use female condoms or plastic male condoms, another contraceptive method or abstain from sex until treatment is completed.

Severe allergic reaction to condom (hives or rash over much of body, dizziness, difficulty breathing, or loss of consciousness during or after condom use).

- Stop using latex condoms.
- Refer for care; severe allergic reaction to latex could lead to life-threatening anaphylactic shock. Choose another method.
- If client/partner cannot avoid risk of STIs, suggest female condoms or plastic male condoms, if available.



3-packs of 'Sensuous' male condoms available from most clinics in Vanuatu

Questions and Answers about Male Condoms.

1. **Are condoms effective at preventing pregnancy?**
   Yes, male condoms are effective, but only if used correctly with every act of sex. Many people do not use condoms every time they have sex or do not use them correctly. This reduces protection from pregnancy.

2. **How well do condoms help protect against HIV infection?**
   Condoms are 80-95% effective in protecting people from HIV infection when used correctly with every act of sex. This means that condom use prevents 80% to 95% of HIV transmissions that would have occurred without condoms. (It does not mean that 5% to 20% of condom users will become infected with HIV.)

3. **Does using a condom only some of the time offer any protection from STIs, including HIV?**
   For best protection, a condom should be used with every act of sex. In some cases, however, occasional use can be protective. e.g. if a person has a regular, faithful partner and has one act of sex outside of the relationship, using a condom for that one act can be very protective. For people who are exposed to STIs, including HIV frequently, however, using a condom only some of the time will offer limited protection.

4. **Will using condoms reduce the risk of STI transmission during anal sex?**
   Yes. STIs can be passed from one person to another during any sex act that inserts the penis into any part of another person's body (penetration). The risk of becoming infected with HIV is 5 times higher with unprotected receptive anal sex than with unprotected receptive vaginal sex. When using a latex condom for anal sex, a water- or silicone-based lubricant is essential to help keep the condom from breaking.

5. **Do condoms often break or slip off during sex?**
   No. Used properly, condoms rarely break. It is important to teach people the right way to open, put on, and take off condoms (see graphics above) and also to avoid practices that increase the risk of breakage (see What Condom Users Should NOT Do, above).

7. **What can men and women do to reduce the risk of pregnancy and STIs if a condom slips or breaks during sex?**
   If a condom slips or breaks, taking ECPs can reduce the risk that a woman will become pregnant (see Chapter 12). Little can be done to reduce risk of STIs, however. Washing the penis does not help. Vaginal douching is not very effective in preventing pregnancy, and it increases a woman's risk of acquiring STIs, and pelvic inflammatory disease. If exposure to HIV is certain, treatment with antiretroviral medications (post-exposure prophylaxis), can help reduce HIV transmission. If exposure to other STIs is certain, a provider can treat presumptively for those STIs - that is, treat the client as if he or she were infected.

8. **Can a man put 2 or 3 condoms on at once for more protection?**
   There is little evidence about the benefits of using 2 or more condoms. It is generally not recommended because of concerns that friction between the condoms could increase the chance of breakage.

9. **Will condoms make a man unable to have an erection (impotent)?**
   No. Condoms do not cause impotence. A few men may have problems keeping an erection when using condoms, however. Some men may have difficulty keeping an erection because condoms can dull the sensation of having sex. Using more lubrication may help increase sensation for men using condoms.

10. **Aren't condoms used mainly in casual relationships or by people who have sex for money?**
    No. While many casual partners rely on condoms for STI protection, married couples use condoms for pregnancy protection, too.

11. **Is allergy to latex common?**
    No. Allergy to latex is uncommon, and mild allergic reactions to condoms are very rare. Severe allergic reactions to condoms are extremely rare.

17. Female Condoms

- Sheaths, or linings, that fit loosely inside a woman's vagina, made of thin, transparent, soft plastic film.
  - Have flexible rings at both ends; one at the closed end helps to insert the condom, the other at the open end holds part of the condom outside the vagina.
- Different brand names include Care, Dominique, FC Female Condom, Femidom, Femy, Myfemy and Woman's Condom.
- Have a silicone-based lubricant on the inside and outside.
- Work by forming a barrier that keeps sperm out of the vagina, preventing pregnancy. Also keep infections in semen, on the penis, or in the vagina from infecting the other partner.

In Vanuatu, female condoms are from clinics, some pharmacies and from some community-based condom distributors.

Why some women say they like female condoms.

- Women can initiate their use.
- Have a soft, moist texture that feels more natural than male latex condoms during sex.
- Help protect against both pregnancy and STIs, including HIV.
- Outer ring provides added sexual stimulation for some women.
- Can be used without seeing a health care provider.

Why some men say they like female condoms.

- Can be inserted ahead of time so do not interrupt sex.
- Are not tight or constricting like male condoms.
- Do not dull the sensation of sex like male condoms.
- Do not have to be removed immediately after ejaculation.

How Effective?

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

Protection against HIV and other STIs:

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

Return of fertility after use of condoms is stopped: No delay

Protection against HIV and other STIs:

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

Source: WHO et al., 2011 op cit.

Side Effects, Health Benefits and Health Risks.

Side Effects	Known Health Benefits.	Known Health Risks.
None.	Help protect against unplanned pregnancy and STIs/HIV.	None.

Medical Eligibility Criteria for

Female Condoms

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

For information on eligibility criteria for latex female condoms, see Medical Eligibility Criteria for Male Condoms, Chapter 16 (see also for information on managing clients with latex allergy).

Providing Female Condoms

When to Start

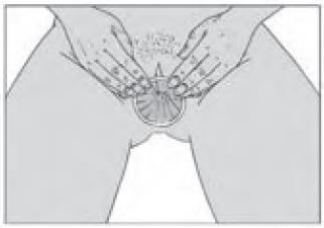
Any time the client wants.

Explaining How to Use

IMPORTANT: Show the client how to insert the female condom. Use a model, picture or your hands to demonstrate (create an opening similar to a vagina with one hand and insert female condom with other hand).

Explain the 5 Basic Steps of Using a Male Condom

Basic Steps	Important Details
1. Use a new female condom for each act of sex	• Check the condom package. Do not use if torn or damaged. Avoid using a condom past the expiry date - do so only if newer condoms are not available. • Wash hands with mild soap and clean water before inserting the condom.
2. Before any physical contact, insert the condom into the vagina	• Can be inserted up to 8 hours before sex. For best protection, insert condom before the penis comes in contact with the vagina. • Choose a position that is comfortable for insertion - squat, raise one leg, sit, and lie down. • Rub sides of the female condom together to spread the lubricant evenly. • Grasp the ring at the closed end, and squeeze it so it becomes long and narrow. • With the other hand, separate the outer lips (labia) and locate the opening of the vagina. • Gently push inner ring into vagina as far up as it will go. Insert a finger into condom to push into place. About 2-3 cm of condom and the outer ring remain outside vagina.
3. Ensure that the penis enters the condom and stays inside the condom	• Man or woman should carefully guide the tip of his penis inside the condom – not between condom and wall of the vagina. • If penis goes outside the condom, withdraw and try again. • If the condom is accidentally pulled out or pushed into vagina during sex, put condom back in place.
4. After the man withdraws his penis, hold the outer ring of the condom, twist to seal in fluids. Gently pull it out of the vagina	• Female condom does not need to be removed immediately after sex. • Remove condom before standing up, to avoid spilling semen. • If couple has sex again, use a new condom. • Reuse of female condoms is not recommended (see Questions and Answers about Female Condoms, Q5).
5. Dispose of the used condom safely	• Wrap the condom in its package and put in the rubbish or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing.



Supporting the User	
Ensure correct use	• Ask client to explain/demonstrate 5 basic steps of using female condom. • Use a model to practice inserting the condom and then taking it out.
Give clients condoms to use until they can return	• Give plenty of condoms and lubricant. • Tell client where she can buy female condoms, if needed.
Explain importance of using a condom with every act of sex	• Just one unprotected act of sex can lead to pregnancy or an STI (or both). • If condom not used for one act of sex, try to use one the next time. A mistake once or twice does not mean that it is pointless to use condoms in the future.
Explain about ECPs	• Explain ECP use in case of errors in condom use - including not using a condom - to help prevent pregnancy (see Chapter 12). Give ECPs.
Discuss ways to talk about using condoms	• Discuss skills and techniques for negotiating condom use with partners (see Bringing Up Condom Use, Chapter 15).

Tips for New Users

- Suggest practice putting in and taking out the condom before the next time she has sex. Reassure that correct use becomes easier with practice; may take several goes before a woman is comfortable with it.
- Try different positions to see which way insertion is easiest for her.
- The female condom is slippery. Insertion easier if done slowly, especially the first few times.
- If a client is switching from another method to the female condom, continue with the previous method until able to use female condom with confidence.

Lubricants for Female Condoms

Plastic female condoms come lubricated with a silicone-based lubricant. Unlike most male condoms, which are made of latex, plastic condoms can be used with any type of lubricant - whether made with water, silicone, or oil.

Some female condoms come with additional lubricant in the package; additional lubrication can include clean water, saliva, any oil or lotion, or a lubricant made of glycerine or silicone.

Helping Continuing Users - Managing Any Problems.

Problems with use.

May or may not be due to the method.

- Problems with condoms affect clients' satisfaction and use of the method. They deserve the provider's attention. If the client reports any problems, listen to the client's concerns and give advice.

Difficulty inserting the female condom

- Assess how client inserts a female condom; demonstrate with a model or hands. Correct any errors.

Inner ring uncomfortable or painful

- Reinsert or reposition condom so that the inner ring is tucked back behind the pubic bone, out of the way.

Condom squeaks or makes noise during sex

- Add more lubricant to the inside of the condom or onto the penis.

Condom slips, is not used, or is used incorrectly

- ECPs can help prevent pregnancy (see Chapter 12).
- Little can be done to reduce the risk of STIs if a condom breaks, slips, or is not used (see Question and Answers about Male Condoms, Q7 – Chapter 16). If signs or symptoms of STIs, assess or refer.
- If a client reports slips, she may be inserting the female condom incorrectly. Ask her to show how she is inserting the condom, using a model or demonstrating with her hands. Correct any errors.

Difficulty persuading partner to use condoms or not able to use a condom every time

- Discuss ways to talk with her partner about the importance of condom use for protection from pregnancy and STIs (see Bringing Up Condom Use text box, Chapter 16).

Mild irritation in or around the vagina or penis (itching, redness, or rash)

- Usually goes away on its own without treatment.
- Add lubricant to inside of the condom or onto the penis to reduce rubbing that may cause irritation.
- If symptoms persist, assess or refer for possible vaginal infection or STI.
  - If no infection and irritation continues or recurs, the client may have an allergy to latex.
  - If not at risk of STIs, including HIV, choose another method.

Suspected pregnancy

- Assess for pregnancy.
- A woman can safely use female condoms during pregnancy for continued STI protection.

Questions and Answers about Female Condoms.

1. **Is the female condom difficult to use?**
   No, but it does require practice and patience. See Tips for New Users, above.

2. **Can female condoms effectively prevent both pregnancy and STIs, including HIV?**
   Yes. Female condoms offer dual protection, against both pregnancy and STIs, including HIV, if used consistently and correctly.

3. **Can a female condom and a male condom be used at the same time?**
   No. Male and female condoms should not be used together. This can cause friction that may lead to slipping or tearing of the condoms.

4. **What is the best way to make sure the penis goes into the condom and not outside the condom?**
   To avoid incorrect use, the man or woman should guide the tip of the penis inside the outer ring of the condom. If penis goes between the walls of the vagina and the condom, withdraw and try again.

5. **Can the female condom be used more than once?**
   Reuse of the female condom is not recommended.

6. **Can the female condom be used while a woman is having her monthly bleeding?**
   Women can use the female condom during their period. The female condom cannot be used at the same time as a tampon, however. The tampon must be removed before inserting a female condom.

7. **Isn't the female condom too big to be comfortable?**
   No. Female condoms are the same length as male condoms, but wider and flexible to fit and shape to any sized vagina or penis.

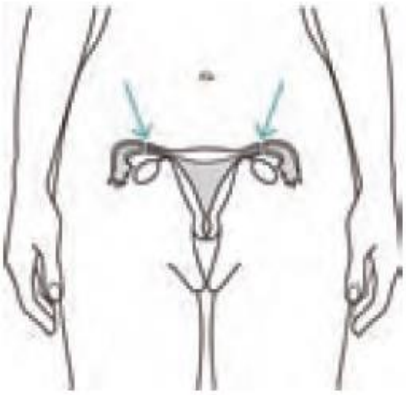
8. **Can a female condom get lost inside a woman's body?**
   No. The female condom remains in a woman's vagina until she takes it out. It cannot go past a woman's cervix and into the womb (uterus) because it is too large for that.

9. **Can the female condom be used in different sexual positions?**
   Yes. The female condom can be used in any sexual position.

Female condoms come with lubricant and information for use and protection from STIs and HIV

18. Female Sterilization

- Permanent contraception for women who will not want more children.
- The 2 surgical approaches most often used:
  - Minilaparotomy; making a small incision in the abdomen. The fallopian tubes are brought to the incision to be cut or blocked.
  - Laparoscopy; inserting a long thin lens into the abdomen through a small incision to see and block/cut fallopian tubes.
- Also called tubal sterilization, tubal ligation, tubectomy, bi-tubal ligation, tying the tubes, minilap, and 'the operation'.
- Works because the fallopian tubes are blocked/cut. Eggs released from ovaries cannot move down tubes, and so do not meet sperm.



Source: WHO et al., 2011 op cit.

In Vanuatu, female sterilization is performed routinely at the Vila Central Hospital and Northern District Hospital in Luganville, Santo. Outreach surgical teams may sometimes perform female sterilization at other provincial hospitals.

How Effective?

One of the most effective methods but carries a small risk of failure:

- Less than 1 pregnancy per 100 women over the first year after having the sterilization procedure (5 per 1,000); 995 of every 1,000 women relying on female sterilization will not become pregnant.
- A small risk of pregnancy remains.
- Effectiveness varies depending on how the tubes are blocked, but pregnancy rates are low with all techniques. One of the most effective techniques is cutting and tying the cut ends of the fallopian tubes after childbirth (postpartum tubal ligation).

Why some women say they like Female Sterilization.

- Has no side effects.
- No need to worry about contraception again.
- Is easy to use; nothing to do or remember.

Fertility does not return because sterilization generally cannot be stopped or reversed. The procedure is intended to be permanent. Reversal surgery is difficult, expensive, and not available in most areas. When performed, reversal surgery often does not lead to pregnancy (see Question and Answers about Female Sterilization, Q7).

Protection against sexually transmitted infections (STIs): No protection; use condoms to prevent STIs.

Side Effects, Health Benefits, Health Risks and Complications

Side Effects

None

Known Health Benefits.

Helps protect against unplanned pregnancy and PID.

May help protect against ovarian cancer.

Known Health Risks.

Uncommon to extremely rare:

- Complications of surgery and anaesthesia.

Complications of Surgery (see also Managing any Problems, below).

Uncommon to extremely rare:

- Female sterilization is a safe method of contraception. It requires surgery and anaesthesia, however, which carry some risks such as infection or abscess of the wound. Serious complications are uncommon.
- Risk of complications with local anaesthesia is significantly lower than with general anaesthesia. Complications can be kept to a minimum if appropriate techniques are used and if the procedure is performed in an appropriate setting.

Correcting Misunderstandings *(see also Questions and Answers about Female Sterilization).*
Female sterilization:

- Does not make women weak.
- Does not cause lasting pain in back, uterus, or abdomen.
- Does not remove a woman's uterus or lead to a need to have it removed.
- Does not cause hormonal imbalances.
- Does not cause heavier bleeding or irregular bleeding or otherwise change women's menstrual cycles.
- Substantially reduces the risk of ectopic pregnancy.

Medical Eligibility Criteria for

Female Sterilization

All women can have female sterilization. No medical conditions prevent a woman from sterilization. This checklist asks client about known medical conditions that may limit when, where, or how the sterilization procedure should be performed. Ask client questions below. If she answers 'no' to all of the questions, then the female sterilization procedure can be performed in a routine setting without delay. If she answers 'yes' to a question, follow the instructions, which recommend caution, delay, or special arrangements:

- ***Caution***: procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition.
- ***Delay:*** postpone female sterilization. Treat and resolve conditions before female sterilization. Give client another method to use until the procedure can be performed.
- ***Special*****:** arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff and equipment to provide general anaesthesia. Choose another method to use until the procedure can be performed.

1. Do you have any current or past female conditions or problems (gynaecologic or obstetric conditions or problems), such as infection or cancer? If so, what problems?

❑ NO ❑ YES

► If she has any of the following, use ***caution***:

- Past pelvic inflammatory disease since last pregnancy.
- Breast cancer.
- Uterine fibroids.
- Previous abdominal or pelvic surgery.

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

- Current pregnancy.
- 7–42 days postpartum.
- Postpartum after a pregnancy with severe pre-eclampsia or eclampsia.
- Serious postpartum or post-abortion complications (such as infection, haemorrhage, or trauma) except uterine rupture or perforation (*special*; see below)
- A large collection of blood in the uterus.
- Unexplained vaginal bleeding that suggests an underlying medical condition.
- Pelvic inflammatory disease.
- Purulent cervicitis, chlamydia, or gonorrhoea.
- Pelvic cancers (treatment may make her sterile in any case).
- Malignant trophoblast disease.

► If she has any of the following, make ***special*** arrangements:

- AIDS (see Female Sterilization for Women with HIV text box, above).
- Fixed uterus due to previous surgery or infection.
- Endometriosis.
- Hernia (abdominal wall or umbilical).
- Postpartum or post-abortion uterine rupture or perforation.

2. Do you have any cardiovascular conditions, such as heart problems, stroke, high blood pressure, or complications of diabetes? If so, what?

❑ NO ❑ YES

► If she has any of the following, use ***caution***:

- Controlled high blood pressure.
- Mild high blood pressure (140/90 to 159/99 mm Hg).
- Past stroke or heart disease without complications.

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

- Heart disease due to blocked or narrowed arteries.
- Blood clots in deep veins of legs or lungs.

► If she has any of the following, make ***special*** arrangements:

- Several conditions together that increase chances of heart disease or stroke, such as older age, smoking, high blood pressure, or diabetes.
- Moderately high or severely high blood pressure (160/100 mm Hg or higher).
- Diabetes for more than 20 years or damage to arteries, vision, kidneys, or nervous system caused by diabetes.
- Complicated valvular heart disease.

3. Do you have any lingering, long-term diseases or any other conditions? If so, what?

❑ NO ❑ YES

► If she has any of the following, use ***caution***:

- Epilepsy.
- Diabetes without damage to arteries, vision, kidneys, or nervous system.
- Hypothyroidism.
- Mild cirrhosis of the liver, liver tumours (Are her eyes or skin unusually yellow?), or schistosomiasis with liver fibrosis.
- Moderate iron-deficiency anaemia (haemoglobin 7‑10 g/dl).
- Sickle cell disease.
- Inherited anaemia (thalassaemia).
- Kidney disease.
- Diaphragmatic hernia.
- Severe lack of nutrition (Is she extremely thin?).
- Obesity (Is she extremely overweight?).
- Elective abdominal surgery at time sterilization is desired.
- Depression.
- Young age.
- Uncomplicated lupus.

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

- Gallbladder disease with symptoms.
- Active viral hepatitis.
- Severe iron-deficiency anaemia (haemoglobin less than 7 g/dl).
- Lung disease (bronchitis or pneumonia).
- Systemic infection or significant gastroenteritis.
- Abdominal skin infection.
- Undergoing abdominal surgery for emergency or infection, or major surgery with prolonged immobilization.

► If she has any of the following, make ***special*** arrangements:

- Severe cirrhosis of the liver.
- Hyperthyroidism.
- Coagulation disorders (blood does not clot).
- Chronic lung disease (asthma, bronchitis, emphysema, lung infection).
- Pelvic tuberculosis.
- Lupus with positive (or unknown) antiphospholipid antibodies, with severe thrombocytopenia, or on immunosuppressive treatment.

Providing Female Sterilization

When to Perform the Procedure

IMPORTANT: If there is no medical reason to delay, a woman can have sterilization procedure any time if it is reasonably certain she is not pregnant (use Annex 1: Pregnancy Checklist).

Woman's Situation	When to Perform
Having menstrual cycles or switching from another method	**Any time of the month** • Any time within 7 days after the start of period. No need for backup method before procedure. • If >7 days after start of period, have procedure any time it is reasonably certain she is not pregnant. • If switching from oral contraceptives, continue taking pills until she has finished the pill pack to maintain her regular cycle. • If she is switching from IUCD, have procedure immediately (see Chapter 15).
No monthly bleeding	• Any time it is reasonably certain she is not pregnant.
After childbirth	• Immediately or within 7 days after giving birth, if she has made a voluntary, informed choice in advance. • Any time 6 weeks or more after childbirth if it is reasonably certain she is not pregnant.
After miscarriage or abortion	• Within 48 hours after uncomplicated abortion, if she has made a voluntary, informed choice in advance.
After taking ECPs	• Sterilization can be done within 7 days after the start of period or any other time it is reasonably certain she is not pregnant. Use backup method or oral contraceptives the day after she finishes taking the ECPs until the procedure.

Ensuring Informed Consent

IMPORTANT: Friendly, informed counselling will help a woman make an informed choice and be a successful and satisfied user, without later regret (see Because Sterilization Is Permanent text box, below). Involving her partner in counselling can be helpful but is not required.

The 6 Points of Informed Consent

Counselling must cover all 6 points of informed consent. To give informed consent to sterilization, the client must understand the following points:

1. Temporary contraceptives also are available to the client.
2. Voluntary sterilization is a surgical procedure.
3. There are certain risks of the procedure as well as benefits (explain these so client can understand).
4. If successful, the procedure will prevent the client from ever having more children.
5. The procedure is considered permanent and probably cannot be reversed.
6. The client can decide against the procedure at any time before it takes place (without losing rights to other medical, health, or other services or benefits).

Because Sterilization is Permanent

A woman or man considering sterilization should think carefully: 'Could I want more children in the future?' Counsellors can help client make an informed choice. If the answer is 'Yes, I could want more children', offer another family planning method.

Counsellors might ask questions to help:

- 'Do you want to have any more children in the future?'
- 'If not, do you think you could change your mind later? What might change your mind? For example, suppose one of your children died?'
- 'Suppose you lost your spouse, and you married again?'
- 'Does your partner want more children in the future?'

Clients who cannot answer these questions may need to think further about their decisions about sterilization.

In general, people most likely to regret sterilization:

- Are young.
- Have few or no children.
- Have just lost a child.
- Are not married.
- Are having marital problems.
- Have a partner who opposes sterilization.

None of these characteristics rules out sterilization, but health care providers should make especially sure that people with these characteristics make informed, thoughtful choices.

A convenient and safe time for voluntary sterilization may be just after delivery or abortion, however these women are more likely to regret it later. Pre-labour counselling and decision-making help to avoid regrets.

The Decision About Sterilization Belongs to the Client Alone.

A woman may consult her partner about the decision to have sterilization and may consider their view, but the decision cannot be made for them by a partner, family member, health care provider or anyone else. Service providers must ensure that the decision for or against sterilization is made by the client and is free from coercion.

Explaining the Procedure

A client needs to know what will happen during the sterilization procedure. Learning to perform sterilization requires training and practice under direct supervision; therefore the following provides a summary description only.

Note: The description below is for procedures done more than 6 weeks after childbirth. The procedure used up to 7 days after childbirth is slightly different.

The Minilaparotomy Procedure

1. Provider uses proper infection-prevention procedures at all times.
2. Provider performs physical and pelvic examination to assess the condition and mobility of the uterus.
3. Woman usually receives light sedation (with pills or into a vein) to relax her. She stays awake. Local anaesthetic is injected above the pubic hair line.
4. Provider makes a small vertical incision (2–5 cm) in the anaesthetized area. This usually causes little pain (for women who have just given birth, incision made horizontally at the lower edge of the navel).
5. Provider inserts a special instrument (uterine elevator) into vagina, through the cervix, and into the uterus to raise the 2 fallopian tubes so they are closer to the incision. This may cause discomfort.
6. Each tube is tied and cut or else closed with a clip or ring.
7. Provider closes the incision with stitches and covers it with an adhesive bandage.
8. Client receives instructions on what to do after she leaves the clinic or hospital (see Explaining Self-Care for Female Sterilization, below). She usually can leave in a few hours.

The Laparoscopy Procedure

1. The provider uses proper infection-prevention procedures at all times.
2. Provider performs physical and pelvic examination to assess the condition and mobility of the uterus.
3. Woman usually receives light sedation (with pills or into a vein) to relax her. She stays awake. Local anaesthetic is injected under the naval.
4. Provider places a special needle into the abdomen and, through the needle, inflates (insufflates) abdomen with gas or air. This raises the wall of the abdomen away from the pelvic organs.
5. Provider makes a small incision (about 1 cm) in the anaesthetized area and inserts a laparoscope (a long, thin tube containing lenses) to see inside the body and find the 2 fallopian tubes.
6. Provider inserts an instrument through the laparoscope (or, sometimes, through a second incision) to close off the fallopian tubes.
7. Each tube is closed with a clip or a ring, or by electric current applied to block the tube.
8. Provider removes the instrument and laparoscope. The gas or air is let out of the abdomen. Provider closes the incision with stitches and covers it with an adhesive bandage.
9. Client receives instructions on what to do after she leaves the clinic or hospital (see Explaining Self-Care for Female Sterilization, below). She usually can leave in a few hours.

Supporting the User	
Explaining Self-Care for Female Sterilization	
Before the procedure the woman should	• Use another contraceptive until the procedure. • Not eat anything for 8 hours before surgery. She can drink clear liquids until 2 hours before surgery. • Not take any medication for 24 hours before the surgery (unless she is told to do so). • Wear clean, loose-fitting clothing to the health facility if possible. • Not wear nail polish or jewellery. • If possible, bring a friend or relative to help her go home afterwards.
After the procedure, the woman should	• Rest for 2 days and avoid vigorous work and heavy lifting for a week. • Keep incision clean and dry for 1 to 2 days. • Avoid rubbing the incision for 1 week. • Not have sex for at least 1 week. If pain lasts more than 1 week, avoid sex until all pain is gone.
What to do about the most common problems	• She may have some abdominal pain and swelling after the procedure. It usually goes away within a few days. Suggest ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever. She should not take aspirin, which slows blood clotting. Stronger pain reliever is rarely needed. If she had laparoscopy, she may have shoulder pain or feel bloated for a few days.
Plan the follow-up visit	• Following up within 7 days or at least within 2 weeks is strongly recommended. No woman should be denied sterilization, however, because follow-up would be difficult or not possible. • A health care provider checks the site of the incision, looks for any signs of infection, and removes any stitches. This can be done in the clinic, in the client's home (by a specifically trained paramedical worker, for example), or at any other health centre.

Helping Users - Managing Any Problems.

Problems Reported as Complications.

Problems affect women's satisfaction with sterilization. They deserve the provider's attention. If the client reports any problems, listen to the client's concerns and give advice.

Infection at the incision site (redness, heat, pain, pus)

- Clean the infected area with soap and water or antiseptic.
- Give oral antibiotics for 7 to 10 days.
- Ask the client to return after taking all antibiotics if the infection has not cleared.

Abscess (a pocket of pus under the skin caused by infection)

- Clean the area with antiseptic.
- Cut open (incise) and drain the abscess.
- Treat the wound.
- Give oral antibiotics for 7 to 10 days.
- Ask the client to return after taking all antibiotics if she has heat, redness, pain, or drainage of the wound.

Severe pain in lower abdomen (suspected ectopic pregnancy)

- See Managing Ectopic Pregnancy, below.

Suspected pregnancy

- Assess for pregnancy, including ectopic pregnancy.

Managing Ectopic Pregnancy

Ectopic pregnancy is one which occurs outside the uterine cavity. Early diagnosis is important. Ectopic pregnancy is rare but could be life-threatening (see Questions and Answers about Female Sterilization, Q11).

In the early stages of ectopic pregnancy, symptoms may be absent or mild, but eventually they will become severe. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy:

- Unusual abdominal pain or tenderness.
- Abnormal vaginal bleeding or no monthly bleeding – especially if a change from her usual bleeding pattern.
- Light-headedness or dizziness, and fainting.

Ruptured ectopic pregnancy: Sudden stabbing lower abdominal pain, on one side or throughout the body, suggests a ruptured ectopic pregnancy (fallopian tube breaks due to pregnancy). Right shoulder pain may develop due to blood from ruptured ectopic pregnancy pressing on diaphragm. Within a few hours the abdomen becomes rigid and the woman goes into shock.

Care: Ectopic pregnancy is a life-threatening emergency requiring immediate surgery. If ectopic pregnancy is suspected, perform a pelvic examination only if facilities for immediate surgery are available, or refer.

Questions and Answers about Female Sterilization.

1. **Will sterilization change a woman's monthly bleeding or make monthly bleeding stop?**
   No. Sterilization does not cause major changes to bleeding patterns.

2. **Will sterilization make a woman lose her sexual desire? Will it make her fat?**
   No. After sterilization a woman will look and feel the same as before. She can have sex the same as before. She will not gain weight because of the sterilization procedure.

3. **Should sterilization be offered only to women who have had a certain number of children, who have reached a certain age, or who are married?**
   No. There is no justification for denying sterilization to a woman just because of her age, the number of her living children, or her marital status, and health care providers must not impose rigid rules about these things. Each woman must be allowed to decide for herself whether or not she will want more children and whether or not to have sterilization.

4. **Is it not easier for the woman and the health care provider to use general anaesthesia? Why use local anaesthesia?**
   Local anaesthesia is safer. General anaesthesia is more risky than the sterilization procedure itself. Correct use of local anaesthesia removes the single greatest source of risk in female sterilization procedures – general anaesthesia.

5. **Does a woman who has had a sterilization procedure ever have to worry about getting pregnant again?**
   Generally, no. Female sterilization is very effective at preventing pregnancy and is intended to be permanent. It is not 100% effective, however. Women who have been sterilized have a slight risk of becoming pregnant:

6. **Pregnancy after female sterilization is rare, but why does it happen at all?**
   Most often it is because the woman was already pregnant at the time of sterilization. In some cases an opening in the fallopian tube develops. Pregnancy also can occur if the provider makes a cut in the wrong place instead of the fallopian tubes.

7. **Can sterilization be reversed if the woman decides she wants another child?**
   Generally, no. Sterilization is intended to be permanent. People who may want more children should choose a different family planning method. Surgery to reverse sterilization is possible for only some women - those who

have enough fallopian tube left. Even among these women, reversal often does not lead to pregnancy. The procedure is difficult and expensive, and not yet available in Vanuatu.

8. **Is it better for the woman to have female sterilization or the man to have a vasectomy?**
   Each couple must decide for themselves which method is best for them. Both are very effective, safe, permanent methods for couples who know that they will not want more children. Ideally, a couple should consider both methods. If both are acceptable to the couple, vasectomy would be preferable because it is simpler, safer, easier, and less expensive than female sterilization.

9. **Will the female sterilization procedure hurt?**
   Yes, a little. Women receive local anaesthetic to stop pain, and they remain awake. A woman can feel the health care provider moving her uterus and fallopian tubes. This can be uncomfortable. A woman may feel sore and weak for several days or even a few weeks after surgery, but she will soon regain her strength.

10. **How can health care providers help a woman decide about female sterilization?**
    Provide clear, balanced information about female sterilization and other family planning methods, and help a woman think through her decision fully. Thoroughly discuss her feelings about having children and ending her fertility. For example, a provider can help a woman think how she would feel about possible life changes such as a change of partner or a child's death. Review The 6 Points of Informed Consent to be sure the woman understands the sterilization procedure.

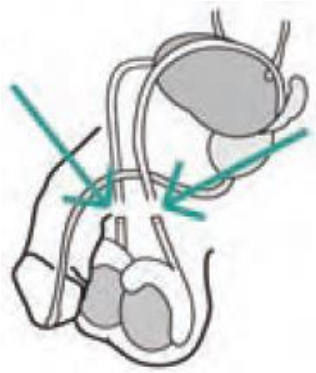
11. **Does female sterilization increase the risk of ectopic pregnancy?**
    No. Female sterilization greatly reduces the risk of ectopic pregnancy.

12. **Where can female sterilization be performed?**
    Minilaparotomy and laparoscopy can be performed routinely at the Vila Central Hospital and the Northern District Hospital in Luganville, Santo. Occasionally, outreach surgical teams may perform female sterilization at other provincial hospitals.

13. **What are trans-cervical methods of sterilization?**
    Trans-cervical methods involve new ways of reaching the fallopian tubes, through the vagina and uterus. A microcoil, Essure, is already available in some countries. Essure is a spring-like device that a specifically trained clinician using a viewing instrument (hysteroscope) inserts through the vagina into the uterus and then into each fallopian tube. Over the 3 months following the procedure, scar tissue grows into the device. The scar tissue permanently plugs the fallopian tubes so that sperm cannot pass through to fertilize an egg. Essure is unlikely to be introduced in Vanuatu any time soon, however, because of the high cost and complexity of the viewing instrument required for insertion.

19. Vasectomy

- Permanent contraception for men who will not want more children.
- Through a puncture/small incision in the scrotum, the provider locates each of the 2 tubes that carries sperm to the penis (vas deferens) and cuts/blocks it by cutting and tying it closed or by applying heat or electricity (cautery).
- Also called male sterilization and male surgical contraception.
- Works by closing off each vas deferens, keeping sperm out of semen.
- Semen is ejaculated, but it cannot cause pregnancy.



Source: WHO et al., 2011 op cit.

In Vanuatu, vasectomy is performed routinely at the Vila Central Hospital and the Northern District Hospital in Luganville, Santo. Occasionally, outreach surgical teams may perform vasectomy at other provincial hospitals.

How Effective?

One of the most effective methods but carries a small risk of failure:

- Where men can have their semen examined after vasectomy, less than 1 pregnancy per 100 women over the first year after their partners have had vasectomies (2 per 1,000). This means that 998 of every 1,000 women whose partners have had vasectomies will not become pregnant.
- Vasectomy is not fully effective for 3 months after the procedure.
  - Some pregnancies occur within the first year because the couple does not use condoms/other contraceptive in first 3 months.
- A small risk of pregnancy remains beyond the first year after vasectomy.
- If the partner of a man who has had a vasectomy becomes pregnant, it may be because:
  - The couple did not use another method in first 3 months
  - The provider made a mistake.
  - The cut ends of the vas deferens grew back together.

Why some men say they like Vasectomy.

- Is safe, permanent, and convenient
- Has fewer side effects and complications than many methods for women
- The man takes responsibility for contraception - takes burden off the woman
- Increases enjoyment and frequency of sex

Fertility does not return because vasectomy generally cannot be stopped or reversed. The procedure is intended to be permanent. Reversal surgery is not available in Vanuatu.

Protection against sexually transmitted infections (STIs): No protection; use condoms to prevent STIs.

Side Effects, Health Benefits, Health Risks and Complications

Side Effects.
None

Known Health Benefits.
None

Known Health Risks.
None

Complications (see also Managing Any Problems, below)

Uncommon: Severe scrotal or testicular pain that lasts for months or years (see Questions and Answers about Vasectomy, Q2).

Very rare: Infection at incision site (uncommon with conventional incision technique; very rare with no-scalpel technique; see below).

Rare: Bleeding under the skin that may cause swelling or bruising (haematoma).

Correcting Misunderstandings *(see also Questions and Answers about Vasectomy).*

Vasectomy:

- Does not remove the testicles; tubes carrying sperm from the testicles are blocked.
- Does not decrease sex drive or sexual function. A man's erection is as hard, it lasts as long, and he ejaculates the same as before.
- Does not prevent transmission of STIs, including HIV.

Medical Eligibility Criteria for

Vasectomy

All men can have vasectomy. No medical conditions excludes this. This checklist asks the client about known medical conditions that may limit when, where, or how the vasectomy procedure should be performed. Ask the client the questions below. If he answers 'no' to all of the questions, then the vasectomy procedure can be performed in a routine setting without delay. If he answers 'yes' to a question below, follow the instructions, which recommend caution, delay, or special arrangements.

In the checklist below:

- ***Caution:*** procedure can be performed in a routine setting with extra preparation and precautions, depending on the condition.
- ***Delay:*** postpone vasectomy. Conditions must be treated and resolved before vasectomy can be performed. Use backup method[33] until the procedure can be performed.
- ***Special:*** arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff and equipment. Use backup method the procedure can be performed.

1. Do you have any problems with your genitals, such as infections, swelling, injuries, or lumps on your penis or scrotum? If so, what problems?

❑ NO ❑ YES

► If he has any of the following, use ***caution***:

- Previous scrotal injury.
- Swollen scrotum due to swelling in spermatic cord or testes (large varicocele or hydrocele).
- Undescended testicle - one side only (vasectomy is performed only on the normal side. If any sperm present in a semen sample after 3 months, other side must be done, too).

► If he has any of the following, ***delay*** vasectomy:

- Active STI.
- Swollen, tender (inflamed) tip of the penis, sperm ducts (epididymis), or testicles.
- Scrotal skin infection or a mass in the scrotum.

► If he has any of the following, make ***special*** arrangements:

- Hernia in groin (provider can perform vasectomy at same time as repairing hernia. If this is not possible, hernia should be repaired first).
- Undescended testicles - both sides.

2. Do you have any other conditions or infections? If so, what?

❑ NO ❑ YES

► If he has any of the following, use ***caution***:

- Diabetes.
- Depression.
- Young age.
- Lupus with positive (or unknown) antiphospholipid antibodies or on immunosuppressive treatment.

► If he has any of the following, ***delay*** vasectomy:

- Systemic infection or gastroenteritis.
- Filariasis or elephantiasis.

► If he has any of the following, make ***special*** arrangements:

- AIDS.
- Blood fails to clot (coagulation disorders).
- Lupus with severe thrombocytopenia.

[33] Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell him that spermicides and withdrawal are the least effective contraceptive methods. If possible, give him condoms.

Providing Vasectomy

When to Perform the Procedure

Any time a man requests it (if there is no medical reason to delay).

Ensuring Informed Consent

IMPORTANT: Friendly, informed counselling will help a man make an informed choice and be a successful and satisfied user, without later regret (see Because Sterilization Is Permanent text box, Chapter 18). Involving his partner in counselling can be helpful but is not required.

The 6 Points of Informed Consent

Counselling must cover all 6 points of informed consent. To give informed consent to vasectomy, the client must understand the following points:

1. Temporary contraceptives also are available to the client.
2. Voluntary vasectomy is a surgical procedure.
   There are certain risks of the procedure as well as benefits (explain these so client can understand).
3. If successful, the procedure will prevent the client from ever having any more children.
4. The procedure is considered permanent and probably cannot be reversed.
5. The client can decide against the procedure at any time before it takes place (without losing rights to other medical, health, or other services or benefits).

Vasectomy Techniques

Reaching the Vas: No-Scalpel Vasectomy: recommended technique for reaching each of the 2 tubes in the scrotum (vas deferens) that carries sperm to the penis. It is becoming the standard around the world.

Differences from conventional procedure using incisions:

- Uses one small puncture instead of 1 or 2 incisions in the scrotum.
- No stitches required to close the skin.
- Special anaesthesia technique needs only one needle puncture instead of 2 or more.
- Less pain and bruising and quicker recovery.
- Fewer infections and less collection of blood in the tissue (haematoma).

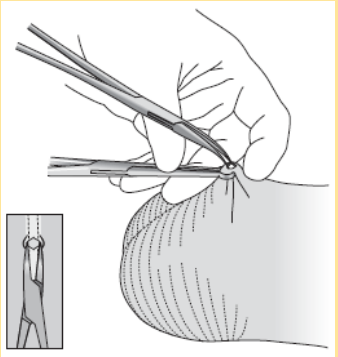
Both no-scalpel and conventional incision procedures are quick, safe and effective.

Blocking the Vas: ligation and excision - cutting and removing a short piece of each tube and then tying both remaining cut ends of the vas. This procedure has a low failure rate.

Explaining the Procedure

A client needs to know what will happen during the vasectomy procedure. Learning to perform vasectomy requires training under direct supervision; therefore the following provides a summary description only.

1. Provider uses proper infection-prevention procedures at all times.
2. Client receives injection of local anaesthetic in his scrotum to prevent pain. He stays awake throughout the procedure.
3. The provider feels the skin of the scrotum to find each vas deferens.
4. The provider makes a puncture or incision in skin:
   - Using the no-scalpel vasectomy technique, the provider grasps the tube with specially designed forceps and makes a tiny puncture in the skin at the midline of the scrotum with a special instrument.
   - Using the conventional procedure, the provider makes 1 or 2 small incisions in the skin with a scalpel.
5. Provider lifts out a small loop of each vas from the puncture or incision, then cuts and ties each tube closed with thread (or cautery). (see Vasectomy Techniques, previous page).
6. The puncture is covered with an adhesive bandage, or the incision may be closed with stitches.
7. Client receives instructions on what to do after he leaves the clinic or hospital (see Explaining Self-Care for Vasectomy, below). He usually can leave within an hour.



Source: WHO et al., 2011 op cit.

Supporting the User	
Explaining Self-Care for Vasectomy	
Before the procedure the woman should	• Wear clean, loose-fitting clothing to the health facility.
After the procedure, the man should	• Rest for 2 days if possible. • Use cold compresses on the scrotum for the first 4 hours to decrease pain and bleeding. He will have some discomfort, swelling, bruising for 2-3 days. • Wear snug underwear or pants for 2-3 days to support scrotum and lessen swelling, bleeding, pain. • Keep puncture/incision site clean and dry for 2-3 days. Use a towel to wipe body clean but do not soak in water. • Do not have sex for at least 2-3 days. • Use condoms or other method for 3 months after the procedure.
What to do about pain/discomfort?	• Discomfort in scrotum lasts 2-3 days. Suggest ibuprofen (200–400 mg), paracetamol (325–1000 mg. Do not take aspirin, which slows blood clotting.
Plan the follow-up visit	• Return in 3 months for semen analysis, (see Questions and Answers about Vasectomy, Q4). • No man should be denied a vasectomy because follow-up would be difficult.

Helping Users - Managing Any Problems.

Problems Reported as Complications.

Problems affect men's satisfaction with vasectomy. They deserve the provider's attention. If the client reports complications of vasectomy, listen to his concerns and, if appropriate, treat.

Bleeding or blood clots after the procedure

- Reassure that minor bleeding and small uninfected blood clots go away without treatment within 2-3 weeks.
- Large blood clots may need to be surgically drained.
- Infected blood clots require antibiotics and hospitalization.

Infection at the puncture or incision site (redness, heat, pain, pus)

- Clean infected area with soap and water or antiseptic.
- Give oral antibiotics for 7 to 10 days and return afterwards if the infection has not cleared.

Abscess (a pocket of pus under the skin caused by infection)

- Clean the area with antiseptic.
- Cut open (incise) and drain the abscess.
- Treat the wound.
- Give oral antibiotics for 7 to 10 days and return afterwards if heat, redness, pain or drainage of the wound.

Pain lasting for months

- Suggest elevating the scrotum with snug underwear or pants.
- Suggest soaking in warm water.
- Aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg.
- Antibiotics if infection is suspected.
- If pain persists and cannot be tolerated, refer (see Questions and Answers about Vasectomy, Q2).

Questions and Answers about Vasectomy.

1. **Will vasectomy make a man lose his sexual ability? Will it make him weak or fat?**
   No. After vasectomy, a man will look and feel the same as before. He can have sex the same as before. His erections will be as hard and last as long as before, and ejaculations of semen will be the same. He can work as hard as before, and he will not gain weight because of the vasectomy.

2. **Will there be any long-lasting pain from vasectomy?**
   Rarely, but some men report having chronic pain or discomfort in the scrotum or testicles that can last from 1 to 5 years or more after a vasectomy. The cause of the pain is unknown; may result from pressure caused by the build-up of sperm that has leaked from an improperly sealed or tied vas deferens, or from nerve damage. Severe, long-lasting pain following vasectomy is uncommon, but all men considering a vasectomy should be told about this risk.

3. **Does a man need to use another contraceptive method after a vasectomy?**
   Yes, for the first 3 months. If his partner has been using a contraceptive method, she can continue to use it during this time. Not using another method for first 3 months is main cause of pregnancies after vasectomy.

4. **Is it possible to check if a vasectomy is working?**
   Yes. A provider can examine a semen sample under a microscope to see if it still contains sperm. A semen examination is recommended at any time after 3 months following the procedure, but is not essential.

5. **What if a man's partner gets pregnant?**
   Vasectomies sometimes fail and a client's partner could become pregnant as a result. If a man's partner becomes pregnant during the first 3 months after his vasectomy, remind the man that for the first 3 months they needed to use another contraceptive method. Offer semen analysis and repeat vasectomy if required.

6. **Will the vasectomy stop working after a time?**
   Generally, no. Vasectomy is intended to be permanent.

7. **Can a man have his vasectomy reversed if he decides that he wants another child?**
   Generally, no. Vasectomy is intended to be permanent. People who may want more children should choose a different family planning method.

8. **Is it better for the man to have a vasectomy or for the woman to have female sterilization?**
   Each couple must decide for themselves which method is best for them. Both are very effective, safe, permanent methods for couples who know that they will not want more children. Ideally, a couple should consider both methods. Vasectomy may be preferable because it is simpler, safer, easier and less expensive.

9. **How can health care providers help a man decide about vasectomy?**
   Provide clear, balanced information about vasectomy and other family planning methods, and help a man think through his decision fully. Thoroughly discuss his feelings about having children and ending his fertility.

10. **Should vasectomy be offered only to men who have reached a certain age or have a certain number of children?**
    No. There is no justification for denying vasectomy to a man just because of his age, the number of his living children, or his marital status.

11. **Can a man who has a vasectomy transmit or become infected with STIs, including HIV?**
    Yes. Vasectomies do not protect against STIs, including HIV. Condoms are still required to protect against STIs, including HIV.

13. **Where can vasectomies be performed?**
    If no pre-existing medical conditions require special arrangements, vasectomy can be performed in almost any health facility, including health care centres, family planning clinics, and the treatment rooms of private doctors. Where other vasectomy services are not available, mobile teams can perform vasectomies and any follow-up examinations in basic health facilities, so long as basic medications, supplies, instruments, and equipment can be made available.

20. Fertility Awareness Methods

- 'Fertility awareness' means that a woman knows how to tell when the fertile time of her menstrual cycle starts and ends (the fertile time is when she can become pregnant).
- Sometimes called periodic abstinence or natural family planning.
- A woman can use several ways, alone or in combination, to tell when her fertile time begins and ends.
- ***Calendar-based methods*** involve keeping track of days of the menstrual cycle to identify the start and end of the fertile time. e.g. Standard Days Method and calendar rhythm method
- ***Symptoms-based methods*** depend on observing signs of fertility.
  - Cervical secretions: When a woman sees or feels cervical secretions, she may be fertile. She may feel just a little vaginal wetness.
  - Basal body temperature (BBT): A woman's resting body temperature goes up slightly after ovulation, when she could become pregnant. Temperature stays higher until the beginning of her next period. e.g. Two Day Method, BBT method, ovulation method (also known as Billings method or cervical mucus method), and the symptothermal method.
- Work primarily by helping a woman know her fertile period. Pregnancy prevented through avoiding unprotected vaginal sex during these fertile days - usually by abstaining or by using condoms (or withdrawal, but this is among the least effective methods).

How Effective?

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

- As commonly used, in the first year about 25 pregnancies per 100 women using periodic abstinence. This means that 75 of every 100 women relying on periodic abstinence will not become pregnant.
- Pregnancy rates with consistent and correct use vary for different types of fertility awareness methods.
- In general, abstaining during fertile times is more effective than using another method during fertile times.

Return of fertility after fertility awareness methods are stopped: No delay
Protection against sexually transmitted infections (STIs): No protection; use condoms to prevent STIs.

Why Some Women Say They Like Fertility Awareness Methods

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

Side Effects, Health Benefits and Health Risks

Side Effects.	Known Health Benefits.	Known Health Risks.
None	Helps prevent unplanned pregnancy	None

Medical Eligibility Criteria for

Calendar-Based Methods

All women can use calendar-based methods. No medical conditions prevent the use of these methods, but some conditions can make them harder to use effectively.

- ***Caution:*** additional or special counselling may be needed to ensure correct use of the method.
- ***Delay:*** use of a particular fertility awareness method should be delayed until the condition is evaluated or corrected. Choose another method to use until she can start the calendar-based method.

In the following situations use ***caution*** with calendar-based methods:

- Menstrual cycles have just started or have become less frequent or stopped due to older age (Menstrual cycle irregularities are common in young women in the first several years after their first monthly bleeding and in older women who are approaching menopause).

In the following situations ***delay*** starting calendar-based methods: • Recently gave birth or is breastfeeding. ***Delay*** until client has had at least 3 menstrual cycles and her cycles are regular. For several months after regular cycles have returned, use with caution. • Recently had an abortion or miscarriage. ***Delay*** until the start of her next period. • Irregular vaginal bleeding.
In the following situations ***delay*** or use ***caution*** with calendar-based methods: • Taking mood-altering drugs such as anti-anxiety therapies (except benzodiazepines), antidepressants (selective serotonin reuptake inhibitors [SSRIs], tricyclic, or tetracyclic), long-term use of certain antibiotics, or long-term use of any nonsteroidal anti-inflammatory drug (aspirin, ibuprofen or paracetamol). These drugs may delay ovulation.

Providing Calendar-Based Methods

When to Start

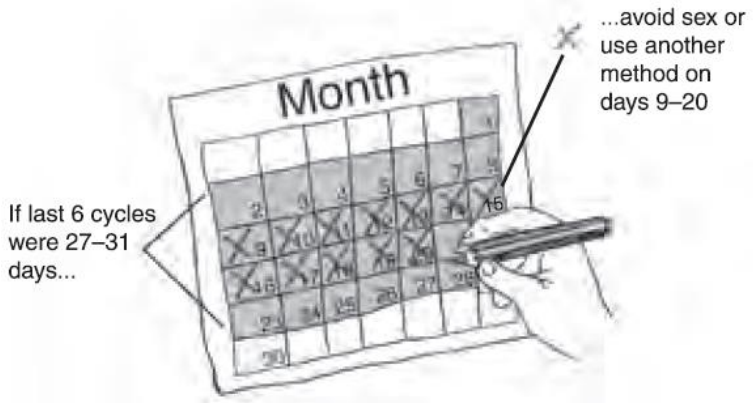
Once trained, a woman or couple usually can begin using calendar-based methods at any time. Give clients who cannot start immediately another method to use until they can start.

Woman's Situation	When to Perform
Having regular menstrual cycles	**Any time of the month** • No need to wait until the start of next monthly bleeding.
No monthly bleeding	• Delay calendar-based methods until monthly bleeding returns.
After childbirth (whether or not breastfeeding)	• Delay the Standard Days Method until she has had 3 menstrual cycles and the last one was 26–32 days long. • Regular cycles will return later in breastfeeding women.
After miscarriage or abortion	• Delay the Standard Days Method until the start of her next period, when she can start if she has no bleeding due to injury to the genital tract.
Switching from a hormonal method	• Delay Standard Days Method until the start of her next period. • If switching from injectables, delay Standard Days Method at least until her repeat injection is due, then start at the beginning of her next period.
After taking EPCs	• Delay the Standard Days Method until the start of her next monthly bleeding.

Explaining how to use Calendar-Based Methods

Standard Days Method	
IMPORTANT: Can use Standard Days Method if most of her menstrual cycles are 26-32 days long. If >2 longer or shorter cycles within a year, Standard Days Method is less effective - choose another method.	
Keep track of days of the menstrual cycle	• A woman keeps track of the days of her menstrual cycle, counting the first day of period as day 1.
Avoid unprotected sex on days 8–19	• Days 8-19 of every cycle are considered fertile. • Avoid vaginal sex or use condoms during days 8-19. Can also use withdrawal, but is less effective. • Couple can have unprotected sex on all the other days of the cycle - days 1-7 at the beginning and day 20 until her next period begins.
Use memory aids if needed	• Mark a calendar or use some other memory aid to keep track of days of her cycle.
Calendar Rhythm Method	
Keep track of days of the menstrual cycle	• Before relying on this method, record number of days in each menstrual cycle for at least 6 months. The first day of period is always counted as day 1.
Estimate the fertile time	• Subtract 18 from the length of her shortest recorded cycle. This estimates first day of her fertile time. • Subtracts 11 days from the length of her longest recorded cycle. This estimates last day of her fertile time.
Avoid unprotected sex during fertile time	• Avoid vaginal sex or use condoms during days 8-19. Can also use withdrawal, but is less effective.

Update calculations monthly	• Updates calculations each month, always using the 6 most recent cycles. Example: – If shortest of last 6 cycles was 27 days, 27 – 18 = 9. Avoid unprotected sex on day 9. – If longest of last 6 cycles was 31 days, 31 – 11 = 20. It OK to have unprotected sex again on day 21. – Unprotected sex to be avoided from day 9-20 of her cycle.



Medical Eligibility Criteria for

Symptoms-Based Methods

All women can use symptoms-based methods. No medical conditions prevent the use of these methods, but some conditions can make them harder to use effectively.

- ***Caution:*** additional or special counselling may be needed to ensure correct use of the method.
- ***Delay:*** use of a particular fertility awareness method should be delayed until the condition is evaluated or corrected. Choose another method to use until she can start the calendar-based method.

In the following situations use ***caution*** with symptoms-based methods:

- Recently had an abortion or miscarriage
- Menstrual cycles have just started or have become less frequent or stopped due to older age (Menstrual cycle irregularities are common in young women in the first several years after their first monthly bleeding and in older women who are approaching menopause).
- Chronic condition that raises body temperature (for BBT and symptothermal methods).

In the following situations ***delay*** starting symptoms-based methods:

- Recently gave birth or breastfeeding (delay until normal secretions have returned - usually at least 6 months after childbirth for breastfeeding women and at least 4 weeks after childbirth for women who are not breastfeeding. For several months after regular cycles have returned, use with caution).
- Acute condition that raises body temperature (for BBT and symptothermal methods).
- Irregular vaginal bleeding.
- Abnormal vaginal discharge.

In the following situations ***delay*** or use ***caution*** with symptoms-based methods:

- Taking mood-altering drugs such as anti-anxiety therapies (except benzodiazepines), antidepressants (selective serotonin reuptake inhibitors [SSRIs], tricyclic, or tetracyclic), anti-psychotics (including chlorpromazine, thioridazine, haloperidol, risperdone, clozapine, or lithium), long-term use of certain antibiotics, any nonsteroidal anti-inflammatory drug (aspirin, ibuprofen or paracetamol). These drugs may affect cervical secretions, raise body temperature, or delay ovulation.

Providing Symptoms-Based Methods

When to Start

Once trained, a woman or couple usually can begin using symptoms-based methods at any time. Women not using a hormonal method can practice monitoring their fertility signs before they start using symptoms-based methods. Give clients who cannot start immediately another method to use until they can start.

Woman's Situation	When to Perform
Having regular menstrual cycles	**Any time of the month** • No need to wait until the start of next monthly bleeding.
No monthly bleeding	• Delay symptoms-based methods until monthly bleeding returns.
After childbirth (whether or not breastfeeding)	• Start symptoms-based methods once normal secretions have returned. • Normal secretions will return later in breastfeeding women.
After miscarriage or abortion	• Start immediately with special counselling and support, if no infection-related secretions or bleeding due to injury to the genital tract.
Switching from a hormonal method	• Start in the next menstrual cycle after stopping a hormonal method.
After taking ECPs	• Start once normal secretions have returned.

Explaining how to use Symptoms-Based Methods

Two Day Method

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

Check for secretions	• Check for cervical secretions every afternoon and/or evening, on fingers, underwear, or tissue paper or by sensation in or around the vagina. • As soon as she notices any secretions of any type, colour, or consistency, she considers herself fertile that day and the following day.
Avoid sex or use other method on fertile days	• Avoid vaginal sex or use condoms during days 8-19. Can also use withdrawal, but is less effective.
Resume unprotected sex after 2 days	• Couple can have unprotected sex after the woman has had 2 dry days (days without secretions of any type) in a row.

Basal Body Temperature (BBT) Method

IMPORTANT: If fever or other changes in body temperature, the BBT method will be difficult to use.

Take body temperature daily	• Take body temperature at the same time each morning before getting out of bed and before eating. Record temperature on a special graph. • Watch for temperature to rise slightly - 0.2° to 0.5° C – just after ovulation (usually about midway through the menstrual cycle).
Avoid sex or use other method until 3 days after temperature rise	• Avoid vaginal sex or use condoms from first day of period until 3 days after temperature has risen above regular levels. Can also use withdrawal, but is less effective.
Resume unprotected sex until next monthly bleeding begins	• When temperature has risen above regular levels and stayed higher for 3 full days, ovulation has occurred and the fertile period has passed. • Can have unprotected sex on the 4th day and until next period begins.

Ovulation Method

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

Check cervical secretions daily	• Check every day for cervical secretions on fingers, underwear or tissue paper or by sensation in or around the vagina.
Avoid unprotected sex on days of heavy monthly bleeding	• Ovulation might occur early in the cycle, during the last days of monthly bleeding, and heavy bleeding could make mucus difficult to observe.
Resume unprotected sex until secretions begin	• Between the end of monthly bleeding and the start of secretions, can have unprotected sex, but not on 2 days in a row (avoiding sex on the second day allows time for semen to disappear and for cervical mucus to be observed).

	• Sex in evenings is recommended, after woman has been in an upright for at least a few hours and has been able to check for cervical mucus.
Avoid unprotected sex when secretions begin and until 4 days after 'peak day'	• As soon as secretions noticed, consider woman to be fertile and should avoid unprotected sex. • Continue to check cervical secretions each day. Secretions have a 'peak day' – the last day that they are clear, slippery, stretchy, and wet. She will know this has passed when, on the next day, her secretions are sticky or dry, or she has no secretions at all. She continues to consider herself fertile for 3 days after that peak day and avoid unprotected sex.
Resume unprotected sex	• Can have unprotected sex on the 4th day after her peak day and until her next monthly bleeding begins.
Symptothermal Method (basal body temperature + cervical secretions + other fertility signs)	
Avoid unprotected sex on fertile days	• Users identify fertile and non-fertile days by combining BBT and ovulation method instructions. • Can also identify fertile time by other signs such as breast tenderness and ovulatory pain (lower abdominal pain or cramping around the time of ovulation). • Avoid unprotected sex between the first day of period and either the fourth day after peak cervical secretions or the third full day after the rise in temperature (BBT), whichever happens later. • Some women who use this method have unprotected sex between the end of monthly bleeding and the beginning of secretions, but not on 2 days in a row.

Helping Continuing Users - Managing Any Problems.

Problems with Use.

- Problems with fertility awareness methods affect women's satisfaction and use of the method. They deserve the provider's attention. If the client reports problems, listen to her concerns and give advice.

Inability to abstain from sex during the fertile time

- Discuss the problem openly with the couple and help them feel at ease, not embarrassed.
- Discuss use of condoms, withdrawal or sexual contact without vaginal sex during the fertile time.
- If she has had unprotected sex in the past 5 days she can consider ECPs (see Chapter 12).

Calendar-Based Methods

Cycles are outside the 26–32 day range for Standard Days Method

- If she has 2 or more cycles outside the 26 to 32 day range within any 12 months, suggest she use the calendar rhythm method or a symptoms-based method instead.

Very irregular menstrual cycles among users of calendar-based methods

- Suggest she use a symptoms-based method instead.

Symptoms-Based Methods

Difficulty recognizing different types of secretions for the ovulation method

- Counsel the client and help her learn how to interpret cervical secretions.
- Suggest she use the Two Day Method (does not require user to tell difference among types of secretions).

Difficulty recognizing the presence of secretions for the ovulation method or the Two Day Method

- Provide additional guidance on how to recognize secretions.
- Suggest she use a calendar-based method instead.

Questions and Answers about Fertility Awareness Methods.

1. **Can only well-educated couples use fertility awareness methods?**
   No. Couples with little or no formal schooling can use fertility awareness methods. Couples must be highly motivated, well trained in their method, and committed to avoiding unprotected sex during the fertile time.

2. **Are fertility awareness methods reliable?**
   For many couples, these methods provide reliable information about the fertile days. If the couple avoids vaginal sex, or uses condoms during the woman's fertile time, fertility awareness methods can be very effective. Using withdrawal during the fertile time is less effective.

3. **What is new about the newer fertility awareness methods, the Standard Days Method and the Two Day Method?**
   These new fertility awareness methods are easier to use correctly than some of the older ones. Thus, they could appeal to more couples and be more effective for some people. They are like older methods, however, in that they rely on the same ways of judging when a woman might be fertile - by keeping track of the days of the cycle for the Standard Days Method and by cervical secretions for the Two Day Method.

4. **How likely is a woman to become pregnant if she has sex during monthly bleeding?**
   During monthly bleeding the chances of pregnancy are low but pregnancy is still possible. Bleeding itself does not prevent pregnancy, nor does it promote pregnancy, either. In the first several days of monthly bleeding, the chances of pregnancy are lowest. For example, on day 2 of the cycle (counting from the first day of bleeding as day 1), the chance of getting pregnant is extremely low (less than 1%). As the days pass, the chances of pregnancy increase, whether or not she is still bleeding. The risk of pregnancy rises until ovulation. The day after ovulation the chances of pregnancy begin to drop steadily. Some fertility awareness methods that depend on cervical secretions advise avoiding unprotected sex during monthly bleeding because cervical secretions cannot be detected during bleeding and there is a small risk of ovulation at this time.

5. **How many days of abstinence or use of another method might be required for each of the fertility awareness methods?**
   The number of days varies based on the woman's cycle length. The average number of days a woman would be considered fertile – and would need to abstain or use another method - with each method is: Standard Days Method, 12 days; Two Day Method, 13 days; symptothermal method, 17 days; ovulation method, 18 days.

21. Withdrawal

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

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

- One of the least effective methods.
- As commonly used, about 27 pregnancies per 100 women whose partner uses withdrawal over the first year. This means that 73 of every 100 women whose partners use withdrawal will not become pregnant.

Return of fertility after fertility awareness methods are stopped: No delay
Protection against sexually transmitted infections (STIs): No protection; use condoms to prevent STIs.

Medical Eligibility Criteria for
Withdrawal
All men can use Withdrawal. No medical conditions prevent its use.

Using Withdrawal **Explaining How to Use**	
When the man feels close to ejaculating	• He should withdraw his penis from the woman's vagina and ejaculate outside the vagina, keeping his semen away from her external genitalia.
If man has ejaculated recently	• Before sex he should urinate and wipe the tip of his penis to remove any sperm remaining.
Giving Advice on use	
Learning proper use can take time	• Suggest the couple also use another method until the man feels that he can use withdrawal correctly with every act of sex.
Greater protection from pregnancy is available	• Suggest an additional or alternative method. Couples who have been using withdrawal effectively should not be discouraged from continuing.
Some men may have difficulty using withdrawal	• Men who cannot sense consistently when ejaculation is about to occur. • Men who ejaculate prematurely.
Can use ECPs	• Explain ECP use in case a man ejaculates before withdrawing (see Chapter 12). Give ECPs if available.

22. Lactation Amenorrhoea Method

- A temporary family planning method based on the natural effect of breastfeeding on fertility ('Lactational' means related to breastfeeding. 'Amenorrhoea' means not having monthly bleeding).
- The lactational amenorrhoea method (LAM) requires 3 conditions. All 3 must be met:
  1. The mother's period has not returned.
  2. The baby is fully (exclusively) or nearly fully breastfed and is fed often, day and night.
  3. The baby is less than 6 months old.
- *'Fully breastfeeding'* includes both exclusive breastfeeding (the infant receives no other liquid or food, not even water, in addition to breast milk) and almost-exclusive breastfeeding (the infant receives mainly breast milk, with addition of some occasional vitamins, water, juice or other nutrients).
- *'Nearly fully breastfeeding'* means that the infant receives some liquid or food in addition to breast milk, but the majority of feedings (more than three-fourths of all feeds) are breast milk.
- Works primarily by preventing the release of eggs from the ovaries (ovulation). Frequent breastfeeding temporarily prevents the release of the natural hormones that cause ovulation.

How Effective?

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

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

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

Protection against sexually transmitted infections (STIs): No protection; use condoms to prevent STIs.

Why Some Women Say They Like the Lactiational Amenorrhoea Method

- It is a natural family planning method.
- It supports optimal breastfeeding, providing health benefits for the baby and the mother.
- It has no direct cost for family planning or for feeding the baby.

Side Effects, Health Benefits and Health Risks

Side Effects.

None. Any problems are the same as for other breastfeeding women.

Known Health Risks.

None

Known Health Benefits.

Helps protect against:

- Risk of unplanned pregnancy

Encourages:

- The best breastfeeding patterns, with health benefits for both mother and baby

Medical Eligibility Criteria for

Lactational Amenorrhoea Method

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

- Has HIV infection including AIDS (see The Lactational Amenorrhea Method for Women with HIV text box, below).
- Is using certain medications during breastfeeding (including mood-altering drugs, reserpine, ergotamine, anti-metabolites, cyclosporine, high doses of corticosteroids, bromocriptine, radioactive drugs, lithium, and certain anticoagulants).
- The newborn has a condition that makes it difficult to breastfeed (including being small-for-date or premature and needing intensive neonatal care, unable to digest food normally, or having deformities of the mouth, jaw, or palate).

Lactational Amenhorroea Method for Women with HIV

- Women who are infected with HIV or who have AIDS can use LAM. There is a chance, however, that mothers will transmit HIV to their infants through breastfeeding. Without any antiretroviral (ARV) therapy, if infants of HIV-infected mothers are mixed-fed (breast milk and other foods) for 2 years, between 10 and 20 of every 100 will become infected with HIV through breast milk. Exclusive breastfeeding reduces this risk of HIV infection through breastfeeding by about half. Reducing the length of time of breastfeeding also greatly reduces the risk. For example, breastfeeding for 12 months reduces transmission by 50% compared with breastfeeding for 24 months. HIV transmission through breast milk is more likely among mothers with advanced disease or who are newly infected.
- Women taking ARV therapy can use LAM (giving ARV therapy to an HIV-infected mother very significantly reduces the risk of HIV transmission through breastfeeding).
- HIV-infected mothers should receive the appropriate ARV interventions and should exclusively breastfeed their infants for the first 6 months of life, introduce appropriate complementary foods at 6 months, and continue breastfeeding for the first 12 months. Breastfeeding should then stop only once a nutritionally adequate and safe diet without breast milk can be provided.
- At 6 months - or earlier if her monthly bleeding has returned or she stops exclusive breastfeeding - a woman should begin to use another contraceptive method in place of LAM and continue to use condoms. Urge women with HIV to use condoms along with LAM to prevent transmission of HIV and other STIs.

Providing the Lactational Amenorrhoea Method

When to Start

Woman's Situation	When to Perform
Within 6 months after childbirth	• Start breastfeeding immediately (within one hour) or as soon as possible after the baby is born. In the first few days after childbirth, the yellowish fluid produced by the mother's breasts (colostrum) contains substances very important to the baby's health. • Any time if she has been fully or nearly breastfeeding her baby since birth and her monthly bleeding has not returned.
When can a woman use LAM?	
A breastfeeding woman can use LAM to space her next birth and as a transition to another contraceptive method. She may start LAM at any time if she meets all 3 criteria required for using the method.	
Ask the mother these 3 questions: 1. Has your period returned? 2. Are you regularly giving the baby other food besides breast milk or allowing long periods without breastfeeding, either day or night? 3. Is your baby more than 6 months old?	
If the answer to all of these questions is no…	**…she can use LAM.** • There is only a 2% chance of pregnancy at this time. Woman may choose another family planning method at any time - but preferably not a method with oestrogen while her baby is less than 6 months old.
But, when the answer to any one of these questions is yes…	**…her chances of pregnancy increase.** • Begin using another family planning method and continue breastfeeding for the child's health.
Explaining how to use the Lactational Amenorrhoea Method	
Breastfeed Often	• An ideal pattern is feeding on demand (that is, whenever the baby wants to be fed) and at least 10-12 times a day in the first few weeks after childbirth and thereafter 8-10 times a day, including >1/night in first months. • Daytime feedings should be no more than 4 hours apart, and night-time feedings no more than 6 hours apart. • Some babies may not want to breastfeed 8-10 times a day and may want to sleep through the night. Give gentle encouragement to breastfeed more often.
Start other foods at 6 months	• Start giving other foods in addition to breast milk when the baby is 6 months old. At this age, breast milk can no longer fully nourish a growing baby.

Plan follow-up visit	• Plan for the next visit while the LAM criteria still apply, to assist choice of another method and continue to be protected from pregnancy. • Give condoms or progestin-only pills now. Use if baby is no longer fully or nearly fully breastfeeding, if her period returns, or if the baby reaches 6 months of age before she can come back for another method. Plan for a follow-on method. Give her any supplies now.

Helping Continuing Users - Managing Any Problems.

Problems with Use.

- Problems with breastfeeding or LAM affect women's satisfaction and use of the method. If the client reports any problems, listen to her concerns, give her advice, and, if appropriate, treat.

Questions and Answers about the Lactational Amenorrhoea Method.

1. **Can LAM be an effective method of family planning?**
   Yes. LAM is very effective if the woman's monthly bleeding has not returned, she is fully or nearly fully breastfeeding, and her baby is less than 6 months old.

2. **When should a mother start giving her baby other foods besides breast milk?**
   Ideally, when the baby is 6 months old. Along with other foods, breast milk should be a major part of the child's diet through the child's second year or longer.

3. **Can women use LAM if they work away from home?**
   Yes. Women who are able to keep their infants with them at work or nearby and are able to breastfeed frequently can rely on LAM as long as they meet all 3 criteria for LAM. Women who are separated from their infants can use LAM if breastfeeds are less than 4 hours apart. Women can also express their breast milk at least every 4 hours, but pregnancy rates may be slightly higher for women who are separated from their infants.

4. **What if a woman learns that she has HIV while she is using LAM? Can she continue breastfeeding and using LAM?**
   If a woman is newly infected with HIV, the risk of transmission through breastfeeding may be higher than if she was infected earlier, because there is more HIV in her body. The breastfeeding recommendation is the same as for other HIV-infected women, however. HIV-infected mothers or their infants should receive the appropriate ARV therapy, and mothers should exclusively breastfeed their infants for the first 6 months of life, then introduce appropriate complementary foods and continue breastfeeding for the first 12 months of life. At 6 months - or earlier if her monthly bleeding has returned or she stops exclusive breastfeeding - she should begin to use another contraceptive method in place of LAM and continue to use condoms.

Annex 1: Pregnancy Checklist[34]

Ask the client questions 1–6. As soon as the client answers 'yes' to any question, stop and follow the instructions below.

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

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

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

[34] Source: WHO, John Hopkins Bloomberg School of Public Health & USAID, 2011; *Family Planning: A Global Handbook for Providers: 2011 Update*; p. 372.