



ZIMBABWE NATIONAL
FAMILY PLANNING COUNCIL



Family Planning: It's Your Choice

FAMILY PLANNING

GUIDELINES FOR ZIMBABWE

2018



A GUIDE TO ESSENTIAL PRACTICE

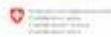


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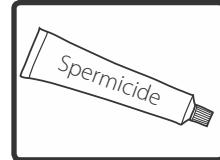
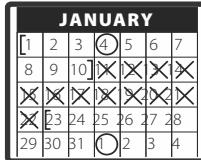
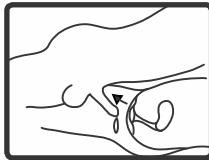
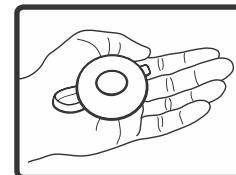
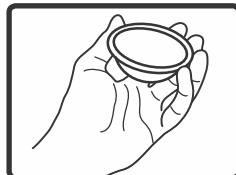
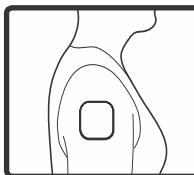
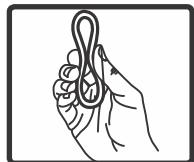
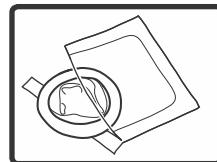
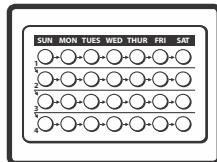
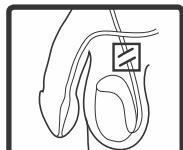
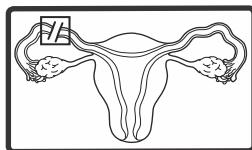
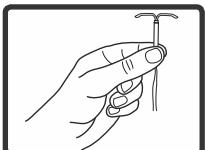
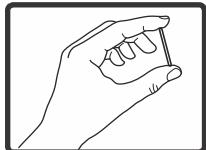
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FAMILY PLANNING

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FOREWORD

The Government of Zimbabwe, through the Ministry of Health and Child Care (MoHCC) and Zimbabwe National Family Planning Council (ZNFPC) has been committed to the delivery of an efficient and effective family planning programme to its citizens since independence. The commitment has been supported by national manuals, policies and strategic documents as well as regional and international protocols and commitments that the government has ratified and made over the years.

Regionally, Zimbabwe ratified the Protocol to the African Charter on Human and People's Rights of Women in Africa and the Maputo Plan of Action for the Operationalisation of the Sexual and Reproductive Health and Rights Continental Policy Framework. On the international front, the country adopted the Sustainable Development Goals and made commitments at the 2012 London Summit on Family Planning (Fp2020). All these are endeavours meant to improve access, delivery and provision of quality family planning (FP) and reproductive health services to the population.

As part of efforts to keep in trend with developments in contraceptive technology and practice, provide modern quality and effective contraceptives and efficiently deliver world class family planning services, it has become prudent for the nation to provide family planning and reproductive health practitioners with updated FP guidelines, based on recent WHO and other global guidance. Health workers are therefore encouraged to use these FP Guidelines alongside other manuals produced by ZNFPC and MOHCC as good practice in family planning and reproductive health services provision.

ZNFPC and MOHCC remain committed to the public and value efforts of our health workers, partners and stakeholders in the provision of FP services, and, as such, we will continuously engage stakeholders for the good of our national family planning programme. To our health workers' representatives, partners and stakeholders, we extend our profound gratitude to your efforts towards the development of these guidelines. Your efforts will certainly make a difference in the lives of Zimbabwean citizens.



Major General Dr. Gerald Gwinji
Permanent Secretary for Health and Child Care



PREFACE

The Zimbabwe National Family Planning Guidelines 2018 were developed with guidance and adaptation from the 2018 WHO Global Family Planning Handbook for Providers and other WHO documents listed in the references. Unless cited otherwise, all illustrations, tables and information boxes were adapted from the stated documents or the WHO Global Family Planning Handbook for Providers, 2018. A small technical working group worked with a consultant in coming up with the final document.

The Postpartum Family Planning Best Practice (Chapter 12) was adapted with permission from the RCOG 2015 Postpartum Contraception Best Practice.

The Medical Eligibility Criteria for Contraception was adapted from the 5th Edition of the WHO Medical Eligibility Criteria, 2015. This was updated with information from the “Hormonal Contraceptive Eligibility for women at high risk of HIV” released in December 2016.



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Ms Margret Nyandoro - Deputy Director Reproductive Health, MoHCC.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health
BBT	Basal Body Temperature
BP	Blood Pressure
CDC	United States Centres for Disease Control and Prevention
CHCs	Combined Hormonal Contraceptive Methods
CI	Coitus Interruptus
CIC	Combined Injectable Contraceptives
CIN	Cervical Intraepithelial Neoplasia
COC	Combined Oral Contraceptive
CPR	Contraceptive Prevalence Rate
CRPD	United Nations Convention on the Rights of Persons with Disabilities
Cu-IUCD	Copper bearing Intrauterine Contraceptive Device
Cu-IUD	Copper bearing Intrauterine Device
CVR	Combined contraceptive vaginal ring
CYP3A4	Cytochrome P450 3A4 enzyme
DMPA	Depot Medroxy Progesterone Acetate
DMPA-IM	Depot Medroxy Progesterone Acetate - Intramuscular
DMPA-SC	Depot Medroxy Progesterone Acetate - Subcutaneous
DVT	Deep Vein Thrombosis
EC	Emergency Contraception
ECP	Emergency Contraception Pill
EE	Ethinyl Estradiol
E-IUD	Emergency Intrauterine Device
EMA	European Medicines Agency
ETG	Etonogestrel
FAB	Fertility Awareness-Based Methods
FAM	Fertility Awareness Method
FP	Family Planning
HB	Haemoglobin
HCP	Health Care Provider
HIV	Human Immuno-Deficiency Virus
HTSP	Healthy Timing and Spacing of Pregnancy
IUCD	Intra Uterine Contraceptive Device
IUD	Intrauterine Device
LAM	Lactational Amenorrhoea Method
LARC	Long Acting Reversible Contraceptives
LNG	Levonorgestrel
LNG-IUCD	Levonorgestrel releasing Intrauterine Contraceptive Device
LNMP	Last Normal Menstrual Period
MEC	Medical Eligibility Criteria
MI	Myocardial Infarction
MOHCC	Ministry of Health and Child Care
NA	Not Applicable





NET-EN	Norethisterone Enanthate
NNRTI	Non-Nucleotide Reverse Transcriptase Inhibitor
NRTI	Nucleoside Reverse Transcriptase Inhibitor
OC	Oral Contraceptive (Pill)
P	Combined Contraceptive Patch
PE	Pulmonary Embolism
PID	Pelvic Inflammatory Disease
PIH	Pregnancy Induced Hypertension
POC	Progestogen Only Contraceptive
POI	Progestogen Only Injectable
POP	Progestogen Only Pill
PPIUCD	Postpartum Intrauterine Contraceptive Device
PPFP	Postpartum Family Planning
PSI	Population Services International
PSZ	Population Services Zimbabwe
PVR	Progesterone-releasing Vaginal Ring
RH	Reproductive Health
RTI	Reproductive Tract Infection
STER	Sterilization (male and female)
STI	Sexually Transmitted Infection
SVT	Superficial Venous Thromboembolism
UN	United Nations
TL	Tubal Ligation
TSS	Toxic Shock Syndrome
PPIUCD	Postpartum IUCD
UNFPA	United Nations Population Fund
UPA	Ulipristal Acetate
VSC	Voluntary Surgical Contraception
VTE	Venous Thromboembolism
WHO	World Health Organization
ZNFWPC	Zimbabwe National Family Planning Council





HOW TO USE THIS GUIDELINE

These guidelines are meant as a quick reference by nurses, midwives doctors and students. They are by no means exhaustive and for in depth study they should be used in conjunction with other reference materials and relevant textbooks.

These guidelines do not include details on specialized skills that require specific training. Please refer to procedure and training manuals for any such details.

Family planning services should be integrated into existing sexual and reproductive health structures according to National guidelines.
Any queries regarding the guidelines should be directed to the Zimbabwe National Family Planning Council in writing.

The contents table has been colour coded to match the colour of each chapter for easy reference.





DEFINITION OF TERMS

Combined Hormonal Contraceptives (CHCs)

These are methods that contain both oestrogen and progesterone and include the combined oral contraceptives (COCs), Combined Injectable Contraceptives (CICs), the patch and vaginal ring.

Intrauterine Contraceptive Device (IUCD) and Intrauterine Device (IUD)

These terms mean the same thing and are used interchangeably in this document.

Post- Partum Family Planning (PPFP) and Post-Partum IUCD (PPIUCD)

Post-Partum Family Planning refers to the entire method mix of family planning methods that can be offered immediately after birth. PPIUCD refers specifically to the insertion of an IUCD immediately after birth.

Progesterone only Contraceptives (POC) These are progesterone only containing contraceptive methods which include pills, injectables, implants and the IUCD

DMPA-SC and DMPA-IM

DMPA-SC - Depo Medroxy Progesterone Acetate given subcutaneously

DMPA-IM - Depo Medroxy Progesterone Acetate given intramuscularly

Post-placental IUCD- IUCD inserted within 10 minutes after vaginal or caesarean delivery of the placenta

Perfect use of a contraceptive method is when used correctly all the time

Typical use of a contraceptive method is what generally happens in real life.



INTRODUCTION

1. What is Family Planning?

Family planning is a conscious decision by individuals or couples to choose for themselves when to start having children, how many children to have, how to space them or when to stop having children by using modern contraception and/or natural methods. (K4 health)

Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and treatment of infertility.¹ [WHO Family Planning/Contraception Fact sheet July 2017]

1.1 What are the benefits of Family Planning?

a) Reducing maternal mortality by preventing pregnancy-related health risks in women

Family planning is one of the 4 pillars of safe motherhood.

A couple or woman's ability to choose when to become pregnant has a direct impact on the health and well-being of the woman. In one analysis of 172 countries, Family Planning was estimated to have reduced maternal mortality by about 44%. In the same analysis, family planning was estimated to have reduced maternal mortality in Zimbabwe by about 58% and by about 38% using a different estimation method.² Zimbabwe's maternal mortality ratio at 651 per 100 000 live births is unacceptably high.³ Below are some of the ways that family planning directly reduces maternal mortality:

- **Overall reduction of exposure to pregnancy:** By reducing the likelihood of unintended pregnancies family planning contributes to reduction in the incidence of pregnancy related complications and therefore reduction in maternal deaths.
- **Safe Birth Spacing:** Short birth intervals of less than 24 months after a term pregnancy and less than 6 months after a miscarriage are associated with increased maternal mortality and morbidity in subsequent pregnancies. Family planning adoption by women, men or couples allows safe birth spacing intervals (see table 1.2).

Delaying first birth: Family planning allows delay of first pregnancies in adolescents and young women who are at increased risk of medical complications and death from early childbearing. Adolescent (15-19yrs) fertility remains high in Zimbabwe, with nearly 1 in every 10 adolescent girls giving birth every year ZDHS 2015. Adolescents and young women are at higher risk of complications such as preeclampsia, anaemia and obstructed labour and have higher chances of delivering preterm or low birth-weight babies.





- **Reduction of unintended pregnancies in women of high parity:** Family planning helps prevent unintended pregnancies in women of high parity; who are at risk of life threatening obstetric complications such as post-partum haemorrhage, morbidly adherent placenta and uterine rupture.
- **Reduction of unintended pregnancies in older women:** Family planning helps prevent unintended pregnancies in women older than 40 years who are at high risk of both obstetric and medical complications during pregnancy which include; preeclampsia/eclampsia, deep vein thrombosis and postpartum haemorrhage.
- **Reducing vulnerability to abortion risks:** Family planning's contribution to reduced rates of unintended pregnancies also reduces the need for unsafe abortion.

In addition, family planning contributes to reduction in maternal mortality indirectly in the following ways:

- **Promoting enabling access in maternity care:** Evidence suggests that contraceptive users are more likely to access antenatal care services and deliver at health facilities.⁴
- **Preserving healthy status of women:** Women who adopt family planning methods are likely to be healthier, of lower parity with less chances of nutrition conditions such as anaemia.⁵
- **Improving economic well-being of family:** Evidence also suggest that family planning adopters have a better standard of living than non-adopters. This implies less competition for expenditure and in the event of pregnancy complications family planning adopters are likely to be better prepared and equipped with the necessary financial resources that may be required such as transport to the health facility etc.⁶

b) Reducing infant mortality

Safe Birth Spacing: Family planning can prevent closely spaced and ill-timed pregnancies and births, which contribute to some of the world's highest infant mortality rates.⁷ In Zimbabwe, approximately one in 15 children dies before his or her fifth birthday, and about 70 percent of these deaths occur during infancy (ZDHS 2015). Infants of mothers who die as a result of giving birth also have a greater risk of death and poor health.

WHO recommends birth spacing intervals of at least 24 months after a term pregnancy and at least 6 months after a miscarriage for healthier pregnancy outcomes

c) HIV Prevention

Family planning reduces the risk of unintended pregnancies among women living with HIV, resulting in fewer infected babies and orphans. Zimbabwe is one of the 22 countries with the highest number of pregnant women living

with HIV and has committed to the Global Plan on Elimination of New HIV infections Among Children and Keeping Their Mothers Alive. One of the 4 prongs of the Elimination of Mother to Child Transmission of HIV (eMTCT) strategy pertains to the prevention of unintended pregnancy among HIV positive women. Thus FP plays a key role in reducing unintended pregnancy among HIV positive women, hence reducing chances of HIV transmission to their babies. In addition, male and female condoms play an important role in the prevention of both unintended pregnancy and STIs including HIV.

In addition, male and female condoms provide dual protection against unintended pregnancies and against STIs including HIV.

d) Empowering people and enhancing education

Family planning

- Has direct links with improving social, economic, health and environmental outcomes for communities.
- Empowers women and men to take responsibility of their lives and make informed choices about their basic sexual and reproductive rights; contributing meaningfully to their overall development and that of their societies and nations.
- Represents an opportunity for women to pursue personal and professional development goals as well as participate in public life, including paid employment.

e) Reducing adolescent pregnancies

Many adolescent girls who become pregnant have to leave school. This has long-term implications for them as individuals, their families and communities.

Given the highlighted benefits; national investment in family planning is therefore key to improving the socio-economic and health status of men, women, children and communities in Zimbabwe. The government of Zimbabwe has developed strategies to optimize delivery and utilization of family planning services for the benefit of the nation.

1.2 Zimbabwe National Family Planning Strategic Direction

The Zimbabwe National Family Planning Council and Ministry of Health and Child Care launched a new strategy and costed implementation plan in 2017 to direct delivery of family planning services for the period 2016-2020, guided by the following vision and mission.

VISION

Quality integrated family planning services for all by 2020.

MISSION

To provide rights based quality integrated FP services through innovation and co-ordination.

The new strategic goals are in alignment with Global Family Planning Strategic Goals. The launch of new global and national strategic goals has also necessitated the review of the Zimbabwe National Family Planning Guidelines for health providers to align with the new strategic direction and current global recommendations.

1.2.1 Zimbabwe Family Planning Strategic Goals

The Zimbabwe National Family Planning Costed Implementation Plan (2016-2020), the document that operationalises the National Family Planning Strategy, has the following goals and objectives summarized in the table below.

Table 1:1

GOALS	PERFORMANCE TARGETS
<ul style="list-style-type: none"> To increase Contraceptive Prevalence Rate (CPR) from 67% to 68% by 2020; and Reduce teenage pregnancy rate from 24% to 12% by 2020. 	<ul style="list-style-type: none"> Reduce unmet need for FP services among married women from 10.4% to 6.5% by 2020; Unmet need for FP among adolescent girls reduced from 12.6% to 8.5% Unmet need among the rural population reduced from 10.9% to 9.5% Increase the knowledge of LAPM among all women and men from 46% to 51% by 2020; Maintain stock out levels of FP commodities below 5% from 2015 to 2020

1.2.2 Guiding Principles on use of guidelines by health providers.

The following principles are expected to guide the implementation of these guidelines as stated in the National Family Planning Strategy 2016-2020.

VALUES

Universal Access:

Ensuring provision of rights based comprehensive integrated quality FP services are made gender sensitive, affordable and accessible to all.

Rights:

Affording everyone, the right to make informed choice of FP method and to have a child as and when they decide. Everyone has the right to information, service and care on integrated Sexual and Reproductive Health (SRH).

Efficiency:

Embark on strategies that will bring most benefit with minimal costs. For achieving faster results, innovation, efficiency and quality should be encouraged for improving utilisation of integrated FP services and rapid scale up of effective interventions.

Choice based:

Individuals and couples have the right to choose a family planning method of their choice, including use of natural methods and should be appropriately counseled.

Accountability:

The implementation of FP programme should ensure efficient and transparent use of resources by establishing mechanisms for holding service providers accountable at every level for the outcomes of the programme and the use of resources.

1.3 What's new in this edition of Guidelines?

1.3.1 WHO 2015 Medical Eligibility Criteria

These guidelines have been reviewed to align with the World Health Organisation 2015 WHO Medical Eligibility Criteria and 2018 Family Planning Handbook for Service Providers.

1.3.2 Post-partum Family Planning

A new chapter on postpartum family planning adapted; with permission from the Royal College of Obstetricians and Gynecologists Best Practice on postpartum family planning. Most Zimbabwean women attend antenatal care and give birth at a health facility. This provides a unique opportunity for health providers to counsel and provide services to a considerable number of women, men and couples on the family planning choices available to them immediately after a woman has given birth.

1.3.3 Human Rights

A new section has been included with information on human rights, and articulates the role of the service provider in providing rights-based FP services.

1.3.4 Pre-conception Counselling

The guidelines provide pre-conception advice that service providers can offer to HIV Sero-Discordant Couples.

1.3.5 Persons With Disabilities

The guidelines have a new section with guidance on serving the needs of person with different forms of disability.

1.3.6 Starting of Re-starting a method after taking Emergency Contraception

Through the chapters, information has been provided on when to start or re-start the different FP methods after taking emergency contraception.

1.3.7 Colour Coding

To make it easier for a busy health provider to locate the pages on any family planning method quicker for reference purposes, the various chapters have been colour coded.

1.3.8 Checklists

Checklists from the WHO Family Planning Handbook for providers have been adapted and included in this edition of guidelines to assist the health providers as job aids and standardize quality of care.

1.4 Key Implementation Issues for Health Providers

1.4.1 Adequate Counseling of women, men and couples

Adequate counseling on family planning methods, particularly on side effects results in improved adherence, retention and continuation of family planning methods. Health providers are urged and strongly recommended to counsel men and women or couples as well as young people adequately. Couples' counseling is recommended if acceptable to the woman; as there is growing evidence of the benefits of couples counseling.

Couples' counseling apparently results in higher continuation rates with the couples' chosen method than individual counseling. Counseling on Family Planning includes the counseling of sub-fertile couples who desire to have children. Sub-fertile women, men and couples should be referred for specialist assessment and treatment. Management of infertility and subfertility are however beyond the scope of these guidelines.

1.4.2 Sexual and Reproductive Health Integration

Family planning service delivery is for most women the first entry point into the health system. A woman or couple who seek family planning services should be counseled, and offered a comprehensive Reproductive, Maternal, New born, Child, Adolescent health and nutrition package, which would include HIV counseling, testing and treatment, cervical cancer screening, breast cancer screening services, immunization services, information services on fitness and well-being, maternal health, child health, antenatal care, intra-partum and post-partum care, with reference to relevant national guidelines for the different thematic areas. There should be no missed opportunity. Such integration should also expand into community health services.

1.4.3 Respect for clients' reproductive health rights

Health is one of the most essential assets that all peoples across the globe; regardless of race religion, socio-economic status or political affiliation may have. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), to which Zimbabwe is signatory, specifically calls upon States to ensure that women especially those in rural areas participate in and benefit from rural development and have access to adequate health care counselling and family planning services. Thus Sexual and Reproductive Health (SRH) including Family Planning, are an essential aspect of women's right to health.

Similar to the provisions of the CEDAW, the Programme of Action for the International Conference on Population and Development (ICPD) 1994 and the Beijing Platform for Action, highlighted the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, and the right of access to appropriate health-care services.

In accordance with these provisions, service providers at all levels of care must respect the reproductive health rights for individual clients and provide comprehensive family planning information to enable informed decision making. The 2018 WHO FP Handbook for Service providers highlights the following 9 human rights principles that guide family planning services and emphasises that health care workers can contribute to all of them.

Human Rights Principles Pertaining to Family Planning

Principle	What the Service Provider Can Do
 Non-discrimination	<ul style="list-style-type: none"> Welcome all clients equally. Respect every client's needs and wishes. Set aside personal judgments and any negative opinions. Promise yourself to give every client the best care you can
 Availability of contraceptive information and services	<ul style="list-style-type: none"> Know the family planning methods available and how to provide them. Make sure that the facility is well stocked with contraceptive supplies Do not rule out any method that a client is eligible for. Do not hold back information.
 Accessible information and services	<ul style="list-style-type: none"> Make sure that the health care facility is accessible to including those with physical disability. Plan for and carry out outreach, when possible. Do not ask clients, even young clients, to get someone else's permission to use family planning or a certain family planning method.
 Acceptable information and services	<ul style="list-style-type: none"> Be friendly and welcoming and help clients feel that way about your facility. Put yourself in the client's shoes. Think of what is important to the clients - what they want and how they want it provided.
 Quality	<ul style="list-style-type: none"> Update your knowledge and skills and keep up with new trends in family planning practice. Use good communication skills. Check that contraceptives you provide are not out-of-date.

 Informed decision-making	<ul style="list-style-type: none">• Explain family planning methods clearly, including how to use them, how effective they are, and what side effects they may have, if any.• Help clients consider what is important to them in a family planning method.
 Privacy and confidentiality	<ul style="list-style-type: none">• Do not discuss your clients with others except with permission and as needed for their care.• When talking with clients, find a place where others cannot hear.• Do not tell others information your clients have shared with you.• Promptly put away clients' records.
 Participation	<ul style="list-style-type: none">• Ask clients what they think about family planning services.• Act on what they say to improve care.
 Accountability	<ul style="list-style-type: none">• Hold yourself accountable for the care that you give clients and for their rights.

1.4.4 Quality

Health Providers should adhere to standard best practices and protocols to ensure provision of quality family planning services.

1.4.5 Equity

Family planning services should be provided equitably. Some clients may require more resource allocation than others. For example, a visually impaired or hearing-impaired client may require longer counseling time than whose sight or hearing are is fully functional. The latter for example may require an extra resource person like a sign language expert in the counseling room whereas a visually impaired person may require recorded audio information on family planning especially in the absence of information written in 'Braille'. Likewise, an illiterate client may require longer counseling times in the appropriate language compared to a literate one. The health provider needs to be aware of these unique needs and adjust accordingly.

1.5 Serving Diverse groups

1.5.1 Clients with Disabilities



Contraceptive provision to people with special needs requires further consideration. Among these are persons with disability. Health care providers must treat persons with disabilities in the same way they treat those without disabilities. Persons with disabilities have the same reproductive health needs as those without disabilities but are often their information needs are considered in the development of information packages for those without disabilities. This is despite the fact that persons with disabilities are often more vulnerable to abuse than those without, making them more susceptible to the acquisition of HIV and STIs. In some instances, persons with disabilities have been sterilized without their informed consent, forced to have abortions or coerced into unwanted marriages or subjected to gender based violence. Decisions on appropriate contraception must consider the nature of the disability, the expressed desires of the individual and the nature of the method. For example barrier methods barrier may present with difficulties to persons with physical disability. Similarly women challenged intellectually may for example, be prone to forgetting to take pills daily or express their method preference clearly.

To adequately care for persons with disabilities, efforts must be made to make it known in the community that the health facility serve persons with disabilities without discrimination. Health facilities should be made physically accessible by e.g. providing ramps for wheelchairs and having larger bathrooms with supporting bars. In addition, service providers doing outreaches should go out of their way to identify and reach out to persons in the community who have limited mobility. Simple IEC materials with graphics, larger print, and some in Braille should be developed and made available in different formats such as print, audio video, CD or cassette tape. Service providers may need especially to use demonstrations, well as describing methods, speak slowly, pause often and check client comprehension in the process. Final decision on the method should be based on informed choice.

Respecting the rights of persons with disabilities should be included in health-workers' pre-service curriculum and re-enforced during in-service training.

Women with mental and psychiatric disorders

Where the nature of the condition such as mental disability or psychiatric disease does not allow for autonomy the ethical principles of doing no harm or the least harm, maximizing good and distributive justice should still be adhered to in provision of family planning services and the next of kin or decision maker should still be provided with adequate information to make an informed choice.

1.5.2 Adolescents

Adolescence is defined by the World Health Organisation (WHO) as the period between the ages of 10 – 19 years. The Zimbabwe National Adolescent fertility study revealed that 9% of the adolescents aged 10-19 years had ever been pregnant. When broken down by age group, 17% of the adolescents aged 15-19 years and 0.2% among the 10-14 years-olds had experienced pregnancy.¹¹ Health providers must thus be aware of risk factors for adolescent pregnancy and offer comprehensive integrated RMNCAH services inclusive of educational, counseling and contraceptive services where needed. Community engagement and intersectoral co-ordination between ministries are key interventions to ensure reduction of adolescent pregnancies.

Risk Factors for adolescent pregnancy according to the National Adolescent fertility study

Age: Adolescent fertility increases from 2% among the 15-year olds to 42% among 19-year olds

Marital status: Married adolescents are likely to fall pregnant than the unmarried ones.

Orphan hood: Increases the likelihood of adolescent pregnancy

Poor economic status: Increases likelihood of adolescent pregnancy.

Adolescent pregnancy in the family: Adolescents with siblings who got pregnant in adolescence were also at higher risk than those whose siblings had no history of adolescent pregnancy.

Rural background: also predisposed to pregnancy.

Ethnicity: Certain tribes at higher risk

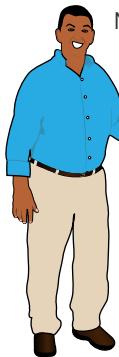
Religion: Adolescents from the apostolic sect were at higher risk of pregnancy.

Sexual abuse: Also predisposed to adolescent pregnancy.

Access to media: Adolescents with no access to radio, TV or newspaper were likely to fall pregnant

In Zimbabwe, adolescents are also at increased risk of STIs, including HIV. Adolescents, have also been shown to have higher discontinuation rates of family planning methods mainly because they tend to be less tolerant of side effects. Expanding the number of method choices offered, as well as proper education and counseling can lead to improved satisfaction, increased acceptance and increased prevalence on contraceptive use.

1.5.3 Serving Men in Family Planning



Men are largely the decision makers in most homes. During a field visit in preparation for review of these national family planning guidelines, most health providers expressed concern over the number of women who requested early removal of implants due to pressure from their husbands because of bleeding side effects. It is therefore critical for family planning service providers to come up with innovations that ensure that men have access to adequate information regarding family planning within their local community if the nation is to meet its 2020 targets to increase LAPM uptake. An increasing body of evidence suggests that couples' counseling on family planning services is more effective than individual counseling. However, a client should not be denied family planning services if their spouse or partner is unable to attend family planning counseling sessions with them.

1.6 Choice of Contraceptive Method

The choice of a contraceptive method depends on many factors. These factors include:

- ✓ Effectiveness of the contraceptive method in preventing unplanned pregnancy.
- ✓ Acceptability.
- ✓ Feasibility.
- ✓ Sustainability.
- ✓ Safety of the method for a particular client profile.
- ✓ Return to fertility.

Consistent and correct use can vary greatly with such characteristics as age, income, users' desires to prevent or delay pregnancy, and culture, religion and should be considered in all cases.

The Medical Eligibility Criteria described in detail in Chapter 2 is a standard way of medically determining appropriate family planning method options for a client.

Healthy Timing and Spacing of Pregnancies (HTSP) Definition

Healthy Timing and Spacing of Pregnancies (HTSP) is a Family Planning (FP) intervention that is associated with the best health outcomes for new-borns, infants, mothers and the whole family through the practice of recommended pregnancy spacing.

Potential Benefits of HTSP vs. Potential Risks of Not Practicing HTSP

Table 1.2.

POTENTIAL BENEFITS OF HTSP	POTENTIAL RISKS IF HTSP IS NOT PRACTICED
For the Newborn Child	
<ul style="list-style-type: none"> When couples adopt HTSP their newborns have a greater potential to be born strong and healthy. Newborns may be breastfed for a longer period. Newborns can experience the substantial nutritional and immune health benefits of breastfeeding for a full two years or more. Mothers who are not caring for a toddler (less than 3 years old) may be better able to provide care and attention to the nutritional needs of their newborns. Mother-baby bonding is enhanced by breastfeeding, which in turn enhances the child's psychomotor and social capabilities 	<ul style="list-style-type: none"> Risk of newborn, infant, and under-five mortality is higher. There may be a greater chance of a pre-term low-birth-weight baby, or the baby may be born too small for its gestational age. If the mother is too exhausted from a new pregnancy, the last-born child may be neglected and, consequently, be at a higher risk of being malnourished and ill. When breastfeeding stops before six months: The emotional link may not be as well nurtured and may diminish the child's psychomotor and social capabilities; The newborn may not experience the benefits of full immune protection afforded by breast milk.
For Infants and Children Less Than Five Years of Age	
<ul style="list-style-type: none"> Mother may have more time to dedicate to nourishing infants and older children's development if there isn't a newborn to take care of. A mother may have more time to spend with her older children and is more likely to meet their emotional needs. 	<ul style="list-style-type: none"> It may be harder to dedicate time and energy to feed other children well during their first two years if the mother is also pregnant or has another newborn to take care of. <p>Infants and children may not grow well and are more likely to die before the age of five</p>
For the Mother	
<ul style="list-style-type: none"> The mother has a reduced risk of emotional pressure to conceive soon after previous birth and the associated complications, pre-eclampsia, prolonged labor, iron-deficiency anaemia, and maternal death. She may have more time to take care of the last-born child. 	<ul style="list-style-type: none"> The more emotional pressure a woman is subjected to in becoming pregnant too soon, the more resentful she may feel, and the stress may prevent her from having a fulfilling relationship. Mothers are at an increased risk for the following: Iron-deficiency anemia;

- She does not have to deal with the demands of a new pregnancy while the last-born child is still in need of her attention.
 - She may breastfeed uninterrupted for a full two years; longer duration of breastfeeding is linked to a reduced risk of breast and ovarian cancer.
 - She may be more rested and can build up nutritional stores to support another healthy pregnancy.
 - She may have less chances of experiencing pregnancy complications.
 - She may have more free time for herself, her children, and her partner.
 - She may have more time to prepare physically, emotionally, and financially for a subsequent pregnancy.
 - She experiences increased opportunities for participation in educational, economic, and social activities.
 - Her status and quality of life improves.
- Prolonged or obstructed labor;
 - Pre-eclampsia;
 - Premature rupture of the membranes; and maternal death

For Men

- His partner may find more time to be with him. This may contribute to the strengthening of the couple's relationship.
 - Expenses associated with a new pregnancy and the newborn will not be added to the expenses already demanded by the last-born child.
 - More time between births may allow a man more time to plan financially and emotionally before the birth of the next child, if the couple plans to have one.
 - A sense of satisfaction increases from:
- The resultant emotional and financial stress may prevent couples from having a fulfilling relationship.
 - If the mother is too tired from a new pregnancy and raising an infant, she may not have the time or energy to spend with her partner.

- Safe-guarding the health and well-being of his partner and children; and
- Supporting his partner in making healthy decisions regarding FP and HTSP as well as raising a healthy family

- Safe-guarding the health and well-being of his partner and children; and
- Supporting his partner in making healthy decisions regarding FP and HTSP as well as raising a healthy family

For the Family

- The economic and emotional burden of parenthood is reduced.
- Families can devote more resources to providing their children with adequate food, clothing, housing, and educational opportunities.
- Additionally, there are added expenses if the mother gets sick while she is pregnant or if there is an emergency, which is more likely to occur when pregnancies are not spaced at healthy intervals
- HTSP is associated with reduced risk of death and illnesses among mothers, newborns, infants, and children.
- It helps reduce poverty and improve the quality of life among community residents.
- It relieves the pressures that rapidly growing populations place on economic, social, and natural resources

- A new pregnancy demands its own expenses: antenatal care, better nourishment for the mother, maternity clothes, savings for the delivery costs, and costs associated with immediate attention and clothing for the newborn. More family expenses may lead to difficult financial circumstances or poverty.
- Less time for family members to spend with each other due to extra time needed for the care of the newborn and the extra time needed to work to pay for expenses.
- Lack of HTSP results in a poor quality of life for community residents
- Economic growth is impeded, making it more difficult to achieve improvements in education, environmental quality, and health.

MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE

2 What is the Medical Eligibility Criteria (MEC)?

The MEC presents current WHO guidance on the safety of various contraceptive methods for use in the context of specific health conditions and characteristics. In the MEC, the safety of each contraceptive method is determined by several considerations in the context of the medical condition or medically relevant characteristics.

2.1 What are the determining factors of the MEC?

- Whether the contraceptive method worsens the medical condition or creates additional health hazards
- Whether the medical circumstance makes the contraceptive less effective.

The safety of the contraceptive method is weighed along with benefits of preventing unintended pregnancy.

2.2 Interpretation of MEC categories in practice

- Categories range from 1 to 4
Classification of method as category 1 client can freely use the method.
- Classification of a method as category 2 indicates the method can generally be used for that condition, but careful follow-up may be required.
- Classification of a method as category 3 implies that the family planning method should generally not be offered for that medical condition or circumstance.
- For a method/condition classified as category 4, the use of that family planning method is contraindicated for that medical condition or circumstance.



Table 2.1 showing Medical Eligibility Criteria Categories

CATEGORIES	WITH LIMITED CLINICAL JUDGEMENT (At clinic or hospital)	WITH CLINICAL JUDGEMENT (At Provincial or Central Hospital with specialists)
Category 1	A condition for which there is no restriction for the use of the contraceptive method.	Use method in any circumstances Yes (Use the method)
Category 2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks.	Generally, use the method
Category 3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method.	Use of method not usually recommended unless other more appropriate methods are not available or not acceptable No (Do not use the method -CONSULT specialist)
Category 4	A condition which represents an unacceptable health risk if the contraceptive method is used.	Method not to be used

2.3 Background of the WHO Medical Eligibility Criteria Fifth Edition, 2015

The medical eligibility criteria in this document were based on the WHO Medical Eligibility Criteria for Contraceptive Use, 2015. Each condition was defined as representing either an individual's characteristics (e.g., age, history of pregnancy) or a known pre-existing medical/pathological condition (e.g., diabetes, hypertension). Institutional health and service delivery environments will decide the most suitable means for screening for conditions according to the public health importance. Client history will often be the most appropriate approach. Health providers are encouraged to use the WHO MEC wheel shown below as an adjunct tool.

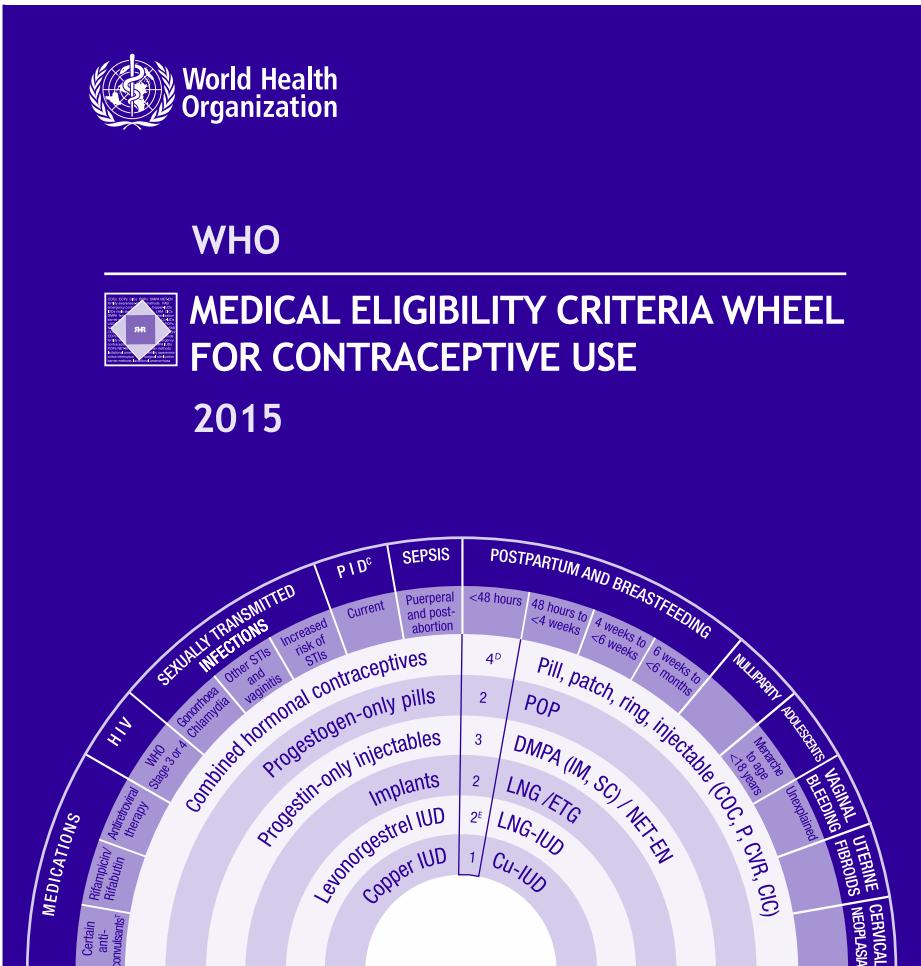


Fig 1: The WHO Medical Eligibility Criteria Wheel used by health providers as a job aid.



In 2014, World Health Organization (WHO) convened two meetings of a Guideline Development Group (GDG), consisting of 68 individuals representing a wide range of stakeholders for the purpose of reviewing and, where appropriate, revising its Medical eligibility criteria for contraceptive use, fourth edition (MEC) guidance. Fourteen topics (encompassing over 575 recommendations) were reviewed by the GDG as part of the revision. All other existing recommendations within the fourth edition were confirmed by the GDG and did not undergo formal review for the updated fifth edition of the MEC.

Recommendations are provided for:

- ✓ Combined hormonal contraceptive use (CHC) by age group.
- ✓ CHC use among breastfeeding women.
- ✓ CHC use among postpartum women.
- ✓ CHC use among women with superficial venous disorders.
- ✓ CHC use among women with known dyslipidaemias without other known cardiovascular risk factors.
- ✓ Progestogen-only contraceptive (POC) and Levonorgestrel releasing intrauterine device.
- ✓ Use of subcutaneously administered Depot Medroxy Progesterone acetate (DMPA-SC) has not yet been adopted for public health setting use in Zimbabwe.
- ✓ Sino-Implant (II) is a new method which is currently not in use in Zimbabwe.
- ✓ Use of implants among post- partum women.
- ✓ Emergency contraceptive pills (ECPs) – Ulipristal acetate (UPA) as a new method added to the guideline; use of CYP3A4 inducers and obesity as new conditions for ECP use.
- ✓ Intrauterine device (IUCD) use for women with increased risk of sexually transmitted infections (STIs).
- ✓ Use of progesterone-releasing vaginal ring as a new method added to the guideline.
- ✓ Hormonal contraception for women at high risk of HIV infection, women living with HIV, and women living with HIV using antiretroviral therapy (ART).

2.4 Summary of the Fifth Edition MEC Recommendations

Topics reviewed for the Medical eligibility criteria for contraceptive use (MEC), fifth edition.

Table 2.2 Adopted from WHO MEC for contraception Fifth Edition 2015

Topic	MEC Recommendations
Recommendations for combined hormonal contraceptive (CHC) use by age group (CHCs include combined oral contraceptives, combined injectable contraceptives, combined patch and combined vaginal ring)	
40 years	Women from menarche through 40 years of age can use CHCs without restriction (MEC Category 1).
40 years	Women 40 years and older can generally use CHCs (MEC Category 2).
2. Recommendations for CHC use among breastfeeding women	
6 weeks postpartum	Breastfeeding women 6 weeks postpartum should not use CHCs (MEC Category 4).
6 weeks to 6 months postpartum	Breastfeeding women 6 weeks to 6 months postpartum (primarily breastfeeding) generally should not use CHCs (MEC Category 3).
6 months postpartum	Breastfeeding women 6 months postpartum can generally use CHCs (MEC Category 2).
3. Recommendations for CHC use among postpartum women	
21 days postpartum without other risk factors for venous thromboembolism (VTE)	Women who are 21 days postpartum and do not have other risk factors for VTE generally should not use CHCs (MEC Category 3).
21 days postpartum with other risk factors for VTE	Women who are 21 days postpartum with other risk factors for VTE should not use CHCs (MEC Category 4).
21 days to 42 days	Women who are 21 days to 42 days postpartum

Topic	MEC Recommendations
postpartum without other risk factors for VTE	without other risk factors for VTE can generally use CHCs (MEC Category 2).
21 days to 42 days postpartum with other risk factors for VTE	Women who are 21 days to 42 days postpartum with other risk factors for VTE generally should not use CHCs (MEC Category 3).
42 days postpartum	Women who are 42 days postpartum can use CHCs without restriction (MEC Category 1).
4. Recommendations for CHC use among women with superficial venous disorders	
Varicose veins	Women with varicose veins can use CHCs without restriction (MEC Category 1).
Superficial venous thrombosis (SVT)	Women with SVT can generally use CHCs (MEC Category 2).
5. Recommendations for CHC use among women with known dyslipidaemias	
Known dyslipidaemias without other known cardiovascular risk factor	Women with known dyslipidaemias without other known cardiovascular risk factors can generally use CHCs (MEC Category 2).
6. Recommendations for progestogen-only contraceptive (POC) and Levonorgestrel-releasing intrauterine device (LNGIUD) use among breastfeeding women	
6a. POC use among breastfeeding women (POCs include progestogen-only pills, implants and injectables)	

Topic	MEC Recommendations
6 weeks postpartum	<p>Breastfeeding women who are 6 weeks postpartum can generally use progestogen-only pills (POPs) and Levonorgestrel (LNG) and Etonogestrel (ETG) implants (MEC Category 2).</p> <p>Breastfeeding women who are < 6 weeks postpartum generally should not use progestogen-only injectables (POIs) (DMPA or NET-EN) (MEC Category 3).</p>
6 weeks to 6 months Postpartum	<p>Breastfeeding women who are 6 weeks to 6 months postpartum can use POPs, POIs, and LNG and ETG implants without restriction (MEC Category 1).</p>
6 months postpartum	<p>Breastfeeding women who are 6 months postpartum can use POPs, POIs, and LNG and ETG implants without restriction (MEC Category 1).</p>
6b. LNG-IUD use among breastfeeding women	
48 hours postpartum	<p>Breastfeeding women who are 48 hours postpartum can generally use LNG-IUDs (MEC Category 2).</p>
48 hours to 4 weeks postpartum	<p>Breastfeeding women who are 48 hours to < 4 weeks postpartum generally should not have an LNG-IUD inserted (MEC Category 3).</p>
4 weeks postpartum	<p>Breastfeeding women who are ≥ 4 weeks postpartum can use an LNG-IUD without restriction (MEC Category 1).</p>
Puerperal sepsis	<p>Breastfeeding (and non-breastfeeding) women with puerperal sepsis should not have an LNG-IUD inserted (MEC Category 4).</p>

Topic	MEC Recommendations
7. Recommendations for use of subcutaneously-administered Depot Medroxy Progesterone Acetate (DMPA-SC) – new method added to the guideline	All recommendations Recommendations for DMPA-SC will follow the current recommendations for DMPA-IM (intramuscular).
8. Recommendations for Sino-implant (II) – new method added to the guideline	All recommendations Recommendations for Sino-implant (II) will follow the current recommendations for LNG implants.
9. Recommendations for emergency contraceptive pills (ECPs) – Ulipristal Acetate (UPA) as a new method added to the guideline; use of CYP3A4 inducers and obesity as new conditions for ECP use	Pregnancy For pregnant women, ECP use is not applicable.
Breastfeeding	Breastfeeding women can use combined oral contraceptive pills (COCs) or LNG for ECPs without restriction (MEC Category 1). Women who are breastfeeding can generally use UPA for ECPs (MEC Category 2).
Past ectopic pregnancies	Women who have experienced past ectopic pregnancies can use COCs, LNG or UPA for ECPs without restriction (MEC Category 1).
History of severe cardiovascular disease	Women with history of severe cardiovascular disease, including Ischaemic Heart Disease, cerebrovascular attack or other thromboembolic conditions, can generally use COCs, LNG or UPA for ECPs (MEC Category 2).
Migraines	Women with migraines can generally use COCs, LNG or UPA for ECPs (MEC Category 2).

Topic	MEC Recommendations
Severe liver disease	Women with severe liver disease, including jaundice (a personal characteristic and sign of liver disease prior to diagnosis), can generally use COCs, LNG or UPA for ECPs (MEC Category 2).
Use of CYP3A4 inducer	Women using CYP3A4 inducers can use COCs, LNG or UPA for ECPs without restriction (MEC Category 1).
Repeat use of ECP	There are no restrictions on repeated use for COCs, LNG or UPA for ECPs (MEC Category 1).
Rape	There are no restrictions for use of COCs, LNG or UPA for ECPs in cases of rape (MEC Category 1).
Obesity	Women who are obese can use COCs, LNG or UPA for ECPs without restriction (MEC Category 1).
10. Intrauterine device (IUD) use for women with increased risk of sexually transmitted infections (STIs)	
IUD initiation	Many women with increased risk of STIs can generally undergo either copper-bearing IUD (Cu-IUD) or LNG-IUD initiation (MEC Category 2). Some women at increased risk (very high individual likelihood) of STIs generally should not have an IUD inserted until appropriate testing and treatment occur (MEC Category 3).
IUD continuation	Women at increased risk of STIs can generally continue use of either Cu-IUD or LNG-IUD (MEC Category 2).
11. Recommendations for use of progesterone-releasing vaginal ring - new method added to the guideline	
Breastfeeding and 4 weeks	Women who are actively breastfeeding and are 4 weeks postpartum can use the progesterone-

Topic	MEC Recommendations
postpartum	releasing vaginal ring without restrictions (MEC Category 1).
12. Recommendations for use of hormonal contraception for women at high risk of HIV infection, women living with HIV, and women living with HIV using antiretroviral therapy (ART)	
12a. Women at high risk of HIV infection	Women at high risk of acquiring HIV can use the following hormonal contraceptive methods without restriction: COCs, combined injectable contraceptives (CICs), combined contraceptive patches and rings, POPs, POIs (DMPA and NET-EN), and LNG and ETG implants (MEC Category 1). Women at high risk of acquiring HIV can generally use LNG-IUDs (MEC Category 2).
12b Women living with asymptomatic or mild HIV clinical disease (WHO stage 1 or 2)	Women living with asymptomatic or mild HIV clinical disease (WHO stage 1 or 2) can use the following hormonal contraceptive methods without restriction: COCs, CICs, combined contraceptive patches and rings, POPs, POIs (DMPA and NET-EN), and LNG and ETG implants (MEC Category 1). Women living with asymptomatic or mild HIV clinical disease (WHO stage 1 or 2) can generally use the LNG-IUD (MEC Category 2).
12c. Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4)	Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4) can use the following hormonal contraceptive methods without restriction: COCs, CICs, combined contraceptive patches and rings, POPs, POIs (DMPA and NET-EN), and LNG and ETG implants (MEC Category 1). Women living with severe or advanced HIV clinical disease (WHO stage

Topic	MEC Recommendations
	3 or 4) generally should not initiate use of the LNG-IUD (MEC Category 3) until their illness has improved to asymptomatic or mild HIV clinical disease (WHO stage 1 or 2).
	Women who already have an LNG-IUD inserted and who develop severe or advanced HIV clinical disease need not have their IUD removed (MEC Category 2 for continuation).
12d. Women living with HIV using antiretroviral therapy (ART)	<p>[IMPORTANT NOTE: Despite an apparent decrease in contraceptive efficacy among women living with HIV using implants and an Efavirenz containing ART regimen, the effectiveness remains very high, especially in comparison with other shorter-acting hormonal methods. Data are still needed to support strategies for optimizing the effectiveness of contraceptive implants, including duration of effectiveness, when used with Efavirenz-containing ART regimens.]</p>
Nucleoside/nucleotide reverse transcriptase inhibitor (NRTI)	<p>Women taking any NRTI can use the following hormonal contraceptive methods without restriction: COCs, CICs, combined contraceptive patches and rings, POPs, POIs (DMPA and NET-EN), and LNG and ETG implants (MEC Category 1).</p>
	<p>Women taking any NRTI can generally use the LNG-IUD (MEC Category 2), provided that their HIV clinical disease is asymptomatic or mild (WHO Stage 1 or 2). Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4) and taking any NRTI generally should not initiate use of the LNG-IUD (MEC Category 3 for initiation) until their illness has improved to asymptomatic or mild HIV clinical disease.</p>
	<p>Women taking any NRTI who already have had an</p>

Topic	MEC Recommendations
	LNG-IUD inserted and who develop severe or advanced HIV clinical disease need not have their IUD removed (MEC Category 2 for continuation).
Non-nucleoside/nucleotide reverse transcriptase inhibitors (NNRTIs) containing Efavirenz or Nevirapine containing ART	<p>Women using NNRTIs containing either Efavirenz or Nevirapine can generally use COCs, CICs, combined contraceptive patches and rings, POPs, NET-EN, and LNG and ETG implants (MEC Category 2).</p> <p>Women using Efavirenz or Nevirapine can use DMPA without restriction (MEC Category 1).</p> <p>Women using NNRTIs containing either Efavirenz or Eevirapine can generally use the LNG-IUD (MEC Category 2), provided that their HIV clinical disease is asymptomatic or mild (WHO Stage 1 or 2). Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4) and using Efavirenz or Nevirapine generally should not initiate use of the LNG-IUD (MEC Category 3 for initiation) until their illness has improved to asymptomatic or mild HIV clinical disease.</p> <p>Women using Efavirenz or Nevirapine who already have had an LNG-IUD inserted and who develop severe or advanced HIV clinical disease need not have their IUD removed (MEC Category 2 for continuation).</p>
NNRTIs containing Etravirine and Rilpivirine	Women using the newer NNRTIs containing Etravirine and Rilpivirine can use all hormonal contraceptive methods without restriction (MEC Category 1).

Topic	MEC Recommendations
	<p>Women taking newer NNRTIs can generally use the LNG-IUD (MEC Category 2), provided that their HIV clinical disease is asymptomatic or mild (WHO Stage 1 or 2). Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4) and using newer NNRTIs generally should not initiate use of the LNGIUD (MEC Category 3 for initiation) until their illness has improved to asymptomatic or mild HIV clinical disease.</p> <p>Women using newer NNRTIs who already have had an LNGIUD inserted and who develop severe or advanced HIV clinical disease need not have their IUD removed (MEC Category 2 for continuation).</p>
Protease inhibitors (e.g. ritonavir and ARVs boosted with ritonavir)	<p>Women using protease inhibitors (e.g. Ritonavir and ARVs boosted with ritonavir) can generally use COCs, CICs, combined contraceptive patches and rings, POPs, NET-EN, and LNG and ETG implants (MEC Category 2).</p> <p>Women using protease inhibitors (e.g. ritonavir and ARVs boosted with ritonavir) can use DMPA without restriction (MEC Category 1).</p> <p>Women using protease inhibitors (e.g. Ritonavir and ARVs boosted with Ritonavir) can generally use the LNG-IUD (MEC Category 2), provided that their HIV clinical disease is asymptomatic or mild (WHO Stage 1 or 2). Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4) and using protease inhibitors generally should not initiate use of the LNG-IUD (MEC Category 3 for initiation) until their illness has improved to asymptomatic or mild HIV clinical disease.</p>

Topic	MEC Recommendations
	Women using protease inhibitors who already have had an LNGIUD inserted and who develop severe or advanced HIV clinical disease need not have their IUD removed (MEC Category 2 for continuation).
Raltegravir (integrase inhibitor)	<p>Women using the integrase inhibitor Raltegravir can use all the following hormonal contraceptive methods without restriction: COCs, CICs, combined contraceptive patches and rings, POPs, POIs (DMPA and NET-EN), and LNG and ETG implants (MEC Category 1).</p> <p>Women using Raltegravir can generally use the LNG-IUD (MEC Category 2), provided that their HIV clinical disease is asymptomatic or mild (WHO Stage 1 or 2). Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4) and using Raltegravir generally should not initiate use of the LNG-IUD (MEC Category 3 for initiation) until their illness has improved to asymptomatic or mild HIV clinical disease.</p> <p>Women using Raltegravir who already have had an LNG-IUD inserted and who develop severe or advanced HIV clinical disease need not have their IUD removed (MEC Category 2 for continuation).</p>

For those who are familiar with the fourth edition of the MEC, the following summaries highlight changes that appear in the fifth edition of the guidelines. These changes include: changes to MEC categories; recommendations for new conditions issued in the fifth edition; changes to the labelling of certain conditions (to be consistent with current clinical practice); and details for the new contraceptive methods included in this fifth edition.⁸

SUMMARY OF CHANGES OF WHO MEC 2015

Table 2.3. Summary of changes from 4th to 5th

(Adapted from WHO Medical Eligibility for contraceptive use 2015, table 2.4-2.6.)

Guidance to read the table

Please consult table 2.2 above for each contraceptive method or refer to original tables 2.4-2.6 in the full document, WHO Medical Eligibility Criteria 2015, Fifth Edition for a clarification to this classification where the MEC is labelled “a”

In general where the MEC appears as 2/3 the implication is that MEC for that Family Planning method is either 2 or 3 depending on HIV clinical stage for that medical condition or circumstance. The “a” is a pointer to the fact that there is an explanation for that classification which the health provider may want to read further on as highlighted.

I -represents MEC for initiation of method

C-represents MEC for continuation of family planning method e.g. A woman on Effavirenz with Stage 3 HIV disease should not initiate Cu-IUCD as Stage 3 HIV disease categorizes the IUCD into MEC 3. She can insert it however if she later improves to Stage 2 HIV disease. However, a woman who already has a Cu-IUCD in situ and then develops Stage 3 HIV disease need not remove it, but continues on it. Therefore, continuation of Cu -IUCD is MEC 2.

CONDITION	COC/P/CVR	CIC	POP	NET-ET	LNG/ETG	Implants	Cu-IUD	LNG-IUD
Postpartum (breastfeeding women)								
Breastfeeding								
a) < 6 weeks postpartum	4		4	2a	3a	2a	1	1
b) ≥ 6 weeks to < 6 months (primarily breastfeeding)	3		3	1	1	1	1	1
c) ≥ 6 months postpartum	2		2	1	1	1	1	1
Postpartum (non-breastfeeding women)								
a) < 21 days				1	1	1	1	1
(i) without other risk factors for VTE	3a		3a	1	1	1	1	1
(ii) with other risk factors for VTE	4a		4a	2	2	2	1	2

CONDITION	COC/P/CVR	CIC	POP	DMPA NET-ET	LNG/ETG Implants	Cu-IUD	LNG-IUD
Postpartum (breastfeeding women)							
b) ≥ 21 days to 42 days	4	4	1	1	1	1	1
(i) without other risk factors for VTE	2a	2a	1	1	1	1	1
(ii) with other risk factors for VTE	3a	3a	2	2	2	1	2
c) > 42 days<6 months	3	3	1	1	1	1	1
Postpartum ('breastfeeding or non-breastfeeding women, including after caesarean section)							
a) < 48 hours including insertion immediately after delivery of the placenta	4	4	2	3	2	1	not BF=1; BF=2

CONDITION	COC/P/CVR	CIC	POP	DMPA NET-ET	LNG/ETG Implants	Cu-IUD	LNG-IUD
Postpartum (breastfeeding women)							
b) ≥ 48 hours to < 4 weeks		4	4	2	3	2	3
c) ≥ 4 < 6 weeks	4	4	2	3	2	1	1
d) Puerperal sepsis	4	4	2	3	2	4	4
Superficial venous disorders							
a) Varicose veins	1	1	1	1	1	1	1
b) Superficial venous thrombosis	2a	2a	1	1	1	1	1
Known dyslipidaemias without other known cardiovascular risk factors	2a	2a	2a	2a	2a	1a	2a

CONDITION	COC/P/CVR	CIC	POP	DMPA NET-ET	LNG/ETG Implants	Cu-IUD	LNG-IUD
Postpartum (breastfeeding women)							
STIs						1	C
a) Current purulent cervicitis or chlamydial infection or gonorrhoea	1	1	1	1	1	4	2
b) Other STIs (excluding HIV and hepatitis)	1	1	1	1	1	2	2
c) Vaginitis (including Trichomonas vaginalis and bacterial vaginosis)	1	1	1	1	1	2	2
d) increased risk of STIs	1	1	1	1	1	2/3a	2

CONDITION	COC/P/CVR	CIC	POP	DMPA NET-ET	LNG/ETG Implants	Cu-IUD	LNG-IUD
Postpartum (breastfeeding women)							
HIV/AIDS							
High risk of HIV	1	1	1	2(updated 2016)	1	2	2
Asymptomatic or mild HIV clinical disease (WHO stage 1 or 2)	1a	1a	1a	1a	1a	2	2
Severe or advanced HIV clinical disease (WHO stage 3 or 4)	1a	1a	1a	1a	1a	3	2
Antiretroviral therapy	1	C	1	C			
a) Nucleoside reverse transcriptase inhibitors (NRTIs)							
Abacavir (ABC)	1	1	1	1	1	2/3a	2a
						2/3a	2a

CONDITION	COC/P/CVR	CIC	POP	DMPA NET-ET	LNG/ETG Implants	Cu-IUD	LNG-IUD
Postpartum (breastfeeding women)							
Tenofovir (TDF)	1	1	1	1	1	2/3a	2a
Zidovudine (AZT)	1	1	1	1	1	2/3a	2a
Lamivudine (3TC)	1	1	1	1	1	2/3a	2a
Didanosine (DDI)	1	1	1	1	1	2/3a	2a
Emtricitabine (FTC)	1	1	1	1	1	2/3a	2a
Stavudine (D4T)	1	1	1	1	1	2/3a	2a
b) Non-nucleoside reverse transcriptase inhibitors (NNRTIs)							
Efavirenz (EFV)	2a	2a	2a	1=DMPA 2=NET-ENA		2/3a	2a
Etravirine (ETR)	1	1	1	1	1	2/3a	2a
Nevirapine (NVP)	2a	2a	2a	1=DMPA 2=NET-ENA	2a	2/3a	2a

CONDITION	COC/P/CVR	CIC	POP	DMPA NET-ET	LNG/ETG Implants	Cu-IUD	LNG-IUD
Postpartum (breastfeeding women)							
Rilpivirine (RPV)	1	1	1	1	1	2/3a	2a
c) Protease inhibitors (PIs)							
Ritonavir-boosted atazanavir (ATV/r)	2a	2a	2a	1=DMPA 2=NET-ENA	2a	2/3a	2a
Ritonavir-boosted lopinavir (LPV/r)	2a	2a	2a	1=DMPA 2=NET-ENA	2a	2/3a	2a
Ritonavir-boosted darunavir (DRV/r)	2a	2a	2a	1=DMPA 2=NET-ENA	2a	2/3a	2a
Ritonavir (RTV)	2a	2a	2a	1=DMPA 2=NE-ENA	2a	2/3a	2a
d) Integrase inhibitors							
Raltegravir (ral)	1	1	1	1	1	2/3a	2a

Progestrone-releasing vaginal ring (PVR)

Condition	Category
Pregnancy	NA
Breastfeeding and ≥ 4 weeks postpartum	1

Emergency contraceptive pills (ECPs)

Condition	COC	LNG	UPA
Pregnancy			
Breastfeeding	1	1	2a
Past ectopic pregnancy	1	1	1
Obesity	1a	1a	1a
History of severe cardiovascular disease (ischaemic heart disease, cerebrovascular attack, or other thromboembolic conditions)	2	2	2
Migraine	2	2	2
Severe liver disease (including jaundice)	2	2	2
CYP3A4 inducers (e.g. Rifampicin, Phenytoin, Phenobarbital, Carbamazepine, Efavirenz, Fosphenytoin, Nevirapine, Oxcarbazepine, Primidone, Rifabutin, St John's wort/Hypericum perforatum)	1a	1a	1a
Repeated ECP use	1a	1a	1a
Rape	1	1	1

Please consult the relevant table for each contraceptive method in the full document, for a clarification to this classification.

The above tables and use of the WHO MEC wheel is recommended for MEC determination

Table 2.4. Family Planning Methods at a glance (Adapted from WHO Family Planning/Contraception Fact sheet July 2017)

Method	Description	How it works	Effectiveness to prevent pregnancy	Comments
Combined oral contraceptives (COCs) or “the pill”	Contains two hormones (estrogen and progestogen)	Prevents the release of eggs from the ovaries (ovulation)	>99% with correct and consistent use (perfect use) 92% as commonly used (typical use)	Reduces risk of endometrial and ovarian cancer
Prgestogen-only pills (POPs) or “the minipill” 41	Contains only progestogen hormone, no estrogen	Thickens cervical mucous to block sperm and egg from meeting and prevents ovulation	99% with correct and consistent use (perfect use) 90–97% as commonly used (typical use)	Can be used while breastfeeding; must be taken at the same time each day
Implants	Small, flexible rods or capsules placed under the skin of the	Thickens cervical mucous to	>99%	Health-care provider must insert and remove; can be used

Method	Description	How it works	Effectiveness to prevent pregnancy	Comments
	upper arm; contains progestogen hormone only	blocks sperm and egg from meeting and prevents ovulation	for 3-5 years depending on implant; irregular vaginal bleeding common but not harmful	
Progestogen only injectables	Injected into the muscle or under the skin every 2 or 3 months, depending on product	Thickens cervical mucous to block sperm and egg from meeting and prevents ovulation	>99% with correct and consistent use (perfect use)	Delayed return to fertility (about 1-4 months on the average) after use; irregular vaginal bleeding common, but not harmful
			97% as commonly used (typical use)	
Monthly injectables or combined injectable contraceptives (CIC)	Injected monthly into the muscle, contains estrogen and progestogen	Prevents the release of eggs from the ovaries (ovulation)	>99% with correct and consistent use (perfect use)	Irregular vaginal bleeding common, but not harmful
			97% as commonly used (typical use)	

Method	Description	How it works	Effectiveness to prevent pregnancy	Comments
Combined contraceptive patch and combined contraceptive vaginal ring (CVR)	Continuously releases 2 hormones - a progestin and an estrogen- directly through the skin (patch) or from the ring.	Prevents the release of eggs from the ovaries (ovulation)	The patch and the CVR are new and research on effectiveness is limited. Effectiveness studies report that it may be more effective than the COCs, both as commonly and consistent or correct use.	The Patch and the CVR provide a comparable safety and pharmacokinetic profile to COCs with similar hormone formulations.
Intrauterine device (IUD): copper containing	Small flexible plastic device containing copper sleeves or wire that is inserted into the uterus	Copper component damages sperm and prevents it from meeting the egg	>99%	Longer and heavier periods during first months of use are common but not harmful; can also be used as emergency contraception

Method	Description	How it works	Effectiveness to prevent pregnancy	Comments
(IUD) Levonorgestrel	A T-shaped plastic device inserted into the uterus that steadily releases small amounts of Levonorgestrel each day	Thickens cervical mucous to block sperm and egg from meeting	>99%	Decreases amount of blood lost with menstruation over time; Reduces menstrual cramps and symptoms of endometriosis; amenorrhea (no menstrual bleeding) in a group of users
Male condoms	Sheaths or coverings that fit over a man's erect penis	Forms a barrier to prevent sperm and egg from meeting	98% with correct and consistent use (Perfect use)	Also protects against sexually transmitted infections, including HIV

Method	Description	How it works	Effectiveness to prevent pregnancy	Comments
Female condoms	Sheaths, or linings, that fit loosely inside a woman's vagina, made of thin, transparent, soft plastic film	Forms a barrier to prevent sperm and egg from meeting	90% with correct and consistent use (Perfect use)	Also protects against sexually transmitted infections, including HIV
Male sterilization (vasectomy)	Permanent contraception to block or cut the vas deferens tubes that carry sperm from the testicles	Keeps sperm out of ejaculated semen	>99% after 3 months semen evaluation 97-98% with no semen evaluation	3 months delay in taking effect while stored sperm is still present; does not affect male sexual performance; voluntary and informed choice is essential
Female sterilization (tubal ligation)	Permanent contraception to block or cut the fallopian tubes	Eggs are blocked from meeting sperm	>99%	Voluntary and informed choice is essential

Method	Description	How it works	Effectiveness to prevent pregnancy	Comments
Lactational amenorrhea method (LAM)	Temporary contraception for new mothers whose monthly bleeding has not returned; requires exclusive or full breastfeeding day and night of an infant less than 6 months old	Prevents the release of eggs from the ovaries (ovulation)	99% with correct and consistent use (Perfect use)	A temporary family planning method based on the natural effect of breastfeeding on fertility

Method	Description	How it works	Effectiveness to prevent pregnancy	Comments
Emergency contraception pills (Ulipristal acetate 30 mg or Levonorgestrel 1.5 mg)	Pills taken to prevent pregnancy up to 5 days after unprotected sex	Delays ovulation	If all 100 women used progestin-only emergency contraception, one would likely become pregnant.	Does not disrupt an already existing pregnancy
Standard Days Method or SDM	Women track their fertile periods (usually days 8 to 19 of each 26 to 32-day cycle) using cycle beads or other aids	Prevents pregnancy by avoiding unprotected vaginal sex during most fertile days	95% with consistent and correct use.	Can be used to identify fertile days by both women who want to become pregnant and women who want to avoid pregnancy. Correct, consistent use requires partner cooperation.
Basal Body Temperature (BBT) Method	Woman takes her body temperature at the same time each morning before getting out of bed observing for an	Prevents pregnancy by avoiding unprotected vaginal sex during fertile	88% with common use (Arevalo et al 2002)	If the BBT has risen and has stayed higher for 3 full days, ovulation has occurred, and the fertile period has passed. Sex can

Method	Description	How it works	Effectiveness to prevent pregnancy	Comments
	increase of 0.2 to 0.5 degrees C.	days		resume on the 4th day until her next monthly bleeding.
Two Day Method	Women track their fertile periods by observing presence of cervical mucus (if any type color or consistency)	Prevents pregnancy by avoiding unprotected vaginal sex during most fertile days,	96% with correct and consistent use (Perfect use).	Difficult to use if a woman has a vaginal infection or another condition that changes cervical mucus. Unprotected coitus may be resumed after 2 consecutive dry days (or without secretions)
			86% with typical or common use. (Arevalo, 2004)	May have to be used with caution after an abortion, around menarche or menopause, and in conditions which may increase body temperature.
Sympto-thermal Method	Women track their fertile periods by observing changes in the cervical mucus (clear texture), body temperature (slight increase) and consistency of the cervix (softening).	Prevents pregnancy by avoiding unprotected vaginal sex during most fertile	98% with correct and consistent use (Perfect use).	Reported 98% with typical use (Manhart et al, 2013)

Traditional Methods			
Calendar method or rhythm method	Women monitor their pattern of menstrual cycle over 6 months, subtracts 18 from shortest cycle length (estimated 1st fertile day) and subtracts 11 from longest cycle length (estimated last fertile day)	The couple prevents pregnancy by avoiding unprotected vaginal sex during the 1st and last estimated fertile days, by abstaining or using a condom.	91% with correct and consistent use (Perfect use). 75% with common use (Typical use)
Withdrawal (coitus interruptus)	Man withdraws his penis from his partner's vagina, and ejaculates outside the vagina, keeping semen away from her external genitalia	Tries to keep sperm out of the woman's body, preventing fertilization	96% with correct and consistent use (Perfect use)

COMBINED ORAL CONTRACEPTIVES

3. What Are Combined Oral Contraceptives?

- Pills that contain low doses of 2 hormones—a progestin and oestrogen—like the natural hormones progesterone and oestrogen in a woman's body.
- Combined oral contraceptives (COCs) are also called “the Pill,”
- Each cycle consists of 28 pills, 21 of which contain the active ingredient and 7 contain iron supplements or 7 placebos.



3.1. Types of COCs

- **Monophasic:** All 21 active pills contain the same amount of Oestrogen and Progestin e.g., Control Pill, Marvelon and Duofem.
- **Biphasic:** The 21 active pills contain 2 different amounts of Oestrogen and Progestin combinations e.g. Logynon (no longer in circulation in Zimbabwe).
- **Triphasic:** The 21 active pills contain 3 different amounts of Oestrogen and Progestin combinations e.g., Trinordiol.

3.2. How do they work?

- Inhibit ovulation.
- Thicken cervical mucus, preventing sperm penetration.
- Change the endometrium, making implantation less likely.
- Reduce sperm transport in upper genital tract (fallopian tubes).



3.3. How effective are they?

- 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.
- As commonly used, about 8 pregnancies per 100 women using COCs over the first years that is, 92 of every 100 women using COCs will not become pregnant.
- When no pill-taking mistakes are made (perfect use), less than 1 pregnancy per 100 women using COCs over the first year (3 per 1,000 women).
- Return to fertility after COCs are stopped is immediate.
- No Protection against sexually transmitted infections (STIs).

3.4. What are the side effects?

Some users report the following:

- Changes in bleeding patterns including:
 - Lighter bleeding and fewer days of bleeding.
 - Irregular bleeding.
 - Infrequent bleeding.
 - No monthly bleeding.
- Headaches.
- Dizziness.
- Nausea.
- Breast tenderness.
- Weight change.
- Mood changes.
- Acne (can improve or worsen, but usually improves).
- Other possible physical changes:
- Blood pressure increases a few points (mm Hg). When increase is due to COCs, blood pressure declines quickly after use of COCs stops.

3.5. Initiating COCs

COCs can be started:

- If the client is having menses or within the first 7 days of the menstrual cycle, no back up method is required.
- If the client has no menses and the service provider is reasonably sure the client is not pregnant, a back-up method is required, for seven (7) days e.g., condom or abstinence.

(a) Postpartum:

- For breastfeeding women initiate COCs after 6 months. Before 6 months the client can use other appropriate methods e.g. POP, Implants, PPIUCD, barrier methods, PPIUCD.
- For non-breastfeeding women, start COCs after three weeks. (See MEC in Chapter 2).

(b) Post abortion

- Start COCs immediately or within 7 days after first- or second-trimester abortion, no need for a backup method.
- If it is more than 7 days after first- or second-trimester abortion, she can start COCs anytime it is reasonably certain she is not pregnant.

Women can begin using COCs:

- Without a pelvic examination.
- Without any blood tests or other routine laboratory tests.
- Without cervical cancer screening.
- Without a breast examination.
- Even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant.

NB. In line with the integrated RMNCAH model and in accordance with SRHR and HIV Service Guidelines, it is highly recommended that women also be offered breast and cervical cancer screening where appropriate when they seek FP services

3.6. Drug Interactions

The following anticonvulsants and antibacterial interact with COCs lowering their effectiveness:

- Anticonvulsants: Carbamazepine, Emoxipimide, Phenobarbitone, Phenytoin and Primidone.
- Antibacterials: Rifampicin.
- ART Therapy e.g. Efavirenz, Ritonavir.



Counsel the woman about the potential reduction in effectiveness of COCs. Women using these drugs will require back up method for up to seven days after treatment or change of method.

3.7. Instructions for a client who has initiated COCs

- Start first pill of first packet today. If you are starting the pills without a period, use a back-up method for 7 days. If you start within day 1 to 7 of the menstrual cycle no back up method is needed.
- Take one pill at the same time every day, even if your husband or partner is away.
- You may experience bleeding from day 3 of taking the inactive pills.
- Always start a new packet of pills the day after you have finished the current packet, even if you have not bled, are still bleeding or have finished bleeding. Report back to the clinic if you do not bleed.
- If you forget to take a pill, take it as soon as you remember and then take your regular pill at the regular time. This means you may take two pills on one day.
- If you forget to take more than one pill, leave the forgotten pills and continue taking your pills (even if you have a little spotting). Use a back-up method for 7 days.

- If you have diarrhoea and vomiting, use a back-up method for the time that you are having diarrhoea/vomiting and 7 days after the diarrhoea/ vomiting ends.
- If you attend a clinic for treatment or see a doctor, inform him/her that you are on the pill.
- Use condoms in addition to COC use, if you think there is any chance that you or your partner is at risk of exposure to STIs, including HIV/AIDS.
- Return for more pills before the last packet is finished.
- Report back at once if you have any problems.
- Always store pills in a dry and safe place, out of the reach of children.

When to Start or Restart a Woman on COC After Taking POP or COC Emergency Contraception (ECP): (Adapted from WHO FP Handbook for Service providers 2018):

- A Woman can start or restart COCs immediately after she takes the ECPs. No need to wait for her next monthly bleeding.
- A continuing user who needed ECPs due to pill-taking errors can continue where she left off with her current pack. If she does not start immediately but returns for COCs, she can start at any time if it is reasonably certain she is not pregnant.
- All women will need to use a backup method for the first 7 days of taking pills.

After taking Ulipristal Acetate (UPA) ECPs:

- A woman can start or restart COCs on the 6th day after taking UPA-ECPs. No need to wait for her next monthly bleeding. COCs and UPA interact. If COCs are started sooner, and thus both are present in the body, one or both may be less effective.
- Give her a supply of pills and tell her to start them on the 6th day after taking the UPA-ECPs.
- She will need to use a backup method from the time she takes the UPA-ECPs until she has been taking COCs for 7 days.
- If she does not start on the 6th day but returns later for COCs, she may start at any time if it is reasonably certain she is not pregnant.

3.8. Danger-Warning Signs for the client

The client should report to the health centre if she experiences the following:

- | | |
|----------|---|
| A | <i>Abdominal pain.</i> |
| C | <i>Chest pain with shortness of breath.</i> |
| H | <i>Headaches.</i> |
| E | <i>Eye problems (vision loss or blurred vision).</i> |
| S | <i>Severe leg pain.</i> |

3.9. Stopping/Switching

- Stop COCs anytime of the menstrual cycle for a client who wants to plan a pregnancy.
- Switch to another method, anytime of the menstrual cycle.

In deciding number of cycles to give to the client at the initial and subsequent visit, service providers should consider operational and client factors.

Table 3.1. Health Benefits, and Risks

Known Health Benefits	Known Health Risks
<p>Help protect against:</p> <ul style="list-style-type: none"> • Risks of pregnancy • Cancer of the lining of the uterus (endometrial cancer) • Cancer of the ovary • Symptomatic pelvic inflammatory disease <p>May help protect against:</p> <ul style="list-style-type: none"> - Ovarian cysts - Iron-deficiency anaemia <p>Reduce:</p> <ul style="list-style-type: none"> • Menstrual cramps • Menstrual bleeding problems • Ovulation pain • Excess hair on face or body • Symptoms of polycystic ovarian syndrome (irregular bleeding, acne, excess hair on face or body) • Symptoms of endometriosis (pelvic pain, irregular bleeding) 	<p>Very rare:</p> <ul style="list-style-type: none"> • Blood clot in deep veins of legs or lungs (deep vein thrombosis or pulmonary embolism) • Extremely rare: <ul style="list-style-type: none"> • Stroke • Heart attack

Table 3.2. Giving Advice on Side Effects

IMPORTANT: Thorough counseling about bleeding changes and other side effects is an important part of providing the method. Counseling about bleeding changes 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 possibly other side effects.
Explain about these side effects	Side effects are not signs of illness. Most side effects usually become less or stop within the first few months of using COCs. Common, but some women do not have them.
Explain what to do in case of side effects	Keep taking COCs. Skipping pills risks pregnancy and can make some side effects worse. Take each pill at the same time every day to help reduce irregular bleeding and also help with remembering. Take pills with food or at bedtime to help avoid nausea. The client can come back for help if side effects bother her.

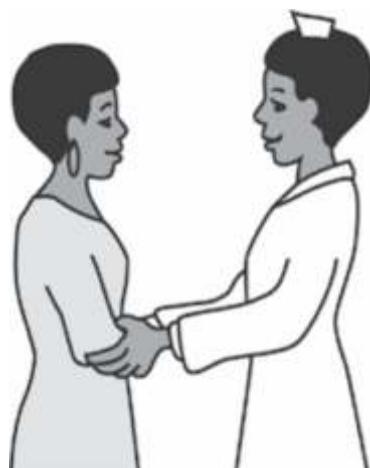


Table 3.3 Management of side effects

PROBLEM	ASSESSMENT	MANAGEMENT OF THE PROBLEM
Headache	<p>Rule out any other causes of headaches (e.g., eye or neurologic problems)</p> <p>Ask if headache started with COC use or any change of pattern</p> <p>Check blood pressure</p>	<p>If headaches are mild, reassure client</p> <p>Treat with mild analgesic</p> <p>Review when necessary</p> <p>If headache is severe, with other symptoms refer for management</p> <p>If any other cause is found, treat as per clinic practice</p>
Hypertension (BP160/100 mmHg and above)	<p>Determine if first episode of high blood pressure</p> <p>Ask relation with initiation of COCs</p> <p>Check blood pressure</p>	<p>If BP rises in client with normal BP while using COCs and diastolic pressure is less than 100mmHg, continue COCs and monitor closely</p> <p>If any danger warning signs occur e.g. blurred vision and loss of speech, stop COCs immediately</p> <p>Stop COCs if diastolic is 100 mmHg and above</p> <p>Help client choose another method without oestrogen</p> <p>Monitor BP every month</p> <p>Refer for further management if no improvement</p>
Amenorrhoea (Absence of menses)	<p>Rule out pregnancy:</p> <p>Ask about LNMP to rule out pregnancy</p> <p>Ask about duration of pill use and how she has been taking the pills</p> <p>Perform pelvic examination</p> <p>Perform a pregnancy test</p> <p>Determine age of client to rule out Menopause</p>	<p>If pregnant, stop COCs counsel client about ANC. Assure client that the COCs would not harm the baby</p> <p>Counsel client to come to the health centre if amenorrhoea persists and is a concern to her</p> <p>Client can switch to another method</p>

PROBLEM	ASSESSMENT	MANAGEMENT OF THE PROBLEM
Bleeding/ Spotting	<p>Ask if client is taking a new drug e.g. Rifampicin</p> <p>Determine when client began use of COCs and consistency in taking the pills</p> <p>Do speculum and pelvic examination to exclude gynaecological conditions e.g. cancer of the cervix to rule out other gynaecological conditions e.g. incomplete abortion, ectopic pregnancy</p>	<p>If gynaecological conditions treat or refer according to clinic guidelines</p> <p>If drug interaction, use condoms during short term treatment and seven days if long term treatment, counsel client to choose another method</p> <p>Give her non-steroidal anti-inflammatory (NSAID)</p> <p>If bleeding persist or starts after several months she can change method after excluding other causes</p> <p>Give client a new starting day</p> <p>If bleeding persists, provide higher dose pills or stop COCs and help client choose another method.</p>
Breast changes (fullness or tenderness)	<p>Rule out pregnancy</p> <p>Check for lumps</p> <p>Check for discharge if not breastfeeding</p> <p>If breastfeeding and breasts are tender, examine for breast infection</p>	<p>If pregnant, counsel and refer to ANC</p> <p>If not pregnant, breast tenderness improves within 3 months of starting COCs. Reassure client.</p> <p>If breast lump or discharge suspicious of cancer, refer for diagnosis</p> <p>If infection for breastfeeding clients, treat infected breast whilst she continues breast feeding from the uninfected breast (express the affected breast)</p> <p>If not infected, recommend well-fitting bra for additional support</p>

PROBLEM	ASSESSMENT	MANAGEMENT OF THE PROBLEM
Nausea and vomiting	<p>Ask how pills are taken e.g., morning or on empty stomach</p> <p>Check pregnancy</p> <p>Rule out any other illnesses</p>	<p>Counsel client to take pills with meals</p> <p>If pregnant counsel and refer for ANC</p> <p>If not pregnant counsel client that condition will improve after 3 months of COCs</p> <p>If problem worsens or intolerable counsel client to make an informed choice of another method</p>
Mood changes or changes in sex drive	<p>Ask about changes in her life that could affect her mood or sex drive, including changes in her relationship with her partner.</p>	<p>Give her support as appropriate</p> <p>If major depression refer for care</p>

Table 3.4. Medical Eligibility Criteria Checklist for COCs

Ask the client below about known medical conditions. Examinations and tests are not necessary. If she answers “no” to all the questions, then she can start COCs, if she wants. 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-month-old?

NO YES

If fully or nearly fully breastfeeding: Give her COCs and tell her to start taking them 6 months after giving birth or when breast milk is no longer the baby’s main food—whichever comes first. If partially breastfeeding: She can start COCs as soon as 6 weeks after childbirth.

2. Have you had a baby in the last 3 weeks and you are not breastfeeding?

NO YES

Give her 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 (deep vein thrombosis, or VTE), then she should not start COCs at 3 weeks after childbirth, but start at 6 weeks instead. These additional risk factors include previous VTE, thrombophilia, caesarean delivery, blood transfusion at delivery, postpartum haemorrhage, pre-eclampsia, obesity (>30 kg/m²), smoking, and being bedridden for a prolonged time.)

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 high blood pressure, or if she is being treated for high blood pressure, do not provide COCs. Refer her for a blood pressure check if possible or help her choose a method without oestrogen.

Check blood pressure if possible:

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

(One blood pressure reading in the range of 140–159/90–99 mm Hg is not enough to diagnose high blood pressure. Give her a backup method* to use until she can return for another blood pressure check, or help her choose another method now if she prefers. If her blood pressure at next check is below 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. Help her 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. Help her choose another method but not the combined patch or combined vaginal ring.

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

NO YES

If she reports heart attack, heart disease due to blocked or narrowed arteries, or stroke, do not provide COCs. Help her choose a method without oestrogen but not progestin-only injectables. If she reports a current blood clot in the deep veins of the legs or lungs (not superficial clots), help her choose a method without hormones.

Backup methods include abstinence, male and female condoms and withdrawal. Tell her that withdrawal is one of the least effective contraceptive methods. If possible, give her condoms.

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 and on one side of the head that can last from 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

If she has migraine aura at any age, do not provide COCs. If she has migraine headaches without aura and is age 35 years or older, do not provide COCs. Help these women choose a method without oestrogen. If she is under 35 and has migraine headaches without aura, she can use COCs

11. Are you taking medications for seizures such as Carbamazepine? 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. They can make COCs less effective. Help her 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?

NO YES

If so, she can start COCs 2 weeks after the surgery. Until she can start COCs, she should 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 provide COCs. Help her 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. For complete classifications, see Medical Eligibility Criteria for contraceptive use. 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.

Information Box 3.1

Dispelling Myths

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.

Information Box 3.2

Key Points for Providers

- For greatest effectiveness a woman must take pills daily and start each new pack of pills on time.
- Bleeding changes are common but not harmful. Typically, irregular bleeding for the first few months and then lighter and more regular bleeding.
- Client must take any missed pill as soon as possible. Missing pills risks pregnancy and may make some side effects worse.
- Can be given to women at any time to start later. If pregnancy cannot be ruled out, give her pills to take later, when her monthly bleeding begins.
- Do not disrupt an existing pregnancy.

PROGESTIN-ONLY PILLS (POPS)

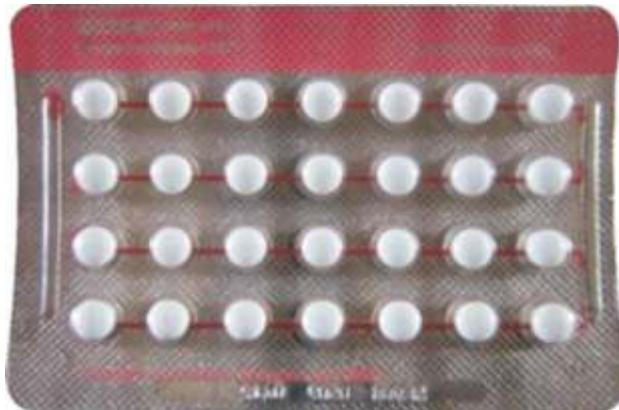


This chapter focuses on progestin-only pills for breastfeeding women. Women who are not breastfeeding also can use progestin-only pills. Guidance that differs for women who are not breastfeeding is noted.

4. What Are Progestin-Only Pills?

- ✓ Pills that contain very low doses of a Progestin like the natural hormone progesterone in a woman's body.
- ✓ Do not contain oestrogen, and so can be used throughout breastfeeding and by women who cannot use methods with oestrogen.

Progestin-only pills (POPs) are also called “minipills” and progestin-only oral contraceptives



Secure pills

4.1. Types of POPs

- 28 pill packet e.g. Secure which is locally branded.
- 28 pill packet e.g. Micronor internationally branded but not on the procurement priority list for Zimbabwe.
- 28 pill packet e.g. Exluton,

4.2. How do they work?

- Thickens cervical mucus making sperm penetration difficult.
- Partial inhibition of ovulation (50% of cycles).
- Changes the endometrium making implantation less likely.
- Reduces sperm transport in the upper genital tract (fallopian tubes).



4.3. How effective are they?

Effectiveness depends on the user: For women who have monthly bleeding, risk of pregnancy is greatest if pills are taken late or missed completely. For perfect use effectiveness is 98%.

4.3.1. Breastfeeding women

- As commonly used, about 1 pregnancy per 100 women using POPs over the first year will conceive. 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).

4.3.2. Less effective for women not breastfeeding

- As commonly used (typical use), about 3 to 10 pregnancies per 100 women using POPs over the first year will conceive. This means that 90 to 97 of every 100 women will not become pregnant.
- When pills are taken every day at the same time, less than 1 pregnancy per 100 women using POPs over the first year conceive.
- Return to fertility after POPs are stopped is immediate.

No Protection against sexually transmitted infections (STIs).

4.4. What are the side Effects?

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).
 - Frequent bleeding, irregular bleeding, infrequent bleeding, prolonged bleeding, no monthly bleeding.
- Headaches.
- Dizziness.
- Mood changes.
- Breast tenderness.
- Abdominal pain.
- Nausea.

4.5. Drugs Interactions with POPs

The following drugs/medicines reduce efficacy of POPs:

- Anticonvulsants e.g. Phenytoin, Barbiturates, Carbamazepine.
- Antibacterials e.g. Rifampicin.
- Anti – retrovirals e.g. Effavirenz.
- Counsel about potential reduction in the effectiveness of POPs.
- Women using these methods require back-up method e.g. condoms up to seven days after treatment or change of methods.

4.6. Initiating POPs

Start POPs:

- If the client has menses or within the first 7 days of the menstrual cycle, no back up method is required.
- If the client has no menses, backup method is required for seven days, e.g. male or female condoms.
- Anytime during the menstrual cycle when reasonably sure the client is not pregnant.
- Backup method is required for seven days.
- Give three cycles at initial visit and up to 12 cycles on subsequent visits.

(a) Postpartum

Start POPs:

- Immediately regardless of method of baby feeding.

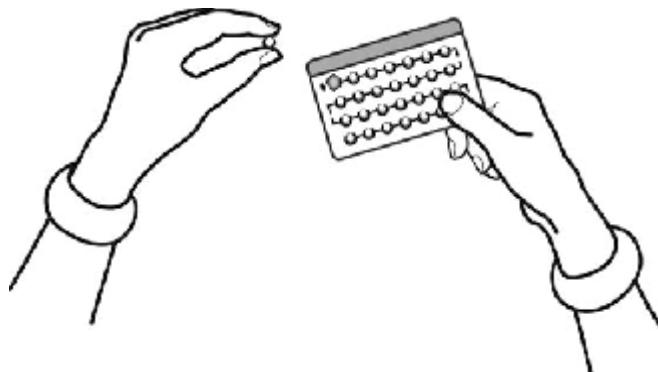
(b) Post abortion

- Start POP immediately or within 7 days post abortion.

Women can begin using POPs:

- Without a pelvic examination.
- Without any blood tests or other routine laboratory tests.
- Without cervical cancer screening.
- Without a breast examination.
- Even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant.

4.7. Instructions for a client who has initiated POPs



- Take the first pill of the first packet today. If you are starting the pills without menses, use a back-up method for seven days.
- Take one pill every day at the SAME TIME until the packet is finished, even if your husband or partner is away.

- When you have finished the present packet, start on the next packet of pills the following day, whether you had a period or not.
- If you forget to take one or more pills continue taking your pills at the usual time. Use a back-up method for seven days.
- Use a back-up method in addition to taking the pills if you have diarrhoea/ vomiting, continue using a back-up method for seven days after the diarrhoea/vomiting has stopped.
- If you are worried at all, inform the health worker at the nearest health centre/CBW.
- Store pills in a dry safe place away from heat and out of the reach of children.
- Use condoms in addition to POPs if you think there is any chance of you or your partner being at risk for exposure to STIs, including HIV& AIDS.
- Return for more pills before the last packet is finished.

If you want to change from one method to the other, report to the health centre.

4.8. Stopping/Switching

- POPs can be stopped at any time of the cycle if the client wants to plan for a pregnancy.
- The client can switch to another method, anytime of the cycle. Backup method required up to 7 days from switching method.

When to Start or Restart POP after Taking Progestin only or COC Emergency Contraception (ECP): (*Adapted from WHO FP Handbook for Service providers 2018*):

- A woman may start or re-start POP immediately after taking Progestin only or Combined oral contraceptive ECPs. *No need to wait for her next monthly bleeding.*
- A continuing user who needed ECPs due to pill-taking errors can continue where she left off with her current pack.
- If she does not start immediately, but returns for POPs, she can start at any time if it is reasonably certain she is not pregnant.
- All women will need to use a backup method for the first 2 days of taking pills.

Starting or Re-starting POP after taking Ulipristal Acetate (UPA) ECPs: (*Adapted from WHO FP Handbook for Service providers 2018*):

- She can start or restart POPs on the 6th day after taking UPA-ECPs. No need to wait for her next monthly bleeding. POPs and UPA interact. If POPs are started sooner, and thus both are present in the body, one or both may be less effective.
- Give her a supply of pills and tell her to start them on the 6th day after taking the UPA-ECPs.
- She will need to use a backup method from the time she takes UPA-ECPs until she has been taking POPs for 2 days.
- If she does not start on the 6th day but returns later for POPs, she may start at any time if it is reasonably certain she is not pregnant.

Information Box 4.1

Key Points for Providers and Clients

- Take one pill every day. No breaks between packs.
- Safe for breastfeeding women and their babies.
- Progestin-only pills do not affect milk production.
- Add to the contraceptive effect of breastfeeding. Together, they provide effective pregnancy protection.
- Bleeding changes are common but not harmful.
- Typically, pills lengthen how long breastfeeding women have no monthly bleeding. For women having monthly bleeding, frequent or irregular bleeding is common.
- Can be given to a woman at any time to start later. If pregnancy cannot be ruled out, a provider can give her pills to take later, when her monthly bleeding begins. In the meantime, male or female condoms may be used.

Information Box 4.2

Dispelling Myths

Progestin-Only Pills:

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

Table 4.1 Giving Advice on Side Effects

IMPORTANT: Thorough counseling about bleeding changes and other side effects is an important part of providing the method. Counseling about bleeding changes 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 who are not breastfeeding may have frequent or irregular bleeding for the first several months, followed by regular bleeding or continued irregular bleeding. Headaches, dizziness, breast tenderness, and possibly other side effects.
Explain about these side effects	Side effects are not signs of illness. Usually become less or stop within the first few months of using POPs. Bleeding changes, however, usually persist. Common, but some women do not have them.
Explain what to do in case of side effects	Keep taking POPs. Skipping pills risks pregnancy. Try taking pills with food or at bedtime to help avoid nausea. The client can come back for help if side effects bother her.

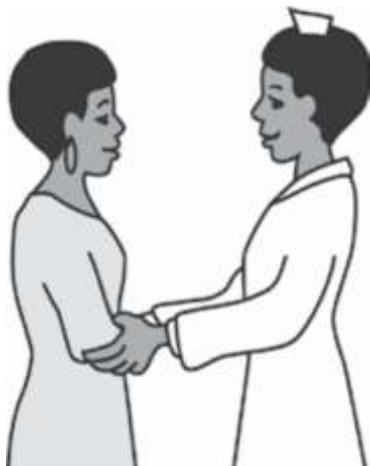


Table 4.2 Medical Eligibility Criteria Checklist

Medical Eligibility Criteria Checklist for Progestin-Only Pills

Ask the client the questions below about known medical conditions. Examinations and tests are not necessary. If she answers “no” to all of the questions, then she can start POPs if she wants. 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

If she can start taking POPs as soon as 6 weeks after childbirth. Give her POPs now and tell her when to start taking them.

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

NO YES

If she reports serious active liver disease (jaundice, severe cirrhosis, liver tumor), 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 she is taking Barbiturates, Carbamazepine, Oxcarbazepine, Phenytoin, Primidone, Topiramate, Rifampicin, Rifabutin, or Ritonavir, do not provide POPs. They can make POPs less effective. Help her choose another method but not combined oral contraceptives.

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.

INJECTABLES

5. What are injectable Family Planning Methods?

These are either combined oestrogen and progesterone (CICs) or progesterone only containing contraceptive methods given at regular intervals as injections.



5.1. What types of injectables are available?

5.1.1. Combined Injectable Contraceptives

Consist of both oestrogen and progesterone and are given monthly. Two examples are named below

- **Medroxyprogesterone acetate (MPA)/estradiol cypionate** marketed as Ciclofem, Ciclofemina, Cyclofem, Cyclo-Provera, Feminenza, Lunella, Lunelle, Novafem.
- **Norethisterone enanthate/oestradiol valerate** (NET-EN /estradiol valerate marketed as Mesigyna and Norigynon.

5.1.2. Progesterone Only Injectables

Each contains a progestin like the natural hormone progesterone and do not contain oestrogen.

- **Intramuscular Depo Medroxy Progesterone Acetate** is the most widely used progestin-only injectable, is also known as "the shot," "the jab," the injection, Depo, Depo-Provera, Megestron, and Petogen. Given every 12 weeks.
- **Subcutaneous Depo Medroxy Progesterone Acetate (Sayana press).** Given every 12 weeks.
- **Norethisterone enanthate (NET -EN)** also marketed as norethindrone enanthate, Noristerat, and Syngestal. Given every 8 weeks.



In Zimbabwe Depo Medroxy Progesterone Acetate (Depo-Provera) is currently the most widely used injectable. The discussion below will focus mainly on Depo-Provera and highlight essential differences with NET-EN as necessary.

5.2. Depo Medroxy Progesterone Acetate

5.2.1. What is Depo Medroxy Progesterone Acetate Injectable?

- The injectable contraceptives Depot Medroxyprogesterone acetate (DMPA).
- (DMPA) contains a progestin like the natural hormone progesterone in a woman's body.
- Does not contain and so can be used throughout breastfeeding and by women who cannot use methods with oestrogen.
- DMPA, the most widely used progestin-only injectable.
- Given by injection into the muscle (intramuscular injection). The hormone is then released slowly into the bloodstream. A different formulation of DMPA (Sayana Press) can be injected just under the skin (subcutaneous injection).

5.2.2. How does it Work?

- Work primarily by preventing the release of eggs from the ovaries (ovulation).

5.2.3 How effective is the injection?



- Effectiveness depends on getting injections regularly: Risk of pregnancy is greatest when a woman misses an 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 may 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: An average of about 4 months longer for DMPA and 1 month longer for NET-EN than with most other methods
- Provides no Protection against sexually transmitted infections (STIs).

Women can begin using progestin-only injectables:

- Without a pelvic examination.
- Without any blood tests or other routine laboratory.
- Without cervical cancer screening.

- Without a breast examination.
- Even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant.

When to Start or Restart Progestin Only Injectable after Taking POP or COC Emergency Contraception (ECP): (Adapted from WHO FP Handbook for Service providers 2018)

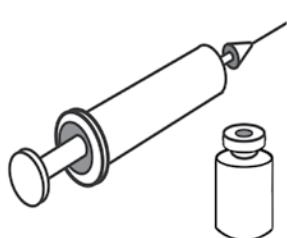
- A woman can start or restart injectables on the same day as taking the ECPs. There is no need to wait for her next monthly bleeding to have the injection.
- She will need to use a backup method for the first 7 days after the injection.
- If she does not start immediately but returns for injectables, the client can start at any time if it is reasonably certain she is not pregnant.

Starting After taking Ulipristal Acetate (UPA) ECPs (Adapted from WHO FP Handbook for Service providers 2018):

- A woman can start or restart injectables on the 6th day after taking UPA-ECPs. No need to wait for her next monthly bleeding to have the injection. Injectables and UPA interact. If an injectable is started sooner, and thus both are present in the body, one or both may be less effective.
- Make an appointment for her to return for the injection on the 6th day after taking UPA-ECPs, for as soon as possible after that.
- She will need to use a backup method from the time she takes UPA-ECPs until 7 days after the injection.
- If she does not start on the 6th day but returns later for injectables, she may start at any time if it is reasonably certain she is not pregnant.

5.2.4 Giving the Injection

1. Obtain one dose of injectable, needle and syringe



- DMPA: 150 mg for injections into the muscle (intramuscular injection). NET-EN: 200 mg for injections into the muscle.
- If possible, use single-dose vials. Check expiration date. If using an open multidose vial, check that the vial is not leaking.
- DMPA: A 2 ml syringe and a 21-23-gauge intramuscular needle.
- NET-EN: A 2 or 5 ml syringe and a 19-gauge intramuscular needle. A narrower needle (21-23 gauge) also can be used.
- For each injection use a disposable auto-disable syringe and needle from a new, sealed package (within expiration date and not damaged), if available.
- Wash hands with soap and water.
- If injection site is dirty, wash it with soap and water.
- No need to wipe site with antiseptic.

2. Prepare vial

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

3. Fill the syringe

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

4. Inject Formula

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



5. Dispose of disposable syringes and needles safely

- Do not recap, bend, or break needles before disposal.
- Place in a puncture-proof sharps container.
- Do not reuse disposable syringes and needles. They are meant to be destroyed after a single use. Reuse might transmit diseases such as HIV and hepatitis.

5.2.5 What are the side effects?

Some users report the following:

- Changes in bleeding patterns:

First 3 months:

- Irregular bleeding.
- Prolonged bleeding.



At one year:

- No monthly bleeding.
- Infrequent bleeding.
- Irregular bleeding.

NET-EN affects bleeding patterns less than DMPA. NET-EN users have fewer days of bleeding in the first 6 months and are less likely to have no monthly bleeding after one year than DMPA users.

- Weight gain.
- Headaches.
- Dizziness.
- Abdominal bloating and discomfort.

- Mood changes.
- Less sex drive.

Other possible physical change:

- Loss of bone density.

5.2.6 Management of late injections If the client is less than 4 weeks late for a repeat injection of DMPA, or less than 2 weeks late for a repeat injection of NET-EN, she can receive her next injection. No need for tests, evaluation, or a backup method.

A client who is more than 4 weeks late for DMPA, or more than 2 weeks late for NET-EN, can receive her next injection if:

- She has not had sex since 2 weeks after she should have had her last injection, or
- She has used a backup method or has taken emergency contraceptive pills (ECPs) after any unprotected sex since 2 weeks after she should have had her last injection, or
- She is fully breastfeeding and she gave birth less than 6 months ago.

She will need a backup method for the first 7 days after the injection.

- If the client is more than 4 weeks late for DMPA, or more than *2 weeks late for NET-EN*, and she does not meet these criteria, additional steps can be taken to be reasonably certain she is not pregnant. These steps are helpful because many women who have been using progestin-only injectables will have no monthly bleeding for at least a few months, even after discontinuation. Thus, asking her to come back during her next monthly bleeding means her next injection could be unnecessarily delayed. She may be left without contraceptive protection.
- **Discuss why the client was late and solutions to prevent this from happening again.** Remind her that she should keep trying to come back every 3 months for DMPA, or every 2 months for NET-EN. If coming back on time is often a problem, discuss using a backup method when she is late for her next injection, taking ECPs, or choosing another method.

5.2.7 Management of side effects

Problems Reported as Side Effects may or may not be due to the method.

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

No monthly bleeding

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

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

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

Weight gain

- Review diet and counsel as needed.

Abdominal bloating and discomfort

- Counsel and reassure patient that this is not harmful. However if this is of acute onset and associated with other symptoms such as vomiting, constipation and distension refer for further assessment and management.

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.
- For modest short-term relief she can try (one at a time), beginning when heavy bleeding starts:
 - 500 mg of mefenamic acid twice daily after meals for 5 days.
 - Norethisterone 5mg three times a day for 5 days.
- If bleeding becomes a health threat or if the woman wants, help her choose another method. In the meantime, she can use one of the treatments described above to help reduce bleeding.
- To help prevent anemia, suggest she take iron tablets and tell her it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).
- If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be .

wrong for other reasons, consider underlying conditions unrelated to method use and refer or manage accordingly

Ordinary headaches (non migrainous)

Give Paracetamol 1g 6 hourly or Ibuprofen 200–400 mg 8 hourly after meals

- Any headaches that get worse or occur more often during use of injectables should be evaluated and client referred or managed accordingly.

Mood changes or changes in sex drive

- Ask about changes in her life that could affect her mood or sex drive, including changes in her relationship with her partner. Give support as appropriate.
- Clients who have serious mood changes such as major depression should be referred for care.

Dizziness

- If dizziness affects client's daily routine consider switching to another method, rule out other causes and refer or manage accordingly.
- Ask about bleeding patterns and rule out anaemia. If Hb is low manage accordingly and consider switching to another family planning method if bleeding is heavy, prolonged and unresponsive to first line therapy highlighted above.

5.2.8 Stopping/ Switching Method

Migraine headaches

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

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

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

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

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

Suspected pregnancy

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

Information Box 5.1

Dispelling Myths

Progestin-only injectables:

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

Information Box 5.2

Key Points for Providers

- Bleeding changes are common but not harmful. Typically, irregular bleeding for the first several months and then no monthly bleeding.
- Return for injections regularly. Coming back every 3 months (12 weeks) for DMPA is important for greatest effectiveness.
- Injection can be as much as 4 weeks late for DMPA. Client should come back even if later.
- Gradual weight gain is common.
- Return of fertility is often delayed. It takes several months longer on average to become pregnant after stopping progestin only injectables than after other methods.

Table 5.1 Health Benefits and Risks of Injectables

Known Health Benefits	Known Health Risks
Help protect against: <p>Risks of pregnancy Cancer of the lining of the uterus (endometrial cancer). - Uterine fibroids.</p>	None
May help protect against: <ul style="list-style-type: none"> • Symptomatic pelvic inflammatory disease. • Iron-deficiency anaemia. 	
Reduces: <ul style="list-style-type: none"> • Sickle cell crises among women with sickle cell anaemia. • Symptoms of endometriosis (pelvic pain, irregular bleeding). 	

Table 5.2 Giving Advice on Side Effects

IMPORTANT: Thorough counseling about bleeding changes and other side effects must come before giving the injection. Counseling about bleeding changes may be the most important help a woman needs to keep using the method.	
Describe the most common side effects	For the first several months, irregular bleeding, prolonged bleeding, frequent bleeding. Later, no monthly bleeding. Weight gain (about 1–2 kg per year), headaches, dizziness, and possibly other side effects.
Explain about these side effects	Side effects are not signs of illness. Common, but some women do not have them. The client can come back for help if side effects bother her.

Table 5.3. Medical Eligibility Criteria Checklist for**Depo Medroxy Progesterone Acetate**

Ask the client the questions below about known medical conditions. Examinations and tests are not necessary. If she answers “no” to all of the questions, then she can start Depo Medroxy Progesterone Acetate if she wants. If she answers “yes” to a question, follow the instructions. In some cases she can still start Depo Medroxy Progesterone Acetate.

1. Are you breastfeeding a baby less than 6 weeks old?**NO YES**

She can start using Depo Medroxy Progesterone Acetate as soon as 6 weeks after childbirth.

2. Do you have severe cirrhosis of the liver, a liver infection, or liver tumor? (Are her eyes or skin unusually yellow? [signs of jaundice])**NO YES**

If she reports serious active liver disease (jaundice, severe cirrhosis, liver tumor), do not provide Depo Medroxy Progesterone Acetate. Help her 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 Depo Medroxy Progesterone Acetate.

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 Depo Medroxy Progesterone Acetate.

If systolic blood pressure is 160 mm Hg or higher or diastolic blood pressure 100 or higher, do not provide Depo Medroxy Progesterone Acetate. 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. Help her choose another method without oestrogen.

Medical Eligibility Criteria Checklist for

Depo Medroxy Progesterone Acetate

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

NO YES

If she reports heart attack, heart disease due to blocked or narrowed arteries, or stroke, do not provide Depo Medroxy Progesterone Acetate. Help her choose another method without oestrogen. If she reports a current blood clot in the deep veins of the leg or in the lung (not superficial clots), and she is not on anticoagulant therapy, help her choose a method without hormones.

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

NO YES

If she has unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition, Depo Medroxy Progesterone Acetate could make diagnosis and monitoring of any treatment more difficult. Help her choose a method to use while being evaluated and treated (but not implants or a copper-bearing or hormonal IUD). After treatment, re-evaluate for use of Depo Medroxy Progesterone Acetate.

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

NO YES

Do not provide Depo Medroxy Progesterone Acetate. Help her 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 Depo Medroxy Progesterone Acetate. Help her choose another 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.

IMPLANTS

Implants are one of the Long Acting Reversible Contraceptive (LARC) methods. LARCs also include Intra-uterine Contraceptive Devices (IUCDs). Implants and IUCDs are the most effective available reversible contraceptives, and once inserted, they last for several years; eliminating the need for daily contraceptive action. Both are reversible and can be removed any time resulting in immediate return to fertility.

6. What Are Implants?

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





6.1. What types of implants are available?

6.1.1. Jadelle:

- The Jadelle® implant contraceptive is a set of 2 small plastic capsules. The capsules are placed under the skin of a woman's upper arm.
- Jadelle capsules contain a progestin, Levonorgestrel similar to a natural hormone that a woman's body makes. It is released very slowly from the two capsules.
- A set of Jadelle capsules prevents pregnancy for at least 5 years.

6.1.2. Implanon:

- The Implanon® implant contraceptive is 1 small plastic capsule. The capsule is placed under the skin of a woman's upper arm.
- The Implanon capsule contains a progestin, Etonorgestrel similar to a natural hormone that a woman's body produces. It is released very slowly from the one capsule.
- Implanon prevents pregnancy for 3 years.
- Implanon NXT is a radio opaque type of implanon with similar chemical composition with implanon. Implanon NXTcontains small amounts of barium sulfate rendering it visible under X ray.

Sino-Implant II

- Is also known as Femplant, Trust Implant, and Zarin: It is a Levonorgestrel containing implant, has 2 rods and is effective for 4 years. The Sino-implant was not in use in Zimbabwe at the time of guidelines development.

6.2. How do Implants Work?

- Thicken cervical mucus, making it difficult for sperm to pass through.
- Inhibits ovulation in about half of menstrual cycles (after first year of use).
- Causes endometrial changes thus inhibiting implantation.
- Reduces sperm transportation in the upper genital tract (fallopian tubes).

6.3. How effective are implants?

- One of the most effective and long term reversible contraceptive 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.
 - Over 3 years of Implanon use: Less than 1 pregnancy per 100 women (1 per 1,000 women)
 - Jadelle starts to lose effectiveness sooner for heavier women: For women weighing 80 kg or more, Jadelle becomes less effective after 4 years of use. Implanon become less effective after 2 years.
 - For women > 80kg replace the implants sooner after 4 years for Jadelle and 2 years for Implanon.
- Return to fertility after implants are removed is immediate.
- Provide no protection against STIs.

6.4. Who can use implants?

- Women who want a highly effective long-term protection against pregnancy.
- Postpartum women regardless of breastfeeding status.
- Post abortion.
- Women with desired family size but do not want permanent contraception.
- Women with histories of ectopic pregnancy.
- Women with raised blood pressure with a diastolic reading of below 100 mmHg.
- Women who do not remember to take a pill every day.
- Women contraindicated to oestrogen contraceptives.

Women can begin using implants:

- Without a pelvic examination.
- Without any blood tests or other routine laboratory tests.
- Without cervical cancer screening.
- Without a breast examination.
- Even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant.

6.5. Initiating Implants

- Anytime of the menstrual cycle when you are reasonably sure the client is not pregnant.
- If the client has menses or is within the first 7 days of the menstrual cycle, no back-up method is required. If no menses, back-up method is required for 7 days.



- If breastfeeding, insert implant 6 weeks after delivery.
- If not breastfeeding insert implant 3 weeks postpartum.
- If post abortion, insert implant immediately or in the first 7 days after treatment of abortion.
- The client can switch to another method anytime in the menstrual cycle and no back up method is required.

6.5.1 When to Start or Re-start Implants after Taking Progestin Only of COC Emergency Contraception (ECP)

(adapted from the WHO Global Family Planning Hand Book for Providers 2018)

- Implants can be inserted on the same day as the woman takes the ECPs. – She will need to use a backup method for the first 7 days.
- If she does not start immediately, but returns for an implant, she can start at any time if it is reasonably certain she is not pregnant.

Initiating Implants after Taking Ulipristal Acetate ECPs (Adapted from WHO FP Handbook for Service providers 2018):

- Implants can be inserted on the 6th day after taking UPA-ECPs. There is no need to wait for her next monthly bleeding. Implants and UPA interact.
- If an implant is inserted sooner, and thus both are present in the body, one or both may be less effective.
- Make an appointment for the woman to return on the 6th day to have the implant inserted, or as soon as possible after that.
- The woman will need to use a backup method from the time she takes UPA-ECPs until 7 days after the implant is inserted.
- If she does not start on the 6th day but returns later for implants, she can start at any time if it is reasonably certain she is not pregnant.

6.5.2 Inserting Implants (adapted from the WHO Global Family Planning Hand Book for Providers 2011)

After taking progestin-only or combined ECPs:

- Implants can be inserted on the same day as she takes the ECPs.
- She will need to use a backup method for the first 7 days.
- If she does not start immediately, but returns for an implant, she can start at any time if it is reasonably certain she is not pregnant.

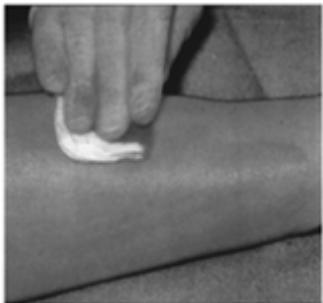
After taking Ulipristal Acetate ECPs:

- Implants can be inserted on the 6th day after taking UPA-ECPs.
- No need to wait for her next monthly bleeding.
- Implants and UPA interact. If an implant is inserted sooner, and thus both are present in the body, one or both may be less effective.



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. (**Please refer to Procedure manual for more details.**)

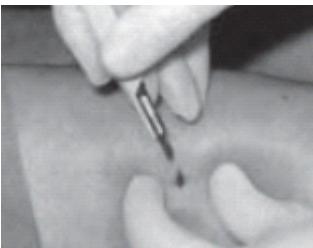
Inserting implants usually takes only a few minutes but can sometimes take longer, depending on the skill of the provider. Related complications are rare and depend on the skill of the provider. (Implanon is inserted with a specially made applicator similar to a syringe and requires specific training. It does not require an incision.)



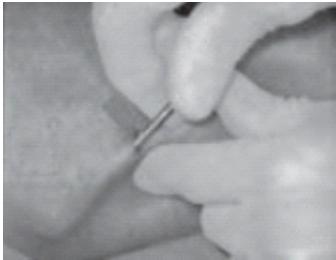
1. Use proper infection-prevention procedures according to protocol.



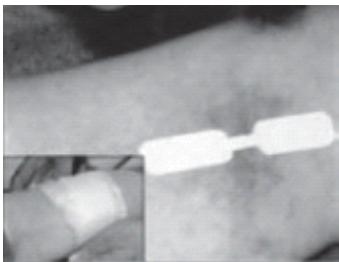
2. Give the woman an injection of local anesthetic under the skin of her arm to prevent pain while the implants are being inserted. This injection may sting. She stays fully awake throughout the procedure.



3. Make a small incision in the skin on the inside of the upper arm.(Implanon does not require an incision).

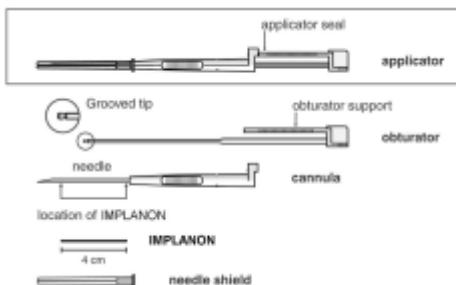


4. Insert the implant/implants just under the skin. The woman may feel some pressure or tugging.



5. After the implant or all implants are inserted, close 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.

Insertion of Implanon and components of Implanon kit



6.5.1. Instructions for the Client after implant insertion

- Keep the insertion area clean and dry for at least 48 hours.
- Remove the bandage on the third day.
- Take a mild analgesic if you experience some discomfort or pain a few hours after insertion.
- Avoid bumping the arm, carrying heavy loads or applying pressure to the site until healed (3-5 days).
- There will be swelling or tenderness at insertion site for a few days.
- You can have sexual intercourse 24 hours after insertion.
- Use condoms if you think there is any chance that you or your partner is at risk of exposure to STIs, including HIV.
- If you have any problems, report to a health centre or service provider.
- Come for review at 1 week and thereafter as necessary.
- Come for removal at any time you want the implants removed or at the end of the effective life of implant (5 years for Jadelle and 3 years for Implanon).
- If your weight is greater than 80kg come for removal at 4 years for Jadelle and 2 years for Implanon.





6.5.2. Indications for Removal of Implant

- If the client wants to conceive.
- Severe or prolonged bleeding.
- Severe hypertension with a diastolic of above 100 mmHg.
- Severe weight gain of above 10kg.
- At the end of the effective life of the implant.

6.5.3. Removing Implants *(Adapted from the WHO Family Planning Hand Book for Providers 2011)*

IMPORTANT: Providers must not refuse or delay when a woman asks to have her implants removed, whatever her reason, whether it is personal or medical. All staff must understand and agree that clients must not be pressured or forced to continue using implants.

Explaining the Removal Procedure

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. (Please refer to training procedure manual for details).

- a. Use proper infection-prevention procedures. (Refer to protocol)
- b. Inject local anesthetic under the skin of the woman's arm to prevent pain during implant removal. This injection may sting. The client remains fully awake throughout the procedure.



- c. Make a small incision in the skin on the inside of the upper arm, near the site of insertion.
- d. Use 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.
- e. Close 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 days and keep down swelling.





6.5.4. Instructions to the Client after Removal of Implants

- Keep the area around the incision clean and dry.
- Remove bandage after 48 hours.

If signs of infection occur, such as fever, inflammation (redness plus heat) at the site or persistent pain for several days, return to the clinic.

6.5.5. Complications of implants

Uncommon:

- Infection at insertion site (most infections occur within the first 2 months after insertion).
- Difficult removal (rare if properly inserted and the provider is skilled at removal).

Rare:

- Expulsion of implant rarely occurs. If this happens it is most often within the first 4 months after insertion.

6.6. What are the Side Effects of implants?

Some users report the following:

- Changes in bleeding patterns including:

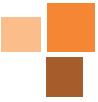
First several months:

- Lighter bleeding and fewer days of bleeding.
- Irregular bleeding.
- Infrequent bleeding.
- No monthly bleeding.

After about one year:

- Lighter bleeding and fewer days of bleeding.
- Irregular bleeding.
- Infrequent bleeding.
- Implanon users are more likely to have infrequent or no monthly bleeding than irregular bleeding.
- Headaches.
- Abdominal pain.
- Acne (can improve or worsen).
- Weight change.
- Breast tenderness.
- Dizziness.
- Mood changes.
- Nausea.





Other possible physical changes:

- ovarian cysts.

6.7. Managing Implants Side Effects and complications

Problems Reported as Side Effects or Complications may or may not be due to the method.

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

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

- Reassure her that many women using implants experience irregular bleeding. It is not harmful and usually becomes less or stops after the first year of use.
- For modest short-term relief, she can take 800 mg ibuprofen or 500 mg Mefenamic acid 3 times daily after meals for 5 days, beginning when irregular bleeding starts.
- If these drugs do not help her, she can try one of the following, beginning when irregular bleeding starts:
- Combined oral contraceptives with the progestin Levonorgestrel. Ask her to take one pill daily for 21 days.
- 50g Ethynodiol dihydrogenate daily for 21 days.
- DO NOT GIVE COCs OR OESTRADIOL IF CONTRAINDICATED.
- If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.

No monthly bleeding

- Reassure client that some women stop having monthly bleeding when using implants and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not infertile. Blood is not building up inside her. (Some women are happy to be free from monthly bleeding).

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 generally not harmful and usually becomes less or stops after a few months.
- For modest short-term relief, she can try any of the treatments for irregular bleeding, above, beginning when heavy bleeding starts. Combined oral contraceptives with 50g of Ethynodiol dihydrogenate may work better than lower-dose pills.





- To help prevent anemia, suggest she take iron tablets and tell her it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).
- If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.

Ordinary headaches (non-migrainous)

- Give Paracetamol 1 g 6 hourly or ibuprofen (200–400 mg) 8 hourly after meals.
- Any headaches that get worse or occur more often during use of implants should be evaluated.

Mild abdominal pain

- Give Paracetamol 1 g 6 hourly or ibuprofen (200–400 mg) 8 hourly after meals.

Acne

- If client wants to stop using implants because of acne, she can consider switching to COCs. Many women's acne improves with COC use.
- Consider locally available remedies.

Weight change

- Review diet and counsel as needed.

Breast tenderness

- Recommend that she wear a supportive bra (including during strenuous activity and sleep).
- Try hot or cold compresses.
- Give Paracetamol 1 g 6 hourly or ibuprofen (200–400 mg) 8 hourly after meals.

Mood changes or changes in sex drive

- Ask about changes in her life that could affect her mood or sex drive, including changes in her relationship with her partner. Give support as appropriate.
- Clients who have serious mood changes such as major depression should be referred for care.



Nausea or dizziness

- Consider locally available remedies for nausea and investigate dizziness as appropriate ruling out anaemia and other neurological causes.

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.
- Give pain relief medication as highlighted above.

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

- Do not remove the implants.
- Clean the infected area with soap and water or antiseptic.
- Give oral antibiotics for 7 to 10 days. (Cloxacillin oral 500mg 6 hourly).
- Ask the client to return after taking all antibiotics if the infection does not clear. If infection has not cleared, remove the implants or refer for removal.
- Expulsion or partial expulsion often follows infection. Ask the client to return if she notices an 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 as noted above 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. If infection is present when she returns, remove the implants or refer for removal.

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

- This is rare, but may occur rarely; usually within a few months of insertion or with infection.
- If no infection is present, replace the expelled rod or capsule through a new incision near the other rods or capsules, or refer for replacement.

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.
- There is no need to treat enlarged ovarian follicles or cysts unless they grow abnormally large, twist, or burst. Reassure the client that they usually disappear on their own. To be sure the problem is resolving, see the client again in 6 weeks, if possible.
- With severe abdominal pain, be particularly alert for additional signs or symptoms of ectopic pregnancy, which is rare and not caused by implants, but it can be life-threatening. 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 this is a change from her usual bleeding pattern.
- Light-headedness or dizziness.
- Fainting.
- If ectopic pregnancy or other serious health condition is suspected, manage appropriately or refer at once for immediate diagnosis and care if at Primary Health Care Facility.

6.8. Stopping/Switching Method

A woman may decide to stop or switch from implants either for medical or non-medical reasons. It is important to counsel the woman that return to fertility after removal of implants is immediate hence she needs a backup method soon after removal if pregnancy is not desired. Below are some medical reasons for stopping implants.

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

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

- Remove the implants or refer for removal.
- Give her a backup method to use until her 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 implants. If however, the condition develops while she is using implants:
 - Remove the implants or refer for removal.
 - Help her choose a method without hormones.
 - Refer for diagnosis and care if not already under care.

Suspected pregnancy

- Assess for pregnancy, including ectopic pregnancy.
- Remove the implants or refer for removal if she will carry the pregnancy to term.
- There are no known risks to a fetus conceived while a woman has implants in place.

Information Box 6.1

Key Points for Providers

- Implants are small flexible rods or capsules that are placed just under the skin in the inner aspect of the upper arm.
- Provide long-term reversible contraception. Very effective for at least 3 to 5 years, depending on the type of implant and immediately reversible.
- Require a specifically trained provider to insert and remove. A woman cannot start or stop implants on her own.
- Little required of the client once implants are in place.
- Bleeding changes are common but not harmful. Typically, prolonged irregular bleeding over the first year, and then lighter, more regular bleeding or infrequent bleeding.

Information Box 6.2

Dispelling myths

Implants:

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

Table 6.1 Known Health Benefits and Risks

Known Health Benefits	Known Health Risks	
<p>Help protect against: Risks of pregnancy. Symptomatic pelvic inflammatory disease.</p>	None	
<p>May help protect against: Iron-deficiency anaemia.</p>		

Table 6.2 Giving Advice on Side Effects

Describe the most common side effects	<p>Changes in her bleeding pattern:</p> <ul style="list-style-type: none"> - Irregular bleeding that lasts more than 8 days at a time over the first year. - Regular, infrequent, or no bleeding at all later. <p>Headaches, abdominal pain, breast tenderness, and possibly other side effects.</p>
Explain about these side effects	<p>Side effects are not signs of illness. Most side effects usually become less or stop within the first year. Common, but some women do not have them. Client can come back for help if side effects bother her.</p>

Table 6.3 Medical Eligibility Criteria Checklist**Medical Eligibility Criteria Checklist for
Implants**

Ask the client the questions below about known medical conditions. Examinations and tests are not necessary. If she answers “no” to all of the questions, then she can have implants inserted if she wants. If she answers “yes” to a question, follow the instructions. In some cases she can still start using implants.

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.

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

NO YES

If she reports serious active liver disease (jaundice, severe cirrhosis, liver tumor), do not provide implants. 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 implants. Help her choose a method without hormones.

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

NO YES

If she has unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition, implants could make diagnosis and monitoring of any treatment more difficult. Help her choose a method to use while being evaluated and treated (not progestin-only injectables, or a copper-bearing or hormonal IUD). After treatment, re-evaluate for use of implants.

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

NO YES

Do not provide implants. 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.

Table 6.4 Giving Specific Instructions for Insertion

Keep arm dry	She should keep the insertion area dry for 4 days. She can take off the elastic bandage or gauze after 2 days and the adhesive bandage after 5 days.
Expect soreness, bruising	After the anaesthetic wears off, her arm may be sore for a few days. She also may have swelling and bruising at the insertion site. This is common and will go away without treatment.
Length of pregnancy protection	Discuss how to remember the date to return. Give each woman the following information in writing on a reminder card, like the one shown below, if possible, and explain: <ul style="list-style-type: none"> – 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 start to lose effectiveness	Return or see another provider before the <ul style="list-style-type: none"> • Implants start losing effectiveness (for removal or, if she wishes, replacement).

Implant Reminder Card

Client's name:

Type of implant:

Remove or replace by: Month:

Year:

If you have any problems or questions, go to:

INTRA UTERINE CONTRACEPTIVE DEVICES (IUCD)

Intra-uterine Contraceptive Devices (IUCDs) are one of the Long Acting Reversible Contraceptive (LARC) methods. LARCs also include Implants, e.g., Jadelle and Implanon. IUCDs and Implants are the most effective available reversible contraceptives, and once inserted, they last for several years; eliminating the need for daily contraceptive action. Both are reversible and can be removed any time resulting in immediate return to fertility.

7. What is the Intra Uterine Contraceptive Device (IUCD)?

The IUCD is a safe and highly effective, small, flexible plastic contraceptive device, which is inserted into the uterine cavity. It is also known as the Intra Uterine Device (IUD). The terms will be used interchangeably in this document.

- Almost all types of IUDs have one or two strings, or threads, tied to them. The strings hang through the cervix into the vagina.

A specifically trained health care provider inserts it into a woman's uterus through her vagina and cervix.



Copper T 380A



Levonorgesterel releasing IUCD



7.1. What types of IUCDs are available?

IUCDs are made of plastic and medicated with copper, or progesterone. The following will be discussed in this document.

- Copper T 380A.
- Levonorgestrel releasing IUCD.

7.2. How do IUCDs Work?

- Inhibit fertilization.
- Immobilise sperms.
- Thickens cervical mucus and changes the endometrial lining (Progesterin releasing IUCD).

7.3. How effective are IUCDs?

7.3.1. Copper-Bearing Intrauterine Device

One of the most effective and long acting reversible contraceptive methods (LARCs):

- 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.
- The TCu-380A IUCD is effective for 12 years.
- Return to fertility after IUD is removed is immediate.
- No protection against sexually transmitted infections (STIs).

7.3.2. Levonorgestrel Releasing Device

One of the most effective and long-lasting methods:

- Less than 1 pregnancy per 100 women using an LNG-IUD over the first year (2 per 1,000 women). This means that 998 of every 1,000 women using LNG-IUDs 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 LNG-IUD.
- Over 5 years of LNG-IUD use: Less than 1 pregnancy per 100 women (5 to 8 per 1,000 women).
- Approved for up to 5 years of use.
- Return to fertility after LNG-IUD is removed is immediate.
- Provides no protection against sexually transmitted infections (STIs).



7.4. Who Can Use IUCDs?

- Clients who prefer a method which does not require taking contraceptive action daily or before sexual intercourse (this includes women who have trouble using barrier methods or remembering to take a pill every day).
- Clients prefer a method which provides highly effective, long-term contraception but does not want a permanent method (voluntary surgical contraception) at this time.

Most women can use IUDs safely and effectively, including women who:

- Have or have not had children.
- Are of any age, including adolescents and women over 40 years old.
- Have just delivered a baby (PPIUCD) or had a miscarriage (if no evidence of infection).
- Are breastfeeding.
- Do hard physical work.
- Are infected with HIV or on antiretroviral therapy and doing well (Please Refer to MEC Wheel or Tables in Chapter 2).

Women can begin using IUDs

- Without an HIV test.
- Without any blood tests or other routine laboratory tests.
- Without cervical cancer screening.
- Without a breast examination.

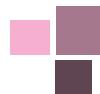


Table 7.1

When performing the 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 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 through 5, if the answer is "yes," manage or refer for diagnosis and treatment as appropriate. Help her choose another method and counsel her about condom use if she faces any risk of sexually transmitted infections (STIs). Give her condoms, if possible. If STI or pelvic inflammatory disease (PID) is confirmed and she still wants an IUCD, it may be inserted as soon as she finishes treatment, if she is 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 IUD insertion?

NO YES If an anatomical abnormality distorts the uterine cavity, proper IUCD placement may not be possible. Help her 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 IUD and to minimize risk of perforation. If size and position cannot be determined, do not insert an IUD. Help her choose another method.

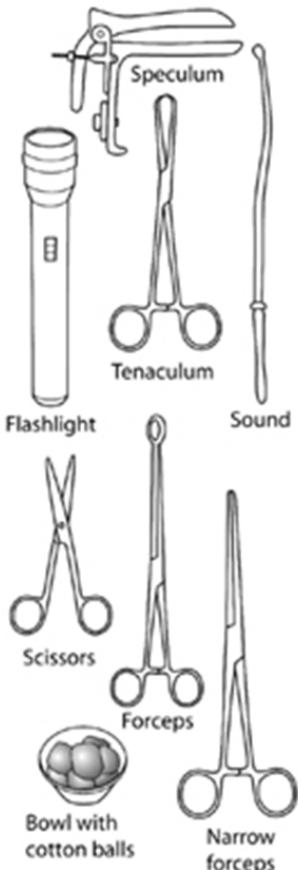
7.5. Initiating IUCDs

7.5.1. Interval IUCD

- Initiated any time during the menstrual cycle when you are reasonably sure the client is not pregnant, preferably from day 1 to 7 of the menstrual cycle.
- Insert IUCD immediately or within 7 days post first trimester abortion, provided there is no evidence of infection. For second trimester insert IUCD 4 weeks after miscarriage.

A woman who has chosen the IUCD needs to know what will happen during insertion. The following description can help explain the procedure to her. Learning IUCD insertion requires training and practice under direct supervision. Therefore, this description is a summary. Please refer to training procedure manual for detailed instructions.

The provider:



- Conduct a pelvic examination to assess eligibility. First do bimanual examination and then insert a speculum into the vagina to inspect the cervix.
- Clean the cervix and vagina with appropriate antiseptic.
- Slowly insert the tenaculum through the speculum and close the tenaculum just enough to gently hold the cervix and uterus steady.
- Slowly and gently pass the uterine sound through the cervix to measure the depth and position of the uterus.
- Load the IUD into the inserter while both are still in the unopened sterile package.
- Slowly and gently insert the IUD and removes the inserter.
- Cut the strings on of the IUD, leaving about 3 centimeters hanging out of the cervix.

After the insertion, the woman rests. She remains on the examination table until she feels ready to get dressed.

7.5.5 Post-Partum IUCD (PPIUCD)

- Inserted within 10 minutes and up 48 hours post vaginal delivery of placenta.
- There are three types of PPIUCD insertions:
 - Post-placental: immediately following the delivering of the placenta.
 - Intra-caesarean: immediately following the removal of the placenta during the caesarean section, the IUCD is inserted manually or with a ring forceps before closure of the uterine incision. Ensure that the threads are well placed in the uterus and do not get caught up in the uterine incision during closure.
 - Early postpartum: not immediately following the delivery/removal of the placenta, but within two days/48 hours, but preferably within 24 hours.

NB: Post-vaginal delivery insertion of the IUCD is different from interval insertion. For greater detail, please refer to Chapter 12 of these guidelines and the training manual for PPIUCD insertions.

Initiating IUCD after Emergency Contraception (ECP) - Adapted from the WHO Hand

- After taking ECP, the IUD can be inserted on the same day that the woman takes the ECPs whether this is Progestin-only, COC or Ulipristal Acetate. There is no need for a backup method.
- If the woman does not have it inserted immediately, but returns for an IUD, she can have it inserted any time *if it can be determined that she is not pregnant* (see *Ruling out Pregnancy Appendix 1*).

Instructions for a client after insertion of IUCD

- The IUCD is effective immediately so one can have sexual intercourse when they feel comfortable.
- Check for threads twice a week in the first six weeks then after every menstrual period. It is important to learn how to check the threads so that one can be sure the IUCD is still in place.

7.5.2. Teach client how to check for the threads

7.6. What are the side effects of IUCDs?

7.6.1. Copper bearing Devices

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

7.6.2. Levonorgestrel Intrauterine Device

- Changes in bleeding patterns, including:
- Lighter bleeding and fewer days of bleeding.
- Infrequent bleeding.
- Irregular bleeding.
- No monthly bleeding.
- Prolonged bleeding.
- Acne.
- Headaches.
- Breast tenderness or pain.
- Nausea.
- Weight gain.
- Dizziness.
- Mood changes.
- Ovarian cyst.

7.7. Indications for Removal of the IUCD

- Personal reasons, e.g., the woman may want to have a child.
- Severe lower abdominal pain.
- Severe prolonged bleeding.
- Evidence of PID.
- Pregnancy before 13th week.
- At the end of the effective life of the IUCD.

7.8. Complications of IUCDs and Management

- These complications are rare but health providers need to be able to diagnose and manage them appropriately when they happen.

7.8.1. Suspected uterine puncturing (perforation)

IF UTERINE PERFORATION IS SUSPECTED IF AT PRIMARY OR SECONDARY CARE LEVEL REFER PATIENT. IF AT PROVINCIAL OR CENTRAL HOSPITAL ADMIT PATIENT FOR CLOSE MONITORING AND SPECIALIST ASSESSMENT.

- If puncturing is suspected at the time of insertion or sounding of the uterus, stop the procedure immediately (and remove the IUD if inserted). Observe the client in the clinic carefully:
- For the first hour, keep the woman at bed rest and check her vital signs (blood pressure, pulse, respiration, and temperature) every 5 to 10 minutes.
- If she has a rapid pulse and falling blood pressure, or new pain or increasing pain around the uterus, refer her to a higher level of care. Resuscitate and manage accordingly.
- If uterine perforation is suspected within 6 weeks after insertion or if it is suspected later and is causing symptoms, refer the client for evaluation to a gynaecologist.

7.8.2. IUD partially comes out (partial expulsion)

- If the IUD partially comes out, remove the IUD. Discuss with the client whether she wants another IUD or a different method. If she wants another IUD, she can have one inserted at any time it is reasonably certain she is not pregnant. If the client does not want to continue using an IUD, help her choose another method.

7.8.3. IUD completely comes out (complete expulsion)

- If the client reports that the IUD came out, discuss with her whether she wants another IUD or a different method. If she wants another IUD, she can have one inserted at any time it is reasonably certain she is not pregnant.
- If complete expulsion is suspected and the client does not know whether the IUD came out, refer for x-ray or ultrasound to assess whether the IUD might have moved to the abdominal cavity. Give her a backup method* to use in the meantime.

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

- Ask the client:
- Whether and when she saw the IUD 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 IUD 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 IUD has been expelled unnoticed.
- Rule out pregnancy before attempting more invasive procedures. Refer for evaluation.
- Give a backup method to use in the meantime, in case the IUD came out.

7.8.5. Infection

Infection as a result of IUCD infection is very rare. It is critical to observe infection prevention and control procedures when inserting the IUCD. However, a client who had pre-existing infection prior to insertion of IUCD may develop severe pelvic inflammatory disease. It is therefore critical to adequately screen for possibility of STIs prior to insertion. Treat all cases of infection with the appropriate antibiotics. There is no need to remove the IUCD during treatment unless the woman requests

Information Box 7.1

Copper-Bearing Intrauterine Device

Key Points for Providers

- Long-term pregnancy protection. Shown to be very effective for 12 years, immediately reversible.
- Reversible anytime within the 12-year period should client wish to discontinue.
- Inserted into the uterus by a specifically trained provider.
- Little action required of the client once the IUD is in place.
- Bleeding changes are common. Typically, longer and heavier bleeding and more cramps or pain during monthly bleeding, especially in the first 3 to 6 months.

Information Box 7.2

Levonorgestrel Intrauterine Device

Key Points for Providers

- Long-term pregnancy protection. Very effective for 5 years.
- Reversible anytime client wishes, with immediate return to fertility.
- Inserted into the uterus by a specially trained provider.
- Little required of the client once the LNG-IUD is in place.
- Bleeding changes are common but not harmful. Typically lighter and fewer days of bleeding, infrequent or irregular bleeding.

Information Box 7.3

Dispelling Myths

Intrauterine Devices:

- 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 IUD 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.

Table 7.2 Copper-Bearing Intrauterine Device

Known Health Benefits	Known Health Risks
<p>Help protect against: Risks of pregnancy.</p> <p>May help protect against: Cancer of the lining of the uterus (endometrial cancer).</p>	<p>Uncommon: May contribute to anaemia if a woman already has low iron blood stores before insertion and the IUD causes heavier monthly bleeding.</p> <p>Complications</p> <p>Rare: Puncturing (perforation) of the wall of the uterus by the IUD or an instrument used for insertion. Usually heals without treatment. Miscarriage, preterm birth, or infection in the rare case that the woman becomes pregnant with the IUD in place.</p>

Table 7.3 Levonorgestrel Intrauterine Device

Known Health Benefits	Known Health Risks
<p>Help protect against: Risks of pregnancy Iron-deficiency anaemia May help protect against: Pelvic inflammatory disease</p> <p>Reduces: Menstrual cramps Symptoms of endometriosis (pelvic pain, irregular bleeding)</p>	<p>Complications</p> <p>Rare: Puncturing (perforation) of the wall of the uterus by the LNG-IUD or an instrument used for insertion. Usually heals without treatment.</p> <p>Very rare: Miscarriage, preterm birth, or infection in the very rare case that the woman becomes pregnant with the LNG-IUD in place.</p>

Table 7.3 Giving Advice on Side Effects

Thorough counselling about bleeding changes must come before IUD 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: Prolonged and heavy monthly bleeding. Irregular bleeding. More cramps and pain during monthly bleeding.
Explain about these side effects	Bleeding changes are not signs of illness. Usually become less after the first several months after insertion. Client can come back for help if problems bother her.

Table 7.4 Giving Advice on Side Effects

Thorough counselling about bleeding changes must come before IUD insertion. Counselling about bleeding changes may be the most important help a woman needs to keep using the method.

Table 7.5 Levonorgestrel Intrauterine Device

Describe the most common side effects	<p>Changes in bleeding patterns:</p> <ul style="list-style-type: none"> No monthly bleeding, lighter bleeding, fewer days of bleeding, infrequent or irregular bleeding. Acne, headaches, breast tenderness and pain, and possibly other side effects.
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Table 7.6 Management of problems related to use of IUCDs

PROBLEM	ASSESSMENT	MANAGEMENT
Amenorrhoea	<ul style="list-style-type: none"> • Ask Client: • Date of LNMP. • When she last felt threads. • Any signs of pregnancy. • Check for pregnancy. • Rule out menopause • Pelvic examination and investigation: Speculum examination to check for strings. Pregnancy test if available. 	<ul style="list-style-type: none"> • If client is over 45 years, explain that amenorrhoea could be related to menopause. • If not pregnant, do not remove the IUCD. Counsel and refer client for investigations. • If pregnant and is less than 12 weeks, strings visible, counsel client for removal of IUCD to minimize risk of infection/abortion. • Remove IUCD if client agrees. • Counsel client to come to the clinic if there is bleeding, cramping or fever (possible signs of abortion). • Do not remove IUCD if: Pregnant and strings/thread Missing strings/thread are not visible. • Pregnancy greater than 12 weeks. Counsel and refer client to ANC.
Bleeding (prolonged bleeding: more than 8 days). (Heavy bleeding: Twice as long or twice as much as normal).	<ul style="list-style-type: none"> • Perform pelvic examination to exclude: • Intrauterine or ectopic pregnancy • Incomplete abortion. • Pelvic infection. • IUCD expulsion. • Check for signs of anaemia. 	<ul style="list-style-type: none"> • If on examination no abnormalities are found counsel client and give iron tablets. • If examination shows enlarged uterus due to fibroids, refer client for evaluation by gynaecologists. • If recurrent infection remove IUCD, treat according to guidelines and remove IUCD. • Remove IUCD if bleeding worsens or client requests removal. • If marked anaemia, remove IUCD and help client choose another method. • Give Ferrous Sulphate for three months.

Partner complaining about strings/threads.	<ul style="list-style-type: none">Check to be sure IUCD is in place (not partially expelled).Do speculum examination to check position of the IUCD.	<ul style="list-style-type: none">If strings/threads are too short remove and reinsert new IUCD and cut strings/threads to 3 - 4cm long.If strings/threads are too long, more than 3 - 4 cm, trim them. Remove and counsel for a new method.
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Table 7.7 Medical Eligibility Criteria Checklist

Medical Eligibility Criteria Checklist for Copper-Bearing Intrauterine Device

Ask the client the questions below about known medical conditions. If she answers “no” to all of the questions, then she can have an IUD inserted if she wants. If she answers “yes” to a question, follow the instructions. In some cases she can still have an IUD inserted. These questions also apply to the Levonorgestrel IUD.

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

NO YES

Delay inserting an IUD until 4 or more weeks after childbirth.

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

NO YES

If she currently has infection of the reproductive organs during the first 6 weeks after childbirth (puerperal sepsis) or she just had an abortion-related infection in the uterus (septic abortion), do not insert the IUD. Treat or refer if she is not already receiving care. Help her choose another method or offer a backup method.* After treatment, re-evaluate for IUD use.

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

NO YES

If she has unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition, use of an IUD could make diagnosis and monitoring of any treatment more difficult. Help her choose a method to use while being evaluated and treated (but not a hormonal IUD, Progestin only injectables, or implants). After treatment, re-evaluate for IUD use.

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

NO YES

Known current cervical, endometrial, or ovarian cancer; gestational trophoblast disease; pelvic tuberculosis: Do not insert an IUD. Treat or refer for care if she is not already receiving care. Help her choose another method. In case of pelvic tuberculosis, re-evaluate for IUCD use after treatment.

Backup methods include abstinence, male and female condoms and withdrawal. Tell her that withdrawal is one of the least effective contraceptive methods. If possible, give her condoms.

5. Do you have AIDS?**NO YES**

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

6. Assess whether she is at very high individual risk for Gonorrhoea or Chlamydia.**NO YES**

Women who have a very high individual likelihood of exposure to Gonorrhoea or Chlamydia should not have an IUD inserted.

7. Assess whether the client might be pregnant.**NO YES**

Ask the client the questions in the pregnancy checklist. If she answers “yes” to any question, she can have an IUD inserted.

For complete classifications, see Medical Eligibility Criteria for Contraceptive 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.

Medical Eligibility Criteria Checklist for Levonorgestrel Intrauterine Device

Ask the client the Medical Eligibility Criteria questions for Copper-Bearing IUDs. Also ask the questions below about known medical conditions. If she answers “no” to all of the questions here and for the copper-bearing IUD, then she can have an LNG-IUD inserted if she wants. If she answers “yes” to a question, follow the instructions. In some cases she can still have an LNG-IUD inserted.

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

NO YES

If she can have the LNG-IUD inserted as soon as 4 weeks after childbirth.

2. Do you now have a blood clot in the deep veins of your legs or lungs?

NO YES

If she reports current blood clot (except superficial clots), and she is not on anticoagulant therapy, help her choose a method without hormones.

3. 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 the LNG-IUD. Help her choose a method without hormones.

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

NO YES

Do not insert the LNG-IUD. Help her choose a method without hormones.

For complete classifications, see Medical Eligibility Criteria for Contraceptive Use. 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.

BARRIER METHODS

8. What are Barrier Methods?

Barrier methods are those methods that prevent sperms from gaining access to the female reproductive tract. These include male and female condoms, cervical diaphragms, cervical caps and spermicides. Some barrier methods such as condoms help prevent transmission of STIs including HIV. The use of diaphragms, cervical caps and spermicides is no longer recommended in Zimbabwe. Barrier methods may be mechanical (e.g. male and female condoms) or, chemical; (e.g. spermicides). (These guidelines will focus on condoms. Ba

8.1. What are condoms?

Condoms are barrier methods used to prevent pregnancy, STIs and HIV infection.



8.2. What Types of condoms are available?

8.2.1. Male Condom

- The male condom is a thin sheath made of latex (synthetic rubber) which provides protection against pregnancy, STI and HIV infection. They are widely available, highly effective and easy to carry.
- There are many types of male condoms differing in shape, colour, scent, lubrication and texture.

8.2.2. Female Condom

- The female condom is a thin sheath worn by woman during sex. It provides continuous lining of the vagina which inhibits exchange of sexual fluids between sexual partners, hence preventing pregnancy and STIs including HIV.
- It has flexible rings at both ends.
- One ring at the closed end helps to insert the condom.





- FC2 – FC2 condoms are made of a synthetic rubber, ‘nitrile’. FC2 has same design and usage as was that of the FC. Which has been replaced by Fc2.
- The Cupid Female Condom – It is a silicone pre-lubricated condom made of rubber latex. It can also be used with water based lubricants e.g. K-Y Jelly. In acceptability study done in 2015 it was accepted by 85% women and 80% men in Zimbabwe.

8.3. How do the condoms work?

- 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.
- The female condom provides additional protection by covering a large area of the genitalia thus protection from STIs e.g. sores on base of penis.

8.4. How effective are condoms?

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

Protection against pregnancy:

- As commonly used, about 15 pregnancies per 100 women whose partners use male condoms over the first year in typical use. 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 (perfect use), about 2 pregnancies per 100 women whose partners use male condoms over the first year.
- Return of fertility after use of condoms is stopped is immediate.
- Provides protection against both pregnancy and STIs including HIV:
- Male condoms significantly reduce the risk of becoming infected with HIV when used correctly with every act of sex.
- When used consistently and correctly, condom use prevents 80% to 95% of HIV transmission that would have occurred without condoms.
- Condoms reduce the risk of becoming infected with many STIs when used consistently and correctly.
 - Protect best against STIs spread by discharge, such as HIV, gonorrhoea, and chlamydia.

How effective are female condoms?

Protection against pregnancy:

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



- When used correctly with every act of sex, about 5 pregnancies per 100 women using female condoms over the first year.
- Return to fertility after use of female condom is stopped is immediate.

Protection against HIV and other STIs:

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

8.5. Who Can Use Condoms?

All men and women can use male and female latex condoms except those allergic to rubber or latex. All women and men can use female 'nitrile' condoms unless they have sensitivity to nitrile.

- Men and women who wish to participate in family planning.
- Partners who need contraception immediately.
- Partners who need dual protection.
- Partners needing a back-up method.
- Partners who are at risk of STI and HIV infection.
- HIV infected women for dual protection.

8.6. How to use a male condom

Condoms can be initiated at any time and do not need a visit to the clinic or hospital for initiation.

The following steps should be followed:

- a. Check the packaging to rule out perforations.
- b. Check the expiry date.
- c. Carefully remove the condom from the packet to avoid tearing.
- d. Pinch the tip and squeeze the air out of the tip of the condom.
- e. Unroll the condom onto the erect penis.
- f. After ejaculation, withdraw the penis from the vagina while still erect. Hold onto the rim of the condom while withdrawing to prevent it from slipping off and the semen spilling into the vagina.
- g. Remove the condom from the penis, wrap it and discard it into a bin or Blair Toilet, bury, or incinerate.
- h. Do not use mineral oil based lubricants (such as petroleum jelly or Vaseline).
- i. Use a male condom only once with each sexual act.

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

Table 8.1 How to use Male Condom

1. Use a new condom for each act of sex
Check the condom package. Do not use if torn or damaged. Avoid using a condom past the expiration date—do so only if a newer condom is not available.
Tear open the package carefully. Do not use fingernails, teeth, or anything that can damage the condom.
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 the condom does not unroll easily, it may be on backwards, damaged, or too old. Throw it away and use a new condom.
If the condom is on backwards and another one is not available, turn it over and unroll it onto the penis.
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.

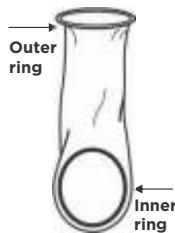


Table 8.2 How to use female Condom

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 expiration date—do so only if newer condoms are not available.

If possible, wash your hands with mild soap and clean water before inserting the condom.



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

Can be inserted up to 8 hours before sex. For the most protection, insert the condom before the penis comes in contact with the vagina.

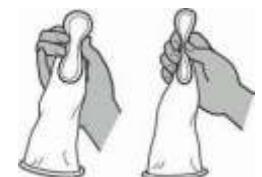
Choose a position that is comfortable for insertion— squat, raise one leg, sit, or lie down.

Rub the sides of the female condom together to spread the lubricant evenly.

Grasp the ring at the closed end, and squeeze it so it becomes long and narrow.

With the other hand, separate the outer lips (labia) and locate the opening of the vagina.

Gently push the inner ring into the vagina as far up as it will go. Insert a finger into the condom to push it into place. About 2 to 3 centimetres of the condom and the outer ring remain outside the vagina.



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

The man or woman should carefully guide the tip of his penis inside the condom—not between the condom and the wall of the vagina. If his penis goes outside the condom, withdraw and try again.

If the condom is accidentally pulled out of the vagina or pushed into it during sex, put the condom back in place.

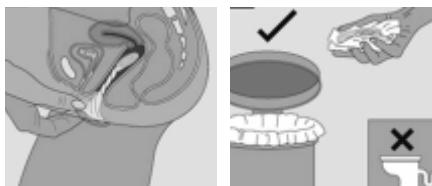


- After the man withdraws his penis, hold the outer ring of the condom, twist to seal in fluids, and gently pull it out of the Vagina. The female condom does not need to be removed immediately after sex.

Remove the condom before standing up, to avoid spilling semen. If the couple has sex again, they should use a new condom.

Reuse of female condoms is not recommended

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



Information Box 8.1

Dispelling Myths

Female condoms:

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

Information Box 8.2

Dispelling Myths

Male condoms:

- Do not make men sterile, impotent, or weak.
- Do not decrease men's sex drive.
- Cannot get lost in the woman's body.
- Do not have holes that HIV can pass through.
- Are not laced with HIV.
- Do not cause illness in a woman because they prevent semen or sperm from entering her body.
- Do not cause illness in men because sperm "backs up."
- Are used by married couples. They are not only for use outside marriage.

Information Box 8.3

Key points for the Provider

- Male condoms help protect against sexually transmitted infections, including HIV. Condoms are the only contraceptive method that can protect against both pregnancy and sexually transmitted infections.
- Require correct use with every act of sex for greatest effectiveness.
- Require both male and female partner's cooperation. Talking about condom use before sex can improve the chances one will be used.
- May dull the sensation of sex for some men. Discussion between partners sometimes can help overcome the objection.

Diaphragms & Cervical Cap

These cover the cervix and leave the vaginal walls exposed to seminal fluid and therefore infection.

Spermicides

Spermicides are chemicals that inactivate or kill sperms. The preparations are in the form of jellies, foams, creams, tablets or pessaries. They are inserted into the vagina before sexual intercourse. The use of diaphragms, cervical caps and spermicides is no longer recommended in Zimbabwe. (See information box 9.4 below).

Information Box 8.4

Spermicides, diaphragms and cervical caps

- The use of spermicides is no longer recommended in Zimbabwe as the frequent use of Nonoxynol increases risk of HIV infection.
- The diaphragm and cervical cap cover the cervix leaving the vaginal walls exposed to infection hence they are no longer recommended for use in Zimbabwe.
- Spermicides are one of the least effective contraceptive methods.
- The 'Diaphragm' and Cervical Cap cover the cervix leaving the vaginal walls exposed to infection, hence they are no longer recommended for use in Zimbabwe.

PERMANENT METHODS

9. What are permanent methods?

Methods for both men and women intended to provide life-long, permanent, and very effective protection against pregnancy. Reversal is usually not possible.

SECTION A

9.1. What types of methods are available for women?

Tubal Ligation

- Tubal ligation is a permanent method of contraception in which the fallopian tubes are occluded through a surgical procedure. Permanent contraception for women who will not want more children.
- The 2 surgical approaches most often used:
 - Mini-laparotomy involves making a small incision in the abdomen. The fallopian tubes are brought to the incision to be cut or blocked.
 - Laparoscopy involves inserting a long thin tube with a lens in it into the abdomen through a small incision. This laparoscope enables the doctor to see and block or cut the fallopian tubes in the abdomen.
- Also called female sterilization, bilateral tubal ligation, tubal sterilization, voluntary surgical contraception, tubectomy, bi-tubal ligation, tying the tubes, minilap, and "the operation."

9.2. How does tubal ligation work?

- By blocking or cutting the fallopian tubes, the sperm is prevented from reaching ova and causing fertilisation.

9.3. How effective is Tubal ligation?

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

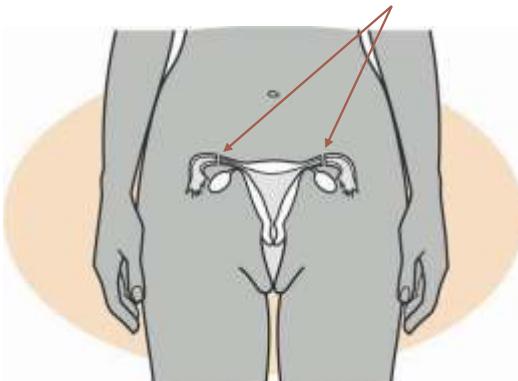
- Less than 1 pregnancy per 100 women over the first year after having the sterilization procedure (5 per 1,000). This means that 995 of every 1,000 women relying on female sterilization will not become pregnant.
- A small risk of pregnancy remains beyond the first year of use and until the woman reaches menopause.
- Over 10 years of use: About 2 pregnancies per 100 women (18 to 19 per 1,000 women).

Effectiveness varies slightly 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).



Fig 10.1 (Adapted from the Family Planning Global Handbook for Providers)

- 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.



Protection against sexually transmitted infections (STIs): None.

9.4. Initiation

- Anytime during the menstrual cycle when one is reasonably sure the client is not pregnant.
- Postpartum - perform tubal ligation within 2 days postpartum or after 6 weeks.
- Post abortion - perform immediately or within 7 days provided there is no evidence of pelvic infection.

9.5. Who can have Tubal ligation?

- Women who have achieved their desired family size.
- Women in whom pregnancy would pose a serious health risk.

9.6. Counseling Issues for Tubal Ligation

- The client must make an informed, voluntary choice and
- A consent form must be signed by the client before the procedure.
- The client has the right to change her mind any time prior to the procedure.
- Incentives should not be given to clients to accept voluntary sterilization.
- Spousal consent is not mandatory but encouraged for marital harmony.
- Counselling session should be documented.

PLEASE REFER TO TRAINING MANUAL FOR OPERATIVE PROCEDURE

9.7. Instructions for the Client after the Procedure

- Keep the operative site dry until dressing is removed.
- Resume normal activities gradually. (Normal activities within 7 days after surgery).

- Resume sexual intercourse when feeling comfortable.
- Avoid heavy lifting and hard work for one week.
- Take mild analgesic every 4 to 6 hours for pain relief.
- Schedule a follow-up visit between 7-14 days after surgery.
- Return anytime if there are concerns and unusual signs and symptoms.

General Information

Inform client that:

- Tubal occlusion is effective from the time the operation is completed, so no backup method is required.
- Menstrual periods will continue as usual. If using a hormonal method before the procedure, especially COC, the amount and duration of menses may increase after surgery.
- Tubal ligation does not provide protection against STI and HIV infection. If either partner is at risk of STI/HIV infection use condoms.

Sterilization procedures should only be performed by well-trained providers in appropriate clinical settings using proper equipment and supplies. Appropriate service delivery guidelines, including infection prevention protocols, should be followed to maximize client safety. Below is a table to provide guidance on the safety of performing tubal ligation.

Table 9.1 Risk assessment for performing Tubal ligation

A	Accept	There is no medical reason to deny sterilization to a person with this condition.
C	Caution	The procedure is normally conducted in a routine setting, but with extra preparation and precautions.
D	Delay	The procedure is delayed until the condition is evaluated and/or corrected. Alternative temporary methods of contraception should be provided.
S	Special	The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anaesthesia, and other backup medical support. For these conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen is also needed. Alternative temporary methods of contraception should be provided, if referral is required or there is otherwise any delay.

Table 9.2 Management of Problems Following Tubal Ligation

PROBLEM	MANAGEMENT
Wound infection	If skin infection is present, treat with antibiotics. If abscess is present, drain and treat with antibiotics. Dress wound until healed.
Post-operative fever: (Temperature >38°C)	Investigate cause of rise in temperature e.g., wound sepsis. Treat based on findings.
Pain at incision site	Check for presence of infection or abscesses. Treat according to findings. Give analgesics.
Haematoma	Apply warm, moist packs on site. Closely observe. Reassure client that it usually resolves overtime. Drain if haematoma is extensive.
Bladder and Intestinal injuries (rare)	Refer to appropriate level of care. If bladder or bowels injured and recognized intra operatively, perform primary repair. If discovered post-operatively, refer to appropriate centre as necessary.

SECTION B

What permanent methods are available for men?

9.8. Vasectomy (Male Surgical Sterilisation)

- Vasectomy is a permanent method of contraception in which the vas deferens is occluded through a simple operation.
- Permanent contraception for men who will not want more children.
- Through a puncture or small incision in the scrotum, the provider locates each of the 2 tubes that carries sperm to the penis (vas deferens) and cuts or 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.

9.9. What are the types of vasectomy?

- Standard method (one or two small incisions).
- No-scalpel technique.

9.10. How does vasectomy Work?

- By blocking the vas deferens, sperms are not present in the ejaculate.

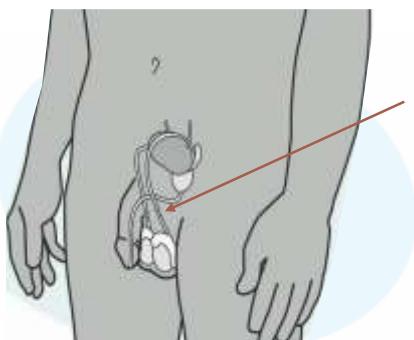
9.11. How effective is vasectomy?

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

- Where men cannot have their semen examined 3 months after the procedure to see if it still contains sperm, pregnancy rates are about 2 to 3 per 100 women over the first year after their partners have had a vasectomy. This means that 97 to 98 of every 100 women whose partners have had vasectomies will not become pregnant.
- 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 or another effective method consistently and correctly in the first 3 months, before the vasectomy is fully effective.



- **A small risk of pregnancy remains beyond the first year after the vasectomy and until the man's partner reaches menopause.**
 - Over 3 years of use: About 4 pregnancies per 100 women
- **If the partner of a man who has had a vasectomy becomes pregnant, it may be because:**
 - The couple did not always use another method during the first 3 months after the procedure.
 - The provider made a mistake.
 - The cut ends of the vas deferens grew back together.

Fertility does not return because vasectomy 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.

Protection against sexually transmitted infections (STIs): None.

9.12. Who can have vasectomy?

- Men who want a permanent method of contraception.
- Men whose wives' health might pose a serious health risk if they become pregnant.
- Partners who are certain they have achieved the desired family size.

9.13. Contraindications for vasectomy

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

9.14. Precautions

Clients with the following conditions are best referred for specialist care.

- Large varicocele.
- Hydrocele.
- Inguinal hernia.
- Orchitis.
- Single or with no living child.
- Symptomatic heart disease or clotting disorders and diabetes mellitus.
- Filariasis.
- Scar tissue.
- Previous scrotal surgery.
- Undescended testes.

PLEASE REFER TO PROCEDURE MANUAL FOR OPERATIVE PROCEDURE

9.15. Counselling issues for vasectomy

- The client must make an informed voluntary choice.
- A consent form must be signed by the client before the procedure.
- The client has the right to change his mind any time prior to the procedure.
- No incentives should be given to the clients to accept vasectomy.
- Spouse's consent is not mandatory but encouraged for marital harmony.
- Counselling sessions should be documented.

9.16. Client Instructions

- Keep bandage on for three days.
- Do not scratch wound while healing.
- Do not let the wound get wet while bathing for the first 3 days after operation.
- Wear a scrotal support and rest for 2 days.
- Take mild analgesics for pain every 4-6 hours.
- If comfortable, you may resume sexual intercourse after 2 to 3 days.
- Use condoms or another family planning method for three months or until you have had 20 true ejaculations.

- Return after a week for review and removal of sutures if non-absorbable sutures were used.
- Come for semen analysis 3 months after the operation to confirm absence of sperms in ejaculate.

9.17. Danger Warning Signs

The client must contact the nearest health centre if any of the following develop:

- Fever ($> 38^{\circ}\text{C}$).
- Bleeding or fluid coming from the incision area.
- A very painful or swollen scrotum.
- Partner misses a period.

9.18. General Information

Inform the client that:

- Vasectomy does not provide protection from pregnancy until after three months or 20 true ejaculations or when no sperms are seen on semen analysis.
- Counsel couple to use another family planning method until vasectomy is effective.
- Vasectomy will not affect sexual performance because the testes will function normally.
- Vasectomy does not provide protection against STI and HIV infection. If either partner is at risk, the couple should use condoms even after vasectomy.

Information Box 9.1

Dispelling Myths

Tubal ligation:

- 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.
- Does not cause any changes in weight, appetite, or appearance.
- Does not change women's sexual behavior or sex drive.
- Substantially reduces the risk of ectopic pregnancy.

Information Box 9.2**Dispelling Myths****Vasectomy:**

- Does not remove the testicles. In vasectomy the tubes carrying sperm from the testicles are blocked. The testicles remain in place.
- Does not decrease sex drive.
- Does not affect sexual function. A man's erection is as hard, it lasts as long, and he ejaculates the same as before.
- Does not cause a man to grow fat or become weak, less masculine, or less productive.
- Does not cause any diseases later in life.
- Does not prevent transmission of sexually transmitted infections, including HIV.

Information Box 9.3**Key Points: Tubal Ligation**

- Permanent. Intended to provide life-long, permanent, and very effective protection against pregnancy. Reversal is usually not possible.
- Involves a physical examination and surgery. The procedure is done by a specially trained provider.
- No long-term side effects.

Information Box 9.4**Key Points: Vasectomy**

- Permanent. Intended to provide life-long, permanent, and very effective protection against pregnancy. Reversal is usually not possible.
- Involves a safe, simple surgical procedure by a trained provider.
- 3-month delay in taking effect. The man or couple must use condoms or another contraceptive method for 3 months after the vasectomy.
- Does not affect male sexual performance.

POSTPARTUM FAMILY PLANNING

10.0. What is postpartum family planning?

This is family planning services offered immediately after childbirth before discharge from the health facility.

10.1 Why is Postpartum Family Planning (PPFP) important?

Postpartum family planning (PPFP) aims to prevent unintended pregnancy and closely spaced pregnancies after childbirth. PPFP is often ignored and a number of biases and misconceptions have limited its availability. Childbirth presents an opportunity for providing contraception at a time when women are often attending a service staffed by healthcare providers with the skills to offer a full range of methods and when women may be highly motivated to start using an effective method. It is clear from the statistics below that PPFP saves lives:

- Worldwide, more than 9 out of 10 women want to avoid pregnancy for 2 years after having had a baby, but 1 in 7 of them is not using contraception.
- PPFP can save mothers' lives – family planning can prevent more than one-third of maternal deaths. PPFP can also save babies' lives – family planning can prevent 1 in 10 deaths among babies if couples space their pregnancies more than 2 years apart.
- Closely spaced pregnancies within the first-year postpartum increase the risks of preterm birth, low birth weight and small-for-gestational-age babies.
- The risk of child mortality is highest for very short birth-to-pregnancy intervals (i.e. less than 12 months).
- The timing of the return of fertility after childbirth is variable and unpredictable. Women can get pregnant before the return of menstruation.

The purpose of a comprehensive PPFP service is to help women to choose the contraceptive method they want to use, to start that method, and to continue to use it for 2 years or longer, depending on their reproductive plans.

It is best practice when talking to women about using contraception postpartum to be helpful and respectful and to listen to what they have to say. Women should be given the opportunity to make an informed choice about their contraceptive method.



10.2. When should contraception be provided?

Some couples start having sex again before 6 weeks after the baby is born. Pregnancy can occur by 6 weeks if a woman does not exclusively breastfeed so it is important to make sure that a method is provided by 4 weeks postpartum. Women who do breastfeed have postpartum amenorrhoea for varying lengths of time, depending on their breastfeeding practices, but ovulation and therefore pregnancy can occur before menstruation resumes. For women who are using the lactational amenorrhoea method (LAM) as their contraceptive, it is important to support them to choose and start another method of family planning by 6 months postpartum. (See LAM section).

- Best practice aims to ensure that women have a method of contraception that they can start before the risk of pregnancy returns after childbirth.

Opportunities exist for making sure that women have counselling and can choose a contraceptive method to use postpartum when they attend for antenatal care, delivery or for postpartum care or immunisation of their new baby. So there are a number of opportunities when PPFP can be provided.

- Best practice is for the chosen method of contraception to be started before the woman leaves the birthing facility.
- If contraception is started at any time within the first 4 weeks after delivery, there is no need to check for pregnancy.

If you miss the opportunity to help a woman start a method of contraception in the first 4 weeks after her baby is born, you can still help her to start as soon as possible.

If a method is started after 4 weeks postpartum, particularly if menstrual cycles have returned, then an assessment of the risk of pregnancy should be made. If pregnancy testing is not available, this should not be a barrier to starting a method. It is reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following WHO criteria and

- Is within 7 days of the start of normal menstruation.
- Has not had sexual intercourse since the start of last normal menstruation.
- Is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [at least 85%] of feeds are breastfeeds), is amenorrhoeic and is no more than 6 months postpartum.

If a woman has had intercourse since the start of last menstruation, use of emergency contraception should be considered for prevention of unintended pregnancy.

It is important to acknowledge that some women may not resume sexual activity for some time after delivery. Their contraceptive needs should be addressed accordingly.

10.3. What can be done to make sure opportunities for providing PPFP are not missed?

PPFP should be discussed at every opportunity. If you can, you should start to discuss PPFP while the woman is still pregnant so that she is able to start her chosen method as soon as possible after delivery.

10.3.1. In the antenatal clinic

- Women should be given verbal and written information about all PPFP options. Women should be told about the particular benefits of PPFP, particularly of intrauterine devices (IUDs) and implants.
- For women who are considering limiting their family size, it may be appropriate to discuss vasectomy or female sterilisation with the woman and her partner at this time.
- For women who are considering limiting their family size and undergoing a planned caesarean section, the possibility of concurrent tubal ligation should be discussed.
- Women should be given the opportunity to ask questions about contraception every time they are seen in the antenatal clinic.
- The method that the woman has chosen should be documented in the appropriate case record so that it can be provided as soon as possible after childbirth.
- If hormonal pills or barrier methods are chosen, these could be provided during late pregnancy so that women have a supply at home to start at the appropriate time after childbirth.

10.3.2. In the labour ward

- Women should be asked whether they have received contraceptive advice antenatally and, if so, the method they have chosen should be confirmed and then provided unless complications during pregnancy or delivery indicate the need for review.
- If the chosen method is not available in the labour ward, the method should be provided before the woman leaves the hospital or she should be referred to the most convenient place where the contraceptive method can be provided.
- In women having a caesarean section, IUDs can be fitted as soon as the placenta has been delivered. Insertion is simple and expulsion rates are low.
- IUD can be inserted from 10 minutes after delivery up to 48 hours post vaginal or caesarean delivery (PPIUCD).
- Contraception should not be discussed with a woman who is in active labour.

10.3.3. In the postnatal ward

- If a woman has not had the chance to discuss contraception before she arrives on the postnatal ward, it should be discussed with her before she leaves the hospital and her chosen method (including an implant, or an IUD if within 10 minutes up to 48 hours of delivery) should be provided.

10.3.4. In the postpartum care clinic

- Women attending for postpartum care should be asked whether they are using, or have a supply of contraception.
- It should be confirmed with women who have chosen their method that they are happy with their choice, are knowledgeable about the method including knowing when to start it if a delay is indicated, have sufficient supplies and know where they can get more (if appropriate).
- If a woman has not chosen a contraceptive method, she should be told about all methods, particularly the most effective methods, and arrangements made to provide her with the method she has chosen.

10.3.5. In the baby immunisation clinic

- Women bringing their babies for neonatal care and immunisation should be asked whether they are using contraception.
- It should be confirmed with women who have chosen their method that they are happy with their choice, are knowledgeable about the method including knowing when to start it if a delay is indicated, have sufficient supplies and know where they can get more (if appropriate).
- If a woman is not using contraception, she should be told about all methods, particularly the most effective methods, and arrangements made to provide her with the method she has chosen.

10.3.6. Which methods can be provided and when can they be started?

There are many myths and misconceptions about which methods of contraception can be provided to women after childbirth, including among providers. All providers should be correctly informed about which methods can be provided.

The most effective reversible methods of contraception are IUDs and contraceptive implants. Once inserted, their failure rates are extremely low (less than 1 unintended pregnancy per 1000 users within the first year of typical use). Unlike other methods of contraception, once IUDs or implants are in place the user needs to do nothing on a regular basis to ensure their effective action. They also need to take steps to get them removed (rather than simply stopping the method) and so continuation rates and pregnancy prevention are high. There is evidence that contraceptive implants, and even more so IUDs are much more likely to prevent early unintended pregnancy following childbirth than all other methods. It is best practice to advise all women at risk of HIV infection to use condoms as well as the method they have chosen for contraception.

Table 10.1 The most effective methods

These methods are generally associated with failure rates of less than 1 per 1000 users.

Intrauterine devices (IUD)

Copper T380 prevents pregnancy for up to 12 years and the Levonorgestrel-releasing IUD (LNG-IUD), ^{*}LNG-IUS for up to 5 years.

Failure rates are less than 1 per 1000 users.

Women with advanced HIV Disease should not have an IUD inserted until their disease is under control on ART or they are asymptomatic

IUDs do not protect against sexually transmitted infections (STIs), including HIV, and are safe for women who have HIV/AIDS.

In the postpartum setting:

IUDs can be inserted following expulsion of the placenta. It is most convenient and best practice to insert them immediately after the placenta has been delivered. If this is not possible, it is good practice to insert the IUDs before the woman leaves the labour ward.

An IUD can be inserted within 10 minutes up to 48 hours after the baby is born.

If the IUD is not inserted within 48 hours, insertion should be delayed until 4 weeks after the birth (referred to as 'interval insertion') to reduce the risk of uterine perforation.

Contraceptive implants

Implants are effective for 3–5 years or more depending on which implant is used.

Failure rates are around 1 per 1000 users.

Implants do not protect against STIs, including HIV.

Return to fertility is immediate after the implant is removed.

In the postpartum setting:

Implants can be inserted immediately postpartum, including before a woman leaves the birthing facility. If inserted before 3 weeks after delivery, there is no need to check for pregnancy.

A postpartum implant use does not interfere with lactation

Efficacy of implants is slightly less in women on 600mg Efavirenz based ART but implants remain more effective than most other contraceptive methods in these women.

Table 10.1 The most effective methods

These methods are generally associated with failure rates of less than 1 per 1000 users.

The IUD can be inserted at the time of caesarean section via the uterine incision once the placenta has been delivered.

Rates of perforation and infection for postpartum IUDs use appear to be similar to or even lower than those associated with interval insertion.

Women at high risk of STI acquisition should not have an IUD inserted.

Women with puerperal sepsis should not have IUD inserted.

After postpartum insertion of IUD, a follow up review should occur at 6 weeks to check placement and string length.

Use of a copper IUDs postpartum does not interfere with breastfeeding.

Return of fertility is immediate after an IUD is removed.

LNG-IUSs can also be used in the postpartum setting.

Table 10.1 The most effective methods

These methods are generally associated with failure rates of less than 1 per 1000 users.

Permanent contraception

Female sterilisation

Failure rates of female sterilisation are around 2 per 1000 women but the method is considered permanent.

Female sterilisation does not protect against STIs, including HIV.

In the postpartum setting:

Female sterilisation can be performed within the first 7 days postpartum or at any time after the baby is 6 weeks old. Between 7 days and 6 weeks there is an increased risk of complications as the uterus has not fully involuted. If a woman is scheduled for sterilisation at a later date, she should be provided with an effective interim method of contraception (e.g. a hormonal method) that will protect her from pregnancy until she undergoes sterilisation.

It may be convenient to perform female sterilisation at the time of elective caesarean section.

Male sterilisation (vasectomy)

Failure rates of male sterilisation (vasectomy) are around 1 per 1000 men but the method is considered permanent.

Vasectomy does not protect against STIs, including HIV.

In the postpartum setting:

Vasectomy can be performed at any time, including during the antenatal or postpartum period. Newborn survival rates should be discussed if considering vasectomy during the antenatal period. A woman whose partner is planning to have a vasectomy should be provided with an effective interim method of contraception (e.g. a hormonal method) that will protect her from pregnancy until the vasectomy has been performed and has been shown effective by an azoospermic semen analysis performed after 12 weeks.

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Table 10.2 Effective methods

These methods are generally associated with failure rates of more than 3 per 100 users.

Progestogen-only injectable (POI) contraceptives

It is recommended that, ideally, initiation of POI is delayed until 6 weeks postpartum. However, this puts women who do not fully breastfeed or discontinue breastfeeding before six weeks at risk of early conception. Thus if no other methods are available or acceptable to the client, POI could be initiated prior to discharge from health facility. Progestogen-only injectable (POI) contraceptives (Depo-Provera® and Norethisterone Enanthate (NET-EN)) last 8–12 weeks and so repeat injections must be given four or more times each year, requiring the woman to return to a provider or be in contact with a community-based distributor. Failure rates are around 3 per 100 users largely because of failure to get repeat injections at the correct time. Amenorrhoea is common with these methods and the return of fertility can take some months after the method is stopped. Unscheduled bleeding may also occur. POI contraceptives do not protect against STIs, including HIV. POI contraceptives do not interfere with breastfeeding.

The lactational amenorrhoea method (LAM)

Although an effective method of birth spacing when used correctly, the lactational amenorrhoea method (LAM) is time-limited as it cannot be used after the first 6 months postpartum and it requires women to be exclusively or near exclusively breastfeeding. LAM is a **transition method for women who have delivered and would want to use a natural method before deciding on a method of choice**. It cannot be used unless all three of these criteria are met: **babies less than 6 months old menstrual periods have not returned** **baby is breastfeeding exclusively** Failure rates for LAM are around 2 per 100 women. Once menstruation returns, breastfeeding frequency decreases or the baby is 6 months old, another method of contraception should be started and all available methods are suitable for use. Ovulation occurs before menstruation hence there is a chance a woman using LAM may fall pregnant before her menstrual periods return so counsel appropriately. LAM does not protect against STIs, including HIV.

Table 10.2 Effective methods

These methods are generally associated with failure rates of more than 3 per 100 users.

Hormonal contraceptive pills
**Progestogen-only (POP) e.g.
 Secure®, mini pills**

Progestogen-only (POP, mini) pills are taken continuously, at the same time every day or they will not prevent pregnancy.
 The failure rate is around 9 per 100 users.
 POPs do not protect against STIs, including HIV.
 In the postpartum setting:
 POPs can be started immediately postpartum.
 Postpartum lactation. POP use does not interfere with breastfeeding

**Combined oral contraceptive e.g.
 Control® and Marvelon 28®
 (COC) pills**

Combined oral contraceptive (COC) pills are usually taken daily. The failure rate is around 9 per 100 woman years.
 COCs do not protect against STIs, including HIV. They are safe for use by women with HIV/AIDS.

In the postpartum setting:
 COCs should not be used by breastfeeding women until the baby is 6 months old because they may interfere with breastfeeding.
 Women who are not breastfeeding may start COCs at 3 weeks postpartum unless they have additional risk factors for venous thromboembolism (VTE), in which case they should not start COCs until 6 weeks after childbirth and should be referred to a specialist, while on alternative contraception

Table 10.3 Least Effective methods

These methods are generally associated with failure rates of more than 12 per 100 users.

Male condoms

The failure rate of male condoms is relatively high, at least 12 per 100 couples.

Male condoms do protect against STIs, including HIV/AIDS provided they are used correctly and consistently.

All HIV positive clients should use dual contraception including condoms

In the postpartum setting:

Male condoms can be used at any time after childbirth.

Male condoms do not interfere with breastfeeding.

Female condoms

The failure rate of female condoms is relatively high, at least 12 per 100 couples.

Female condoms may give some protection against STIs provided they are used correctly and consistently.

In the postpartum setting:

Female condoms can be used at any time after childbirth.

Female condoms do not interfere with breastfeeding.

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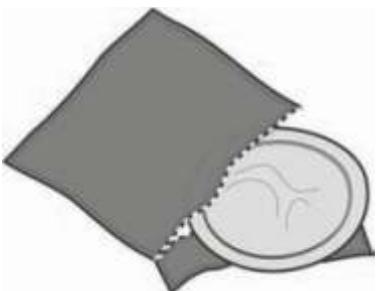


Table 10.3 The Least Effective methods

These methods are generally associated with failure rates of more than 18 per 100 users and are generally not encouraged

Withdrawal (Coitus Interruptus)

Withdrawal failure rates are high at around 18 per 100 couples.
Withdrawal does not protect against STIs, including HIV.

In the postpartum setting:

Withdrawal can be used at any time after childbirth.
Withdrawal does not interfere with breastfeeding.

Fertility awareness based (FAB) methods

All fertility awareness based (FAB) methods have relatively high failure rates of around 24 per 100 women.
No FAB method protects against STIs, including HIV.

In the postpartum setting:

The ability to rely on use of FAB methods postpartum differs with respect to whether the woman is breastfeeding or not.
Breastfeeding women cannot rely on FAB methods until they have completed three to four menstrual cycles after childbirth and so these methods are not recommended for use postpartum.
FAB methods do not interfere with breastfeeding.

Emergency contraception

Emergency contraception can be safely used in the postpartum period even if a woman is breastfeeding. It can be used to prevent unintended pregnancy after intercourse has already occurred.

Levonorgestrel (LNG) emergency contraception can be used at any time postpartum regardless of whether or not a woman is breastfeeding.

High doses of Ethynodiol either alone or in combination with a progestogen (e.g. combined oral contraceptive pills used as emergency contraception) should not be used in the postpartum period because of the theoretical increase in risk of VTE.

Oral EC should not be used as a regular method of contraception because failure rates are high. Emergency IUD insertion is the most effective method of emergency contraception and can be retained for ongoing contraception. See IUDs section above for more detail.

10.4. Giving information about postpartum family planning

General points



It is important to reach women before they are at risk of an unintended pregnancy with information about return of fertility, their options to space or limit future pregnancies, and the benefits to their own and their baby's health of doing so.

Contraception should preferably be discussed with all women while they are still pregnant since this allows them to choose immediate postpartum contraception without the need to make a hurried choice. Patient information leaflets about PPFP options should be given at the antenatal visit. Since inter-birth intervals of at least 2 years are recommended by WHO for the health of both mother and infant, long-acting methods such as post-placental IUD insertion should be encouraged. When discussing the range of contraceptive methods available to women after childbirth, the importance of choosing the most effective method that is acceptable to the woman should be emphasized. IUDs and implants are the most effective reversible methods of contraception.

It is important to listen to what the woman has to say about her experience with contraceptive methods in the past and to try to dispel any misconceptions she may have about particular methods.

Women should be invited to discuss their choice of contraceptive method with their partner or other family members if desired or appropriate. Women who have not decided on their chosen method should be given every opportunity to discuss contraception including during very early labour, if appropriate, or else immediately postpartum. If a woman brings her baby to a clinic for immunisation or if she attends a clinic for any other reason and she is not yet using contraception, available methods should be discussed and provided for her or she should be referred to a service where her chosen method can be provided. If she chooses a method such as sterilisation that cannot be provided there and then, ensure that an interim method is provided in order to prevent unintended pregnancy. In settings that have strong community health systems, the community health workers should also be engaged to disseminate information (both antenatally and postnatally) and to encourage women to seek PPFP services.

Whenever contraceptive counseling is provided, care should be taken to avoid putting undue pressure on the woman to choose a particular method as she is more likely to continue a method if it is acceptable to her. Reminder systems can be developed in antenatal records or client charts to offer family planning counseling at every client contact, in an effort to reduce missed opportunities.

Women at risk of HIV infection and women who are HIV positive should be advised to use condoms in addition to their chosen method of contraception.

10.5. What you need to know about a woman thinking about PPFP?

Women should be asked about infant feeding and, if they are breastfeeding, for how long they plan to continue. Women planning to breastfeed should not use combined hormonal methods of contraception until the baby is 6 months old or until breastfeeding stops, whichever is sooner. Women planning to use LAM should be told when they need to start using another method of contraception, and their chosen method should be provided before they need to start using it.

A medical history should be taken from all women and medical eligibility checked. This will need to be checked again if labour or delivery is complicated (e.g. puerperal sepsis). There should be no restrictions on provision of any method based on age, parity or the number of children a woman has had, unless there is a medical reason. The Appendix on page 16 lists common and/ or important side effects and circumstances in which a method should not be used.



Table 10.4 What do women need to know about PPFP?

Effectiveness and correct use	<p>Women should be told that the most effective methods of postpartum contraception are IUD and implants and that either of these can be provided as soon as the baby is born.</p> <p>Women should be informed about the importance of using their chosen method correctly and consistently. If a woman is likely to find it difficult to remember to take a pill every day, or if her partner is reluctant to use condoms, the benefits of IUDs and implants, which are independent of compliance, should be emphasised.</p>
Side effects	<ul style="list-style-type: none"> Women should be given information about common side effects associated with the chosen method (see the Appendix) and which of these are serious (e.g. symptoms suggestive of VTE in a woman using the combined oral contraceptive pill), and reassured about those that are not serious. They must know where they can go for advice and help if problems arise. Women should be told that if they are experiencing unwanted side effects or problems with their chosen method they should seek advice about changing to an alternative method rather than simply stop using contraception.
Follow-up care and re-supply	<ul style="list-style-type: none"> Women using an IUD or contraceptive implant should be told how long it lasts, when they need to have it replaced or removed, and where this can be done. Women choosing to have an IUD inserted should be followed up at around 6 weeks postpartum or after the first menstrual period to check for expulsion – a convenient opportunity for this may be when she takes her baby to be immunised. Women choosing POI contraceptives (Depo-Provera or NET-EN) should receive clear information about when their next injection is due and where they can get it.
Stopping a method	<ul style="list-style-type: none"> All women should know what to do if they want to stop using a method of contraception, including where to get implants or IUDs removed.
STI prevention	<ul style="list-style-type: none"> All women should be told that the only method of contraception that protects against STIs, including HIV, is the male condom. If they are at risk of STIs, they should be advised to tell their partner to use a condom, as well as continuing with their chosen method of contraception.

10.6. Providing supplies

Since opportunities to obtain further supplies of oral contraceptive pills or condoms may be limited, women should be given an adequate supply of their chosen method. It is best practice to ensure that every woman goes home with a method of contraception and, if appropriate, with instructions about when and how to start using the method. If provision of the chosen method is postponed for any reason, such as interval sterilisation, an effective interim method should be provided.

10.7. Recommendations for services managers

It is not enough for doctors, nurses and other healthcare workers to be well trained to provide postpartum contraception safely and appropriately. Service managers and other staff responsible for health facilities, including procurement, need to play their part in ensuring that no opportunity for providing PPFP is missed.

All healthcare staff should be adequately trained to talk to women about postpartum contraception and, where appropriate, to provide the full range of methods. Staff should be aware that adolescents have a high risk of repeat pregnancy with short birth-to-pregnancy intervals. While all contraceptive methods can be provided to adolescents, long-acting reversible contraception (LARC) methods have been shown to reduce rapid repeat pregnancy in young women.

10.8. Avoiding missed opportunities for PPFP

10.8.1. Ante-natally

- Healthcare providers who provide antenatal care should be given the time and opportunities to be trained to give contraceptive advice.
- Discussion of contraception can become part of any antenatal visit but becomes more important for method selection as the woman approaches term. To ensure that it is being discussed, ‘Contraceptive advice’ can be added to maternity checklists.
- Women can be provided with information (in a variety of forms) about the importance of PPFP and the range of methods available.
- The method of contraception chosen should be documented, e.g. in the Maternity Case Records.
- DVDs or brief talks about PPFP can be provided in clinic waiting rooms. Posters emphasizing the importance and advantages of PPFP should be available and visible.
- The woman’s choice should be communicated to the local community-based distribution (CBD) network, if available, so that a CBD worker can provide follow-up care as needed.
- Reminders should be placed in the antenatal record for providers to structure their discussion of PPFP options with women.



10.8.2. In the labour ward

- Ensure that healthcare professionals (HCPs) who provide intrapartum care are trained to give contraceptive advice and to provide all methods, including IUD and implant insertion.
- Ensure that contraceptive implants and IUDs and the necessary equipment for their insertion are available at all times.

10.8.3. In the postnatal ward

- When women come in to the delivery suite too late in labour to discuss contraception, HCPs should raise the issue on the postnatal ward.
- HCPs on the postnatal ward should be competent to discuss all methods of contraception and to insert implants and IUDs.
- Ensure that all methods of contraception are available in the postnatal ward, including contraceptive implants and IUDs, and that the necessary equipment for insertion (including long forceps, implant inserters and a supply of IUDs) is available at all times.

10.8.4. In baby immunisation and postnatal clinics

- Ensure that HCPs at baby immunisation clinics are trained to give contraceptive advice and to provide all methods, including implants and IUDs, or are able to refer appropriately.

10.8.5. In all settings

- Ensure the involvement of all appropriate partners including CBD workers, midwives and peer educators.
- Facilitate training of all relevant staff in PPFP and particularly in IUD and implant insertion and follow-up care.
- Make every effort to avoid stock-outs of contraceptives and the instruments required for IUD and implant insertion.
- Ensure that emergency contraception is available in all settings.
- Ensure that there are arrangements in place to facilitate timely access to vasectomy and interval female sterilisation.



POSTPARTUM FAMILY PLANNING

Family Planning and HIV Integration

Please refer to National ART Guidelines 2016 for a more detailed discussion. Family planning has a critical role to play in curbing the HIV/AIDS epidemic. Integrating programs provides opportunities to reach important populations with critical information and services. The rationale for integrating family planning and HIV services, especially in high HIV prevalence settings, has long been apparent: Sexually active individuals are at risk of both unintended pregnancies and STIs, including HIV. Family planning and HIV/AIDS key areas for integration include:

- Prevention of mother-to-child transmission of HIV (PMTCT),
- Voluntary counselling and testing, antiretroviral therapy (ART)
- The development of innovative contraceptive technologies to protect against unintended pregnancy, HIV, and other sexually transmitted infections (STIs).
- Safer conception for HIV discordant couples

The women who want to delay or avoid pregnancy but aren't using a modern method of contraception include women who are HIV-positive and those at risk of HIV. Determining the number, timing, and spacing of children is a right of all women and couples no matter their HIV status. Family planning is an integral part of mitigating the impact of HIV/ AIDS. Family planning can help achieve HIV prevention goals and improve maternal and child health outcomes. Likewise, HIV services can help expand access to family planning services. Family planning and HIV/AIDS programs often serve similar populations. When programs and services meet multiple client needs, satisfaction with the health system increases, and scarce financial and human resources are better utilized.

Sub-Saharan Africa; Zimbabwe included has particular needs for both HIV and family planning services. No opportunity should be missed. Both family planning and HIV/AIDS prevention, care, and treatment services are useful entry points for many types of services that people in their reproductive years need. Clients of HIV counseling and testing may be at risk for unintended pregnancy as well as HIV infection or other STIs. Integrating family planning with counseling and testing can improve access to family planning services. Interventions to prevent mother-to-child HIV transmission provide an opportunity to integrate family planning services and contribute to reducing HIV infections among infants. Antiretroviral therapy services are expanding to enable a growing number of individuals living with HIV to have access to care and support. As people begin to feel better, they may resume sexual activity, thus increasing the need for reproductive health care within treatment services.



HIV positive women or couples whether concordant or discordant have a right to choose conceive and have children. The service provider should be able to offer pre-conception counselling to the HIV positive woman or couple.

Safer Conception for HIV Sero-discordant Couples

When a couple wants to have a child and one partner has HIV while the other does not (a sero-discordant couple), the service provider should counsel the client using the following points:



- The partner with HIV should take antiretroviral (ARV) therapy consistently and correctly until the HIV is suppressed to the point that it cannot be detected.
- If the partner with HIV is not virally suppressed on ARV therapy, the partner who does not have HIV (HIV-negative) may following advice from doctor, consider taking pre-exposure prophylaxis (PrEP) with ARVs during the period when they are trying to conceive.
- In some settings where available, if the woman has HIV but the man does not, a safe option for conception is artificial insemination with the uninfected partner's semen.

Both partners should be screened and treated for any other STIs before trying for conception.

Availing family planning methods at HIV counseling and testing centers as well as opportunistic infection clinics is one of the strategies of integrating family planning and HIV services.

Most ARVs regimens interact with hormonal contraceptive methods. (REFER TO WHO MEC 2015 Chapter 2). Recently there have been concerns among health providers and clients on increased failure rate of Jadelle for women on Efavirenz based regimens. The evidence to date for ARV-associated contraceptive failure leading to pregnancy has only been linked to drug interactions between Efavirenz and the Levonorgestrel-releasing Jadelle implant. However, decreased blood levels of hormone with Implanon use remains a concern and requires further monitoring. Currently, there is no evidence linking contraceptive method failure rates with non-efavirenz-containing ART regimens. There are data on other ARVs including Nevirapine and Lopinavir/Ritonavir that are reassuring, but additional data are needed for other regimens.

Despite an apparent decrease in contraceptive efficacy among women living with HIV using implants and an Efavirenz-containing ART regimen, the effectiveness remains very high, especially in comparison with other shorter-acting hormonal methods. Data are still needed to support strategies for optimizing the effectiveness of contraceptive implants, including duration of effectiveness, when used with Efavirenz-containing ART regimens.

Well women (stage 1 and 2 disease) who are HIV positive and on ART can safely use the intra-uterine device. (Refer to WHO MEC 2015 – annex 3).

KEY MESSAGES

Counsel Adequately

Every effort should be made to ensure that women and couples have access to a variety of contraceptive methods and are able to select the method that best fits their individual needs and circumstances. Accurate and comprehensive information including counseling should be used to inform clients about the risks, benefits, and effectiveness of all available methods. Women living with HIV on Efavirenz-containing regimens should be informed about the possibility of decreased contraceptive effectiveness and counseled on dual contraceptive method use, including correct and consistent use of male or female condoms.



The Benefits of Using Jadelle Still Outweigh the Risk of Failure

Women and couples have the right to make a voluntary informed decision about their contraceptive and reproductive health options, including women living with HIV who might wish to choose implants after weighing the risks and benefits of available methods. Use of implants by HIV-positive women who are also using certain ART regimens (specifically those containing Efavirenz or Nevirapine, as well as some protease inhibitors) is classified by the WHO medical eligibility criteria (MEC) guidance as category 1: the advantage of using the method generally outweighs the theoretical or proven risks (in this case, of potentially reduced contraceptive efficacy). Implants have however not been shown to reduce the efficacy of ARVs.

SUPPORT WOMEN AND COUPLES WHO EXPERIENCE CONTRACEPTIVE FAILURE

It is critical to adequately support women and couples who would have experienced contraceptive failure and refer them appropriately for antenatal care. Additional counselling may be required to help them come to terms

with the realities of an unintended pregnancy as well as further counselling on interventions to prevent mother to child transmission.

DOCUMENT!

Any contraceptive failure should be documented and reported to supervisor and forwarded to the Zimbabwe National Family Planning Council.

NEW OPPORTUNITIES FOR IMPROVED EFFICACY OF JADELLE FOR WOMEN ON EFFAVIRENZ

- The dose of Effavirenz has been reduced to 400mg from 600mg. There is no evidence yet but the reduced dose may reduce the drug interactions and improve the efficacy of Jadelle.
- Potential for introduction of newer ARVs in the future with less interaction.

NB: In-spite of the reduced efficacy of Jadelle for women on Effavirenz based regimens, Jadelle remains more effective than some of the shorter-term methods such as pills.

Sexually Transmitted Infections (STI)

Sexually transmitted infections are infections caused by sexual contacts. These are caused by bacteria, viruses, and parasites and can be found on skin, mouth, oral cavity, in and around genitals and anus and rectum. It is also present in body fluids, like blood, serum and semen. Many STIs are symptomless in initial phases. The most common manifestations are pain and discomfort and later pelvic inflammatory disease, infertility, cervical cancer and in some cases, after many years of no treatment, affectation of other systems of the body. Some infections can also spread from mother to the baby. STIs increases the chance of HIV infections.

People who are not in steady or faithful sexual relationship and have multiple partners or are in steady relationship but their partners are infected are at risk of STIs, including HIV, which is also a type of STI. The risk is substantially higher for individuals who do not consistently use condoms.

The STIs include: Syphilis (bacteria), Gonorrhoea (bacteria), Chanchroid (bacteria), Trichomoniasis (parasite), Hepatitis B (virus), Herpes (virus), HIV (virus) and Human Papilloma Virus (virus).

STI infected people can use all FP methods, however, they will not be protected from acquiring STIs if their partner/s is/are infected by STIs. Therefore, the only method of preventing STI infections and their transmission is consistent and correct use of condoms, both male and female.

Some STIs can be treated and early treatment is highly recommended to cure infection and prevent or reduce severity of chronic symptoms. While symptoms of STIs are often not visible or felt in early phases, it is advised to seek medical attention if one suspects infection. Most vaginal discharges are not due to STIs so they should not be linked with STIs without laboratory examination.

POST ABORTION FAMILY PLANNING

Following a first trimester miscarriage (either spontaneous or induced), a woman's fertility resumes almost immediately, usually within 2 weeks.

- After second-trimester miscarriage, a woman's fertility usually resumes within 4 weeks.
- Guidelines for postpartum contraception do not apply to post abortal contraception. Women should be offered methods after treatment for a miscarriage that would be both appropriate for and acceptable to them.

Special concerns for postpartum contraception related to breastfeeding do not apply to post abortal women. Also, limitations on methods containing estrogen don't apply.

Communicating with a Patient after a Miscarriage

The way healthcare workers communicate with a woman following miscarriage can affect the completeness and accuracy of information post miscarriage women give, their comfort during the procedure, the success or failure of treatment, and their ability to recognize seek care for complications that may occur after discharge. Attitudes of providers towards women are an important factor in quality of care women seeking miscarriage care are far more likely than to the groups to encounter negative provider attitudes.

When interacting with women after a miscarriage always:

- Respect and support the women and their situations while meeting immediate medical needs.
- Be non-judgemental.
- Create an atmosphere of trust between providers/staff and women.
- Respect women's needs for confidentiality and privacy.
- Be empathetic.
- Respect clients' beliefs and values.
- Post miscarriage Counselling.
- Counseling should be done when the women's condition is stable and she is comfortable. This should be done before the women are discharged from hospital.

The Goals of post abortal counseling are to:

- Help the client decide on her future reproductive goals.
- Help the client to decide on an appropriate contraceptive method.
- Counsel the client on how to use the method effectively.



- Prepare her to use the method effectively.
- Help the client make informed decisions about other related RH issue e.g. STI/HIV&AIDS prevention and cervical cancer screening.

Contraceptive Options for Women Following Miscarriage

Method	Timing	Remarks
Hormonal Contraceptives : POPs, COCs, Implants & Injectables	start using immediately preferably on the first day following 1st and 2nd trimester abortion	Provide adequate Counseling If informed decision cannot be guaranteed delay long term methods and provide temporary method. Access to a skilled service provider in insertion and removal of Implants required
IUCD	First Trimester Delay insertion until serious injury has healed, haemorrhages controlled and acute anaemia improves	If formed decision cannot be made delay insertion and provide temporary method. Following second trimester abortion the uterine cavity is larger and the risk of perforation is greater. Access to a skilled provider is necessary.
	Second Trimester IUCD can be inserted immediately if risk or presence of infection is ruled out.	
Natural Family Planning (NFP)	NFP is not recommended for immediate use post abortion.	Ovulation after abortion will be difficult to predict. Methods unreliable until regular menstrual patterns resume.
Condoms	Start using as soon as intercourse is resumed	Temporary method if initiation of another method must be postponed. Provides for dual protection against both pregnancy and STIs HIV & AIDS.
Vasectomy	Perform at any time as timing is not Related to abortion.	Not immediately effective and a temporary method is required for 12 weeks. Adequate counselling and informed decision must precede vasectomy.

Method	Timing	Remarks
Tubal Ligation	<p>Can be performed immediately after treatment of complications of abortion.</p> <p>Do not perform until infection is fully resolved and injury healed.</p> <p>Delay if severe anemia due to blood loss.</p>	Counsel client adequately to allow an informed choice and consent before tubal ligation procedure.

NATURAL FAMILY PLANNING METHODS

12. What are Natural Family Planning/Fertility Awareness Based

Methods (NFP/FAM)

- Natural Family Planning methods are based on full awareness of the woman's reproductive cycle. The couple voluntarily avoids sexual intercourse during the fertile period of the woman's cycle or has intercourse during the fertile phase to achieve a pregnancy. "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.



12.1. What are the types of Methods?

- A woman can use several ways, alone or in combination, to tell when her fertile time begins and ends.
- Calendar-based methods involve keeping track of days of the menstrual cycle to identify the start and end of the fertile time.
 - Examples: Standard Days Method and calendar rhythm method.
 - Symptoms-based methods depend on observing signs of fertility.
 - Cervical secretions: When a woman sees or feels cervical secretions, she may be fertile. She may feel just a little vaginal wetness.
 - Basal body temperature (BBT): A woman's resting body temperature goes up slightly after the release of an egg (ovulation), when she could become pregnant. Her temperature stays higher until the beginning of her next monthly bleeding.
 - Examples: Two Day Method, BBT method, ovulation method (also known as Billings method or cervical mucus method), and the symptothermal method.

12.2. How do they work?

- (a) For contraception: Intercourse is avoided during the phase of the cycle when conception is most likely to occur.
- (b) For conception: Intercourse is planned when conception is most likely (near the mid-cycle-days 10-15).



12.3. How effective are they?

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. (How these women identified their fertile time is not known. Pregnancy rates for most of the specific fertility awareness methods as commonly used are not available.) This means that 75 of every 100 women relying on periodic abstinence will not become pregnant. Some newer fertility awareness methods may be easier to use and, thus, more effective.
- 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 is immediate.
- No Protection against sexually transmitted infections (STIs).

12.4. Who Can Use (NFP/FAM)?

For Contraception

- Women of any reproductive age and parity.
- Partners with religious reasons for not wanting to use other methods.
- Women unable to use other methods for medical reasons.
- Partners willing and motivated to observe, record and interpret fertility signs.

For Conception

- Partners who are trying to achieve a pregnancy.

Contraindications for Contraception

- Women with irregular menstrual cycles. (Calendar method only)
- Women whose partner will not co-operate to abstain from sexual intercourse during the fertile phase.
- Women without established cycles, youth, breast feeding and immediately post abortion.
- Women who dislike touching their genitalia.

Client Instructions

Calendar Method

- The method is based on the fact that most women ovulate 12–16 days before each menstrual bleeding no matter how long that cycle is:

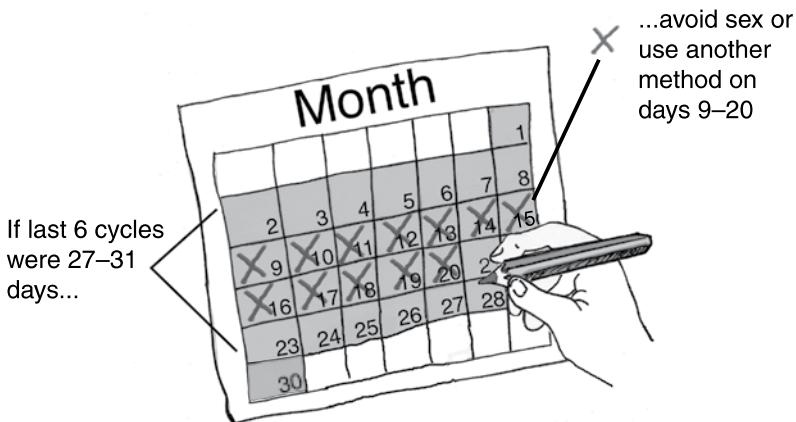
Use a standard calendar.

- Record the length of each menstrual cycle for the next 6 menstrual cycles.
- Call the first day of bleeding in each cycle day one.
- The last day of each cycle is the day before the next menstrual bleeding.

- To find the earliest day on which you are likely to be fertile, subtract 18 days from the length of your shortest cycle.
- To find the day you are no longer likely to be fertile subtract 11 from your longest cycle. The days in between are the days you are likely to be fertile.
- For contraception avoid sexual intercourse during this period.
- For conception have sexual intercourse during this period when you are most likely to be fertile.

Example:

- Shortest cycle - 27 days - 18 = 9.
- Longest cycle - 30 days - 11 = 19.
- Therefore first fertile day will be day 9 and last fertile day will be day 19 of your cycle.



Basal Body Temperature Method (Ovulation)

- This method is based on the fact that a woman's temperature rises slightly after ovulation and remains elevated for the rest of the period until she menstruates.
- Do not have sexual intercourse from the first day of your menstruation.
- Bleeding until the thermal shift has occurred for 3 consecutive days.
- Take your temperature before rising up in the morning (at the same time each day) for the first ten days of the menstrual cycle.
- Record the temperature on a special Basal Body Temperature Chart.
- Look on the chart to find the highest of the normal temperatures during the first days of your cycle.
- Draw a line 0.15°C above the highest of these 10 temperatures. This line is called the cover line or temperature line.
- Continue taking your temperature every day until your third consecutive temperature is recorded above the cover line.
- You can have intercourse any time after the evening of your third consecutive high temperature until the beginning of your menstrual bleeding.

Cervical Mucus (Billings)

- The method is based on mucus changes that occur before ovulation. The mucus becomes slippery and stretchy and the changes are greatest after ovulation.
- To use this method, you must observe and record your cervical mucus signs everyday beginning with the day your menstrual bleeding ends.
- Do not have intercourse during the days of your menstrual bleeding.

During the early infertile phase of your cycle, you can have sexual intercourse on the evening of every other dry day.

- Semen changes the character of the mucus, therefore check cervical mucus on the day semen is not present in the vagina.
- Do not have sexual intercourse from the beginning to the end of the fertile phase - from the day you notice any cervical mucus or vaginal wetness.
- The last day you have cervical mucus is your peak day. Continue to abstain from intercourse for 3 more days.
- You can have intercourse from 4th day of no wet cervical mucus until your next menstrual bleeding.

Sympto-thermal Method (Cervical Mucus and BBT)

- The Sympto-thermal combines recording the Basal Body Temperature with observing the cervical mucus and other physical signs of ovulation.
- These signs include breast tenderness, mid-cycle pain, spotting and abdominal heaviness.
- When using this method, the couple must abstain from intercourse beginning from first appearance of wet cervical mucus until ovulation has been confirmed by 3 days of elevated temperature or 4 days of post ovulation mucus.
- Abstaining from sexual intercourse on the days of the menstrual cycle when the woman's signs and symptoms indicate she may become pregnant is called periodic abstinence.

Be aware of body changes. Remember the rules cervical secretions: avoid unprotected sex from the first day of using cervical secretions or feeling of vaginal wetness until the 4th day after the peak day of slippery secretions
Basal body temperature (BBT): Avoid unprotected sex from the first day of menstrual bleeding until body temperature has risen and stayed up for 3 days.

Calendar (rhythm): Determine the fertile time through calendar calculations. Avoid unprotected sex between the first and last days of the estimated fertile time.

Cervical secretions and BBT: Avoid unprotected sex from the first day of cervical secretions until both the 4th day after the peak day of slippery secretions and the 3rd full day after the rise in body temperature.

Other Natural Family Planning Methods

Abstinence

What is Abstinence?

Abstinence is a self-enforced limit in engaging in any bodily activities that are typically related to desire. Most commonly, the term being abstinent refers to sexual abstinence, which means not having any type of sexual intercourse or sex play with a partner.

Abstinence is the only birth control method that is 100 percent effective in preventing pregnancy as well as sexually transmitted diseases according to the Centre for Disease Control and Prevention.¹²

- Technically, abstinence is considered to be a natural birth control method. This is because abstinence is an action that a person can physically do (without any assistance or device) to prevent conception from occurring.

Advantages Abstinence

- It can be a positive way of dealing with sexuality or resolving feelings about sexual intimacy that stem from religious or moral beliefs.
- It has no medical or hormonal side effects.
- It doesn't cost anything.

Disadvantages of Being Abstinent

- People may find it hard to practice abstinence for long periods of time.
- If the client has not had sexual education or been given information about contraception, and they choose to stop being abstinent, they may not be prepared to protect themselves from pregnancy or sexually transmitted infections.

Reasons People Choose Abstinence

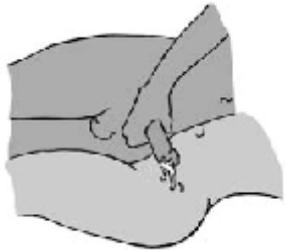
Women and men abstain from sex for many reasons, and these reasons may change throughout their lifetimes. Some people may choose to become abstinent even after they have been sexually active. A client may choose to be abstinent for these reasons:

- The client wants 100 percent prevention against pregnancy and sexually transmitted infections.
- Abstinence aligns with the client's religious beliefs, personal morals, or values.
- The client may want to wait until they feel they are ready to be in a sexual relationship.
- The client wants to focus on his or her career, school, extracurricular activities, or hobbies.
- The client may have medical reasons.
- The client wants to wait until marriage.
- The client is in the process of getting over a breakup or the death of a spouse or romantic partner.
- The client just wants to have romance and fun without the responsibilities that come along with having sex.

Staying Abstinent

Staying abstinent can be difficult but not impossible. It is a choice that the client will have to make every day. Counsel and support the client's choice of method. Also counsel the client on other available methods of family planning and how to access them should they need them.

Withdrawal



What is withdrawal (Also Known as Coitus Interruptus)?

This is when a man withdraws his penis before ejaculation during sexual intercourse. Withdrawal requires a lot of motivation by the couple and is one of the least effective family planning methods. Counsel the clients appropriately and give warning of the high risk of pregnancy. Provide information on other available methods and respect the client's choice of method.

Information Box 13.1

Dispelling Myths

Fertility awareness methods:

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

Information Box 13.1**Key Points**

- Fertility awareness methods require partners' cooperation. Couple must be committed to abstaining or using another method on fertile days.
- Must stay aware of body changes or keep track of days, according to rules of the specific method.
- No side effects or health risks.

EMERGENCY CONTRACEPTION

14. What Is Emergency Contraception?

Emergency contraception (EC) refers to the methods of family planning that are used to prevent pregnancy following unprotected sexual intercourse. EC is the only method partners can use to prevent pregnancy after unprotected sexual intercourse or a contraceptive accident.

14.1. What are the types of Emergency Contraception.?

- (a) Combined Oral Contraceptives (COC).
- (b) Progestin only pill (POP).
- (c) Copper containing IUCDs.

14.2. How do Hormonal Emergency Contraceptives work?

Depending on when a woman uses emergency contraception during her menstrual cycle, the pills can prevent ovulation, fertilization or implantation. Emergency contraceptive pills are not abortifacients and are not effective once the process of implantation has begun.

14.3. How effective are they?

- 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.
- 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.
- Return to fertility after taking ECPs is immediate. 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.
- Provide no protection against sexually transmitted infections (STIs).

14.4. Indications for Emergency Contraception

Emergency contraception is meant for clients in need of emergency protection e.g., in the following conditions:

- Sexual intercourse where no contraceptive has been used. When there has been a contraceptive accident or misuse:



- Condom breakage, slippage or leakage.
- Failed 'coitus interruptus'.
- IUCD expulsion.
- Missed pills.
- Victims of sexual assault.

14.5. Contraindications for Emergency Contraception

- Women who are pregnant or suspected to be pregnant

Table 14.1 When to start Emergency Contraception

TYPE	INSTRUCTION
POP 750 LNG (Postinor 2, Revoke 72), Fragonon.	1 Pill taken as soon as possible within 120 hours of unprotected sex then 1 pill after 12 hours.
High dose COCs (YUZPE) method. (50µg Ethinyl/estradiol-(EE) (e.g., Ovral or Neogynon).	Two tablets taken as soon as possible within 120 hours of unprotected sexual intercourse and repeated after 12 hours.
Low dose COCs (30µgEE) e.g., Control or Microgynon, Duofem, Marvelon and Control Pill.	Four tablets taken as soon as possible within 120 hours of unprotected sexual intercourse and repeated after 12 hours.
POPs 75 LNG (Ovrette), Excluton and Secure.	Twenty tablets taken as soon as possible within 120 hours of unprotected sex and repeated after 12 hours.

14.6. What are the side effects?

- Some users report the following:
- 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.



14.7. Health Benefits and Risks of emergency contraception

- Reduce unwanted pregnancies.
- Reduce abortion.

14.8. The Emergency IUCD

- A copper releasing IUCD is inserted within five days after unprotected intercourse. The IUCD may be left in situ to provide long term contraception. For short-term use remove at next period. This method is highly effective for preventing pregnancy.

14.9. Communication with Clients

Counselling Considerations for EC

- Clients should be counselled appropriately if pregnancy is not prevented.
- Clients should be counselled on a more consistent and regular contraceptive method.
- Inform the client that after use of ECs menstruation may come one week earlier or later than usual.

Client Education

- Educate all contraceptive users especially adolescents about the availability of emergency contraceptives.
- Inform clients that EC is safe and can be used anytime during the menstrual cycle.
- Educate clients that EC does not protect against STIs/HIV&AIDS.
- Provide IEC materials to increase knowledge of and demand for EC.

Client Instructions

- If you vomit within 2 hours of taking the pills take another dose preferably with food or antiemetic.
- Do not delay treatment unnecessarily as the methods may become less effective overtime.
- Do not take extra pills as this will not reduce risk of pregnancy but increase nausea and vomiting.
- If your menstrual period is more than one week later than expected return to your provider for pregnancy test.

Information Box 14.1

Dispelling Myths

- 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.

Information Box 14.2**Key points**

- Emergency contraceptive pills help to prevent pregnancy when taken up to 5 days after unprotected sex. The sooner they are taken, the better.
- Do not disrupt an existing pregnancy.
- Safe for all women—even women who cannot use ongoing hormonal contraceptive methods.
- Provide an opportunity for women to start using an ongoing family planning method.
- Many options can be used as emergency contraceptive pills. Dedicated products, progestin-only pills, and combined oral contraceptives all can act as emergency contraceptives.

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Guidance on Ruling Out Pregnancy (adapted from WHO FP Handbook 2018)

Ruling out pregnancy is recommended before starting a hormonal contraceptive and before IUD insertion. Family planning providers have 3 tools available for this routine task:

- Medical history (often collected using the Pregnancy Checklist see Appendix 2)
- Pregnancy tests
- Delaying the start of the method until the client's next monthly bleeding.

Important points to note

- Unless the client has missed her monthly bleeding, ruling out pregnancy **starts with the Pregnancy Checklist** (Appendix 2). This checklist can provide reasonable certainty that a woman is not pregnant.
- **Pregnancy tests are not likely to work before the first day of missed monthly bleeding.** Using a test earlier is pointless and wasteful.
- **The only contraceptive method known to pose a health risk if started during pregnancy is the IUD (either copper or hormonal).** If the Pregnancy Checklist cannot rule out pregnancy, a provider should use another tool to rule out pregnancy before inserting an IUD.
- **All hormonal methods except the LNG-IUD can be provided without delay** even when uncertainty about pregnancy exists. Follow-up is required in some cases (see job aid on next page).
- **Delaying the start of the method is the worst choice** among the 3 tools for assessing pregnancy. She may become pregnant before her next monthly bleeding. The other tools should be used first whenever possible.
- Both the Pregnancy Checklist and a pregnancy test are highly accurate for ruling out pregnancy when used appropriately.

When the checklist can be used, there is no need for a test.



APPENDIX 2

Pregnancy Checklist

Ask the client questions 1–6. As soon as the client answers “yes” to any question, stop and follow the instructions below.

Yes	No
1. Did your last monthly bleeding start within the past 7 days	
2. Have you abstained from sexual intercourse since the last monthly bleeding, delivery, abortion or miscarriage	
3. Have you been using a reliable contraceptive method consistently and correctly since your last monthly bleeding, delivery, abortion, or miscarriage?	
4. Have you had a baby in the last 4 weeks?	
5. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no monthly bleeding since then?	
6. Have you had a miscarriage or abortion in the past 7 days?	

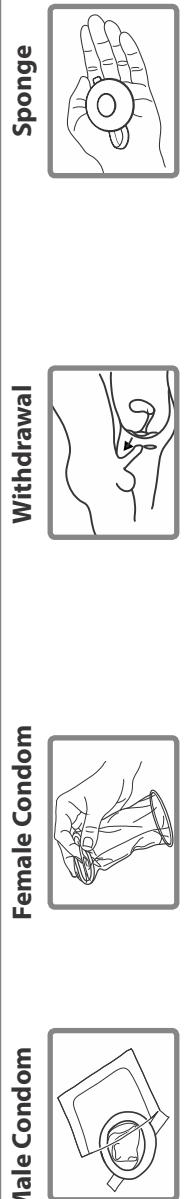
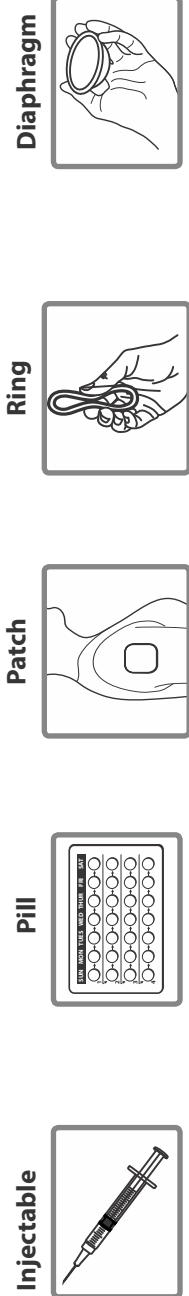
If the client answers NO to all of the questions, pregnancy **CANNOT** be ruled out using the checklist. Rule out pregnancy by other means.

If the client answers YES to at least one of the questions, you can be reasonably sure she is not pregnant

If the client is planning to use a copper-bearing IUD, the 7-day window is expanded to 12 days



FAMILY PLANNING METHODS



Condoms should always be used to reduce the risk of sexually transmitted infections.

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FAMILY PLANNING

GUIDELINES FOR ZIMBABWE

2018

A GUIDE TO
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