

THE PHILIPPINE CLINICAL STANDARDS MANUAL ON FAMILY PLANNING 2014 EDITION



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About the DOH and the FP Program

The goal of the family planning (FP) Program is to provide universal access to FP information and services whenever and wherever these are needed. To achieve this goal, the DOH FP Program will (1) address the need to help couples and individuals achieve their desired family size within the context of responsible parenthood and improve their reproductive health to attain sustainable development and (2) ensure that quality FP services are available in DOH-retained hospitals, LGU-managed health facilities, NGOs, and the private sector.

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FOREWORD

One of the key components for achieving Universal Health Care or Kalusugan Pangkalahatan is the full implementation of Republic Act No. 10354: “Responsible Parenthood and Reproductive Health Act of 2012” (RPRH Act). This law ensures universal access to reproductive health services, including family planning. The RPRH Act and its implementing rules require the government to promote and provide information and access, without bias, to all modern methods of family planning, whether natural or artificial, which have been proven medically safe, legal, non-abortionifacient, and effective in accordance with scientific and evidence-based medical research standards. In this context, the DOH and its partners must ensure that family planning services are available, accessible, affordable, and of high quality by making clinical practices uniform and by adapting the best medical science currently known.

As the gold standard for family planning and contraceptive services in the Philippines, the Philippine Clinical Standards Manual on Family Planning provides updated content on clinical practice using existing family planning methods as well as information on new ones. Through this manual, the DOH affirms its commitment to ensuring quality family planning services by instituting practices that are at par with international standards.

Together with the contributors, reviewers, and editors of this manual, I hope that this updated version serves as an easy-to-use and reliable guide for all frontline healthcare professionals. Through this guide, we are ensuring the success of our health programs by safeguarding the right kind and quality of service for those who are most in need.



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WHAT ARE THE UPDATES?

The updates featured in this version were adapted from the latest evidence-based recommendations and guidelines, including the (1) Medical Eligibility Criteria for Contraceptive Use (4th Edition, 2010), the (2) Selected Practice Recommendations for Contraceptive Use: 2008 Update of the WHO, and the (3) 2013 CDC Practice Recommendations. Specific questions on how to use different contraceptive methods were addressed. This manual provides updates on the following:

- New chapter on informed choice and voluntarism (p. 1)
- Continuous and extended use of combined oral contraceptives (p. 41)
- Quick start of contraceptives (pp. 37, 42, 51, 58, 61, 68, 81, 95, 105, 122, 129, 166, 168, 172, 189, 233, 238)
- Late reinjections for progestin-only injectables (p. 83)
- Correction of misconceptions about each FP method (pp. 73, 104, 116, 156, 168, 172, 212)
- New subcutaneous DMPA (p. 74)
- Guidelines on the insertion and removal of contraceptive subdermal implants (pp. 91, 95)
- Guidelines on pelvic examination prior to IUD insertion (p. 107)
- Guidelines on postplacental and immediate postpartum insertion of TCu IUD (pp. 111, 115)
- Endoscopic and hysteroscopic bilateral tubal ligation (pp. 182, 183)
- When to start relying on the effectiveness of vasectomy after surgery (p. 206)
- Effect of increased body mass index (BMI) on certain contraceptives (p. 213)
- New subchapter on contraception for female victims of sexual violence, with information on when to initiate regular contraceptives (p. 231)
- Guidelines on the use of the Yuzpe method and the levonorgestrel-only pill (p. 234)

- Subchapter on contraception in disaster and crisis situations (p. 240)
- New chapter on sexually transmitted infections (p. 245)
- Effects of antiretrovirals on hormonal contraception (p. 255)
- Effects of antibiotics on contraceptives (p. 255)
- Relevant RPRH law provisions and related IRR (p. 306)
- Pregnancy checklist (p. 325)
- 2013 PhilHealth benefits for FP (p. 329)
- New DOH commodity forms (p. 385)

LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome	COC	Combined Oral Contraceptive
AMTSL	Active Management of Third Stage of Labor	CPR	Contraceptive Prevalence Rate
AO	Administrative Order	DMPA	Depot-Medroxyprogesterone Acetate
ARMM	Autonomous Region of Muslim Mindanao	DOH	Department of Health
ARV	Antiretroviral Drugs	DSWD	Department of Social Welfare and Development
ASC	Ambulatory Surgical Clinic	DVT/PE	Deep Vein Thrombosis/Pulmonary Embolism
ASL	Authorized Stock Level	ECP	Emergency Contraceptive Pill
BBT	Basal Body Temperature	EE	Ethinyl Estradiol
B-hCG	Beta Human Chorionic Gonadotropin	FAB Method	Fertility Awareness-Based Method
BHW	Barangay Health Worker	FHSIS	Field Health Services Information System
BHS	Barangay Health Station	FP	Family Planning
BMI	Body Mass Index	FSH	Follicle Stimulating Hormone
BP	Blood Pressure	HIV	Human Immunodeficiency Virus
BTL	Bilateral Tubal Ligation	HLD	High-Level Disinfection
CBMIS	Community-Based Monitoring Information System	IE	Internal Examination
CBT	Competency-Based Training	IEC	Information, Education, and Communication
CDLMIS	Contraceptive Distribution Logistics Management Information System	IM	Intramuscular
CHC	Combined Hormonal Contraceptive	IUD	Intrauterine Device
CHT	Community Health Team	IUS	Intrauterine System
CIC	Combined Injectable Contraceptive	LAM	Lactational Amenorrhea Method

LARC	Long-Acting and Reversible Contraceptive	RTI	Reproductive Tract Infections
LGU	Local Government Unit	SDM	Standard Days Method
LH	Luteinizing Hormone	SLE	Systemic Lupus Erythematosus
LNG	Levonorgestrel	SMR	Supply Management Recording
MCP	Maternity Care Package	STI	Sexually Transmitted Infections
MDG	Millennium Development Goals	TCL	Target Client List
MEC	Medical Eligibility Criteria	TFR	Total Fertility Rate
MIS	Management Information System	USAID	United States Agency for International Development
NDHS	National Demographic and Health Survey	VSC	Voluntary Surgical Contraception
NDS	National Demographic Survey	VTE	Venous Thromboembolism
NET-EN	Norethisterone Enanthate	WHO	World Health Organization
NFP	Natural Family Planning	WRA	Women of Reproductive Age
NGO	Nongovernment Organization		
NOH	National Objectives for Health		
NSAID	Non-Steroidal Anti-Inflammatory Drug		
NSV	No-Scalpel Vasectomy		
OB-GYNE	Obstetrics-Gynecology		
PE	Physical Examination		
PhilHealth	Philippine Health Insurance Corporation		
PHO	Provincial Health Office		
PID	Pelvic Inflammatory Disease		
POC	Progestin-Only Contraceptive		
POI	Progestin-Only Injectable		
POP	Progestin-Only Pill		
RH	Reproductive Health		
RHU	Rural Health Unit		

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Chapter 1

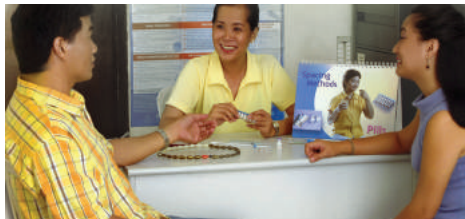
INFORMED CONSENT AND VOLUNTARISM

WHAT IS INFORMED CHOICE AND VOLUNTARISM (ICV)?

The quality of care in family planning (FP) requires that the rights of FP clients are safeguarded by service providers at all times. The rights of FP clients, especially the right to information and choice, must be honored through appropriate FP counseling. Clients must be able to make voluntary and informed choices based on accurate, balanced, and complete information. The Department of Health (DOH) AO 2011-0005 defines Informed Choice and Voluntarism (ICV) as

“A standard in the delivery of FP services, ensuring that clients freely make their own decision based on accurate and complete information on a broad range of available modern FP methods, and not by any special inducements or forms of coercion or misinterpretation.”

Healthcare providers are responsible for ensuring that an FP client makes a voluntary and informed choice. This factor is considered as one of the pillars that guide FP program implementation.



QUALITY OF CARE IN FP : CLIENT RIGHTS AND PROVIDER NEEDS

The quality of FP services can be further enhanced by safeguarding the rights of clients and by providing the needs of healthcare professionals. Healthcare providers need proper training, adequate supplies, good working environment, as well as good management support and supervision. Basic client rights include the following:

Right to information	To learn about the benefits and availability of family planning
Right to access	To obtain services regardless of sex, creed, color, marital status, social status, or location
Right to choice	To decide freely on whether to practice family planning and which method to use
Right to safety	To be able to practice safe and effective family planning
Right to privacy	To be counseled and be provided with services in a private environment
Right to confidentiality	To be assured that personal information is kept between the client and the provider
Right to dignity	To be treated with courtesy, consideration, and attentiveness
Right to comfort	To be provided with utmost care and attention during service
Right to continuity	To receive FP services and supplies as long as needed
Right to opinion	To express views on the services offered

INFORMED CHOICE AND VOLUNTARY DECISION MAKING AS A VITAL PROGRAM STRATEGY

The DOH recognizes that ensuring ICV will translate to better and longer method use, improved client compliance, and satisfied clients who will encourage others to participate in FP programs. This is effectively done through face-to-face, verbal, and nonverbal exchange of information with clients. ICV is a vital foundation of FP Program success.

ENSURING INFORMED AND VOLUNTARY DECISIONS

Service providers must be aware of the principles of ICV. Table 1 explains the principles of ICV and provides hypothetical examples of noncompliance or vulnerability. Service providers must be aware that their best interest might violate ICV principles and the rights of the client.

ICV Principle	Clarification/Interpretation	Examples of Non-compliance/ Vulnerability
Service providers or referral agents shall not implement or be subject to quotas or other numerical targets relative to the total number of births, number of FP acceptors, or acceptors of a particular FP method.	A quota or target is a predetermined number of births, FP acceptors, or acceptors of a particular method that a service provider or a barangay health worker is assigned or required to achieve. Indicators for planning, budgeting, and reporting are exempted.	Dionisia, the midwife–owner of a lying-in, discovers that her employed midwife failed to achieve her required 10 PPIUD insertions per month and thus deducts 5% from her salary.
No payment of incentives, bribes, gratuities, or financial reward to the following: <ul style="list-style-type: none"> An individual in exchange for becoming a FP acceptor Program personnel for achieving a numerical target or quota relative to the total number of births, number of FP acceptors, or acceptors of a particular FP method 	Provider payments violate the provision only when payment is based on a quota or target set as a predetermined number of total births, number of FP acceptors, or number of acceptors of a particular method. Incentives, bribes, gratuities, and financial rewards should not be a form of inducement to accept a particular method.	The best “performing” health providers in a program receive supplies and/or equipment as reward on the basis of the number of FP acceptors.
No denial of rights and benefits for those who do not accept FP.	Health facilities shall not deny any right or benefit, including the right to participate in any program of general welfare or the right to access healthcare, as a consequence of the decision not to accept FP services.	Mothers who did not accept any FP method are denied immunization services.
Comprehensible information on chosen FP method. Full disclosure for experimental contraceptive method and procedures.	Clients must receive comprehensible information about the risks, benefits, side effects, and contraindications of the method they want to use in accordance with local standards.	Service providers withhold full information on FP methods from the clients.

ICV Principle	Clarification/Interpretation	Examples of Non-compliance/ Vulnerability
Informed consent must be documented prior to permanent methods, namely, bilateral tubal ligation (BTL) or vasectomy.	Service providers should ensure that informed consent has been discussed and secured from every acceptor of a permanent FP method prior to the procedure. Six elements should be explained to the clients.	While Sally was in painful labor, she was asked to sign the consent for BTL.
FP programs/projects must provide information and access to a broad range of FP methods and services, either directly or through referral.	During counseling, potential FP clients should be made aware of all the modern FP methods. If methods such as intrauterine device and BTL, which require a certain level of skill from providers, are unavailable, the provider should be able to refer the client to a facility where the services are available.	Mara goes to the hospital desiring to have BTL. However, no doctor is available to conduct the procedure. The nurse simply tells her that the method is unavailable and sends Mara home with no alternative method or referral.
No discrimination should be made against applicants for grants or funding because of religious or conscientious commitment to offer only natural FP.		Chastity Foundation was denied funding because it strictly promoted only natural FP methods.
Funding of programs with involuntary sterilization or coercive abortion is not allowed.	Practice of abortion is illegal in the country, as stipulated in the Revised Penal Code. Program beneficiaries are not allowed to join advocacy activities lobbying for abortion as an FP method.	

INFORMED CONSENT

Informed consent is different from informed choice. Informed consent is a written voluntary decision of an FP client stating that he/she accepts the particular method (e.g., sterilization, IUD, or implant insertion) before undergoing the procedure. The service provider is assumed to have already provided adequate counseling prior to the acknowledgment of the decision.

The RPRH Act of 2012 implementing rules and regulations include the following provisions regarding informed consent in availing FP services:

- Any minor availing of FP services must have written consent of their parents or guardians.
- Any minor who has had a previous pregnancy or is already a parent still requires parental consent prior to availing of FP services.
- Spousal consent is needed prior to undergoing permanent surgical contraceptive methods.



Chapter 2

COUNSELING FOR EFFECTIVE CONTRACEPTION

Good counseling is an essential part of family planning (FP) services. It guides clients in making informed decisions about the safest and most suitable method of contraception that meets their needs and conditions. An effective counseling dispels clients' fears and allows misconceptions to be corrected and clarified. Current counseling strategies emphasize client-centered sessions, client empowerment, and an equal footing between the provider and the client.



Counseling services must be provided in person, particularly in a private and face-to-face setting. This setup helps assure the client of the confidentiality of the counseling session.

WHO IS THE FP COUNSELOR?

An FP counselor is any individual who is responsible for helping a client make an informed, voluntary, and well-considered decision about fertility and contraception. He/she may be a nurse, midwife, doctor, or health educator who has received the Basic Comprehensive FP Course or the Competency-Based Training (CBT) Level 1/Level 2. An FP counselor must have the following characteristics:

- Knowledgeable in the various FP methods
- Demonstrates a positive attitude toward work (i.e., enthusiastic, persistent, and patient)
- Sensitive, understanding, and helpful in addressing clients' needs and assessing their situations

WHO IS THE CLIENT?

Although each client is unique in need, background, and situation, the provider must consider the type of client in establishing the appropriate counseling services while ensuring the individualized nature of the counseling session. These considerations ensure that no important element is missed or overlooked. Table 2 describes the various types of FP clients and how to effectively counsel them.

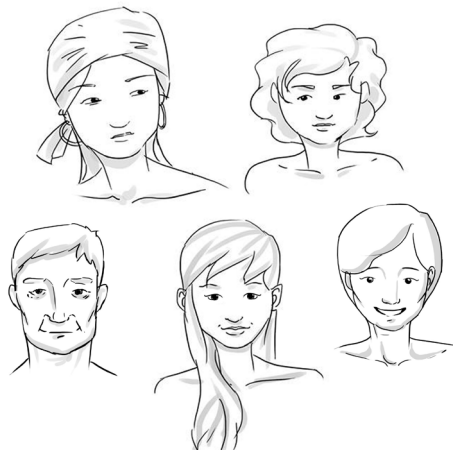


Table 2. Client type and corresponding counseling tasks

CLIENT TYPE: New client with a method in mind

COUNSELING TASKS

1. Discuss the client's needs and situation as well as the client's reproductive intent.
2. Determine the correctness and accuracy of the client's knowledge of the method. Clarify any misconceptions.
3. Determine if the client is medically eligible for the method and if the method is suitable to the client's needs and situation.
4. If the client is eligible, discuss the correct use of the method and how to deal with side effects.
5. Provide the method (including any backup as needed).
6. If the client is ineligible, discuss the reasons for the ineligibility, and inform the client of other options.

CLIENT TYPE: New client with no method in mind

COUNSELING TASKS

1. Discuss the client's needs and situation and the factors that he/she considers important in choosing an FP method.
2. Discuss relevant information about each method, and assist the client in determining the most suitable method. Include in the discussion the client's medical eligibility, and ensure that her choice is an informed one.
3. Clarify any misconceptions.
4. Discuss how to correctly use the chosen method and how to handle any side effect.
5. Provide the method.

CLIENT TYPE: Returning clients with no problems

COUNSELING TASKS

1. Recheck the client's knowledge about his/her chosen contraceptive method. Provide updates if any.
2. Discuss how the client is doing with the current method, including observations that the client may deem too trivial to report but may actually be important enough to have the method modified.
3. Provide the method.
4. Schedule a follow-up visit.

CLIENT TYPE: Returning clients with problems

COUNSELING TASKS

1. Perform a thorough probe of the client's concern about the current method.
2. Explain the possible causes, and discuss the options available to the client.
3. If a new method is required, educate the client about the appropriate use and the potential side effects. Provide a temporary backup method during the transition if needed.
4. Provide the method.
5. Schedule a follow-up visit.

Basic contraceptive education provides essential information, especially during the first counseling session. The information should include the following:

Method effectiveness

- Method effectiveness is the typical or average likelihood of pregnancy for all users of a particular method regardless of whether they have used this method correctly and consistently.
- It also refers to the lowest likelihood of pregnancy when the method is used correctly and consistently as reported in reliable studies.
- This information includes how a method works and the failure rates or pregnancy rates during utilization of a particular method.
- Method effectiveness may be the most important selection criterion for some clients.



Advantages and disadvantages

- Clients have varying perceptions on the advantages and disadvantages of each method.
- The information provided to the client must therefore be adapted to his/her requirements and current conditions. For instance, taking a pill daily may be preferred by some while tedious for others. Some may prefer injectables or IUDs despite the temporary discomfort associated with these methods.

Side effects and complications

- The appropriate disclosure of the side effects of a particular method helps the client arrive at an informed decision. It also boosts user satisfaction and motivation for continued use.
- Clients must be informed that some effects are temporary or self-limiting and are not serious. However, FP service providers should emphasize the potentially dangerous symptoms that require immediate consultation, although such cases are rare.

Use of the chosen method

- The information about the use of certain methods should be correct and clear because many failure cases result from errors in usage. The provider must make sure that the client has adequately understood the directions.
- A useful approach is to ask the client to repeat the instructions to avoid misunderstandings. This part of client education must include the following:
 - How the method is used and when to start
 - What to do if any side effects, problems, or bothersome symptoms are noted
 - What are the danger signs that should prompt immediate consultation
 - What special strategies to use to reduce errors of usage (e.g., developing techniques to remember taking the pill daily)
 - What to do when errors do occur (e.g., forgotten pill)



When to return

- The client must be informed when to return for follow-up, resupply, or assessment and management of symptoms.
- The FP service provider should encourage the client to return any time and for any reason.
- However, the service provider should also inform the client that unless absolutely necessary, return visits are not mandatory.

Education on the prevention of sexually transmitted infections (STIs)

- Educating clients on the prevention of STIs has become an emergent need and hence an integral part of counseling because of the increase in the number of STI cases globally.
- If a client is likely to acquire an STI, he/she should be instructed on the proper use of condoms apart from the method currently used.
- The ABCDE of safe sex should also be emphasized.

ABCDE of Safe Sex

Abstinence

Being mutually faithful

Condom use

Do not share needles

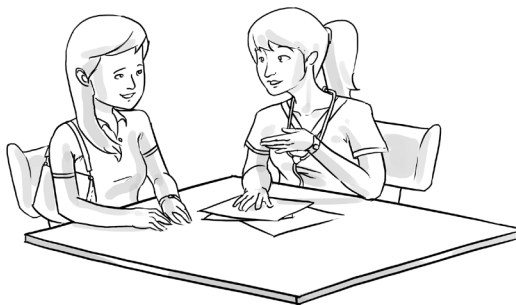
Education and information

DOs OF COUNSELING

- Treat every client respectfully.
- Make the client feel at ease.
- Be polite and sincere at all times.
- Create a feeling of trust.
- Create a relaxed, friendly, nonjudgmental environment.
- Assure client privacy and confidentiality.
- Listen, and get to know the clients (including their fears, limitations, misconceptions, needs, and situation).
- Converse in simple and clear language.
- Be alert to special needs such as STI protection.
- Give correct and appropriate information.
- Allow time for the client to process and clarify information and to ask questions without fear of criticism or judgment.
- Make sure that the client has understood the information correctly.

THE “GATHER” COUNSELING PROCESS

The “GATHER” counseling process includes learning, weighing choices, making decisions, and carrying out these decisions to effectively use an FP method. The six steps involved are represented by the word “GATHER” for easy recall.



G – Greet clients in an open, respectful manner.

- Give them your full attention.
- Talk in a private place if possible.
- Assure the clients of confidentiality.
- Ask clients how you can help, and explain what the clinic can offer in response.

A – Ask clients about themselves.

- Help clients talk about their FP and reproductive health experiences, their intentions, concerns, wishes, and current health situation and family life.
- Ask if the clients have a particular FP method in mind.
- Pay attention to their words, gestures, and expressions.
- Try to put yourself in the clients' context. Express your understanding.
- Find out the clients' knowledge, needs, and concerns about FP so you can respond helpfully.

T – Tell clients about choices.

- Depending on clients' needs, tell them what reproductive health choices they have, including FP methods or using no method at all. Focus on methods that interest the clients most, but briefly mention other available methods.
- Explain other available services that clients may want.

H – Help clients make informed choices.

- Help clients think about what course of action best suits their situations and plans.
- Encourage clients to express their opinions and ask questions. Respond fully and openly.
- Consider the Medical Eligibility Criteria for the FP method or methods that interest the clients.
- Ask if the client's sex partner will support his/her decisions. If possible, discuss choices with both partners.
- Make sure that the client has made a clear decision. Ask, "What have you decided to do?" or "What method have you decided to use?"

E – Explain fully how to use the chosen method.

- After a client chooses an FP method, provide the necessary supplies if appropriate.
- Explain how the supplies are used or how the procedure will be performed.
- Encourage questions, and answer them openly and fully.
- Give condoms to anyone at risk for STIs, and encourage them to use condoms along with any other FP method.
- Make sure that the clients understand how to use their chosen method.

R – Return visits should be welcomed.

- Discuss and agree on when the client will return for a follow-up or for additional supplies if needed.
- Always invite the client to come back any time for any reason or problem.

ENSURING INFORMED CONSENT (1)

- Informed consent is an ESSENTIAL part of the staff–client process and should be secured prior to any healthcare intervention.
- Voluntary informed consent must be obtained in writing before providing a client with any clinical service during the initial visit.
- The consent form and its contents must be fully explained to the client. The consent form explains to the client the routine procedures that will be performed. It contains statements recognizing that consent is voluntarily given, that the client received counseling and education, that all of the client’s questions have been adequately addressed and clarified, and that the client has understood all the information provided.
- Prior to signing the consent form, the client must have received all the necessary information, must have been given the opportunity to ask questions or clarify issues, must have received the appropriate answers and clarifications, and must have understood all information correctly.
- The consent form contains the signature of the client, the signature of the person obtaining the consent, and the date. The signature of the staff authenticates the client’s signature and is not proof of client understanding.
- The consent form must be written in a language that the client understands. Otherwise, the form must be translated and witnessed by an interpreter.
- If the client is unable to read for whatever reason, the form must be read to him or her in full before he or she is asked to sign.
- If the client is not able to give an informed consent (e.g., clients who are mentally challenged or adolescents), the parent or legal guardian must sign the consent form.



Method-specific consent

This consent form is used if the client selects a method of contraception that requires a procedure (e.g., subdermal implants, IUD insertion, sterilization). Before signing this form, the client must have received information on the benefits and risks, effectiveness, potential side effects, complications, discontinuation issues, and danger signs of the contraceptive method chosen.

For permanent methods, the following should be discussed with the client when obtaining an informed consent for sterilization methods:

1. Temporary contraceptives also are available to the client.
2. Voluntary sterilization/vasectomy is a surgical procedure.
3. The procedure has certain risks and benefits, all of which have been explained in a way that the client can understand.
4. If successful, the procedure will prevent the client from having children.
5. The procedure is considered permanent and probably cannot be reversed.
6. The client can decide against the procedure at any time before it takes place (without losing rights to other medical, health, or other services or benefits).

FP COUNSELING FOR YOUNG MOTHERS

- Adolescent clients require skilled counseling and age-appropriate information.
- Adolescents who seek FP services must be informed about all the methods of contraception.
- They must also be informed about abstinence as well as contraceptive and safe sex practice options to reduce risks for STIs and HIV AIDS.
- Providers must not assume that adolescents are sexually active simply because they are seeking FP services.
- As the contraceptive needs of adolescents frequently change, counseling should prepare them for their use of a variety of methods that are effective and appropriate for their needs.
- Adolescents must be assured that the counseling sessions and follow-up visits are confidential. However, counselors should encourage family participation (e.g., mothers of adolescent clients) in the decision-making process of minors who are seeking FP counseling and services.



SUCCESSFUL COUNSELING

- Counseling is considered successful if the client starts and continues to use the method with satisfaction.
- Good counseling results in a client who is confident in the chosen method and consistently complies with the directions of its usage and the required subsequent visits.
- The client also acknowledges that personal needs and rights have been met and fears or misapprehensions have been allayed and addressed.



Chapter 3

CLIENT ASSESSMENT

This chapter describes the first step in providing FP services—the assessment of FP clients’ needs and conditions to ensure that they are medically eligible for their chosen method. The chapter discusses the definition and scope of client assessment and discusses the overall concept and classification of the WHO MEC for Contraceptive Use, which serves as the basic reference in assessing FP clients.

OBJECTIVES OF FP CLIENT ASSESSMENT

All clients who attend FP/reproductive health (RH) clinics should undergo assessment. Client assessment is aimed at the following objectives:

- To determine the health status of a client, particularly his/her eligibility for contraceptive use
- To gather data about the client’s health through medical history taking, physical examination (PE), and laboratory examination, if needed.
- To determine if the client is in good health or needs further management, close follow-up, and/or referral.



THE MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE

The recommended reference for assessing clients is the MEC for Contraceptive Use endorsed by the WHO. It gives recommendations based on the latest clinical and epidemiological data available on the safety of FP methods for people with certain health conditions. Based on these recommendations, the eligibility criteria for initiating and continuing the use of a specific contraceptive method are classified under one of four categories (Table 3).

Table 3. Categories used in recommending contraceptive methods based on WHO MEC

Category 1	A condition where the use of a certain method has no restrictions. Provide the method.
Category 2	A condition where the advantages of using a certain method generally outweigh the theoretical or proven risks. This condition indicates that the method can generally be used but careful follow-up may be required.
Category 3	A condition where the theoretical or proven risks of a certain method usually outweigh the advantages. The use of this method is not usually recommended unless other appropriate methods are not available or acceptable. A follow-up, including a careful clinical judgment and access to clinical services, will be required. For clients under this category, the severity of the condition and the availability, practicality, and acceptability of alternative methods should be considered.
Category 4	A condition where the use of a certain method has an unacceptable health risk. Do not provide the method.

Where resources for clinical judgment are limited (i.e., community-based services), the four-category classification framework can be simplified into two categories. With this simplification, a Category 3 classification indicates that a client is not medically eligible to use the method. These categories are summarized in Table 3.

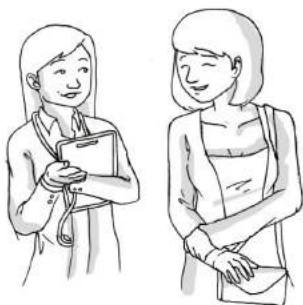


Table 4. Simplified MEC categories

Category	With clinical judgment	With limited clinical judgment
1	Use the method under any circumstance.	YES, use the method.
2	Generally use the method.	
3	Use of the method is not usually recommended unless other appropriate methods are not available.	NO, do not use the method.
4	Method must not be used.	

In applying the eligibility criteria, service delivery practices that are essential for the safe use of contraceptives should be distinguished from practices that may be appropriate for good healthcare but are not related to the safe use of the method. Promoting good healthcare practices unrelated to safe contraception should be considered neither as a prerequisite nor as an obstacle to the provision of a contraceptive method but as a complement to it. (Refer to the summary tables on MEC for Contraceptive Use in Appendix E.)

STEPS IN CLIENT ASSESSMENT

The basic steps in client assessment are as follows:

1. Client history taking

- Interview the client about his/her past and present medical/RH status.
- The client's history helps the service provider evaluate and assess the client's RH status and identify his/her RH needs.
- It facilitates the identification of risk factors or precautions when using an FP method.
- It is also useful in helping the client choose the most appropriate contraceptive method.



The MEC Checklists for Safe Use of Contraceptives (Appendix E) are used in taking the client's medical history and in performing physical and/or pelvic and laboratory examinations. The Family Planning Service Record or FP Form 1 (Appendix F) is used to record the results of the assessment.

2. Physical examination*

PE ensures the safe use of an FP method and thus ensures the client's safety. A thorough PE also helps the service provider in the following circumstances:

- Identification of any health problems that may warrant the provision of FP/RH care
- Evaluation of client's health status while he/she is using an FP method to monitor any changes that call for precautions on the use of the method
- Confirmation of conditions suspected or noted during the client history taking.

**A female client assessed by a male health provider may request a companion during the PE.*

Timing of PE

- Perform an initial physical examination to determine/ensure safe use of FP methods, particularly for intrauterine device (IUD), bilateral tubal ligation (BTL), and no-scalpel vasectomy (NSV).
- Conduct as needed or whenever an indication, complaint, or unusual symptom that may be related to the use of an FP method exists.

Steps in conducting a PE

- a. Prepare the client.
 - Make the client comfortable.
 - Explain the procedure, and assure privacy during the examination.
 - Request the client to empty his/her bladder and wash his/her perineum.
- b. Prepare the instruments/supplies for the pelvic exam if needed.
- c. Check the client's vital signs (blood pressure, heart rate, respiratory rate, temperature), height, and weight.

d. Conduct a general PE as necessary.

- Breast examination may be conducted during the initial visit of all clients and yearly as part of a general checkup. Conversely, clients must be asked to examine themselves weekly until they have mastered the technique and then monthly—preferably one week after every menstruation. Refer the client to the appropriate facility whenever a distinct mass is identified or suspected.
- Abdominal examination is performed to check for tenderness, organ enlargement, or masses.
- Pelvic examination should be offered to all women who visit the clinic for the first time and as part of general screening.
 - It includes an examination of the external genitalia, the use of a speculum for cervix and vaginal canal visualization, bimanual pelvic examination, and recto-vaginal examination.
 - It must be performed on all women requesting an IUD, surgical sterilization, or diaphragm insertion.
 - Recto-vaginal examination is not routinely carried out but may be indicated if the client has symptoms and signs of pelvic masses. Refer the client to a physician for any abnormal findings.
- Male genitalia examination of clients for vasectomy is required to detect signs, symptoms, and conditions (e.g., infections, masses, discharge, and bleeding), which may delay the procedure.



3. Laboratory examinations

- In some cases, findings during the history taking or PE may require confirmation through laboratory tests.
- Laboratory tests are not required for all clients but should be performed as needed.
- A service provider should be familiar with these tests and their interpretation, should know when to request them, and should understand how these tests can help manage the client's condition.

4. Applicability of various procedures or tests

- Some examinations or procedures should be performed before providing a contraceptive method.
- Clients with known medical problems or other special conditions may need additional examinations or tests before being considered as candidates for a particular contraceptive method.

Table 5 shows the applicability of various procedures or tests for contraceptive methods. These classifications focus on the relationship between the procedures or tests and the safe introduction of a contraceptive method. They are not intended to address the appropriateness of these examinations or tests in other circumstances. For example, some procedures or tests that are not considered necessary for safe and effective contraceptive use may be appropriate for good preventive healthcare or for diagnosing or assessing suspected medical conditions.



Table 5. Applicability of various procedures or tests for contraceptive methods*

Specific situation	COC	CIC	POP	POI	Implants	IUD	Condom	Diaphragm cervical cap	Spermicides	BTL	Vasectomy
Breast exam by provider	C	C	C	C	C	C	C	C	C	C	NA
Pelvic/Genital exam	C	C	C	C	C	A	C	A	C	A	A
Cervical cancer screening	C	C	C	C	C	C	C	C	C	C	NA
Routine lab tests	C	C	C	C	C	C	C	C	C	C	C
Hemoglobin test	C	C	C	C	C	B	C	C	C	B	C
STI risk assessment: Med Hx & PE	C	C	C	C	C	A ¹	C ²	C ²	C ²	C	C
STI/HIV screening: Lab tests	C	C	C	C	C	B ¹	C ²	C ²	C ²	C	C
BP screening	C ³	C ³	C ³	C ³	C ³	C	C	C	C	A	C ⁴

Source: WHO Medical Eligibility Criteria for Contraceptive Use, Fourth Edition, 2009.

***Class A** = essential and mandatory in all circumstances for the safe and effective use of a contraceptive method.

Class B = contributes substantially to the safe and effective use of a contraceptive method but implementation may be considered within the public health and/or service context. The risk of not performing an examination or test should be balanced against the benefits of making the method available.

Class C = does not contribute substantially to the safe and effective use of a contraceptive method.

Notes

Medical Eligibility Criteria for Contraceptive Use, Third Edition, 2009, states that

¹ Women who are likely to become exposed to gonorrhea or chlamydial infection should generally not have an IUD inserted unless other methods are not available or not acceptable. Women who have current purulent cervicitis or gonorrhea or chlamydial infection should not have an IUD inserted until these conditions are addressed or until medical eligibility is ensured.

² Women at high risk of HIV infection should not use spermicides containing nonoxynol-9. Using diaphragms and cervical caps with nonoxynol-9 is not usually recommended for women at high risk of HIV infection unless other appropriate methods are not available or not acceptable. The contraceptive effectiveness of diaphragms and cervical caps without nonoxynol-9 has been insufficiently studied and should be assumed to be less than that of diaphragms and cervical caps with nonoxynol-9.

³ Blood pressure measurements are ideally taken before initiation of COCs, CICs, POPs, POIs, and implants. However, blood pressure measurements are unavailable in many settings where pregnancy morbidity and mortality risks are high and hormonal methods are among the few methods widely available. In such settings, women should not be denied the use of hormonal methods simply because their blood pressure cannot be measured.

⁴ For procedures performed using local anesthesia with ephedrine.

How Can the Health Provider Determine if a Woman Is Not Pregnant?

- Pregnant women should not use FP methods for obvious reasons; however, condoms should be used to protect against sexually transmitted infections.
- In the absence of any signs or symptoms of pregnancy, a healthcare provider can usually tell if a woman is not pregnant by asking screening questions (see Appendix C, p. 325). Pregnancy tests or PE are usually not needed.
 - A woman is certainly not pregnant if
 - Her menstrual period started within the last seven days.
 - She gave birth within the last four weeks.
 - She had an abortion or miscarriage within the last seven days.
 - She gave birth within the last six months, is breastfeeding often, and has not yet had a menstrual period.
 - A woman who does not meet any of the above conditions is still not pregnant if
 - She has not had vaginal sex since her last menstrual period.
 - She used a reliable FP method correctly during her last sexual intercourse and if her last menstrual period is less than five weeks ago.
- Pregnancy cannot be ruled out for a woman who had sex and her last period was five weeks ago or more. The following early signs of pregnancy should be considered:
 - Late menstrual period
 - Breast tenderness
 - Nausea
 - Vomiting
 - Weight change
 - Fatigue
 - Mood changes
 - Changes in eating habits
 - Frequent urination



- Consider the following late signs of pregnancy for a woman whose last menstrual period has been more than 12 weeks ago. A PE must be performed for confirmation.
 - Large breasts
 - Dark nipples
 - Increased vaginal discharge
 - Enlarged abdomen
 - Movements of a baby
- A woman whose answers cannot rule out pregnancy should either have a pregnancy test, if available, or wait until her next menstrual period before starting a method. She should be provided with condoms and instructions on how to use them.



FLOW OF ACTIVITIES AND SERVICES FOR CLIENTS IN A GIVEN HEALTH FACILITY

Figures 1 and 2 illustrate the flow of activities and services for (a) a new FP client and (b) a returning FP client in a given health facility, respectively. Both figures reflect the specific steps to be followed and the key decision points to be made while clients are being served in the clinic (from the time they enter the facility up to the provision of the FP method).

Figure 1. Flow of activities and services for a new FP client

COUNSELING

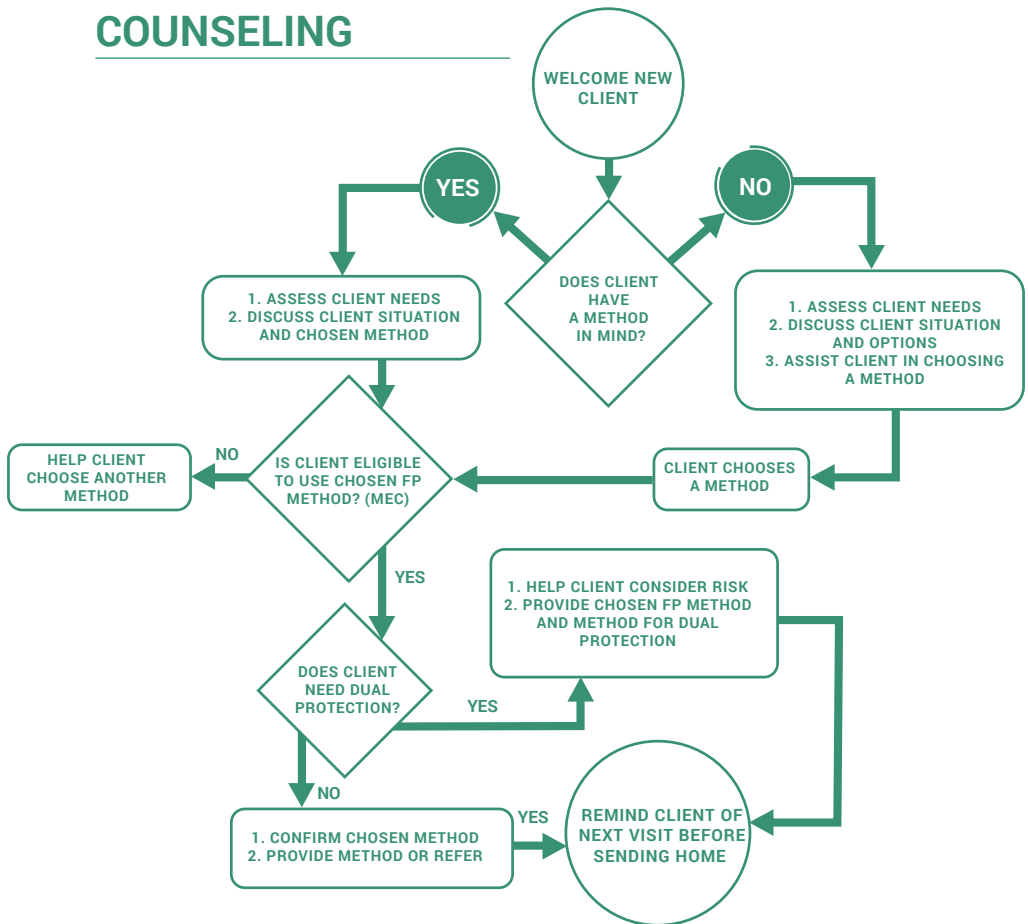
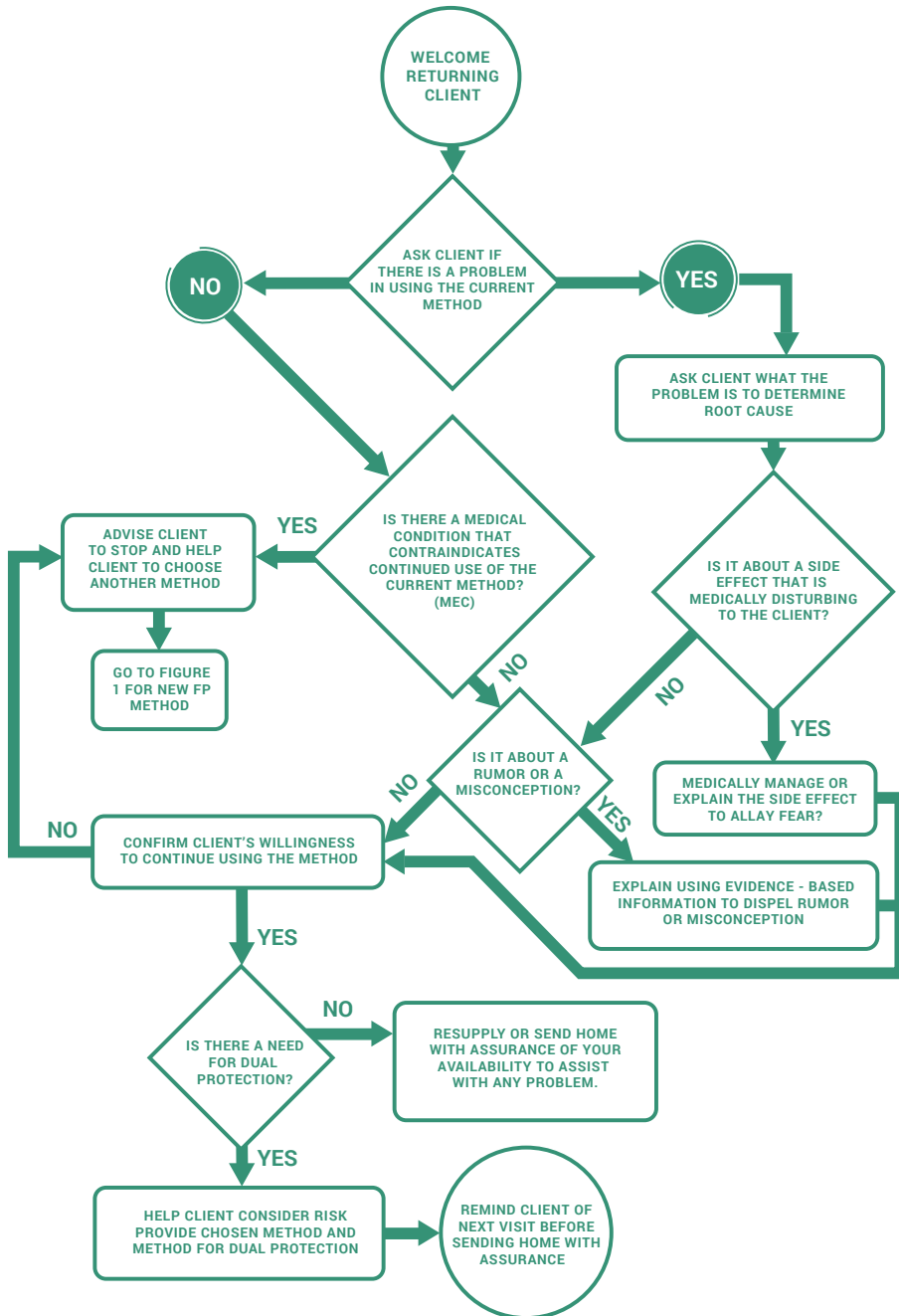


Figure 2. Flow of activities and services for a returning FP client



RECORDING CLIENT ASSESSMENT RESULTS

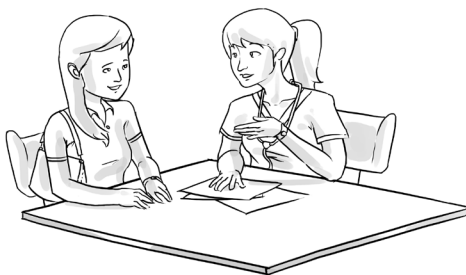
The basic record used in assessing a client's condition is the Family Planning Service Record or FP Form 1 (Appendix F). Similar to the individual treatment record used in other programs, this record or form contains essential client information that would help the health worker provide quality FP/RH services. The service provider fills out and updates the FP Form 1 every time the client comes back for a follow-up visit.

This form contains the following:

- Personal, obstetrical, and gynecological information
- FP, medical, and family history
- Physical exam findings and laboratory results
- Medical observations and complaints presented by the client.

It is used by workers from the Department of Health, local government units, government organizations, and non-government organizations when admitting new clients to the program and transferees from other service points.

Information on succeeding visits and services related to FP are recorded on this form. Other visits and services not related to FP are recorded and filed at the rural health units, main health center, or barangay health stations.



Chapter 4

COMBINED HORMONAL CONTRACEPTIVES:

Pills, Patches, Rings, and Injectables

WHAT ARE COMBINED HORMONAL CONTRACEPTIVES (CHCs)?

CHCs are drugs that contain hormones (estrogen and progestogen) similar to those naturally found in a woman's body. These drugs are regularly administered to prevent conception.



HOW DO CHCs WORK?

- CHCs suppress ovulation or the release of an egg from the ovary.
- The estrogen in CHCs creates a negative feedback mechanism that tricks the brain into thinking that the body has enough hormones that the ovaries no longer need to produce an egg. This phenomenon prevents follicular development, which is necessary for ovulation. Pregnancy cannot occur without a released egg.
- Aside from preventing follicular rupture during ovulation, the progesterone in CHCs makes the cervical mucus thick and impairs the entry of sperm into the uterus.

HOW EFFECTIVE ARE CHCs?

CHCs are 99.7% effective in preventing pregnancy when used properly. With typical use, the effectiveness rate is lower at 92.0%.

HOW CAN CHCs BE ADMINISTERED?

The drugs may be administered orally, transdermally, transvaginally, or intramuscularly. CHC injectables are discussed in a separate section.

WHAT ARE THE ADVANTAGES OF USING CHCs?

- Safe, as proven through extensive studies
- Convenient and easy to use
- Makes menstrual cycles regular and predictable
- Reduces heavy menstrual bleeding
- Reduces symptoms of gynecologic conditions, such as painful menses and endometriosis
- Reduces the risk of ovarian and endometrial cancer
- Reversible, rapid return of fertility after discontinued use
- Does not interfere with intercourse

WHAT ARE THE DISADVANTAGES OF USING CHCs?

- Often used incorrectly and inconsistently, lowering its effectiveness
- Has side effects such as nausea, dizziness, or breast tenderness, which are not generally harmful but cannot be tolerated by some women
- May pose health risks for some women
- Offers no protection against sexually transmitted infections (STIs), including human immunodeficiency virus (HIV)
- Effectiveness may be lowered when taken with certain drugs, such as rifampicin and most anticonvulsants
- May suppress lactation
- Requires regular resupply
- Combined oral contraceptives (COCs) require daily intake

WHO CAN USE CHCs?

- CHCs are appropriate for most women who want a highly effective and easily reversible method for preventing pregnancy and for those who are not at risk of cardiovascular complications.
- The WHO MEC screening checklist for CHCs (Table 6) should be used to determine the eligibility of the clients and the suitability of the method.

- COCs have been used for more than 50 years. The other CHCs utilized through different delivery systems are relatively new.
- The WHO MEC Working Group concluded that the evidence available for COCs applies to other CHCs because of the lack of definitive evidence.

Table 6. MEC categories for CHCs

Category 1: Use the method without restriction.

- | | |
|---|---|
| • Menarche to 40 years old | • Benign breast disease or family history of cancer |
| • Women who may or may not have given birth | • Women with gestational trophoblastic disease, endometrial cancer, or ovarian cancer |
| • More than 42 days postpartum | • Among women with uterine anatomical abnormalities (e.g., fibroids) |
| • Any time post-abortion | • Current or history of PID or STIs such as HIV/AIDS |
| • Past ectopic pregnancy | • Schistosomiasis |
| • History of pelvic surgery | • Tuberculosis |
| • Minor surgery without immobilization | • Malaria |
| • Varicose veins | • History of gestational diabetes |
| • Epilepsy | • Any thyroid disorder |
| • Depressive disorders | • Chronic or carrier viral hepatitis |
| • Women with irregular vaginal bleeding patterns | • Mild liver cirrhosis |
| • Diagnosed with benign ovarian tumor, endometriosis, severe dysmenorrhea | • Thalassemia or iron-deficiency anemia |
| • Cervical ectropion | • Current use of nucleoside reverse transcriptase inhibitors, broad-spectrum antibiotics, antifungal, or antiparasitics |

Category 2: Generally use the method but with more than the usual follow-up.

- Women more than 40 years old
- Breastfeeding women, more than six months after childbirth
- Non-breastfeeding women, 21 to 42 days postpartum
- Women who smoke and are less than 35 years old
- Body mass index of more than or equal to 30 kg/m²
- History of high blood pressure during pregnancy
- Family history of deep vein thrombosis/pulmonary embolism
- Major surgery WITHOUT prolonged immobilization
- Superficial thrombophlebitis
- Known hyperlipidemia
- Uncomplicated valvular heart disease
- Systemic lupus erythematosus with negative antiphospholipid antibodies
- Continued use in women with non-migrainous headache
- Initiation of method in women with migraine, without aura, aged less than 35 years
- Unexplained vaginal bleeding prior to evaluation
- Women diagnosed with cervical intraepithelial neoplasia or cervical cancer prior to treatment
- Undiagnosed breast mass
- Diabetes, without vascular disease
- Asymptomatic or symptomatic gall bladder disease treated with cholecystectomy
- History of pregnancy-related cholestasis
- Benign liver tumors such as focal nodular hyperplasia
- Sickle cell disease
- Current use of non-nucleoside reverse transcriptase inhibitors

WHO CANNOT USE CHCs?

Category 3: Do not use the method unless no other appropriate method is available under close supervision.

- Breastfeeding women, six weeks to six months after childbirth
- Non-breastfeeding women, less than 21 days postpartum, without other risk factors for VTE
- Non-breastfeeding women, more than 21 days postpartum, with other risk factors for VTE
- Women who smoke less than 15 cigarettes/day and are more than 35 years old
- Multiple risk factors for arterial cardiovascular disease such as old age, smoking, diabetes, and hypertension
- History of hypertension, in which blood pressure CANNOT be evaluated
- Adequately controlled hypertension, in which blood pressure CAN be evaluated
- Have increased blood pressure (systolic of 140 mm Hg to 159 mm Hg or diastolic of 90 mm Hg to 99 mm Hg)
- Initiation of method in women with migraine, without aura, aged more than 35 years
- History of breast cancer with no evidence of disease in the last five years
- Diabetes with nephropathy, retinopathy, neuropathy, or other vascular diseases
- Known hyperlipidemias
- Symptomatic gall bladder disease
- History of COC-related cholestasis (for COC, patch, and ring users)
- Initiation of method in women with acute or flare viral hepatitis
- Current use of ritonavir-boosted protease inhibitors, anticonvulsant therapies
- Current use of rifampicin/rifabutin therapy (for COC, patch, and ring users)

Category 4: Do NOT use the method.

- Breastfeeding women, less than six months after childbirth
- Women who smoke more than 15 cigarettes/day, aged more than 35 years (for COC, patch, and ring users)
- Have high blood pressure (systolic of more than or equal to 160 mm Hg or diastolic of more than or equal to 100 mm Hg)
- Hypertension with vascular disease
- History or currently diagnosed with DVT/PE on anticoagulant therapy
- Major surgery with prolonged immobilization
- Known thrombogenic mutations
- Current or history of ischemic heart disease or stroke
- Complicated valvular heart disease
- Women diagnosed with systemic lupus erythematosus and with positive (or unknown) antiphospholipid antibodies
- Migraine with aura at any age
- Diagnosed with breast cancer
- Severe liver cirrhosis (for COC, patch, and ring users)
- Liver tumors such as hepatocellular adenoma or malignant hepatoma (for COC, patch, and ring users)

WHAT ARE THE IMMEDIATE AND LASTING EFFECTS OF CHC USE?

CHCs have the following effects:

- Reduces menstrual bleeding and helps prevent iron deficiency anemia, which is common and often serious in the Philippines (especially in remote areas).
- Decreases the risk of cancers of the uterine lining and the ovary. The protective effect develops after a year of use, increases with duration of use, and persists for at least 15 years after discontinuation.
- Prevents ectopic pregnancy, which can be life-threatening. This effect is caused by the action (ovulation cessation) of estrogen–progestin contraceptives.
- Regulates menstrual patterns, relieves the symptoms of acne, and reduces the risk of benign breast disease.
- Does not increase the risk of developing breast cancer.

WHAT ARE THE SIDE EFFECTS OF CHC USE?

Some women on CHCs experience the following:

- Nausea or vomiting (usually occurs during the first few cycles)
- Weight changes
- Breast tenderness
- Abdominal cramps
- Skin discoloration
- Bladder and vaginal infections

Others report the following:

- Changes in sex drive (either increased or decreased)
- Loss of scalp hair
- Intolerance to contact lenses (due to water retention)

Many of the aforementioned complaints disappear after the first few cycles of use. Menstrual cycles often become regular within three months from CHC initiation. However, new formulas are likely to cause the following menstrual irregularities.

- Spotting
- Breakthrough bleeding (which should be reported to a doctor)
- Lack of menstrual period altogether (rare)

In some women, side effects unique to the transvaginal ring and transdermal patch are increased vaginal secretions and skin irritation, respectively. Clients should be asked to return to the clinic for any symptom.

WHAT ARE THE POTENTIAL COMPLICATIONS AND ADVERSE EFFECTS OF CHC USE?

- Only a few life-threatening complications can be attributed to CHCs, and these complications can be reduced by the proper initial screening of clients.
- The most serious side effect of CHC use is an increased risk of cardiovascular disease, specifically blood clots, heart attacks, and strokes. However, even these complications occur less frequently because of the low hormone content in CHCs and the early screening of women with high risk.
- Healthy users of low-dose CHCs have a three- to sixfold higher risk of developing venous thrombosis compared with healthy women who do not use COCs. Nevertheless, the absolute risk remains minimal.
- Research has shown that certain types of progestins (such as desogestrel and gestodene) may slightly increase the risk of venous thrombosis and other cardiovascular complications among CHC users.
- Women who use low-dose CHCs and who do not smoke, do not have high blood pressure, or do not have diabetes are not at increased risk of heart attack or stroke when compared with non-users.

IS A REFERRAL NEEDED? HOW AND WHEN?

Only a few life-threatening complications can be attributed to CHC use. These complications can be reduced by the proper initial screening of the client.

The following signs and symptoms require medical attention:

- **J**aundice
- **A**bdominal pain (severe constant pain)
- **C**hest pain (severe constant pain) or shortness of breath
- **H**eadaches (intense pain that starts or becomes worse after starting the pills)
- **E**ye problems (brief loss of vision, seeing flashes of light or zigzag lines)
- **S**evere arm or leg pain (difficulty in moving)

When these symptoms occur, clients are instructed to return to the clinic or go directly to referral facilities.



WHAT ARE THE DRUG INTERACTIONS OF CHCs?

- The effectiveness of CHCs is not affected by most broad-spectrum antibiotics.
- Some medications can reduce the effectiveness of CHCs. These medications include the following:
 - Certain antimicrobials (rifampicin)
 - Anticonvulsants, such as phenytoin (Dilantin), carbamazepine, barbiturates (Phenobarbital), primidone, topiramate, oxcarbazepine, and lamotrigine
 - Some antiretroviral drugs (ARVs)
- ARVs can increase or decrease the bioavailability of steroid hormones in CHCs. Thus, consistent condom use should be recommended to compensate for any possible reduction in contraceptive effectiveness as well as to prevent STI or HIV transmission.
- Protease inhibitors and ritonavir protease inhibitors may generally decrease the effectiveness of CHCs.

WHEN CAN A WOMAN SWITCH AND DISCONTINUE CHCs?

- The client may switch any time without finishing her current cycle of CHCs.
 - A woman who wants to prevent pregnancy but wants to stop CHCs should consider starting another contraceptive method before discontinuing CHCs.
 - A woman who wants to switch from CHCs to progestin-only contraceptives (POCs) should begin immediately after her last hormonally active day on CHC.
 - A woman switching to a certain contraceptive method may need a backup method until the effectivity of the new method. However, when a woman begins another hormonal method within five days after taking her last active pill, she does not need a backup method.

WHAT HAPPENS WHEN THE CLIENT STOPS USING CHCs?

- Fertility returns rapidly.
- Temporary spotting or bleeding may be experienced by the client.

HOW IS CHC SUPPLY MANAGED?

- Clients must be informed about where to go for resupply of contraceptives.
- Clients should be provided with enough supply of contraceptive pills to ensure the continuity of use.

IS FOLLOW-UP NEEDED? HOW AND WHEN?

- Clients should be advised to return to the clinic three months after the initial visit and then annually thereafter. Clients should be encouraged to return quarterly for resupply and for proper recording/reporting.
- Clients should return to the clinic for any problems or questions that may arise at any time.
- During the annual follow-up, a physical and pelvic examination may be performed as part of good medical practice. Cervical and breast cancer screening procedures are usually undertaken.

WHAT COUNSELING TIPS SHOULD BE PROVIDED TO THE CLIENT?

The following points must be emphasized:

- Correct use of the method, including instructions for missed pills.
- Signs and symptoms that require the attention of a health provider.
- The fact that CHCs do not protect the client against STIs, including HIV, and that use of condoms is necessary.
- Smoking increases the risk of serious circulatory disorders. Women who intend to use CHCs should be advised to quit smoking.
- The absence of any bleeding or spotting during the seven-day hormone-free period may be a sign of pregnancy.

COMBINED ORAL CONTRACEPTIVE PILLS

The most widely used CHCs are COCs, which are commonly referred to as “pills.” The readily available preparations are as follows:

- **Monophasic low-dose COCs**
contain 20 µg to 35 µg ethinyl estradiol (EE) and progestogen-like levonorgestrel (LNG) in all 21 “active tablets.” (“High-dose” COCs that contain 50 µg EE or more plus a high dose of progestogen are only used for special indications.)
- **Biphasic low-dose COCs**
contain two combinations of estrogen and progestogen, e.g., 7 tablets of 40 µg EE plus 25 µg desogestrel and 15 tablets of 30 µg EE plus 125 µg desogestrel.
- **Triphasic low-dose COCs**
contain the same hormones but in three dose ratios, e.g., 6 tablets of 30 mcg EE plus 50 mcg LNG, 5 tablets of 40 mcg EE plus 75 mcg LNG, and 10 tablets of 30 mcg EE plus 125 mcg LNG.
- **Quadriphasic preparations**
include four different combinations of estradiol valerate (EV) and dienogest.



The following significant changes have been made over the past decades to improve the combined oral contraceptives:

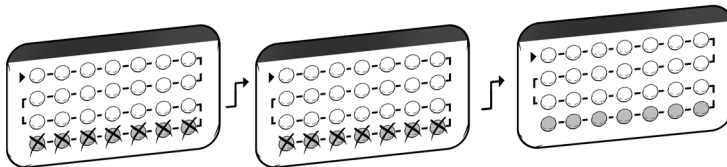
- Gradual reduction in the estrogen component from the original 175 mcg mestranol to the present-day pills that contain 30 mcg to 35 mcg EE and the “very low-dose” pills with only 20 mcg EE
- Use of different estrogens (estradiol [E2] and EV) and progesterones (drospirenone, dienogest, and norgestrel)
- Extended or continuous contraceptive cycles

Table 7 lists the low-dose COCs available in the Philippines.

Table 7. Low-dose COCs available in the Philippines	
Content	Brand Names
Monophasic Preparations	
EE 30 mcg, Norgestrel 150 mcg	Logentrol
EE 30 mcg, Levonorgestrel 150 mcg	Lady
EE 30 mcg, Gestodene 75 mcg	Gynera
EE 30 mcg, Desogestrel 150 mcg	Marvelon
EE 20 mcg, Gestodene 75 mcg	Meliane
EE 30 mcg, Norethisterone 400 mcg	Micropil
EE 30 mcg, Levonorgestrel 150 mcg	Microgynon
EE 30 mcg, Gestodene 75 mcg	Minulet
EE 20 mcg, Desogestrel 150 mcg	Mercilon
EE 30 mcg, Levonorgestrel 150 mcg	Nordette
EE 30 mcg, Levonorgestrel 150 mcg	Rigevidon 21 +7
EE 30 mcg, Levonorgestrel 125 mcg	Trust Pill
EE 30 mcg, Drospirenone 3 mcg	Yasmin
EE 20 mcg, Drospirenone 3 mcg	Yaz
Biphasic Preparations	
EE 40 mcg, Desogestrel 25 mcg (7 tabs)	Gracial
EE 30 mcg, Desogestrel 125 mcg (15 tabs)	
Triphasic Preparations	
EE 30 mcg, LNG 50 mcg (6 tabs)	Trinordiol, Triquilar, Logynon
EE 40 mcg, LNG 75 mcg (5 tabs)	
EE 30 mcg, LNG 125 mcg (10 tabs)	
Quadriphasic Preparations	
EV 3 mg (2 tabs)	Qlaira
EV 2 mg Dienoest 2 mg (5 tabs)	
EV 2 mg Dienoest 3 mg (17 tabs)	
EV 1 mg (2 tabs)	

HOW ARE COC PILLS USED?

- Pills should be taken once daily even if the client is not having sex daily.
- If monthly menstruation/withdrawal bleeding is desired, a pack with 21 active pills that contain the “active” hormones estrogen and progesterone should be taken with a seven-day rest period before starting a new pack.
- A 28-day pack including seven placebo or non-hormone tablets should be taken continuously. The client should start a new pack immediately the day after the last pill of the current pack. A rest period is not required.
- If menstruation/withdrawal bleeding is not desired (continuous or extended use of pills may be resorted to):
 - A monophasic pack with 21 active pills that contain the hormones estrogen and progesterone should be taken continuously, and a new pack should be started immediately the day after the last pill of the current pack.
 - A 28-day monophasic pack may be used similarly and continuously (taking only the 21 “active pills”) after discarding the seven additional placebo or non-hormone tablets.
 - A seven-day rest period may be ideal every after three continuous cycles (menstruates every three months or four times a year).



In other countries, these three continuous cycle preparations are already available prepacked as continuous birth control pills in extended cycles for convenience. They are commercially known as Seasonale and Seasonique. Seasonale has 84 pills each containing 0.03 mg EE/0.15 mg LNG and 7 placebo pills. Seasonique has 84 pills each containing 0.03 mg EE/0.15 mg LNG and 7 pills each containing 0.01 mg EE.

- With multiphasic preparations, skipping the placebo week may result in a sudden change in hormone levels. As this change may cause irregular bleeding, multiphasic preparations are not recommended for continuous use.
- Pill users should have a backup contraceptive method, such as condoms, in case of missed pills.
- The client's clinical history should be taken to determine her medical eligibility.
 - Get her blood pressure.
 - No other examination is necessary for use of the method, but it does not rule out the need for other reproductive health procedures, such as physical and pelvic examinations, cervical smears for cancer screening, or some routine laboratory examinations as part of standard operating procedures and good medical practice.



WHEN SHOULD USE OF COCs BEGIN?

- COCs are best taken within the first five days of the menstrual period because pregnancy is not possible at this time.
- Women who start COCs after the fifth day of the onset of their menstruation should practice abstinence or use a backup contraceptive for the next seven days.
- Women who have not recently given birth can start taking COCs any time as long they are certain that they are not pregnant.
- Postpartum/post-abortion women
 - Breastfeeding women may begin COCs at six months postpartum or when they quit breastfeeding. COCs contain estrogen, which may decrease breast milk production.
 - Postpartum women who are not breastfeeding may begin taking COCs three weeks after delivery.
 - Following an abortion, women may begin taking oral contraceptives immediately. No backup contraception is needed if the method is started within the first five days following an abortion.

WHAT SHOULD BE DONE WHEN COC PILLS ARE MISSED?

For pills containing 30 mcg to 35 mcg EE

- Women who miss one to two active (hormone-containing) pills should take one pill as soon as possible and then take the next pill at the regular time even if this means taking two pills in one day (see Figure 3). A backup contraceptive method is not necessary.
- Women who miss three or more active COC pills in a row or those who start a pack three or more days late should take an active pill as soon as possible and then continue taking one pill each day. These women should abstain from sex or use a backup contraceptive for seven days in a row.
- Women who miss three or more pills on the third week should take one pill as soon as possible, if possible from a new pack; alternatively, these women can take the active pills in the current pack until they get a new pack (and throw away the inactive pills). These women might miss a period or get their period late.

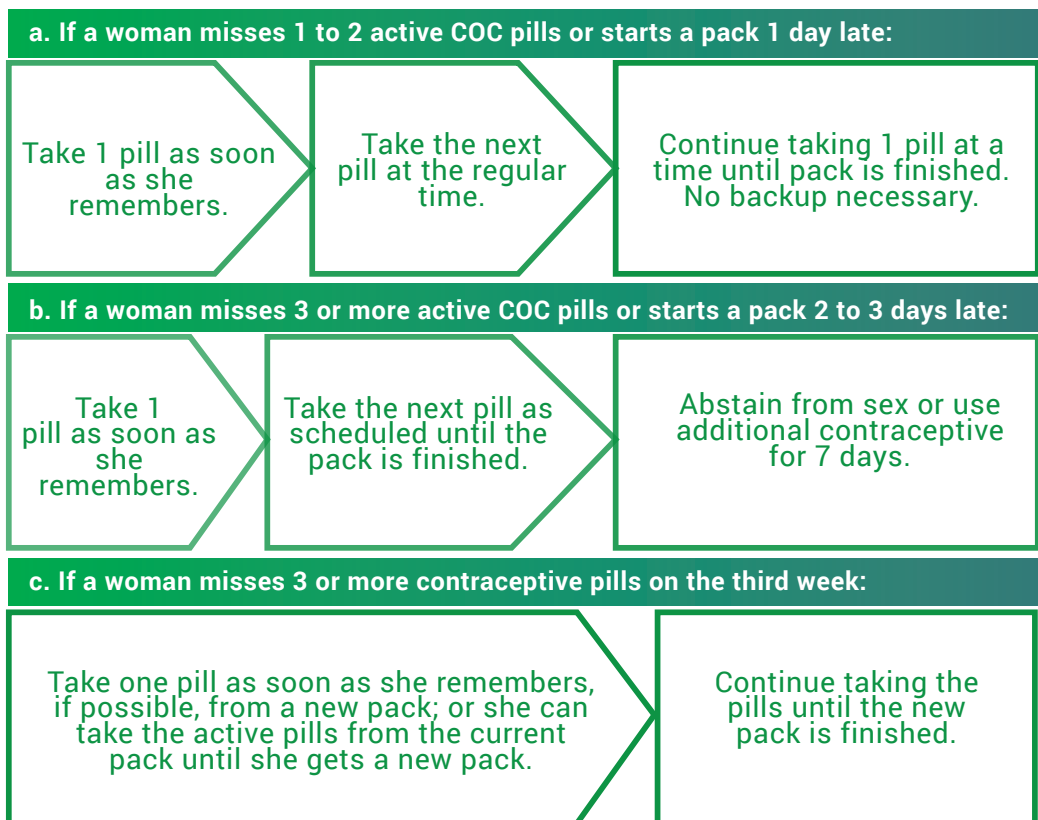
For pills containing 20 mcg or less EE

- Women who miss one or two active (hormone-containing) pills should take one pill as soon as possible and then take the next pill at the regular time even if this means taking two pills in one day (see Figure 3). A backup contraceptive method is necessary.
- Women who miss two or more active pills or start the pack two or more days late should take one pill as soon as possible, if possible from a new pack; alternatively, these women can take the active pills in the current pack until they get a new pack (and throw away the inactive pills). These women might miss a period.

In case of severe vomiting (for any reason) or diarrhea

- If vomiting occurs within two hours after taking an active (hormonal) pill, the client should take another active pill.
- If severe vomiting or diarrhea occurs for more than 24 hours, the client should continue taking the pills (if she can) despite the discomfort.
- If severe vomiting or diarrhea continues for two or more days, the client should follow the procedures for missed pills.

Figure 3. Procedure to follow when a woman misses her pills



COMBINED INJECTABLE CONTRACEPTIVES

WHAT ARE COMBINED INJECTABLE CONTRACEPTIVES?

Combined injectable contraceptives (CICs) are monthly injectable preparations that contain a short-acting natural estrogen and a long-acting progestogen. Once given intramuscularly, these hormones are slowly released for 28 to 30 days. CICs come in the following preparations:

- 25 mg depot-medroxyprogesterone acetate and 5 mg estradiol cypionate (Cyclofem) intramuscularly injected once a month.
- 50 mg norethindrone enanthate and 5 mg estradiol valerate (Mesigyna) intramuscularly injected once a month. This preparation is available in the Philippines as Norifam.



HOW EFFECTIVE ARE CICs?

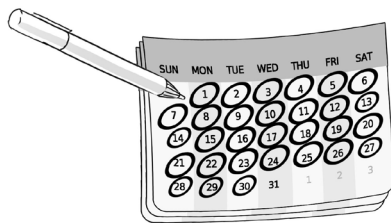
CICs are 99.9% effective in preventing pregnancy when used properly. With typical use, the effectiveness rate is lower at 97.0%.

WHAT ARE THE ADVANTAGES OF USING CICs?

- Immediate effectiveness
- Pelvic examination not required prior to use
- Does not interfere with intercourse
- Few side effects
- Can be provided by a trained nurse or midwife
- Contributes to decreased menstrual flow (lighter, shorter periods)
- Reduces menstrual cramps
- May improve anemia as menses are reduced
- Reduces the risk of ectopic pregnancy
- Protects against some causes of pelvic inflammatory disease (PID)

WHAT ARE THE DISADVANTAGES OF USING CICs?

- Some nausea, dizziness, mild breast tenderness, headaches, and spotting (minimal bleeding) caused by the estrogen component of CICs but to a lower degree than those caused by COCs. These side effects disappear within two or three injections because the “natural” estrogen approximates the physiologic dose.
- Effectiveness may be lowered by rifampicin and most anticonvulsants.
- CICs can delay return to fertility by a few weeks from the last injection.
- CICs can cause serious side effects, such as cardiovascular disease, but such cases are rare.
- CICs do not protect against STIs, such as the human papillomavirus and HIV/AIDS.
- CICs cause changes in the menstrual bleeding pattern (irregular bleeding/spotting) of some women.
- Users of CICs must return for injection every 30 days.



WHO CAN USE CICs?

- This method is useful for women who want a highly effective contraceptive method but have problems adhering to other CHC regimens.
- This method is also suitable for women who want the convenience of an injectable contraceptive without the bleeding irregularities associated with progesterone-only injectables.

Table 8. MEC categories for CICs

Category 1: Use the method without restriction.

- Menarche to 40 years old
- Women who may or may not have given birth
- More than 42 days postpartum
- Any time post-abortion
- Past ectopic pregnancy
- History of pelvic surgery
- Minor surgery without immobilization
- Varicose veins
- Epilepsy
- Depressive disorders
- Women with irregular vaginal bleeding patterns
- Diagnosed with benign ovarian tumor, endometriosis, severe dysmenorrhea
- Cervical ectropion
- Benign breast disease, or family history of cancer
- Women with gestational trophoblastic disease, endometrial cancer, or ovarian cancer
- Among women with uterine anatomical abnormalities (e.g., fibroids)
- Current or history of PID or STIs such as HIV/AIDS
- Schistosomiasis
- Tuberculosis
- Malaria
- History of gestational diabetes
- Any thyroid disorder
- Chronic or carrier viral hepatitis
- Mild liver cirrhosis
- Thalassemia or iron-deficiency anemia
- Current use of nucleoside reverse transcriptase inhibitors, broad-spectrum antibiotics, antifungal, or antiparasitics

Category 2: Generally use the method but with more than the usual follow-up.

- Women more than 40 years old
- Breastfeeding women, more than six months after childbirth
- Non-breastfeeding women, 21 to 42 days postpartum
- Women who smoke and are less than 35 years old
- Women who smoke less than 15 cigarettes/day and are more than 35 years old
- Body mass index of more than or equal to 30 kg/m²
- History of high blood pressure during pregnancy
- Family history of DVT/PE
- Major surgery WITHOUT prolonged immobilization
- Superficial thrombophlebitis
- Known hyperlipidemia
- Uncomplicated valvular heart disease
- Systemic lupus erythematosus with negative antiphospholipid antibodies
- Continued use in women with non-migrainous headache
- Initiation of method in women with migraine, without aura, aged less than 35 years
- Unexplained vaginal bleeding prior to evaluation
- Women diagnosed with cervical intraepithelial neoplasia or cervical cancer prior to treatment
- Undiagnosed breast mass
- Diabetes, without vascular disease
- Asymptomatic or symptomatic gall bladder disease treated with cholecystectomy
- Symptomatic gall bladder disease
- History of COC or pregnancy-related cholestasis
- Benign liver tumors such as focal nodular hyperplasia
- Sickle cell disease
- Current use of non-nucleoside reverse transcriptase inhibitors, some anticonvulsant therapies, or rifampicin/rifabutin therapy

WHO CANNOT USE CICs?

The medical conditions classified under MEC 3 and MEC 4 for CHCs and CICs are almost the same. However, for certain conditions such as those enumerated below, MEC for CICs differ:

- Smoking > 15 cigarettes/ day (MEC 3)
- Rifampicin or rifabutin therapy (MEC 2)

Category 3: Do not use the method unless no other appropriate method is available under close supervision.

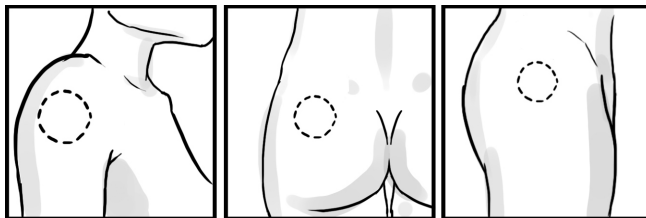
- Breastfeeding women, six weeks to six months after childbirth
- Non-breastfeeding women, less than 21 days postpartum, without other risk factors for VTE
- Women who smoke more than 15 cigarettes/day, aged more than 35 years
- Multiple risk factors for arterial cardiovascular disease such as older age, smoking, diabetes, and hypertension
- History of hypertension, in which blood pressure CANNOT be evaluated
- Adequately controlled hypertension, in which blood pressure CAN be evaluated
- Have increased blood pressure (systolic of 140 mm Hg to 159 mm Hg or diastolic of 90 mm Hg to 99 mm Hg)
- Initiation of method in women with migraine, without aura, aged more than 35 years
- History of breast cancer with no evidence of disease in the last 5 years
- Diabetes with nephropathy, retinopathy, neuropathy, or other vascular diseases
- Severe liver cirrhosis
- Benign liver tumors such hepatocellular adenoma and hepatoma
- Initiation of method in women with acute or flare viral hepatitis
- Current use of ritonavir-boosted protease inhibitors and lamotrigine

Category 4: Do NOT use the method.

- Breastfeeding women, less than six months after childbirth
- Have high blood pressure (systolic of more than or equal to 160 mm Hg or diastolic of more than or equal to 100 mm Hg)
- Hypertension with vascular disease
- History or currently diagnosed with DVT/PE on anticoagulant therapy
- Major surgery with prolonged immobilization
- Known thrombogenic mutations
- Current or history of ischemic heart disease or stroke
- Complicated valvular heart disease
- Women diagnosed with systemic lupus erythematosus and with positive (or unknown) antiphospholipid antibodies
- Migraine with aura at any age
- Diagnosed with breast cancer

HOW ARE CICs USED?

A woman using CICs must be injected with one vial of the drug monthly. The drug may be injected into the muscles of the upper arm, thigh, or buttocks. Infection prevention principles must be observed in giving the injection and disposing of the needles and syringes.



WHEN SHOULD USE OF CICs BEGIN?

- Any time as long as the client is not pregnant.
- Between day 1 and day 7 of the menstrual cycle, preferably on day 1.
- If the client is reasonably sure that she is not pregnant, she may start using CICs even after the first seven days of her menstrual cycle. However, she will need to abstain from sex or use a backup for the next seven days after the injection.
- Among postpartum women:
 - Later than six months for breastfeeding women because CICs may affect the quantity of breast milk;
 - At three to six weeks after childbirth for non-breastfeeding women.
- Immediately or within seven days for clients who just had an abortion.

WHEN CAN THE NEXT INJECTION BE PROVIDED?

The best time to provide the next injection is on the same date each month (a four-week schedule is practical). This information must be emphasized when counseling clients because it indicates the duration of drug effectiveness.



WHAT SHOULD BE DONE IF THE NEXT INJECTION IS DELAYED?

- Instruct the client to return to the clinic after 30 days for the next injection. She should comply with the scheduled date.
- If, for some reason, the next injection was not given after 30 days, the client should abstain from sexual intercourse or make her partner use a condom until she gets the next injection.
- Instruct the client to come back to the clinic regardless of how late the next injection is as long as she is reasonably certain that she is not pregnant.
- The grace period of CICs is seven days without the need for extra contraceptive protection.
- A client who comes in after seven days of the due date can have the injection provided that she is definitely not pregnant. She also needs to abstain from sex or use a backup contraceptive method for the next seven days.

WHAT ARE THE IMMEDIATE AND LASTING EFFECTS OF USING CICs?

- CICs may reduce menstrual flow and regulate menstrual pattern, thereby reducing the incidence of anemia and dysmenorrhea.
- The effects produced by COCs are presumably present in CIC users. However, CICs are relatively new; thus, epidemiologic data on their long-term effects are lacking.

WHAT ARE THE COMMON SIDE EFFECTS OF CIC USE?

- Vaginal bleeding/spotting.
 - Changes in bleeding patterns with CIC use are fewer than those with use of progestin-only injectables because of the estrogenic effect on cycle control.
 - Irregular bleeding may occur in 30% of women users during the first three months, but the majority of these women have normal cycles at the end of the first year.
 - Amenorrhea (absence of any bleeding) for at least three consecutive months is uncommon.
- Other side effects may include weight gain, dizziness, and mild headaches. These effects are not dangerous and are transitory.
- Certain drugs (rifampicin and most anticonvulsants) may reduce the effectiveness of CICs. Clients must inform their providers if they are taking any medications.



WHAT ARE THE POTENTIAL COMPLICATIONS AND ADVERSE SIDE EFFECTS OF CIC USE?

- The estrogens in CICs have a shorter life span and are less potent than those in COCs.
 - Consequently, the estrogen-related side effects associated with CIC use are assumed to be less than those associated with COCs.
- CICs have minimal effect on blood pressure, blood coagulation, lipid metabolism, and liver function (no first-pass effect) compared with COCs.
- Unlike the contraceptive hormone components of COCs, those of CICs remain in a woman's system for several weeks after discontinued use.
- However, the WHO MEC recommends the use of COCs and CICs for almost the same conditions.

WHAT ARE THE DRUG INTERACTIONS OF CICs?

- Drug interactions of CICs are the same as those of CHCs.
- The effectiveness of CICs is not affected by most broad-spectrum antibiotics.
- Similar to the effectiveness of other CHCs, that of CICs can be diminished by some medications:
 - Certain antimicrobials (rifampicin)
 - Certain anticonvulsants, such as phenytoin (Dilantin), carbamazepine, barbiturates (such as Phenobarbital), primidone, topiramate, and oxcarbazepine
 - Some ARVs, such as non-nucleoside reverse transcriptase inhibitors and ritonavir-boosted protease inhibitors. ARVs can increase or decrease the bioavailability of steroid hormones in CHCs; thus, consistent condom use must be recommended to prevent STI and HIV transmission and to compensate for any possible reduction in contraceptive effectiveness.

WHEN CAN A WOMAN SWITCH AND DISCONTINUE CICs?

- The client may switch any time without finishing her current cycle on CICs.
 - A woman who wants to prevent pregnancy but wants to stop CICs should consider starting another contraceptive method before discontinuing CICs.
 - A woman switching to a certain contraceptive method may need a backup method until the effectivity of the new method.

WHAT HAPPENS WHEN CLIENTS STOP USING CICs?

- The return to fertility after the client's last injection has no significant delay. More than 50% of women become pregnant within six months of discontinuing CICs and 80% within one year.
- Women who discontinue CICs are likely to experience temporary spotting or bleeding.



IS A REFERRAL NEEDED? HOW AND WHEN?

Only a few life-threatening complications can be attributed to CIC use. These complications can be reduced by the proper initial screening of the client.

The following signs and symptoms require medical attention:

- **J**aundice
- **A**bdominal pain (severe constant pain)
- **C**hest pain (severe constant pain) or shortness of breath
- **H**eadaches (intense pain that starts or becomes worse after every injection)
- **E**ye problems (brief loss of vision, seeing flashes of light or zigzag lines)
- **S**evere arm or leg pain (difficulty in moving)



When these symptoms occur, clients are instructed to return to the clinic or go directly to referral facilities.

HOW IS CIC SUPPLY MANAGED?

- Clients must be informed about where to go for reinjection or purchase of the CIC.
- Clients are advised to use the same preparation unless otherwise advised by the provider.

IS FOLLOW-UP NEEDED? HOW AND WHEN?

- Clients should be advised to return to the clinic a month after their first injection. Remind them to comply with the scheduled date of the next injection or to return no matter how late they are.
- Clients should return to the clinic at any time for any problems or questions that may arise.
- During the annual follow-up, a physical and pelvic examination may be performed as part of good medical practice. Cervical and breast cancer screening procedures are usually undertaken.

WHAT COUNSELING TIPS SHOULD BE PROVIDED TO THE CLIENT?

The following points must be emphasized:

- Timing of injection: when to receive the first injection and date of succeeding injections.
- Signs and symptoms that require consultation with a health provider.
- The fact that CHCs do not protect the client against STIs, including HIV, and that use of condoms is necessary.
- Smoking increases the risk of serious circulatory disorders. Women who intend to use CHCs should be advised to quit smoking.

CONTRACEPTIVE TRANSDERMAL PATCHES

WHAT ARE CONTRACEPTIVE TRANSDERMAL PATCHES?

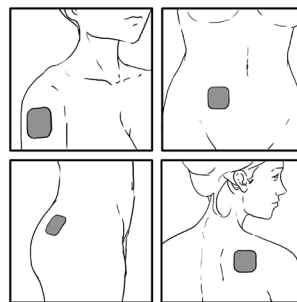
- These are medicated adhesive patches containing EE and norelgestromin. They are an alternative way of administering CHCs.
- The weekly application provides convenience. Its route of administration prevents food interactions and avoids the first-pass metabolism in the liver.
- These patches are as effective as COCs. However, the patch needs to be changed only once a week for three weeks, unlike the pill that must be taken at the same time every day.



Transdermal patches are commercially available in other countries as Ortho Evra and Evra. The 20 cm² Ortho Evra contraceptive patch contains 750 µg EE and 6000 µg norelgestromin. The 20 cm² Evra contraceptive patch contains 600 µg EE and 6000 µg norelgestromin. The contraceptive patch is intended to gradually release approximately 20 µg/day EE and 150 µg/day norelgestromin into the systemic circulation.

HOW IS THE CONTRACEPTIVE TRANSDERMAL PATCH USED?

- The patch may be applied to the buttock, abdomen, upper arm, or upper torso.
- The breast or areas surrounding the breast must be avoided because it might cause breast tenderness as a result of high local estrogen concentration.
- A different site must be used each time a new patch is applied.
- Patch sites must be free of lotions, creams, or other topical applications to prevent decreased absorption of the contraceptives.
- The patch is changed once a week for three weeks (total of 21 days), followed by a patch-free week.
- The patch should always be changed and applied on the same day of the week. If the client wants to switch to a new day for changing her patch, the switch should be made during the patch-free week.



WHEN SHOULD USE OF CONTRACEPTIVE TRANSDERMAL PATCH BEGIN?

- The patch is recommended to be applied on the first day of menstruation.
- Alternatively, women can start the patch any time as long as they are not pregnant.
- If the patch is initiated more than five days from the onset of menstruation, abstinence or backup contraception should be used during the first seven days of use.

WHAT SHOULD BE DONE WHEN PATCH CHANGE IS DELAYED?

Delay in beginning the first patch in a cycle:

- When a new patch cycle is delayed beyond the scheduled start day, users are instructed to apply a patch as soon as possible and to avoid intercourse or use backup contraception for at least seven days.
- The day the patient applies the new patch becomes the new “patch change day.”

Delay in beginning the second or third patch in a cycle:

- When the patch is left on for two extra days, adequate contraception steroid levels are continuously released for 48 hours. If the client changes the patch within this period, then “patch change day” remains the same without the need for backup contraception.
- After this two-day period, failure to replace the second or third patch in a cycle increases the risk for contraceptive failure. Therefore, the client must avoid sex or use backup contraception for seven days.
- The day the patient applies the new patch becomes the new “patch change day.”

Delay in removing the third patch in a cycle:

- The client must remove the patch as soon as possible.
- The “patch change day” is not altered.

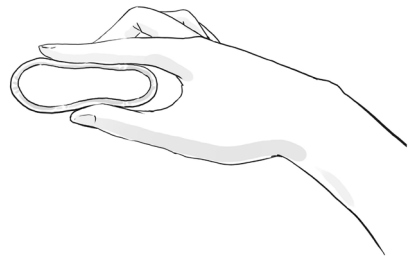
WHAT SHOULD BE DONE WHEN THE CONTRACEPTIVE TRANSDERMAL PATCH FALLS OFF?

- A patch that becomes partially or completely detached for less than 24 hours but is still adhesive enough should be reapplied on the same location.
- Additional adhesives or tape should not be used.
- A patch that is no longer adhesive should be immediately replaced with a new patch.
- If detached longer than 24 hours, a new patch should be applied, and this day of the week becomes the new “patch change day.”
- Users must avoid intercourse or use backup contraception for the first seven days.

CONTRACEPTIVE VAGINAL RINGS

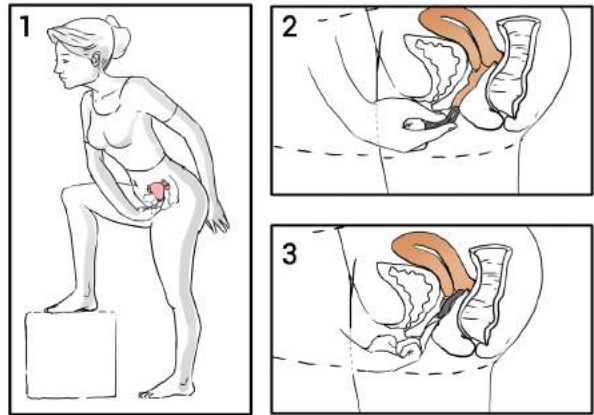
WHAT ARE CONTRACEPTIVE VAGINAL RINGS?

- This sustained-release delivery system comes in the form of a flexible plastic ring. It produces a consistent concentration of the circulating contraceptive hormones that prevent the daily fluctuations associated with the use of COCs.
- Similar to transdermal patches, vaginal rings have no food interactions and avoid the first-pass metabolism in the liver.
- The once-a-month application is convenient and effective for women who always forget to take the scheduled pill the same time every day.
- Users have reported good cycle control and acceptance.
- Approximately two-thirds of some 100 vaginal ring users, compared with fewer than half of some 100 COC users, reported expected bleeding patterns during all their cycles. Such good cycle control may be attributed to the correct use of the method or to the fact that the ring continuously releases hormones, thereby preventing the daily fluctuations in hormone levels during COC use.
- No randomized controlled trials have been conducted to compare NuvaRing with COCs. Large non-randomized trials suggest that the efficacy and side effects of NuvaRing are comparable to those of COCs. Vaginitis, vaginal discharge, and vaginal irritation are more common in NuvaRing users than in COC users.
- Commercially available in other countries as NuvaRing, the ring delivers 120 µg etonogestrel and 15 µg EE each day of use.
- Like Evra patch users, NuvaRing users may have higher compliance rates than COC users (92% versus 75% in one group of comparative studies).



HOW IS THE CONTRACEPTIVE VAGINAL RING USED?

- Once the ring is inserted, it is left in place for three weeks in a row.
- After three full weeks, the ring is removed, followed by a “ring-free” week before a new ring is inserted for the next cycle.
- Menstruation/withdrawal bleeding usually comes two to three days after the ring is removed.



WHEN SHOULD USE OF CONTRACEPTIVE VAGINAL RING BEGIN?

- The ring may be inserted within the first five days after the start of menstruation.
- If the vaginal ring is inserted later than five days after the start of the period, the client should avoid sex or use another contraceptive during the first week of ring use.

WHAT SHOULD BE DONE WHEN THE CONTRACEPTIVE VAGINAL RING FALLS OUT?

- Wash the ring with lukewarm or cool water (DO NOT use hot water), and put it back in as soon as possible.
- Use a backup contraceptive for seven days if the ring is out of the vagina for more than three hours.

WHAT SHOULD BE DONE WHEN THE CONTRACEPTIVE VAGINAL RING IS LEFT IN PLACE LONGER THAN REQUIRED?

Up to four weeks after insertion:

- The ring must be removed from the vagina as soon as possible, followed by a ring-free week.
- A new ring is then inserted after the ring-free week if contraception is still desired.

More than four weeks after insertion:

- The ring must be removed from the vagina as soon as possible.
- A new ring is then immediately inserted, after which sex should be avoided or a backup method should be used for seven days.



Chapter 5

PROGESTIN-ONLY CONTRACEPTIVES:

Pills, Injectables, and Implants

Progestin-only contraceptives contain only the hormone progestin, like the natural hormone progesterone in a woman's body. Examples of such contraceptives include Progestin-only pills (POPs), progestin-only injectables, and subdermal implants.

PROGESTIN-ONLY PILLS

WHAT ARE PROGESTIN-ONLY PILLS?

POPs are oral hormonal contraceptives containing only progestins at low doses. Only two kinds of POPs are available in the Philippines:

- o 0.5 mg lynestrenol (e.g., Exluton, Daphne)
- o 75 µg desogestrel (e.g., Cerazette)

Both are available in 28-tablet packets.



HOW EFFECTIVE ARE POPs?

- For breastfeeding women, POPs are 99.5% effective with perfect use and 99% effective with typical use. These effectiveness rates are lower for women who are not breastfeeding.
- POPs must be taken at the same time every day. When taken even a few hours late, these pills will be less effective.

HOW DO POPs WORK?

- POPs prevent ovulation in 50% of cycles in lynestrenol preparation and 97% of cycles in desogestrel preparation. Suppression of ovulation is more common in older women and those who are breastfeeding. This process takes effect after at least seven days of regular pill intake.
- POPs mainly thicken the cervical mucus and impair the entry of sperm into the uterus. These changes are effective 48 hours after beginning the pill.

WHAT ARE THE ADVANTAGES OF USING POPs?

- Can be used by breastfeeding mothers six weeks after childbirth without affecting the quality and quantity of breast milk
- No estrogen side effects
- Promotes compliance in pill taking, as women take one pill every day with no break, and instructions are easily understandable
- Can be very effective during breastfeeding
- May help prevent benign breast disease, endometrial and ovarian cancer, and pelvic inflammatory disease

WHAT ARE THE DISADVANTAGES OF USING POPs?

- May induce changes in menstrual bleeding among women who are not breastfeeding (e.g., irregular periods, spotting or bleeding between periods [common], and amenorrhea possibly for several months [less common]) and prolongs or causes heavy menstrual bleeding in other women
- May cause headaches and breast tenderness (less common)
- Must be taken at approximately the same time each day to be effective, as taking a pill more than three hours late increases the risk of pregnancy for women who are not breastfeeding, and missing two or more pills increases the risk significantly
- Offers no protection against STIs such as HIV/AIDS
- Effectiveness may be reduced when certain drugs, such as the following, are taken:
 - Carbamazepines, oxcarbazepine, primidone, topiramate, modafinil, phenytoin, and barbiturates for epilepsy
 - Rifampicin for tuberculosis
 - Medicated charcoal for stomach upset
 - Ritonavir and ritonavir-boosted protease inhibitors (antiretroviral)

WHO CAN USE POPs?

The WHO MEC screening checklist for POPs (Table 9) should be used to determine the eligibility/suitability of the method to the client.

Table 9. MEC categories for POPs

Category 1: Use the method without restriction.

- | | |
|--|--|
| • Women of reproductive age | • Depressive disorders |
| • Women who may or may not have given birth | • Diagnosed with benign ovarian tumor, endometriosis, severe dysmenorrhea |
| • Breastfeeding women, more than six weeks after childbirth | • Women with gestational trophoblastic disease, endometrial cancer, or ovarian cancer |
| • Any time for non-breastfeeding postpartum women | • Cervical ectropion, cervical intraepithelial neoplasia, or cervical cancer prior to treatment |
| • Any time post-abortion | • Benign breast disease, or family history of cancer |
| • History of pelvic surgery | • Among women with uterine anatomical abnormalities (e.g., fibroids) |
| • Women who smoke at any age | • Current or history of PID or STIs such as HIV/AIDS |
| • Body mass index of more than or equal to 30 kg/m ² | • Schistosomiasis |
| • Adequately controlled hypertension, in which blood pressure CAN be evaluated | • Increased blood pressure (systolic of 140 mm Hg to 159 mm Hg or diastolic of 90 mm Hg to 99 mm Hg) |
| • Tuberculosis | • Malaria |
| • Epilepsy | • History of gestational diabetes |
| • Family history of DVT/PE | • Any thyroid disorder |
| • Surgery WITHOUT immobilization | • History of pregnancy-related cholestasis |
| • Superficial venous thrombosis | • Any classification of viral hepatitis |
| • Any type of valvular heart disease | • Mild liver cirrhosis |
| • Non-migrainous headache | • Anemias such as thalassemia, sickle cell disease, or iron-deficiency anemia |
| • Initiation of method in women with migraine, without aura | • History of high blood pressure during pregnancy |
| • Current use of nucleoside reverse transcriptase inhibitors, lamotrigine, broad-spectrum antibiotics, antifungal, or antiparasitics | |

Category 2: Generally use the method but with more than the usual follow-up.

- Past ectopic pregnancy
- Multiple risk factors for arterial cardiovascular disease such as older age, smoking, diabetes, and hypertension
- History of hypertension, in which blood pressure CANNOT be evaluated
- Have high blood pressure (systolic of more than or equal to 160 mm Hg or diastolic of more than or equal to 100 mm Hg)
- Hypertension with vascular disease
- History or currently diagnosed with DVT/PE on anticoagulant therapy
- Major surgery with prolonged immobilization
- Known thrombogenic mutations
- Initiation of method in women with current and history of ischemic heart disease or stroke
- Known hyperlipidemia
- Systemic lupus erythematosus with negative antiphospholipid antibodies
- Migraine with aura at any age
- Women with irregular vaginal bleeding patterns
- Unexplained vaginal bleeding prior to evaluation
- Undiagnosed breast mass
- Diabetes with or without vascular disease
- Any gallbladder disease
- History of COC-related cholestasis
- Benign liver tumors such as focal nodular hyperplasia
- Current use of non-nucleoside reverse transcriptase inhibitors

For the MEC screening checklist and a complete classification of medical conditions, see the *Medical Eligibility Criteria* in Appendix E.

WHO CANNOT USE POPs?

According to the WHO MEC, clients with the following characteristics and conditions cannot use the method:

Category 3: Do not use the method unless no other appropriate method is available under close supervision.

- Breastfeeding women, less than six weeks after childbirth
- Acute DVT/PE
- Continued use in women with current or history of ischemic heart disease or stroke
- Systemic lupus erythematosus with positive antiphospholipid antibodies
- History of breast cancer with no evidence of disease in the last five years
- Severe liver cirrhosis
- Liver tumors such as hepatocellular adenoma or malignant hepatoma
- Current use of ritonavir-boosted protease inhibitors, anticonvulsant therapies, or rifampicin/rifabutin therapy

Category 4: Do NOT use the method.

- Diagnosed with breast cancer

WHAT ARE THE IMMEDIATE AND LASTING EFFECTS OF POP USE?

- Amenorrhea (no monthly bleeding)
 - Reassure the client that this condition is normal for breastfeeding women and is not harmful.
 - For non-breastfeeding clients, reassure them that some women using POPs stop having monthly bleeding, which is not harmful and does not indicate infertility. Blood need not be lost monthly, and the woman is not infertile.
- Breakthrough (irregular) bleeding (bleeding at unexpected times that bothers the client)
 - Reassure the client that many women using POPs experience irregular bleeding whether breastfeeding or not. This condition is not harmful and becomes less frequent or stops after several months of use. Other possible causes of breakthrough bleeding include vomiting or diarrhea and taking of anticonvulsants or rifampicin.

- Headaches
 - Suggest pain relievers (paracetamol, aspirin, ibuprofen).
 - If headache worsens or occurs often during POP use, the client should be evaluated.
- Breast tenderness
- Nausea or dizziness: suggest taking POPs at bedtime or with food.
- No known lasting/serious side effects of POP use have been reported.

HOW ARE POPs USED?

The POP screening checklist (Appendix E) should be used to determine the eligibility/suitability of the method to the client.

Starting POPs

For clients who are menstruating

- Ideally, the client should start the first pill within the first five days of the menstrual period (preferably on the first day). A backup method is not necessary.
- The client can also start at any time as long as she is reasonably certain that she is not pregnant. If the client is unsure, provide her with POPs now, but instruct her to start taking them on the first day of her next menstrual cycle.
- If the POPs are started after the first five days of the menstrual cycle, the client should use a backup method for the next two days.

For amenorrheic clients (no monthly bleeding)

- The client can start POPs at any time as long as she is reasonably certain that she is not pregnant.
- The client will need to abstain from sex or use a backup method for the next two days of taking pills.



For postpartum clients who are fully or nearly fully breastfeeding

- ***Less than six months after giving birth***
 - Clients may be given a supply of POPs but should be instructed to start only after six weeks of giving birth.
 - If menstrual bleeding has not returned, the client can start POPs any time between six weeks and six months. A backup method is not necessary.
 - If menstrual bleeding has returned, the client should take POPs within the first five days of the menstrual cycle. If POPs are taken after this period, the client should use a backup method for the next two days of taking pills.
- ***More than six months after giving birth***
 - If menses have not returned, the client can start POPs at any time as long as she is reasonably certain that she is not pregnant. However, a backup method should be used for the first two days of taking pills. If unsure, POPs may be taken but only during the client's next monthly bleeding.

For postpartum clients who are partially breastfeeding

- ***Less than six weeks after giving birth***
 - Clients may be given a supply of POPs but should be instructed to start only after six weeks of giving birth.
- ***More than six weeks after giving birth***
 - If menses have not returned, the client can start POPs at any time as long as she is reasonably certain that she is not pregnant. However, a backup method should be used for the first two days after starting the pills. If unsure, POPs may be taken but only during the client's next menses.
 - If menstrual bleeding has returned, the client should take POPs within the first five days of the menstrual cycle. If POPs are taken after this period, the client should use a backup method for the next two days of taking pills.

For postpartum clients who are not breastfeeding

- *Less than four weeks after giving birth*
 - The client can start POPs immediately or at any time. A backup method is not necessary.
- *More than four weeks after giving birth*
 - If menses have not returned, the client can start POPs at any time as long as she is reasonably certain that she is not pregnant. A backup method should be used for the first two days after starting the pills. If unsure of pregnancy, POPs may be taken but only during the client's next menses.
 - If menstrual bleeding has returned, the client should take POPs within the first five days of the menstrual cycle. If POPs are taken after this period, the client should use a backup method for the next two days of taking pills.

For clients switching from another hormonal method

- The client can start POPs immediately if she has been using another hormonal method consistently and correctly or if she is reasonably certain that she is not pregnant.
- If the client previously used an injectable contraceptive, she should start POPs when the repeat injection would have been given.

For clients switching from a non-hormonal method (other than intrauterine device [IUD])

- The client can begin using POPs within five days after the start of her menstrual bleeding. No additional contraceptive is needed.
- The client can also start POPs at any time if she is reasonably certain that she is not pregnant. However, she must abstain from sex or use a backup contraceptive for the first two days if more than five days have passed since the start of her menstrual bleeding.

For clients switching from an IUD (including a hormone-releasing IUD)

- The client can start POPs within the first five days of her menstrual cycle. No need for a backup method. The IUD can be removed upon taking the POPs.
- If the client starts taking POPs after the first five days of her menstrual cycle and she has been sexually active, do not remove the IUD until her next monthly bleeding.
- If the client starts taking POPs after the first five days of her current menstrual cycle and she has NOT been sexually active, the IUD can stay in place and be removed during her next menstrual cycle; or the IUD can be removed, and she can use a backup method for the next two days.

Taking the POP

- The client should take one pill every day at the same time until the packet is finished; she should start a new packet the day after she finishes the previous packet.



Managing missed pills

- Remember to emphasize the importance of not forgetting any pill, even for just a few hours.
- Advise the client that if she missed one or more pills, she may have spotting or breakthrough bleeding, and her risk of becoming pregnant increases.
- The client needs to resume taking the pills as soon as possible.
- If the client missed taking a lynestrenol-containing POP by more than three hours or a desogestrel-containing POP by more than 12 hours, she must abstain from sexual intercourse or use a barrier method of contraception during the first 48 hours after restarting the pills.
- If the client is breastfeeding and amenorrheic and missed one or more pills by more than three hours, she must take one pill as soon as possible and continue to take the pills as usual. If more than six months postpartum, use a backup method for the next two days.

- o Remind the client to keep track of her periods while taking POP. If she fails to have her menses for more than 45 days, she should see her healthcare provider for an examination and a pregnancy test.
- o If the client experiences spotting or bleeding between periods, she should continue taking the pills on schedule. If bleeding is very heavy or is accompanied by pain, fever, or cramps, she should return to the clinic. In most cases, the bleeding is not serious and will stop in a few days. Bleeding is especially likely if she missed a pill. Bleeding is common in the first few months of taking pills.

WHAT ARE THE POTENTIAL COMPLICATIONS AND ADVERSE EFFECTS OF POPs?

“Ovarian cysts” or follicles that continue to grow beyond the usual size in a normal menstrual cycle are common among POP users. These cysts may cause some abdominal pain but rarely require treatment.

WHAT HAPPENS WHEN A CLIENT STOPS USING POPs?

Return of fertility is immediate when the client stops or is more than three hours late in taking the POPs.

WHEN SHOULD CLIENTS SEE A SERVICE PROVIDER?

Serious complications are rare with POPs. However, the client must return to the clinic if she has any questions or if any of the following arises (may or may not be caused by POPs):

- Prolonged and/or heavy bleeding (twice as long or more than usual for the client)
- Headaches that start or worsen after starting POPs
- Yellowish discoloration of the skin
- Symptoms of pregnancy (i.e., missed period after several regular cycles), especially if she has signs of ectopic pregnancy, including abdominal pain or tenderness and faintness

WHAT COUNSELING TIPS SHOULD BE OFFERED TO THE CLIENT?

- In general, the effectiveness of POPs is slightly lower than that of COCs, particularly when a pill is missed.
- Side effects, such as breakthrough bleeding and amenorrhea, are common with POPs.
- If the woman is breastfeeding and is concerned about transmitting the hormone in her milk, explain that no evidence suggests that the amount of hormone negatively affects the baby.
- Instructions to clients, such as when to start, what to do with missed pills, and need for follow-up/return visits, should be emphasized.

WHAT ARE THE FACTS ABOUT POPs?

Contrary to popular beliefs,

- POPs do not affect milk production.
- POPs do not cause birth defects and will not harm the fetus if a woman becomes pregnant while taking POP or accidentally takes POP when she is already pregnant.
- women who stop using POPs can become pregnant as quickly as women who stop non-hormonal methods.
- POPs do not cause cancer.
- POPs neither affect a woman's sexual behavior nor cause mood changes.
- POPs reduce the risk of ectopic pregnancy.



PROGESTIN-ONLY INJECTABLES

WHAT ARE PROGESTIN-ONLY INJECTABLES (POIs)?

- POI contraceptives contain the synthetic hormone progestin and are administered via deep intramuscular (IM) injection.
- These contraceptives are available in the Philippines in the following preparations:
 - 1 mL of 150 mg depot medroxyprogesterone acetate (DMPA; Depo-Provera)
 - 3 mL of 150 mg DMPA (Depo-Trust)
 - 1 mL ampoule of 200 mg norethisterone enanthate (NET-EN; Noristerat)
- DMPA is given every three months, whereas NET-EN is given every two months.



Another preparation is *DMPA SQ (Uniject)*, which contains only 104 mg of progestin (30% less than that in the regular DMPA). It is available only in the US and the UK. This preparation is given subcutaneously every three months and has similar contraceptive effectiveness but with fewer side effects, such as weight gain.



HOW EFFECTIVE ARE POIs?

- POIs are 99.7% effective with perfect use and 97.0% effective with typical use, which means about three pregnancies for every 100 women who use the method during the first year. This number is reduced to less than one pregnancy per 100 users with continued use.
- The effectiveness of injectables depends on whether the client returns on time for the re-injection. The risk of pregnancy increases when the interval between injections increases or when an injection is actually missed.

HOW DO POIs WORK?

- POIs suppress ovulation. After a 150 mg injection of DMPA, ovulation does not occur for at least 14 weeks. Levels of the follicle stimulating hormone (FSH) and luteinizing hormone (LH) are reduced, and an LH surge does not occur.

- POIs thicken the cervical mucus and impair the entry of sperm into the uterus.

WHAT ARE THE ADVANTAGES OF USING POIs?

- Long-acting and reversible
- No need for daily intake
- Does not interfere with sexual intercourse
- Perceived as culturally acceptable by some women
- May be self-administered and may not always be facility/clinic-based
- Involves neither estrogen-related side effects, such as nausea and dizziness, nor serious complications, such as thrombophlebitis or pulmonary embolism
- Does not affect quantity and quality of breast milk
- Provides beneficial non-contraceptive effects:
 - Helps prevent iron-deficiency anemia because of scanty menses and the consequent amenorrhea
 - Does not affect anti-epileptic drug levels, particularly lamotrigine
 - Reduces the risk of ectopic pregnancies
 - Prevents endometrial cancer, uterine fibroids, and symptomatic pelvic inflammatory disease
 - Reduces sickle cell crises among women with sickle cell anemia
 - Reduces symptoms of endometriosis (pelvic pain and irregular bleeding)

WHAT ARE THE DISADVANTAGES OF USING POIs?

- Delays return to fertility by an average of 10 months from the last injection.
- Requires an injection every two or three months
- Does not protect against STIs such as HIV/AIDS
- Results in menstrual irregularity during the first few months of use
- Amenorrhea, which causes some women to become anxious about not having menses
- Impossible to discontinue immediately (only until DMPA is cleared from the body)
- Possible bone loss for long-term users, although a study has shown potential reversibility

WHO CAN USE POIs?

Most women of any reproductive age or parity can generally use POIs safely and effectively.

Table 10. MEC categories for POIs

Category 1: Use the method without restriction.

- Women aged 18 to 45 years old
- Women who may or may not have given birth
- Breastfeeding women, more than six weeks after childbirth
- Any time for non-breastfeeding postpartum women
- Any time post-abortion
- Past ectopic pregnancy
- History of pelvic surgery
- Women who smoke at any age
- Body mass index of more than or equal to 30 kg/m² and more than 18 years old
- Malaria
- History of high blood pressure during pregnancy
- Family history of DVT/PE
- Surgery WITHOUT immobilization
- Superficial venous thrombosis
- Any type of valvular heart disease
- Epilepsy
- Depressive disorders
- Current use of non-nucleoside reverse transcriptase inhibitors, nucleoside reverse transcriptase inhibitors, ritonavir-boosted protease inhibitors, certain anticonvulsants, rifampicin or rifabutin therapy (for DMPA only)
- Diagnosed with benign ovarian tumor, endometriosis, severe dysmenorrhea
- Women with gestational trophoblastic disease, endometrial cancer, or ovarian cancer
- Among women with uterine anatomical abnormalities (e.g., fibroids)
- Benign breast disease, or family history of cancer
- Cervical ectropion
- Current or history of PID or STIs such as HIV/AIDS
- Schistosomiasis
- Tuberculosis
- Women with body mass index of more than or equal to 30 kg/m² and who are less than 18 years old (for NET-EN only)
- History of gestational diabetes
- Any thyroid disorder
- History of pregnancy-related cholestasis
- Any classification of viral hepatitis
- Mild liver cirrhosis
- Anemias such as thalassemia, sickle cell disease, or iron-deficiency anemia
- Non-migrainous headache
- Current use of lamotrigine, broad-spectrum antibiotics, antifungal, or antiparasitics

Category 2: Generally use the method but with more than the usual follow-up.

- Menarche to 18 years old
- Women more than 45 years old
- Women with body mass index of more than or equal to 30 kg/m², and less than 18 years old (for DMPA only)
- History of hypertension, in which blood pressure CANNOT be evaluated
- Adequately controlled hypertension, in which blood pressure CAN be evaluated
- Have increased blood pressure (systolic of 140 mm Hg to 159 mm Hg or diastolic of 90 mm Hg to 99 mm Hg)
- History or currently diagnosed with DVT/PE on anticoagulant therapy
- Major surgery with prolonged immobilization
- Known thrombogenic mutations
- Known hyperlipidemia
- Systemic lupus erythematosus on immunosuppressive treatment
- Migraine with or without aura
- Women with irregular vaginal bleeding patterns
- Diagnosed with cervical intraepithelial neoplasia or cervical cancer prior to treatment
- Undiagnosed breast mass
- Diabetes with non-vascular disease
- Any gallbladder disease
- History of COC-related cholestasis
- Benign liver tumors such as focal nodular hyperplasia
- Current use of non-nucleoside reverse transcriptase inhibitors and ritonavir-boosted protease inhibitors, certain anticonvulsants, rifampicin or rifabutin therapy (for NET-EN only)

WHO CANNOT USE POIs?

According to the WHO MEC, clients with the following characteristics and conditions cannot use the method:

Category 3: Do not use the method unless no other appropriate method is available and with close supervision.

- Breastfeeding women, less than six weeks after childbirth
- Multiple risk factors for arterial cardiovascular disease such as old age, smoking, diabetes, and hypertension
- Have high blood pressure (systolic of more than or equal to 160 mm Hg or diastolic of more than or equal to 100 mm Hg)
- Hypertension with vascular disease
- Acute DVT/PE
- Current or history of ischemic heart disease or stroke
- History of breast cancer with no evidence of disease in the last five years
- Unexplained vaginal bleeding prior to evaluation
- Initiation of method in women with systemic lupus erythematosus (with positive antiphospholipid antibodies and severe thrombocytopenia)
- Diabetes with nephropathy, retinopathy, neuropathy, or other vascular diseases
- Severe liver cirrhosis
- Liver tumors such as hepatocellular adenoma or malignant hepatoma

Category 4: Do NOT use the method.

- Diagnosed with breast cancer

ARE POIs SAFE TO USE?

- POIs are very safe. Similar to other progestin-only contraceptives, POIs can be used by women who want a highly effective contraceptive, including those who are breastfeeding or who are not eligible to use estrogen-containing low-dose combined oral contraceptives (COCs).
- There is no known harm to the fetus if DMPA is given during pregnancy.
- Extensive studies by the WHO emphasize that DMPA presents no overall risks for cancer, congenital malformations, or infertility. Research has revealed the following:
 - Similar to COCs, DMPA exerts a strong protective effect against endometrial cancer.
 - The use of DMPA does not increase the risk of breast cancer.
 - No relationships exist between ovarian cancer and the use of DMPA.
 - DMPA does not increase the risk of liver cancer in areas where hepatitis is endemic.

WHAT ARE THE POSSIBLE SIDE EFFECTS OF POIs?

- The following changes in menstrual bleeding patterns are possible:
 - Amenorrhea
 - Menstrual irregularity: breakthrough bleeding and spotting, which are common
- On very rare occasions, allergic reactions occur immediately following an injection.

WHAT ARE THE MODES OF ADMINISTRATION OF POIs?

POIs are best administered using autodisable (AD) syringes or disposable syringes and needles when available using the following dosing schemes:

- One dose of DMPA (150 mg) by deep IM injection given every 12 weeks
- One dose of NET-EN (200 mg) by deep IM injection given every eight weeks



Disposable syringes and needles should not be reused. Sharps disposal containers improve injection safety for clients, healthcare workers, and communities by reducing the reuse of needles and by preventing needle stick injuries. Place AD and disposable syringes and needles in puncture-proof containers.



HOW IS DMPA ADMINISTERED?

1. Wash hands thoroughly with soap and water and then dry.
2. Check vial for contents/dosage and the expiration date. If contents are less than the indicated volume, do not use the vial.
3. Gently shake the vial (vigorous shaking will make the solution foamy). Remove the metal cover from the vial without touching the rubber stopper. Failure to mix the solution will cause some of the drug to remain as sediment in the vial, resulting in an inadequate dose and, possibly, lower contraceptive effectiveness.
4. Swab the skin at the injection site with alcohol or other antiseptics to remove any visible dirt. Allow the antiseptic to dry before the injection.
5. Put the vial in a flat surface and slightly tilt the vial, or hold the vial upside down at eye level while aspirating the solution. Doing so ensures that the solution is completely aspirated from the vial.
6. Slowly aspirate the contents of the vial. Make sure that none is spilled as air is expelled from the syringe. Use a 2 mL to 5 mL disposable syringe with a 21–23 gauge needle, 1–1.5 inches in length.
7. Inject the contents of the syringe deep into the upper outer arm (deltoid muscle) or into the upper outer quadrant of the buttocks (gluteal muscle) to prevent hitting the sciatic nerve.

8. Do not massage the injection site. Instruct the client not to massage or rub the site, as this can cause the DMPA to be absorbed fast.
9. Dispose used assembled needle and syringe in puncture-proof sharps containers.
10. Wash and dry hands thoroughly.

WHEN SHOULD POI USE BEGIN?

For interval clients

- Any time that the client is reasonably certain that she is not pregnant.
- Within the first seven days of the menstrual cycle, the client needs no backup method.
- After seven days of the menstrual cycle, advise the client to use a backup method or to exercise abstinence for the next seven days.

For breastfeeding clients

- As early as six weeks after delivery.
- If the client's menses have resumed, she can start injectables at any time as long as she is reasonably certain that she is not pregnant.
- *Fully or nearly fully breastfeeding*
 - Less than six months after giving birth
 - Delay her first injection until six weeks after giving birth.
 - If the client's monthly bleeding has not returned, she can start POIs at any time between six weeks and six months. A backup method is not necessary.
 - If the client's monthly bleeding has returned, she can start POIs as advised for women having menstrual cycles.
 - More than six months after giving birth
 - If the client's monthly bleeding has not returned, she can start POIs at any time as long as she is reasonably certain she is not pregnant. Instruct the client to use a backup method for the next seven days after the injection.
 - If the client's monthly bleeding has returned, she can start POIs as advised for women having menstrual cycles.



- *Partially breastfeeding*

- Less than six weeks after giving birth
 - Delay the client's first injection until at least six weeks after giving birth. However, if chances are strong that she cannot come back for the method at six weeks and she asks for an injectable, she may be given the first shot.
- More than six weeks after giving birth
 - If the client's monthly bleeding has not returned, she can start POIs at any time as long as she is reasonably certain that she is not pregnant. Instruct the client to use a backup method for the next seven days after the injection.
 - If the client's monthly bleeding has returned, she can start POIs as advised for women having menstrual cycles.

For postpartum women who are NOT breastfeeding

- Less than four weeks after giving birth
 - She can start injectables any time after giving birth. A backup method is not necessary.
- More than four weeks after giving birth
 - If the client's menses have not returned, she can start the injectable at any time as long as she is certain that she is not pregnant. Instruct the client to use a backup method for the first seven days after injection.
 - If the client's menses have returned, she can start the injectable within seven days of her menses without the need for a backup method. If more than seven days have passed since her menses, she can have the injection but will need to use a backup method for the first seven days after the injection.

For post-abortion clients

- May use immediately or within seven days after an abortion.
- If later than seven days, any time that she is reasonably certain that she is not pregnant. She should avoid sex or use condoms for the next seven days.

Clients switching from non-hormonal methods such as IUD

- The client can start POIs immediately.

Clients switching from a hormonal method

- The client can start POIs immediately if she has been using the hormonal method consistently and correctly or if she is reasonably certain that she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method.
- If the client is switching from another injectable, she can have POIs when the next injection would have been given. A backup method is not necessary.

IS FOLLOW-UP NEEDED? HOW AND WHEN?

The client is instructed to return to the clinic for re-injection every three months (12 weeks) for DMPA and every two months (8 weeks) for NET-EN.

Encourage the client to come back on time for her injections.

- DMPA can be administered four weeks early or late; NET-EN can be administered two weeks early or late.
- If the client is less than four weeks late for the next DMPA or less than two weeks late for the next NET-EN injection, she can receive the reinjection. No need for a backup method, and no need to assess for pregnancy, as the client is not likely to be pregnant.
- However, if she is more than four weeks late for the next DMPA injection or more than two weeks late for the next NET-EN injection, she has to be assessed for probability of pregnancy. If she is not likely to be pregnant, she can have her reinjection but should abstain from sex or use a backup method for seven days. She should be instructed to come on time for her scheduled injections; otherwise, her risk of pregnancy increases. If she is unable to adhere to the schedule, ask the client to consider shifting to another method.
- If pregnancy cannot be ascertained, perform a pregnancy test, or ask the client to abstain from sexual activity or use a backup method in the meantime and to return in one month. Pregnancy may be determined then. If the client is not pregnant, she may be given the next injection, and discuss the possibility of shifting to a convenient method for her.
- For any questions or problems, the client should be encouraged to visit the clinic.



WHAT ARE THE IMMEDIATE AND LASTING EFFECTS OF POI USE?

Aside from the long-term effective contraception provided by POIs, these contraceptives commonly cause breakthrough bleeding or spotting during the first months of use. These effects lessen or disappear with time.

Very heavy (twice as much as the usual menses) or prolonged (more than eight days) bleeding is rare but requires attention.

- When bleeding occurs, counsel the client that menstrual irregularities are common.
- Rule out other possible problems/causes.
- To control heavy or prolonged bleeding, COC pills may be given for one to three cycles until bleeding decreases.
 - Non-steroidal anti-inflammatory drugs, such as mefenamic acid (500 mg) or ibuprofen (800 mg), may also be prescribed; the client must be instructed to take one tablet two to three times daily for five days.
 - Tranexamic acid (1 g) may be also be given, along with instructions to take one capsule every six hours for five days.
- Another option is to administer the next injection early (four weeks after the first injection).
- Advise the client to take iron supplements or iron-rich food.
- If the problem persists, refer the client for gynecologic examination.
- Help the client choose another method if the problem is intolerable.

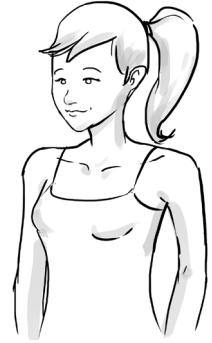
Another 50% of women using DMPA develop amenorrhea after a year of use. This condition is not harmful but occurs because of the effect of the drug on the endometrium.

- Counsel the client that amenorrhea is normal and does not indicate a problem. Assure her that this condition does not indicate pregnancy and that menstrual blood is not building up inside her.
- Explain that this situation can improve her health by preventing anemia.

Weight gain (average of 1 to 2 kg each year) may be experienced because of an increase in appetite. This is a common side effect and can be controlled by shifting to a low-calorie diet.

WHAT ARE THE POTENTIAL COMPLICATIONS OF USING POIs?

- A theoretical concern is that DMPA might affect bone development in women under 18 years. Whether DMPA prevents adolescents from reaching their potential peak bone mass remains unclear. Although DMPA decreases bone mass, reversal has been observed after discontinuation. The WHO concludes that the advantages of the method generally outweigh this theoretical disadvantage.
- A nine-year study by the WHO revealed that DMPA does not increase women's overall risk of breast cancer, invasive cervical cancer, liver cancer, or ovarian cancer. In their study, DMPA decreased the risk of endometrial cancer. Studies are still ongoing on whether DMPA might accelerate the development of pre-existing breast cancer. The WHO Collaborative Study did not find a significantly increased risk of breast or cervical cancer among DMPA users.
- There is no known harm to the fetus if DMPA is given during pregnancy.



WHAT HAPPENS WHEN CLIENTS STOP USING THE POI?

The average delay in return of fertility is 9 to 10 months for DMPA and 6 months for NET-EN from the last injection. This method does not affect fertility in the long term.

IS A REFERRAL NEEDED? HOW AND WHEN?

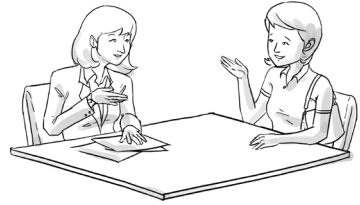
Clients should be instructed to report back to the clinic for any of the following warning signs:

- Recurring unbearable headaches
- Heavy bleeding
- Depression
- Severe lower abdominal pain, which may be a sign of pregnancy
- Pus, prolonged pain, or bleeding at injection site

COUNSELING TIPS

Counsel the client on the possibility of changes in menstrual bleeding patterns, which may include the following:

- Amenorrhea: Reassure the client that amenorrhea is an expected side effect and that she can expect menstrual cycles to return to normal within six months of discontinuing the POIs.
- Menstrual irregularity: Reassure the client that breakthrough bleeding and spotting are common.



Emphasize to the client the proper timing of the injection, that is, the time when the client receives the first injection and when the next injection is due, as well as how often she will receive the injections. Returning for injections regularly (every three months for DMPA) is imperative.

WHAT ARE FACTS ABOUT POIs?

Contrary to popular beliefs,

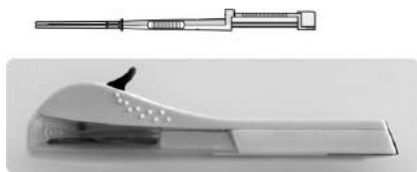
- POIs do not cause birth defects and will not harm the fetus if a woman becomes pregnant while using them or accidentally starts POIs when she is already pregnant.
 - POIs neither disrupt an existing pregnancy nor cause an abortion.
 - bleeding episodes should not be used as a guide for the injection schedule; rather, the injection should be given every three months for DMPA regardless of whether a woman has bleeding or not.
 - POIs are not used to regulate monthly periods, especially for those with irregular cycles.
 - women younger than 35 who smoke any number of cigarettes and women aged 35 years and older who smoke less than 15 cigarettes a day can safely use POIs.
 - POIs generally do not cause changes in a woman's mood or sexual drive.
 - POIs are safe for women with varicose veins. Women with DVT/PE should not use POIs.
 - POIs do not cause a woman to be infertile, but regaining fertility may be delayed after stopping the use of POIs; pregnancy usually becomes possible after around eight months.

SUBDERMAL IMPLANTS

WHAT ARE SUBDERMAL IMPLANTS?

Subdermal implants are progestin-only implants that are inserted under the skin of the inner upper arm of women through a preloaded applicator under local anesthesia. These implants release progestin at a controlled rate and thus provide very small doses to achieve the desired contraceptive effect.

Two preparations of subdermal implants are available:



Source: MSD Drug Sheet, 2012



- The single-rod system (Implanon) releases etonogestrel and has a life span of three years. This implant is 40 mm long with a 2 mm diameter and contains 68 mg of etonogestrel.
- The two-rod system (Jadelle) containing 75 mg of levonorgestrel is effective for up to five years. This implant is 43 mm long, with each rod consisting of a drug-releasing core.

HOW EFFECTIVE ARE SUBDERMAL IMPLANTS?

Subdermal implants are 99.9% effective with perfect use and 99.5% effective with typical use.

WHAT ARE THE ADVANTAGES OF USING SUBDERMAL IMPLANTS?

- Reversible, as fertility returns almost immediately after the rods are removed
- Does not require daily intake
- Does not interfere with intercourse
- Effective within 24 hours after insertion
- No estrogen-related side effects, such as nausea and dizziness
- Does not affect the quantity and quality of breast milk

- Has beneficial non-contraceptive effects:
 - Helps prevent iron-deficiency anemia
 - Makes sickle cell crises less frequent and less painful
 - Helps reduce risk of endometrial cancer
 - Reduces risk of ectopic pregnancies

WHAT ARE THE DISADVANTAGES OF USING THE SUBDERMAL IMPLANT?

- Clients cannot start or stop use on their own. Rods must be inserted and removed by a specially trained healthcare provider.
- Minor surgical procedure with local anesthesia is required to insert and to remove rods.
- Discomfort at the insertion site is common up to several days after insertion.
- Rods must be removed after a certain period.
- Initial cost is high.
- In very rare instances when pregnancy occurs, as many as one in every six pregnancies is ectopic.
- No protection is provided against STIs such as HIV/AIDS.
- Implants are more difficult to remove than to insert.

HOW DO SUBDERMAL IMPLANTS WORK?

- Suppresses ovulation through the action of the progestin
- Thickens cervical mucus, thus hindering sperms from passing through the cervical canal

WHO CAN USE SUBDERMAL IMPLANTS?

The Medical Eligibility Criteria (MEC) screening checklist for subdermal implants (Appendix E) should be used to determine the eligibility/suitability of the method to the client. Clients with the following characteristics and conditions can use the method:

Table 11. MEC Categories for subdermal implants

Category 1: Use the method without restriction.

- Women of reproductive age
- Women who may or may not have given birth
- Breastfeeding women, more than six weeks after childbirth
- Any time for non-breastfeeding postpartum women
- Any time post-abortion
- Past ectopic pregnancy
- History of pelvic surgery
- Women who smoke at any age
- Body mass index of more than or equal to 30 kg/m²
- Any thyroid disorder
- Non-migrainous headache
- History of high blood pressure during pregnancy
- Family history of DVT/PE
- Surgery WITHOUT immobilization
- Superficial venous thrombosis
- Diagnosed with benign ovarian tumor, endometriosis, severe dysmenorrhea
- Have increased blood pressure (systolic of 140 mm Hg to 159 mm Hg or diastolic of 90 mm Hg to 99 mm Hg)
- Current use of nucleoside reverse transcriptase inhibitors, lamotrigine, broad-spectrum antibiotics, antifungal, or antiparasitics
- Depressive disorders
- Any type of valvular heart disease
- Current or history of PID or STIs such as HIV/AIDS
- Benign breast disease, or family history of cancer
- Cervical ectropion
- Tuberculosis
- Epilepsy
- Schistosomiasis
- Among women with uterine anatomical abnormalities (e.g., fibroids)
- Malaria
- History of gestational diabetes
- Adequately controlled hypertension, in which blood pressure CAN be evaluated
- History of pregnancy-related cholestasis
- Any classification of viral hepatitis
- Mild liver cirrhosis
- Anemias such as thalassemia, sickle cell disease, or iron-deficiency anemia
- Women with gestational trophoblastic disease, endometrial cancer, or ovarian cancer

Category 2: Generally use the method but with more than the usual follow-up.

- Multiple risk factors for arterial cardiovascular disease such as old age, smoking, diabetes, and hypertension
- History of hypertension, in which blood pressure CANNOT be evaluated
- Have high blood pressure (systolic of more than or equal to 160 mm Hg or diastolic of more than or equal to 100 mm Hg)
- Hypertension with vascular disease
- History or currently diagnosed with DVT/PE on anticoagulant therapy
- Major surgery with prolonged immobilization
- Known thrombogenic mutations
- Initiation of method in women with current or history of ischemic heart disease or stroke
- Known hyperlipidemia
- Systemic lupus erythematosus with negative antiphospholipid antibodies
- Migraine with or without aura
- Women with irregular vaginal bleeding patterns
- Diagnosed with cervical intraepithelial neoplasia or cervical cancer prior to treatment
- Undiagnosed breast mass
- Diabetes with non-vascular or vascular disease
- Any gallbladder disease
- History of COC-related cholestasis
- Benign liver tumors such as focal nodular hyperplasia
- Current use of non-nucleoside reverse transcriptase inhibitors and ritonavir-boosted protease inhibitors, certain anticonvulsants, rifampicin or rifabutin therapy

WHO CANNOT USE THE METHOD?

Subdermal implants should not be used by women with the following conditions:

Category 3: Do not use the method unless no other appropriate method is available with close supervision.

- Breastfeeding women, less than 6 weeks after childbirth
- Acute DVT/PE
- Continued use in women with current or history of ischemic heart disease or stroke
- Systemic lupus erythematosus with positive antiphospholipid antibodies
- Unexplained vaginal bleeding prior to evaluation
- History of breast cancer with no evidence of disease in the last 5 years
- Severe liver cirrhosis
- Liver tumors such as hepatocellular adenoma or malignant hepatoma

Category 4: DO NOT use the method.

- Diagnosed with breast cancer

HOW IS THE SUBDERMAL IMPLANT USED?

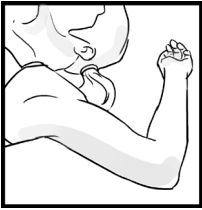
The illustrations below demonstrate the insertion of subdermal implants. Note that these illustrations* should in no manner replace formal training in inserting the implants.

Implant insertion

Inserting implants usually takes a few minutes or longer depending on the skill of the provider. The insertion of Implanon does not require an incision because it is specially made with an applicator similar to a syringe. Aseptic technique must be practiced.

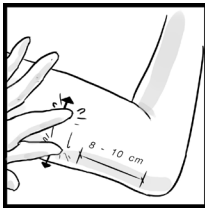
*INFO Project. Insertion and Removal of the New Implants. 2007. Johns Hopkins Bloomberg School of Public Health Merck, Sharpe and Dohme. 2013. Implanon: Reference Guide. MSD

Step 1



Have the woman lie on her back on the examination table with her non-dominant arm flexed at the elbow and externally rotated so that her wrist is parallel to her ear or her hand is positioned next to her head.

Step 2

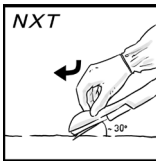


Mark the insertion site (8 cm to 10 cm from the medial epicondyle).

Anesthetize the insertion area (by injecting 2 mL of 1% lidocaine) just under the skin along the planned insertion tunnel.

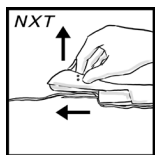
Stretch the skin around the insertion site with the thumb and index finger.

Step 3



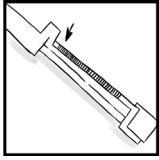
Insert only the tip of the cannula (needle) at 20° for the Classic Implanon and at about 30° for the new Implanon NXT.

Step 4



Lower the applicator to a horizontal position. While lifting the skin with the tip of the needle, slide the needle to its full length. Slight resistance is possible, but caution must be exerted in preventing use of excessive force. If the needle is not inserted to its full length, the implant will not be inserted properly.

Step 5 (for the Classic Implanon)



Break the seal of the applicator.

Turn the obturator (the rounded end of the applicator) at a 90° angle.



Fix the obturator with one hand against the arm. With the other hand, slowly draw the cannula (needle) out of the arm.

Step 5 (for Implanon NXT)



While keeping the applicator in the same position and with the needle inserted to its full length, unlock the purple slider by pushing it slightly down. Move the slider fully back until it stops, leaving the implant now in its final subdermal position and locking the needle inside the body of the applicator. If the slider is not completely moved to the back, the needle will not be fully retracted, and the implant will not be inserted properly. The applicator can now be removed.

Step 6



Always verify the presence of the implant in the woman's arm immediately after insertion by palpation. The presence of the 4 cm rod can be confirmed by palpating both ends of the implant.

Step 7

Apply a small adhesive bandage over the insertion site. Request that the client palpate the implant. Apply sterile gauze with a pressure bandage to minimize bruising. The client may remove the pressure bandage in 24 hours and the small bandage over the insertion site after three to five days.

Jadelle insertion

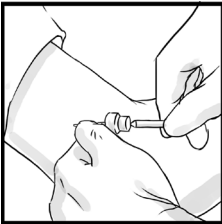
Step 1



Anesthetize the insertion area (by injecting 2 mL of 1% lidocaine). Make a small incision with a scalpel or trocar in the skin on the inside of the upper arm. Alternatively, use the trocar to puncture the skin. Insert the tip of the trocar beneath the skin at a shallow angle. Gently advance the trocar superficially under the skin (not shown).

Note that the trocar has three marks on it. The mark closest to the hub indicates how far the trocar should be introduced under the skin to place the Jadelle implants. The middle mark is not used. The mark closest to the tip indicates how much of the trocar should remain under the skin following placement of the first implant.

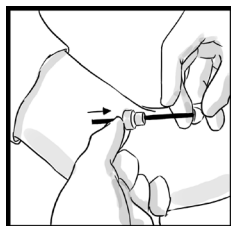
Step 2



When the trocar has been inserted to the mark closest to the hub, remove the obturator, and load the first implant into the trocar using the thumb and forefinger.

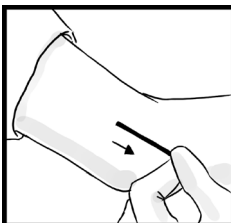
Using the obturator to push, gently advance the implant toward the tip of the trocar until resistance is felt. Never force the obturator.

Step 3



While holding the obturator stationary, withdraw the trocar to the mark closest to the trocar tip. The implant should be released under the skin at this point. The obturator must be kept stationary, and avoid pushing the implant into the tissue. Do not completely remove the trocar until both implants have been placed.

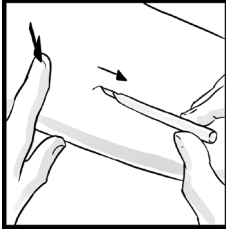
Step 4



To place the second implant, align the trocar so that the second implant will be positioned at about a 30° angle relative to the first implant. Repeat steps 3 and 4. The rods are placed in the shape of a “V” opening toward the shoulder. Leave a distance of approximately 5 mm between the incision and the tips of the implants. Remove the trocar.

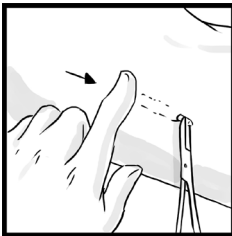
Implant removal

Step 1



Anesthetize the insertion area (by injecting 2 mL of 1% lidocaine). Using the scalpel, make an incision (4 mm for Jadelle and 2 mm for Implanon) close to the proximal ends of the implants (below the bottom of the V for Jadelle and below the single rod for Implanon). Do not make a large incision.

Step 2



Push each implant gently toward the incision with the finger. When the tip of the rod is visible, grasp it with the forceps, and gently pull out the rod with the forceps. Repeat procedure for the second implant (Jadelle).

WHEN SHOULD USE OF SUBDERMAL IMPLANTS BEGIN?

For interval clients

- Any time that the client is reasonably certain that she is not pregnant.
- Within the first seven days of the menstrual cycle, no backup method is needed.
- After the first seven days of the menstrual cycle, condoms should be used, or abstinence should be exercised for the next seven days.

Postpartum, breastfeeding

- As early as six weeks after delivery.
- If only partially breastfeeding, implant should be started at six weeks after childbirth.
- If menses have resumed, the client can start with the implant any time as long as she is reasonably certain that she is not pregnant.

Postpartum, NOT breastfeeding

- Immediately or at any time in the first six weeks after delivery. No need to wait for the client's menstrual period to return.
- After six weeks, implants may be used at any time as long as the client is reasonably certain that she is not pregnant. Otherwise, the client should avoid sex or use condoms until her first menstrual period.

Post-abortion clients

- Immediately or within seven days after an abortion.
- If more than seven days have passed since the abortion, the client may avail of the implants at any time as long as she is reasonably certain that she is not pregnant. She should avoid sex or use condoms for the next seven days.

The table below summarizes the periods when clients can have implants inserted with respect to their previous method.

Table 12. Recommended timing of insertion for women shifting to implants

Previous Method	Timing of Insertion
None or non-hormonal contraceptives	Days 1–5 of cycle
Combined oral contraceptives (COCs)	During hormone-free week
Progestin-only pill (POP)	Any time during treatment
Implanon/Intrauterine System (IUS)	Same day as removal
Progestin-only injectable	When the injection is due
After childbirth, not breastfeeding	Immediately
After childbirth, breastfeeding	Six weeks after childbirth

WHEN SHOULD FOLLOW-UP BE ADVISED?

No routine return visit is required (MEC Recommendation). However, request the client to visit the clinic for removal of the implants according to the manufacturer's recommendations and for any questions or problems that suggest pregnancy or any underlying medical condition. A follow-up visit is recommended for good medical practice. Ask clients to return one week after insertion and yearly thereafter to determine the status of the insertion and to address any complaints.

WHAT ARE THE IMMEDIATE AND LASTING EFFECTS OF USING SUBDERMAL IMPLANTS?

- Light spotting or bleeding between monthly periods is common. Reassure the client that this is normal and common among implant users, especially in the first three to six months. If these conditions are not tolerable, offer the following:
 - Any non-steroidal anti-inflammatory drug (NSAIDs; mefenamic acid or ibuprofen) except aspirin
 - One cycle of low-dose COCs if estrogen is not contraindicated for the client. A COC that has the same progestin in the implant, such as levonorgestrel, is preferable.
- Very heavy or prolonged bleeding may occur but is uncommon. Such bleeding often decreases after the first few months of use. Currently available therapies in stopping unscheduled bleeding in subdermal contraceptive implant users are shown in Table 13.
- Amenorrhea may occur, but counsel the client that
 - This condition is normal among implant users and is not harmful.
 - She is not pregnant.
 - Her body is not producing menstrual blood and that blood is not building up inside her.
 - This condition can help prevent anemia.
 - If the client still finds this unacceptable, remove the implants or refer for removal. Help her choose another method.
- Weight gain is common but can be remedied by dietary management (low-calorie diet). Explain to the client that other women using contraceptive implants lose weight.
- The insertion site might become infected.
- Some women may complain about enlargement of ovaries, or ovarian cysts. If the cysts are less than 5 cm, the implant can remain in place, but the client should be evaluated by a gynecologist. Reassure the client that these cysts usually disappear on their own and do not require surgery. To check if the problem persists, see the client again after three weeks.
- If the cysts are more than 5 cm, immediately refer the client to a gynecologist. Reassure the client that headaches are not serious and that NSAIDs can be provided.

Table 13. Currently available therapies for stopping bleeding among users of subdermal contraceptive implant

Therapy regimen	Supporting evidence
COC taken daily for 21 days followed by a seven-day break. Use for up to three months.	Little published evidence Anecdotally, appears to help in practice
High-dose cyclical progestogen for up to three months (medroxyprogesterone acetate 10 mg twice daily or norethisterone 5 mg twice daily for 21 days with a seven-day break)	No published evidence Anecdotally, appears to help in practice
POP, particularly a desogestrel POP, taken daily for up to three months	No published evidence Anecdotally, may work in some cases
NSAIDs, especially COX-2 inhibitors, taken daily for 5 to 10 days	Some published evidence Anecdotally, may work in practice
Tranexamic acid, 1 g every six hours for five to seven days	POGS Clinical Practice Guidelines on Abnormal Uterine Bleeding

WHAT ARE THE FACTS ABOUT SUBDERMAL IMPLANTS?

Contrary to popular beliefs,

- implants do not cause cancer. Instead, implants help prevent endometrial cancer.
- in case pregnancy occurs, one in every six pregnancies is ectopic.
- if not removed beyond the recommended period of use, implants no longer provide protection from pregnancy and are relatively inert.

WHAT HAPPENS WHEN THE METHOD IS STOPPED?

Fertility returns without undue delay.

IS A REFERRAL NEEDED? HOW AND WHEN?

The following warning signs and symptoms warrant immediate attention:

- Severe lower abdominal pain. Check for ovarian cysts or tumors, PID, appendicitis, or ectopic pregnancy.
- Severe headaches with blurred vision. Remove the implant, or refer the client to a specialist. Help the client choose a non-hormonal contraceptive.
- Pain after insertion of the rod. Check for signs of infection at the insertion site (pain, heat, and redness) or abscess (presence of pus).

Infection but without abscess

- Do not remove the implant.
- Clean the area with soap and water or an antiseptic.
- Give oral antibiotic for seven days, and ask the client to return after a week. If the condition does not improve, remove the implant, or refer the client to an appropriate specialist.

Infection with abscess

- Prepare infected area with antiseptic, make an incision, and drain the pus.
- Remove the implant, or refer the client to a specialist.
- Treat the wound, and give oral antibiotics for seven days.

WHAT COUNSELING TIPS SHOULD BE OFFERED TO THE CLIENT?

Advise the client on the following:

- The physical characteristics of the implants and how they should feel under the skin
- The procedures of insertion and removal, as well as the cost
- When to remove the implant and the implication when the effective life span of the implant has expired
- Possible changes in menstrual patterns, which usually decrease with time
- Side effects and complications to watch out for

Chapter 6

INTRAUTERINE DEVICES:

TCu380 Intrauterine Device and Intrauterine System

WHAT ARE INTRAUTERINE DEVICES (IUDs)?

- An IUD is a small plastic device inserted into a woman's uterine cavity to prevent pregnancy.
- It releases copper or a hormone.
- Almost all IUDs have one or two strings or nylon threads tied to the plastic frame. The strings hang through the cervical opening into the vagina.
- In the Philippines, two types of IUD are available:
 - Copper T380 (TCu) is the IUD currently used in the Philippine Family Planning Program. It is a T-shaped plastic device with a copper coil wrapped around its stem and copper bands around its arms. The device releases copper to prevent fertilization. It has a two-stranded monofilament tail. This type of IUD is effective for 12 years.
 - Hormone-releasing IUDs (e.g., levonorgestrel-releasing IUS or Mirena) are made of plastic and steadily release small amounts of progesterone. This type of IUD is of limited availability locally and is effective for five years.



TCu 380 INTRAUTERINE DEVICE

HOW EFFECTIVE ARE IUDs?

- IUDs are 99.4% effective with perfect use and 99.2% effective with typical use.
- These rates indicate that 992 to 994 of every 1,000 women who use IUDs over the first year will not become pregnant.

WHAT ARE THE ADVANTAGES OF USING THE TCu IUD?

- Highly effective
- Very safe
- Local action
- Has no effect on the amount or quality of breast milk
- Low cost
- Does not interfere with sexual intercourse
- One time application
- Immediate return to fertility upon removal
- Can be inserted immediately after childbirth or after abortion
- Can be easily inserted or removed by a trained provider
- Long-lasting effectiveness (12 years)

WHAT ARE THE DISADVANTAGES OF USING THE TCu IUD?

- Adverse effects
 - Pain and cramping
 - Long and heavy menstrual bleeding
 - Menstrual irregularities
- Device may be expelled, possibly without the client knowing it (especially for postpartum insertions)
- Requires a pelvic examination prior to insertion
- Requires a trained health service provider for insertion and removal
- Does not protect against sexually transmitted infections (STIs)
- Requires regular self-checking of IUD strings during the first year of use

HOW DOES THE TCu IUD WORK?

The TCu 380A IUD prevents pregnancy by a combination of the following mechanisms of action:

- Inhibition of fertilization
- Inhibition of sperm transport into the upper genital tract
- Inhibition of ovum transport

WHO CAN USE THE METHOD?

The IUD is suited for clients who want a long-acting, effective, reversible method of contraception (LARC).

Table 14. MEC categories for IUD

Category 1: Use the method without restriction.

- | | |
|--|---|
| • Women more than 20 years old | • Superficial venous thrombosis |
| • Women who have given birth | • Any type of headache |
| • Immediate postpartum women | • Epilepsy |
| • Post-abortion in the first trimester | • Depressive disorders |
| • History of high blood pressure during pregnancy | • Women with irregular but not heavy vaginal bleeding |
| • History of pelvic surgery | • Any breast disease |
| • Women who smoke at any age | • Hypertension of all classifications |
| • Body mass index of more than or equal to 30 kg/m ² | • Uterine fibroids that do not distort the uterine anatomy |
| • Uncomplicated valvular heart disease | • History of PID and with subsequent pregnancy |
| • Past ectopic pregnancy | • Schistosomiasis |
| • DVT/PE | • Malaria |
| • Known thrombogenic mutations | • Non-pelvic tuberculosis |
| • Women diagnosed with systemic lupus erythematosus but with no risk factors | • Any endocrine condition, such as diabetes or thyroid disorders |
| • Current and history of ischemic heart disease, stroke, or hyperlipidemia | • Any gall bladder disease, hepatitis, cirrhosis, liver tumors, or history of cholestasis |
| • Diagnosed with benign ovarian tumor, cervical ectropion, or cervical intraepithelial neoplasia | • Current intake of any anticonvulsant or antimicrobial |

Category 2: Generally use the method but with more than usual follow-up.

- Menarche to 20 years old
- Women who have not given birth
- Post-abortion in the second trimester
- Complicated valvular heart disease
- Women diagnosed with systemic lupus erythematosus and on immunosuppressive treatment
- Women with heavy or prolonged vaginal bleeding, endometriosis, or severe dysmenorrhea
- Among women with anatomical abnormalities that interfere with IUD insertion (e.g., cervical laceration or stenosis)
- Initiation of the method in women with past PID and no subsequent pregnancy
- Other STIs (excluding gonorrhea, chlamydial, and HIV) and vaginitis
- High risk of HIV
- Initiation of the method in women who are HIV-infected
- Women with AIDS but on anti-retroviral therapy
- Currently on anti-retroviral therapy
- Anemias such as thalassemia, sickle cell disease, or iron-deficiency anemia

WHO CANNOT USE THE METHOD?

Category 3: Do not use the method unless no other appropriate method is available under close supervision.

- 48 hours to 4 weeks after childbirth
- Women diagnosed with systemic lupus erythematosus and with severe thrombocytopenia
- Women with gestational trophoblastic disease but decreased or undetectable beta-hCG levels
- Women with ovarian cancer
- Very high likelihood of exposure to gonorrhea or chlamydial infection
- Women with AIDS

Category 4: Do NOT use the method.

- During pregnancy
- Puerperal sepsis
- Immediate post-septic abortion
- Initiation of method in clients with unexplained vaginal bleeding before evaluation
- Women with gestational trophoblastic disease
- Initiation of method in clients with cervical or endometrial cancer
- Among women with anatomical abnormalities that distort the uterine cavity (e.g., fibroids)
- Current PID
- Initiation of method in clients with current purulent cervicitis, chlamydial infection, or gonorrhea
- Initiation of method in clients with pelvic tuberculosis

HOW IS THE IUD USED?

I. Timing of IUD insertion

For women having menstrual cycles

- Any time during menstrual bleeding.
- Any other time at the client's convenience, provided that the client is certainly not pregnant.
- Clients starting within 12 days after the start of their monthly bleeding do not need a backup method.

For amenorrheic (non-postpartum) women

- Any time, provided that the client is certainly not pregnant. No need for a backup method.

After childbirth (postpartum)

- Within 10 minutes after delivery of placenta or within 48 hours after childbirth.
- Copper IUD is not usually recommended for women more than 48 hours to less than four weeks postpartum, unless other more appropriate methods are available.
- IUD insertion is delayed until four weeks or more after giving birth.
- **Special training is required for immediate postpartum insertion.**

Evidence suggests that the immediate postpartum insertion of IUDs is generally safe and effective, although a recent trial has suggested that the occurrence rate of expulsion is higher in women who had immediate insertion than in those who had delayed insertion.

Post-abortion

- o Any time within 12 days after first- or second-trimester abortion or miscarriage if no infection is present. No need for a backup method.
- o Any time after more than 12 days of first- or second-trimester miscarriage or abortion if no infection is present, provided that the client is certainly not pregnant. No need for a backup method.
- o Clients with infections must be referred to a specialist or be assisted in choosing another method. Clients who still prefer IUDs are inserted with the device once the infection has completely cleared.
- o Immediate post-abortal IUD insertion or miscarriage requires specific training. If the healthcare provider is not specifically trained, IUD insertion is delayed until at least four weeks after miscarriage or abortion.

In general, contraceptive efficacy is high, and PID and perforations are rare. Although the risk of spontaneous expulsion of an IUD is greater in this setting than in interval insertions, this potential disadvantage may be outweighed by the convenience of providing highly effective contraception with completion of abortion in one sitting.

For women switching from another method

- o May use immediately, provided that the client is using the current method consistently and correctly or is certainly not pregnant. No need to wait for the client's next monthly bleeding. No need for a backup method.
- o Clients switching from injectables can be inserted with the IUD when the next injection would have been given. No need for a backup method.

Fully or nearly fully breastfeeding: less than six months after giving birth

- o Between four weeks and six months after giving birth for clients who are still waiting for their monthly bleeding to return. No need for a backup method.
- o The protocol for clients whose monthly bleeding has returned is the same as that for clients who are having menstrual cycles (see previous page).



Fully or nearly fully breastfeeding: more than six months after giving birth

- o Any time for clients whose monthly bleeding has not returned, provided that they are certain that they are not pregnant. No need for a backup method.
- o The protocol for clients whose monthly bleeding has returned is the same as that for clients who are having menstrual cycles.

Partially breastfeeding or not breastfeeding

- o IUD insertion is NOT usually recommended for women less than four weeks postpartum unless inserted less than 48 hours after childbirth.
- o After four weeks postpartum: the IUD can be inserted any time for clients whose monthly bleeding has not returned, provided that the client is certainly not pregnant. No need for a backup method.
- o The protocol for clients whose monthly bleeding has returned is the same as that for clients who are having menstrual cycles.

II. Pelvic examination prior to IUD insertion

A bimanual pelvic examination and STI screening must be done prior to IUD insertion. Performing a pelvic examination will allow the health provider to check for signs of PID or abnormal uterine anatomy.

- Active PID, STI, or anatomical abnormalities resulting in distorted uterus are contraindications of IUD insertion. The PID must be treated before the IUD may be inserted. While she is being treated or if she is at risk for possible STI, recommend the use of condoms and/or alternative FP methods. In the event that there is abnormal uterine anatomy, other FP methods should be offered.
- The following signs are suggestive of PID, STI, or abnormal uterine cavity. If these signs are observed, IUD insertion should be deferred.
 - o Any type of ulcer on the vulva, vagina or cervix (possible STI)
 - o Lower abdominal tenderness when the cervix is moved (possible PID)
 - o Tenderness while palpating for the uterus, ovaries, or fallopian tubes (possible PID)



- o Purulent cervical discharge (possible STI or PID)
- o Bleeding of the cervix when touched (possible STI or cervical cancer)
- o Anatomical abnormality of the uterine cavity preventing the proper IUD insertion
- o Difficulty in determining the size and/or position of the uterus that prevents proper IUD insertion

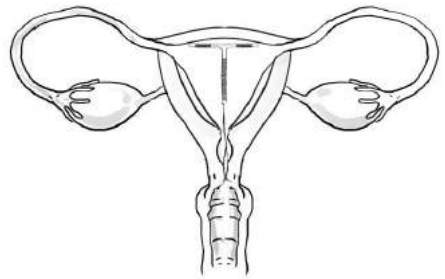
III. Inserting the IUD

- Only a provider who has undergone comprehensive IUD training and practice under direct supervision is allowed to perform IUD insertion.
- The IUD must be placed correctly (high fundal position) while minimizing the client's discomfort and the risk of uterine perforation.

For interval clients

- o Explain the insertion procedure.
- o Show the client the IUD and inserter in the package.
- o Tell the client that she will experience some discomfort or cramping during the procedure.
- o Ask the client to disclose any feeling of discomfort or pain any time. Ibuprofen (200 mg–400 mg), paracetamol (325 mg–1000 mg), or other pain relievers may be given 30 minutes before insertion to help reduce cramping and pain. Do not give aspirin because it slows blood clotting.
- o Talk with the client during the procedure.
 - Guide the client through the procedure in a step-by-step manner and reassure her.
 - Alert the client before a step that may cause pain or might startle her.
 - Ask regularly if the client feels any pain.
- o Clients of IUD insertion must be informed of the insertion procedures. Below is a summary of the procedures that can be used in explaining IUD insertion to a client. Perform all steps carefully.
 1. Follow proper infection prevention measures.
 2. Perform bimanual pelvic examination to determine the position of the uterus.

3. Insert speculum to inspect the vagina and cervix to ensure the absence of any infection.
4. Disinfect the vagina and cervical opening with antiseptic solutions, such as povidone-iodine.
5. Place the tenaculum at the anterior lip of the cervix (2 and 10 o'clock), and gently pull the cervix to stabilize and align the uterine cavity.
6. Measure the depth of the uterine cavity (6 cm to 8 cm) using a uterine sound.
7. Adjust the depth gauge of the IUD inserter for proper placement into the uterine cavity using the “no touch” technique.
8. Load the IUD into the inserter while both are still in the unopened sterile package.
9. Slowly and gently insert the IUD, and remove the inserter.
10. Cut the strings on the IUD, leaving about 3 cm hanging out of the cervix.
11. After the insertion, allow the client to rest on the examination table until she feels ready to get dressed.
12. Do not provide routine antibiotics to IUD users.
13. Provide post-insertion instructions.
14. Ensure that the client is informed of the following:
 - Type of IUD inserted
 - When to have the device removed or replaced
 - Expected side effects, such as cramping, heavier menstrual flow, or bleeding between menses.



15. Inform the client of the following ways to check the IUD.
 - a. Wash hands.
 - b. Sit in a squatting position.
 - c. Ask the client to insert one or two fingers inside the vagina as far as she can until she feels the string.
 - d. Ask the client to determine if the strings have changed in length, which may denote expulsion.
 - e. Tell the client not to pull the strings to avoid IUD displacement.
16. Inform the client of the following periods to check the IUD strings.
 - After each menses when the probability of expulsion is high
 - After noticing any of the following possible symptoms of serious problems:
 - Missed menstrual period, other signs of pregnancy, or an expelled IUD
 - IUD string that seems to be missing or IUD that seems to have been partially or completely expelled. This symptom is determined by the client by feeling something hard (plastic device) in her vagina or cervix.

Preventing Infection at IUD Insertion

1. Follow proper infection prevention procedures.
2. Disinfect instruments by boiling, steaming, or soaking them in disinfectant chemicals.
3. Use a new IUD that is packaged with its inserter.
4. Follow the “no-touch” insertion technique, which includes not letting the loaded IUD or uterine sound touch any unsterile surfaces (e.g., hands, speculum, vagina, and table top). This technique involves the following:
 - Loading the IUD into the inserter while the IUD is still in the sterile package to avoid touching the IUD directly
 - Passing both the uterine sound and the loaded IUD inserter only once through the cervical canal without touching the vaginal wall

For postpartum clients

- Postplacental: After a normal, vaginal delivery, within 10 minutes after placental expulsion
- Intracesarean: During a cesarean procedure before suturing of the uterine incision
- Immediate postpartum: Postplacental and within 48 hours after childbirth before discharge from the health facility

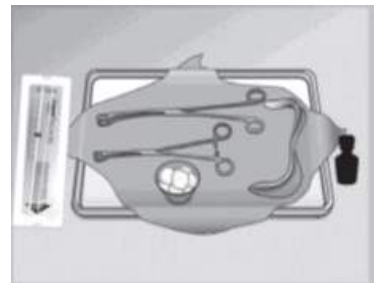
These clients should undergo FP counseling. Particularly, pregnant women are best counseled during their prenatal visits. All IUD clients must be asked to sign a consent form before the insertion procedure.

Postplacental IUD Insertion *(Source: JHPIEGO Postpartum IUD Learning Manual)*

Regardless of the insertion timing (postplacental or immediate postpartum), the forceps insertion technique is recommended. The relevant steps are described below.

1. Palpate the uterus to evaluate the height of the fundus and its contraction, and massage the uterus, if necessary, to promote steady contraction. The size of the uterus must be assessed to anticipate if the strings are likely to protrude through the cervix after insertion.
2. Ensure that the client's buttocks are at the very end of the table (with or without leg supports).

At the preparatory level, the IUD service provider, who may also be the attendant at childbirth, should confirm that correct sterile instruments, supplies, and light sources are available for immediate postplacental (instrumental) insertion. The service provider should obtain a PPIUD kit/tray and a sterile IUD while keeping the package sealed until immediately prior to insertion.



3. Manage labor and delivery (including using a partograph and performing active management of third stage of labor [AMTSL]) and perform a second screening to confirm the absence of the following delivery-related conditions that preclude IUD insertion:
 - Rupture of membranes for greater than 18 hours
 - Chorioamnionitis
 - Unresolved postpartum hemorrhage
 - Genital trauma

If any of these conditions exist, explain to the client that now is not a safe time for IUD insertion and that she may be re-evaluated at six weeks postpartum.

4. If insertion is performed by the same provider who assisted birth, the provider must wear the same pair of high-level disinfected (HLD) or sterile gloves for insertion, provided that the gloves are not contaminated. Alternatively, if insertion is performed by a provider different from the one who assisted birth, ensure that AMTSL has been completed, and then perform hand hygiene by wearing HLD or sterile gloves.
5. Inspect perineum, labia, and vaginal walls for lacerations. Lacerations should be repaired after IUD insertion unless uncontrolled bleeding occurs, which should be attended to first.
6. Confirm that the woman is ready to have the IUD inserted. Answer any questions she might have, and provide reassurance if needed.
7. Open the PPIUD kit/tray. Ensure that the IUD in the sterile package is kept to the side of sterile draped area. Place a dry, sterile cloth on the woman's abdomen.
8. Gently insert a Simms speculum, and visualize the cervix by depressing the posterior wall of the vagina. Clean the cervix and vagina with antiseptic solution two times using a separate swab each time.
9. Gently grasp the anterior lip of the cervix with the ring forceps. The speculum may be removed at this time, if necessary. Leave the forceps aside, still attached to the cervix.



10. Open the sterile package of IUD from the bottom by pulling back the plastic cover approximately one-third of the way. The dominant hand must be used to remove the plunger rod, inserter tube, and card from the package.



11. Use the dominant hand to hold placental or Kelly forceps (or any long forceps) to grasp the IUD inside the sterile package. Hold the IUD by the edge, and prevent the strings from entangling in the forceps.

12. Gently lift the anterior lip of the cervix using ring forceps.

13. Gently insert and slowly advance the IUD (this step overlaps with Step 14).

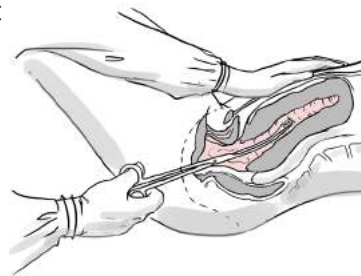
- While avoiding touching the walls of the vagina, insert the placental forceps holding the IUD through the cervix into the lower uterine cavity.
- Gently move the IUD further into the uterus toward the point where a slight resistance is felt against the back wall of the lower segment of the uterus.
- Keeping placental forceps firmly closed, lower the ring forceps, and gently remove them from the cervix; leave them on a sterile towel.

14. “Elevate” the uterus (this step overlaps with Steps 13 and 15).

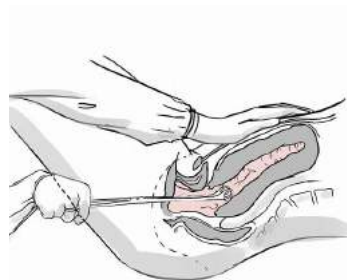
Place the base of the non-dominant hand on the lower part of the uterus (midline, just above pubic bone with fingers toward fundus), and gently push the uterus upward at the abdomen to extend the lower uterine segment. This maneuver will help straighten the lower uterine segment for ease of IUD insertion.

15. Pass the IUD through the lower uterine segment angle (this step overlaps with Step 14).

- Keeping forceps closed, gently move the IUD upward toward the uterine fundus in an angle toward the umbilicus.
- Lower the dominant hand (hand holding placental forceps) to enable the forceps to easily pass the lower uterine angle and follow the contour of the uterine cavity. Avoid perforating the uterus by not using undue force in advancing the Kelly placental forceps bearing the IUD.



16. Continue gently advancing the forceps until the uterine fundus is reached, that is, when the provider feels a resistance. Confirm with the abdominal hand that the IUD has reached the fundus by feeling the uterus through the abdominal wall.
17. While continuing to stabilize the uterus, open the forceps, tilting them slightly toward the midline to release the IUD at the fundus.
18. Keeping the forceps slightly open, slowly remove them from the uterine cavity by sweeping the forceps to the sidewall of the uterus and sliding the instrument alongside the wall of the uterus. Avoid dislodging the IUD or catching the IUD strings as the forceps are removed.
19. Stabilize the uterus until the forceps are completely withdrawn. Examine the cervix to see if any portion of the IUD or strings are visible or protruding from the cervix. If the IUD or strings are seen protruding from the cervix, remove the IUD using the same forceps used for the first insertion; position the same IUD in the forceps inside the sterile package and reinsert.
20. Repair any lacerations (episiotomy) as necessary.



Intracesarean Insertion

- Compared with immediate postplacental vaginal insertion, postplacental placement during a cesarean section is associated with lower expulsion rates.(60) This association is due to the fact that the device is placed in the uterine cavity under direct vision either with the use of forceps or the gloved hand of the surgeon prior to closure of the uterine incision. Notably, the rate of reported perforations in the postpartum period is very low.



- As a precaution, the service provider should review the recent labor and delivery experience of the client, i.e., whether or not the client experienced prolonged ruptured membranes (> 18 hours), prolonged labor, and/or extensive genital trauma, because these conditions can predispose the client to postpartum infection. In such situations, the client who wants to use an IUD should have the insertion deferred until the earliest postpartum visit (e.g., four weeks), during which she can be assessed and have the insertion once infection has been ruled out. The client should be counseled to practice the LAM or to use another FP method of her choosing until she can return for insertion. IUD insertion in the presence of postpartum sepsis may substantially worsen the condition.
- After the delivery of the placenta, the surgeon shall perform the following:
 - a. Massage the uterus until the bleeding subsides; make sure that no tissue is left in the uterine cavity.
 - b. Place the IUD at the uterine fundus manually or with a grasping instrument.
 - c. Before suturing the uterine incision, place the strings in the lower uterine segment near the internal os.
 - d. Close the uterine incision and the abdomen.

Immediate Postpartum Insertion

This procedure is safe and effective. The expulsion rate for postplacental insertion is higher than that for interval insertion but lower than that for immediate postpartum. Nevertheless, immediate insertion after delivery has the following advantages:

- Assurance that the client is not pregnant.
- Women have a high motivation for accepting contraception immediately after delivery.
- Healthcare facilities provide a convenient setting for IUD insertion, particularly with the government's promotion of facility-based delivery.
- Trained attendants are present in the facility.
- Gives women protection from pregnancy without affecting breastfeeding.
- Women who may have difficulty accessing medical care would benefit from receiving a highly effective method of contraception where care is already established.
- There may be less pain during insertion in the postpartum period.

For these reasons, good FP counseling should be provided during antenatal visits or before the client's confinement for childbirth. FP should be part and parcel of the health education sessions being given to would-be mothers.

WHAT ARE THE POTENTIAL COMPLICATIONS AND MANAGEMENT PROCEDURES OF IUDs?

Prolonged or heavy bleeding

Characterize the bleeding:

- o Prolonged bleeding—more than eight days
- o Heavy bleeding—twice as long or twice as much as the usual menses
- o For bleeding of more than three months:
 - Examine possible complications or other conditions (e.g., infection, tumor, or hormonal dysfunctions) that are unrelated to IUD.
 - Check for anemia. If present, recommend iron supplementation.
 - If bleeding has no gynecologic cause, the following is the recommended management:
 - Non-steroidal anti-inflammatory drugs, such as ibuprofen (400 mg) or indomethacin (25 mg), should be taken twice daily after meals for five days, beginning when irregular bleeding starts, to achieve modest short-term relief.
 - Tranexamic acid (1500 mg) should be taken thrice daily for three days and then 1000 mg once daily for two days, beginning when heavy bleeding starts.
 - Iron tablets may be taken.

Cramping

- Cramping is common within the first three to six months of IUD use. This symptom eventually disappears.
- If mild cramping occurs only around the time of menses and no other abnormality is observed, reassure the client, and give her a pain reliever (paracetamol or mefenamic acid).
- If cramping is severe or continuous for more than three months, examine the client for other problems, such as partially expelled IUD or infection. If no problem is noted and the client wishes to continue using the IUD, give her a pain reliever.



- If cramping is severe and occurs between menses and is unacceptable to the client, remove the IUD.

Missing string

- If the string is not visible during checkup and the device is not found inside the uterus, the IUD may have been expelled unnoticed.
- Check for a history of IUD expulsion.
- Determine the risk of pregnancy, and ask the client the following:
 - When she last menstruated
 - When she last felt the string
 - If she noticed any signs that she may be pregnant
- Perform a pelvic exam to determine if the strings are high in the cervix or hidden by a fold of the vagina, and check for signs of pregnancy.
- If pregnancy is suspected, refer the client to a physician who will do the necessary tests or examinations.
- If pregnancy has been ruled out, confirm expulsion, offer the client a backup contraception, and ask her to return during her next menses.
- Upon her return during menses and the strings are still not visible, sound the uterus to determine if the device is still inside. If so, explore the uterus and cervix to remove the strings.
- If the string could not be found, refer the client for an ultrasound to locate the IUD. If the result is negative, the device may have been expelled unnoticed. Discuss reinsertion, or advise the use of another contraceptive method.

Pregnancy with IUD

- If the client is pregnant, rule out ectopic pregnancy, and refer the client to a specialist immediately. Ectopic pregnancy is life-threatening and requires emergency treatment.
- If IUD strings are visible,
 - Explain that the IUD must be removed to avoid risk of infection, miscarriage, or premature birth.
 - Remove the IUD gently by pulling the strings.

- If strings are not visible,
 - Perform an ultrasound to determine the location of the device.
 - If the device had not been expelled and is not accessible, do not attempt to remove it. Consider the case a high-risk pregnancy, and refer the client to a physician to closely monitor signs of a possible complication.
 - Inform the client of the risks, and advise her to seek immediate care for heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever.

Pelvic inflammatory disease

Pelvic infection associated with IUD use may occur when the insertion is performed under unsanitary conditions or when the IUD is inserted in the presence of an undiagnosed STI. It may also develop later in women at risk of STIs. The usual symptoms of PID are vaginal discharge, pelvic pain or tenderness, abnormal bleeding, chills, and fever, but the infection can be silent.

- Refer the client to a doctor who will diagnose and treat the PID with the appropriate antibiotics. The immediate removal of the IUD is unnecessary.
- If the client does not want to keep the IUD, remove the device after the start of antibiotic treatment.
- If the infection does not improve, remove the IUD, and continue the antibiotics.
- Facilitate the treatment and counseling of the sexual partner.
- Counsel the client about condom use and, if possible, give her condoms.
- Treatment of serious cases requires hospitalization and possibly surgical intervention.
- Counsel the client to use an alternative method of contraception that prevents STI/HIV/AIDS transmission such as condom.

Uterine perforation

- Perforation is rare and usually occurs at the time of insertion.
- It occurs when the IUD is not inserted in the correct direction of the uterine cavity or when the length of the uterine cavity is not correctly determined. The risk of perforation is increased by forceful insertion or sounding.
- Careful insertion by a trained provider is important. According to the WHO, the probability of perforation at the time of insertion is 1 in 1,000 cases.

- Signs of perforation
 - Sharp pain during insertion
 - Loss of resistance to upward pressure of inserter or uterine sound
 - Signs of hemorrhage, which is a rare but serious complication (falling blood pressure and rising pulse rate) that requires emergency surgical procedure
 - May be asymptomatic
- If perforation occurs during insertion, perform the following:
 - Stop the procedure, and refer the client to a gynecologist or surgeon, if necessary.
 - Perforation can be confirmed by x-ray (if the client is not pregnant) or ultrasound.
 - In the absence of any sign of hemorrhage, provide alternative contraception, and refer the client immediately.
 - Follow up with the client after one week.

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 the client wants another IUD, she can have one inserted at any time, provided that she is certain that she is not pregnant.
- If the client does not want to continue using an IUD, assist her in choosing another contraceptive method.

Partner can feel IUD strings during sex

- Explain that this phenomenon sometimes occur when strings are cut too short.
- If the partner finds the strings bothersome, describe the available options:
 - Strings can be cut even shorter so they are not coming out of the cervical canal. The client's partner will not feel the strings, but she will no longer be able to check her IUD strings.
 - If the client wants to check, the IUD can be removed, and a new one can be inserted. To avoid discomfort, the strings should be cut so that 3 cm hang out of the cervix.

The use of IUDs is associated with some side effects and is not free from complications. Thus, the client must be instructed to return to the health facility for consultation when she experiences any of the associated side effects and complications or if she has new concerns.

A client who is not satisfied after treatment and counseling must be informed of the possibility of removing the IUD and replacing it with another contraceptive method.

WHAT ARE THE INDICATIONS FOR IUD REMOVAL? WHEN AND HOW SHOULD THE IUD BE REMOVED?

When the client requests for or develops medical conditions that require IUD removal, the provider should not refuse or delay the removal. Staff members must not pressure or force the client to continue using the IUD and instead offer her alternative FP methods. Some of the reasons for IUD removal include the following:

- Presence of side effects especially pain and bleeding, which are intolerable to the client
- Medical reasons
 - Pregnancy, if threads are visible
 - Acute PID (endometritis or salpingitis) if necessary and after antibiotics have been started for at least 24 hours
 - Perforation of the uterus or cervix or IUD translocation
 - Partial expulsion
 - Abnormal, heavy bleeding that puts the client's health at risk

When to remove the TCu IUD

- When the effective life span of the IUD has been reached. Recommend the replacement of copper IUDs at the end of the 12th year of use.
- At menopause (at least one year after the last period).
- Any time during the menstrual cycle.

How to remove the TCU IUD

1. Follow proper infection prevention procedures.
2. Insert the speculum to visualize the cervix and the IUD strings.
3. Grasp the strings with forceps.
4. Pull IUD strings slowly and gently.

The client must be informed of these steps before the removal procedure. If removal is not easy or the thread is not visible but the device has been shown to be in utero, have the IUD removed using alligator forceps or Novak's curette (an IUD hook) by a trained health provider.

What happens when IUD is removed

The IUD is a reversible means of contraception. Most women who discontinue IUD use to become pregnant conceive as rapidly as a non-IUD user. Sufficient evidence indicates that no relation exists between the duration of IUD use and the return to fertility.



IF SWITCHING FROM AN IUD TO ANOTHER CONTRACEPTIVE METHOD IS DESIRED, WHEN CAN THE OTHER METHOD BE STARTED?

The following guidelines (2) ensure that the client is protected from pregnancy without interruption when switching from a copper-bearing IUD or a hormonal IUD to another method. See also *When to Start* for each method.

Switching to	When to start
Combined oral contraceptives (COCs), progestin-only pills (POPs), progestin-only injectables, monthly injectables, combined patch, combined vaginal ring, or implants	<ul style="list-style-type: none"> • If starting during the first seven days of monthly bleeding (first five days for COCs and POPs), start the hormonal method now, and remove the IUD. No need for a backup method. • If starting after the first seven days of monthly bleeding (after the first five days for COCs and POPs) and the client has had sex since her last monthly bleeding, start the hormonal method now. The IUD should be kept in place until the client's next monthly bleeding. • If starting after the first seven days of monthly bleeding (after the first five days for COCs and POPs) and the client has not had sex since her last monthly bleeding, the IUD can stay in place and be removed during her next monthly bleeding. Alternatively, the IUD can be removed, and a backup method can be used.
Male or female condoms, spermicides, diaphragms, cervical caps, or withdrawal	<ul style="list-style-type: none"> • Immediately the next time she has sex after the IUD is removed.
Fertility awareness-based methods	<ul style="list-style-type: none"> • Immediately after the IUD is removed.
Female sterilization	<ul style="list-style-type: none"> • If starting during the first seven days of monthly bleeding, remove the IUD, and perform the female sterilization procedure. No need for a backup method. • If starting after the first seven days of monthly bleeding, perform the sterilization procedure. • The IUD can be kept in place until the client's follow-up visit or next monthly bleeding. If a follow-up visit is not possible, remove the IUD at the time of sterilization. No need for a backup method.
Male sterilization	<ul style="list-style-type: none"> • Any time • The client can keep the IUD for three months after her partner's vasectomy to prevent pregnancy until the vasectomy is fully effective.
<p>Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Inform the client that spermicides and withdrawal are the least effective contraceptive methods. If possible, give condoms to the client.</p>	

WHEN SHOULD THE FOLLOW-UP VISIT BE SCHEDULED?

A follow-up visit after the client's first monthly bleeding or three to six weeks after IUD insertion is recommended. No client should be denied an IUD because follow-up would be difficult or not possible. Follow-up visits after insertion may be done because of the following reasons:

- Routine yearly checkup as part of good health practice
- Any time the client has questions, concerns, or finds unusual signs and symptoms, which may suggest the following possible adverse effects/ complications:
 - Fever, chills, or unusual vaginal discharge, which can indicate an infection
 - Severe bleeding or abdominal cramping especially in the first month after insertion, which can indicate an infection
 - Irregular bleeding and/or pain in any cycle, which can indicate dislocation or perforation
- When removal/replacement of the device is due

A routine pelvic examination during the follow-up visit is not required. However, this examination may be appropriate in some settings or for some clients. Conduct a pelvic examination, particularly if the evaluation suggests the following:

- An STI or PID
- Partial or complete removal of the IUD

WHAT COUNSELING TIPS CAN BE PROVIDED FOR THOSE WHO PLAN OR CHOOSE TO USE AN IUD?

Discuss the following specific issues in detail during the counseling sessions:

- Characteristics of IUDs
- Client's current and future risk for STIs
- Effectiveness and mechanism of IUD
- Insertion and removal procedures
- Instructions for use and follow-up visit
- Possible side effects and complications
- How to check the strings



- Warning signs of complications that require immediate return to the clinic or referral (PAINS)

P: period is late

A: abdominal pain during intercourse

I: infection

N: not feeling well

S: string is missing

WHAT ARE THE COMMONLY ASKED QUESTIONS ABOUT IUDs?(2)

1. Does the IUD cause PID?

- By itself, the IUD does not cause PID. Gonorrhea and chlamydia are the primary direct causes of PID. However, IUD insertion when a woman has gonorrhea or chlamydia may lead to PID. This condition is not common. When it does happen, it is most likely to occur in the first 20 days after IUD insertion. In a group of clients where STIs are common and screening questions identify half the STI cases, 1 case of PID may be reported in every 666 IUD insertions (or less than 2 per 1,000).

2. Can young women and older women use IUDs?

- Yes. There is no minimum or maximum age limit. An IUD should be removed after menopause has occurred, i.e., 12 months after the client's last monthly bleeding.

3. If a current IUD user has an STI or has become at very high individual risk of becoming infected with an STI, should her IUD be removed?

- No. If a woman develops a new STI after her IUD has been inserted, she is not especially at risk of developing PID because of the IUD. She can continue to use the IUD while she is being treated for the STI.
- Removing the IUD has no benefit and may leave her at risk of unwanted pregnancy. Counsel her on condom use and other strategies to avoid STIs in the future.

4. Does the IUD make a woman infertile?
 - No. A woman can become pregnant once the IUD is removed just as quickly as a woman who has never used an IUD, although fertility decreases as women get older. Studies show no increased risk of infertility among women who have used IUDs, including young women and women with no children. However, a woman who develops PID and is not treated, whether or not this woman has an IUD, is at risk for infertility.
5. Can a woman who has never had a baby use an IUD?
 - Yes. A woman who has not had children can generally use an IUD, but she should understand that the IUD is more likely to be expelled because her uterus may be smaller than the uterus of a woman who has given birth.
6. Can the IUD travel from the woman's uterus to other parts of her body, such as her heart or her brain?
 - The IUD never travels to the heart, brain, or any other part of the body outside the abdomen. The IUD normally stays within the uterus like a seed within a shell. In rare instances, the IUD may come through the wall of the uterus into the abdominal cavity. This condition is usually caused by a mistake during insertion. If it is discovered within six weeks or so after insertion or if it is causing symptoms at any time, the IUD must be removed by laparoscopic surgery or laparotomy. However, an out-of-place IUD usually causes no problems and should be left where it is. The client will need another contraceptive method.
7. Should a woman have a "rest period" after using her IUD for several years or after the IUD reaches its recommended time for removal?
 - No. A "rest period" is not necessary. Removing the old IUD and immediately inserting a new one pose less risk of infection than two separate procedures. In addition, a woman could become pregnant during a "rest period" before her new IUD is inserted.

8. Should antibiotics be routinely given before IUD insertion?

- No, usually not. Most recent research done where STIs are not common suggests that PID risk is low with or without antibiotics. The risk of infection is minimal when appropriate questions to screen for STI risk are used and IUD insertion is done with proper infection prevention procedures (including the no-touch insertion technique). However, antibiotics may be considered in areas where STIs are common and STI screening is limited.

9. Must an IUD be inserted only during a woman's monthly bleeding?

- No. An IUD can be inserted at any time to a woman having menstrual cycles during her menstrual cycle, provided that she is certainly not pregnant. Inserting the IUD during her monthly bleeding may be a good time because she is not likely to be pregnant and insertion may be easier. However, signs of infection are difficult to detect during monthly bleeding.

10. Should a woman be denied an IUD because she does not want to check her IUD strings?

- No. A woman should not be denied an IUD because she is unwilling to check the strings. The importance of checking the IUD strings has been overemphasized. IUD expulsion is uncommon, especially with the woman not noticing.
- The IUD is most likely to come out during the first few months after IUD insertion; during monthly bleeding; among women who have had an IUD inserted soon after childbirth, a second-trimester abortion, or miscarriage; and among women who have never been pregnant. A woman can check her IUD strings if she wants reassurance that it is still in place. Alternatively, she can watch carefully in the first month or so and during monthly bleeding to see if the IUD has come out.

11. Do IUDs increase the risk of ectopic pregnancy?

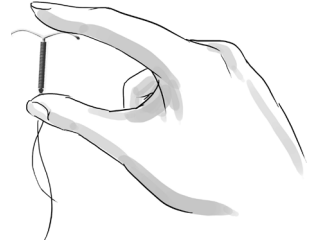
- No. IUDs greatly reduce the risk of ectopic pregnancy. Ectopic pregnancies are rare among IUD users. The rate of ectopic pregnancy among women with IUDs is 12 per 10,000 women per year.
- On the rare occasions that the IUD fails and pregnancy occurs, 6 to 8 of every 100 of these pregnancies are ectopic. Thus, a great majority of pregnancies after IUD failure are not ectopic. Nevertheless, ectopic pregnancy can be life threatening. Thus, a provider should be aware that ectopic pregnancy is possible after IUD failure.



THE INTRAUTERINE SYSTEM

WHAT IS THE INTRAUTERINE SYSTEM (IUS)?

- The IUS is an intrauterine device that contains levonorgestrel (LNG), which is released into the uterus.
- The IUS consists of a plastic T-shaped frame. The stem of the T has a tiny reservoir that contains 52 mg of the progesterone hormone LNG.
- Once the IUS is fitted, approximately 20 µg of LNG is delivered to the lining of the uterus daily over a five-year period.
- The IUS is used for contraception and for the management of heavy or prolonged menstrual periods with no known cause (idiopathic menorrhagia).



HOW EFFECTIVE IS THE IUS?

The IUS is 99.9% effective with perfect and typical use. It is thus highly effective and long lasting. From the first to the fifth year of IUS use, less than 1 pregnancy per 100 women using an LNG-IUS is reported.

WHAT ARE THE ADVANTAGES OF USING THE IUS?

- Provides long-term effect (five years)
- Reduces menstrual bleeding and decreases pain
- Decreases blood loss and thus protects against iron-deficiency anemia
- Menstruation and fertility return one month after IUS removal
- Reduces risk of pelvic infection
- Reduces the symptoms (e.g., pelvic pain, irregular bleeding) of endometriosis

WHAT ARE THE DISADVANTAGES OF USING THE IUS?

- Needs to be inserted by a trained provider
- Poses high risk of ectopic pregnancy when it fails
- More expensive than copper IUD

HOW DOES THE IUS WORK?

In addition to the effects of IUD in general, the use of the IUS has the following results:

- Increases the thickness of the cervical mucus and hinders the passage of the sperm into the uterus
- Prevents the release of an egg from the ovary (ovulation), but this prevention does not necessarily occur in all women who use the IUS

WHEN IS THE IUS INSERTED?

- Usually within the week of beginning a period
- Six weeks after delivery
- Immediately after an abortion or miscarriage if no infection exists
- Any time, provided that the client is certainly not pregnant

WHO CAN USE THE IUS?

The IUS is appropriate for women who

- Want a long-acting, effective, reversible contraceptive method
- Are breastfeeding
- Show change in risk status while using another method (e.g., estrogen-containing methods)
- Do not want more children but are not ready to undergo surgical sterilization

Table 15 shows the MEC for IUS.

Table 15. MEC categories for IUS

Category 1: Use the method without restriction.

- | | |
|---|--|
| • Women more than 20 years old | • Depressive disorders |
| • Women who have given birth | • Women with irregular but not heavy vaginal bleeding |
| • Any time for non-breastfeeding postpartum women | • Initiation in women with heavy or prolonged bleeding |
| • More than 4 weeks after childbirth | • Diagnosed with benign ovarian tumor, endometriosis, severe dysmenorrhea |
| • Post-abortion in the first trimester | • Cervical ectropion |
| • Past ectopic pregnancy | • Benign breast disease or family history of cancer |
| • History of pelvic surgery | • History of gestational diabetes |
| • Women who smoke at any age | • Non-pelvic tuberculosis |
| • Body mass index of more than or equal to 30 kg/m ² | • Adequately controlled hypertension, in which blood pressure CAN be evaluated |
| • Schistosomiasis | • Malaria |
| • Have increased blood pressure (systolic of 140 mm Hg to 159 mm Hg or diastolic of 90 mm Hg to 99 mm Hg) | • History of PID and with subsequent pregnancy |
| • History of high blood pressure during pregnancy | • Uterine fibroids that do not distort the uterine anatomy |
| • Family history of DVT/PE | • Any thyroid disorders |
| • Surgery without immobilization | • History of pregnancy-related cholestasis |
| • Superficial venous thrombosis | • Any classification of viral hepatitis |
| • Uncomplicated valvular heart disease | • Mild liver cirrhosis |
| • Non-migrainous headache | • Epilepsy |
| • Anemias such as thalassemia, sickle cell disease, or iron-deficiency anemia | • Current intake of any anticonvulsant or antimicrobial |

Category 2: Generally use the method but with more than usual follow-up.

- Menarche to 20 years old
- Women who have not given birth
- Have high blood pressure (systolic of more than or equal to 160 mm Hg or diastolic of more than or equal to 100 mm Hg)
- History of hypertension, in which blood pressure CANNOT be evaluated
- Post-abortion in the second trimester
- Continued use in women with increased risk of STIs
- History or current DVT/PE on anticoagulant therapy
- Major surgery with prolonged immobilization
- Current and history of ischemic heart disease, stroke, or hyperlipidemia
- Known thrombogenic mutations
- Complicated valvular heart disease
- Use of any antiretroviral therapy
- Migraine without aura
- Continued use in women with heavy or prolonged vaginal bleeding
- Women diagnosed with cervical intraepithelial neoplasia
- Women diagnosed with systemic lupus erythematosus and on immunosuppressive treatment or with severe thrombocytopenia
- Undiagnosed breast mass
- High risk of HIV
- Among women with anatomical abnormalities that interfere with IUD insertion (e.g., cervical laceration or stenosis)
- Initiation of the method in women with past PID and no subsequent pregnancy
- Hypertension with vascular disease
- Other STIs (excluding gonorrhea, chlamydial, and HIV) and vaginitis
- Continued use in women with endometrial cancer or ovarian cancer
- Initiation of the method in women who are HIV-infected
- Women with AIDS but on anti-retroviral therapy
- Currently on anti-retroviral therapy
- Diabetes, with or without vascular disease
- Any gall bladder disease
- History of cholestasis related to COC use
- Benign liver tumors such as focal nodular hyperplasia
- Continued use in women with cervical cancer prior to treatment

WHO CANNOT USE THE IUS?

Category 3: Do not use the method unless no other appropriate method is available under close supervision.

- Undiagnosed breast mass
- Continued use in women with endometrial cancer or ovarian cancer
- Among women with anatomical abnormalities that interfere with IUD insertion (e.g., cervical laceration or stenosis)
- Initiation of the method in women with past PID and no subsequent pregnancy
- Continued use in women with increased risk of STIs
- Other STIs (excluding gonorrhea, chlamydial, and HIV) and vaginitis
- High risk of HIV
- Initiation of the method in women who are HIV-infected
- Women with AIDS but on anti-retroviral therapy
- Currently on anti-retroviral therapy
- Diabetes, with or without vascular disease
- Any gall bladder disease
- History of cholestasis related to COC use
- Benign liver tumors such as focal nodular hyperplasia
- Use of any antiretroviral therapy

Category 4: Do NOT use the method.

- During pregnancy
- Puerperal sepsis
- Immediate post-septic abortion
- Initiation of method in clients with unexplained vaginal bleeding before evaluation
- Women with gestational trophoblastic disease
- Initiation of method in clients with cervical or endometrial cancer
- Diagnosed with breast cancer
- Among women with anatomical abnormalities that distort the uterine cavity (e.g., fibroids)
- Current PID
- Initiation of method in clients with current purulent cervicitis, chlamydial infection, or gonorrhea
- Initiation of method in clients with pelvic tuberculosis

WHAT ARE THE POSSIBLE SIDE EFFECTS OF IUS?

The following are the possible side effects that IUS users may experience:

- Headache
- Nausea
- Acne
- Mood changes
- Weight gain
- Back pain
- Breast tenderness or pain
- Excessive fluid retention in the body tissues, resulting in swelling (edema)
- Development of fluid-filled sacs (cysts) in the ovaries
- Inflammation of the lining of the vagina (vaginitis)
- Changes in menstrual bleeding
- Lower abdominal pain



According to the WHO (74), the risk of uterine perforation or puncturing with IUS insertion using the prescribed instrument is rare. If it does occur, it usually heals without treatment. The risk of miscarriage, preterm birth, and infection when an IUS is in place and the woman becomes pregnant is very rare.

WHAT COUNSELING TIPS SHOULD BE OFFERED TO THE CLIENT?

- Recommend a gynecological examination before IUS insertion, six weeks after insertion, and then yearly (or more frequently if clinically needed).
- The IUS provides effective contraception for five years and must be removed by a doctor after this time. However, inform the client that it can be removed earlier if required or if the patient no longer desires its use.
- Give antibiotics to a client with any heart valve defects when the IUS is inserted or removed to prevent inflammation of the heart valves and the sac surrounding the heart (endocarditis).
- Advise a client who has missed a period of six weeks to consult her doctor to ensure that the IUS has not been expelled and that she is not pregnant. The IUS might have been causing her periods to stop.

WHEN IS IUS REMOVAL RECOMMENDED?

- Recommend the removal of the IUS if the client experiences recurrent pelvic infection or inflammation of the womb lining (endometritis) or if an infection does not respond to treatment within a few days.
- An IUS may be expelled from the uterus without the user noticing it, although an increase in menstrual bleeding or pain may serve as a warning. The effectiveness of the IUS is lost or decreased if it is expelled or partially expelled, respectively.
- Show the client how to check the removal threads on her IUS when it is inserted to make sure that it is still in place. Tell her to consult a doctor if she cannot find the threads.
- Ask the client to consult her doctor if she experiences lower abdominal pain, particularly in combination with missed periods, or a recurrence of menstrual bleeding if her periods had stopped.
- If pregnancy does occur while the IUS is in place, the IUS should be removed.

Chapter 7

BARRIER METHODS:

Male and Female Condoms, Diaphragm, Cervical Cap, Spermicides

WHAT ARE BARRIER METHODS?

Barrier methods are devices that mechanically or chemically prevent fertilization.

MALE CONDOMS

WHAT ARE MALE CONDOMS?

A male condom is a thin sheath of latex rubber made to fit on a man's erect penis to prevent the passage of sperm cells by forming a barrier that prevents pregnancy. It also helps keep infections in semen, on the penis, or in the vagina from infecting the other partner.

HOW EFFECTIVE IS THE MALE CONDOM?

The effectiveness of this method depends on the user. The risk of pregnancy or sexually transmitted infection (STI) is greatest when condoms are not used with every sexual intercourse.



Protection against pregnancy

- When used correctly with every sexual intercourse, only 2 per 100 women whose partners use male condoms become pregnant over the first year of use.
- As commonly used, about 15 per 100 women whose partners use male condoms become pregnant over the first year of use.

Protection against human immunodeficiency virus (HIV) and other STIs

- When used consistently and correctly, condoms prevent 80% to 95% of HIV transmission that would have occurred without a condom.
- When used consistently and correctly, condoms reduce the risk of STIs.

HOW IS THE MALE CONDOM USED?

The following steps must be followed by the user when using a condom before sexual intercourse:

1. Hold the pack, and look for any perforation or damage; check the expiration date as well. If the pack is damaged or has expired, discard it.
2. Open the package properly and carefully; do not use fingernails, teeth, or anything that can damage the condom.
3. Hold the condom in a way that the tip of the condom is facing away from the penis.
4. Press the tip of the condom between the thumb and index finger of one hand, and maintain it there while the other hand places the condom with the rolled side out over the erect penis. Pressing the tip prevents air accumulation.
5. Unroll the condom all the way down to the base of the erect penis; put on the condom before the entry of the penis into the vagina.
6. After ejaculation, hold the rim of the condom at the base of the penis so it will not slip off while withdrawing the penis out of the vagina before it completely loses its erection.
7. Remove the condom by sliding it off the penis, making sure not to spill semen on the vaginal opening.
8. Make a knot of the condom, place it inside the package, and wrap it with a paper and dispose of it properly. Reuse of male condoms is NOT recommended.



WHO CAN USE THE MALE CONDOM?

- Couples who ask for its use and are reliable users
- Couples who want to use it as a backup method when the use of another method is interrupted
- Couples who are at high risk of STIs
- Couples who want to use it as a temporary method until another method is preferred
- Couples who have medical contraindications with other methods or those who personally prefer condom use
- Men who have problems with premature ejaculation, as condoms can help delay ejaculation
- Postvasectomy clients who are waiting for sperm check or semen analysis after three months



WHO CANNOT USE THE MALE CONDOM?

- Either or both sex partners with allergic reaction to latex rubber

WHAT ARE THE KNOWN HEALTH BENEFITS AND RISKS OF MALE CONDOM USE?

- Protects against the risks of pregnancy and against microorganisms that cause STIs, including HIV
- Protects women against some STI-induced conditions (recurring pelvic inflammatory disease and chronic pelvic pain [endometriosis], cervical cancer, and infertility)
- Can cause severe allergic reaction among individuals with latex allergy (extremely rare)

WHAT SHOULD BE DONE IF A SEVERE ALLERGIC REACTION OCCURS?

If the user develops severe allergic reaction to the latex rubber, perform the following:

- Tell the client to stop using latex condoms.
- Refer for care, if necessary. Severe allergic reaction to latex could lead to life-threatening anaphylactic shock. Help the client choose another method unless the client is at risk for STIs.
- If itching continues, the client and partner should be assessed for infection.
- Suggest the use of female condoms or plastic male condoms for clients or partners who cannot avoid the risk of STIs.

WHAT HAPPENS WHEN THE CLIENT STOPS USING THE METHOD?

A client who stops using this method faces the risk of getting his partner pregnant and the risk of getting STIs or HIV.

WHEN IS A REFERRAL NEEDED?

A referral is needed when the client develops symptoms of STIs, such as sores on the genitals, pain when urinating, appearance of discharge, or when the client develops allergic reactions to condoms.

WHAT ARE THE FACTS ABOUT MALE CONDOMS?

Contrary to popular beliefs, condoms

- do not make men sterile, impotent, or weak.
- do not decrease men's sex drive.
- cannot get lost in a 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 sperm or semen from entering her body.
- do not cause illness in men and do not cause sperm to "back up."
- are also used by married couples.

WHAT COUNSELING TIPS SHOULD BE PROVIDED TO THE CLIENT?

- The effectiveness of the condom is enhanced if used with spermicides because it will not only act as a barrier in the union of the sperm and egg cell but also immobilize or kill the sperm cells.
- Water-based lubricants, such as spermicides and glycerin, should be used. Water or the vaginal secretion can also be used. Advise users not to use cooking oil, baby oil, coconut oil, or skin lotion as a lubricant because these products can damage the condom.
- Ensure that the client understands the correct use of a condom. Ask the client to explain the basic steps of using the condom by putting it on a penis model or a similar object and then taking it off.
- Explain the importance of using a condom during sexual intercourse. Emphasize to the client that one unprotected sexual intercourse can lead to pregnancy, STI, or both. If the client forgets to use the condom at one time during sex, encourage him to use the next time and explain again the risks.
- Encourage a client to consistently use a condom.
- Ask clients how they are doing with the method and whether they are satisfied. Ask if they have any questions or anything to discuss.
- Ask clients if they are having any trouble using condoms correctly every time they have sex. Give the clients information or help that they need.

WHAT ARE THE FREQUENTLY ASKED QUESTIONS ABOUT MALE CONDOMS?

1. Are condoms effective in preventing pregnancy?
 - Yes. Male condoms are effective but only if used correctly every time during sexual intercourse. When used consistently and correctly, only 2 of every 100 women whose partners use condoms become pregnant over the first year of use. However, many men do not consistently or correctly use condoms, thereby reducing protection from pregnancy.
2. How well do condoms help protect against HIV infections?
 - On the average, when used correctly and consistently, condoms are 80% to 95% effective in protecting people against HIV infection that would have occurred without condoms. However, this statistic does not indicate that 5% to 20% of condom users will become infected with HIV. For example, about 10 of 10,000 uninfected women whose partners have HIV infection would likely become infected with HIV if each couple had unsafe (i.e., without condom) vaginal sex even once and has no additional risk factors for infection. However, only 1 or 2 of these women would likely become infected with HIV if their male partners correctly used condoms.
3. Are plastic (synthetic) condoms effective in preventing STIs including HIV?
 - Yes. Plastic condoms are expected to provide the same protection as latex condoms, but they have not been studied thoroughly. Plastic condoms are recommended for clients who cannot use latex condoms. However, condoms made of animal skin such as lambskin (also called natural skin condom) are not effective for preventing STIs, including HIV.
4. Do condoms often break or slip off during sex?
 - No. On the average, about 2% of condoms break or slip off completely during sex, primarily because they are used incorrectly. Some studies suggest that some users consistently misuse condoms, which lead to breaks or slips. Users must learn the correct way of opening and removing the condom from the pack, putting it on before and removing it after sexual intercourse, and avoiding practices that increase the risk of breakage.

5. Will condoms make a man unable to have an erection (impotent)?

- No. Impotence has many causes. Some causes are either physical or emotional. Condoms do not cause impotence. A few men may have problems keeping an erection when using condoms; older men may have difficulty keeping an erection because condoms can dull the sensation from having sex. Using more lubrication may help increase sensation for men who use condoms.

6. Are condoms used mainly in casual relationship or by people who have sex for money?

- No. While many casual partners rely on condoms for STI protection, married couples all over the world use condoms to avoid pregnancies or as a family planning method.

FEMALE CONDOMS

WHAT ARE FEMALE CONDOMS?

- A female condom is a thin sheath of soft transparent polyurethane plastic, about 7 cm to 8 cm in diameter and 17 cm long. It has two flexible rings. One ring has a smaller diameter and found at the closed end of the condom, which aids the woman in inserting it high within the vagina near the cervix; the other is wider and found at the open end covering the vulva when properly positioned.
- A female condom works by forming a barrier that keeps sperms out of the vagina, thus preventing pregnancy; it also keeps infections in semen, on the penis, or in the vagina from infecting the other partner.



HOW EFFECTIVE IS THE FEMALE CONDOM?

The effectiveness of this method depends on the user. The risk of pregnancy or STI is greatest when condoms are not used with every sexual intercourse.

Protection against pregnancy

- When typically used, about 21 per 100 women using female condoms become pregnant over the first year of use.
- When used correctly with every sexual intercourse, about 5 of 100 women using female condoms become pregnant over the first year of use.

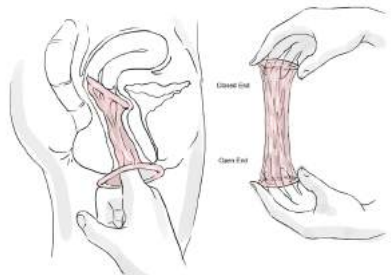
Protection against HIV and other STIs

- Female condoms reduce the risk of STIs, including HIV, when used correctly with every sexual intercourse.

HOW IS THE FEMALE CONDOM USED?

A client can start the method any time she wants. The following steps must be followed by the user when using a condom before sexual intercourse.

1. Check the female condom package for any damage, including the expiry date. Do not use a female condom past its expiration date. If possible, wash your hands with mild soap and clean water before inserting the female condom into the vagina.
2. Insert the condom into the vagina before any physical contact.
 - Insert the condom within 8 hours before sex. To achieve the most protection, insert the condom before the penis comes into contact with the vagina.
 - Assume a position that is comfortable for insertion: squatting, raising one leg, sitting, or lying 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 of the vagina (labia), and locate the vaginal canal.
 - Gently push the inner ring into the vagina as far up as it will go. Insert a finger into the condom to push it in into place. Allow about 2 cm to 3 cm of the condom and the outer ring to cover the outside the vagina.
3. Ensure that the penis enters the condom and stays inside the condom during sexual intercourse.
 - The man or woman should carefully guide the tip of the penis inside the condom, not between the condom and the wall of the vagina. If the 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.



4. After the man withdraws his penis, hold the outer ring of the condom, twist to seal in fluids, and gently pull it out of the vagina.
 - The female condom does not need to be removed immediately after sex.
 - Remove the condom before standing up, to avoid spilling the semen.
 - If the couple has sex again, they should use a new condom.
 - Reuse of female condoms is not recommended.
5. Wrap the used condom in its package, and put it in the rubbish or latrine.

WHO CAN AND CANNOT USE THE FEMALE CONDOM?

- Except for allergy to the condom material, no medical conditions prevent the use of this method.

WHAT ARE THE HEALTH BENEFITS OF THE FEMALE CONDOM?

Known health benefits of female condoms include protection against risk of pregnancy and STIs, including HIV.

WHAT ARE THE SIDE EFFECTS OF THE FEMALE CONDOM?

- Mild irritation in or around the vagina
 - Apply lubricant on the part of the condom that comes into contact with the vaginal wall.
 - If symptoms persist, assess and refer the client to a specialist for the treatment of possible vaginal infection or STI.

WHAT SHOULD BE INQUIRED FROM OR ADVISED TO THE CLIENT DURING FOLLOW-UP?

- Ask how the client is doing with the method and whether she is satisfied. Ask if she has any questions or anything to discuss.
- Ask if she has any trouble using a female condom correctly every time she has sex. Give her any information or help that she needs.
- Inquire from a long-term client any major life changes that may affect her needs, particularly plans for having children and about the risk of STIs or HIV. Follow up as needed.

WHAT HAPPENS WHEN CLIENTS STOP USING THE METHOD?

A client who stops using this method faces the risk of getting pregnant and the risk of getting STIs or HIV.

WHEN IS A REFERRAL NEEDED?

A referral is needed when the client develops symptoms of STIs, such as sores on the genitals, pain when urinating, and vaginal discharge that is foul smelling; and when the client develops severe allergic reactions to the condom.

WHAT ARE THE COMMONLY ASKED QUESTIONS ABOUT FEMALE CONDOMS?

1. Are female condoms difficult to use?
 - No, but practice and patience are required to learn how to use the method.
2. Are female condoms too big to be comfortable?
 - No. Female condoms have the same length as male condoms, except wider. They are very flexible and fit to the shape of the vagina. Female condoms have been carefully designed and tested to fit any woman or man, regardless of her vaginal size or his penis size, respectively.

3. Can female condoms be lost inside a woman's body?

- No. Female condoms remain in a woman's vagina until removed. These condoms cannot enter the cervix and uterus because of their large size.

WHAT COUNSELING TIPS SHOULD BE PROVIDED TO A CLIENT WHO CHOOSES TO USE THE FEMALE CONDOM?

- Reuse of the female condom is not recommended. Always use a new female condom every sexual intercourse.
- Help the client to choose another method if she is not comfortable with using a female condom.
- For clients at risk of STIs and HIV, urge the continued use of female condoms despite discomfort.
- Ensure that the client understands the correct use of female condoms. Ask the client to demonstrate while explaining the basic steps in using a female condom.
- Explain why using a condom with every sexual intercourse is important and that one unprotected sexual intercourse can lead to pregnancy, STI, or both. Encourage the client to always use a condom as an FP method or as a protection against STIs, including HIV.
- Discuss the different approaches or skills that can be applied for negotiating condom use with partners.



DIAPHRAGM

WHAT IS A DIAPHRAGM?

- A diaphragm is a soft latex cup that covers the cervix when used as an FP method.
- The cup is provided with a rim that is firm with a flexible spring that keeps the diaphragm in place.
- It is used with a spermicidal cream, jelly, or foam to improve effectiveness.
- It comes in different sizes and requires fitting by a trained provider.
- It works by blocking sperm cells from entering the cervix while the spermicide kills or disables the sperm from meeting the egg.



HOW EFFECTIVE IS THE DIAPHRAGM?

- The effectiveness of this method depends on the user. The risk of pregnancy is greatest when the diaphragm with spermicide is not used during every sexual intercourse.
- When typically used, about 16 of 100 women who use the diaphragm with spermicide become pregnant over the first year. This means that 84 of every 100 women using the diaphragm will not become pregnant.
- When used correctly with every sexual intercourse, about 6 of 100 women who use the diaphragm with spermicide become pregnant over the first year.
- A diaphragm may provide some protection against certain STIs but should not be relied on as the only protection against STIs.

HOW IS THE DIAPHRAGM USED?

A client can use a diaphragm any time but must wait for six weeks if the client had a full-term delivery or had a second trimester abortion. The provider of this method must observe the following steps:

1. Use proper infection prevention procedures.
2. Instruct the client to assume a lithotomy position for a pelvic examination, and assess for conditions (e.g., uterine prolapse) that may make the diaphragm improper to use.

3. Perform an internal examination to assess the cervix and determine the diaphragm size.
4. Insert a special fitting diaphragm into the client's vagina, and apply it to cover the cervix, making sure that the diaphragm fits properly and does not come out easily.

The following steps must be observed by the user when using a diaphragm:

1. Check the diaphragm for any damage, including the expiration date of the spermicide. Insert the diaphragm less than six hours before having sex. After hand washing with soap and water, squeeze a spoonful of spermicidal cream, jelly, or foam into the diaphragm and around the rim.
2. Press the rim together to ease the insertion of the device into the vagina. Assume a position that is comfortable for insertion: squatting, raising one leg, sitting, or lying down. While holding the diaphragm with the fingers pressing on the rim, insert the diaphragm into the vagina until the cervix is felt, and then apply it to cover the cervix.
3. Feel the diaphragm and the rim to make sure that it covers the entire cervix, fits properly, and does not come out easily.
4. Keep the diaphragm in place for at least 6 hours after having sex but no longer than 24 hours. For multiple sexual intercourse, make sure that the diaphragm is in the correct position, and insert additional spermicide in front of the cap before each sexual intercourse.
5. To remove the diaphragm, wash hands with soap and water, insert finger to feel for the rim, then gently slide a finger under the rim of the diaphragm to pull it down and out.
6. Wash the diaphragm with mild soap and water and dry it after each use.

WHO CAN AND CANNOT USE THE DIAPHRAGM?

- Nearly all women can use the diaphragm safely and effectively.
- Women with severe allergic reaction to latex cannot use this method but can use a plastic-made diaphragm.
- Women with HIV infection or at high risk of HIV infection are not advised to use the diaphragm.

WHAT ARE THE HEALTH BENEFITS, RISKS, AND COMPLICATIONS OF DIAPHRAGM USE?

- The diaphragm protects against the risk of pregnancy.
- The known health risks include urinary tract infection, bacterial vaginosis, or candidiasis.
- The side effects may include vaginal lesions or irritation in or around the vagina or penis.

HOW ARE THE SIDE EFFECTS ADDRESSED?

- Women with allergic reactions to a latex rubber-made diaphragm should use a plastic-made diaphragm.
- The provider can counsel the client to use other effective methods.

WHAT IMPORTANT INFORMATION SHOULD BE PROVIDED TO THE CLIENT WHO CHOOSES TO USE THE DIAPHRAGM?

- Ensure that the client understands the correct use of the diaphragm by allowing her to repeat how and when to insert and remove the diaphragm.
- Explain that the procedure becomes easier with time, i.e., the more practice she has with inserting and removing the diaphragm, the easier it will get.
- Describe common side effects, such as itching and irritation in or around the vagina or penis and how to go about it.
- Clarify that a diaphragm that becomes thin, damaged, or stiff should not be used and should be replaced. The diaphragm should be replaced every two years.

WHAT SHOULD BE INQUIRED FROM OR ADVISED TO THE CLIENT DURING FOLLOW-UP?

- Ask how the client is doing with the method and whether she is satisfied. Ask if she has questions or anything to discuss.
- Ask if she has any trouble using a diaphragm correctly every time she has sex. Give her any information or help that she needs.
- Ask a long-term client if she has had any new health problems since her last visit. Address problems accordingly.
- Inquire from a long-term client any major life changes that may affect her needs, particularly plans for having children and about the risk of STIs or HIV.

WHAT HAPPENS WHEN CLIENTS STOP USING THE DIAPHRAGM?

A client who stops using this method faces the risk of getting pregnant and the risk of getting STIs or HIV.

WHAT ARE THE FACTS ABOUT DIAPHRAGMS?

Contrary to popular beliefs, a diaphragm does not

- affect the enjoyment of sex.
- pass through the cervix.
- cause cervical cancer.

WHAT COUNSELING TIPS SHOULD BE PROVIDED TO A CLIENT WHO CHOOSES TO USE THE DIAPHRAGM?

- The diaphragm should be fitted at least six weeks after childbirth or second trimester abortion, when the uterus and cervix have returned to normal size. However, recommend the use of an alternative method until the sixth week.
- Reiterate that the risk of pregnancy is greatest when the diaphragm with spermicide is not used during every sexual intercourse.
- Do not provide a diaphragm for clients who have HIV infections or at high risk for HIV infections. Suggest using condoms instead.

CERVICAL CAP

WHAT IS A CERVICAL CAP?

- A cervical cap is a cup-shaped device made of soft rubber that fits over the cervix and is held in place at least partially by suction between its firm flexible rim and the surface of the cervix at the upper vaginal wall.
- It is one of the least effective methods of FP.

HOW EFFECTIVE IS THE CERVICAL CAP?

- The effectiveness of this method depends on the user. The risk of pregnancy is greatest when the method is not used during every sexual intercourse.
- When typically used, about 32 per 100 women who use the cervical cap with spermicide become pregnant over the first year of use. This statistic indicates that 68 of every 100 women using the cervical cap will not become pregnant.
- When used correctly with every sexual intercourse, about 20 per 100 women who use the cervical cap become pregnant over the first year of use.

HOW IS THE CERVICAL CAP USED?

A client can use the cervical cap any time but have to wait for six weeks if the client has had a full-term delivery or a second trimester abortion. The provider of this method must observe the following steps:

1. Use proper infection prevention procedures.
2. Instruct the client to assume a lithotomy position for a pelvic examination, and assess for conditions (e.g., uterine prolapse) that may make the cervical cap impossible to use.
3. Perform an internal examination to assess the cervix and determine the cervical cap size.
4. Insert a special fitting cervical cap into the client's vagina, and apply it to cover the cervix, making sure that the cervical cap fits properly and does not come out easily.

Use of cervical cap

1. Check the cervical cap for any damage, including the expiration date of the spermicide used. Insert the cervical cap at any time up to 42 hours before having sex. After hand washing with soap and water, fill one third of the cap, including around the rim, with spermicidal cream, jelly, or foam.
2. Press the rim of the cap around the cervix until it is completely covered, and then press gently on the dome of the cap to apply suction and seal the cap.
3. Feel the cervical cap and the rim to make sure it covers the entire cervix, fits properly, and does not move out easily.
4. For multiple sexual intercourse, make sure that the cap is in the correct position and insert additional spermicide in front of the cervical cap before each sexual intercourse.

Removal of cervical cap

1. Leave the cervical cap for at least 6 hours after the sexual intercourse but not more than 48 hours from the time it was inserted.
2. Tip the cap rim sideways to break the seal on the cervix, and then gently pull the cap down and out of the vagina.
3. Wash the cervical cap with mild soap and water and dry it after each use.

WHO CAN AND CANNOT USE THE CERVICAL CAP?

- Nearly all women can use the cervical cap safely and effectively.
- Women who develop lesions on the cervix when in contact with the cervical cap cannot use this method.
- Women with HIV infection or at high risk of HIV infection are not advised to use the cervical cap.

WHAT ARE THE HEALTH BENEFITS, RISKS, AND COMPLICATIONS OF CERVICAL CAP USE?

- The cervical cap protects against the risk of pregnancy.
- The known health risks include urinary tract infection, bacterial vaginosis, or candidiasis.
- The side effects may include vaginal lesions or irritation in or around the vagina or penis.

HOW ARE THE SIDE EFFECTS OF CERVICAL CAP USE ADDRESSED?

Women with allergic reactions to cervical cap may discontinue its use. The provider can counsel her to use other effective methods.

WHAT IMPORTANT INFORMATION SHOULD BE PROVIDED TO THE CLIENT WHO CHOOSES TO USE THE CERVICAL CAP?

- Ensure that the client understands the correct use by allowing her to repeat how and when to insert and remove the cervical cap.
- Explain that the procedure becomes easier with time, i.e., the more practice she has with inserting and removing the cervical cap, the easier it will get.
- Describe common side effects, such as itching and irritation in or around the vagina or penis and how to go about it.
- Clarify that a cervical cap that becomes thin, damaged, or stiff should not be used and should be replaced. The cervical cap should be replaced every two years.

WHAT SHOULD BE INQUIRED FROM OR ADVISED TO THE CLIENT DURING FOLLOW-UP?

- Ask how the client is doing with the method and whether she is satisfied. Ask if she has questions or anything to discuss.
- Ask if she has any problems using the cervical cap correctly every time she has sex. Give her any information or help that she needs.
- Tell her where else she can obtain more spermicides if needed.
- Ask a long-term client if she has had any new health problems since her last visit. Address problems accordingly.
- Inquire from a long-term client any major life changes that may affect her needs, particularly plans for having children and about the risk of STIs or HIV.

WHAT HAPPENS WHEN CLIENTS STOP USING THE CERVICAL CAP?

A client who stops using this method faces the risk of getting pregnant and the risk of getting STIs or HIV.

WHAT ARE THE FACTS ABOUT CERVICAL CAPS?

Contrary to popular beliefs, a cervical cap does not

- affect the enjoyment of sex.
- pass through the cervix.
- cause cervical cancer.

WHAT COUNSELING TIPS SHOULD BE PROVIDED TO THE CLIENT WHO CHOOSES TO USE THE CERVICAL CAP?

- The cervical cap should be fitted after six weeks of childbirth or second trimester abortion, when the uterus and cervix have returned to normal size. However, recommend the use of an alternative method until the sixth week.
- Reiterate that the risk of pregnancy is greatest when the cervical cap with spermicide is not used with every sexual intercourse.
- Do not provide a cervical cap to clients who have HIV infections or at high risk for HIV infections and for clients that have been treated for cancer. Suggest using condoms instead.



SPERMICIDES

WHAT ARE SPERMICIDES?

- Spermicides are chemical substances that kill the sperms and are available in different forms, such as gel, aerosol foam, foam tablet, film tablet, and cream.
- Vaginal spermicides are sperm-killing substances, such as nonoxynol-9, benzalkonium chloride, chlorhexidine, menfegol, octoxynol-9, and sodium docusate, which are inserted deep in the vagina, near the cervix, before sex.
- Spermicides work by causing the membrane of sperm cells to break, killing them or slowing their movement. This phenomenon keeps the sperm from meeting the egg.
- Spermicide as a contraceptive is NOT currently used in the Philippines because spermicides are not readily available in drug stores.

HOW EFFECTIVE IS THE SPERMICIDE?

- The effectiveness of the method depends on the user. It is one of the least effective FP methods.
- When typically used, about 29 per 100 women who use spermicides become pregnant during the first year. This statistic indicates that 71 of every 100 women using spermicide will not become pregnant.
- When used correctly with every sexual intercourse, about 18 per 100 women who use spermicides become pregnant over the first year.

HOW ARE SPERMICIDES USED?

Spermicides can be used any time the client wants. The provider of this method must observe the following steps:

1. Explain the process of inserting spermicides into the vagina. Check first the expiration date, and avoid using spermicides that are past their expiration date.
 - For foam or cream: shake can of foam; squeeze spermicide from the can or tube into a plastic applicator. Insert the applicator deep into the vagina, near the cervix, and push the plunger.
 - For tablets, suppositories, jellies: insert the spermicide deep into the vagina, near the cervix, with an applicator or with fingers.

2. Explain when to insert spermicide into the vagina.
 - Foam or cream can be inserted any time less than one hour before sex.
 - Tablets, suppositories, jellies, and film can be inserted between 10 minutes and 1 hour before sex, depending on type.
3. Explain use of spermicide for multiple sexual acts. Instruct the client to insert additional spermicide before each act of vaginal sex. Douching is not recommended after sex because it will wash away the spermicide and increases the risk of STIs. If the client must douche, wait for at least six hours before doing so.

WHO CAN AND CANNOT USE SPERMICIDES?

- Nearly all women can use spermicides.
- Those who cannot use the method include persons who are at high risk for HIV infection and those who have HIV/AIDS.

WHAT ARE THE BENEFITS OF SPERMICIDE USE?

- This method can be used without seeing a healthcare provider.
- It can be inserted ahead of time; thus, it does not interrupt sex.
- Use is controlled by the client.

HOW ARE THE SIDE EFFECTS OF SPERMICIDE USE ADDRESSED?

- Some users report irritation in or around the vagina or penis. Vaginal lesions are the other possible physical changes.
- Clients deserve provider's attention if side effects or problems with spermicide affect their satisfaction with and use of the method.
- The provider should listen to the client's concerns, give her advice, and treat if necessary.
- The provider should also help the client to choose another method if she wishes or if problems cannot be resolved.

WHAT IMPORTANT INFORMATION SHOULD BE PROVIDED TO THE CLIENT WHO CHOOSES TO USE SPERMICIDES?

- Ensure that the client understands the correct use by asking her to repeat how and when to insert the spermicide.
- Assure the client that spermicide use does not cause birth defects or harm the fetus if a woman becomes pregnant while using the spermicide or accidentally uses the spermicide while she is already pregnant and that it does not cause cancer.
- Tell the client to avoid too much use of the spermicide nonoxynol-9 because it may increase the risk of HIV infection or cause vaginal irritation or small lesions on the lining of the vagina or on the external genitals.

WHAT SHOULD BE INQUIRED FROM OR ADVISED TO THE CLIENT DURING FOLLOW-UP?

- Ask how the client is doing with the method and whether she is satisfied. Ask if she has questions or anything to discuss.
- Ask if she has any problems using the spermicide correctly every time she has sex. Give her any information or help that she needs.
- Ask a long-term client if she has had any new health problems since her last visit. Address problems accordingly.
- Ask a long-term client about major life changes that may affect her contraceptive needs, particularly plans for having children and STI/HIV risk.

WHAT ARE THE FACTS ABOUT SPERMICIDES?

Spermicides do not

- reduce vaginal secretions or make women bleed during sex.
- cause cervical cancer or birth defects.
- protect against STIs.
- change men's or women's sex drive or reduce sexual pleasure for most men.
- stop women's monthly bleeding.

Chapter 8

FERTILITY AWARENESS-BASED METHODS

WHAT ARE FERTILITY-AWARENESS BASED METHODS?

Fertility awareness-based (FAB) contraceptive methods are based on the recognition of the beginning and end of the fertile period of a woman's menstrual cycle. Sometimes called periodic abstinence or natural family planning (NFP), these methods require abstaining from sexual intercourse during the fertile phase to avoid conception. The success of these methods depends on the woman's ability to identify the fertile phase of each menstrual cycle, the competence of the teacher-provider, and the couples' motivation and discipline to practice abstinence when required. FAB methods provide an alternative for women who want to use natural methods for medical, religious, or personal reasons.

FAB methods include the following:

- **Calendar-based methods**
These methods keep track of the days of the menstrual cycle to identify the start and end of the fertile period. The two calendar-based methods are the calendar rhythm method and the Standard Days Method (SDM). The SDM is the only DOH-recommended method.
- **Symptoms-based methods**
These methods depend on observing signs of fertility (cervical mucus or Billings Ovulation Method, Two-Day Method, basal body temperature [BBT] method, and symptothermal method).

HOW DO FAB METHODS WORK?

- FAB methods use one or more indicators to identify the start and end of the fertile period during a menstrual cycle.
- Practicing abstinence during the fertile period prevents pregnancy.
- Support and cooperation of the partner are necessary for the correct use of the method.

WHAT ARE THE ADVANTAGES OF FAB METHODS?

- Can be used either to avoid pregnancy or to become pregnant
- No physical side effects
- Very little or no cost
- Immediately reversible
- Acceptable for some religious groups that reject or discourage the use of other methods
- No hormonal side effects
- Involves men and encourages responsibility on FP
- Educates couple about women's fertility cycles

WHAT ARE THE DISADVANTAGES OF FAB METHODS?

- May inhibit sexual spontaneity
- Difficult to practice (abstinence) on fertile days for some couples
- Will not work without continuing cooperation and commitment of the couple
- Requires consistent and accurate record keeping on body changes
- Can become unreliable or difficult to use when menstrual cycle length is short, long, or irregular; when fertility signs and symptoms are affected by illness; or when users are apprehensive or find difficulties in following instructions
- Does not protect against sexually transmitted infections, including human immunodeficiency virus (HIV)/autoimmune deficiency syndrome (AIDS)

HOW EFFECTIVE ARE FAB METHODS?

The effectiveness of FAB methods depends on the user. The risk of pregnancy is greatest when couples have sex on fertile days without using a backup method. When typically used, about 25 per 100 women who use periodic abstinence become pregnant over the first year of use. The pregnancy rates for the typical use of specific FAB methods are not available. Table 16 shows the pregnancy rates for the consistent and correct use of FAB methods and abstinence on fertile days.

Table 16. Pregnancy rates with consistent and correct use and abstinence on fertile days

Method	Pregnancies per 100 Women Over the First Year
Standard Days Method	5
Calendar Rhythm method	9
Two-Day Method	4
Basal Body Temperature (BBT) Method	1
Billings Ovulation Method	3
Symptothermal Method	2

Source: Family Planning: A Global Handbook for Providers WHO 2011

HOW MANY DAYS SHOULD A WOMAN ABSTAIN OR USE ANOTHER METHOD BEFORE SHE CAN EFFECTIVELY USE EACH OF THE FAB METHODS?

The number of days required for a woman to practice abstinence or use another method before the effective use of FAB methods, as shown in the table below, depends on the length of her menstrual cycle.

Table 17. Length of time to practice abstinence and use another method before effective use of FAB methods is achieved

Method	No. of Days to Abstain or Use Another Method
Standard Days Method	12
Two-Day Method	13
Billings Ovulation Method	18
Symptothermal Method	17

Source: Family Planning: A Global Handbook for Providers WHO 2011

WHAT ARE THE WHO-MEC FOR FAB METHODS?

Table 18. MEC categories for FAB methods

ACCEPT	The method has no restriction.
CAUTION	The method requires extra or special counseling to ensure correct use.
DELAY	The method should be delayed until a condition is evaluated or corrected.

IS FOLLOW-UP NECESSARY?

Routine return visits are not required. However, the client or the couple can meet with the FP service provider during the first few cycles if they want further assistance.

The FP service provider should assure the client that she is welcome to return in the following cases:

- She has problems, questions, or wants another method.
- She has any major change in health status.
- She thinks she might be pregnant.
- She is having difficulty identifying her fertile days.
- She is having trouble avoiding sex or using another method on the fertile days.



Follow-up visits should also be encouraged to check whether the couple is using the method correctly and to review the observations or records of fertility signs.

WHAT IMPORTANT INFORMATION ABOUT FAB METHODS SHOULD BE PROVIDED TO CLIENTS?

- To be effective, the use of FAB methods requires partners' cooperation. The couple must be committed to abstain or use another method of contraception on fertile days.
- The woman must be aware of body changes or keep track of the days according to the rules of the method being used.
- This method has no side effects or health risks.

CALENDAR-BASED METHODS

WHAT ARE CALENDAR-BASED METHODS?

Calendar-based methods are FAB methods that use calendar calculations to determine the period when becoming pregnant is unlikely.

All women can use calendar-based methods. Although no medical conditions prevent the use of these methods, some conditions make them difficult to use.

Table 19. MEC for calendar-based methods

- **Accept** means that the FAB methods can be used without restriction. This approach applies in the following:
 - Women with vaginal discharge
 - Women with diseases that elevate body temperature, both acute and chronic diseases
- **Caution** means that additional or special counseling may be needed to ensure correct use of the method. This approach applies in the following situations:
 - Menstrual irregularities among young women in their first several years after menarche and in older women approaching menopause may make the identification of the fertile period difficult.
- **Delay** means that use of a particular fertility awareness-based method should be delayed until the condition is evaluated or corrected. Give the client another method to use until she can start the calendar-based method. This approach applies in the following situations:
 - Recently gave birth or is breastfeeding. This method can only be recommended if the client has had at least three menstrual cycles and if her cycles are regular again.
 - Recently had an abortion or miscarriage. Delay the use of the method until the start of the client's next monthly bleeding.
 - Irregular vaginal bleeding.
- **Delay or use with caution** in the following situations that may affect signs of fertility or delay ovulation:
 - Taking any mood-altering drugs such as anti-anxiety therapies (except benzodiazepines) and antidepressants (selective serotonin reuptake inhibitors, tricyclic, or tetracyclic)
 - Long-term use of certain antibiotics
 - Long-term use of any nonsteroidal anti-inflammatory drug (such as aspirin and ibuprofen) or paracetamol

Standard Days Method

WHAT IS THE STANDARD DAYS METHOD?

The SDM is based on the physiology of the menstrual cycle and the functional life span of the ovum and the sperm. It can be used by women if their menstrual cycles are 26 to 32 days long. The client uses color-coded CycleBeads to mark the fertile and infertile days of her menstrual cycle and to monitor her cycle length. Clients using this method abstain from sexual intercourse on fertile days (days 8 to 19) to avoid pregnancy.



HOW EFFECTIVE IS THE SDM?

About 5 per 100 women who consistently and correctly use the method and abstain on fertile days become pregnant over the first year of use.

WHO CAN USE THE SDM?

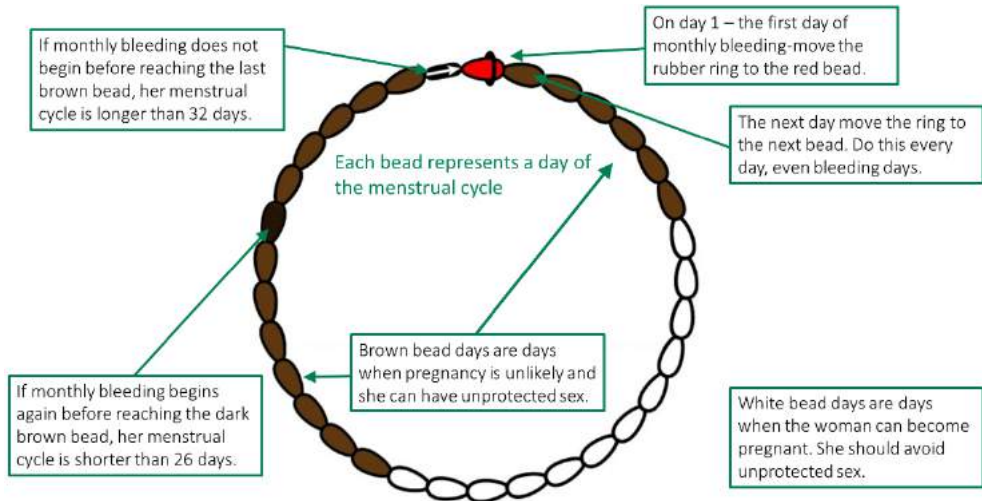
The SDM works well for women who usually have menstrual cycles that are 26 to 32 days long.

WHO CANNOT USE THE SDM?

Women with cycles that are NOT 26 to 32 days long cannot use the method.

HOW AND WHEN IS THE SDM USED?

- The client keeps track of the days of her menstrual cycle and counts the first day of her monthly bleeding as day 1.
- Using the CycleBeads, the client moves the ring to the red bead to begin a new cycle and marks that day on her calendar. She moves the rubber ring one bead every day.
- Days 8 to 19 of every cycle (when the ring is on the white beads) are considered fertile days for all SDM users.
- The couple avoids vaginal sex (or uses condoms, spermicides, or withdrawal) during days 8 to 19.
- The couple can have unprotected sex on all the other days of the cycle (when the ring is on the brown beads)—days 1 to 7 at the beginning of the cycle and from day 20 until her next monthly bleeding begins.





Source: Georgetown University Medical Center

iCycleBeads™ is a smartphone app that allows a woman to use the SDM through her Android or iOS device. The application asks for the woman's first day of the period and creates a calendar or a virtual representation of the CycleBeads. With a click of a button, this period tracking tool shows the user where she is in her cycle and whether she is on a day when pregnancy is likely or not.

WHAT ARE THE SIDE EFFECTS OF THE SDM?

The SDM has no known side effects.

HOW ARE PROBLEMS RELATED TO SDM USE MANAGED?

If the client has two or more cycles outside the 26–32 day range within any 12 months, suggest the use of the symptoms-based method.

SYMPTOMS-BASED METHODS

WHAT ARE SYMPTOMS-BASED METHODS?

The use of symptom-based methods requires training for the client. Ideally, the couple should be trained to use this method to recognize the signs of fertility when abstinence from sex should be practiced.

WHEN SHOULD THE USE OF SYMPTOMS-BASED METHODS BEGIN?

- Clients with regular menstrual cycles can start the method any time of the month. They do not need to wait for the start of the next monthly bleeding.
- Clients with no monthly bleeding (menses) should delay symptom-based methods until their monthly bleeding returns.
- Clients who recently gave birth (regardless of whether they are breastfeeding) can start symptom-based methods once their normal secretions have returned. Normal secretions will return later in breastfeeding women than in non-breastfeeding women.
- Clients can start symptom-based methods immediately after a miscarriage or an abortion as long as they do not have infection-related secretions or bleeding due to genital tract injury.
- Clients switching from a hormonal method can start symptom-based methods in the next menstrual cycle after stopping the hormonal method.

WHO CAN USE SYMPTOMS-BASED METHODS?

All women can use symptoms-based methods. Although no medical conditions prevent the use of these methods, some conditions make them difficult to use effectively.



Table 20. MEC for symptoms-based methods

- **Acceptable use** in most women, even for
 - Women who are four weeks or more in postpartum
 - Non-breastfeeding women

- **Use caution** in the following situations:
 - Recently had an abortion or miscarriage.
 - Menstrual cycles have just started or have become less frequent or stopped because of older age. Menstrual cycle irregularities are common in young women in the first several years after the menarche and in women who are nearing the menopausal period.
 - Has a chronic condition that raises body temperature (for BBT and symptothermal methods).

- **Delay** the use of symptom-based methods in the following situations:
 - Recently gave birth or is breastfeeding. Delay until normal secretions have returned—usually at least six months after childbirth.
 - Not breastfeeding. In this case, the client must wait at least four weeks after childbirth. For several months after regular cycles have returned, clients should use the method with caution.
 - Has an acute condition that raises body temperature (for BBT and symptothermal methods).
 - Has abnormal vaginal discharge.
 - Has irregular vaginal bleeding.

- **Delay or use with caution** in the following situations that may affect cervical secretions, raise body temperature, or delay ovulation:
 - Taking any mood-altering drugs, such as anti-anxiety therapies (except benzodiazepines), antidepressants, and antipsychotics (including chlorpromazine, thioridazine, haloperidol)
 - Long-term use of certain antibiotics
 - Long-term use of any nonsteroidal anti-inflammatory drug (e.g., aspirin and ibuprofen), paracetamol, or antihistamines

Two-Day Method

WHAT IS THE TWO-DAY METHOD?

The Two-Day Method is a FAB method that involves cervical secretions as an indicator of fertility and women checking the presence of secretions every day.

If a woman notices any secretions today or yesterday, she should consider herself fertile and avoid intercourse today.

HOW EFFECTIVE IS THE TWO-DAY METHOD?

About 4 per 100 women who consistently and correctly use the method and abstain on fertile days become pregnant over the first year of use.

HOW IS THE TWO-DAY METHOD USED?

The following pointers should be given to clients:

- Check for cervical secretions every afternoon and/or evening on underwear or by sensation in or around the vagina using the fingers or tissue paper. Distinguishing the characteristics of the secretions (i.e., amount, color, consistency, slipperiness, stretchability, or viscosity) is not necessary.
- A client who notices any secretions of any type, color, or consistency should consider herself fertile that day and the following day.
- Avoid sex, or use another method on fertile days. The couple avoids vaginal sex or uses a barrier method on each day with secretions and on each day following a day with secretions.
- The couple can have unprotected sex again after the woman has had two dry days (days without secretions of any type) in a row.

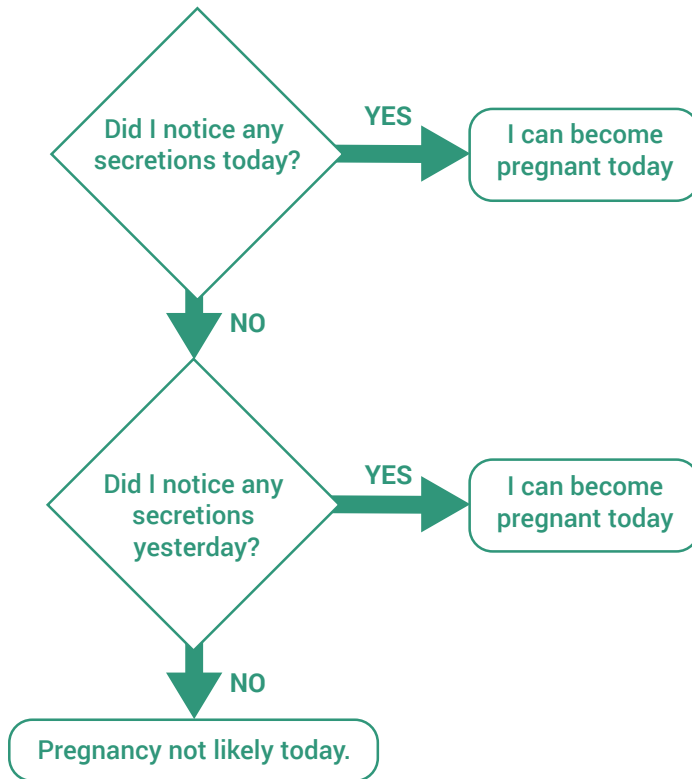
WHAT ARE THE SIDE EFFECTS OF THE TWO-DAY METHOD?

The Two-Day Method has no known side effects.

HOW ARE PROBLEMS RELATED TO THE USE OF THE TWO-DAY METHOD MANAGED?

A woman who has a vaginal infection or another condition that changes cervical mucus may find the Two-Day Method difficult to use.

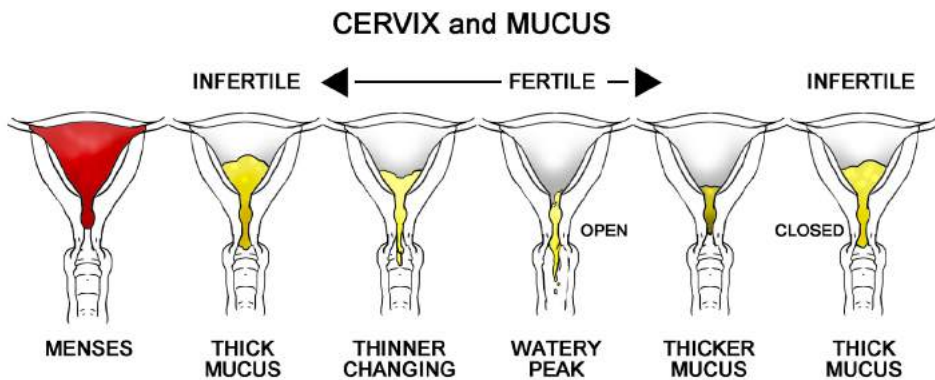
Figure 4. Two-Day Method algorithm



Billings Ovulation Method

WHAT IS THE BILLINGS OVULATION METHOD?

The ovulation method or the Billings Ovulation Method involves the observation of wet and dry sensations in the vulva. The feeling of wetness and the secretion of wet, slippery, and clear mucus indicate a fertile period. The feeling of dryness and having no secretion or the presence of pasty, non-stretchy mucus or unchanging mucus pattern a day after menstruation indicates the infertile period.



HOW EFFECTIVE IS THE BILLINGS OVULATION METHOD?

About 3 per 100 women who consistently and correctly use the method and abstain on fertile days become pregnant over the first year of use.

HOW AND WHEN IS THE BILLINGS OVULATION METHOD USED?

- The client checks daily for any cervical secretions on underwear by tissue paper or by finger in or around the vagina.
- The client must avoid unprotected sex on days of heavy monthly bleeding because ovulation might occur early in the cycle, particularly during the last days of monthly bleeding, and heavy bleeding could make mucus difficult to observe.

- A couple can have unprotected sex between the end of monthly bleeding and the start of secretions every other day but not for two days in a row. Avoiding sex on the second day allows time for semen to disappear and for cervical mucus to be observed.
- A couple can have sex in the evenings after the woman has been in an upright position for at least a few hours and has been able to verify the absence of cervical mucus.
- A client who notices any secretions should consider herself fertile and should avoid unprotected sex.
 - Secretions have a “peak day”—the last day that the client secretes clear, slippery, stretchy, and wet mucus (*spinnbarkeit* mucus).
 - The client will know that this day has passed when her secretions the following day are sticky or dry or when she has no secretions at all.
 - She should continue to consider herself fertile for the next three days after that peak day and should abstain from sex or use another contraceptive method.
 - Unprotected sex can be resumed on the fourth day after the woman’s peak day and until her next monthly bleeding begins.
- A client who has a vaginal infection or another condition that changes cervical mucus may find this method difficult to use.



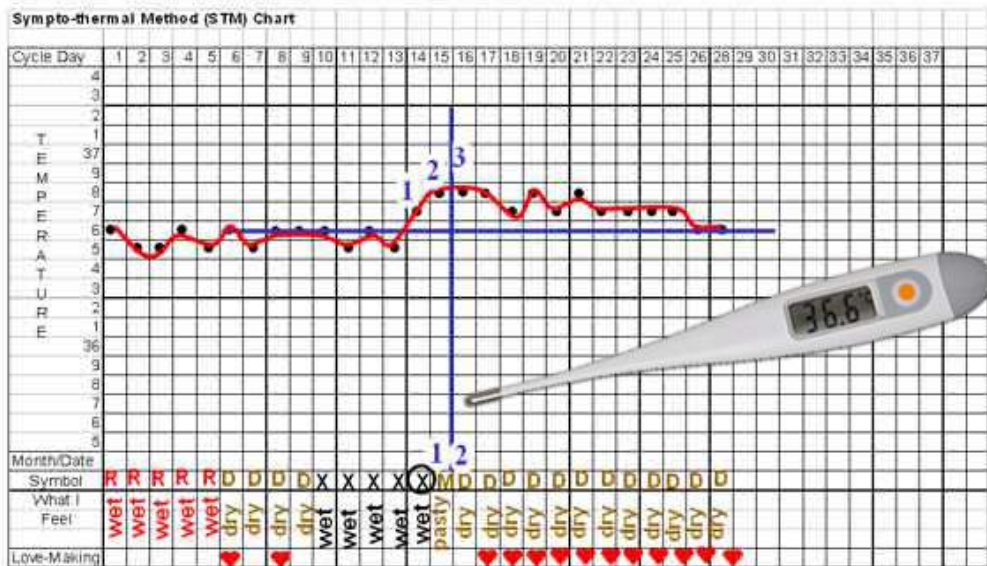
WHAT ARE THE SIDE EFFECTS OF THE BILLINGS OVULATION METHOD?

The Billings Ovulation Method has no known side effects.

Basal Body Temperature Method

WHAT IS THE BBT METHOD?

The BBT method involves identifying the fertile and infertile periods of a woman's cycle by taking and recording daily the rise in body temperature during and after ovulation. BBT is the temperature of the body at rest after at least three hours of continuous sleep before temperature taking. A woman's BBT rises during her ovulation period and stays high until the next menstruation because of a rise in progesterone level.



HOW EFFECTIVE IS THE BBT?

About 1 per 100 women who consistently and correctly use the method and abstain on fertile days become pregnant over the first year of use.

HOW IS THE BBT METHOD USED?

- The client takes her body temperature at the same time each morning before she gets out of bed or does anything. She records her temperature on a special graph using a special thermometer. She watches for her temperature to rise slightly—0.2 °C to 0.5 °C (0.4 °F to 1.0 °F)—just after ovulation (about midway through the menstrual cycle).
- The couple should avoid sex or use another method from the first day of menses until three days after the rise in temperature.
- A BBT that has risen above the client's regular temperature and stayed high for three full days indicates that ovulation has occurred and that the fertile period has passed. The couple can have unprotected sex on the fourth day and until her next monthly bleeding begins.
- A client who has fever/colds or other changes in the body temperature may find the method difficult to use.

WHAT ARE THE SIDE EFFECTS OF THE BBT?

The BBT method has no known side effects.

Symptothermal Method

(BBT + CERVICAL SECRETIONS + OTHER FERTILITY SIGNS)

WHAT IS THE SYMPTOTHERMAL METHOD?

The client identifies her fertile and infertile days by combining BBT, cervical mucus observations, and other fertility signs, such as breast tenderness and ovulatory pain to avoid unprotected sex on fertile days.

HOW EFFECTIVE IS THE SYMPTOTHERMAL METHOD?

About 2 per 100 women who consistently and correctly use the method and abstain on fertile days become pregnant over the first year of use.

HOW IS THE SYMPTOTHERMAL METHOD USED?

The couple avoids unprotected sex between the first day of monthly bleeding and either the fourth day after peak cervical secretions or the third full day after the rise in temperature (BBT), whichever occurs later. Some women who use this method have unprotected sex between the end of menses and the beginning of secretions, but not on two days in a row.

WHAT ARE THE SIDE EFFECTS OF THE SYMPTOTHERMAL METHOD?

The symptothermal method has no known side effects.

Chapter 9

LACTATIONAL AMENORRHEA METHOD (LAM)

WHAT IS THE LACTATIONAL AMENORRHEA METHOD?

The LAM primarily works by preventing ovulation. Frequent breastfeeding temporarily prevents the release of the natural hormones that cause ovulation. This method is considered effective under the following three conditions: (1) the monthly menstruation has not returned, (2) the baby is fully or nearly fully breastfed and often day and night, and (3) the baby is less than six months old.

HOW EFFECTIVE IS THE LAM?

- When typically used, about 2 per 100 women in the first six months after childbirth become pregnant.
- When used correctly, about 1 per 100 women who use the method in the first six months after childbirth become pregnant.

The risk of pregnancy is the greatest when a woman cannot fully or nearly fully breastfeed her infant.

HOW IS THE LAM USED?

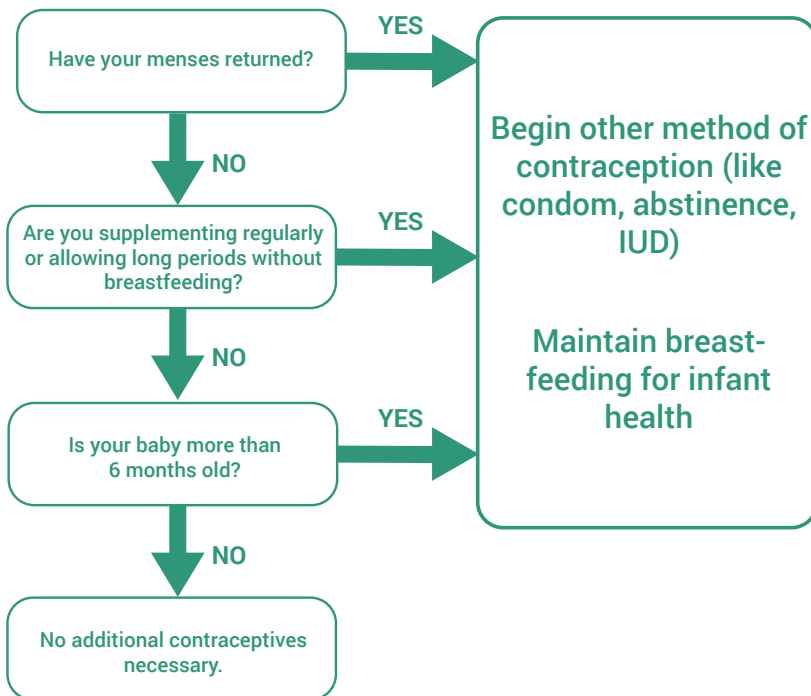
- The LAM can be started immediately after birth up to six months after childbirth. The client should breastfeed immediately (within one hour) or as soon as possible after the baby is born.
- The method can be used any time if the client has been fully or nearly fully breastfeeding her baby since birth and her monthly bleeding has not returned.



The following points should be provided to the client:

- o Feed on demand (whenever the baby wants to be fed) and at least 10 to 12 times a day in the first few weeks after childbirth and 8 to 10 times a day thereafter, including at least once at night in the first months.
- o Daytime feedings should not be more than four hours apart, and nighttime feedings should not be more than six hours apart. Some babies may need gentle encouragement to breastfeed more often even at night.
- o Start other foods at six months in addition to breast milk. At this age, breast milk can no longer fully nourish a growing baby.
- o The client should plan for another method while the LAM criteria still apply to continue protection from pregnancy.

Figure 5. Algorithm of the LAM



WHAT ARE THE ADVANTAGES OF THE LAM?

- The LAM is universally available to all postpartum breastfeeding women.
- With the LAM, protection from an unplanned pregnancy begins immediately postpartum.
- The LAM contributes to improved maternal and child health and nutrition breastfeeding and weaning practices.
- The LAM serves as a bridge toward the use of other FP methods.

WHAT ARE THE DISADVANTAGES OF THE LAM?

- The effectiveness of the LAM may decrease among mothers who are separated from their child for extended periods.
- Full or nearly full breastfeeding may be difficult to maintain for up to six months.

WHO CAN USE THE LAM?

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

- Has HIV/AIDS
- Is using certain medications during breastfeeding (including mood-altering drugs, reserpine, ergotamine, antimetabolites, cyclosporine, high doses of corticosteroids, bromocriptine, radioactive drugs, lithium, and certain anticoagulants)
- The newborn has a condition that makes breastfeeding difficult (including premature babies and those that need intensive neonatal care, are unable to digest food normally, or have deformities of the mouth, jaw, or palate)

WHEN SHOULD THE CLIENT SWITCH FROM THE LAM TO ANOTHER METHOD?

When any of the three LAM criteria is no longer met, another FP method must be introduced to the client in a timely manner to ensure birth spacing.

- The client can switch to another method any time she wants while using the LAM. A client is considered not pregnant if she still meets the three LAM criteria. She can begin a new method with no need for a pregnancy test, examinations, or evaluations.
- To prevent pregnancy, the client must switch to another method as soon as any of the three LAM criteria no longer applies.

The FP service provider should help the client choose a new method before she needs it. A client who wishes to continue breastfeeding can choose from several hormonal or non-hormonal methods.

WHAT IMPORTANT INFORMATION SHOULD BE PROVIDED TO CLIENTS WHO CHOOSE TO USE THE LAM?

- The LAM is an FP method based on breastfeeding that provides contraception for the mother and the best nutrition for the baby.
- The LAM can be effective for up to six months after childbirth as long as monthly menstruation has not returned and the client is fully or nearly fully breastfeeding.
- For optimum effectiveness, the LAM requires frequent breastfeeding (day and night). The baby should be fully or nearly fully breastfed.

Chapter 10

LONG-ACTING AND PERMANENT METHODS:

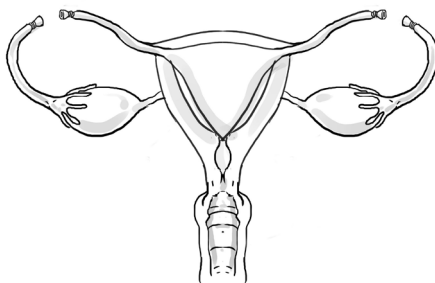
Bilateral Tubal Ligation and Vasectomy

Long-acting and permanent methods are one of the most effective types of modern contraceptives. These safe and cost-effective methods are performed in health facilities by specially trained providers. Proper counseling must be conducted prior to the surgical procedures because these methods are considered permanent.

FEMALE STERILIZATION: BILATERAL TUBAL LIGATION

WHAT IS FEMALE VOLUNTARY SURGICAL CONTRACEPTION?

It is a safe and simple surgical procedure that provides permanent contraception for women who do not want more children. The procedure, also known as bilateral tubal ligation (BTL), involves cutting or blocking the two fallopian tubes. Although this section also presents endoscopic approaches to BTL, the standard procedure is minilaparotomy under local anesthesia with light sedation.

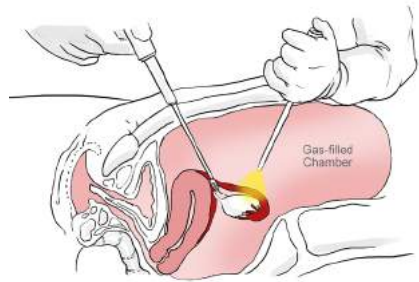


WHAT ARE THE DIFFERENT METHODS OF FEMALE VOLUNTARY SURGICAL CONTRACEPTION?

Endoscopic methods

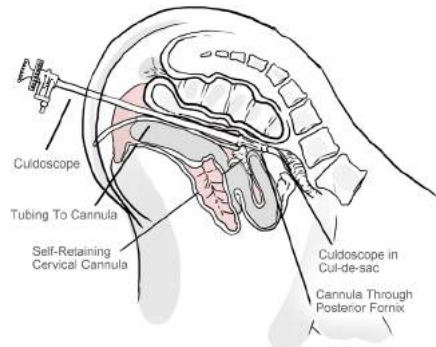
Laparoscopic tubal ligation

- One of the popular methods of BTL with a success rate for preventing pregnancy in more than 99 out of 100 women.
- Through the use of a specialized tool called a laparoscope, the doctor is able to view the insides of a woman's abdominal cavity and block both fallopian tubes, thus preventing pregnancy.
- With laparoscopic tubal ligation, a small incision or cut is made just below the umbilicus, through which a metallic tube called a trocar is inserted to access the abdominal cavity. Through the trocar, the laparoscope is inserted, thus enabling the insides of the abdomen to be viewed and the uterus and fallopian tubes to be identified. The fallopian tubes may then be blocked with Falope rings, clips, bands, and suture ligation; segmentally destroyed through electrocoagulation; or be partially or completely removed (salpingectomy).
- Although the most common types of anesthesia administered for laparoscopic BTL are spinal and general anesthesia, the preferred procedure in the country for keeping the client comfortable is local anesthesia with analgesia and sedation. Laparoscopic BTL is usually performed on an out-patient basis.



Culdoscopy

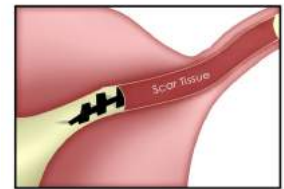
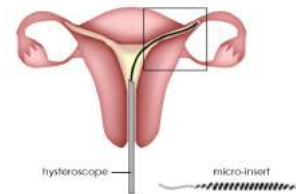
- A type of vaginal sterilization procedure. The vaginal approach of tubal ligation was once the preferred technique. However, this procedure is associated with higher risks than laparoscopic tubal ligation surgery. Thus, surgeons have been favoring the transabdominal over the transvaginal approach.



- A major advantage of a culdoscopy is that no abdominal incisions are made. Culdoscopy tends to be reserved for obese patients or for women with a retroverted uterus. This transvaginal procedure involves a small incision made through the vaginal wall. However, a culdoscopy may be difficult to perform because it requires a woman to be in a knee-to-chest position while under local anesthesia.
- During culdoscopy, an incision is made into the posterior vaginal fornix (the recess behind the cervix). A culdoscope, which is a type of endoscope with light that is used to visualize female pelvic organs, is inserted through the incision into the peritoneal cavity. The culdoscope aids the surgeon in locating the fallopian tubes. The fallopian tubes are pulled through the incision into the vagina. The culdoscope is removed, and the tubes are closed off (tied, clipped, or sealed shut) and put back into place. The incision is then stitched closed.
- A BTL by culdoscopy takes about 15 to 30 minutes and is performed as an outpatient procedure.

Hysteroscopic tubal ligation

- A transcervical sterilization device was approved by the U.S. Food and Drug Administration in 2002. This micro-insert is known as Essure. It is placed hysteroscopically to block the fallopian tubes from within the uterine cavity. The insert contains inner polyethylene terephthalate fibers to induce fibrotic reaction and is held in place by a flexible stainless steel inner coil and an outer nickel titanium alloy coil. The device is designed to stimulate tissue growth in and around the insert to form an occlusion of the fallopian tube lumen. The tissue barrier formed prevents sperm from reaching and fertilizing an ovulated egg. It usually takes three months before the tubes are considered effectively occluded with the completeness of the blockage, which is confirmed by a hysterosalpingogram.
- The short-term efficacy rate of this method is equal to or better than that of the other sterilization methods. However, the long-term efficacy rates are still unavailable. This method is not suitable for future reversal. This type of device is not yet commercially available in the Philippines.



MINILAPAROTOMY UNDER LOCAL ANESTHESIA-BILATERAL TUBAL LIGATION

BTL by minilaparotomy under local anesthesia is the accepted standard procedure of the Department of Health (DOH). Local anesthesia is used because it is safe and allows the client to go home the same day. General anesthesia is riskier than the sterilization procedure itself. Correct use of local anesthesia removes the single greatest source of risk in female sterilization procedures, that is, general anesthesia. Moreover, women usually feel nauseous after general anesthesia (which does not occur as often after local anesthesia). However, when using local anesthesia with sedation, providers must take care not to overdose the client with the sedative.

Through a small incision in the client's abdomen, a segment of both fallopian tubes is cut off or blocked. With disruption in the continuity of the tubes, the woman's egg cannot meet the man's sperm.

HOW EFFECTIVE IS FEMALE STERILIZATION?

Female sterilization is 99.5% effective with perfect and typical use.

WHAT ARE THE ADVANTAGES OF FEMALE STERILIZATION?

- Permanent method of contraception. A single procedure leads to lifelong, safe, and very effective contraception.
- Does not involve hormones. No changes in libido (sexual desire), menstrual cycle, or breastfeeding ability.
- It is an outpatient procedure.
- Nothing to remember, no supplies needed, and no repeated clinic visits required.
- Results in increased sexual enjoyment, as the woman does not need to worry about pregnancy.
- No known long-term side effects or health risks.
- Can be performed immediately after a woman gives birth.
- Can be performed without any routine laboratory tests, blood tests, or cervical cancer screening

WHAT ARE THE DISADVANTAGES OF FEMALE STERILIZATION?

- Uncommon complications of surgery :
 - Infection or bleeding at the incision site
 - Injury to internal organs
 - Anesthesia risks, which are uncommon with local anesthesia
- BTL is a permanent method of family planning (FP), and some women may regret the decision later. Reversal surgery is difficult, expensive, and unavailable in most areas. Successful reversal is not guaranteed. Clients who may want to become pregnant in the future should not choose this method. FP counseling is crucial.
- In rare cases when pregnancy occurs, it is more likely to be ectopic compared with pregnancies in women who have not undergone the procedure.
- The procedure requires an operating room set-up and should be performed by a trained provider.
- Physical activities, such as heavy work and lifting heavy objects, immediately after surgery are limited. The client may resume normal activities a week after the procedure.
- The method does not protect against STIs such as HIV/AIDS.

WHO CAN USE THIS METHOD?

- Female sterilization is safe for all women. Women can have BTL even during monthly bleeding, as long as she is reasonably certain that she is not pregnant.
- No medical conditions prevent a woman from using female sterilization. However, some client conditions may limit when, where, or how the female sterilization procedure should be performed. The WHO Medical Eligibility Criteria (MEC) provide evidence-based recommendations based on clients' conditions and characteristics (see Table 21 of Appendix E, p. 333). The service provider is encouraged to use these tools as a guide in determining the suitability of clients to the female sterilization procedure.



Table 21. MEC categories for female sterilization

Accept the method in the following situations:

- | | |
|--|---|
| • Women who may or may not have given birth | • History of PID and with subsequent pregnancy |
| • Breastfeeding women | • Family history of cancer |
| • Less than 7 days postpartum OR more than 42 days postpartum | • Other STIs (excluding gonorrhea, chlamydial, and HIV) and vaginitis |
| • Mild pre-eclampsia | • High risk of HIV |
| • Uncomplicated abortion | • HIV-infected |
| • Past ectopic pregnancy | • Uncomplicated schistosomiasis |
| • Women who smoke at any age | • Non-pelvic tuberculosis |
| • Past medical or family history of DVT/PE | • Malaria |
| • Surgery without prolonged immobilization | • History of gestational diabetes |
| • History of cholestasis | • Asymptomatic gallbladder disease |
| • Migraine or non-migrainous type of headache | • Benign liver tumors such as focal nodular hyperplasia |
| • Chronic or carrier viral hepatitis | • Symptomatic gallbladder disease that has been treated |
| • Women with gestational trophoblastic disease but decreased or undetectable beta-hCG levels | • Known thrombogenic mutations, superficial venous thrombosis, or hyperlipidemias |
| • Diagnosed with benign ovarian tumor, cervical ectropion, or cervical intraepithelial neoplasia | • Women with irregular vaginal bleeding patterns |
| • Undiagnosed breast mass | • Mild liver cirrhosis |
| • History of benign breast disease | • Diagnosed with simple goiter |
| • History of breast cancer with no evidence of disease in the last 5 years | • Sterilization concurrent with cesarean section |

Use caution in the following situations:

- Young age
- Body mass index of more than or equal to 30 kg/m²
- Adequately controlled hypertension
- Have increased blood pressure (systolic of 140 mm Hg to 159 mm Hg or diastolic of 90 mm Hg to 99 mm Hg)
- History of stroke or ischemic heart disease
- Uncomplicated valvular heart disease
- Diagnosed with systemic lupus erythematosus
- Diagnosed with epilepsy or depressive disorders
- Current breast cancer
- Uterine fibroids
- History of PID and WITHOUT subsequent pregnancy
- Schistosomiasis with liver fibrosis
- Diabetes with non-vascular diseases
- Hypothyroidism
- Liver tumors such as hepatocellular adenoma or malignant hepatoma
- Thalassemia or sickle cell disease
- Iron-deficiency anemia with hemoglobin level between 7 g/dL to 10 g/dL
- Diaphragmatic hernia
- Kidney disease
- Severe nutritional deficiencies
- Previous abdominal or pelvic surgery
- Elective sterilization concurrent with abdominal surgery

WHO CANNOT USE THIS METHOD?

Delay use in the following situations:

- Currently pregnant
- Women who are 7 to 42 days postpartum
- Postpartum women with
 - Severe pre-eclampsia or eclampsia
 - Prolonged rupture of membranes, 24 hours or more
 - Puerperal sepsis, intrapartum or puerperal fever
 - Severe antepartum or postpartum hemorrhage
 - Severe trauma to the genital tract
- Post-abortion sepsis or fever, hemorrhage, or severe trauma or hematoma along the genital tract
- Acute DVT/PE
- Major surgery with prolonged immobilization
- Current ischemic heart disease
- Unexplained vaginal bleeding prior to evaluation
- Women with gestational trophoblastic disease, cervical cancer, endometrial cancer, or ovarian cancer
- Current PID
- Current purulent cervicitis, chlamydial infection, or gonorrhea
- Current symptomatic gall bladder disease
- Acute or flare viral hepatitis
- Iron-deficiency anemia
- Local infection
- Acute respiratory diseases such as bronchitis or pneumonia
- Systemic infection or gastroenteritis
- Sterilization concurrent with abdominal surgery without previous counseling or due to infectious condition

Special consideration should be undertaken prior to surgery in the following conditions:

- Postpartum or post-abortion uterine rupture or perforation
- Multiple risk factors for arterial cardiovascular disease such as old age, smoking, diabetes, and hypertension
- Have high blood pressure (systolic of more than or equal to 160 mm Hg or diastolic of more than or equal to 100 mm Hg)
- Hypertension with vascular disease
- Diagnosed with DVT/PE and on anticoagulant therapy
- Complicated valvular heart disease
- Diagnosed with systemic lupus erythematosus
- Endometriosis
- Women with AIDS
- Pelvic tuberculosis
- Diabetes with nephropathy, retinopathy, neuropathy, or other vascular diseases
- Hyperthyroidism
- Severe liver cirrhosis
- Coagulation disorders
- Chronic respiratory diseases such as asthma, bronchitis, emphysema, or lung infection
- Fixed uterus due to previous surgery or infection
- Abdominal wall or umbilical hernia

WHAT ARE THE STEPS IN CONDUCTING A FEMALE STERILIZATION PROCEDURE?

Timing of the procedure

A client can undergo female sterilization

- At any time that she is reasonably certain that she is not pregnant, except between seven days and six weeks after childbirth.
- Immediately after childbirth or within seven days if she has made a voluntary, informed choice in advance.
- Six weeks or more after childbirth if she abstains from unprotected sex or correctly uses a reliable method of contraception.
- Immediately after an abortion (within 48 hours).

Before the procedure

Instruct the client to

- Not eat any solid food for at least six hours before surgery, but the client may drink clear fluids up to two hours before the operation.
- Bathe thoroughly and clean the belly, genital area, and inner thighs well before going to the health facility.
- Wear clean, loose-fitting clothing.
- Not wear jewelry or nail polish.
- Bring a friend or relative to help her go home after the procedure.

Ensure informed consent by

- Reinforcing counseling to avoid regret and emphasizing that BTL is a permanent method.
- Explaining to the client the six elements of informed consent written on the Informed Consent Form.
- Checking that the Informed Consent Form is signed correctly by the client.

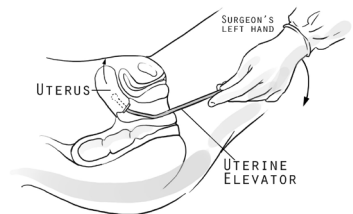
Assess client's suitability for the procedure by

- Reviewing her medical history (FP Form 1) to learn about her past and current health conditions, including the medications taken within 24 hours.
- Checking the client's conditions in accordance with the WHO MEC recommendations.
- Performing physical and pelvic examinations.

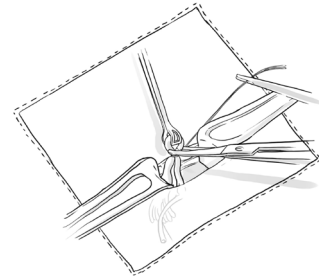
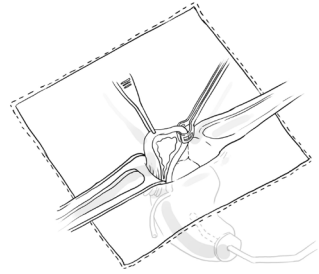
Prepare the client for the procedure (e.g., empty the bladder, change to hospital gown, remove nail polish and false teeth, if any).

Actual procedure

1. Observe proper infection prevention practices at all times.
2. Perform a pelvic examination to reconfirm earlier findings and to assess the condition of the uterus and its mobility.
3. Give the client IV fluids.
4. Insert the uterine elevator for interval cases to manipulate the uterus. This step is not performed for women who have just given birth.



5. Slowly administer intravenous sedative and analgesia.
6. Administer local anesthetic to intended incision site: two finger breadths from the upper border of the pubic bone for interval cases and just below the navel for postpartum women.
7. Make a small horizontal incision (2 cm to 5 cm) in the anesthetized area.
8. When the abdomen is opened, depress the uterine elevator to raise the uterus for easy identification of the fallopian tubes.
9. Tie and cut each tube.
10. Close the incision with stitches, apply antiseptic, and cover the wound with bandage.
11. Transfer the client to the recovery area.



After the procedure

- Observe the client for at least two hours. Discharge the client when her vital signs are stable and when she can tolerate food intake.
- Instruct the client to
 - Rest for one to two days and avoid heavy lifting for a week.
 - Keep the incision clean and dry for two days.
 - Avoid rubbing and scratching the incision for one week.
 - Take analgesic (paracetamol, mefenamic acid, ibuprofen) for pain.
 - Avoid sex until it is comfortable for her to do so, which is usually one week after the procedure.
- Provide client with written post-operative instructions.

Follow-up

Instruct the client to return to the clinic

- For a follow-up visit seven days after the procedure to ensure that the wound is healing well.
- At any time she has questions or problems.

WHAT ARE THE COMPLICATIONS?

Be aware of the warning signals and possible complications that may occur after the female sterilization procedure. Immediately refer the client to the appropriate health facility when she experiences any of the following:

- High fever ($> 38^{\circ}\text{C}$) in the first four weeks
- Pus or bleeding from the wound
- Pain, heat, swelling, or redness of the wound that worsens or does not subside
- Abdominal pain, cramping, or tenderness that worsens
- Fainting or extreme dizziness
- If the client thinks she might be pregnant with symptoms of
 - A missed period
 - Nausea
 - Breast tenderness
- If she has signs of ectopic pregnancy, such as
 - Lower abdominal pain or tenderness on one side
 - Abnormal or unusual vaginal bleeding
 - Faintness (indicating shock)



WHAT COUNSELING TIPS SHOULD BE PROVIDED TO A CLIENT?

Sterilization should not be offered only to women who have had a certain number of children or who have reached a certain age. Each woman must be allowed to decide whether she will want more children and whether or not to undergo sterilization.

Female sterilization is permanent. Thus, the FP counselor must ensure informed choice. A friendly counselor who listens to a woman's concerns, answers her questions, and gives clear, practical information about the procedure (especially its permanence) will help a woman make an informed choice. Informed choice results in a satisfied user without later regret.

Counseling must include the six elements of informed consent. When the client desires to undergo female sterilization, she signs an informed consent form that proves that the six elements have been discussed.

The six elements of informed consent are as follows:

- Temporary contraceptives are available to the client.
- Voluntary sterilization is a surgical procedure.
- The surgical procedure involves risks. Among the risks is the possibility that the procedure may fail.
- The effect of the procedure should be considered permanent.
- The procedure does not protect against sexually transmitted disease, including HIV/AIDS.
- The client can decide against the procedure at any time before the operation is performed without losing the right to medical health or other services or benefits.

In general, people who are most likely to regret sterilization are those who

- Are young
- Have few or no children
- Are not married
- Are having marital problems
- Have a partner who opposes sterilization

- Have just given birth or undergone an abortion, although these periods are convenient and safe for BTL. Women undergoing the procedure at these times may be more likely to regret doing so later. Thorough counseling during pregnancy, especially during antenatal visits, and a decision made before labor and delivery help avoid regrets.

Involving the client's spouse in counseling is helpful, as spousal consent is now being required by service providers. However, FP service providers should ensure that the decision to undergo sterilization is voluntarily made (not pressured or forced) by the client.

WHAT ARE THE FACTS ABOUT FEMALE STERILIZATION?

Contrary to popular beliefs, female sterilization does NOT

- make women weak.
- cause lasting pain in back, uterus, or abdomen.
- remove a woman's uterus or lead to a need to have it removed.
- cause hormonal imbalances.
- cause heavier bleeding or irregular bleeding or otherwise change women's menstrual cycles.
- cause any changes in weight, appetite, or appearance.
- change women's sexual behavior or sex drive.
- increase the risk of ectopic pregnancy.
- cause prolonged soreness and weakness.

KEY POINTS

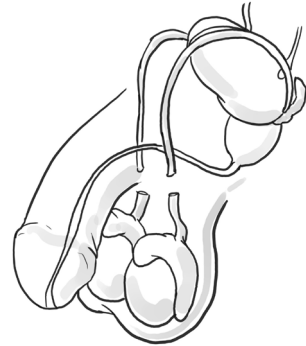
- Bilateral tubal ligation
 - is a safe and simple surgical procedure.
 - provides permanent contraception for women who do not want more children.
 - can be performed in a number of ways, including through endoscopic procedures, but the DOH-approved standard is by minilaparotomy under local anesthesia.
 - can be performed at any time that the client is reasonably certain that she is not pregnant.
 - is safe for all women.
 - is permanent. Counselors must ensure informed, voluntary choice to avoid regrets.
- If no pre-existing medical conditions require special arrangements, minilaparotomy can be provided in maternity centers and basic health facilities where surgery can be performed. These facilities include both permanent and temporary sites that can refer the client to a higher level of care in case of an emergency.



MALE VOLUNTARY SURGICAL CONTRACEPTION: VASECTOMY

WHAT IS MALE VOLUNTARY SURGICAL CONTRACEPTION?

It is a permanent method of contraception for men in which the vas deferens (the tube that serves as the passageway of sperm) is tied and cut or blocked through a small opening on the scrotal skin. This procedure is also known as vasectomy.



WHAT ARE THE DIFFERENT APPROACHES TO VASECTOMY?

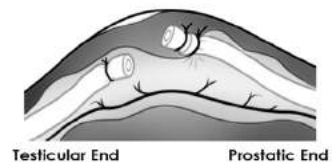
- Traditional/incisional vasectomy is a procedure in which a small midline or two lateral incisions are made in the scrotal skin using a scalpel.
- No-scalpel vasectomy (NSV) is a procedure in which a puncture wound is made at the midline of the scrotal skin using a vas dissecting forceps to reach both vas on either side. The advantages of this procedure (i.e., less pain and tissue trauma and shorter operating and recovery time) make it a highly preferable method.

Types of Vas Occlusion

After the vas has been delivered through the incision site, it can be occluded through the following approaches:

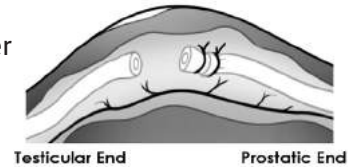
Fascial interposition

- After the vas is cut and tied, the fibrous tissue that covers it is pulled over one of the cut ends of the vas and tied. A barrier is thus created between the cut ends (i.e., testicular and prostatic) of the vas.
- This procedure improves the efficacy of contraception by providing additional safety against the entry of sperm cells into the ejaculate.



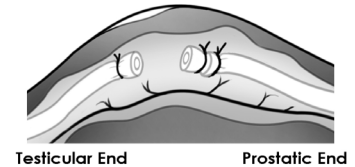
Open-ended

- One of the cut ends of the vas deferens is tied while the other is left open.
- In an open-ended procedure, the tube end connected to the testis is left open while the other that leads to the prostate is tied.
- This procedure is one of the popular types of vasectomy because of the low risk for complications.
- This method also inflicts the least amount of pain and discomfort to the client.



Close-ended

- The close-ended method refers to the closing or sealing of both the open ends of the vas deferens that have been cut.



HOW EFFECTIVE IS VASECTOMY?

- Vasectomy is 99.8% effective with perfect and typical use.
- However, full effectiveness can only be achieved three months after the procedure. Some pregnancies occur within the first year because the couple did not consistently and correctly use a backup method in the first three months before the vasectomy was fully effective.
- Clearing the male reproductive tract (vas, ejaculatory ducts, and urethra) of live sperm takes three months.

WHAT IS THE MECHANISM OF ACTION INVOLVED IN VASECTOMY?

Three months after the procedure, sperm is absent in the seminal fluid as a result of the blocking of the vas deferens. Hence, no fertilization can occur.

WHAT ARE THE ADVANTAGES OF VASECTOMY?

- Very effective three months after the procedure
- Permanent, safe, simple, and easy to perform
- Can be performed in a clinic, office, or at a primary care center [(Barangay Health Station(BHS)/Rural Health Unit (RHU)]
- No resupplies or repeated clinic visits
- No long-term health risks
- A reasonable option for couples whose female partner could not undergo permanent contraception
- Does not result in the loss of sexual ability, erection, and ejaculation
- Does not affect male hormonal function, erection, and ejaculation
- Does not lessen but may actually increase the couple's sexual drive and enjoyment
- Allows the client to have sex as before but without fear of getting his partner pregnant, which may also result in better sex

WHAT ARE THE DISADVANTAGES OF VASECTOMY?

- May be uncomfortable because of slight pain and swelling two to three days after the procedure
- Not effective immediately (clearing the male reproductive tract of live sperm takes three months)
- Difficult and expensive to reverse
- May cause bleeding, which may result in hematoma in the scrotum
- Can only be performed by a trained service provider
- May have recanalization of tubes (which is rare and unusual)
- Provides no protection against sexually transmitted infections (STIs), including human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS).

WHO CAN USE THE METHOD?

No medical condition absolutely restricts a man's eligibility for sterilization. However, some conditions and circumstances indicate that certain precautions should be taken. The World Health Organization (WHO) Medical Eligibility Criteria (MEC) provides an evidence-based classification of conditions into different categories of recommendations (Table 22).

Table 22. MEC categories for male sterilization

Accept the method in the following situations:

- High risk of HIV
- Infected with HIV
- Diagnosed with sickle cell disease

Use with caution in the following conditions:

- Young age
- Diagnosed with depressive disorders
- Diabetes
- Previous scrotal injury
- Large varicocele or hydrocele
- Cryptorchidism



WHO CANNOT USE THE METHOD?

The WHO MEC table and checklist for male sterilization are provided in Appendix E.

Delay the use in the following situations:

- Local infection
 - Scrotal skin infection
 - Active STI
 - Balanitis
 - Epididymitis or orchitis
- Systemic infection or gastroenteritis
- Filariasis, elephantiasis
- Intrasrotal mass

Special consideration should be undertaken prior to surgery in the following conditions:

- Diagnosed with AIDS, on antiretroviral therapy
- Coagulation disorders
- Inguinal hernia

WHAT ARE THE STEPS IN CONDUCTING AN NSV PROCEDURE?

Before the procedure

No-scalpel vasectomy is performed by a trained physician in a clinic, primary care center, or hospital. Reinforce counseling on vasectomy as a permanent procedure.

Assess the client as follows:

- Ask questions about the client's past and current health, including any medications taken within 24 hours before surgery.
- Perform physical and scrotal examinations.
- Check the WHO MEC recommendations for the client's conditions.

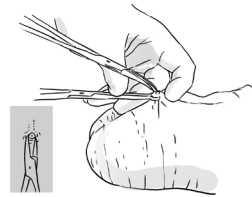
Ensure informed consent by

- Reinforcing counseling to avoid regrets and emphasizing that vasectomy is a permanent method.
- Explaining to the client the six elements of informed consent written on the Informed Consent Form.
- Checking that the Informed Consent Form is signed correctly by the client.

Prepare client for the procedure.

Actual procedure

1. Observe proper infection prevention practices at all times.
2. Feel the vas deferens underneath the scrotal skin, inject the full length of the needle, and administer approximately 2 cc. of 2% lidocaine. Repeat for the other vas.
3. Again, feel the vas deferens underneath the scrotal skin, and gently sweep the vas toward the midline, anesthetized area.
4. Grasp the vas with the ringed clamp.
5. Puncture the scrotal skin just above the grasped portion of the vas using dissecting forceps.
6. Expose the vas, deliver a loop of vas from the puncture site, tie the vas at two points, and cut a segment of vas between the ties.
7. Cover the cut end of the vas connected to the prostate with fascia.
8. Meticulously check for bleeding because hematoma formation is a common complication.
9. Let the vas fall back in place.
10. Feel the other vas, and sweep it toward the midline.
11. Grasp the vas with the ringed clamp, and perform the next steps as with the first vas.
12. Apply antiseptic to puncture site and cover with Band-aid strip.



After the procedure

Instruct the client to

- Take oral analgesics immediately before the anesthetic wanes as needed.
- Rest from heavy or strenuous work for two days.
- Wear tight fitting underwear or pants to relieve some pain, swelling, or bleeding.
- Keep wound dry and clean for the next two days.
- Abstain from unprotected sex for at least three months and after a sperm analysis shows the absence of live sperm.

Inform the client that

- He can resume sexual activity a week after the procedure or when he is comfortable, but he should use a condom or another contraceptive protection for three months after the procedure.
- He can choose to have a seminal fluid test performed after three months to verify whether sperm is still present in the semen.

Follow-up

The client is instructed to return to the clinic

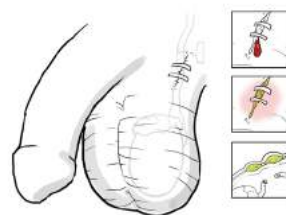
- Immediately for any signs of complications (see below).
- At any time when he has concerns about the procedure.
- Within two weeks to check for any postoperative problems.
- After three months for microscopic sperm check to confirm effectiveness of the procedure.

HOW ARE COMPLICATIONS OF VASECTOMY MANAGED?

Be aware of the warning signals and possible complications that may occur after the vasectomy. Instruct the client to return to the clinic immediately for further management when the warning signals occur.

- Bleeding or blood clots after the procedure
 - Reassure the client that minor bleeding and small uninfected blood clots usually disappear without treatment within a couple of weeks.
 - Large clots may need referral for surgical drain.
 - Infected blood clots require antibiotics and hospitalization.

- Redness, heat, pain, pus at the incision site as signs of infection
 - Clean the infected area with soap and water or antiseptic.
 - Give oral antibiotics for 7 to 10 days.
 - Instruct the client to return after taking all antibiotics if the infection has not cleared.
- Pus under the skin caused by infection (abscess)
 - Clean the area with antiseptic.
 - Open and drain the abscess.
 - Treat the wound.
 - Give oral antibiotics for 7 to 10 days.
 - Ask the client to return after taking all antibiotics and still the problem persists.
- Pain lasting for months
 - Suggest elevating the scrotum with supporter.
 - Suggest soaking in warm water.
 - Suggest pain relievers (e.g., mefenamic acid, ibuprofen, paracetamol, aspirin).
 - Provide antibiotics if infection is suspected.
 - If pain persists, refer to a specialist for further management.



WHAT COUNSELING TIPS SHOULD BE PROVIDED TO A CLIENT?

Considering the irreversibility or permanence of vasectomy, special care must be taken to ensure a voluntary informed choice by the client. Particular attention must also be given in the case of young people, men who have not yet been fathers, and clients with medical and mental health problems. A friendly counselor who listens to a man's concerns, answers his questions, and gives clear, practical information about the procedure, especially its permanence, will help the client make an informed choice. Informed choice results in a satisfied user without later regret.

Counseling must include the six elements of informed consent. When the client desires to undergo vasectomy, he signs an informed consent form that proves that the following six elements have been discussed:

- Temporary contraceptives are available to the client.
- Voluntary sterilization is a surgical procedure.
- The surgical procedure involves risks, in addition to benefits. Among the risks is the possibility that the procedure may fail.
- The effect of the procedure should be considered permanent.
- The procedure does not protect against sexually transmitted disease, including HIV/AIDS.
- The client can decide against the procedure at any time before the operation is performed without losing the right to medical health or other services or benefits.

In general, people who are most likely to regret sterilization are those who

- Are young
- Have few or no children
- Are not married
- Are having marital problems
- Have a partner who opposes sterilization

Involving the client's spouse in counseling is helpful. The decision about sterilization should be made by the client and his spouse as per the Responsible Parenthood and Reproductive Health (RPRH) Law. Family planning (FP) service providers have a duty to ensure that the decision for or against sterilization is voluntarily (not pressured or forced) made by the client.

WHAT ARE THE FACTS ABOUT VASECTOMY?

Vasectomy

- Does not involve the removal of the testicles. The procedure involves cutting and blocking the tubes that carry sperm.
- Does not decrease sexual drive.
- Does not affect sexual function. A man's erection is still the same, and he ejaculates the same as before the procedure.
- Does not cause the man to grow fat or become weak, less masculine, or less productive.

- Does not cause diseases later in life.
- Does not prevent transmission of STIs, including HIV.

WHAT ARE THE FREQUENTLY ASKED QUESTIONS REGARDING VASECTOMY?(2)

1. What advantages does vasectomy have over other forms of contraceptives?

Vasectomy

- Is permanent (it lasts for life).
- Involves a safe, simple, and quick surgery with few risks and side effects.
- Will reduce costs needed for supplies of other contraceptives.
- Has fewer risks than other forms of contraceptives.

2. Does vasectomy hurt?

- A vasectomy usually takes about 30 minutes and can be performed under local anesthesia. Most men feel little pain, if any, with an NSV. Mild discomfort is felt with the application of anesthesia, which will make the area of operation numb. A slight tugging sensation may be felt during the procedure. The effects of the anesthesia will last for several hours, thus providing sufficient time for the client to go home, lie down, and apply an ice pack. Oral pain relievers, such as paracetamol, will be all that may be required for inflammation and pain relief. A small amount of swelling may last for three to seven days. Some bruising may be observed on the scrotum after the procedure. This bruising usually heals within a few days.

3. Will vasectomy involve long-lasting pain?

- Some men report having chronic pain or discomfort in the scrotum or testicles that can last from one year to more than five years after a vasectomy. Few men may have severe pain that they regret having the vasectomy. Severe, long-lasting pain following a vasectomy is uncommon, but all men considering a vasectomy should be informed about this risk.

- The cause of the pain is unknown. The pain may result from the pressure caused by the build-up of sperm that has leaked from an improperly sealed or tied vas deferens or from nerve damage. Treatment includes elevating the scrotum and taking pain relievers.

4. What happens to sperm that is not ejaculated during sexual intercourse? Will it collect in the scrotum and cause it to burst or cause other problems?

- The body absorbs sperms that are not ejaculated. Sperm cannot accumulate in the scrotum or cause harm to a man's body in any way.

5. Is it possible to check if a vasectomy is working?

- Yes. The service provider can examine a semen sample under a microscope to verify whether it still contains sperm.
- It is recommended, but not essential, to have a semen examination at any time after three months following the procedure.
 - If no motile sperm cells are seen, then the vasectomy is deemed successful.
 - If less than one motile sperm is found in every 10 high-power fields in the fresh sample, then the client can rely on his vasectomy and stop using a backup method.
 - If his semen contains more moving sperm, the client should continue to use a backup method and return to the clinic monthly for semen analysis.
 - If his semen continues to have moving sperm, he may need to have a repeat vasectomy.

6. Will the vasectomy stop working after a time?

- Generally, no. Vasectomy is intended to be permanent. In rare cases, however, the tubes that carry sperm grow back together, and the man will require a repeat vasectomy.

7. Can a man have his vasectomy reversed if he decides that he wants another child?

- Generally, no. Vasectomy is intended to be permanent. People who may want more children should choose a different FP method. Surgery to reverse vasectomy is possible for only some men, and reversal often fails to result in pregnancy. The procedure is difficult and expensive, and providers who are able to perform such surgery are difficult to find. Thus, vasectomy should be considered irreversible.

8. Is it better for the man to have a vasectomy or for the woman to have female sterilization?

- Each couple must decide for themselves as to which method is best for them. Both are very effective, safe, permanent methods for couples who know that they will not want more children. Ideally, a couple should consider both methods. If both are acceptable to the couple, vasectomy would be preferable because it is simpler, safer, easier, and less expensive than female sterilization.

9. Should vasectomy be offered only to men who have reached a certain age or have a certain number of children?

- No. No justification exists for denying vasectomy to a man just because of his age, the number of his living children, or his marital status. Healthcare providers must not impose rigid rules about age, number of children, age of last child, or marital status. Each man must be allowed to decide for himself as to whether he will want more children and whether he will have a vasectomy.

10. Does vasectomy increase a man's risk of cancer or heart disease later in life?

- No. Evidence from extensive studies shows that vasectomy does not increase risks of cancer of the testicles (testicular cancer), cancer of the prostate (prostate cancer), or heart disease.

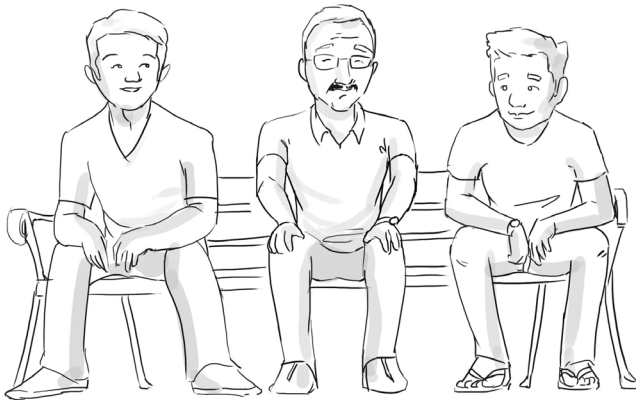
11. Can a man who has a vasectomy transmit or become infected with STIs, including HIV?

- Yes. Vasectomies do not protect against STIs, including HIV. All men at risk of STIs, including HIV, whether or not they have had vasectomies, need to use condoms to protect themselves and their partners from infection.

KEY POINTS

Vasectomy

- is a very simple surgery that can be performed in almost any health facility, including the treatment rooms of doctors.
- is a permanent method of contraception that is intended to provide life-long, safe, and very effective contraception.
- is not immediately effective because it takes three months to clear the male reproductive tract of live sperm. The man or couple must use another contraceptive method for three months after the procedure.
- does not affect male sexual performance.
- is permanent and thus requires the counselor to ensure informed choice.



Chapter 11

SPECIAL POPULATIONS

CONTRACEPTION FOR THE ADOLESCENT

The incidence rate of teen pregnancies in the Philippines was 13.6% in 2013.(97) In the ASEAN region, the Philippines ranks third among countries with the highest incidence rate of teenage pregnancy. Pregnancy among adolescents (adolescents as defined by the WHO as individuals aged 10 to 19 years) is associated with several potential medical problems, including the following:

- High health risk
- Unsafe abortion
- Inadequate or lack of prenatal care
- Sexually transmitted disease from unprotected sex



Teen pregnancy also has social consequences, such as loss of educational and employment opportunities as well as emotional and financial unpreparedness for raising a child. The percentage of sexually active young people who use any contraceptive method remains low at 21%.

Contraception for adolescents has the following features:

- All currently available modern contraceptive methods are safe for adolescents.
- The use of progestogen-only injectables, such as depot medroxyprogesterone acetate (DMPA), for individuals below 18 years old has raised concerns because of their potential effects on bone density. However, the WHO clarified that such effects are balanced against the risk of an unplanned pregnancy.

- Young people often do not have the medical conditions that limit the use of certain contraceptive methods in older clients.
- Certain adolescent groups may be at a high risk for acquiring HIV and other sexually transmitted infections (STIs). This fact should greatly influence the selection of an appropriate contraceptive method for them.
- High discontinuation rates in this age group are due to low threshold to tolerance to some side effects. Therefore, members of this age group must be counseled about the temporary nature of these effects to motivate them to continue using the contraception.
- For some adolescents, the use of a daily regimen may be inappropriate because of the unpredictable frequency of intercourse and the need for privacy with regard to birth control use and sexual practices.
- For married or teenage mothers, healthy timing and spacing of pregnancy should be emphasized so that they may opt to use a long-acting reversible contraceptive method.
- Educating adolescents on contraceptive methods and FP services should be done to provide correct information and improve knowledge on contraceptive use and appropriateness of contraception.

The provision of adequate reproductive health (RH) counseling services for adolescents remains challenging because of the barriers posed by factors such as national policies, culture, misconception, poverty, and lack of education. RH counseling services must be made accessible, available, affordable, and understandable in a supportive and non-judgmental environment. Just like any client, young individuals must be assured of confidentiality and privacy and must not be subjected to unnecessary procedures before they can avail of the appropriate contraceptive method. Young individuals must be counseled first to delay sexual activity until a later time when they are more capable of starting a family.

RECOMMENDED METHODS

Combined hormonal contraceptives: combined oral contraceptives, combined contraceptive patch, combined contraceptive vaginal ring, combined injectable contraceptives

- These methods can be used by adolescents without restriction (MEC 1). However, daily intake of pills may be difficult for some individuals, particularly for those who value confidentiality and have issues with compliance.
- Injectables and vaginal rings may effectively address the need for secrecy.
- COCs containing 20 µg estradiol have been observed to reduce bone mineral density; however, high formulation shows negligible effects.

Progesterone-only contraceptives: progesterone-only pill, DMPA or norethisterone enantate injectables, and levonorgestrel and etonogestrel implants

- Both implants and progesterone-only pills can be used without restriction.
- The potential effect of injectable DMPA (MEC 2) on bone mineral density is waived by its preventive effect on unplanned pregnancy.
- Studies show that DMPA causes a loss of bone mineral density; however, discontinued use of DMPA allows the recovery of the lost density. Whether DMPA ultimately affects the peak bone mass levels of adolescents in the long run remains unclear.

Barriers: condoms, spermicide, diaphragm, and cervical cap

- Barrier methods can be used without restrictions.
- Condoms provide dual protection against sexually transmitted diseases; in addition, they are affordable, readily available, and convenient to use.
- Young men may need to practice condom application because they are more likely to commit errors than older, more experienced users.
- Diaphragms and cervical caps are among the least effective methods, may not be as readily available, and may be cost restrictive. However, they can be used for safe and reversible contraception as needed, provided that the user is appropriately counseled and motivated with regard to the use of this method.



Intrauterine devices (IUDs): copper-bearing IUDs, IUS

- These devices can generally be used (MEC 2), but three factors should be considered:
 - Expulsion is likely to occur in nulliparous adolescents who have started sexual activity because of the small size of the uterus.
 - The risk of failure is less than the risk of pregnancy.
 - This method may not be appropriate for certain adolescents at higher risk for STIs.

Fertility-awareness based methods

- Adolescents can use this modality if motivated enough to observe strict compliance.
- However, young women, especially those with irregular cycles, must avoid using this method because of its high failure rate.
- Special counseling is necessary for young individuals to ensure correct usage of this method.



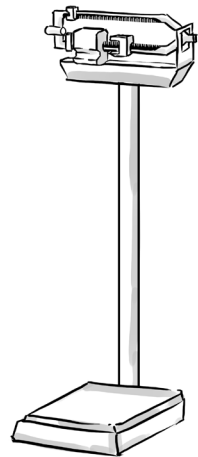
METHODS TO AVOID

Sterilization: tubal ligation, vasectomy

- These methods must be used with caution for this age group because they are considered permanent.
- Adolescents who wish to undergo these procedures must be counseled on the availability of other methods that provide safe, long-term, but reversible contraception.

Special Population: **CONTRACEPTION FOR WOMEN WITH OBESITY**

Safe and effective contraception is greatly needed by women with body mass indices (BMIs) of 30 kg/m² and above because of the increased risk of pregnancy-related complications. Obesity often has co-morbid conditions, such as cardiovascular disease, diabetes, gall bladder disease, and cancer. An increase in weight also has the potential to decrease the effectiveness of certain methods. For instance, increased metabolic rate results in the quick elimination of hormonal agents from the body, and increased blood volume that comes with an increase in weight can reduce blood levels of hormones. This condition potentially compromises contraceptive efficacy. The problem cannot be solved by simply doubling the dose of these hormones because such practice will obviously introduce significant health risks. Another important issue is whether a particular method (e.g., such as the use of oral contraceptive pills) actually causes further weight gain. Therefore, the selection of the most appropriate options poses a considerable challenge and requires a conscientious review of the current evidence that addresses these issues.



RECOMMENDED METHODS

Intrauterine devices (IUDs)

- These devices include copper-bearing IUD and levonorgestrel-releasing IUD.

Barriers

- Barriers include condoms, spermicides, diaphragm, and cervical cap.

IUDs and barriers are categorized as MEC 1 and have no restrictions for use in this population of patients, even among those less than 18 years of age.

Progestin-only contraceptives: progestin-only pills, depot medroxyprogesterone acetate (DMPA)/norethisterone enantate, levonorgestrel and etonogestrel implants

- These methods are categorized as MEC 1 and can therefore be used without restrictions by women with obesity.
- However, for women with obesity who are less than 18 years old, DMPA is categorized as MEC 2, considering the potential but reversible effects on bone mineral density.
- Therefore, women with obesity can generally use these agents with consideration of the potential reversible effects on bone mineral density.
- Evidence suggests the increased likelihood of weight gain among adolescent DMPA users with obesity compared with non-users with obesity, combined oral contraceptive (COC) users with obesity, and users with normal weight. (59)
- Levonorgestrel implant (Jadelle) users who weigh more than 60 kg should be advised to return to their healthcare provider after four years (instead of five years) for implant replacement or for a new contraceptive method.(106) Levonorgestrel blood levels are lower for these women at the end of implant use compared with non-obese users and are inversely related to body weight. (105)
- Obese etonogestrel implant (Implanon) users should also be advised to return after two years for implant replacement or for a new contraceptive method.(55) Etonogestrel blood levels are also lower at the end of implant use for these women compared with non-obese users and are inversely related to body weight.
- Levonorgestrel exhibits a rapid decrease in efficacy with increasing weight. (102,104)

Combined hormonal contraceptives (CHCs): COC pills, combined injectable contraceptives, combined contraceptive patch, combined contraceptive vaginal rings

- The above agents are categorized as MEC 2 for women with obesity.
- These methods can generally be given because the advantages of use outweigh the risks.
- Compared with non-users with obesity, however, venous thromboembolism is likely to occur among those using these agents.

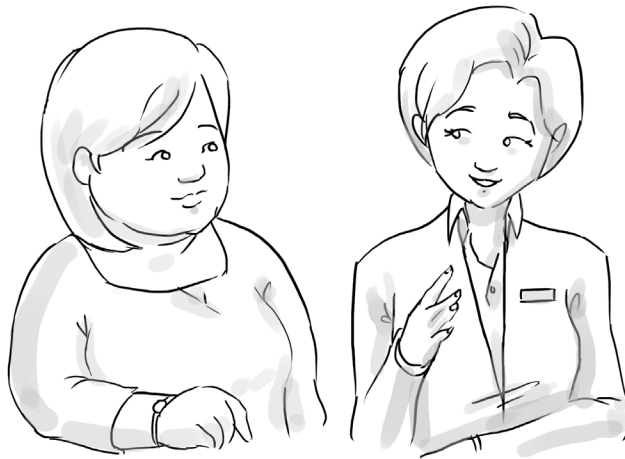
- Acute myocardial infarction, strokes, and weight gain as a result of the use of combined contraceptive pills do not appear to be more frequent for these women.
- The use of COCs and vaginal rings generally does not cause weight gain. For yet unknown reasons, some women do undergo weight changes with COC intake, but these changes appear to reverse upon discontinuation.
- The issue of whether the effectiveness of these methods is influenced by weight or BMI cannot be established at present.
- The use of the Yuzpe method in women with obesity has not been fully studied; thus, its use for emergency contraception in this population cannot be recommended.(102,104)

METHODS TO AVOID

Female Sterilization

- With severe obesity, caution is recommended before employing a procedure because of technical challenges.
- Additional precautions and preparations should be in place in secondary or tertiary hospitals.
- Fallopian tubes may be difficult to access through small incisions because of abdominal wall thickness.
- Associated complications, such as wound infections and breakdown, may also be increased.
- In addition, general or spinal anesthesia and its attendant risks are very likely.
- Prevention of airway obstruction and inadequacy of oxygen delivery are particularly challenging in patients with obesity.
- Alternatively, vasectomy can be offered to the partner.

NOTE: Some overweight women may benefit from employing natural methods of contraception because of the lack of systemic side effects. However, regular monitoring and testing cannot be overemphasized because these methods usually exhibit less effectiveness than other contraceptive options. For this reason, fertility awareness-based methods may not be appropriate for women with conditions that increase risks and dangers during pregnancy. Women with obesity, especially those with co-morbid medical conditions, are all likely to fall under this category.



Special Population: **CONTRACEPTION FOR WOMEN SMOKERS**

The consequences of smoking, such as increased risk of cancer and respiratory diseases, are generally the same for both women and men. However, some smoking-related health problems are unique to women. One such problem is the effect of smoking on contraceptive options, specifically those utilizing hormonal agents. Of great importance is the effect of agents, such as combined oral contraceptives (COCs), on the risk of developing cardiovascular diseases, such as stroke, heart attack, and blood clot formation, especially in women smokers 35 years of age and above. Smoking also increases the risk of cervical cancer and early menopause for women and results in adverse pregnancy outcomes, such as low birth weight infants, abortion, stillbirth, and perinatal mortality. Infertility problems may also arise among women smokers.



RECOMMENDED METHODS

Progestin-only contraceptives

- These contraceptives include progestin-only pills, depot medroxyprogesterone acetate/norethisterone enantate, and levonorgestrel and etonogestrel implants.

Intrauterine devices (IUDs)

- These devices include copper-bearing IUD and levonorgestrel-releasing IUD.

Barriers

- Barriers include condoms, spermicides, diaphragm, and cervical cap.

Sterilization

- Sterilization includes tubal ligation and vasectomy.

The absence of estrogen use in the above methods make them safe and acceptable options for smokers, regardless of age and number of cigarettes consumed per day (MEC 1).

Combined hormonal contraceptives (CHCs)

- Women who smoke and are less than 35 years of age can use the following agents (MEC 2): COC pills, combined injectable contraceptives, combined contraceptive patch, and combined contraceptive vaginal rings.
- For women over 35 years of age who consume less than 15 cigarettes per day, only CICs fall under this category (MEC 2).

METHODS TO AVOID

(SMOKERS OLDER THAN 35 YEARS OLD WHO CONSUME 15 OR MORE CIGARETTES PER DAY)

CHCs: COC pills, CICs, combined contraceptive patch, combined contraceptive vaginal rings

- For women over 35 who smoke less than 15 sticks daily, COC pills, combined contraceptive patch, and combined vaginal rings should be avoided because risks are greater than the advantages from their use (MEC 3).
- If a woman smokes at least 15 sticks a day, then all four of these methods are unacceptable (MEC 4) because of the higher risks of cardiovascular diseases, such as heart attacks (myocardial infarction). These risks increase with the number of cigarettes consumed per day. In such cases, the woman is encouraged to quit smoking and should be assisted in the selection of safe birth control alternatives.

Special Population: **CONTRACEPTION FOR POSTPARTUM WOMEN**

The postpartum period may provide a good opportunity for a woman to start contraception for several reasons. The woman is likely to access healthcare, and she may be motivated to avoid an unplanned pregnancy soon after giving birth. If the woman is not breastfeeding, ovulation may resume approximately 25 days after she has given birth. Short intervals of less than three years between pregnancies are associated with greater risks for adverse outcomes, such as maternal death, third trimester bleeding, premature rupture of membranes, uterine infection, maternal anemia, abortion, and low birth weight.(107) Thus, the importance of initiating the use of a contraceptive method at postpartum should be highlighted.



RECOMMENDED METHODS

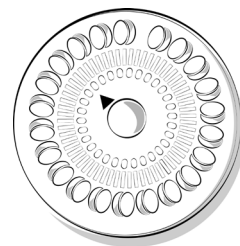
Lactation amenorrhea method

- This temporary contraceptive method is a good option because it provides an ongoing and safe contraceptive that a fully breastfeeding woman can employ up to six months after giving birth.
- The LAM is based on the natural effect of breastfeeding against ovulation. It is reliable and effective provided that three conditions are met:
 - The woman's menses has not yet resumed after giving birth.
 - Breastfeeding is exclusive (full), and the baby is fed often both day and night ("exclusive" means that no other source of food or water is employed).
 - The baby is under six months old.

- While the Medical Eligibility Criteria (MEC) state that NO medical conditions preclude breastfeeding, other options may be preferred in certain cases. Among these cases are the following:
 - Women with human immunodeficiency virus (HIV). These women can transmit HIV to their offspring via infected breast milk. However, current evidence supports breastfeeding if the mother and/or her exposed infant has already been administered with antiretroviral drugs, as these agents significantly lower risk of transmission (see Chapter 12).
 - Women on certain medications, such as the following: mood-altering agents, reserpine, antimetabolites, cyclosporine, bromocriptine, radioactive drugs, high doses of corticosteroids, lithium, ergots, and anticoagulants.
 - Conditions in the newborn that impede effective breastfeeding, such as the following: congenital anomalies affecting the mouth, jaw, or palate; low birth weight babies or premature infants that require intensive or critical neonatal care; and metabolic disorders that hinder normal food digestion and processing. Edmond and Bahl (108) recommend feeding with expressed breast milk through nasogastric or orogastric tubes, spoons, or small cups when babies have poor sucking ability for its nutritional benefits to infants.

Progestin-only contraceptives: progesterone-only pill, depot medroxyprogesterone acetate (DMPA) or norethisterone enantate injectables, and levonorgestrel and etonogestrel implants

- Breastfeeding women who are
 - more than six weeks postpartum can use progestin-only contraceptives.
 - between six weeks and six months postpartum with no monthly bleeding may use progestin-only contraceptives. A backup method is not necessary.
 - less than six months postpartum with monthly bleeding can use progestin-only contraceptives.
 - more than six months postpartum can use progestin-only contraceptives provided that she is reasonably certain that she is not pregnant. She will need to use a backup method for the first two days of taking pills.



- Postpartum non-breastfeeding women who are
 - less than four weeks postpartum can start on progestin-only contraceptives any time. A backup method is not necessary.
 - more than four weeks postpartum can use progestin-only contraceptives provided that she is reasonably certain that she is not pregnant. She will need to use a backup method for the first two days of taking pills.
- No restrictions exist for the use of these agents as birth control methods (MEC 1) because these agents provide effective contraception without adversely affecting breastfeeding unless the client has risks of thrombosis.

Female sterilization: tubal ligation

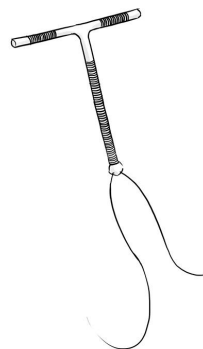
- Surgical sterilization can be performed less than seven days after giving birth or during the time of a cesarean section procedure.
- Only the client's (not the husband's) consent is required to perform this procedure.
- Performing this procedure is acceptable (MEC A) even if the woman is breastfeeding, has mild (but not severe) preeclampsia, and at 42 days and beyond postpartum (see Methods to Avoid below).

Male sterilization: vasectomy

- The woman's partner or husband can undergo vasectomy any time during the woman's postpartum period.

Intrauterine devices (IUDs)

- The copper-bearing IUD is a good option, as evidence points to a lower incidence of expulsion if insertion is performed immediately postpartum, especially after delivery of the placenta.
- No restrictions exist for copper-bearing IUD insertion within 48 hours postpartum in both breastfeeding and non-breastfeeding women (MEC 1).
- Levonorgestrel-releasing IUD is also a good option if the woman is NOT breastfeeding. This approach is NOT recommended if the woman is breastfeeding because of concerns about early neonatal exposure to hormonal agents at less than six weeks of age (MEC 3).



- Both types of IUDs are also recommended contraceptive choices (MEC 1) for women four weeks postpartum or beyond (see also Methods to Avoid below).

Barriers

- Male condoms are recommended options any time postpartum (MEC 1).
- Diaphragms and cervical caps are recommended at six weeks postpartum and beyond.

METHODS TO AVOID

Combined pills and combined injectables: combined oral contraceptives (COCs) and combined injectable contraceptives (CICs)

- Women breastfeeding for at least six weeks (MEC 4), women breastfeeding for six weeks to six months (MEC 3), and women not breastfeeding but are less than 42 days postpartum (MEC 2–4) should not use combined hormonal contraceptives (CHCs) because of a high risk for venous thromboembolism (VTE).
- Women 42 days postpartum have a 22- to 84-fold increased risk for VTE compared with controls. The use of COCs or CICs during this period also affects the quality and quantity of milk production in breastfeeding women.



Progestin-only contraceptives: progesterone-only pill, DMPA or norethisterone enantate injectables, and levonorgestrel and etonogestrel implants

- For breastfeeding women who are less than six weeks postpartum, the use of progestin-only methods is not recommended unless contraceptive options are limited despite high pregnancy morbidity and mortality rates (MEC 3). This recommendation stems from a concern about early neonatal exposure to hormonal agents in breast milk. Current studies do not demonstrate any harmful effects of this exposure on infants less than six weeks of age. However, the investigational designs are not enough to provide convincing data regarding issues on serious or long-term subtle effects. The adverse findings on animal studies with regard to neurologic effects have not yet been established in humans.

Female sterilization: tubal ligation

- The procedure is delayed (MEC D) in the following conditions until such time that these conditions have been resolved or have been addressed appropriately:
 - For women 7 to 42 days postpartum because of the increased risk of complications from an incompletely involuted uterus
 - Severe preeclampsia or eclampsia because of increased risk from elevated blood pressure
 - Prolonged rupture of membranes for 24 hours or more, as well as puerperal sepsis or intrapartum or puerperal fever because of the greater risk of infections
 - Severe antepartum or postpartum bleeding, as well as severe trauma to birth canal because of dangers posed by additional blood loss and aggravation of anemia
 - Uterine rupture or perforation because of additional blood loss or damage to abdominal organs

IUDs

- Insertion of IUDs at 48 hours to less than 4 weeks postpartum must be avoided because of increased chances of expulsion at a time of uterine involution (MEC 3).
- The procedure is contraindicated in postpartum women (MEC 4) who have puerperal sepsis and those with more than 18 hours of premature ruptured membranes.

Barriers: diaphragm and cervical cap

- The diaphragm and cervical cap are inappropriate for use prior to complete uterine involution.
- These devices may also prove difficult to apply and uncomfortable at this time, especially for those who have episiotomies.

Fertility awareness-based methods

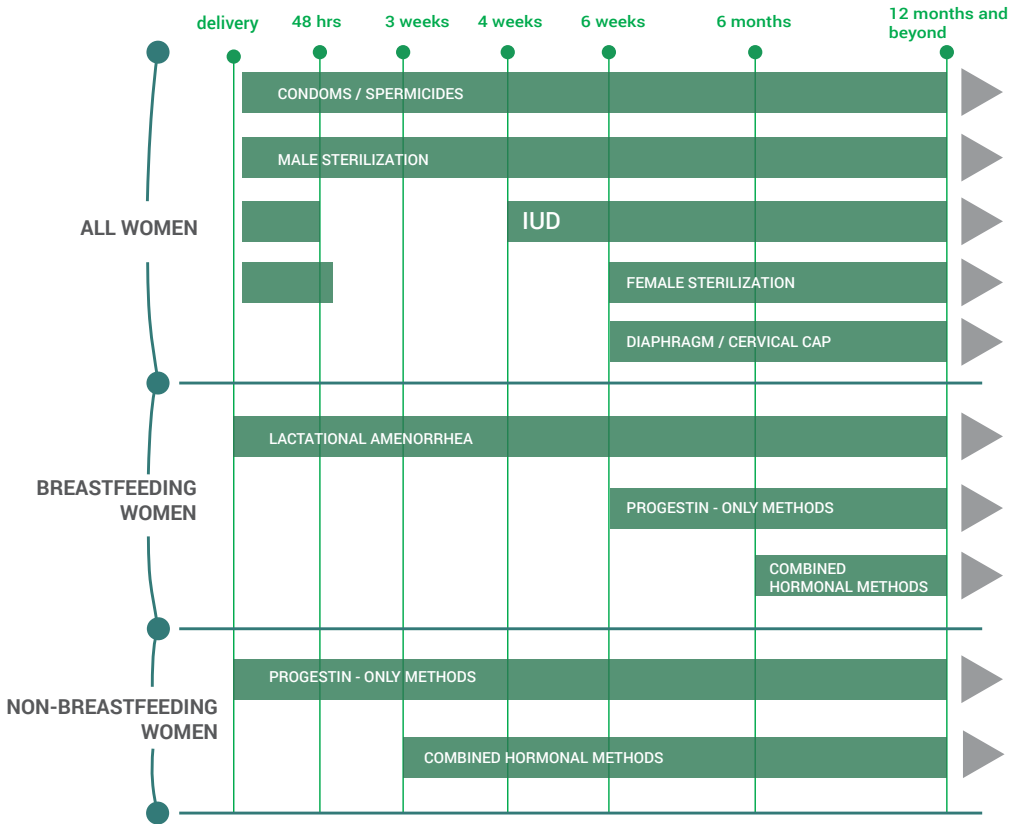
- Most fertility awareness-based methods are best delayed or used with caution until the postpartum period has ended or until regular menstruation has resumed.
- Such options may be less effective in a breastfeeding woman than in a non-breastfeeding woman. At less than six weeks postpartum, the fully breastfeeding mother is likely to be amenorrheic and usually does not experience fertility and hormonal changes. However, chances of ovulation increase over time, especially if breastfeeding is non-exclusive. Alternative options should be given.
- After menses resume and fertility signs can be detected, the woman may use symptoms-based methods (e.g., cervical secretions or Billings). Calendar-based methods are best reserved for when the woman has had at least three consecutive menstrual cycles. The Standard Days Method can be used if she has already achieved four consecutive menstrual cycles, with the most recent having an interval of 26 to 32 days. However, before these times, a barrier contraceptive is advised.
- As for the non-breastfeeding woman, she does not have adequate ovarian function to produce obvious evidence of fertility or hormonal changes at four weeks postpartum. Thus, an appropriate contraceptive method is needed at this time. However, beyond four weeks, the non-breastfeeding woman will most probably begin to exhibit detectable fertility signs and hormonal changes. Calendar-based methods can then be used after at least three consecutive menstrual cycles. The Standard Days Method can be used after at least four consecutive menstrual cycles, with the most recent having an interval of 26 to 32 days.

Figure 6 presents the recommended family planning methods that may be used during the first year postpartum and beyond based on the MEC for Contraceptive Use.(59) For postpartum women, the following contraceptives are recommended:

- From delivery up to six months postpartum, a woman who is exclusively breastfeeding and has no menstrual period yet can use the LAM safely. When the client uses the LAM and decides to change to another method or when the client no longer fits the criteria for the LAM, other contraceptive methods should be provided in a timely manner.
- Intrauterine devices (Cu-IUD) can be inserted immediately up to 48 hours after birth or at any time after four weeks postpartum.
- Female sterilization can also be performed immediately up to seven days after birth or at any time after six weeks postpartum.
- For non-breastfeeding women, IUDs and progestin-only methods can be initiated immediately following birth. COCs can be initiated three weeks after birth.
- For breastfeeding women, all progestin-only methods can be initiated at six weeks following birth, as per WHO MEC. CHCs cannot be initiated until six months after birth.
- All women, breastfeeding or not, can initiate use of condoms immediately after birth and diaphragms or cervical caps after six weeks.



Figure 6. Postpartum family planning methods



Special Population: **CONTRACEPTION FOR THE PERIMENOPAUSE**

Perimenopause (or menopausal transition) is the period before, during, and after the menopause. The average duration is approximately five years starting from when ovarian function begins to decline until the absence of menstruation for one year. Women usually enter the menopause at around 45 to 55 years of age. Before menopause, the woman enters the transitional phase, which is characterized by on and off episodes of ovulation. Despite the decline in fertility during this period, pregnancy can still occur during ovulation. Therefore, protection from an unplanned pregnancy is still required until complete anovulatory menstrual cycle is established because pregnancies in the late reproductive years are associated with high maternal and perinatal morbidity and mortality. The likelihood of certain fetal malformations also increases in pregnancies in this age group.



Perimenopausal women have contraceptive needs that may differ from those of younger women. Aside from the effectiveness of a family planning method, concerns regarding non-contraceptive benefits may be prominent. These concerns include protection from gynecologic cancers, osteoporosis, and benign growths (myomas and polyps) as well as control of menstrual cycle irregularities, hot flashes, and other menopausal symptoms.

The perimenopausal period is also associated with declined sexual intercourse, hence the lack of motivation to use any contraceptive at this time. Women who are conscious of impending menopause may erroneously think that they are already safe from pregnancy. The need for effective and safe contraception may even be essential for some perimenopausal women who may already have cardiovascular diseases, hypertension, and diabetes because these conditions increase pregnancy risks. These conditions may also contraindicate the safe use of some contraceptives. Thus, this age group has limited options.

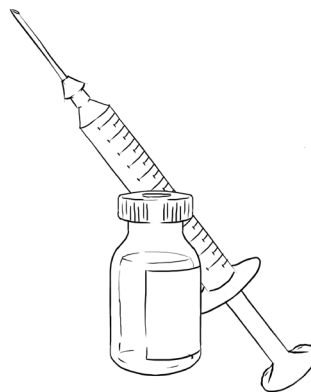
Another concern is determining when contraception can be discontinued for those already on a contraceptive method. The following are the current guidelines:

- Use of a family planning method is recommended for one year after the last menstrual bleeding because determining when menopause has actually occurred is difficult. Menstruation during perimenopause often no longer occurs regularly or at monthly intervals.
- A woman already on a hormonal method who wishes to discontinue is advised to use a non-hormonal method until menstruation is absent for one year.
- If the woman has a copper intrauterine device (IUD) in place, the device is removed 12 months after the last menstrual period.

RECOMMENDED METHODS

Progesterone-only contraceptives: progesterone-only pill, depot medroxyprogesterone acetate (DMPA) or norethisterone enantate (NET-EN) injectables, and levonorgestrel and etonogestrel implants

- Progesterin-only pills and implants can be used without restrictions in this age group (MEC 1).
- They are ideal for women who have contraindications to estrogen.
- The injectables can generally be used despite certain theoretical or proven risks (MEC 2).
- Concerns regarding the use of DMPA or NET-EN injectables in older women include reduced HDL levels (good cholesterol levels) and hypoestrogenic effects, which may persist for some time after discontinued use. These phenomena may increase the risks for aggravating hypertension, strokes, and ischemic heart conditions.
- Bone mineral density also decreases during DMPA use but may be restored after discontinued use. Whether prior DMPA use increases the woman's fracture risk during the postmenopausal period remains unclear.



Intrauterine devices (IUDs): copper-bearing IUDs and levonorgestrel-releasing IUDs

- The use of IUDs in this age group has no restrictions (MEC 1).
- Expulsion rates in these women are considerably lower than those in younger women.
- However, insertion in some cases may be more difficult because of tight cervical canals.

Barriers: condoms, spermicide, diaphragm, and cervical cap

- Perimenopausal women can use these methods without limitations or contraindications (MEC 1). In fact, these methods may be ideal for the protection of older women with decreased frequency of sexual intercourse.
- The higher failure rates of barriers compared with hormonal methods may not be an important concern because of the decreased fertility that occurs in the menopausal transition phase.
- Barrier methods would be a good choice for women in this age group because these methods do not pose proven or theoretical risks as with hormonal agents.

Sterilization: tubal ligation, vasectomy

- Permanent sterilization is an acceptable option (MEC A) when couples no longer want any more children.
- However, some older persons may have medical conditions that may require delay, more precautions, or referrals to better-equipped facilities in carrying out these procedures.

Combined hormonal contraceptives (CHCs; see also Methods to Avoid): combined oral contraceptives (COCs), combined contraceptive patch, combined contraceptive vaginal ring, and combined injectable contraceptives

- The advantages of CHCs in these women offset their theoretical and proven risks.
- The chances of cardiovascular diseases are naturally greater in perimenopausal women than in young women, and these conditions may be heightened by CHC agents.
- These contraceptives can generally be used (MEC 2) by women who do not have any adverse factor or medical contraindications.

- Although these contraceptives have minimal effect on the bone health of young women, their use may have beneficial effects on the bone density of perimenopausal users.

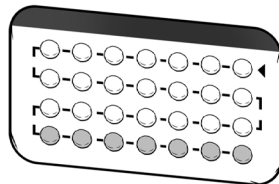
METHODS TO AVOID

Fertility awareness-based methods

- These methods are used with caution in this age group because of increased unreliability resulting from menstrual irregularities that commonly arise at this time, making periods of fertility difficult to establish (MEC C).

Some CHCs

- COCs, patches, or vaginal rings are NOT recommended for women 35 years and older who smoke (regardless of number of cigarettes smoked).
- Combined injectables are likewise NOT used for women 35 years and older who smoke at least 15 sticks daily.
- COCs, patches, injectables, and vaginal rings should NOT be used for women 35 years and older who suffer from migraine attacks.



Special Population: **CONTRACEPTION FOR WOMEN- VICTIMS OF VIOLENCE**

Through the years, violence has been increasingly found to have negative health outcomes. Sexual assault and violence against women have been estimated to account for 20% of the health burden among women aged 15 to 44 years. The general impact of violence on the health of women has been attributed to various reproductive health risks and problems that are consequences of gender-based victimization. These health risks and problems include emotional and psychological disturbances, physical injuries, unwanted pregnancies, sexually transmitted infections (STIs) such as human immunodeficiency virus (HIV), decreased sexual desire, pain during sex, and chronic pelvic pain.



Health providers should discuss and assess the possibility of pregnancy in all women who have been sexually assaulted. The possibility of pregnancy is the usual concern of most women victims (particularly if sex was unprotected). The chance of pregnancy after an assault is reported to be at 2% to 5% among victims not protected by some form of contraception at the time of the attack. Moreover, the risk for acquiring complications such as sepsis, spontaneous abortion, and premature birth is high when the pregnancy is complicated with STI.

The management of victims should be therefore comprehensive to appropriately address violence-related problems. Healthcare providers are expected to provide counseling and social support to promote quick recovery.

Follow-up consultations should also be offered to adequately cover current and long-term consequences of the victimization. All clients should have access to follow-up services, including a medical review at two weeks, three months, and six months post-assault, with referrals for counseling and other support services.(119)

RECOMMENDED METHODS

LEVONORGESTREL (LNG) AND YUZPE METHODS

These can prevent pregnancy in instances of unprotected sex. Yuzpe method consists of higher doses of regular COC pills containing levonorgestrel and ethinyl estradiol.

What are the criteria for administering the LNG and Yuzpe methods among women who have been victims of sexual assault?

- Presence of risk for pregnancy
- Consult for treatment sought within five days from the time of the assault with the expressed desire to prevent pregnancy
- Pregnancy tests or other definitive tests have established that the client is not currently pregnant

If pregnancy cannot be ruled out, can the aforementioned methods still be prescribed?

Yes, as long as the following will be fulfilled:

- Full disclosure to the client that the pills will not be effective if she is already pregnant but will not affect the pregnancy nor harm the fetus
- Advise the client coming to the health facility more than five days after the assault to return for pregnancy testing if she misses her next menstrual period.

What is the mechanism of action of the LNG and Yuzpe methods?

- The LNG and Yuzpe methods work primarily by preventing or delaying the release of eggs from the ovaries but does not prevent implantation.(137)
- They do not work if a woman is already pregnant, near to ovulation, or has ovulated.(137)

Who are eligible to use the LNG and Yuzpe methods?

Any woman can use this method because they are only used in the short term. (29,123)

What are the precautions and contraindications for the use of LNG and Yuzpe methods?

- Known or suspected pregnancy. Note that accidental intake of these drugs elicits no known harm to a pregnant woman, the course of her pregnancy, or the fetus.
- They do not protect against STIs and HIV.

When to use the LNG and Yuzpe methods?

- These methods must be taken within 72 hours or up to 5 days by any woman in the reproductive age group who has had unprotected sexual intercourse.

How effective are the LNG and Yuzpe methods?

- LNG and Yuzpe must be taken as soon as possible after unprotected sex. Doing so can prevent pregnancy when taken any time up to five days of unprotected sex.
- Yuzpe method:
 - Only 2 in 100 women become pregnant, corresponding to a risk reduction of 75% when no emergency contraception method is taken (114)
 - Less effective than LNG
- Levonorgestrel regimen
 - Effective for at least four days after sexual intercourse and extends up to five days.
 - Expected pregnancy rate decreases by 85%.(115)
 - Only 1 in 100 women who have had unprotected sex become pregnant.
 - LNG is not effective for women with a body mass index of 30 kg/m².(102,104)

Table 23. Estimated number of pregnancies out of 100 women with unprotected sex during the second or third week of the menstrual cycle according to the type of contraceptive used:

No ECP	8
LNG pills	1
Yuzpe method	2

How are LNG pills used?

LNG can be taken in one of the following doses:

- Single dose: 1.5 mg LNG
- Split dose: 0.75 mg LNG followed by a second dose of 0.75 mg LNG 12 hours later

Note: In other countries, LNG pills (e.g., Norlevo, Levonelle, and Lonel) are available in 1.5 mg or 0.75 mg doses.

How is the Yuzpe method used?

Within five days after unprotected sex, the Yuzpe method can be administered using any one of the following regimens as soon as possible if available for two doses with a 12-hour interval:

- 0.1 mg ethinyl estradiol + 0.5 mg LNG
- 0.1 mg ethinyl estradiol + 1 mg norgestrel
- 0.1 mg ethinyl estradiol + 2 mg norethisterone

COCs contain different amounts of estrogen and progestins. Thus, the number of pills to be given depends on the preparation of the brand chosen. Not all brands of COCs can be utilized for emergency contraception. However, the acceptable brands available for the Yuzpe Method (Table 24) offer equivalent efficacy.

Table 24. Recommended dose of acceptable brands used for the Yuzpe Method.

Brand	First Dose	Second Dose (12 hours after first dose)	LNG (per dose)	Ethinyl estradiol (per dose)
Azul	4 beige pills	4 beige pills	0.6 mg	0.15 mg
Blush	4 beige-yellow pills	4 beige-yellow pills	0.5 mg	0.125 mg
Charlize	4 beige pills	4 beige pills	0.6 mg	0.12 mg
Femenal	2 active pills	2 active pills	0.5 mg	0.10 mg
Femme	4 yellow pills	4 yellow pills	0.6 mg	0.12 mg
Lady	4 beige pills	4 beige pills	0.6 mg	0.12 mg
Minipil	5 active pills	5 active pills	0.5 mg	0.10 mg
Nordette	4 active pills	4 active pills	0.6 mg	0.12 mg
Nordirol 21	2 active pills	2 active pills	0.5 mg	0.10 mg
Norfem	4 active pills	4 active pills	0.6 mg	0.12 mg
Protec	4 white pills	4 white pills	0.6 mg	0.12 mg
Safe Pill (150/30)	4 active pills	4 active pills	0.6 mg	0.12 mg
Safe Pill (250/50)	2 active pills	2 active pills	0.5 mg	0.10 mg
Seif	4 beige pills	4 beige pills	0.6 mg	0.12 mg
Trust Pill	4 beige-yellow pills	4 beige-yellow pills	0.5 mg	0.12 mg

***The following oral contraceptive brands are NOT recommended for use as Yuzpe method: Althea, Cerazette, Daphne, Diane-35, Gracial, Minulet, Yasmin, and Yaz. These brands contain a different progesterone component and do not contain LNG.

Which among the LNG and Yuzpe methods is more preferred for emergency contraception?

If both LNG and combined (Yuzpe) COC products are readily available, the LNG regimen is more preferred because it is more effective and has lesser adverse effects than the Yuzpe regimen. However, if only one of these products is available, the client should consider using that product immediately rather than delaying the treatment.

If the client does not have a menstrual period within three weeks after taking the pills, the possibility of pregnancy must be considered, and she should be encouraged to seek appropriate evaluation and care.

What are the side effects of LNG and Yuzpe methods?

Because of the relatively high dosage of LNG and Yuzpe, the following side effects may be experienced:

- Nausea/vomiting
- Tolerable abdominal pain
- Breast pain
- Vaginal bleeding
- Change in menstrual schedule



How are the side effects of LNG and Yuzpe method use addressed?

- Explain to the patient that side effects are not signs of illness.
- Routine use of anti-nausea medications is not recommended. However, if nausea is experienced with the first of the two doses, an anti-nausea medication (e.g., 50 mg meclizine) may be taken one-half to one hour before the second dose.
- If the client vomits within two hours after taking any of the two doses, she should take another dose after taking the anti-nausea medication one-half to one hour before. If vomiting continues, she can repeat the dose by inserting the previously required number of oral pills high into her vagina. If vomiting occurs more than two hours from taking a dose, she need not repeat the intake.

What advice will be appropriate for a client who has not had her menses within three weeks after taking the pills?

The client should be informed that the possibility of pregnancy must be considered and she should be encouraged to seek appropriate evaluation and care. (116)

WHAT ARE THE COMMONLY ASKED QUESTIONS ABOUT THE LNG AND YUZPE METHODS?

1. *Can LNG and Yuzpe be used for abortion?*

- No. These methods only delay or prevent ovulation and slow down sperm transport up the woman's reproductive tract by avoiding fertilization from taking place before the sperm from the unprotected sexual intercourse reaches the end of its life span. Once fertilization has occurred, the hormones from the contraceptives cannot disrupt an ongoing pregnancy.

2. *Can LNG and Yuzpe increase a woman's chance of ectopic pregnancy?*

- No. So far, no evidence suggests increased risk for ectopic pregnancies in women who become pregnant on the LNG and Yuzpe methods compared with all pregnancies in general.

3. *Can the LNG and Yuzpe methods cause fetal defects or birth problems to an existing pregnancy?*

- No. The intake of these contraceptives will not cause fetal defects or birth problems compared with all pregnancies in general.

4. *Should the LNG and Yuzpe methods be used as a regular contraceptive method?*

- No, because all other contraceptive methods are more effective in preventing pregnancies and have less of the unwanted side effects. These methods are only best for preventing pregnancies that might result from having unprotected sex during a believed fertile period. These methods only delay ovulation; therefore, pregnancy may still occur if another unprotected sexual intercourse occurs. Hence, contraceptive selection and use is important.
- Other contraceptive methods for regular use should be discussed with the client to prevent any future need for the LNG and Yuzpe methods.

When can the client start using their contraceptive method of choice after the use of LNG and Yuzpe methods?

The risk of STIs and HIV and emotional and physical abuse is apparent after sexual assault. These conditions should be addressed aside from offering further FP methods.

When the client feels comfortable in addressing future FP concerns, she may initiate the use of a regular method after the LNG and Yuzpe methods (Table 25).

Table 25. Timing of initiation and recommendations on the client's desired FP method after the LNG and Yuzpe methods.

Desired method	When to initiate? What is recommended?
Condoms or other barrier methods	<ul style="list-style-type: none"> Start using immediately at the next sexual intercourse
Hormonal methods: Oral contraceptives Contraceptive patch Vaginal ring Injectables Implants	<ul style="list-style-type: none"> Start the following day of the last ECP dose. The client should use abstain or use another method for the first seven days. Alternatively, start on the next menstrual period, but abstain from sex or use another method in the interim. Before insertion of implants, a pregnancy test to rule out pre-existing pregnancy may be advisable for practical or cost reasons (not for safety reasons).
Intrauterine device (IUD)	<ul style="list-style-type: none"> It may be inserted after the start of the next menstrual period.
Sterilization	<ul style="list-style-type: none"> The procedure may be performed after the start of the menstrual period following ECP use. Use a temporary method until the sterilization is completed.
Fertility awareness-based methods	<ul style="list-style-type: none"> Initiate after the first normal menstrual period following ECP use. Note that the first bleeding episode after taking ECPs may not be a "normal" menstrual period. Use a barrier method until the first normal period.

CONVENTIONAL HORMONAL CONTRACEPTIVE USE

The use of hormonal contraceptives has no restrictions among women who are victims of violence, except if they have conditions that contraindicate their use. (120) These contraindications are discussed in Chapter 3. A woman suspected or known to be currently suffering from domestic or intimate partner violence and expresses her desire to prevent pregnancy can be encouraged to and counseled on these options. The health provider can suggest the use of contraceptives, such as the injectable form, even without the knowledge of the partner.

WHEN SHOULD FOLLOW-UP EVALUATION BE SCHEDULED?

No scheduled follow-up is required after using the methods unless the client identifies a problem or question. However, she should be encouraged to seek follow-up care if she

- Needs management of issues related to rape.
- Desires evaluation for STIs.
- Needs ongoing contraception or wishes to switch methods.
- Has not had a menstrual period by three weeks after taking Yuzpe method, which could be a sign of pregnancy.
- Has irregular bleeding with lower abdominal pain more than a few days after taking the Yuzpe method, which could be symptoms of an ectopic pregnancy.
- Has any other health concerns.

METHODS TO AVOID OR USE WITH PRECAUTION DURING THE IMMEDIATE POST-ASSAULT PERIOD

IUD

In case of rape, IUDs do not protect against STI/HIV/pelvic inflammatory disease (PID). IUD insertion may even potentially increase the risk for PID if the victim acquired a chlamydia or gonorrhea infection. (128) Hence, for these types of infection, IUD insertion should be avoided. This concern is considered to be low for other STIs. Therefore, the WHO MEC does not recommend the use of IUDs unless other more appropriate methods are not available (Category 3). Meanwhile, the use of IUD may be recommended for victims of rape who are at low risk for STI (WHO MEC Category 1).

Special Population: **CONTRACEPTION IN DISASTER AND CRISIS SITUATIONS**

In disaster situations, women are at higher risks for unwanted or unplanned pregnancies and sexually transmitted infections (STIs) for several reasons.(131) Some of these reasons include the following:

- Routine behavior, that is, taking the daily pill or using condoms, may be disrupted and forgotten while attending to emergent needs.
- Access to contraceptives becomes difficult.
- Comfort-seeking behavior, such as intimacy and sex, may increase.



The risk of women and children for domestic violence and sexual assault is also increased, resulting in higher predisposition to STIs, possible spread of human immunodeficiency virus (HIV), unwanted pregnancies, unsafe abortions, and other adverse outcomes, such as trauma, as well as maternal and neonatal deaths.(130) Notably, women have more miscarriages, premature deliveries, fetuses with intrauterine growth restriction, and low birth weight infants after disasters. Adolescents, aside from vulnerability to exploitation, violence, and transactional sex, may also be prone to risk-taking behavior.

Four key aspects of reproductive healthcare in disaster and crisis situations should be addressed:

- Safe motherhood (antenatal care, delivery care, and postpartum care)
- Family planning
- Prevention and care of STIs and HIV/AIDS
- Protection from and response to sexual and gender-based violence

The following measures should be immediately undertaken:

- Determine contraceptive availability.
- Document the type, quantity, and expiration dates of the contraceptives.
- Distribute condoms to men and women.
- Provide emergency contraception, as needed.
- Promote use of injectable hormonal contraceptives.
- Plan protective measures against violence and exploitation for women and children

The following long-term measures must be employed:

- Institute OB-GYN healthcare services with trained staff in evacuation centers or camps.
- Provide education sessions on sexual health and reproductive health rights in these centers.
- Provide educational materials on the above topics.
- Establish a family planning program (as part of a comprehensive reproductive health program) that covers effective counseling, contraceptive choices, follow-up, education, and general information dissemination.

CONTRACEPTIVES AND SPECIAL CONSIDERATIONS IN DISASTER/CRISIS AREAS*

Male/female condoms

- Condoms are suitable in disaster-hit areas because of their easy distribution by any provider, lack of medical contraindications, and prevention of STI transmission, including HIV.
- Failure rates, especially during the first year of use, may be higher than those for other methods because of improper or incorrect usage.
- Counseling must be given as early as possible in the post-emergency phase to ensure correct usage and to motivate both the man and woman to start and continue to use the method.

Emergency contraceptive pills (See *Women-Victims of Violence*)

Injectables

- The advantage of this method is that women are not required to remember to take a daily pill, which may be difficult during a crisis.
- Pregnancy rates are approximately 3% in the first year of use.
- Irregular or prolonged bleeding often appears during the first three to six months of use (much less for the combined injectable). For the progestin-only injectable, bleeding becomes infrequent or disappears after the first few injections. This advantage may prove appealing for women because of the less-than-ideal sanitary set-up and inaccessibility to hygienic products and water in evacuation areas or camps.

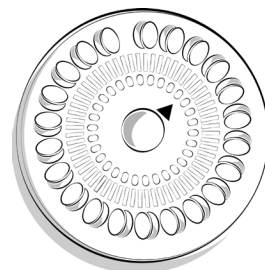
- These methods can safely be provided by medical, paramedical, or any personnel trained in administering injections using the MEC checklist to determine client eligibility.
- Regular supply of the contraceptives and proper disposal of needles must be ensured.

Combined oral contraceptive (COC) pills

- Pregnancy rate during the first year of use is approximately eight percent and declines thereafter.
- The pills can be dispensed by paramedical personnel or any trained provider using the MEC checklist to determine client eligibility.
- A regular supply and easy access to pills MUST be ensured in the camps or centers, as well as in the community.

Progestogen-only pills (POPs)

- Approximately 1 in 100 breastfeeding women becomes pregnant within the first year of use.
- This method is ideal for women in evacuation centers or camps who are breastfeeding and need additional protection because POPs do not affect the quality or quantity of breast milk.
- Additional advantage is that this method may prolong lactation amenorrhea.
- The pills can be dispensed by paramedical personnel or any trained provider using the MEC checklist to determine client eligibility.
- Similar to COCs, a steady regular supply of POPs must be established for easy access by clients.



Intrauterine devices (IUDs)

- The advantage of IUDs is that they are among the most effective methods of contraception with pregnancy rates of only 6 to 8 per 1000 women during the first year of use.
- The use of such devices in disaster areas depends on the availability of devices and skilled medical or paramedical providers for insertion.

- IUDs are suitable for clients coming from areas where the method is already known and where the IUD is likely to be available once the client has returned.
- Clients must also have access for post-insertion follow-up if the need for removal arises or if any complications occur (uncommon).

Implants

- Approximately 1 in 100 women becomes pregnant over the first year of implant placement.
- Prolonged protection is experienced for three, five, or seven years depending on the implant.
- This method requires a minor surgical procedure; thus, trained physicians are the sole providers.
- Clients must have access to follow-up and removal upon demand in the area of origin or in the new destination.

Lactation amenorrhea method

- For this method to be successful, the client must be fully or nearly fully breastfeeding, menses have not yet resumed, and the infant is less than six months old. Otherwise, an additional method, such as the POP, is needed.
- Pregnancy rates are approximately 2 per 100 women in the first six months.



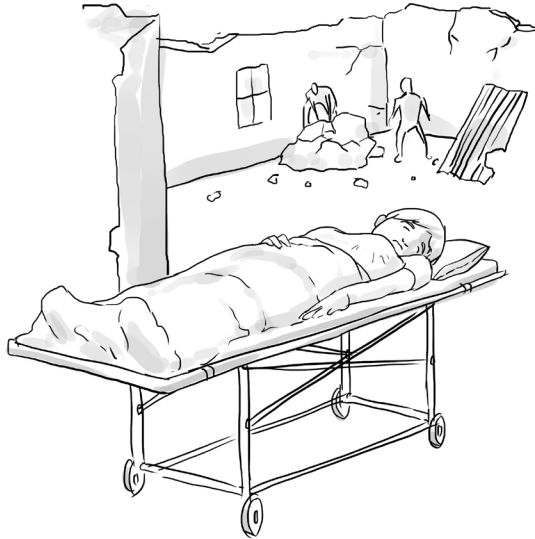
Male and female sterilization

- These permanent methods of contraception are suitable for couples who no longer desire any children.
- Pregnancy rate for vasectomy is approximately 2 per 1000 over the first year after the male partners have had vasectomies, whereas that for tubal ligation is 5 pregnancies per 1000 over the first year.
- Access to these methods may not be as easy in the early phase of the crisis compared with other contraceptive options because of the need for a facility to perform the procedure. Such facility and the physicians who are trained to perform the procedure may not be available initially. Nevertheless, every effort must be exerted to make these services accessible to clients at the soonest possible time.

Fertility awareness-based methods

- Pregnancy rate is approximately 20 for 100 women over the first year of use.
- Clients should be well counseled and motivated to follow the instructions closely when determining the time of the month during which fertilization is possible. This step is especially critical because couples may be burdened by more pressing concerns, such as finding food and water sources, as well as dealing with the loss of relatives, homes, and livelihood.

*Adapted with modifications from Public Health Guide for Emergencies. Chapter on Reproductive Health Care.³See respective sections for detailed information on the following methods.



Chapter 12

SEXUALLY TRANSMITTED INFECTIONS AND CONTRACEPTION

WHAT ARE SEXUALLY TRANSMITTED INFECTIONS (STIs)?

STIs can be contracted through vaginal, anal, or oral sex acts, as well as through the sharing of sex toys and digital penetration.(134-140) Infections can be acquired from body fluids (e.g., semen) in and around the genital area. STIs can also be transmitted from mother to child during pregnancy and childbirth, as well as through blood or tissue transfer. Other sources of STI include the mouth, throat, and rectum. Occasionally, the infection can also be contracted through some non-sexual means.

WHO ARE AT RISK FOR STIs?(143)

- Persons with multiple sexual partners
- Persons with partners who have multiple sexual partners
- Persons with partners having symptoms and/or recently diagnosed with STI
- Those with sexual partners who do not always use condoms when having sex with others
- Those who are sexually active but have no long-term relationships
- Those living in a community where several people are infected with STIs
- Married or unmarried persons who are concerned about STIs or human immunodeficiency virus (HIV) in his or her partner who has sexual relationships with other partners.

The risk of STI acquisition is influenced by a person's behavior, the behavior of the person's sexual partner or partners, and the occurrence of these infections in the community.(141) Thus, the healthcare provider should be aware of the type of STIs and the sexual behavior common in a certain locality. With this knowledge, the providers can improve the provision of risk assessment for STIs among their clients and provide the appropriate treatment. Recognition of the risk for STIs by the clients will serve as their guide in selecting the appropriate steps to protect themselves and others.

WHAT ARE THE CAUSES OF STIs?

STIs are caused by more than 30 microorganisms, including bacteria, viruses, protozoan parasites, and ectoparasites.(139-141) The different types of STIs are tabulated below according to the manner of transmission, symptoms, associated diseases, and curability.

STI	Organism	Transmission	Associated diseases	Curable?
Chancroid	<i>Hemophilus ducreyi</i>	Vaginal, anal, and oral sex	Both sexes: painful genital ulcers; may be accompanied by inguinal swelling (bubo)	Yes
Chlamydia	<i>Chlamydia trachomatis</i>	Vaginal and anal sex Rarely from genitals to mouth From mother to child during pregnancy	Men: urethral discharge (urethritis), epididymitis, orchitis, infertility Women: cervicitis, endometritis, salpingitis, pelvic inflammatory disease, infertility, preterm rupture of membranes, perihepatitis; commonly asymptomatic Both sexes: proctitis, pharyngitis, Reiter's syndrome Neonates: conjunctivitis, pneumonia	Yes
Gonorrhea	<i>Neisseria gonorrhoea</i>	Vaginal and anal sex or contact between mouth and genitals From mother to child during delivery	Men: urethral discharge (urethritis), epididymitis, orchitis, infertility Women: cervicitis, endometritis, salpingitis, pelvic inflammatory disease, infertility, preterm rupture of membranes, perihepatitis Both sexes: proctitis, pharyngitis, disseminated gonococcal infection Neonates: conjunctivitis, corneal scarring and blindness	Yes
Granuloma inguinale (Donovanosis)	<i>Klebsiella (Calymmatobacterium) granulomatis</i>	Vaginal and anal sex Close non-sexual contact	Both sexes: nodular swellings and ulcerative lesions of the inguinal and anogenital areas	Yes

STI	Organism	Transmission	Associated diseases	Curable?
Lympho-granuloma venereum	<i>Chlamydia trachomatis</i>	Vaginal and anal sex	Both sexes: ulcer, bubo, proctitis	Yes
Non-gonococcal	<i>Mycoplasma genitalium</i> <i>Ureaplasma urealyticum</i>	Vaginal sex	Men: urethral discharge (nongonococcal urethritis) Women: bacterial vaginosis; probably pelvic inflammatory disease	Yes
Syphilis	<i>Treponema pallidum</i>	Genital or oral contact with an ulcer, including vaginal and anal sex Mother to child during delivery	Both sexes: primary ulcer (chancre) with local adenopathy, skin rashes, condylomata lata; bone, cardiovascular, and neurological damage Women: pregnancy wastage (abortion, stillbirth), premature delivery Neonates: stillbirth, congenital syphilis	Yes

Adapted from Family Planning: A Global Handbook for Providers, Global strategy for the prevention and control of sexually transmitted infections: 2006–2015 and Zenilman JM, Shahmanesh M. Sexually Transmitted Infections: Diagnosis, Management, and Treatment 2012

Table 27. Viral types of STIs

STI	Organism	Transmission	Associated diseases	Curable?
Acquired immunodeficiency syndrome (AIDS)	HIV	Vaginal and anal sex; very rarely, oral sex In blood, from mother to child during pregnancy or delivery or in breast milk	Both sexes: HIV-related disease, AIDS	No
Cytomegalovirus infection	Cytomegalovirus	Vaginal sex	Both sexes: subclinical or nonspecific fever, diffuse lymph node swelling, liver disease, etc.	No
Genital herpes	Herpes simplex type 2	Genital or oral contact with an ulcer, including vaginal and anal sex; also genital contact in area without ulcer	Both sexes: anogenital vesicular lesions and ulcerations Neonates: neonatal herpes (often fatal)	No
Genital warts	Human papilloma virus	Skin-to-skin and genital contact or contact between mouth and genitals From mother to child during pregnancy or delivery	Men: penile and anal warts, carcinoma of the penis Women: vulval, anal and cervical warts, cervical carcinoma, vulval carcinoma, anal carcinoma Neonates: laryngeal papilloma	No
<i>Molluscum contagiosum</i>	<i>Molluscum contagiosum</i>	Vaginal sex Intimate contact	Both sexes: genital or generalized umbilicated, firm skin nodules	No
Viral hepatitis	Hepatitis B	Vaginal and anal sex, or from penis to mouth In blood, from mother to child during delivery or in breast milk	Both sexes: acute hepatitis, liver cirrhosis, liver cancer	No

Adapted from Family Planning: A Global Handbook for Providers, Global strategy for the prevention and control of sexually transmitted infections: 2006–2015 and Zenilman JM, Shahmanesh M. Sexually Transmitted Infections: Diagnosis, Management, and Treatment 2012

Table 28. Protozoan and lice-causing STIs

STI	Organism	Transmission	Associated diseases	Curable?
Trichomoniasis	<i>Trichomonas vaginalis</i>	Vaginal, anal, and oral sex From mother to child during delivery	Men: urethral discharge (nongonococcal urethritis); often asymptomatic Women: vaginosis with profuse, frothy vaginal discharge; preterm birth, low birth weight babies Neonates: low birth weight	Yes
Pubic lice	<i>Phthirus pubis</i>	Genital contact Direct skin-to-skin contact	Both sexes: itching, excoriations, papules	Yes
Scabies	<i>Sarcoptes scabiei</i>	Genital contact Fomite transmission	Both sexes: nocturnal pruritus, symmetrically distributed burrows, papules, pustules, nodules, and excoriations	Yes

Adapted from Family Planning: A Global Handbook for Providers, Global strategy for the prevention and control of sexually transmitted infections: 2006–2015 and Zenilman JM, Shahmanesh M. Sexually Transmitted Infections: Diagnosis, Management, and Treatment 2012

HOW ARE STIs DETECTED?

STIs are not commonly detected early because the majority do not immediately present with symptoms, as in cases of chlamydia and gonorrhea infection. However, early detection is important in preventing the transmission and occurrence of long-term health consequences.



The following steps should be taken to facilitate the early identification of STIs:

1. Make inquiries as to whether the client or the client's partner experiences genital sores or unusual genital discharge.
2. Be aware of the signs of STIs when doing a pelvic or genital examination.
3. Educate the client about the risks of acquiring STIs.

4. If the client currently has signs or symptoms of an STI, prompt diagnosis and immediate treatment or referral to an appropriate healthcare provider or facility must be carried out.
5. Tell the clients to watch out for genital sores, warts, or unusual genital discharge that may occur on them or on their sexual partners.

In addition to developing awareness of the risk factors, the provider should look for signs and symptoms of an STI in a client. A particular type of STI may present with a specific manifestation. With the recognition of the specific signs and symptoms, diagnosis of the corresponding STI can be achieved (Table 29).

Table 29. Common signs and symptoms according to possible causative STI

Signs and symptoms	Causative STI
Discharge from the penis or vagina: pus, clear or yellow-green	Common: Chlamydia, gonorrhea Uncommon: Trichomoniasis
Abnormal vaginal bleeding or bleeding after sex	Chlamydia, gonorrhea, pelvic inflammatory disease
Burning sensation or pain during urination	Chlamydia, gonorrhea, herpes
Lower abdominal pain or pain during sex	Chlamydia, gonorrhea, pelvic inflammatory disease
Swollen and/or painful testicles	Chlamydia, gonorrhea
Itching or tingling in the genital area	Common: Trichomoniasis Uncommon: Herpes
Blisters or sores on the genitals, anus, surrounding areas, or mouth	Herpes, syphilis, chancroid
Warts on the genitals, anus, or surrounding areas	Human papillomavirus
Unusual vaginal discharge—changes from normal vaginal discharge in terms of color, consistency, amount, and/or odor	Common: Trichomoniasis Uncommon: Chlamydia, gonorrhea

Adapted from Family Planning: A Global Handbook for Providers

WHAT STRATEGIES ARE ESSENTIAL IN THE TREATMENT, PREVENTION, AND CONTROL OF STIs?

Whenever an infection is diagnosed or suspected, effective treatment should be provided promptly to avoid complications and to break the chain of transmission. Prevention of transmission is the most effective strategy in the management of STIs. It avoids exposure to the long-term consequences and complications of STI. Family planning services must include schemes such as those below that will emphasize the prevention of transmission for client protection. (142-143)

- Promotion of safer sexual behavior
 - Education and counselling of persons at risk on how to avoid STIs through changes in sexual behavior and use of recommended preventive services
 - Introduction of prevention and care activities
- Promotion of early healthcare-seeking behavior, which will facilitate the identification of asymptomatic and symptomatic persons unlikely to seek diagnostic and treatment services
- Institution of a comprehensive approach to case management
 - Identification of the STI syndrome
 - Appropriate antimicrobial (antibiotic, antiparasitic, or antiviral) treatment for the syndrome
 - Education and counselling on method by which to avoid or reduce risk of infection with sexually transmitted pathogens, including HIV
 - Promotion of the correct and consistent use of condoms, which may be used in addition to the chosen contraceptive (dual protection)
- Notification, evaluation, treatment, and counseling of sex partners of persons who are infected with an STI
- Pre-exposure vaccination of persons at risk for vaccine-preventable STIs

WHAT IS DUAL PROTECTION?

For the prevention of STIs, a couple can use condoms consistently and correctly during every sexual act in addition to another family planning method of their choice, such as an oral contraceptive. This practice is good for those who are at risk of acquiring STIs because it protects against pregnancy and STIs.



WHAT ARE THE EFFECTS OF CONTRACEPTION ON STIs?

Several queries on the tendency of contraceptives to increase the risk of STIs have been raised. The available literature cites the following effects of contraceptives on STIs (Table 30), as well as the effect of STIs, particularly their treatment, on contraceptives:

Table 30. Effects of contraception on STIs with corresponding recommendations

FP Method : Hormonal contraceptives (128)

Effect on Developing STI

- The risk of acquiring STI is not increased for both uninfected and HIV-infected women.
- The risk of HIV transmission to uninfected partners is not observed to increase.
- Does not offer protection against STIs or HIV.

Recommendation/s

- No restriction should be imposed on the use of any of the hormonal contraceptives for women who are at high risk for STIs (WHO Category 1).
- If a risk for STIs or HIV exists, the correct and consistent use of condoms is recommended, either alone or with another contraceptive method.

FP Method : Intrauterine device (IUD)

Effect on Developing STI

- Risk of infection is higher only during the first 20 days after insertion. Such infection is most strongly related to the insertion process.(159)
- The risk of pelvic inflammatory disease (PID) associated with gonococcal and chlamydial infection does not increase with IUD insertion.(138)
- The absolute risk of subsequent PID is found to be lower among women who have no STI at the time of IUD insertion than among women with STI during insertion.(128)
- The association of the risk for HIV acquisition with IUD use is not increased. Its use among HIV-infected women is not known to increase the risk of transmission to sexual partners.(59,128)

Recommendation/s

- Strict infection prevention practices must be followed to minimize the risk of infection and serious disease.
- Removal of the IUD with the occurrence of PID is unnecessary if continued use is desired. However, continued use should be based on the client's informed choice and her current risk factors for STIs and PID.(59)
- Insertion should be avoided in women at high risk for or currently infected with gonorrhea, chlamydia, purulent cervicitis, or PID.(59,128)
- If STI or PID develops with or without IUD, the condition should be treated by using appropriate antibiotics to permit continued safe use of IUD.
- A client with HIV can have an IUD inserted. However, the same is not recommended for a client with AIDS unless she is clinically well and on antiretroviral (ARV) therapy.(128)

FP Method : Barrier method and spermicides

Effect on Developing STI

Generally, evidence has established the protective effect of barrier methods against transmitting and getting infected with STIs.(141-142)

1. Male Condoms

- Prevents transmission by 80% to 95% when used correctly.(142)
- Its consistent use is estimated to reduce the likelihood of becoming infected with HIV when exposed to the virus by 10 to 20 times (compared with inconsistent or non-users). (144)
- Among heterosexual relationships involving one HIV-infected and one uninfected partner, its correct and consistent use lessens the likelihood of HIV-negative partners to become infected by 80% (compared with persons in similar relationships who do not use it).(145-146)
- Condoms may not prevent the acquisition of human papilloma virus (HPV), but they may protect against HPV-associated diseases such as genital warts, cervical intraepithelial neoplasia II or III and invasive cervical cancer.(147)

2. Female Condoms: may be as effective as male condoms in the prevention of chlamydia and gonorrhea transmission.(148-149)

3. Diaphragms (150)

- Its use affords protection against cervical gonorrhea, chlamydia, and trichomonias infection.
- However, even if it is combined with lubricants, it is less effective in preventing STIs, particularly HIV.

4. Spermicides and non-specific topical microbicides: their use has been reported to be ineffective in the prevention of HIV and STIs.(150)

Recommendation/s

Use consistently and correctly to maintain its highly protective effect against STIs that spread by discharge, which include HIV, gonorrhea, and chlamydia.(59)

Should not be relied on as the sole source of protection against HIV infection.

Spermicides containing N-9 should not be recommended for STI/HIV prevention.(150)

FP Method : Lactation amenorrhea method on HIV transmission

Effect on Developing STI	Recommendation/s
<p>If HIV-infected mothers not on ARV therapy are on mixed feeding with breast milk and other foods for two years, about 10 to 20 infants of every 100 of these mothers will become infected with HIV through breast milk.(151)</p> <p>Administration of ARV drugs to an HIV-infected mother or HIV-exposed infant or both can significantly reduce the risk of HIV transmission through breastfeeding.(129,151)</p>	<p>Exclusive breastfeeding for 6 to 12 months is recommended for HIV-infected mothers receiving appropriate ARV interventions.(59,152) Breastfeeding can also serve as a form of contraception.(151)</p> <p>Beneficial in developing countries, where infant and child mortality rates are high.(151)</p> <p>In well-resourced countries with low infant and child mortality rates, avoidance of breastfeeding remains appropriate. (151).</p>

WHAT ARE THE EFFECTS OF STI MEDICATIONS ON CONTRACEPTION?

With contraceptive use, family planning health providers should routinely ask their clients about current and previous medication use. Clients using hormonal contraception should also be informed about the potential interaction that may alter contraceptive efficacy. Particularly in cases of STIs, antimicrobial therapy is the main mode of treatment and may potentially alter hormonal contraceptive blood levels. Hence, clients should also be encouraged to seek advice before taking new medications. They should be aware of the duration of simultaneous drug intake as well as the nature of the condition for which the drug must be taken. Table 31 shows the effects of STI medications on contraceptives.



Table 31. Effect of STI medications on contraceptives

Commonly used medications to treat STIs	Effect on contraceptive efficacy
Doxycycline	No change
Fluoroquinolones (Ciprofloxacin and Ofloxacin)	No change
Macrolides (Azithromycin)	Erythromycin – less potent in increasing plasma concentration of estrogen and dienogest Azithromycin - No change
Antiretrovirals	
Nucleoside Reverse Transcriptase Inhibitors (NRTIs)	No change
Non-NRTIs	Increased effect of ethinyl estradiol (EE) Decreased effect of levonorgestrel
Protease Inhibitors and Ritonavir-boosted Protease Inhibitor	
<ul style="list-style-type: none"> Atazanavir/ritonavir 	Increased effect of EE and norethindrone (NET)
<ul style="list-style-type: none"> Darunavir/ritonavir 	Decreased effect of EE, no change in NET
<ul style="list-style-type: none"> Fos-amprenavir/ ritonavir 	Decreased effect of EE and NET
<ul style="list-style-type: none"> Indinavir 	No change
<ul style="list-style-type: none"> Lopinavir/ritonavir 	Decreased effect of EE, no change in NET
<ul style="list-style-type: none"> Nelfinavir 	Decreased effect of EE, no change in NET
<ul style="list-style-type: none"> Saquinavir 	No data available
<ul style="list-style-type: none"> Tipranavir/ritonavir 	Decreased effect of EE

The use of hormonal contraceptives among women infected with HIV using ritonavir-boosted protease inhibitors is categorized as MEC 3. Clients on ARV treatment should be advised to use condoms consistently and correctly if they decide to initiate or continue the use of a hormonal contraceptive.(154) This strategy will not only prevent HIV transmission but also compensate for the possible reduction in the effectiveness of the hormonal contraceptive. When a combined oral contraceptive is chosen, a preparation that contains at least 30 µg EE should be selected. This practice will offset the blood-level lowering effects of ARV agents on estradiol. A summary on the recommendations on contraceptive use among clients with STI, HIV/AIDS, and on ARVs is provided in Table 32.

Table 32. Recommendations on contraceptive use among clients with STI, HIV or AIDS, and on ARVs*

CONTRACEPTIVE METHOD	Recommendations for STI cases	
	Permissible	Not recommended
IUD (copper or levonorgestrel-containing IUDs)	HIV IUD user developing gonorrhea or chlamydia infection or PID Clinically well with AIDS and on ARV	High risk for gonorrhea and chlamydia Current gonorrhea and chlamydia infection or purulent cervicitis; PID AIDS and not clinically well and/or not on ARV therapy
Female Sterilization	After documentation of completed treatment and cure from gonorrhea, chlamydia, purulent cervicitis, or PID HIV infection * Clinically well AIDS * While on ARV therapy *	Current AIDS-related illness Existing gonorrhea, chlamydia, purulent cervicitis, or PID
Vasectomy	After documentation of completed treatment and cure from scrotal skin infection and STI HIV infection * Clinically well AIDS * While on ARV therapy *	With active STI With scrotal skin infection Swollen, tender tip of penis, sperm ducts or testicles Current AIDS-related illness
Spermicides (including when used with diaphragm or cervical cap)	STI	High risk for HIV HIV or AIDS with or without ARV
Combined contraceptives: oral, injectables, patch, and ring	STI HIV/AIDS	HIV/AIDS on: Ritonavir treatment Ritonavir plus protease inhibitors (darunavir, nelfinavir, fosamprenavir, lopinavir)
Progestin-only pills and implants	STI HIV/AIDS	Efavirenz Nevirapine
Progestin-only injectables	No special considerations; can be safely used	

* Precautionary measures should be practiced by the health provider performing the procedure

Source: Family Planning: A Global Handbook for Providers

Faculty of Sexual and Reproductive Healthcare. Drug interactions with hormonal contraception. 2011

Clients who are taking drugs that favor the enhanced metabolism of hormonal contraceptives should use additional contraception. The consistent and correct use of condoms is the most preferred method. The advantage of this strategy is contraception promotion and protection from acquiring and transmitting STIs.

KEY POINTS

- STIs are caused by bacteria, viruses, and parasites. If not managed accordingly and appropriately, complications and adverse sequelae will set in. Healthcare providers must be aware of the causes, risk factors, signs, and symptoms of STIs.
- Early detection of STIs is important in instituting the appropriate management approach that aims to control and prevent further spread of infection.
- Healthcare providers should adequately educate and counsel their clients regarding STIs. This practice is essential in the management of STIs because the clients play an active role in controlling and preventing transmission.
- The family planning health provider and clients should be aware of the possible effects of contraception on STIs and the effects of STI treatment on contraceptives, particularly the hormonal types. This awareness and knowledge will assist healthcare providers in providing the appropriate advice and counselling on contraceptive use.
- The primary concerns for STI management include the institution of specific treatment and the prevention of transmission. The most effective method in terms of pregnancy and STI transmission prevention is the consistent and correct use of condoms as part of the dual protection strategy.
- The clients should be encouraged to familiarize themselves with the signs and symptoms of STIs for early detection. Client should also be encouraged to adhere to the recommended treatment. Referral to a specialist, whenever needed, for existing complications or sequelae should be provided.

Chapter 13

MANAGEMENT OF FAMILY PLANNING SERVICES

PURPOSE

This chapter describes the essential components of the effective management of delivering quality family planning (FP) services in a given health facility.

Specifically, this chapter has the following objectives:

- To define the package of FP services that should be offered by the different categories of health facilities
- To identify the specific requirements of each type of health facility to provide quality FP services
- To describe the necessary management systems for supporting the delivery of FP services, including a description of the principles and techniques of infection prevention and control

RATIONALE

The access and use of FP services depend largely on the capacity of the health facility and its staff to provide the appropriate services in response to the specific conditions and expressed needs of the targeted clients. The effective management of FP clinic services is central to meeting this demand on a sustained basis. The provision of quality FP services requires the following:



- Presence of competent staff with technical skills to provide culturally appropriate and gender-sensitive counseling techniques and to offer a broad range of FP methods
- Provision of accurate evidence-based information to ensure informed choice
- Efficient health infrastructure
- Appropriate state-of-the-art functioning equipment

- Accessibility of services that are readily available, affordable, and acceptable to clients
- Continuous and adequate supply of contraceptives and other materials
- Provision of follow-up care
- Establishment of a sustainable management support system

Such provision also requires the organization of management support systems ranging from planning, organization, implementation, monitoring, and evaluation to ensure the efficient and effective delivery of FP services.

FP SERVICES

The FP services provided by a healthcare facility are summarized below.

1. FP promotion
2. FP counseling and assessment of clients
3. FP method provision
4. Protective measures for infection prevention and control
5. Management of complications and appropriate referral (e.g., reproductive tract infections [RTIs]/sexually transmitted infections [STIs])
6. Client follow-up

Certain health facilities also provide laboratory diagnostic services to FP clients, as needed.

FP Promotion

These services involve the provision of appropriate FP messages to specific groups of clients to improve their knowledge, attitude, and behavior about FP. FP information and education services are focused on the following areas:

- FP as a health intervention
 - Preventing high risk pregnancies
 - Reducing maternal and child deaths through identification of unmet modern FP needs
- Reiteration of health benefits of practicing FP through healthy timing and spacing of births
- FP in the context of poverty mitigation intervention
 - Attaining desired family size
 - Sustaining quality of life to contribute to national development

- Emphasis on the links of FP with health and social development concerns
- Provision of accurate and evidence-based information about FP and FP methods
- Provision of information on the broad range of modern FP methods
- Information on clients' rights and benefits/entitlements

Who should conduct health promotion activities?

Health promotion related to FP services can be provided by health providers (e.g., doctors, nurses, and midwives) community health volunteers (e.g., Community Health Teams [CHTs], barangay service point officers, and other volunteers). These activities can be carried out within health facilities and in a community setting using different methods, such as the following:

- Interpersonal communication (one-on-one interaction with clients)
- Bench conferences (e.g., in the outpatient department units of hospitals)
- Web-based group sessions in communities
- Outreach and facility-based activities
- Small group discussions (e.g., Usapan sessions)

To support health promotion activities, FP information, education, and communication (IEC) materials, such as brochures, fliers, leaflets, and video materials (i.e., FP videos/films) must be provided to clients. These sessions must serve as a venue where client inquiries related to FP can be addressed.



FP Counseling and Assessment of Clients

Counseling is an FP service provided to individual clients through face-to-face communication. In providing this service, the provider helps the targeted client make informed decisions about his/her fertility relative to reproductive choice (see Chapter 2).

Client assessment is the process by which the health worker learns about the health status, the FP needs, and the eligibility of the client for contraceptive use. It is a MUST that all clients who attend FP/reproductive health (RH) clinics undergo assessment (see Chapter 3).

FP Method Provision

After a client undergoes appropriate counseling and assessment, the specific FP method is then provided. The provision of FP methods includes the dispensing of all medically approved, safe, effective, and legally acceptable modern FP methods. The services provided are as follows:

- Assessment of clients, including pelvic examination if required
- Simple laboratory procedures, as needed
- RH cancer screening
 - Other FP services, including identification and management of common gynecological problems (i.e., RTIs), such as STIs/human immunodeficiency virus (HIV)-autoimmune deficiency syndrome (AIDS)

Quality Management System for Family Planning Service Delivery

The following are important requirements that should be fulfilled when managing FP services in facilities.

- A. Appropriate health service infrastructure in an enabling environment
- B. Adequate, committed, and competent staff
- C. Availability of standard equipment, health products, and other logistics

A. Appropriate Health Service Infrastructure in an Enabling Environment

Health facilities should have adequate and efficient infrastructure and a physical set-up (e.g., FP room/clinic) that is conducive to the provision of quality FP services. Such infrastructure ensures confidentiality and privacy during the interview, counseling, and physical examination. The facility should be clean and safe and offer a welcoming atmosphere. A waiting area should also be provided for clients.

To ensure that quality services are maintained, the following measures should be undertaken:

1. Strategically and prominently display the menu of FP services offered and the clinic schedule outside the health facility for client information.
2. Always maintain cleanliness inside and outside the health facility.
3. Ensure that the facility has good lighting and ventilation.
4. Ensure the availability of running water at all times.
5. Designate a waiting area with adequate seats to ensure client comfort, and make IEC materials available while clients are waiting to be served.
6. Ensure that the health facility has the following:
 - A dedicated area for counseling and an examination room that provide visual and auditory privacy to clients as well as a setting wherein clients can be comfortably examined and clinic staff can work with ease and convenience
 - Containers with decontamination solution for used gloves and instruments
 - An area for washing and sterilizing gloves and instruments
 - Clean and functioning toilet facilities
 - Orderly and updated client records kept in confidentiality
 - Storage rooms for contraceptives and other FP supplies that are safe, secured, and maintained in good order condition

B. Adequate, Committed, and Competent Staff

- FP services must be provided by competent service providers, which primarily include physicians, nurses, and midwives who have completed appropriate FP training courses.
- Physicians, nurses, and midwives generally provide appropriate FP information, education, counseling, and FP methods. Physicians also provide supplementary services to manage medical problems that are beyond the scope of work of nurses and midwives. Other healthcare workers (medical technologists, rural sanitary inspectors, nutritionists, dentists, and trained community health volunteers) may also be trained in FP and may function as FP educators/communicators when they perform their work in the clinic.



- CHTs and other trained community health volunteers help generate demand for FP, particularly for women of reproductive age (WRA) with unmet needs. CHTs conduct the profiling and risk assessment of each household member and prepare health use plans together with the heads of the families. The community health volunteers serve as the link or referring arm of household members with health needs to service providers for them to gain access to healthcare.

C. Availability of Standard Equipment, Health Products, and Other Logistics

A health facility must have sufficient logistics management to deliver quality FP services effectively. These logistics include the following:

- A continuous supply of FP commodities to meet the requirements of current and potential FP users
- Medicine and other medical supplies for voluntary surgical contraception (bilateral tubal ligation [BTL] and no-scalpel vasectomy [NSV]), management of complications, and other health-related conditions
- Standard diagnostic equipment/instruments/supplies to perform physical examinations or laboratory tests, as needed
- Supplies and materials for cleaning and maintaining infection prevention and control
- Required forms for recording client information and services, consent forms, referral forms, and supplies
- IEC materials

Table 33 summarizes the FP services delivered at each level of a health facility. The recommended minimum requirements of the various levels of health facilities to provide FP services are specified.

Table 33. Recommended minimum standards for family planning service outlets

FP Service Facility	Minimum Set of FP Services	Required Minimum Staffing with Training	Basic Resource Requirement
<p>Primary Care Facility (City/Rural Health Units) With in-patient beds</p> <ul style="list-style-type: none"> • Infirmery • Birthing home • Without in-patient beds • Medical out-patient clinics • OFW clinics 	<ul style="list-style-type: none"> • FP promotion/education • FP counseling • Provision of FP methods: pills, injectables, condoms, NFP, LAM, SDM, interval/post-partum IUD insertion, insertion and removal of subdermal implants, NSV • Infection prevention and control • Referral for BTL • Risk assessment by history • Management of minor side effects • Routine check-up/follow-up of clients • Follow-up of dropouts/defaulters • Referral for major complications of contraceptives 	<p>Midwife and/or nurse/MD, with the following trainings:</p> <ul style="list-style-type: none"> • Basic FP course or FPCBT Level I • Fertility awareness orientation • FPCBT Level 2 • Interval IUD Skills Training • Postpartum IUD Training • Implant Insertion and Removal Training • NSV Training • All NFPs including SDM <p>Recommended additional courses:</p> <ul style="list-style-type: none"> • Orientation on CSR • DQC for FP current users • NOSIRS and SMR Tools • CBMIS • Orientation on Informed choice and voluntarism 	<p>Basic clinic equipment/instruments/supplies:</p> <ul style="list-style-type: none"> • Stethoscope • BP apparatus • Weighing scale • Examination table • Gooseneck lamp • Instrument tray • Adequate supplies of contraceptives (condoms, pills, and injectables, IUD kit, subdermal implant kits) at authorized stock levels • Auto-disable syringes or disposable syringes with needles • BBT thermometer • NFP charts • Cycle beads • Forms: FP form 1, target client list, MEC checklist by FP method, clinic service records, referral slips, CBMIS forms, IEC materials, NOSIRS, SMR Forms, and consent forms
<p>Custodial Care Facility</p> <ul style="list-style-type: none"> • Sanitarium/Leprosarium 	<p>All services in primary care facility</p>	<p>Same as in primary care facility</p>	<p>Same as in primary care facility</p>

Table 33. Recommended minimum standards for family planning service outlets

FP Service Facility	Minimum Set of FP Services	Required Minimum Staffing with Training	Basic Resource Requirement
Specialized Out-Patient Facility <ul style="list-style-type: none"> Itinerant/ outreach FP services 	All services in primary, custodial care PLUS <ul style="list-style-type: none"> NSV BTL provision Management of complications related to contraceptives 	A team composed of a surgeon, nurse, and/or midwife trained on the above courses PLUS <ul style="list-style-type: none"> Surgeon and nurse or midwife trained on implant, NSV, and BTL 	Basic Resource Requirement <ul style="list-style-type: none"> Stethoscope BP apparatus Adequate supplies of contraceptives including requirements for NFP Forms including client consent forms (e.g., IUD, BTL, NSV) BTL kits, subdermal implant kits, IUD kits, NSV kits (e.g., vas dissecting forceps and vas fixating clamp) OR equipment/ instruments for BTL-MLLA Medical supplies
Level I Hospital	All services offered in primary care facility PLUS: <ul style="list-style-type: none"> Risk assessment by physical exam IUD insertion (interval/ postpartum) Subdermal implant insertion and removal BTL-MLLA Management/referral of complications Diagnosis and management of RTIs, cancer screening (acetic acid wash/ Pap smear) Counseling on infertility Management/referral of complications 	Nurse and/or midwife trained on the above courses PLUS <ul style="list-style-type: none"> Comprehensive FP Training or CBT Level 2 (including PPIUD and implants) NSV training for physicians BTL-MLLA training for physicians Subdermal implant insertion and removal for physicians 	All resources available in Primary Care Facility PLUS <ul style="list-style-type: none"> IUD insertion and removal kit (ovum forceps, scissors, speculum, tenaculum forceps, uterine sound, alligator forceps, and modified placental forceps) Sterilizer or stove with covered pan Sterile gloves, microscope laboratory facilities for RTI diagnosis Acetic acid wash kit, Pap smear kit, NSV kits, vas dissecting forceps, vas fixating clamp, BTL kits, and surgical record forms Subdermal implant kit Consent forms

Table 33. Recommended minimum standards for family planning service outlets

FP Service Facility	Minimum Set of FP Services	Required Minimum Staffing with Training	Basic Resource Requirement
<p>Level II Hospital Health facility with the capacity to provide Levels I and II services</p>	<p>All services offered in Level I PLUS</p> <ul style="list-style-type: none"> • Infertility workup and referral management of other RTIs and gynecological diseases 	<p>A team composed of a physician/ surgeon, nurse, and/or midwife trained on the above courses PLUS</p> <ul style="list-style-type: none"> • Physician and nurse trained for laboratory facilities • Medical technologist 	<p>All resources available in Level I</p> <p>PLUS</p> <ul style="list-style-type: none"> • VSC drugs and supplies • operating room, minilap kit, and NSV kits • Other related equipment (basic laboratory)
<p>Level III Hospital Health facility with the capacity to provide the above services and management of major complications</p>	<p>All of the above</p> <p>PLUS management of major complications</p>	<ul style="list-style-type: none"> • Midwife • Nurse • Medical specialists • Obstetrician–gynecologist • Anesthesiologist • General surgeon • Urologist 	<p>Tertiary hospital requirements</p>

Quality management also entails that mechanisms be set in place to ensure that FP service delivery will be well supported. These mechanisms include the following:

1. Ensuring the availability and accessibility of effective and efficient FP services through standard procedures
2. Maintaining appropriate health facility infrastructure and conducive environment
3. Ensuring that systems are in place to install and support competent and proficient service providers through supportive supervision. Training and deployment of community-based health volunteers should also be given support.
4. Maintaining an efficient logistics management system that includes the following processes:
 - a. Forecasting of health products
 - b. Procurement and financing
 - c. Allocation and distribution
 - d. Warehousing
5. Establishing management support systems
 - a. Information management (e.g., reporting and recording)
 - b. Monitoring and evaluation
 - c. Service delivery network
 - i. Referral system
 - ii. Public-private partnerships
 - d. Quality assurance
 - i. Infection prevention and control
 - ii. Client safety and client responsiveness

Staff Development

Two mechanisms are recommended to develop the capability of staff and improve their competencies in FP service delivery. These mechanisms include attendance in training, post-training evaluation two to six months after training, and regular supervision/coaching/mentoring and monitoring of staff.

Training

- Training is the main vehicle used to enhance and ensure the capability of staff to deliver quality FP services.
- Training refers to the process of developing staff competencies so that they can effectively perform their expected functions and tasks.
- All providers of FP services must undergo the appropriate training specified in Table 29. Given the fast turnover of staff in health facilities, a staff development plan must be established and updated yearly. Such plan must be accompanied by a strong advocacy for budgetary support from local officials and mobilization of funds from other sources.

Supportive Supervision

- Supportive supervision refers to the process of organizing and overseeing the work of subordinates responsible for performing certain assigned functions and tasks.
- This practice is a personal interface between the supervisor and supervisee that must be undertaken regularly for the effective operation of the program and for sustaining staff morale and commitment.
- The process is focused on the mentoring, constructive feedback, and joint resolution of problems while considering subordinates as clients.
- Supervision aims to (a) determine the actual performance of staff in all aspects of their work and (b) renew the enthusiasm of staff for the work they are doing.
- The overall guiding principle of supervision involves guidance, support, and assistance by coaching and mentoring the staff in carrying out their assigned tasks well (see Table 34).

Table 34. Guidelines for staff development

Training of Staff

1. Conduct/update an inventory of the training status of health staff.
2. Conduct training needs analysis (TNA) among staff.
3. Discuss TNA results with staff.
4. Identify gaps in competencies, and identify appropriate training courses.
5. Prepare the staff development plan specifying the following:
 - 5.1 Name of staff to be trained
 - 5.2 Specific training course to attend
 - 5.3 Projected schedule for training
 - 5.4 Potential sources of funds for training
6. Coordinate with the provincial/city or regional health office for training opportunities for health staff on specific training courses.
7. Mobilize resources to support staff training.
8. Send staff to training, and reassign other staff to take on the trainee's tasks.
9. Conduct post-training evaluation two to six months after training for every trainee prior to the issuance of the appropriate certificate.
10. Monitor the application of knowledge and skills learned during the training program.
11. Maintain training certificates and training records.

Supervision of Staff

1. Organize the work of clinic staff and volunteer workers responsible for implementing/ delivering FP services and general clinic operations, including the following:
 - 1.1 Infection control and good housekeeping
 - 1.2 Equipment and supplies maintenance and availability of adequate FP commodities
 - 1.3 Provision of service to FP/RH clients
 - 1.4 Proper recording and reporting
 - 1.5 Demand generation
2. Designate the supervisor of an individual or group of staff who will perform specific tasks, and reflect these designations in the organizational chart.
3. Prepare the supervisory plan by performing the following:
 - 3.1 Identifying staff members who need supervision
 - 3.2 Prioritizing the specific program area where supervision is necessary
 - 3.3 Scheduling the supervision visit/session
4. Implement the supervision plan.
5. Document the results of the supervision.
6. Give feedback to the supervisee.
7. Develop an action plan with the supervisee to address identified gaps.

Efficient Logistics Management System

Logistics management for FP refers to the process of ensuring that the health facility has sufficient FP commodities and supplies to meet the needs of FP clients and has the necessary equipment or instruments for use in delivering quality FP services. With the phasing out of the donated contraceptives from the USAID (condoms were phased out in 2003, whereas pills and injectables were completely phased out in 2007 and 2008, respectively), health facilities need to secure a continuous supply of contraceptives to serve their current and potential FP users. AO No. 158 issued by the DOH stipulates that local government units (LGUs) should

- Develop a contraceptive distribution guideline to map and identify the catchment areas;
- Conduct campaigns to inform the catchment areas of the LGUs regarding the contraceptive distribution guideline;
- Provide resources for delivering contraceptives to the catchment areas;
- Undertake measures to guarantee local availability of contraceptives. These measures include any of the following:
 - Allocate budget to procure contraceptives for free distribution.
 - Make available contraceptives for sale at cost recovery basis or at margins above cost.
 - Allow consigned commodities from social marketing sources or commercial sources to be made available to clients in LGU outlets.
- Continue with the quarterly distribution and inventory of contraceptive stocks.

According to Sec. 10 of the RPRH Law of 2012 (Procurement and Distribution of Family Planning Supplies),

“The DOH shall procure, distribute to LGUs and monitor the usage of family planning supplies for the whole country. The DOH shall coordinate with all appropriate local government bodies to plan and implement this procurement and distribution program. The supply and budget allotments shall be based on, among others, the current levels and projections of the following:

- (a) Number of women of reproductive age and couples who want to space or limit their children;
- (b) Contraceptive prevalence rate, by type of method used; and
- (c) Cost of family planning supplies.

Provided, That LGUs may implement its own procurement, distribution and monitoring program consistent with the overall provisions of this Act and the guidelines of the DOH.”

These processes/conditions would enable the acquisition of commodities from the different procurement sources. To assist in the procurement and distribution process, Supply Management Recording Forms were developed to track the inflow and outflow of FP commodities in a facility and to determine stock level and average monthly usage. The National Online Stock Inventory and Reporting System was developed to report the stock inventory of these FP commodities from the Province to the Region and then to the Central Office.

Recent developments require a health facility to establish the needed logistics and management system encompassing the following concerns:

A. Forecasting of health products

- Forecasting is the process of determining the commodity requirements (supplies and other services) of all clients (i.e., current users and potential clients with unmet needs).

B. Procurement and financing

- Procurement is the process of acquiring commodities from suppliers at affordable prices and ensuring procurement requirements to safeguard the quality of commodities.
- Financing is the process by which the health facility decides on how the FP commodities required by clients will be sourced.

C. Allocation and distribution

- This process involves determining how much and where the various commodities and services will be placed to make them available to different target clients.

D. Warehousing

- Warehousing refers to the process of ensuring that FP commodities are properly kept and maintained in good condition to avoid wastage and to maintain their quality.

Functions of the FP/RH worker in logistics management

Given the above processes and requirements in logistics management, the assigned FP logistics health facility worker must always ensure that supplies are sufficient, that no stock runs out, and that the equipment is in good working condition.

In particular, the FP/RH worker should

- Make a regular inventory of all commodities, supplies, and equipment;
- Properly allocate and distribute the required contraceptives and other supplies (IEC materials, forms, etc.) promptly based on client needs;
- Ensure the appropriate storage of contraceptives, other supplies, and equipment;
- Update and maintain records and reports;
- Regularly monitor the proper use and care of the two types of equipment, namely, the expendable equipment for short-term use and the nonexpendable equipment, which refers to items used for a long time and therefore require proper care and maintenance

Management Support System

Management support systems must be developed and installed in each FP service outlet to ensure the efficient and effective delivery of quality FP services. The management and staff must be able to internalize the importance of these systems and proactively implement programs and services. The following systems must be established:

A. Information Management

This system involves the collection, processing, and analysis of program-related information essential for policymaking, planning, and designing interventions appropriate to the needs of target clients. The aim of management information systems (MIS) is to generate a timely, accurate, and complete set of information as a ready reference for health facility managers and staff when they make decisions to improve the delivery of FP services. The FP information system must be established at each level of operation (e.g., public and private facilities and hospitals) and at the community level (e.g., health use plans).

1. **National Household Targeting System for Poverty Reduction (NHTS-PR)**
 - This information management system identifies who and where the poor are nationwide. This database of poor families allows the national government, as well as private agencies engaged in social protection and services, to objectively select beneficiaries in service delivery. This system is spearheaded by the Department of Social Welfare and Development.

2. **Community-Based Monitoring Information System (CBMIS)**
 - The CBMIS consists of a set of sequenced and continuous steps that enable healthcare providers to identify eligible target clients who do not avail of appropriate health services in a given locality. CBMIS provides and prompts alternative service delivery interventions.
 - Since its inception in the mid-1990s, the CBMIS tool has been expanded to cover not only FP but also selected maternal and child health indicators. The tool is useful in identifying clients with FP unmet needs and has been applied to classify clients according to their capacity to pay for contraceptives. (Refer to the Manual on CBMIS for a copy of the forms and important instructions.)

3. **Facility-based recording and reporting system: The use of the Field Health Services Information System (FHSIS) as the official management information system of the DOH**
 - Clinic management requires a good recording and reporting system. FP workers must be familiar with records and reports, and must know how to accomplish these documentations accurately. Any health facility can adapt and use the records and reports discussed in this section based on their particular need and interest.

Recording Tools: Facility-based documents

In these documents, the data are more detailed and include the day-to-day activities of health workers. The source of data is the services delivered to clients.

FP Service Record or FP Form 1. FP Form 1 is the basic record form used in the FP program and corresponds to the individual treatment record form used in other programs. This form contains essential information about the client that enables the health worker to provide quality FP service. This form is filled out by the service provider and is updated every time the client returns for a follow-up visit (Appendix F, p. 385).



Target Client List (TCL) for FP. The TCL is another essential record accomplished in a manner similar to that for FP Form 1.

This form is helpful because it

- Contains data that help the health worker plan and implement patient care and service delivery;
- Facilitates the monitoring and supervision of service delivery activities to a group of patients/clients identified as eligible/targets to use FP;
- Facilitates the preparation of reports; and
- Provides clinic-level information that can be accessed for future studies.

Summary Tables (ST). STs are forms with 12-month columns retained at the facility (BHS) where the midwife records all monthly data. The midwife records a summary of all data from TCL or registries. The ST is the source of data for reports included in the MW Monthly Consolidation Table (MCT). The PHN records data from all barangays. MCT is the source of documents of the PHN for the Quarterly Form. The MCT serves as the output table of the RHU because it contains a list of indicators per barangay.

Other Records. These forms are kept in the health facility and include NFP charts, referral slips, supplies ledger cards, and requisition and issue vouchers (RIV), which are important for monitoring the availability of FP supplies in the health facility.

Reporting Tools

These tools contain summary data that are transmitted or submitted on a monthly, quarterly, and annual basis to a higher level. The source of data is dependent on the ST and MCT.

Monthly Form Program Report (M1-Brgy) for FP, maternal care, etc. The FP Program indicators found in the TCL and ST are also recorded in M1. The midwife should copy the data from the ST to the Monthly Form, which is submitted monthly to the PHN, which in turn consolidates and prepares the quarterly report.

Quarterly Form Program Report (Q1-RHU). This form is the municipality/city health report that contains the three-month total of indicators categorized on FP. Only one Quarterly Form should be submitted per municipality/city. If the municipality/city has two or more RHUs/MHCs, the consolidation should be performed by or under the direction of the MHO/CHO who sits as Vice Chairman of the Local Health Board. The Quarterly Form is submitted to the Provincial Health Office for consolidation.

For the Hospital Service Statistics Report Form for Family Planning, refer to the Appendix F.

Table 35 shows the guidelines for setting up the information system.

Table 35. Guidelines for setting up an information system	
CBMIS	<ol style="list-style-type: none"> 1. Orient/train staff on CBMIS. 2. Identify the target groups to be covered in the CBMIS. 3. Assign specific areas and number of households to a particular worker for the survey. 4. Conduct a house-to-house interview. 5. Create a master list (TCL of FHSIS) of all women of reproductive age. 6. Identify client needs, and take initial action. 7. Prioritize clients for services. 8. Plan and implement appropriate service delivery interventions. 9. Track clients with FP unmet needs. 10. Update officials/health staff concerned regarding results of CBMIS. 11. Maintain and update the entries in the CBMIS.
Recording System	<ol style="list-style-type: none"> 1. Properly record all pertinent information on clients in FP Form 1. 2. Properly file and maintain these records while observing confidentiality. 3. Check consistency of client information across related forms. 4. Update FP Form 1 of clients per visit to the facility as well as the TCL, and consolidate STI and MCT.
Reporting System	<ol style="list-style-type: none"> 1. Analyze obtained information. 2. Regularly prepare required reports. 3. Submit the following reports on time: <ol style="list-style-type: none"> 3.1 Monthly FHSIS Form or M1 3.2 Quarterly FHSIS Form or Q1 3.3 Annual FHSIS Form 3.4 E-Reporting System
Dissemination and feedback	<ol style="list-style-type: none"> 1. Present analyzed information to concerned health management and staff. 2. Develop an action plan to address findings. 3. Update local officials on results/findings.

Source: CBMIS and FHSIS Manuals.

B. Work and Financial Planning

This system refers to the formulation of a definitive direction and plan of action to address demand for FP services among the population groups. The system involves the identification of approaches and interventions appropriate for the particular situation of the identified beneficiaries. Planning must observe the following principles:

- Objectives and activities aligned with the vision/goal of the LGU/ organization and the overall direction of the National Family Planning Program
- Use of evidence-based information generated through program reviews, records analysis, or updated census information, as well as participation of all health staff and other stakeholders (i.e., private sector)
- Appropriate budgeting and financing of program requirements

Table 36 provides a guide for preparing the Annual Work and Financial Plan for FP.

Table 36. Guidelines for preparing a work and financial plan for FPs

Review of Program Accomplishment and Situation Analysis

1. Conduct health facility self-assessment and identify clinic requirements in terms of staff, training, and logistics; contraceptives based on contraceptive self-reliance, clinic supplies, IEC materials; and service record forms.
2. Review program accomplishments and needs.
 - 2.1 Identify strengths or best practices.
 - 2.2 Identify and summarize gaps/weak areas.
3. Install or update the CBMIS/Master listing of WRA, and identify target population.
 - 3.1 Those with unmet FP needs
 - 3.2 Current FP users
 - 3.3 FP clients who dropped out
4. Prioritize clients to be served.

Priority I: Pregnant/postpartum mothers below 20 years or above 35 years old, parity of 4 or higher, pregnancy interval of less than 3 years, low level of education, poor obstetrics/gynecological history, WRA, and individuals who are sexually active with risky behavior

Priority II: Immediate postpartum, postabortal, and lactating mothers of malnourished children below 5 years.

Priority III: Couples suffering from tuberculosis, malaria, heart and kidney diseases, and STI/HIV/AIDS as well as those with metabolic diseases, such as diabetes mellitus and thyroid disorders

Preparation of the Work and Financial Plan

1. Set goals and objectives for next year based on assessment results.
2. Identify succeeding strategies and activities to realize the objectives.
3. Determine the focal person/staff responsible for the activity.
4. Specify the time frame/scheduled activity.
5. Estimate the amount of resources/funds needed and identified sources.
6. Specify the success indicators to facilitate the monitoring of accomplishments.

Submission of Work and Financial Plan

1. Integrate FP work and financial plans (MIPH/PIPH/CIPH) with the health facility's overall annual plan.
2. Submit to the LGU Planning and Development Office and LCE for approval.
3. Request budget allocation or funding support from key stakeholders.

C. Resource Mobilization

Resources have never been adequate to meet the full requirements of quality FP service delivery in any given health facility. FP training for health staff, replacement or upgrading of FP equipment, and maintenance of supplies and materials are hardly funded from the regular budget allocation for health.

Mobilizing additional resources is important in the effective and efficient management of FP clinic services. Such mobilization involves generating and sustaining the active and coordinated participation of all stakeholders at all levels to facilitate program implementation and service delivery. Resources encompass finances, logistics, cost of operations/activities, and personnel, including time/person-hours and technical expertise.



Different mechanisms can be used to generate additional resources for FP services. These mechanisms entail mobilizing the support and participation of the different stakeholders from the national, regional, local, and community levels through the establishment of sustainable financing schemes for FP services, such as availing of certain Philippine Health Insurance Corporation Benefit Packages where FP services are compensable. These packages include the Inpatient Benefit Package, Maternity Package, or those that are part of outpatient services as long as they are rendered by Philippine Health Insurance Corporation (PhilHealth)-accredited healthcare providers to all eligible PhilHealth members and their dependents in PhilHealth-accredited facilities. Table 37 provides a guide for mobilizing resources for FP service delivery. Refer also to Appendix D (p. 329) for the processing of requirements for PhilHealth accreditation.

Table 37. Guidelines for mobilizing resources for FP services: Identification of resources

1. Determine the total requirement needed to provide FP services to the targeted population.
2. Identify activities/services that can be funded using the existing budget.
3. List the activities/services that lack funding, identify the type of resources needed, and determine the amount to be mobilized.
4. Identify all possible sources of the resources required.
5. Prepare proposals or plans for presentation and submission to targeted contributors/donors.
6. Mobilize resources from the following potential partners through the following activities:
 - 6.1 Advocate/lobby with local officials to procure contraceptives, particularly for the poor segment of your target population from the 20% development fund, 5% Gender and Development Fund, supplemental budget or congressional funds, etc.
 - 6.2 Establish partnerships with the private sector for FP service delivery and contraceptive supplies (e.g., referring clients who are able to pay for private practitioners and pharmacies for contraceptive supplies)
 - 6.3 Coordinate with the DOH–CHD and other institutions for training support and other technical assistance (e.g., prototype IEC materials, copies of protocols and standards, and attendance in training for technical updates)
 - 6.4 Mobilize support from the donor community for financial assistance or technical support.
 - 6.5 Mobilize the participation and contribution of community members in FP service delivery (e.g., participation in establishing community-based information system and referral and follow-up of FP clients).
7. Establish sustainable financing schemes in support of FP
 - 7.1 Comply with the requirements of the PhilHealth for the health facility to be accredited (see Appendix D for the accreditation process and requirements of PhilHealth).
 - 7.2 Advocate the continuous enrollment of indigents to PhilHealth.
 - 7.3 Participate in the Outpatient Benefit Package of PhilHealth, and explore the possibility of using a portion of the capitation funds in procuring contraceptives or supporting other priority activities in the FP



D. Monitoring and Evaluation

Monitoring and evaluation are important processes to monitor the progress and status of program implementation and to assess whether the desired outputs and outcomes are being met as planned. Results of both monitoring and evaluation are expected to generate information that will be used to improve and enhance the provision of FP services, facilitate the implementation of relevant FP-related activities, troubleshoot problem areas, and provide managers and staff with bases for making sound decisions.

Monitoring is the process of keeping track of the progress of FP activity implementation at regular intervals to measure improvement and changes from what were originally targeted and designed.

Evaluation is the process of determining the extent and quality of changes brought about by implementing FP activities and providing FP services to clients or beneficiaries at periodic intervals.

Table 38 provides a guide for monitoring and following up on clients.

Table 38. Guidelines for the monitoring and evaluation of FP clients

1. Review the annual Work and Financial Plan to identify the indicators to be monitored and evaluated.
2. Determine the methodology for data collection to measure each indicator.
3. Designate specific staff/team members to perform the monitoring/evaluation.
4. Decide on the frequency and interval of monitoring/evaluation.
5. Develop monitoring tool/evaluation forms to record findings and data.
6. Orient concerned staff/team on the use of the tool.
7. Conduct monitoring as planned/designed.
8. Conduct an evaluation as planned/designed.
9. Give feedback to management or concerned staff regarding the results of the monitoring/evaluation, preferably during the regular staff meeting.
10. Act on issues and concerns that surfaced during monitoring and evaluation.

Protective measure establishment for infection prevention and control

Infection Control in FP

Infection control in FP refers to the prevention of the spread of infection during the provision of FP methods. This process aims to protect both the clients and providers from the spread of infectious diseases.

Principle of Infection Prevention

Infection prevention refers to stopping the transfer of infectious organisms (germs) between people by

- (1) providing a barrier to body fluids, for example, by wearing gloves; and
- (2) removing infectious organisms, for example, by processing instruments and through waste disposal. Blood, semen, vaginal secretions, and body fluids containing blood can carry infectious organisms. These organisms include HIV (the virus that causes AIDS), hepatitis B virus, staphylococcus bacteria, and many others.

Infections can spread when infection-prevention procedures are not followed and these fluids pass from one person to another.

In the clinic, infectious organisms can be passed between clients and health workers through needle sticks (with used needles) or similar puncture wounds or through broken skin (such as an open cut or scratch). Infectious organisms can be passed from one client to another by surgical instruments, needles, syringes, and other equipment that have not been properly decontaminated, cleaned, and disinfected or sterilized well between clients.

Major Techniques for Preventing and Controlling Infection

Infection control is performed by using any of these techniques: asepsis, antisepsis, decontamination, cleaning, disinfection, and sterilization. Table 39 outlines the basic rules for infection prevention and control.

Table 39. Basic rules for infection control

1. Wash hands (hand washing may be the single most important infection-prevention procedure).
 - Wash hands before and after contact with each client.
 - Use soap and clean running water from a tap or bucket for washing.
 - Wash hands before putting on gloves and whenever they get dirty.
2. Wear gloves.
 - Wear gloves when there is a chance of contact with blood or other body fluids.
 - Before any procedure with each client, put on a new pair of single-use or processed reusable gloves, if possible.
 - Sterilize gloves for any surgical procedure.
3. Perform vaginal examinations only when needed or requested (vaginal exams generally are not needed for most contraceptive methods—except for female sterilization, diaphragm, and IUDs).
 - For vaginal exams, wear either a new pair of single-use gloves or reusable, highly disinfected, or sterile gloves.
 - Perform vaginal exams only when needed—such as for VIA (acetic acid) and Pap smear or upon suspicion of disease when the exam could help with diagnosis or treatment.
4. Clean the client's skin.
 - Appropriately clean the client's skin before an injection or insertion of Norplant implants.
 - Use a locally available antiseptic on dirty skin, or have the patient wash the skin with clean water and soap.
 - Antiseptics have minimal effects when used on clean skin.
5. Clean the cervix with antiseptic as part of the “no touch” technique for IUD insertion.
6. Use a new, single-use needle and syringe.
 - For each injection, use a new, single-use needle and syringe or a sterilized reusable needle and syringe.
 - If reusable needles and syringes cannot be sterilized, use high-level disinfection.
7. After use with each client, reusable instruments, equipment, and supplies should be
 - Decontaminated (soaked in 0.5% chlorine solution [bleach] or another disinfectant),
 - Cleaned with soap and water, and
 - Disinfected (by boiling or steaming) or sterilized (by steam or dry heat).
 - Vaginal specula, uterine sounds, gloves for pelvic exams, and other equipment and instruments that touch mucous membranes should be decontaminated, cleaned, and then either high-level disinfected or sterilized, as appropriate.
 - Scalpel holders and other equipment and instruments that touch human tissue beneath the skin should be decontaminated, cleaned, and then sterilized.
 - Disinfected or sterilized objects should not be touched with bare hands.
 - Gloves should be worn when cleaning instruments and equipment.
 - Linens should be washed in warm, soapy water, and line-dried.
 - After each client, exam tables, bench tops, and other surfaces that will come in contact with unbroken skin should be washed with 0.5% chlorine solution.

Table 39. Basic rules for infection control

8. Dispose of single-use equipment and supplies properly.
 - Do not reuse needles and syringes meant for single use.
 - Do not break, bend, or recap used needles. They should be immediately placed in a puncture-proof container. The container should be buried when three-quarters full.
 - Wash dressings and other soiled solid waste. Wash linens such as beddings, gowns, and surgical drapes by hand or machine and then line-dry or machine-dry. When handling soiled linens, always wear gloves, and hold the linens away from the body and avoid shaking them.



Source: WHO Global Handbook for Providers, 2011.

In handling patients with HIV, healthcare providers are at risk when exposed to needle sticks, mucus membranes, or broken skin. However, the risk is low.

- The average risk of being infected after a needle stick injury with an HIV-infected blood is 3 out of 1,000.
- Exposure of the eyes, nose, or mouth to HIV-infected blood is approximately 1 infection per 1,000 exposures.
- The use of universal precautions best prevents workplace exposure to HIV and other blood-borne infections.

Management of complications and appropriate referral

Management of complications related to FP requires that the health workers are knowledgeable on the adverse effects and complications of each FP method. Timely referral is essential in order to prevent unwanted complications arising from delays in referral to a higher level of facility. A functional service delivery network is a must to provide quality FP services to clients. FP services are made available to FP clients through the network of health facilities in both the public and private sectors in the service delivery network. These services vary in comprehensiveness and degree depending on the capacity of the facility. Some FP methods can also be obtained through pharmacies or drug stores and through the network of community-based volunteer health workers. However, this manual does not provide standards for these set-ups.

Client Follow-up

Follow-up refers to the clinic's responsibility of looking after the needs of clients who had been initially provided with FP or other RH-related services to

- Determine whether clients are satisfied and are correctly using the method that they chose,
- Provide appropriate supplies,
- Answer client questions and reassure them about the side effects of using FP medication and other services,
- Check for medical complications and refer them for further medical evaluation as needed, and
- Identify the reasons for discontinuance of the method or failure to comply with scheduled visits.

Table 40. Steps for FP client follow-up

1. Identify the clients who need follow-up.
 - a. Those who missed their clinic appointments for resupply of oral contraceptives, condoms, and injection of DMPA, or check-up of IUD
 - b. Undecided couples who are motivated
 - c. Acceptors who complain of side effects or have other problems
 - d. High-risk mothers who are not practicing FP
 - e. Those who have just accepted an FP method and transferred immediately to another area
2. Set up priorities to ensure that optimum and quality follow-ups are done by the staff.
3. Schedule follow-up visits.
4. Record the results of follow-up visits.
5. Act on the findings/results of the follow-up.

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CURRENT THRUSTS OF THE NATIONAL FAMILY PLANNING PROGRAM

This section describes the current family planning (FP) program implemented by the Department of Health (DOH). It focuses on meeting the unmet FP needs of women of reproductive age, especially those in the National Household Targeting System for Poverty Reduction (NHTS-PR). It also summarizes the implementing rules and regulations of the newly approved Responsible Parenthood and Reproductive Health (RPRH) Act of 2012.

Situation

The Philippines has substantially reduced the mortality rate of under-five children from 54 per 1,000 live births in 1993 to 30 in 2011 (Family Health Survey [FHS]) as well as infant mortality from 34 to 22. However, the 2013 survey of the NDHS showed that the under-five and infant mortality rates have increased again (Figure 1).

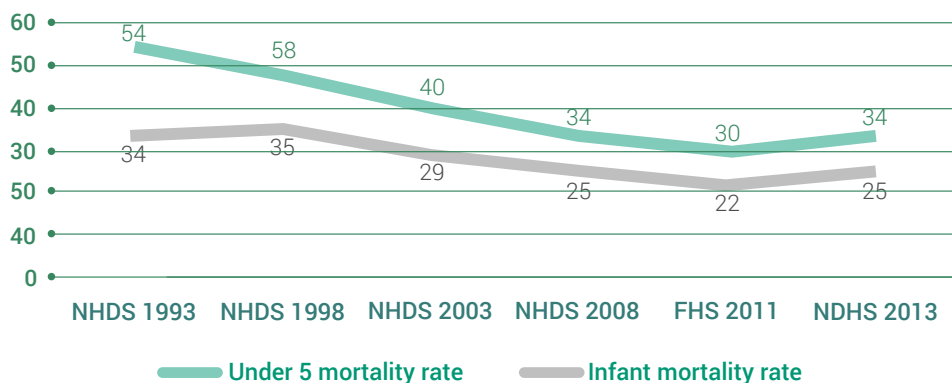


Figure 1. Infant and under-five mortality rates per 1,000 live births.

Source: NDHS and FHS, Philippines, 1993-2013.

The FHS survey showed that the maternal mortality rate decreased from 213 per 100,000 live births in 1988 to 162 in 2008 but sharply increased in 2011 (221 per 100,000 live births) (Figure 2). Despite the increased availability of antenatal care, facility-based delivery, and skilled birth attendance, traditional birth attendants continue to be preferred in poor regions (FHS, 2011).

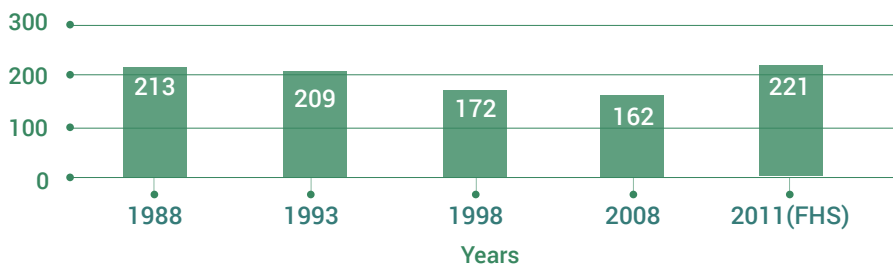


Figure 2. Maternal mortality ratio.

Source: NDHS and FHS, Philippines, 1988-2011.

The Philippine population stood at 96 million in 2012 and is expected to grow by more than 30 percent by 2025 (120.2 million). The total fertility rate (TFR) in the country remains at 3.1 children per woman (2011), which is considerably higher than the desired fertility rate of 2.5 children per woman. The 2013 NDHS showed a slight decrease in the TFR of 3.0 children per woman (Figure 3).

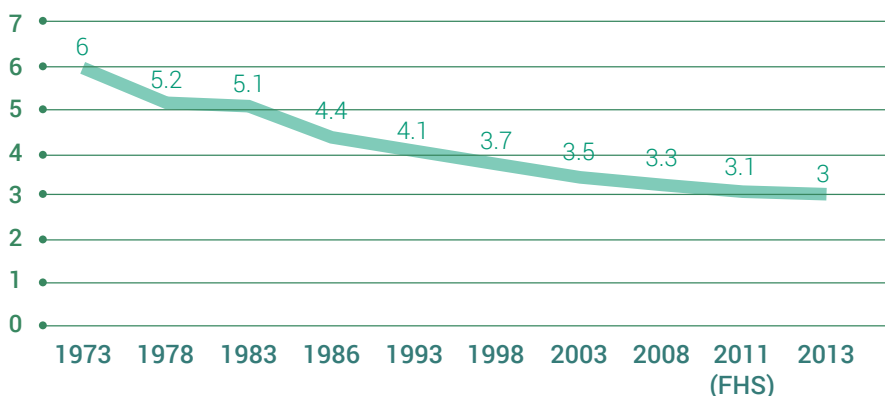


Figure 3. Total fertility rate.

Source: NDS, RFPS, CPS, FHS and NDHS, Philippines, 1973-2013.

The contraceptive prevalence rate gradually increased from 15.4 percent (1968) to 56 percent (NDHS, 2013) in 45 years (Figure 4).

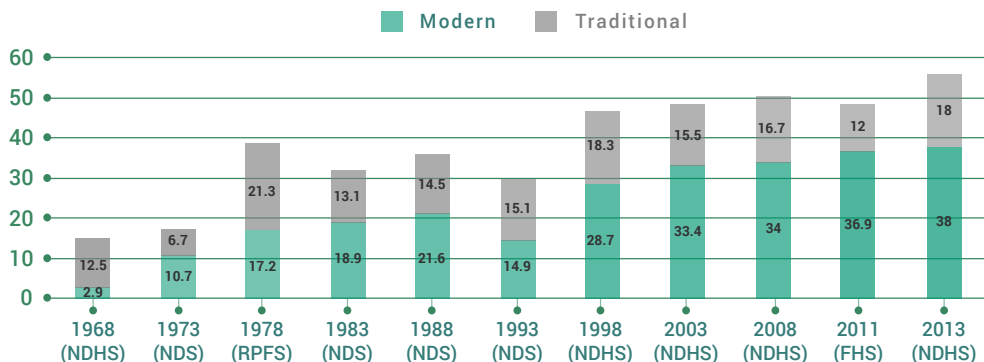


Figure 4. Contraceptive prevalence rate.

Source: NDS, RPFS, FHS and NDHS, Philippines, 1968-2013.

In 2011, the contraceptive prevalence rate (CPR) was 48.9 percent; however, this value significantly varied from one region to another. The 2011 FHS data recorded ARMM as the region with the lowest CPR and Davao as the region with the most number of FP users (Figure 5). The unmet FP needs also slightly declined from 26.2 percent in 1993 to 19.3 percent in 2011 (Figure 6). However, the unmet FP needs increased from 2003 to 2011 by 2 percent.

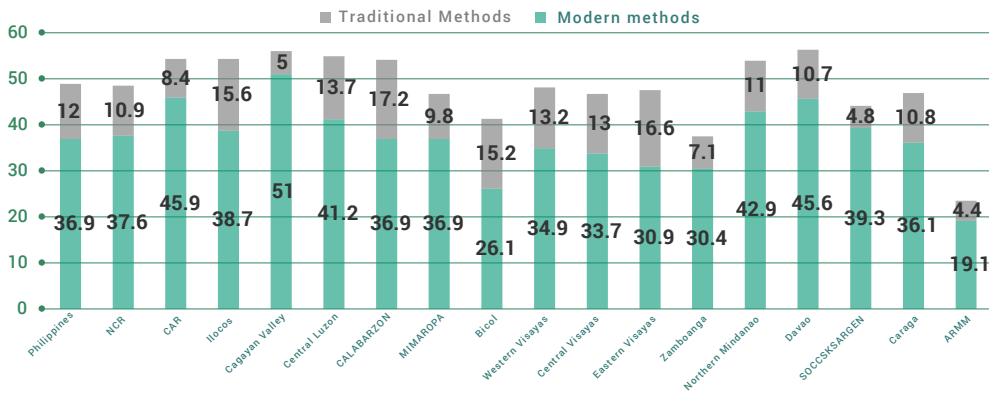


Figure 5. Contraceptive prevalence rate by region.

Source: FHS, Philippines, 2011.

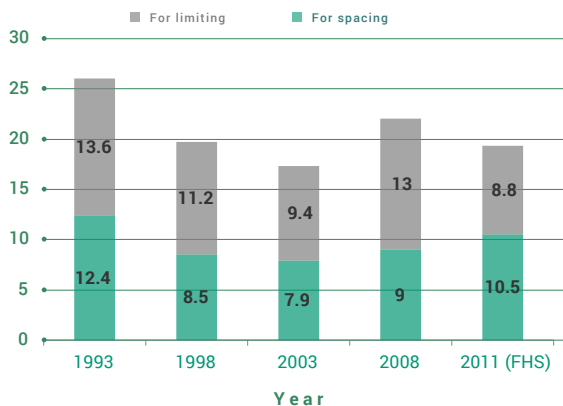


Figure 6. Unmet family planning needs.

Source: NDHS and FHS, Philippines, 1993-2011.

In 2011, the unmet FP needs was 19.3 percent, of which 10.5 percent wanted to space and the other 8.8 percent wanted to limit. These data varied across regions, with ARMM and Zamboanga showing the two highest unmet FP needs (Figure 7).

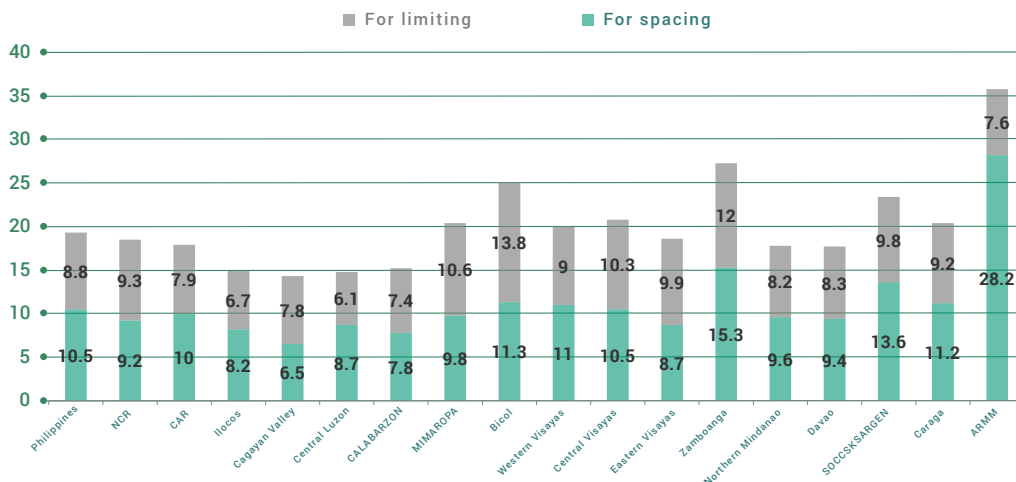


Figure 7. FP unmet needs by region.

Source: FHS, Philippines, 2011.

Philippine FP Program

The Philippine FP Program aims to promote the overall health of all Filipinos by preventing high-risk pregnancies, reducing maternal deaths, and responding to the unmet needs of women. In 2008, the Maternal, Neonatal, and Child Health Nutrition (MNCHN) strategy was established through AO 29 s. 2008. Its goal is to rapidly address the needs of women and reduce maternal and child mortality rates at the local and national levels.

In 2010, the Aquino administration through the Aquino Health Agenda launched Kalusugan Pangkalahatan (KP). Its objectives are to achieve universal healthcare focused on health reform implementation and to ensure that the poorest of the poor receives its benefits.

Vision, Mission, Goal, and Objectives

The National Objectives for Health (NOH) for 2011 to 2016 specifies a clear and concrete way of achieving the targets set in the MDGs. In consonance with the NOH, the FP Program aims to reduce the following:

- Infant deaths from 25 per 1,000 live births (2008) to 17 per 1,000 live births (2016)
- Neonatal mortality from 16 per 1,000 live births (2008) to 10 per 1,000 live births (2016)
- Under-five deaths from 34 per 1,000 live births (2008) to 25.5 per 1,000 live births (2016)
- Maternal mortality ratio from 163 per 100,000 live births (2010) to 50 per 100,000 live births (2016)

Vision

To empower women and men to live healthy, productive, and fulfilling lives with the right to achieve their desired family size through quality, medically sound, and legally permissible FP methods.

Mission

The DOH, in partnership with local government units (LGUs), non-government organizations (NGOs), private sector, and communities, shall ensure the availability of FP information and services to men and women who need them.

Goal

To provide universal access to FP information and services whenever and wherever needed.

Objectives

1. The FP Program addresses the need to help couples and individuals achieve their desired family size within the context of responsible parenthood and improve their reproductive health to attain sustainable development.
2. This program aims to ensure the availability of quality FP services in DOH-retained hospitals, LGU-managed health facilities, NGOs, and the private sector.

Benchmarks

The progress of the FP Program is measured based on the benchmarks listed in Table 1.

Table 1. Benchmarks for measuring the adoption of family planning practices, 2011–2016

Benchmark	From 2011	To 2016
Reduced population growth rate (%)	2.12	1.9
Reduced total fertility rate (No. of children that a woman could have during her reproductive period)	3.1	2.1
Increased contraceptive prevalence rate (%)	48.9	65
Increased use of modern FP (%)	36.9	60.0
Reduced unmet FP needs (%)	19.3	8.6

Source: NOH, DOH, 2011–2016

Family Planning Guiding Principles

The design, management, and implementation of the FP Program abide with the following principles, which are referred to as the Four Pillars of the FP Program:

Responsible Parenthood: It is the will and ability to respond to the needs and aspirations of the family. It promotes the freedom of responsible parents to decide on the timing and size of their families in pursuit of a better life.

Respect for Life: The 1987 Constitution protects the life of the unborn from the moment of conception. Abortion is not a method of FP. Pursuant to this principle, the current administration endorses the term “reproductive health” on the condition that it explicitly excludes abortion.

Birth Spacing: Proper spacing of three to five years from recent pregnancy enables women to recover from pregnancy and to improve their well-being, the health of the child, and husband–wife and parent–children relationships.

Informed Choice: Couples and individuals may choose the methods that they will use to exercise responsible parenthood in accordance with their religious and ethical values and cultural background and subject to conformity with universally recognized international human rights.

Program Components

Under the devolved setup, LGUs are primarily responsible for implementing the program components. The DOH continues to provide policy directions and technical guidelines, set standards, conduct monitoring and evaluation, and perform regulatory functions.

The FP Program has seven components:

1. *Service Delivery*

Quality FP information and services will be made available and accessible to all clients by

- Making the FP Method Mix available in appropriate health service facilities in both public and private sectors: pills, condom, injectables, intrauterine devices, subdermal implants, NFP, lactational amenorrhea method, voluntary surgical contraception services (i.e., bilateral tubal ligation thru minilaparotomy under local anesthesia and vasectomy), and Standard Days Method;
- Ensuring client access and utilization of FP services in the service delivery network
- Establishing a referral mechanism;
- Providing FP services through trained and accredited service providers;
- Recruiting and mobilizing trained FP volunteer health workers/ community health teams (CHTs) to support FP home service delivery with proper and regular supervision and monitoring by LGU health personnel;
- Organizing and deploying itinerant teams; and
- Developing the capacity of hospitals to provide LAPM and all other services for FP.

2. *Training*

Delivery of quality FP information and services is possible only through competent service providers. Competency-based training is the main vehicle for developing the skills of service providers:

- Training of all categories of FP service providers (doctors, nurses, and midwives) in both public and private sectors on relevant courses using DOH-prescribed/accredited curricula to ensure and maintain the quality of FP service provision;

- Conduct of training only by accredited training institutions with certified and competent training staff;
- Attendance of trained FP service providers in refresher courses at least every five years for updates on recent, evidence-based developments and trends; and
- Follow-up and evaluation of trained service providers by the responsible regional office/NGO/LGU trainers after three to six months.

3. *Logistics Management*

The delivery of quality FP services is centered on the continuous and sufficient supply of FP commodities in health facilities. It also requires the installation and maintenance of equipment. This goal can be realized through the following:

- Procurement and allocation of commodities at the national level and direct delivery/ distribution to public health facilities (e.g., rural health units [RHUs] and hospitals) based on reports on consumption
- Use of available contraceptive distribution logistics management information system in terms of storage, distribution, inventory control, authorized stock level, recording, and reporting using the appropriate modified forms
- Local forecasting of contraceptive requirements and procurement
- Installation of equipment with regular inventory and maintenance

4. *Health Promotion and Advocacy*

Information, education, and communication (IEC) are important to generate demands for FP services. Current program thrusts highlight the roles of CHTs and other community-based health volunteers to reach out and provide key messages and adequate information on where to access available services for priority population groups (e.g., NHTS-PR poor households).

Strong advocacy is essential in mobilizing the commitment and support of stakeholders at various levels of administration. Advocacy and IEC need to be intensified by

- Developing a local health promotion plan, particularly on FP;
- Adopting/translating and reproducing prototype IEC materials on FP;
- Institutionalizing local campaigns or similar local endeavors as part of the annual FP Month Celebration and other health events;
- Orienting/educating and counseling women and men of reproductive age on FP (individually or in groups) in appropriate settings (e.g., clinic-based, community-based, and hospital-based);
- Community organization and social mobilization for FP;
- Organizing and deploying CHTs to reach out and identify household members with unmet modern FP needs;
- Networking with various groups of stakeholders at the national, regional, and local levels and with international entities;
- Empowering local officials to ensure the availability and sustainability of FP commodities and other requirements for FP service delivery;
- Creating an enabling environment supportive to FP (i.e., ordinances and resolutions); and
- Monitoring and evaluating IEC and advocacy-related activities on FP.

5. *Monitoring and Evaluation*

Delivery of quality FP information services largely depends on the results of regular monitoring and evaluation by

- Developing a monitoring and evaluation plan to monitor the quality of FP services and to keep track of the progress of FP-related initiatives;
- Allocating funds for regular monitoring and evaluation at various levels of operations;
- Regularly conducting consultative meetings to review and assess program accomplishments at inter- and intra-levels of administration;
- Establishing a feedback mechanism for monitoring and evaluating results for appropriate and immediate action by concerned agencies and authorities; and
- Documenting and disseminating good practices.

6. *Research and Development*

Evidence-based policies, standards, and guidelines are powerful tools that increase the use of quality FP services. Evidence-based IEC and advocacy materials are effective in improving the acceptance of the FP program and in generating support from stakeholders.

- Development of capacities of national- and local-level entities on research and development
- Establishment of collaborative linkages with the academe and research institutions
- Allocation of resources for research and development

7. *Management Information System*

Quality, timely, and accurate information is vital for strategic planning and decision making. This can be ensured by

- Maintaining regular FP client recording and reporting of service statistics for planning purposes;
- Mainstreaming the updated data collection and reporting system including FP services in hospitals;
- Establishing and continuously updating the database on FP service providers and facilities, including accredited training institutions and training providers/trainers;
- Tracking clients with unmet needs through CHT reporting (e.g., CHT forms)
- Adopting and installing the community-based monitoring information system; and
- Analyzing and disseminating relevant information to local officials, FP program managers, and other stakeholders.

Identified Strategies to Reduce Unmet Needs for Modern FP

In 2012, the DOH issued AO 2012-0009 and launched a national strategy to reduce the unmet FP needs of women to achieve the MDGs in 2015. These strategies aim to avert maternal deaths by improving access to FP. The strategies include the following:

1. FP as a program should be implemented at the national and local levels with the active involvement of both public and private sectors. Quantitative estimates should be used to determine the extent of FP services needed and how they can be delivered. Information and education campaign should reach target beneficiaries. Affordable services should be within reach by these target beneficiaries.
2. Implementation of the FP program should be integrated and synchronized with other public health campaigns. Resources should be maximized, and a client-centered approach on delivering FP services should be adopted.
3. Informed choice and voluntarism should be promoted.
4. Areas with the highest unmet needs will be prioritized in delivering additional or enhanced FP services.
5. Contraceptive self-reliance should be encouraged.
6. Interventions to reduce unmet needs should be catered to the conditions of localities in close consultation with LGUs.
7. In urban areas, gaps in LGU services and private sector providers will be bridged through the provision of grants, commodities, and technical assistance.
8. Monitoring and evaluation of the progress in reducing the unmet modern FP needs should be focused on factors that affect the demand and supply of commodities and the resulting outcomes from these interventions.
9. All social and behavioral change communication activities for FP should be in line with the KP thrust.

Responsible Parenthood and Reproductive Health Act of 2012

The Responsible Parenthood and Reproductive Health Act of 2012 or Republic Act No. 10534 was signed into law in December 2012. The law is aimed at addressing the reproductive health issues of Filipinos and averting maternal and child deaths through contraceptive use. Furthermore, the law promotes responsible parenthood by encouraging Filipinos to determine and achieve the number, spacing, and timing of their children according to their own family life aspirations.

The RPRH law mandates the national government to guarantee universal access to medically safe, non-abortifacient, effective, legal, affordable, and quality reproductive healthcare services, methods, devices, and supplies. These services should be provided according to the priority needs of women, children, and other underprivileged sectors, especially those identified through the NHTS-PR (and other identification measures). The families identified in the database may be voluntary beneficiaries of free reproductive healthcare, services, and supplies. This list can be further used as a basis in identifying households who have unmet modern FP needs.

Guiding Principles for Implementation

The DOH reviews and revises existing policies and materials to which the provision of the new law will be incorporated. The guiding principles and rules relevant to FP in the RPRH's IRR are briefly enumerated below.

Section 2 of the RPRH IRR states that

- *Informed choice and voluntarism shall be promoted by all public and private health care providers rendering reproductive health care. Clients shall not be denied any right or benefit (including the right to avail of any program of general welfare or health care) as a consequence of any decision regarding reproductive health care; neither shall they be coerced nor induced to avail of any particular service or health product;*
- *The provision of reproductive health care shall not discriminate between married or unmarried individuals, for all individuals regardless of their civil status have reproductive health concerns;*
- *Since human resource is among the principal assets of the country, effective and quality reproductive health care services must be given primacy to ensure maternal and child health, the health of the unborn, safe delivery and birth of healthy children, and sound replacement rate, in line with the State's duty to promote the right to health, responsible parenthood, social justice and full human development;*
- *The provision of ethical and medically safe, legal, accessible, affordable, non-abortifacient, effective and quality reproductive health care services and supplies is essential in the promotion of people's right to health, especially those of women, the poor, and the marginalized, and shall be incorporated as a component of basic health care;*

- *The State shall promote and provide information and access, without bias, to all modern methods of family planning, whether natural or artificial, which have been proven medically safe, legal, non-abortifacient, and effective in accordance with scientific and evidence-based medical research standards such as those registered and approved by the FDA for the poor and marginalized as identified through the NHTS-PR and other government measures of identifying marginalization: Provided, That the State shall also provide funding support to promote all modern natural methods of family planning, especially the Billings Ovulation Method, consistent with the needs of acceptors and their religious convictions;*
- *Each family shall have the right to determine its ideal family size: Provided, however, That the State shall equip each parent with the necessary information on all aspects of family life, including reproductive health and responsible parenthood, in order to make that determination;*
- *There shall be no demographic or population targets and the mitigation, promotion and/or stabilization of the population growth rate is incidental to the advancement of reproductive health;*

In Section 4 of the law, the service delivery standards include the following:

- *Section 4.03 Availability of Information and Services in General. All public health facilities shall provide full, age- and development-appropriate information on responsible parenthood and reproductive health care to all clients, regardless of age, sex, disability, marital status, or background.*

Within six (6) months from the effectivity of these Rules, the DOH shall review existing and/or develop introductory materials (e.g., primers and/or pamphlets, health use plans, key messages for Community Health Teams, among others) on responsible parenthood and reproductive health care. These introductory materials shall be made available in major local languages, including but not limited to Tagalog, Cebuano, Ilokano, Hiligaynon, Bikol, and Waray. Furthermore, these introductory materials shall include scientifically correct, evidence-based and comprehensible information on mechanisms of action and benefits, including effectiveness, contraindications, possible side effects, correct usage, availability at health care facilities and providers, and other information as determined necessary by the DOH. The DOH shall ensure that all public facilities have copies of these introductory materials freely available to all clients seeking information for reproductive health.

- *Section 4.04 Informed Choice and Voluntarism. To ensure adherence to the principles of the RPRH Act and the delivery of quality reproductive health care services to voluntary recipients, the applicable provisions of DOH guidelines on Informed Choice and Voluntarism shall form part of these Rules.*
- *Section 4.05 Access to Family Planning. All accredited public health facilities shall provide a full range of modern family planning methods, which shall also include medical consultations, supplies and necessary and reasonable procedures for poor and marginalized couples having infertility issues who desire to have children.*

The LGUs, with assistance of the DOH, shall ensure that all public health facilities within the Service Delivery Network shall provide full, age-, capacity-, and development-appropriate information and services on all methods of modern family planning to all clients, regardless of age, sex, gender, disability, marital status, or background.

These services include, but are not limited to the following:

- 1. Fertility awareness and family planning information and education;*
 - 2. Interpersonal communication and counseling (IPCC) services to the client to allow him or her to make a free and informed choice regarding his or her intention/plan;*
 - 3. Provision of modern family planning methods which shall include dispensing of medically safe, legal, and non-abortifacient health products and procedures, among others;*
 - 4. Infertility services;*
 - 5. Referral services where necessary; and*
 - 6. Other family planning information and services as deemed relevant by the DOH.*
- *Section 4.06 Access to Family Planning Information and Services. No person shall be denied information and access to family planning services, whether natural or artificial: Provided, That minors will not be allowed access to modern methods of family planning without written consent from their parents or guardian/s.*

- *Section 4.07 Access of Minors to Family Planning Services. Any minor who consults at health care facilities shall be given age-appropriate counseling on responsible parenthood and reproductive health. Health care facilities shall dispense health products and perform procedures for family planning: Provided, That in public health facilities the minor presents written consent from a parent or guardian;*

Provided further, That a consent shall not be required in the case of abused or exploited minors, where the parent or the person exercising parental authority is the respondent, accused, or convicted perpetrator as certified by the proper prosecutorial office or the court.

Provided further, That in the absence of any parent or legal guardian, written consent shall be obtained only for elective surgical procedures from the grandparents, and in their default, the oldest brother or sister who is at least 18 years of age or the relative who has the actual custody of the child, or authorized representatives of children's homes, orphanages, and similar institutions duly accredited by the proper government agency, among others. In no case shall consent be required in emergency or serious cases as defined in RA 8344.

Provided finally, That in case a minor satisfies any of the above conditions but is still refused access to information and/or services, the minor may direct complaints to the designated Reproductive Health Officer (RHO) of the facility. Complaints shall be acted upon immediately

In Section 8, rules on drugs, supplies, and health product procurement are stated as follows:

- *Section 8.02 Supply and Budget Allotments. The supply and budget allotments for family planning supplies shall be based on the current levels and projections of the following:*
 1. *Number of women of reproductive age and couples who want to space or limit their children;*
 2. *Contraceptive prevalence rate, by type of method used;*
 3. *Cost of family planning supplies; and*
 4. *Other relevant, objective, and needs-based criteria as determined by the DOH.*

The DOH shall develop a methodology to determine the number of women with unmet need for modern family planning, prioritizing the poor as identified by the NHTS-PR or other government procedures of identifying marginalization, which shall be consistent with the above-set criteria.

Health products shall be procured according to the estimated needs of identified populations based on the preferred method mix per age group, as determined by data on observed health-seeking behaviors using the most recent demographic health survey or its equivalent, or by comparable scientific methods as deemed appropriate by the DOH.

The DOH, for planning and budgeting purposes, shall also take into account the procurement of drugs, supplies, and health products at the LGU level. The local availability of reproductive health product stocks, strength of the private sector market, LGU commodity self-reliance activities, and the health product assistance of development partners, shall be considered as factors in the procurement of supplies for that locality.

In Section 12, the duties and responsibilities of the DOH and the national government include the following:

- *Ensure that all skilled health professionals assigned to public health facilities have appropriate training to provide the full range of reproductive health services; Provided, That cities and municipalities shall endeavor that all nurses and midwives assigned to public primary care facilities such as RHUs are given training and certification to administer life-saving drugs within one (1) year from the effectivity of these Rules;*
- *Respond to unmet needs and/or gaps as enshrined in these Rules.*

Appendix B

ANATOMY AND PHYSIOLOGY OF HUMAN REPRODUCTIVE TRACTS

Purpose

This chapter provides an overview of the human reproductive system as part of the introduction to family planning (FP) methods. Specifically, this chapter has the following objectives:

1. To show the different parts and functions of the male and female reproductive systems in relation to the different contraceptives
2. To enumerate the different phases of the menstrual cycle
3. To explain how fertility awareness works

Basic knowledge of the anatomy and physiology of human reproduction will help in understanding the mechanism of reproduction and the action of various contraceptive methods, as described below.

- Fertility awareness-based methods prevent pregnancy through abstinence during the woman's fertile period. The fertile period is determined by observed changes in the cervical mucus and/or basal body temperature and by the length of the menstrual cycle.
- Hormonal methods may either prevent ovulation or thicken the cervical mucus or both.
- Barrier methods prevent the meeting of the egg and the sperm by preventing the transport/ascent of the sperm from the vagina into the uterus/fallopian tubes.
- Voluntary surgical contraceptive methods, such as bilateral tubal ligation, also prevent the meeting of the egg and sperm by blocking the passageway of the sperm from the epididymis to the seminal vesicle (as in vasectomy) or of the ova from the ovary to the fallopian tubes.

MALE REPRODUCTIVE SYSTEM

EXTERNAL GENITALIA

The male external genitalia consist of the following:

1. Penis
 - It is made up of spongy erectile tissues.
 - The penis becomes erect when a man becomes sexually excited; it stiffens and grows in both width and length.
 - An erect penis is approximately 5 inches to 7 inches in length and approximately 1 inch to 1.5 inches in diameter.
 - The penis serves as a passageway of the urine and of the semen during sexual intercourse.
2. Scrotal sac
 - This is a pair of wrinkled skin pouches that contain and protect the testes or testicles.
 - The scrotum controls the temperature of the testicles. The scrotal temperature is approximately 6 °C lower than the body temperature, which is ideal for sperm production.

INTERNAL GENITALIA

The male internal genitalia consist of the following:

1. Testicles (testes)
 - The testicles are the organs that produce the sperm cells and the male hormone testosterone.
 - These organs are located in the wrinkled-looking pouch called the scrotum, which hangs behind the penis.
 - An adult male has two testicles about the size of plums or a native guava. The testicles contain hundreds of thousands of chambers where the sperms develop.
2. Epididymis
 - The epididymis is a small tube located at the base of the testes.
 - It is the site where maturing sperms develop before ascending the seminal vesicles through the vas deferens.

3. Vas deferens (sperm duct)

- The vas deferens passes from the testes to the back of the prostate gland.
- Each of the two sperm ducts joins with the seminal vesicle on each side before entering the prostate gland as a single duct.
- The vas deferens acts as a storage place and passageway for the sperm from the testes to the prostate gland.

4. Seminal vesicles

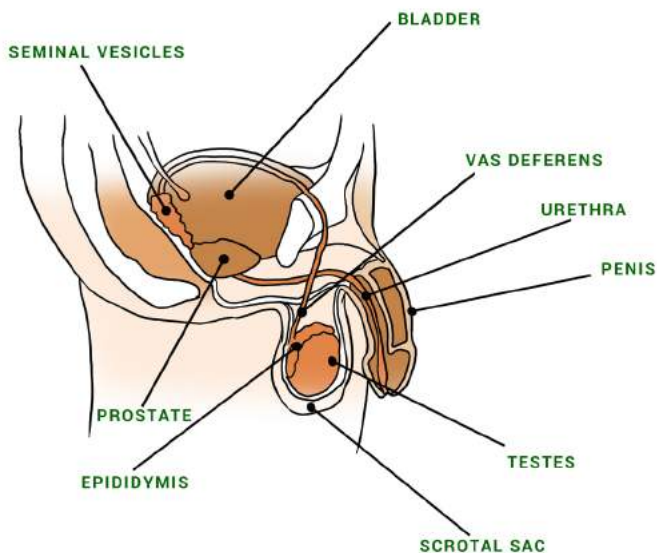
- The seminal vesicles produce the nourishing and lubricating seminal fluid that contributes part of the semen.
- This is where the sperm and the semen mix.

5. Prostate gland

- The prostate gland is situated at the base of the urinary bladder and surrounds part of the urethra.
- It secretes an alkaline fluid that forms part of the semen.

6. Urethra

- The urethra is a duct that passes from the lower part of the bladder through the prostate gland and then into and through the penis.
- It serves as a common pathway for semen or urine.



PHYSIOLOGY

- Sperms are produced daily in the testes of males at the start of puberty. Males remain fertile throughout their lifetimes unless diagnosed with an injury or a disease that affects fertility.
- Sperms are microscopic male reproductive cells that comprise less than 2% of the total ejaculate. They are much smaller than the egg cells. Each has a head and a tail like a tadpole.
- Sperms that are produced pass through the epididymis, vas deferens, and then seminal vesicles where they mix with the seminal fluid.
- Sperms mix with the seminal fluid and enter the prostate gland where additional fluid is added to nourish them.
- Sperms can survive in the vas deferens and seminal vesicle for up to 90 days.
- Sperms ejaculated during sexual intercourse swim through the vagina, cervical opening, uterus, and then fallopian tubes.
- Sperms can live for four to six hours in the vagina but can live for three to five days once they reach the uterus and the fallopian tubes. They usually reach the tubes within 1 hour to 1.5 hours after ejaculation.
- Sperms that reach the top of the uterus are divided between the two fallopian tubes. They swim against the strong current set up by the cilia in the fallopian tubes, which draw the egg down toward the uterus.
- Each ejaculate contains 100 to 600 million sperms in approximately a teaspoon of seminal fluid.
- Only approximately 2,000 of the 100 to 600 million sperms reach the tubes, and only one sperm actually penetrates the egg cell. The rest help in dissolving the covering of the egg to enable one sperm to penetrate it. The rest of the sperms die and are absorbed by the body after fertilization.

FEMALE REPRODUCTIVE SYSTEM

EXTERNAL GENITALIA

The female external genitalia consist of the following:

1. Vagina

- The vagina is the passage that extends from the external structure or vulva to the cervix.
- This passage receives the penis during sexual intercourse.
- It allows the flow of menstrual blood from the uterine cavity to the exterior.
- It is the usual passage through which the baby is born.

2. Labia majora

- The labia majora are made up of two thick outer folds of skin that protect the inner sensitive parts of the vulva.

3. Labia minora

- The labia minora consists of two thinner internal folds of tissues that cover the vaginal opening and meet in front over a sexually sensitive structure called the clitoris.

4. Clitoris

- The clitoris is a small-pea sized organ composed of highly sensitive tissue similar to that of the penis.

5. Urethra

- The urethra is the tube through which the urine passes from the bladder to the exterior at the urethral opening between the clitoris and the vaginal opening.

INTERNAL GENITALIA

The female internal genitalia consist of the following:

1. Uterus

- The uterus is a hollow muscular organ that lies between the bladder and the rectum.
- A lining called the endometrium covers the cavity of the uterus.
- The uterus receives the fertilized ovum.
- It expands as the fetus (baby) grows and expels the baby at birth.

2. Cervix

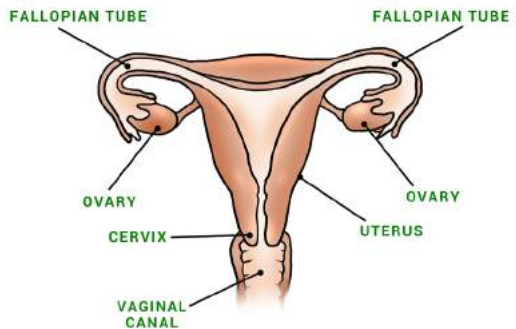
- The cervix is the lower part of the uterus that opens into the vagina.
- Glands called the cervical crypts line the cervical canal. These glands produce cervical mucus under the influence of the hormone estrogen. The spermatozoa depend on the cervical mucus for their survival and transport to the female reproductive tract.

3. Fallopian tubes

- The fallopian tubes are located on each side of the upper part of the uterus.
- The end of each fallopian tube is dilated and opens close to the ovary.
- The fallopian tubes transport the ovum released from the ovary to the uterus.
- They enable the sperm to move from the uterus toward the ovary.
- Fertilization of the ovum by the sperm occurs at the distal third of the fallopian tubes closest to the ovary.

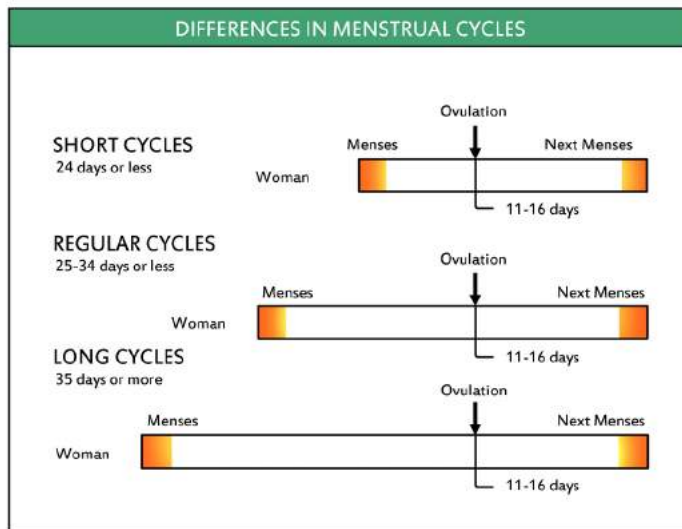
4. Ovaries

- The ovaries are the female reproductive organs that produce the ova or eggs.
- These organs are attached to either side of the uterus.
- They produce two hormones, estrogen and progesterone, which prepare the lining of the uterus to receive a fertilized ovum.



MENSTRUAL CYCLE

- The menstrual cycle begins on the first day of menstrual bleeding and ends on the day before bleeding begins again. Bleeding normally lasts from three to five days.
- The length of a woman's menstrual cycle normally varies by a few days from cycle to cycle.
 - A menstrual cycle is usually 25 to 34 days long (also known as a regular cycle).
 - Some women may have short cycles (24 days or less) or long cycles (35 days or more).
- The postovulatory days are usually fixed in all of these cycles (11 to 16 days), whereas the preovulatory days vary in length.



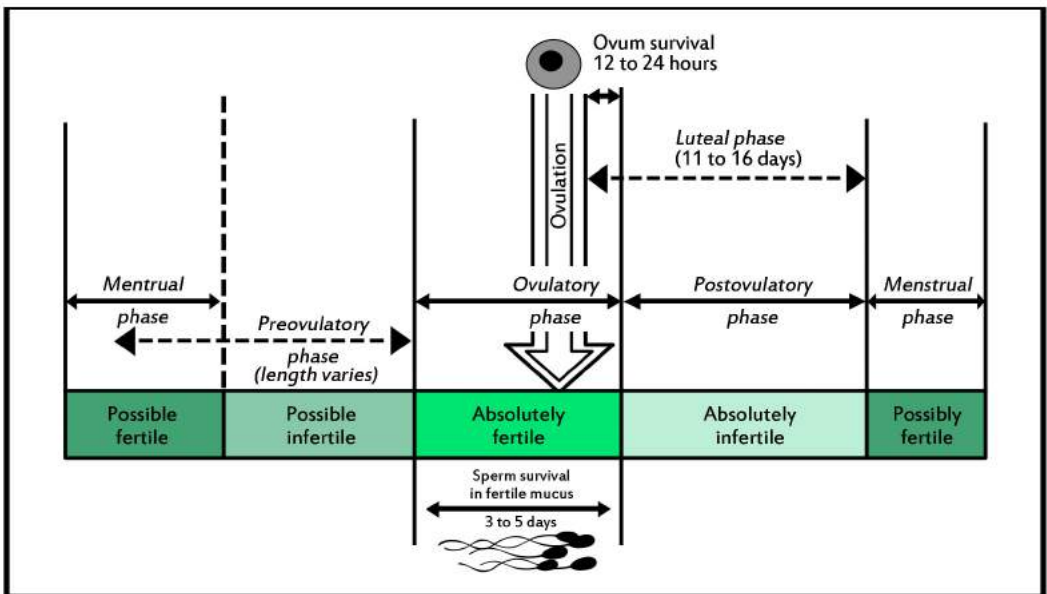
The physiological and anatomical changes during the menstrual cycle are summarized in a matrix in Table 1.

Table 1. Menstrual cycle matrix (based on an average 28-day cycle)

Structures	Menstrual phase	Preovulatory phase	Ovulatory phase	Postovulatory phase
Lining of uterus	Sheds during this phase	Begins to thicken	Continues to thicken	Stays in place until menstruation starts
Egg	Begins to grow in the ovaries	Continues to grow	Matures and is finally released	If not fertilized, dissolves and is absorbed
Cervical mucus	None	At the beginning of this phase, thick, sticky, and opaque	Wet, slippery, stretchy, and clear; vaginal sensation is wet	Loses its wet quality and is no longer sticky and stretchy; vaginal sensation is dry
Basal body temperature	Low (~36 °C–36.5 °C)	Low (~36 °C–36.5 °C)	Slightly drops by 0.2 °C to 0.5 °C	Rises by 0.2 °C to 0.5 °C and remains high until next menstruation starts
Change in cervix	Open	Firm and closed	Soft and open	Firm and closed
Hormonal change	Both estrogen and progesterone levels drop.	Capsule around the egg begins secreting estrogen, and its level rises.	Estrogen slightly drops but remains high; progesterone begins to rise.	Estrogen and progesterone remain high until day 22 when they begin to decrease.

FERTILITY AND JOINT FERTILITY

- Fertility is the ability of a person to bear children. Females and their male partners must be fertile to bear a child.
- Although the female is the one who becomes pregnant, carries the child, and goes through childbirth, fertility involves contributions from both the male and the female, with the former contributing the sperm and the latter contributing the egg.
- During their reproductive years, males are always fertile. Their bodies constantly function every single day and make females pregnant any time. The male's fertility ends either at death or at the diagnosis of an injury or disease that affects fertility.
- By contrast, females undergo changes every few weeks that cause their bodies to be fertile for only a few days at a time and then become infertile during the other days before becoming fertile again. Female fertility ends at menopause.
- Joint or combined fertility involves the united and equal contribution of the male and female in the decision and ability to have a child.



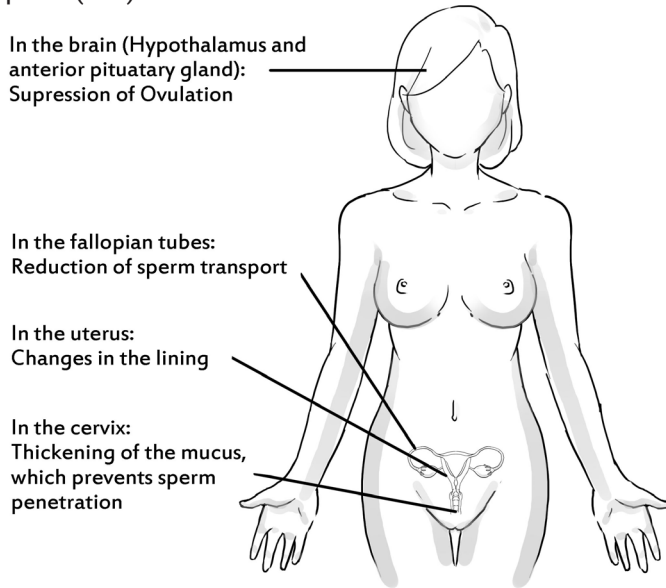
Combined Fertility

MECHANISMS OF ACTION OF DIFFERENT FP METHODS

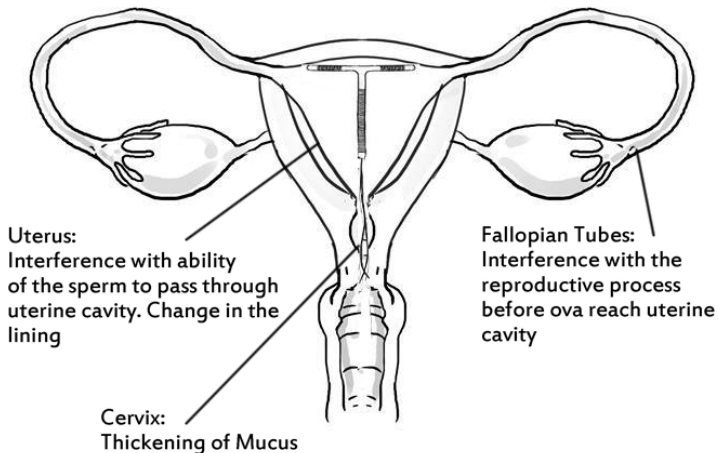
- The brain controls the hormones that regulate the reproductive systems. It also affects sexual activities.
- Hormones are substances produced by special organs or glands in the body; these substances are carried by the bloodstream to targeted parts of the body where certain actions are needed.
- The pituitary gland releases the hormones that control the release of other hormones from other glands in the body and the actions of the reproductive structures in the bodies of both males and females.
- Although most of these actions are involuntary, they can be controlled or modified by the person through various interventions, such as the timing of sexual intercourse, or through the use of contraceptive drugs and devices.

Below are the sites of action of the different FP methods.

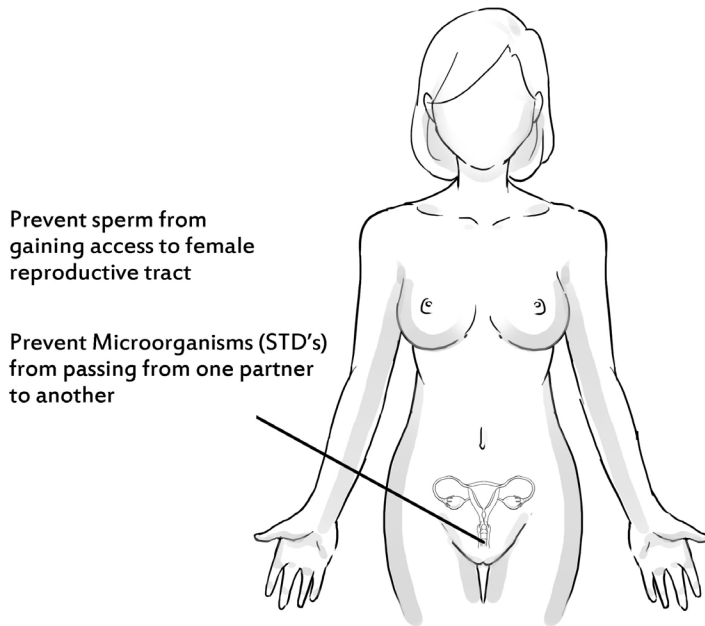
1. Hormonal contraceptives: Combined Oral Contraceptive (COC), Progestin-Only Pill (POP), Progestin-Only Injectable (POI), Combined Injectable Contraceptive (CIC)



2. Intrauterine devices: Copper T380A, IUS



3. Barrier methods: male and female condoms, diaphragm, cervical caps, spermicides



4. Fertility awareness-based methods

- For contraception, sexual intercourse should be avoided during the fertile phase of the menstrual cycle.
- For contraception, sexual intercourse could be near midcycle (usually 10 to 15 days) when conception is most likely.

Appendix C

PREGNANCY CHECKLIST

This section details a pregnancy checklist that can be used by a potential FP client to be reasonably certain that she is not pregnant. A woman who answers “no” to all the questions may or may not be pregnant. In such situations, she may have to use a backup method and will need to wait either until her next monthly bleeding to start her method of choice or until she is certainly not pregnant. Some examples of reasons why a woman may have not experienced monthly bleeding include the following:

- She has given birth more than 6 months ago and is still breastfeeding.
- She continues to have no monthly bleeding after recently stopping a progestin-only injectable.
- She has a chronic health condition that stops her monthly bleeding.

The following may be conducted to further assess the client’s pregnancy:

- The client may take a pregnancy test.
- The health provider may perform a pelvic examination and note the size of the uterus. Ask the client to come back after four weeks to reassess any change or increase in the size of the uterus if monthly bleeding has not returned. Instruct the client to use a backup method during this period.

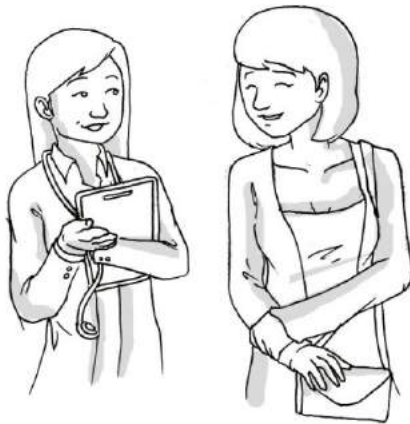
When the client returns, perform the following:

- Provide the client with her preferred contraceptive method if she returns with monthly bleeding
- Perform a second pelvic examination if the client returns still without monthly bleeding after four weeks.
 - A woman who previously had regular monthly bleeding and now has NO bleeding is most likely pregnant and would have some enlargement of the uterus.

- o A woman showing no enlarged uterus, exhibiting no other signs and symptoms of pregnancy, and using a backup method consistently and correctly may avail of her preferred contraceptive method. Advise the client to continue her backup method for the first few days of use, as specified for each method.

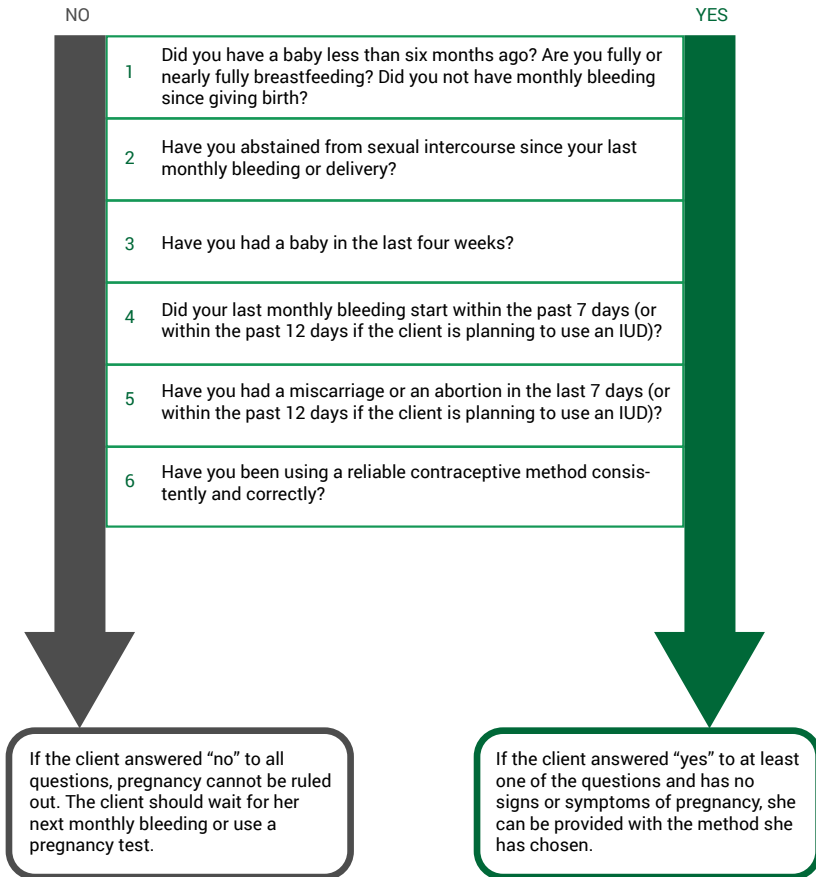
If neither a pregnancy test nor a bimanual examination is available, perform the following:

- Provide the client with a backup method and ask her to return during her next monthly bleeding or in 12 to 14 weeks, whichever comes first.
- The client's preferred contraceptive method may be provided when her monthly bleeding returns. However, if she still does not have bleeding after 12 weeks to 14 weeks, she may be pregnant or have an underlying health problem that causes her to have no monthly bleeding. Refer for appropriate assessment and care.



THE PREGNANCY CHECKLIST

- Ask the client questions 1 to 6. When the client answers “yes” to any question, stop and follow the instructions below.
- If the client answers “yes” to at least one of the questions and she has no signs or symptoms of pregnancy, give her the method she has chosen.
- If the client answered “no” to all questions, pregnancy cannot be ruled out. The client should wait for her next monthly bleeding or use a pregnancy test



Reference: Family Health International (2002). Checklists: Provider Checklists for Reproductive Health Services.

Available from: <www.fhi.org>

Appendix D

PHILHEALTH REQUIREMENTS AND BENEFITS RELATED TO FAMILY PLANNING

The National Health Insurance Program (NHIP) is implemented by the Philippine Health Insurance Corporation (PhilHealth) to provide health insurance coverage and ensure accessible healthcare service to Filipinos.

PROVIDERS OF FAMILY PLANNING (FP) SERVICES WITH PHILHEALTH BENEFITS AND CORRESPONDING ACCREDITATION REQUIREMENTS

Only PhilHealth-accredited health institutions and independent healthcare professionals are qualified to render FP services to clients who are then qualified to enjoy the PhilHealth benefits on FP. PhilHealth-accredited health facilities or health service providers, by nature of the requirements for accreditation, provide quality health services to participate in the NHIP.

A. Healthcare Institutions

Examples of possible institutional healthcare providers that can be accredited are hospitals, ambulatory surgical clinics (ASC), local government health centers, rural health units (RHU), outpatient clinics, health maintenance organizations, preferred provider organizations, community-based healthcare organizations, and other institutional healthcare providers licensed by the Department of Health (DOH). The accreditation requirements for these categories of health facilities are summarized below, as enumerated in the PhilHealth Circular 54, series of 2012.

Hospital

Hospitals that have been in operation for at least three years and have a DOH license to operate can apply for accreditation. Fees are to be paid based on the prevailing rates at the PhilHealth offices (tertiary care hospitals with teaching and training programs pay the most).

Hospital

1. Notarized Application Form
2. PHA Membership Certificate
3. Benchbook Score Sheet
4. Self-Assessment Summary
5. General Performance Commitment
6. Provider Data Record
7. Recent photos of the hospital facilities
8. Latest Audited Financial Statement for continuous accreditations
9. Statement of Intent, if applicable

Ambulatory Surgical Centers and Primary Care Facilities

1. Accomplished PhilHealth application form
2. Duly notarized warranties of accreditation
3. Latest DOH accreditation certificate
4. General Performance Commitment
5. Provider Data Record
6. Recent photos of the internal and external areas
7. Latest Audited Financial Statement for continuous accreditations
8. Statement of Intent, if applicable

Outpatient Clinics for Maternity Care Package (MCP) Providers

For outpatient clinics catering to maternity packages, they need to be in operation for at least three years. Other requirements include the following:

1. General Performance Commitment
2. Provider Data Record
3. Affiliation with a PhilHealth-accredited secondary hospital
4. Recent photos of the internal and external areas
5. Location map
6. Proof of training on IUD insertion of the healthcare professional
7. Statement of Intent, if applicable

Additional Requirements for Continuous Accreditation of MCP Providers

1. Certificate of Compliance as a BEmONC facility
2. Certificate as Newborn Screening Facility issued by CHD or Newborn Screening Resource Center

B. Health Professional Providers

Providers of FP benefits must be accredited physicians for both inpatient and outpatient care, particularly for surgical FP procedures, such as bilateral tubal ligation and vasectomy. Practitioners in hospitals have to apply for accreditation at PhilHealth. Physicians have separate requirements from midwives.

Accreditation Requirements for Physicians

1. Duly accomplished and notarized application form
2. A licensed practitioner
3. A member in good standing of a PhilHealth-recognized national association of physicians such as the Philippine Medical Association
4. Certificate of residency training
5. TIN card
6. Certificate of Registration
7. Affidavit-sworn declaration of current year's gross income

Accreditation Requirements for Midwives under the MCP

To become an accredited provider of MCPs, midwives must have competency on the expanded functions of a midwife and shall have two partner physicians (one for obstetric cases and one for newborn cases). Other requirements include the following:

1. Application form properly filled out and notarized
2. PRC license
3. Certificate of Good Standing in any PhilHealth-recognized national association of midwives

FP and maternity-related health insurance coverage provided by PhilHealth includes MCPs and FP methods, such as insertion of intrauterine devices, bilateral tubal ligation, or vasectomy. Below is a tabulation of the 2013 PhilHealth benefit claims related to maternity and FP, considered as first case.

Medical Cases and Corresponding Case Rates of the Philippine Health Insurance Corporation as of 2013

RVS Code	Description	Case Rate	Professional Fee	Healthcare Institution Fee
55250	Vasectomy, unilateral or bilateral	4,000	1,000	3,000
58300	Insertion of intrauterine device (IUD)	2,000	800	1,200
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	4,000	1,000	3,000
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	5,680	1,680	4,000
59402	Routine obstetric care including antepartum care, vaginal delivery, and/or postpartum care for hospitals; with bilateral tubal ligation	10,500 (includes PhP 1,500 for antenatal diagnostics and meds)	3,600	5,400

These cases are allowed as second cases along with an exemption from 50% second case rule.

Allowed as Second Medical Cases and Corresponding Case Rates of the Philippine Health Insurance Corporation as of 2013

RVS Code	Description	Case Rate	Professional Fee	Healthcare Institution Fee
55250	Vasectomy, unilateral or bilateral	4,000	1,000	3,000
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	4,000	1,000	3,000

Appendix E

SUMMARY TABLES AND CHECKLISTS: WHO MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE

New contraceptive technologies continue to be developed. However, some health-care practices are still based on scientific studies of contraceptive products that are no longer in wide use or on the personal preference of service providers. These outdated practices often result in limited access to family planning services for clients. The Medical Eligibility Criteria (MEC) for Contraceptive Use (59) have been developed (2009) to reduce or eliminate this barrier.

WHAT IS THE WHO-MEC?

- Medical screening of clients based on the best available evidence on family planning practices
- Recommendations for the use of specific contraceptive methods by women and men who have certain characteristics or pre-existing medical conditions
- Assistance for healthcare providers who counsel women, men, and couples about the choice of contraceptive method

WHAT IS THE PURPOSE OF THE WHO-MEC?

- To reduce medical barriers for contraception
- To address misconceptions on who can use contraception
- To improve access and quality of care in family planning
- To promote safe use of contraceptives

Each condition represents either an individual's characteristics (e.g., age) or a known pre-existing medical or pathological condition (e.g., hypertension). The conditions that affect the eligibility of a client for using each contraceptive method are classified under four categories (Table 1).

Table 1. World Health Organization Medical Eligibility Criteria for Contraceptive Use

WHO Category	Conditions/classifications criteria
Category 1	The method has no restrictions.
Category 2	The advantages of the method generally outweigh the theoretical or proven risks.
Category 3	The theoretical or proven risks usually outweigh the advantages of using the method.
Category 4	The method has an unacceptable health risk.

Where resources for clinical judgment are limited, the four-category classification framework can be simplified into two categories (Table 2).

Table 2. Simplified two-category classification

WHO Category	With clinical judgement	With limited clinical judgement
Category 1	Use the method in any circumstances.	Use
Category 2	Generally use the method.	Use
Category 3	Use of the method is not usually recommended unless other appropriate methods are not available or acceptable.	Do not use
Category 4	Method must not be used.	Do not use

Conversely, fertility awareness-based methods are classified (Table 3) based on whether a method is safe to use (A); whether extra precautions, preparations, or counseling are required (C); or whether the use of a method should be delayed until circumstances change (D). For female and male sterilization, a fourth category (S) signifies that a special arrangement should be made for the procedure (Table 4).

Table 3. MEC for fertility awareness-based methods

MEC Categories	Conditions/classifications criteria
A (Accept)	The method has no restrictions.
C (Caution)	The method requires extra or special counseling to ensure correct use.
D (Delay)	The method should be delayed until a condition is evaluated or corrected. An alternative temporary method of contraception should be offered.

Table 4. MEC for female and male sterilization

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

Summary Tables for WHO Medical Eligibility Criteria for Contraceptive Method

CONDITION	Combined Oral Contraceptives	Combined Injectable Contraceptives	Progestin-only OCs	Progestin-only Injectables
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY				
PREGNANCY	NA	NA	NA	NA
AGE	Menarche to < 40 years = 1		Menarche to < 18 years = 1	Menarche to < 18 years = 2
	≥ 40 years = 2		18 – 45 years = 1	18 - 45 years = 1
			> 45 years = 1	> 45 years = 2
PARITY				
a) Nulliparous	1	1	1	1
b) Parous	1	1	1	1
BREASTFEEDING (BF)				
a) < 6 weeks post-partum	4	4	3	3
b) 6 weeks to < 6 months (primarily breastfeeding)	3	3	1	1
c) ≥ 6 months post-partum	2	2	1	1
POSTPARTUM (non-breastfeeding women)				
a) < 21 days				
(i) without other risk factors for VTE	3	3	1	1
(ii) with other risk factors for VTE	3/4	3/4		
b) ≥ 21 days			1	1
(i) without other risk factors for VTE	2	2		

S

Progestin-only Implants	Copper IUDs (TCu-380A IUD)	Progestin-bearing IUD (LNG-IUD)	Vasectomy	Bilateral Tubal Ligation (BTL)
NA	4	4	NA	Delay
Menarche to < 18 years = 1	Menarche to < 20 years = 2		Young age = Caution	Young age = Caution
18 - 45 years = 1	≥ 20 years = 1			
> 45 years = 1				
1	2	2		Accept
1	1	1		Accept
3				Accept
1				
1				
				a) < 7 days = Accept 7 to < 42 days = Delay ≥ 42 days = Accept
1				b) Pre-eclampsia / eclampsia: (i) Mild pre-eclampsia = Accept (ii) Severe pre-eclampsia / eclampsia = Delay
1				c) Prolonged rupture of membrane: 24 hours of more = Delay
				d) Puerperal sepsis, intrapartum hemorrhage = Delay

CONDITION	Combined Oral Contraceptives	Combined Injectable Contraceptives	Progestin-only OCs	Progestin-only Injectables
(ii) with other risk factors for VTE	2/3	2/3		
c) >42 days	1	1		
POSTPARTUM (breastfeeding or non-breastfeeding women, including post-caesarean section)				
a) < 48 hours including insertion immediately after delivery of placenta				
b) > 48 hours to < 4 weeks				
c) > 4 weeks				
d) Puerperal sepsis				
POSTABORTION				
a) First trimester	1	1	1	1
b) Second trimester	1	1	1	1
c) Immediate post-septic abortion	1	1	1	1
PAST ECTOPIC PREGNANCY	1	1	2	1

Progestin-only Implants	Copper IUDs (TCu-380A IUD)	Progestin-bearing IUD (LNG-IUD)	Vasectomy	Bilateral Tubal Ligation (BTL)
				e) Severe antepartum or postpartum hemorrhage = Delay
	1	1 = not BF 3 = BF		f) Severe trauma to the genital tract: cervical or vaginal tear at time of delivery = Delay
	3	3		g) Uterine rupture or perforation = Special
	1	1		
	4	4		
1	1	1		a) Uncomplicated = Accept
1	2	2		b) Post-abortion sepsis or fever = Delay
1	4	4		c) Severe post-abortion hemorrhage = Delay
				d) Severe trauma to the genital tract: cervical or vaginal tear at time of abortion = Delay
				e) Uterine perforation = Special
				f) Acute hematometra = Delay
1	1	1		Accept

CONDITION	Combined Oral Contraceptives	Combined Injectable Contraceptives	Progestin-only OCs	Progestin-only Injectables
HISTORY OF PELVIC SURGERY including caesarean section) (see also postpartum section)	1		1	1
SMOKING				
a) Age < 35	2	2	1	1
b) Age ≥ 35				
(i) < 15 cigarettes/day	3	2	1	1
(ii) > 15 cigarettes/day	4	3	1	1
OBESITY				
a) ≥ 30 kg/m ² body mass index (BMI)	2	2	1	1
b) Menarche to <18 years old and > 30 kg/m ² BMI	2	2	1	DMPA = 2 NET-EN = 1
BLOOD PRESSURE MEASUREMENT UNAVAILABLE	NA	NA	NA	NA
CARDIOVASCULAR DISEASE				
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (such as older age, smoking, diabetes, and hypertension)	3/4	3/4	2	3

Progestin-only Implants	Copper IUDs (TCu-380A IUD)	Progestin-bearing IUD (LNG-IUD)	Vasectomy	Bilateral Tubal Ligation (BTL)
1	1	1		
1	1	1		Accept
1	1	1		Accept
1	1	1		Accept
				Caution
1	1	1		
1	1	1		
NA	NA	NA		
2	1	2		Special

CONDITION	Combined Oral Contraceptives	Combined Injectable Contraceptives	Progestin-only OCs	Progestin-only Injectables
HYPERTENSION				
a) History of hypertension where blood pressure CANNOT be evaluated (including hypertension during pregnancy)	3	3	2	2
b) Adequately controlled hypertension, where blood pressure CAN be evaluated	3	3	1	2
c) Elevated blood pressure levels (properly taken measurements)				
(i) systolic 140-159 mm Hg or diastolic 90-99 mm Hg	3	3	1	2
(ii) systolic >160 mm Hg or diastolic >100 mm Hg	4	4	2	3
d) Vascular disease	4	4	2	3
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is measurable and normal)	2	2	1	1
DEEP VENOUS THROMBOSIS (DVT) / PULMONARY EMBOLISM (PE)				
a) History of DVT/PE	4	4	2	2
b) Acute DVT/PE	4	4	3	3

Progestin-only Implants	Copper IUDs (TCu-380A IUD)	Progestin-bearing IUD (LNG-IUD)	Vasectomy	Bilateral Tubal Ligation (BTL)
2	1	2		
1	1	1		Caution
1	1	1		Caution
2	1	2		Special
2	1	2		Special
1	1	1		Accept
2	1	2		Accept
3	1	3		Delay

CONDITION	Combined Oral Contraceptives	Combined Injectable Contraceptives	Progestin-only OCs		Progestin-only Injectables
c) DVT/PE and established on anti-coagulant therapy	4	4	2		2
d) Family history (first degree relatives)	2	2	1		1
e) Major surgery					
(i) with prolonged immobilization	4	4	2		2
(ii) without prolonged immobilization	2	2	1		1
f) Minor surgery without immobilization	1	1	1		1
KNOWN THROMBOGENIC MUTATIONS (e.g. Factor V Leiden; Prothrombin mutation; Protein S, Protein C and Antithrombin deficiencies)	4	4	2		2
SUPERFICIAL VEINOUS THROMBOSIS					
a) Varicose veins	1	1	1		1
b) Superficial thrombophlebitis	2	2	1		1
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE	4	4	I	C	3
			2	3	
STROKE (history of cerebrovascular accident)	4	4	I	C	3
			2	3	

Legend:

I - Initiation

C - Continuation

Progestin-only Implants		Copper IUDs (TCu-380A IUD)	Progestin-bearing IUD (LNG-IUD)		Vasectomy	Bilateral Tubal Ligation (BTL)
2		1	2			Special
1		1	1			Accept
2		1	2			Delay
1		1	1			Accept
1		1	1			Accept
2		1	2			Accept
1		1	1			Accept
1		1	1			Accept
I	C	1	I	C		Delay
2	3		2	3		
I	C	1	2			Caution
2	3					

CONDITION	Combined Oral Contraceptives		Combined Injectable Contraceptives		Progestin-only OCs		Progestin-only Injectables	
KNOWN HYPERLIPIDEMIAS (screening is NOT necessary for safe use of contraceptive methods)	2/3		2/3		2		2	
VALVULAR HEART DISEASE								
a) Uncomplicated	2		2		1		1	
b) Complicated (pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis)	4		4		1		1	
RHEUMATIC DISEASES								
SYSTEMIC LUPUS ERYTHEMATOSUS							I	C
a) Positive (or unknown) antiphospholipid antibodies	4		4		3		3	3
b) severe thrombocytopenia	2		2		2		3	2
c) Immunosuppressive treatment	2		2		2		2	2
d) None of the above	2		2		2		2	2
NEUROLOGIC CONDITIONS								
HEADACHES	I	C	I	C	I	C	I	C
a) Non-migrainous (mild or severe)	1	2	1	2	1	1	1	1

Legend:

I - Initiation

C - Continuation

Progestin-only Implants		Copper IUDs (TCu-380A IUD)		Progestin-bearing IUD (LNG-IUD)		Vasectomy	Bilateral Tubal Ligation (BTL)
2		1		2			Accept
1		1		1			Caution
1		2		2			Special
3		I	C	3			Special
		1	1				
2		3	2	2			Special
2		2	1	2			Special
2		1	1	2			Caution
I	C			I	C		Accept
1	1	1		1	1		

CONDITION	Combined Oral Contraceptives		Combined Injectable Contraceptives		Progestin-only OCs		Progestin-only Injectables	
b) Migraine								
(i) without aura								
Age < 35	2	3	2	3	1	2	2	2
Age > 35	3	4	3	4	1	2	2	2
(ii) with aura (at any age)	4	4	4	4	2	3	2	3
EPILEPSY	1		1		1			1
DEPRESSIVE DISORDERS								
DEPRESSIVE DISORDERS	1		1		1			1
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS								
VAGINAL BLEEDING PATTERNS								
a) Irregular pattern without heavy bleeding	1		1		2			2
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	1		1		2			2
UNEXPLAINED VAGINAL BLEEDING (suspicious for serious condition)								
Before evaluation	2		2		2			3
ENDOMETRIOSIS	1		2		1			1
BENIGN OVARIAN TUMORS (including cysts)	1		1		1			1
SEVERE DYSMENORRHEA	1		1		1			1

Legend:

I - Initiation

C - Continuation

Progestin-only Implants		Copper IUDs (TCu-380A IUD)		Progestin-bearing IUD (LNG-IUD)		Vasectomy	Bilateral Tubal Ligation (BTL)
2	2	1		2	2		Accept
2	2	1		2	2		Accept
2	3	1		2	3		Accept
1		1		1			Caution
1		1		1		Caution	Caution
				I	C		Accept
2		1		1	1		
2		2		1	2		Accept
3		I	C	I	C		Delay
		4	2	4	2		
1		2		1			Special
1		1		1			Accept
1		2		1			Accept

CONDITION	Combined Oral Contraceptives	Combined Injectable Contraceptives	Progestin-only OCs	Progestin-only Injectables
GESTATIONAL TROPHOBLASTIC DISEASE				
a) Decreasing or undetectable Beta-HCG levels	1	1	1	1
b) Persistently elevated Beta-HCG levels or malignant disease	1	1	1	1
CERVICAL ECTROPION	1	1	1	1
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	2	2	1	2
CERVICAL CANCER (awaiting treatment)	2	2	1	2
BREAST DISEASE				
a) Undiagnosed mass	2	2	2	2
b) Benign breast disease	1	1	1	1
c) Family history of cancer	1	1	1	1
d) Current breast cancer	4	4	4	4
e) Breast cancer in the past and no evidence of current disease for 5 years	3	3	3	3
ENDOMETRIAL CANCER	1	1	1	1
OVARIAN CANCER	1	1	1	1

Legend:

I - Initiation

C - Continuation

Progestin-only Implants	Copper IUDs (TCu-380A IUD)		Progestin-bearing IUD (LNG-IUD)		Vasectomy	Bilateral Tubal Ligation (BTL)
1	3		3			Accept
1	4		4			Delay
1	1		1			Accept
2	1		2			Accept
2	I	C	I	C		Delay
	4	2	4	2		
2	1		2			Accept
1	1		1			Accept
1	1		1			Accept
4	1		4			Caution
3	1		3			Accept
1	I	C	I	C		Delay
	4	2	4	2		
1	I	C	I	C		Delay
	3	2	3	2		

CONDITION	Combined Oral Contraceptives	Combined Injectable Contraceptives	Progestin-only OCs	Progestin-only Injectables
UTERINE FIBROIDS				
a) Without distortion of the uterine cavity	1	1	1	1
b) With distortion of the uterine cavity	1	1	1	1
ANATOMICAL ABNORMALITIES				
a) That distort the uterine cavity				
b) That do not distort the uterine cavity				
PELVIC INFLAMMATORY DISEASE (PID)				
a) Past PID (assuming no current risk factors of STIs)				
(i) with subsequent pregnancy	1	1	1	1
(ii) without subsequent pregnancy	1	1	1	1
b) PID - current	1	1	1	1
STIs				
a) Current purulent cervicitis or chlamydial infection or gonorrhoea	1	1	1	1
b) Other STIs (excluding HIV and hepatitis)	1	1	1	1

Legend:

I - Initiation

C - Continuation

Progestin-only Implants	Copper IUDs (TCu-380A IUD)		Progestin-bearing IUD (LNG-IUD)		Vasectomy	Bilateral Tubal Ligation (BTL)
1	1		1			Caution
1	4		4			Caution
	4		4			
	2		2			
	I	C	I	C		Accept
1	1	1	1	1		
1	2	2	2	2		Caution
1	4	2	4	2		Delay
1	I	C	I	C		Delay
	4	2	4	2		
1	2	2	2	2		Accept

CONDITION	Combined Oral Contraceptives	Combined Injectable Contraceptives	Progestin-only OCs	Progestin-only Injectables
c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	1	1	1	1
d) Increased risk of STIs	1	1	1	1
HIV/AIDS				
HIGH RISK OF HIV	1	1	1	1
HIV-INFECTED	1	1	1	1
AIDS	1	1	1	1
Clinically well on ARV therapy	If on treatment, see DRUG INTERACTIONS section			
OTHER INFECTIONS				
SCHISTOSOMIASIS				
a) Uncomplicated	1	1	1	1
b) Fibrosis of the liver	1	1	1	1
TUBERCULOSIS				
a) Non-pelvic	1	1	1	1
b) Known pelvic	1	1	1	1
MALARIA	1	1	1	1
ENDOCRINE CONDITIONS				
DIABETES				
a) History of gestational disease	1	1	1	1
b) Non-vascular disease (i) non-insulin dependent	2	2	2	2

Legend:

I - Initiation

C - Continuation

Progestin-only Implants	Copper IUDs (TCu-380A IUD)		Progestin-bearing IUD (LNG-IUD)		Vasectomy	Bilateral Tubal Ligation (BTL)
1	2	2	2	2		Accept
1	2/3	2	2/3	2		Accept
1	1	C	1	C	Accept	Accept
	2	2	2	2		
1	2	2	2	2	Accept	Accept
1	3	2	3	2	Special	Special
	2	2	2	2		
1	1		1			Accept
1	1		1			Caution
1	1	C	1	C		Accept
	1	1	1	1		
1	4	3	4	3		Special
1	1		1			Accept
1	1		1		Caution	Accept
2	1		2			Caution

CONDITION	Combined Oral Contraceptives		Combined Injectable Contraceptives		Progestin-only OCs	Progestin-only Injectables
(ii) insulin dependent	2		2		2	2
c) Nephropathy / retinopathy / neuropathy	3/4		3/4		2	3
d) Other vascular disease or of > 20 years' duration	3/4		3/4		2	3
THYROID DISORDERS						
a) Simple goiter	1		1		1	1
b) Hyperthyroid	1		1		1	1
c) Hypothyroid	1		1		1	1
GASTROINTESTINAL CONDITIONS						
GALLBLADDER DISEASE						
a) Symptomatic						
(i) treated by cholecystectomy	2		2		2	2
(ii) medically treated	3		2		2	2
(iii) current	3		2		2	2
b) Asymptomatic	2		2		2	2
HISTORY OF CHOLESTASIS						
a) Pregnancy-related	2		2		1	1
b) Past COC-related	3		2		2	2
VIRAL HEPATITIS						
	I	C	I	C		
a) Acute or flare	3/4	2	3	1	1	1

Legend:

I - Initiation

C - Continuation

Progestin-only Implants	Copper IUDs (TCu-380A IUD)	Progestin-bearing IUD (LNG-IUD)	Vasectomy	Bilateral Tubal Ligation (BTL)
2	1	2		Caution
2	1	2		Special
2	1	2		Special
1	1	1		Accept
1	1	1		Special
1	1	1		Caution
2	1	2		Accept
2	1	2		Accept
2	1	2		Delay
2	1	2		Accept
1	1	1		Accept
2	1	2		Accept
				Delay
1	1	1		

CONDITION	Combined Oral Contraceptives		Combined Injectable Contraceptives		Progestin-only OCs	Progestin-only Injectables
b) Carrier	1	1	1	1	1	1
c) Chronic	1	1	1	1	1	1
CIRRHOSIS						
a) Mild (compensated)	1		1		1	1
b) Severe (decompensated)	4		3		3	3
LIVER TUMORS						
a) Benign (adenoma)					3	3
(i) Focal nodular hyperplasia	2		2		2	2
(ii) Hepatocellular adenoma	4		3		3	3
b) Malignant (hepatoma)	4		3/4		3	3
ANEMIAS						
THALASSEMIA	1		1		1	1
SICKLE CELL DISEASE	2		2		1	1
IRON-DEFICIENCY ANEMIA	1		1		1	1
DRUG INTERACTIONS						
ANTIMICROBIAL THERAPY						
a) Broad spectrum antibiotics	1		1		1	1
b) Antifungals	1		1		1	1
c) Antiparasitics	1		1		1	1

Progestin-only Implants	Copper IUDs (TCu-380A IUD)	Progestin-bearing IUD (LNG-IUD)	Vasectomy	Bilateral Tubal Ligation (BTL)
1	1	1		Accept
1	1	1		Accept
1	1	1		Accept
3	1	3		Special
3	1	3		
2	1	2		Accept
3	1	3		Caution
3	1	3		Caution
1	2	1		Caution
1	2	1	Accept	Caution
1	2	1		Hemoglobin <7 g/dL = Delay Hemoglobin ≥ 7 to <10 g/dL = Caution
1	1	1		
1	1	1		
1	1	1		

CONDITION	Combined Oral Contraceptives	Combined Injectable Contraceptives	Progestin-only OCs	Progestin-only Injectables
d) Rifampicin or rifabutin therapy	3	2	3	DMPA = 1 NET-EN = 2
ANTICONVULSANT THERAPY				
a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	3	2	3	DMPA=1 NET-EN=2
b) Lamotrigine	3	3	1	1
ANTIRETROVIRAL THERAPY				
a) Nucleoside reverse transcriptase inhibitors (NRTIs)	1	1	1	DMPA = 1 NET-EN = 1
b) Non- nucleoside reverse transcriptase inhibitors (NNRTIs)	2	2	2	DMPA = 1 NET-EN = 2
c) Ritonavir-boosted protease inhibitors	3	3	3	DMPA = 1 NET-EN = 2
OTHER CONDITIONS RELEVANT ONLY FOR MALE / FEMALE SURGICAL STERILIZATION				
LOCAL INFECTIONS				
a) scrotal skin infection				
b) active STI				
c) balanitis				
d) epididymitis or orchitis				
e) abdominal skin infection				

Progestin-only Implants	Copper IUDs (TCu-380A IUD)		Progestin-bearing IUD (LNG-IUD)		Vasectomy	Bilateral Tubal Ligation (BTL)
2	1		1			
2	1		1			
1	1		1			
	I	C	I	C		
1	2/3	2	2/3	2		
2	2/3	2	2/3	2		
2	2/3	2	2/3	2		
						Delay
					Delay	
					Delay	
					Delay	
						Delay

CONDITION	Combined Oral Contraceptives	Combined Injectable Contraceptives	Progestin-only OCs	Progestin-only Injectables
COAGULATION DISORDERS				
PREVIOUS SCROTAL INJURY				
SYSTEMIC INFECTION OR GASTROENTERITIS				
LARGE VARICOCELE				
LARGE HYDROCELE				
FILARIASIS, ELEPHANTIASIS				
INTRASCROTAL MASS				
CRYPTORCHIDISM				
INGUINAL HERNIA				
RESPIRATORY DISEASES				
a) Acute (bronchitis, pneumonia)				
b) Chronic				
(i) asthma				
(ii) bronchitis				
(iii) emphysema				
(iv) lung infection				
FIXED UTERUS DUE TO PREVIOUS SURGERY OR INFECTION				
ABDOMINAL WALL OR UMBILICAL HERNIA				
DIAPHRAGMATIC HERNIA				

Progestin-only Implants	Copper IUDs (TCu-380A IUD)	Progestin-bearing IUD (LNG-IUD)	Vasectomy	Bilateral Tubal Ligation (BTL)
			Special	Special
			Caution	
			Delay	Delay
			Caution	
			Caution	
			Delay	
			Delay	
			Caution	
			Special	
				Delay
				Special
				Special
				Special
				Special
				Special
				Special
				Special
				Caution

CONDITION	Combined Oral Contraceptives	Combined Injectable Contraceptives	Progestin-only OCs	Progestin-only Injectables
KIDNEY DISEASE				
SEVERE NUTRITIONAL DEFICIENCIES				
PREVIOUS ABDOMINAL OR PELVIC SURGERY				
STERILIZATION CONCURRENT WITH ABDOMINAL SURGERY				
a) Elective				
b) Emergency (without previous counseling)				
c) Infectious condition				
STERILIZATION CONCURRENT WITH CAESAREAN SECTION				

Progestin-only Implants	Copper IUDs (TCu-380A IUD)	Progestin-bearing IUD (LNG-IUD)	Vasectomy	Bilateral Tubal Ligation (BTL)
				Caution
				Caution
				Caution
				Caution
				Delay
				Delay
				Accept

MEDICAL ELIGIBILITY CRITERIA CHECKLIST

The checklists provided by the WHO can serve as a guide to determine the medical eligibility of clients for their chosen contraceptives. A client not suited for his/her method of choice should be offered other appropriate alternative methods depending on his/her medical condition.

MEC Checklist for Combined Oral Contraceptives (COCs)

Ask the client the questions below. If she answers “NO” to ALL of the questions, then she CAN use the combined oral contraceptive pills. If she answers “YES” to a question below, follow the instructions.

1. Are you breastfeeding a baby less than 6 months 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, and tell her to start taking them 3 weeks after childbirth. If she is at risk of developing a blood clot in a deep vein (deep vein thrombosis or venous thromboembolism [VTE]), then she should start at 6 weeks instead. These additional risk factors include previous VTE, thrombophilia, cesarean delivery, blood transfusion at delivery, postpartum hemorrhage, pre-eclampsia, obesity (> 30 kg/m²), smoking, and being bedridden for a long time.
3. Do you smoke cigarettes and are you 35 years of age or older?
 - NO
 - YES. 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 tumor? (Are her eyes or skin unusually yellow?)
- NO
 - YES. If she reports serious active liver disease (jaundice, active hepatitis, severe cirrhosis, liver tumor) or ever had jaundice while using COCs, do not provide COCs. Help her choose a method without hormones.
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 estrogen. 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 estrogen 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 mm Hg/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 if she prefers. If her blood pressure at next check is below 140/90 mm Hg, 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 estrogen but not progestin-only injectables.
7. Do you currently have gallbladder disease or take medication for a 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 estrogen 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.
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 a throbbing, severe head pain, often 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 worsened 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 or older, do not provide COCs. Help the client choose a method without estrogen. If she is under 35 and has migraine headaches without aura, she can use COCs.
11. Are you taking medications for seizures? Are you taking rifampicin or rifabutin for tuberculosis or other illnesses?
- NO
 - YES. If she is taking barbiturates, carbamazepine, lamotrigine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, rifabutin, or ritonavir, do not provide COCs. These drugs can reduce the effectiveness of COCs. Help her choose another method but not progestin-only pills. If she is taking lamotrigine, help her choose a method without estrogen.

12. Do you have several conditions (older age, smoking, high blood pressure, or diabetes) that could increase your chances of heart disease (coronary artery disease) or stroke?
- NO
 - YES. Do not provide COCs. Help her choose a method without estrogen but not progestin-only injectables.

MEC Checklist for Combined Injectable Contraceptives (CICs)

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 monthly injectables. If she answers “YES” to a question, follow the instructions. In some cases, she can still start monthly injectables.

1. Are you breastfeeding a baby less than 6 months old?
 - NO
 - YES. If fully or nearly fully breastfeeding: She can start 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 using monthly injectables as soon as 6 weeks after giving birth.
2. Have you had a baby in the last 3 weeks and you are not breastfeeding?
 - NO
 - YES. She can start using CICs as soon as 3 weeks after childbirth. If she is at risk of developing a blood clot in a deep vein (deep vein thrombosis, or VTE), then she should start at 6 weeks instead.
3. Do you smoke 15 or more cigarettes a day and is more than 35 years of age?
 - NO
 - YES. Do not provide CICs. Urge her to stop smoking, and help her choose another method.

4. Do you have severe cirrhosis of the liver, a liver infection, or a liver tumor? (Are her eyes or skin unusually yellow [signs of jaundice]?)
- NO
 - YES. If she reports serious active liver disease (jaundice, active hepatitis, severe cirrhosis, liver tumor), do not provide monthly injectables. Help her choose a method without hormones. (If she has mild cirrhosis or gall bladder disease, she can use monthly injectables.)
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 monthly injectables. Refer her for a blood pressure check, if possible, or help her choose another method without estrogen.
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 CICs. Help her choose a method without estrogen but not progestin-only injectables.
7. 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 monthly injectables. Help her choose a method without estrogen but not progestin-only injectables. If she reports a current blood clot in the deep veins of the leg or in the lung (not superficial clots), help her choose a method without hormones.
8. Do you have or have you ever had breast cancer?
- NO
 - YES. Do not provide CICs. Help her choose a method without hormones.

9. Do you sometimes see a bright area of lost vision in the eye before a very bad headache (migraine aura)? Do you get a throbbing, severe head pain, often 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 worsened by light, noise, or moving about.
- NO
 - YES. If she has migraine aura at any age, do not provide monthly injectables. If she has migraine headaches without aura and is age 35 or older, do not provide monthly injectables. Help the client choose a method without estrogen. If she is under 35 and has migraine headaches without aura, she can use monthly injectables.
10. Are you planning a major surgery that will keep you from walking for one week or more?
- NO
 - YES. She can start using CICs 2 weeks after the surgery. Until she can start monthly injectables, she should use a backup method.
11. Do you have several conditions (older age, smoking, high blood pressure, or diabetes) that could increase your chances of heart disease (coronary artery disease) or stroke?
- NO
 - YES. Do not provide CICs. Help her choose a method without estrogen but not progestin-only injectables.
12. Are you taking lamotrigine or ritonavir?
- NO
 - YES. Do not provide CICs. Monthly injectables can make lamotrigine less effective. Ritonavir can make monthly injectables less effective. Help her choose a method without estrogen. Women should also not use CICs if they report having thrombogenic mutations or lupus with positive (or unknown) antiphospholipid antibodies.

MEC Checklist for Progestin-only Pills (POPs)

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 using POPs. If she answers “YES” to a question, follow the instructions. In some cases, she can still start POPs.

1. Are you breastfeeding a baby less than 6 weeks old?
 - NO
 - YES. She can start taking POPs as soon as 6 weeks after childbirth. Give her POPs, and tell her when to start taking them.
2. Do you have severe cirrhosis of the liver, a liver infection, or a 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 currently have a serious problem 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. These drugs can reduce the effectiveness of POPs. 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, risks, and side effects of the method. When relevant to the client, point out any conditions that would make the method inadvisable.

MEC Checklist for Progestin-only Injectables (POIs)

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 using progestin-only injectables. If she answers “YES” to a question, follow the instructions. In some cases, she can still start using progestin-only injectables.

1. Are you breastfeeding a baby less than 6 weeks old?
 - NO
 - YES. She can start using progestin-only injectables as soon as 6 weeks after childbirth.

2. Do you have severe cirrhosis of the liver, a liver infection, or a 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 progestin-only injectables. 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 progestin-only injectables. Check her blood pressure if possible.
 - If she is currently being treated for high blood pressure and it is adequately controlled or if her blood pressure is below 160/100 mm Hg, provide progestin-only injectables.

- If systolic blood pressure is 160 mm Hg or higher or diastolic blood pressure is 100 or higher, do not provide progestin-only injectables. Help her choose another method without estrogen.
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 estrogen.
 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 progestin-only injectables. Help her choose another method without estrogen. 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, progestin-only injectables could complicate the diagnosis and monitoring of any treatment. Help her choose a method to use while being evaluated and treated (but not implants or a copper-bearing or hormonal intrauterine device [IUD]). After treatment, re-evaluate for the use of progestin-only injectables.
 7. Do you have or have you ever had breast cancer?
 - NO
 - YES. Do not provide progestin-only injectables. 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 progestin-only injectables. Help her choose another method without estrogen. Be sure to explain the health benefits, risks, and side effects of the method. When relevant to the client, point out any conditions that would make the method inadvisable.

MEC Checklist for Subdermal 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 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 currently have a serious problem 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 complicate the diagnosis and monitoring of any treatment. Help her choose a method to use while being evaluated and treated (not progestin-only injectables or a copper-bearing/hormonal IUD). After treatment, re-evaluate for implant use.
5. Do you have or have you ever had breast cancer?
 - NO
 - YES. Do not provide implants. Help her choose a method without hormones.

MEC Checklist for Copper-Bearing IUDs

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 answers “YES” to a question, follow the instructions. In some cases, she can still have an IUD inserted.

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 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 are these 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 IUD use after treatment.

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 gonorrhea or chlamydia.
 - Women who have a very high individual likelihood of exposure to gonorrhea or chlamydia should not have an IUD inserted.

7. Assess whether the client might be pregnant.
 - Ask the client the questions in the pregnancy checklist (see Appendix). If she answers “YES” to any question, she can have an IUD inserted. For complete classifications, see Medical Eligibility Criteria for Contraceptive Use. Be sure to explain the health benefits, risks, and side effects of the method. When relevant to the client, point out any conditions that would make the method inadvisable.

MEC Checklist for Intrauterine System (IUS)

Ask the client the MEC questions for copper-bearing IUDs. Furthermore, 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 IUS inserted. If she answers “YES” to a question, follow the instructions. In some cases, she can still have an IUS inserted.

1. Did you give birth less than 4 weeks ago?
 - NO
 - YES. She can have the IUS 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 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 the IUS. 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, risks, and side effects of the method. When relevant to the client, point out any conditions that would make the method inadvisable.

MEC Checklist for Female Sterilization

Ask the client the questions below. If she answers “NO” to all of the questions, then the female sterilization procedure can be performed in a routine setting without delay. If she answers “YES” to a question, follow the instructions, which recommend caution, delay, or special arrangements.

1. Do you have any current or past female conditions or problems (gynecologic or obstetric conditions or problems), such as infection or cancer? If so, what are these problems?
 - NO
 - YES. If she has any of the following, use CAUTION: Past pelvic inflammatory disease (PID) since last pregnancy, breast cancer, uterine fibroids, previous abdominal, or pelvic surgery.

If she has any of the following, DELAY female sterilization: Current pregnancy; 7 to 42 days postpartum; postpartum with severe pre-eclampsia or eclampsia; serious postpartum or postabortion complications (such as infection, hemorrhage, or trauma) except uterine rupture or perforation; a large collection of blood in the uterus, unexplained vaginal bleeding that suggests an underlying medical condition, PID, purulent cervicitis, chlamydia, or gonorrhea; pelvic cancers (treatment may make her sterile in any case); or malignant trophoblast disease.

If she has any of the following, make SPECIAL arrangements: AIDS, fixed uterus due to previous surgery or infection, endometriosis, hernia (abdominal wall or umbilical), postpartum or post-abortion uterine rupture or perforation.

2. Do you have any lingering, long-term diseases or any other conditions? If so, what are these conditions?

NO

YES. If she has any of the following, use CAUTION: Epilepsy; diabetes without damage to arteries, vision, kidneys, or nervous system; hypothyroidism; mild cirrhosis of the liver; liver tumors; schistosomiasis with liver fibrosis; moderate iron-deficiency anemia (hemoglobin 7–10 g/dL); sickle cell disease; inherited anemia (thalassemia); kidney disease; diaphragmatic hernia; severe lack of nutrition; obesity; elective abdominal surgery at time sterilization is desired; depression; young age; or uncomplicated lupus.

If she has any of the following, DELAY female sterilization: Gallbladder disease with symptoms, active viral hepatitis, severe iron-deficiency anemia (hemoglobin less than 7 g/dL), lung disease (bronchitis or pneumonia), systemic infection or significant gastroenteritis, abdominal skin infection, undergoing abdominal surgery for emergency or infection, or major surgery with prolonged immobilization.

If she has any of the following, make SPECIAL arrangements: Severe cirrhosis of the liver, hyperthyroidism, coagulation disorders (blood does not clot), chronic lung disease (asthma, bronchitis, emphysema, lung infection), pelvic tuberculosis, lupus with positive (or unknown) antiphospholipid antibodies, with severe thrombocytopenia, or on immunosuppressive treatment.

MEC Checklist for Male Sterilization

Ask the client the questions below. If he answers “NO” to all of the questions, then the vasectomy procedure can be performed in a routine setting without delay. If he answers “YES” to a question below, follow the instructions, which recommend caution, delay, or special arrangements.

1. Do you have any problems with your genitals, such as infections, swelling, injuries, or lumps on your penis or scrotum? If so, what are these problems?

NO

YES. If he has any of the following, use CAUTION: Previous scrotal injury, swollen scrotum due to swollen veins or membranes in the spermatic cord or testes (large varicocele or hydrocele), undescended testicle—one side only. (Vasectomy is performed only on the normal side. Then, if any sperm are present in a semen sample after 3 months, vasectomy is also performed on the other side.)

If he has any of the following, DELAY vasectomy: Active sexually transmitted infection; swollen, tender (inflamed) tip of the penis, sperm ducts (epididymis), or testicles; scrotal skin infection or a mass in the scrotum.

If he has any of the following, make SPECIAL arrangements: Hernia in the groin (if able, the provider can perform the vasectomy while repairing the hernia. If such a procedure is not possible, the hernia should be repaired first) or undescended testicles—both sides.

2. Do you have any other conditions or infections? If so, what are they?

NO

YES. If he has the following, use CAUTION: Diabetes, depression, young age, lupus with positive (or unknown) antiphospholipid antibodies, or on immunosuppressive treatment.

If he has any of the following, DELAY vasectomy: Systemic infection or gastroenteritis, filariasis, or elephantiasis.

If he has any of the following, make SPECIAL arrangements: AIDS, blood fails to clot (coagulation disorders), or lupus with severe thrombocytopenia.

MEC Checklist for Fertility Awareness-based Methods

Ask the client the questions below. If she answers “NO” to all of the questions, then she can use any fertility awareness-based method. If she answers “YES” to a question below, follow the instructions. No conditions restrict use of these methods, but some conditions can make them difficult to use effectively.

1. Do you have a medical condition that would make pregnancy especially dangerous? (Medical Conditions and Method Choice)
 - NO
 - YES. She may want to choose an effective method. If not, stress careful use of fertility awareness-based methods to avoid pregnancy.
2. Do you have irregular menstrual cycles? Vaginal bleeding between periods? Heavy or long monthly bleeding? For younger women: Are your periods just starting? For older women: Have your periods become irregular, or have they stopped?
 - NO
 - YES. Predicting her fertile time with only the calendar method may be difficult or impossible. She can use basal body temperature (BBT) and/or cervical mucus, or she may prefer another method.
3. Did you recently give birth or have an abortion? Are you breastfeeding? Do you have any other condition that affects the ovaries or menstrual bleeding, such as stroke, serious liver disease, hyperthyroid, hypothyroid, or cervical cancer?
 - NO
 - YES. These conditions do not restrict the use of fertility awareness-based methods. However, these conditions may affect fertility signs, making fertility awareness-based methods difficult to use. Therefore, a woman or couple may prefer a different method. If not, they may need further counseling and follow-up to use the method effectively.

4. Have you had any infections or diseases that may change cervical mucus, basal body temperature, or menstrual bleeding, such as sexually transmitted disease, PID in the last 3 months, or vaginal infection?
- NO
 - YES. These conditions may affect fertility signs, making fertility awareness-based methods difficult to use. However, a woman can use fertility awareness-based methods easily once an infection is treated and reinfection is avoided.
5. Do you take any drugs that affect cervical mucus, such as mood-altering drugs, lithium, tricyclic antidepressants, or antianxiety therapies?
- NO
 - YES. Predicting her fertile time correctly may be difficult or impossible if she uses only the cervical mucus method. She can use BBT and/or the calendar method, or she may prefer another method. Be sure to explain the health benefits, risks, and side effects of the method. When relevant to the client, point out any conditions that would make the method inadvisable.

Appendix F SAMPLES OF DEPARTMENT OF HEALTH FAMILY PLANNING FORMS

Appendix F1 Baseline Physical Inventory and Drug Expiration Record

Baseline Physical Inventory and Drug Expiration Record								
Program :								
Personnel in charge :								
Date accomplished :								
Item No.	Product and Preparation	Manufacturer	Lot Number	Expiration Date	Mark (x) if stocks expire within the next 6 months	Physical count of usable* stocks	Losses	Remarks

Appendix F2 Daily Stock Record Book

Daily Stock Record Book							
Program :							
Stock Name and Preparation							
Units of Stock							
Year							
Month							
Day	Stocks Received Form :	Quantity Received	Quantities dispensed at the RHU patients	Expiration Date	Quantity Issued to Midwives	Losses	Balance
Previous Month's Balance							
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
End of the Month Balance							

Appendix F3 Daily Dispensing Record Book

Daily Dispensing Record Book
 Program : _____

Date	Name of Client	Address	Age	Quantity Dispensed	Signature of Client	Remarks

Drug Names / Preparation

Appendix F4 Daily Stock Issue Record

Daily Stock Issue Record
Name of Program : _____

Date	Quantity Dispensed	Issued to: (facility and name)	Signature

Appendix F5 Monthly Physical Inventory and Drug Expiration Record

Monthly Physical Inventory and Drug Expiration Record										
Program :										
Personnel in charge :										
Date accomplished :										
Item No.	Product and Preparation	Manufacturer	Lot Number	Expiration Date	Mark (x) if stocks expire within the next 6 months	Physical count of usable* stocks (A)	Balance of Stocks based on the Daily Stock Record*** (B)	Losses (B-A)	Remarks	

Appendix F6 Commodity Order Form

COMMODITY ORDER FORM

Faculty Name :
 Faculty Address :

COMMODITY	UNIT	SOURCE	A ENDING BALANCE OF LAST DELIVERY	B ADJUSTMENTS (PLUS OR MINUS)	C TOTAL AVAILABLE	D ACTUAL STOCK ON HAND NOW	E USED SINCE LAST DELIVERY	F NO. OF MONTHS SINCE LAST DELIVERY	G AVERAGE MONTHLY USAGE	H AUTHORIZED STOCK LEVEL	I QUANTITY REQUIRED	J EXCESS STOCK REQUIRED	K STOCK DELIVERED	L ENDING BALANCE	M REMARKS
					(A + B)		(C - D)	(E / F)	(G × 6)	(H - D)				(D - J + K)	

Appendix F7a FP Service Record (FP Form 1)

FAMILY PLANNING SERVICE RECORD		SIDE A	
MEDICAL HISTORY HEENT <input type="checkbox"/> Epilepsy/Convulsion/ Seizure <input type="checkbox"/> Severe Headaches/dizziness <input type="checkbox"/> Visual disturbance/blurring of vision <input type="checkbox"/> Yellowish conjunctivae <input type="checkbox"/> Enlarged thyroid CHEST / HEART <input type="checkbox"/> Severe chest pain <input type="checkbox"/> Shortness of breath and easy fatigability <input type="checkbox"/> Breast / axillary mass <input type="checkbox"/> Nipple discharge (specify if blood or pus) <input type="checkbox"/> Systolic of 140 and above <input type="checkbox"/> Diastolic of 90 and above <input type="checkbox"/> Family history of CVA (strokes), heart attack, asthma, rheumatic heart diseases ABDOMEN <input type="checkbox"/> Mass in the abdomen <input type="checkbox"/> History of gall bladder disease <input type="checkbox"/> History of liver disease GENITAL <input type="checkbox"/> Mass in the uterus <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Intermenstrual bleeding <input type="checkbox"/> Postcoital bleeding EXTREMITIES <input type="checkbox"/> Severe varicosities <input type="checkbox"/> Swelling or severe pain in the legs not related to injuries SKIN <input type="checkbox"/> Yellowish skin HISTORY OF ANY OF THE FOLLOWING <input type="checkbox"/> Smoking <input type="checkbox"/> Allergies <input type="checkbox"/> Drug intake (anti - tuberculosis, anti - diabetic, anticonvulsant) <input type="checkbox"/> STI / HIV / AIDS / PID / STD <input type="checkbox"/> Bleeding tendencies (nose, gums, etc.) <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes OBSTETICAL HISTORY <input type="checkbox"/> Number of pregnancies ___ Full Term ___ Premature ___ Abortion ___ Living Children <input type="checkbox"/> Date of last delivery ___/___/___ <input type="checkbox"/> Type of last delivery ___ <input type="checkbox"/> Past menstrual period ___ <input type="checkbox"/> Last menstrual period ___ <input type="checkbox"/> Number of days menses ___ Scanty ___ Moderate ___ Heavy ___ Painful ___ Regular <input type="checkbox"/> Hydatidiform mole (within the last 12 months) <input type="checkbox"/> Ectopic pregnancy STI RISKS <input type="checkbox"/> With history or multiple partners <input type="checkbox"/> For women: <input type="checkbox"/> Unusual discharge from vagina <input type="checkbox"/> Itching or sores in or around vagina <input type="checkbox"/> Pain or burning sensation <input type="checkbox"/> Treated for STI in the past <input type="checkbox"/> For Men: <input type="checkbox"/> Pain or burning sensation <input type="checkbox"/> Open sores anywhere in genital area <input type="checkbox"/> Pus coming from penis <input type="checkbox"/> Treated for STIs in the past	PHYSICAL EXAMINATION Blood pressure : _____ mm/Hg Weight _____ kg/lbs Pulse rate _____ /min CONJUNCTIVA <input type="checkbox"/> Pale <input type="checkbox"/> Yellowish NECK <input type="checkbox"/> Enlarged thyroid <input type="checkbox"/> Enlarged lymph nodes BREAST <input type="checkbox"/> Mass <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Skin - orange peel or dimpling <input type="checkbox"/> Enlarged axillary lymph nodes THORAX <input type="checkbox"/> Abnormal heart sounds/cardiac rate <input type="checkbox"/> Abnormal breath sounds/respiratory rat ABDOMEN <input type="checkbox"/> Enlarged liver <input type="checkbox"/> Mass <input type="checkbox"/> Varicosities EXTREMITIES <input type="checkbox"/> Edema <input type="checkbox"/> Varicosities PELVIC EXAMINATION <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top; padding: 5px;"> PERINEUM <input type="checkbox"/> Scars <input type="checkbox"/> Warts <input type="checkbox"/> Reddish <input type="checkbox"/> Laceration VAGINA <input type="checkbox"/> Congested <input type="checkbox"/> Bartholin's cyst <input type="checkbox"/> Warts <input type="checkbox"/> Skene's gland discharge <input type="checkbox"/> Rectocele <input type="checkbox"/> Cystocele CERVIX <input type="checkbox"/> Congested <input type="checkbox"/> Erosion <input type="checkbox"/> Discharge <input type="checkbox"/> Polyps/cysts <input type="checkbox"/> Laceration CONSISTENCY <input type="checkbox"/> Firm <input type="checkbox"/> Soft </td> <td style="width: 50%; vertical-align: top; padding: 5px;"> UTERUS Position <input type="checkbox"/> Mid <input type="checkbox"/> Anteфлекed <input type="checkbox"/> Retroфлекed Size <input type="checkbox"/> Normal <input type="checkbox"/> Large <input type="checkbox"/> Mass Uterine Depth ___ cms. (for intended IUD users) ADNEXA <input type="checkbox"/> Mass <input type="checkbox"/> Tenderness </td> </tr> </table> RISKS FOR VIOLENCE AGAINST WOMEN (VAW) <input type="checkbox"/> History of Domestic Violence or VAW <input type="checkbox"/> Unpleasant relationships with partner <input type="checkbox"/> Partner does not approve of the visit to FP clinic <input type="checkbox"/> Partner disagrees to use FP Referred to : <input type="checkbox"/> DSWD <input type="checkbox"/> WCPU <input type="checkbox"/> NGOs <input type="checkbox"/> Others (specify _____) ACKNOWLEDGEMENT: This is to certify that the Physician/Nurse/Midwife of the clinic has fully explained to me the different methods available in family planning and I freely choose the _____ method. _____ Date Client Signature	PERINEUM <input type="checkbox"/> Scars <input type="checkbox"/> Warts <input type="checkbox"/> Reddish <input type="checkbox"/> Laceration VAGINA <input type="checkbox"/> Congested <input type="checkbox"/> Bartholin's cyst <input type="checkbox"/> Warts <input type="checkbox"/> Skene's gland discharge <input type="checkbox"/> Rectocele <input type="checkbox"/> Cystocele CERVIX <input type="checkbox"/> Congested <input type="checkbox"/> Erosion <input type="checkbox"/> Discharge <input type="checkbox"/> Polyps/cysts <input type="checkbox"/> Laceration CONSISTENCY <input type="checkbox"/> Firm <input type="checkbox"/> Soft	UTERUS Position <input type="checkbox"/> Mid <input type="checkbox"/> Anteфлекed <input type="checkbox"/> Retroфлекed Size <input type="checkbox"/> Normal <input type="checkbox"/> Large <input type="checkbox"/> Mass Uterine Depth ___ cms. (for intended IUD users) ADNEXA <input type="checkbox"/> Mass <input type="checkbox"/> Tenderness
PERINEUM <input type="checkbox"/> Scars <input type="checkbox"/> Warts <input type="checkbox"/> Reddish <input type="checkbox"/> Laceration VAGINA <input type="checkbox"/> Congested <input type="checkbox"/> Bartholin's cyst <input type="checkbox"/> Warts <input type="checkbox"/> Skene's gland discharge <input type="checkbox"/> Rectocele <input type="checkbox"/> Cystocele CERVIX <input type="checkbox"/> Congested <input type="checkbox"/> Erosion <input type="checkbox"/> Discharge <input type="checkbox"/> Polyps/cysts <input type="checkbox"/> Laceration CONSISTENCY <input type="checkbox"/> Firm <input type="checkbox"/> Soft	UTERUS Position <input type="checkbox"/> Mid <input type="checkbox"/> Anteфлекed <input type="checkbox"/> Retroфлекed Size <input type="checkbox"/> Normal <input type="checkbox"/> Large <input type="checkbox"/> Mass Uterine Depth ___ cms. (for intended IUD users) ADNEXA <input type="checkbox"/> Mass <input type="checkbox"/> Tenderness		

 CLIENT NO. : _____ TYPE OF ACCEPTOR : New to the program Continuing User PREVIOUSLY USED METHOD : _____ DATE/TIME : _____ NAME OF CLIENT : _____ NAME OF SPOUSE : _____ NO. OF LIVING CHILDREN : _____ METHOD ACCEPTED : COC Injactable Condom IUD BTL NSV LAM SDM BRT BOM / CMM / STM Implant Interval PLAN MORE CHILDREN : _____ YES NO REASON FOR PRACTICING FP : _____ HIGHEST EDUC. _____ OCCUPATION _____ DATE OF BIRTH _____ DATE OF BIRTH _____ HIGHEST EDUC. _____ OCCUPATION _____ AVERAGE MONTHLY INCOME : _____ SHEET _____ BARANGAY _____ MUNICIPALITY _____ PROVINCE _____ || **Reminder : Kindly refer to PHYSICIAN for any checked (/) mark prior to provision of any method for further evaluation** | | |

Appendix F7b FP Service Record (FP Form 1)

SIDE B	FAMILY PLANNING SERVICE RECORD				
CLIENT NUMBER : _____ NAME OF CLIENT : _____ <small>(Last Name, Given Name, MI)</small> Date of Birth : ___/___/___ Education : _____ Occupation : _____ Address : _____ <small>(No. Street Barangay Municipality Province)</small>	DATE SERVICE GIVEN	METHOD TO BE USED/ SUPPLIES GIVEN <small>(cycles, pieces, etc.)</small>	REMARKS <ul style="list-style-type: none"> • MEDICAL OBSERVATION • COMPLAINTS/ COMPLICATION • SERVICE RENDERED/ PROCEDURES/ INTERVENTIONS • DONE (i.e laboratory examination, treatment, referrals, etc.) 	NAME AND SIGNATURE OF PROVIDER	NEXT SERVICE DATE

Appendix F7c FP Service Record (FP Form 1)

Instructions for completing the FP Service Record or FP Form 1

Side A

1. Fill out or check the required information at the far right of the form:
 - Client number
 - Husband's name, giving the family name first, date of birth, education, and occupation
 - Wife's name using her maiden family name, date of birth, education, and occupation
 - Monthly family income in peso
 - Choose "yes" or "no" for the couple's plan for more children
 - "New" or "current" for type of acceptor
 - Number of children: desired and actual
 - Birth interval desired in years
 - Previous method used; duration of use and reason for discontinuation
 - New / current method
 - Completed desired family size, economic, others for reasons for accepting permanent methods
 - Complete address of the client: number of the house, street, barangay, municipality, and province
 - Wife's age
2. Fill in the required information on medical, obstetrical/ gynecological history, physical examination, pelvic examination, client signature and date, name, and address of health facility.
3. Refer to a physician for any abnormal history/findings prior to provision of any method for further evaluation.

Side B

1. Fill in the required information at the far left of the form on client number and name.
2. On the first column, record the date when the service was delivered to the client.
3. On the second column, record the method accepted/number of supplies given.
4. On the third column, record the following:
 - Medical observations
 - Complaints
 - Services rendered, procedures/interventions done (Lab, treatment)
 - Reasons for stopping or changing the methods
 - Laboratory results
5. On the fourth column, record the name of the provider with the corresponding signature.
6. On the fifth column, record the next service date or appointment date.

Appendix F8a Target Client List (TCL) for Family Planning Non-surgical Methods

TARGET CLIENT LIST FOR FAMILY PLANNING
(PUT NAME OF FP METHOD)

DATE REGISTRATION	FAMILY SERIAL NO.	NAME	ADDRESS	AGE Birthdate	TYPE OF CLIENT	PREVIOUS METHODS
mm/dd/yy					(use codes)	(use codes)
(1)	(2)	(3)	(4)	(5)	(6)	(7)

Type of Client CU = Current Users
 NA = New Acceptors

Other Acceptors
 *CU - CM = Changing Method
 *CU - CC = Changing Clinic
 *CU - RS = Restarter

**Previous Method:
 CON = Condom
 INJ = DMPA or CIC
 IUD = Intrauterine Device or (PP - IUD and I - IUD)
 PILLS = pills
 IMP = Single rod sub-dermal Implant
 NONE or New Acceptor

NFP - BBT = Basal Body Temperature
 NFP - CM = Cervical Mucus Method
 NFP - STM = Symptothermal Method
 NFP - LAM = Lactational Amenorrhea Method

SCM = Standard Days Method
 MSTR/Vasec = Male Ster./Vasectomy
 FSTR/BTL = Female Ster./Bilateral tubal ligation

Appendix G8b Target Client List (TCL) for Family Planning Non-surgical Methods

Instructions for completing the Target Client List (TCL) for Family Planning Nonsurgical Methods

The TCL is filled out by health workers when providing services and is updated every time a client comes back for a follow-up visit. It has the following purposes:

1. It helps the health worker plan and carry outpatient care and service delivery.
2. It facilitates the monitoring and supervision of service delivery activities.
3. It facilitates the preparation of reports,
4. It provides clinic-level data that can be accessed for further studies.

Column 1: DATE (OF REGISTRATION)—Indicate in this column the month, day, and year a client made the first clinic visit for FP service.

Column 2: FAMILY SERIAL NUMBER—Indicate in this column the number that corresponds to the family number written on the family folder or envelop on the individual treatment record.

Column 3: CLIENT’S NAME—Write the client’s complete name.

Column 4: ADDRESS—Record the client’s present permanent place of residence.

Column 5: METHOD ACCEPTED—Write on this column the code of the method being accepted by the client.

CODES:

- i. LAM: Lactational Amenorrhea Method
- ii. NFP: Natural Family Planning Method
 - BBT: Basal Body Temperature
 - CM: Cervical Mucus
 - ST: Symptothermal
 - SDM: Standard Days Methods
- iii. PILLS
- iv. Injectable/DMPA: Depo-Medroxyprogesterone Acetate
- v. IUD: Intrauterine Device
- vi. CON: Condom
- vii. VSC: Voluntary Surgical Contraception
 - BTL: Bilateral Tubal Ligation
 - VS: Vasectomy or Male Sterilization

Column 6: CATEGORIES AND CODES OF CLIENTS—Write on this column the code of the following client categories.

- i. New Acceptor (NA)—A client using a contraceptive method for the first time or who is new to the program.
- ii. Current Users—FP clients who have been carried over from the previous month after deducting the drop-outs of the present month and adding the new acceptors in the current month. Current users constitute specific FP methods used during the month which include condom, injectables, IUD, LAM, NFP, pills, male sterilization, and female sterilization.
- iii. Re-Starter (RS)—These are new acceptors who have stopped FP practice for at least one month and have resumed using the same method in the same clinic.

Column 7: PREVIOUS METHOD—Refers to last method used prior to accepting a new method. Enter in this column the same codes as for the Method Accepted (Column 5). Add code for None to cover “New to Program.”

Appendix F8c Target Client List (TCL) for Family Planning Non-surgical Methods

Instructions for completing the Target Client List (TCL)...continued

Column 8: FOLLOW-UP VISITS—Write the next scheduled date of visit in the appropriate column for the month followed by a slash, e.g., 3-31/. When the client returns for the scheduled visit, write the date at the right of the slash, e.g., 3-31/3-29. A client who is scheduled for a particular month but fails to make the clinic visit will have only one date entered for that particular month.

Column 9: DROPOUT—If a client fails to return for the next service date, he or she is considered a dropout. Enter the date the client became a dropout under column “Date” and indicate the reason under column “Reason.”

Column 10: AGE OF WIFE—Enter in this column the age of the female client. In the case of a male client, enter the age of the client’s wife.

Column 11: NUMBER OF LIVING CHILDREN—Record the number of living children.

Column 12: REMARKS—Indicate in this column the date and reason for every referral made (to other clinics) and referral received (from other clinics), which can be due to medical complications or unavailable family planning services.

Dropouts Form (When a dropout is a “dropout”):

1. LACTATIONAL AMENORRHEA METHOD (LAM)

If the client

- a. reaches 6 months postpartum period;
- b. has her menses any time within 6 months postpartum (Bleeding or spotting within 56 days postpartum is not considered as menses);
- c. practices mixed regular feeding and/or regularly introduces solid food, liquid, vitamins within the first 6 months.

2. NATURAL FAMILY PLANNING (NFP)

- a. Basal body temperature (BBT)—If the user fails to chart her own fertile and infertile periods, she is considered a dropout.
- b. Cervical/Mucus or Billings Ovulation Method—If the user fails to chart her own fertile and infertile periods, she is considered a dropout.
- c. Symptothermal Method—If the user fails to chart her own fertile and infertile periods, she is considered a dropout.

Note: Validate chart monthly if client needs to be dropped.

3. PILLS

If the client

- a. fails to return for a resupply on the scheduled date unless client was validated getting supply from other sources other than the clinic;
- b. gets supply and/or transfers to another clinic; the client is considered as a current user in the clinic where she transferred, but is a dropout in her former clinic;
- c. desires to stop the pills for any reason.

Appendix F8d Target Client List (TCL) for Family Planning Non-surgical Methods

Instructions for completing the Target Client List (TCL)...continued

4. INJECTABLE (DMPA)

If the client

- a. fails to return for more than 2 weeks from the scheduled date of injection unless client was validated getting supply from other sources other than the clinic;
- b. gets herself injected with DMPA in another clinic; the client is considered a current user in the clinic where she transferred, but is a dropout in her former clinic;
- c. stops to receive the injection for any reason.

5. INTRAUTERINE DEVICE (IUD)

If the client

- a. does not return to the clinic for check-up or has not been followed-up for 2 years;
- b. requests for IUD removal;
- c. has had her IUD expelled.

6. CONDOM

If the client

- a. fails to return for a resupply on scheduled visit unless client was validated getting supply from other sources other than the clinic;
- b. gets supply from another clinic and/or transfers to another clinic; the client is considered a current user in the clinic where she transferred, but is a dropout in her former clinic;
- c. stops using the method for any other reason.

7. VOLUNTARY SURGICAL CONTRACEPTION

- a. Tubal ligation – If the client is already menopausal (average: 50 years old);
 - b. Vasectomy – indefinite.
-

Appendix F9a FHSIS Report Form/M1

Form FHSS/M 1 : page



RH



PH/CHO



DH/CH



RHU/MHC



BHS/BC

Section 3 - Family Planning

1. Number of clients by category and method

Method	Cont. User (Begin Month)	Acceptors		Dropout
		New	Other	
Pill				
IUD				
Condom				
LAM				when any of the criteria is not met
BTL				at age 50
Vasectomy				
NFP				

2. Number of referrals received and made by this facility this month by reason

	Medical Complications	Services		
		RCM	Surgical	Other
Made				
Received				

3. Number of Family Planning visits made to this facility this month

Appendix F9b TFHSIS Report Form/M1

Instructions for completing the FHSIS Report Form/M1

This report form collects information on family planning methods seen at the facility during the current month.

1. Number of Acceptors and Dropouts

- For each new acceptor of a family planning method seen at the facility this month, place a tick in the bigger box under the (1) “Acceptor New,” alongside the method accepted.
- “New Acceptor” includes clients who are new to the program.
- Others including CM, CC, and RS should be tallied under “Acceptors – Others”
- For clinics performing surgical Family Planning procedures, the number of vasectomy and tubal ligation procedures done should be indicated with a tick in the bigger box under the “Acceptor” column.
- For each dropout from a “Program Method” (i.e., Pill, IUD, and Condom) during the month, place a tick in the box for the method dropped in item 1.
- In this item, a CM client should be counted as a dropout alongside the method discontinued.
- At the end of each month, count the number of ticks in the bigger box and write the total in the smaller box.
- To get the total CU at the end of the month, apply this formula from Clinical Standard: Current users at the beginning of the month + Acceptors (new) + Acceptors (others) – Dropouts = Current users at the end of the month

2. Number of Clients Referred

- This item collects information on the number of client referrals MADE by the reporting clinic to other clinics, and referrals RECEIVED by the reporting clinic from other clinics, and also the reasons for the referrals.
- Referrals are classified as either for treatment of medical complications or for provision of FP services. Classify as service reasons only those referrals which have no medical complications involved, and the type of resource for which the client was referred (RCM, Surgical, or Others).

3. Number of Family Planning Visits

- Each time a client is seen in the facility/clinic for family planning services during the month, place a tick in the bigger box in Item 3. Family Planning visits include:
- Visits by clients to accept a method or to receive a resupply of pills or condoms;
- Visits by clients who are subsequently referred to another clinic, and;
- Visits made for other reasons but during which time information, education, and communication (IEC) for FP was substantially discussed.

Appendix F10a Hospital Service Statistics Report Form for Family Planning

Hospital Service Statistics Report Form for Family Planning

Name of Hospital (1)	Month and Year (2)	Minilaparotomy			Laparoscopy (6)	Other female VSC + CS (7)	Total female VSC (8)	Vasectomy (9)	PP IUD (10)	IUD Interval (11)	DMPA (12)	Pills (13)	Implant (14)	Condom (15)	Other methods (16) please specify		
		0 - 48 hrs postpartum (3)	3 - 27 days (4)	Interval (5)													
TOTAL																	

Appendix F10b Hospital Service Statistics Report Form for Family Planning

Instructions for completing the Hospital Service Statistics Report Form

The Hospital Service Statistics Report Form is accomplished by the different hospitals (OPD and OB-Gyne Department of Medical Centers or Regional, Provincial, District, City, and Municipal hospitals). This report is due quarterly and should be submitted by each hospital to its respective provincial health office copy furnished the Center for Health and Development (CHD), National Center for Disease Prevention and Control-Family Planning (NCDPC-FP), and National Center for Health Facility Development (NCHFD).

Please print or type

Name of hospital _____

Address _____

City _____

Region _____

Province _____

Date accomplished: _____

Reporting period:

From: Day: _____ Month: _____ Year: _____

To: Day: _____ Month: _____ Year: _____

Name of person filling out form:

Title: _____

Signature: _____

Instructions for completing the form:

1. State the name of hospital in column 1 and month and year procedures performed in column 2.
2. Enter the number of all procedures performed at each hospital for the current reporting period.
 - Under Columns 3 to 6, report the numbers of mini laparotomy procedures performed according to timing after the last delivery and the number of laparoscopy procedures.
 - Under Column 7 "Other female", report all other types of female voluntary surgical contraception during Caesarean sections.
 - Add the number of female voluntary surgical contraception procedures performed during the period (Columns 3 to 7, and report the total in Column 8).
 - Report vasectomies performed under Column 9.
 - If IUD services were provided, report these under Columns 10 and 11. "Postpartum (PP) IUD" means the IUD was inserted after delivery, but before the woman left the hospital.
 - If DMPA, pills, Norplant, and condoms were provided, report these under Columns 12, 13, 14, and 15, respectively.
 - If other family planning methods were provided, specify which methods and report these in Column 16.

Appendix G

SAMPLE INFORMED CONSENT FORM

SAMPLE INFORMED CONSENT FORM

For Subdermal Implant Acceptors

Benefits and Risks

- My physician and/or provider have discussed with me the benefits, risks, and side effects of using the subdermal implant.
- I understand that I may experience certain side effects, including but not limited to: menstrual bleeding irregularities, acne, headache, breast symptoms, weight gain, and abdominal pain.
- I am aware that there may be bruising and discomfort at the insertion site, and that there is a possibility that I may have an allergic reaction.
- Although the subdermal implant has been proven to be a very effective contraceptive method, I am aware that there is still a small chance of pregnancy (less than one pregnancy for every 100 women using subdermal implants for one year).

Procedure

- I understand that a local anesthetic will be used to reduce the pain and discomfort during the insertion procedure.
- I have informed my physician of any known allergies, particularly against local anesthetic agents, as well as ingredients contained in the subdermal implant.
- I am aware that the insertion and removal of the subdermal implant may leave a small scar, and that some individuals are predisposed to forming thickened and/or enlarged scars.
- I understand that the subdermal implant has to be removed after three years and that I am responsible for returning to the clinic to have it removed.

Voluntariness and Confidentiality

- My decision to have the subdermal implant inserted is completely voluntary. I have been made aware that this will not affect the services and/or treatment I receive in this facility.
- I understand that I may choose to discontinue using the subdermal implant at any time and for any reason. I may opt to have it removed at this facility, or in any other facility of my choosing.
- I have been assured that confidentiality for my personal information will be maintained.

Based on the information above, I _____, freely give my consent for the physician to insert a subdermal implant in my arm. My signature indicates that I have read and fully understand the statements printed above.

Printed Name

Signature

Date

Name and Signature of Physician

Name and Signature of Witness/Spouse

Date: _____

Date: _____

Informed Consent Form for Sterilization Clients

I, _____, the undersigned, request that a Surgical Sterilization (bilateral tubal ligation vasectomy) be performed on my person. I make this request of my own free will, without having been forced, pressured, or given any special inducement.

I understand the following:

1. There are temporary methods of contraception available to my partner and me.
2. The procedure to be performed on me is a surgical procedure, the details of which have been explained to me.
3. This surgical procedure involves risks, in addition to benefits, both of which have been explained to me.
4. The procedure should be considered permanent. However, no surgical procedure can be guaranteed to work 100% on all people. There is a small failure rate. If the procedure is successful, I will be unable to have any more children.
5. This surgical procedure will not protect me and my partner from sexually transmitted infections (STIs), including HIV (the virus that causes AIDS).
6. I can decide against the procedure at any time before the operation is performed (and no medical, health, or other benefits or services will be withheld from me as a result).

Signature or mark of the client

Date

Signature of attending physician or delegated assistant

Date

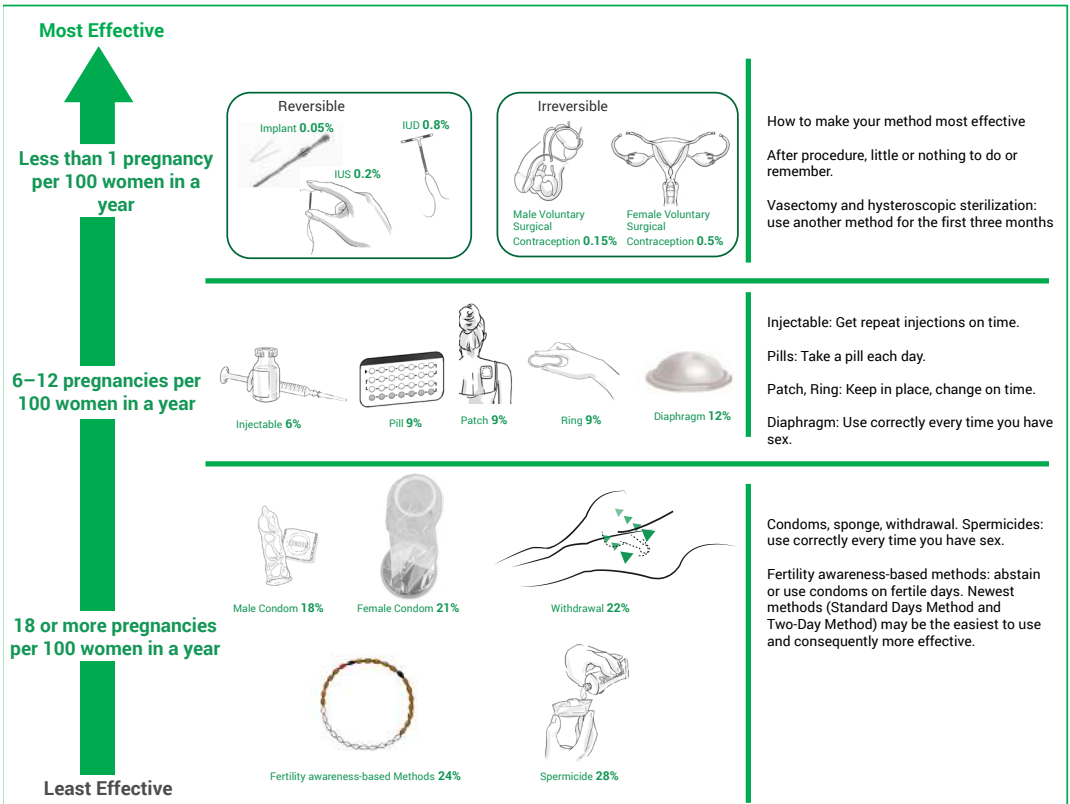
If the client cannot read, a witness of the client's choosing, of the same sex and speaking the same language, must sign the following declaration:

I, the undersigned, attest to the fact that the client has affixed his/her thumbprint or mark in my presence.

Signature or mark of witness/spouse

Date

Appendix H METHOD EFFECTIVENESS



Percentages indicate the number out of every 100 women who experienced an unintended pregnancy within the first year of typical use of each contraceptive method.

Condoms should always be used to reduce the risk of STIs.

Other Methods of Contraception:

Lactational Amenorrhea Method: LAM is a highly effective, temporary method of contraception.

Adapted from 1) World Health Organization, John Hopkins Bloomberg School of Public Health/Center for Communications Program. Family planning: a global handbook for providers 2011 Update. Baltimore; 2011; 2) U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. US selected practice recommendations for contraceptive use; 2013. Available from <http://www.cdc.gov/mmwr/pdf/rr/rr62e0614.pdf>

GLOSSARY

Abscess. A collection of pus surrounded by inflammation.

Acquired immune deficiency syndrome (AIDS). A progressive, usually fatal condition (syndrome) that reduces the body's immune system or ability to fight infections. Caused by infection with the human immunodeficiency virus.

Amenorrhea. Absence of menstrual periods (monthly vaginal bleeding).

Antiretroviral (ARV) therapy. A group of drugs used to treat patients with AIDS. These drugs are usually taken in different combinations at once to slow down the progression of AIDS.

Backup method. A family planning method (e.g., condoms or spermicide) that can be used temporarily for extra protection against pregnancy when needed, such as when starting a new method, when supplies run out, and when a pill user misses several pills in a row.

Bacterial vaginosis. An overgrowth of bacteria normally found in the vagina. It is not a sexually transmitted infection.

Breakthrough bleeding. Vaginal bleeding between menstrual periods.

Breastfeeding and breastfeeding patterns. Feeding the infant with breast milk. Patterns include the following:

Exclusive breastfeeding. Breast milk is the sole source of nutrition of the infant with no supplementation of other liquids, even water.

Fully breastfeeding. Breast milk is almost exclusively the source of nutrition of the infant, but water, juice, and vitamins are infrequently given.

Nearly fully breastfeeding. Breast milk is about $\frac{3}{4}$ of the total nutrition of the infant. Some liquids or food is also given.

Partially breastfeeding. Breast milk is less than $\frac{3}{4}$ of the total nutrition of the infant. Nutrition is more supplemented with liquids or food.

Candidiasis. A vaginal infection caused by yeast-like fungus. It is not a sexually transmitted infection.

Cardiovascular disease (or problems). Any disease or abnormal condition of the heart, blood vessels, or blood circulation.

Cerebrovascular disease. Any disease of the blood vessels of the brain.

Cervical mucus. A thick fluid plugging the cervical opening. It is usually thick enough to prevent sperm from entering the uterus. At midcycle, however, under the influence of estrogen, the mucus becomes thin and watery, and sperm can easily pass into the uterus.

Cervix. The lower portion of the uterus extending into the upper vagina. The glands located in the cervical canal produce mucus under the influence of estrogen.

Chancroid. A painful ulcer on the genitals caused by the bacterium *Haemophilus ducrei*. It is a sexually transmitted infection that requires treatment.

Chlamydia. A sexually transmitted infection caused by a bacterium. It is a common sexually transmitted infection that can cause infertility.

Cholestasis. Reduced flow of bile secreted by the liver.

Cirrhosis (of the liver). A liver disease involving destroyed liver cells and diminished liver function. Can block blood flow to the liver, causing high blood pressure or jaundice.

Community Health Team (CHT). A group of health volunteers serving critical roles in increasing the awareness and recognition of health risks among families, promoting healthy behaviors, and prompting individuals to seek and utilize affordable and accessible healthcare services, particularly among poor families.

Conception (fertilization). Union of an ovum or egg cell with a sperm.

Coronary artery disease. Narrowing of the arteries that supply blood to the myocardium (muscular middle layer of the heart wall). May eventually result in damage to the heart muscle.

Cover line. A horizontal line drawn across the basal body temperature chart on the highest temperature from days 6 to 10.

Contraceptive prevalence rate (CPR). Proportion of married women aged 15 to 49 years who are using any family planning method at the time of the survey.

Diabetes (diabetes mellitus). A chronic disorder caused by the ineffective production or use of insulin. People with diabetes (diabetics) cannot use carbohydrates in food properly, causing glucose (sugar) accumulation in the blood and urine. Symptoms include excessive urination and excessive thirst. Diabetics, especially if untreated, are at risk of developing serious long-term complications, such as nephropathy, neuropathy, and retinopathy.

Disinfect (high-level disinfection). To destroy all living microorganisms except some forms of bacteria.

Deep venous thrombosis (DVT). A condition wherein a blood clot (thrombus) forms in a vein within the muscles, such as those on the legs.

Dysmenorrhea. Painful menstrual periods.

Eclampsia. A major toxic condition of late pregnancy, labor, and the period immediately after delivery that is characterized by convulsions (involuntary muscle contractions or seizures). In serious cases, this condition is sometimes followed by coma and death. It occurs as a complication of preeclampsia.

Ectopic pregnancy. Pregnancy anywhere outside the uterus, such as in the fallopian tubes or ovaries. It is an emergency condition because the fetus often grows to a size large enough to cause fatal internal bleeding in the mother's abdomen.

Effectiveness of contraceptive method with typical use or common use. The likelihood of pregnancy for all users taken together, whether or not they use the methods correctly and consistently.

Effectiveness of contraceptive method with correct and consistent use. The likelihood of pregnancy as reported in reliable studies.

Ejaculation. The semen released from the penis.

Endometriosis. A condition where endometrial tissue is located outside the uterus. The tissue may attach itself to the reproductive organs or to other organs in the abdominal cavity. May cause pelvic adhesions in the abdominal cavity and in the fallopian tubes. Endometriosis may also interfere with ovulation and with embryo implantation.

Endometrium. The inner membrane of the uterus that thickens and sheds once a month, causing monthly bleeding except during pregnancy.

Estrogen. Female hormone responsible for sexual development. Contained in some hormonal contraceptives.

Fallopian tubes. Extend from the ovaries and are connected to the uterus. Fertilization of the egg and the sperm occurs along either of the two fallopian tubes.

Fertilization. Union of the ovum and the sperm.

Genital herpes. A sexually transmitted infection caused by the virus Herpes simplex.

Genital warts. Soft growths on the genital area caused by the human papilloma virus. It is a sexually transmitted infection.

Gestational diabetes. Diabetes that develops only during pregnancy. Occurs because the usual hormone production is changed and sugar is not utilized efficiently.

Gestational trophoblastic disease. A tumor that forms in the uterus as a mass of cysts that resemble a bunch of grapes.

Gonorrhea. A genitourinary infection transmitted sexually or through the birth canal. It is caused by the bacterium *Neisseria gonorrhoeae*.

Heavy smoker. A person who smokes 15 or more cigarettes per day.

Hepatitis. Inflammation of the liver, usually caused by a virus but sometimes by a toxin.

Hernia. The projection of an organ, part of an organ, or any bodily structure through the wall that normally contains it.

Human immunodeficiency virus (HIV). The cause of AIDS. HIV can be transmitted by sexual contact (heterosexual or homosexual), by contaminated blood products (especially blood transfusion), through contaminated needles or surgical instruments, and from mother to fetus or infant before or during birth. A mother infected with HIV may pass the virus to the baby through her breast milk.

Human papilloma virus (HPV). A common and contagious virus that causes genital warts or cervical cancer. The virus is spread by sexual activity or skin-to-skin contact.

Hydrocele. A collection of fluid in a body cavity, particularly in the testes or along the spermatic cord.

Hypertension. Higher blood pressure than normal. Normal blood pressure in adults varies in each person. Generally, diastolic (resting) blood pressure from 90 mm Hg to 99 mm Hg is considered mild hypertension, 100 mm Hg to 109 mm Hg is considered moderate hypertension, and 110 mm Hg or greater is considered severe hypertension. Systolic (pumping) blood pressure from 140 mm Hg to 159 mm Hg is considered mild hypertension, 160 mm Hg to 179 mm Hg is considered moderate hypertension, and 180 mmHg or greater is considered severe hypertension.

Implantation. The process by which an embryo attaches to the endometrium lining of the uterus where it obtains its source of nourishment.

Informed choice. A decision made freely based on clear, accurate, and relevant information. It is a goal in family planning counseling.

Informed choice and voluntarism (ICV). A standard in the delivery of FP services ensuring that each client freely makes his/her own decision based on accurate and complete information on different modern FP methods and not by any special inducements or forms of coercion or misinterpretation.

Ischemic heart disease (a.k.a. ischemia). Reduced blood flow (and thus reduced oxygen) to tissues of the body. A reduced flow in the coronary arteries (arteries of the heart) is called ischemic heart disease or myocardial ischemia.

Jaundice. A symptom of liver disease. A person with jaundice typically has abnormal yellowing of the skin and whites of the eyes.

Kalusugan Pangkalahatan (KP). Also known as the Aquino Health Agenda to achieve Universal Healthcare. It is a focused approach to health reform implementation, ensuring that all Filipinos, especially the poor, receive the benefits of health reform. The three thrusts of KP are (1) rapid expansion in National Health Insurance Program enrollment and benefit delivery using national subsidies for poor families, (2) improved access to quality hospital and healthcare facilities through accelerated upgrading of public health facilities, and (3) attainment of health-related millennium development goals by applying additional effort and resources in localities with a high concentration of families who cannot receive critical public health services.

Laparoscope. A device consisting of a tube, lens, or camera that allows the internal visualization of the body or organ. Can be used during bilateral tubal ligation in women.

Laparoscopy. An operation performed using small incisions using a laparoscope.

Menopause. The time in a woman's life when menstrual periods stop. Occurs when a woman's ovaries stop producing eggs and monthly bleeding from the uterus stops.

Migraine. Severe, recurrent headache, usually accompanied by sensitivity to light and affecting only one side of the head, with sharp pain and sometimes nausea, vomiting, and trouble seeing.

Minilaparotomy. A form of female voluntary surgical contraception performed by cutting the fallopian tubes using a laparoscope.

Nonsteroidal anti-inflammatory drug (NSAID). A group of drugs that reduce inflammation, pain, redness, swelling, and fever. Examples include mefenamic acid and ibuprofen.

National Online Stock Inventory Reporting System (NOSIRS). A logistics management initiative with standard and formal reporting systems that can generate logistics information at all levels of the healthcare system. NOSIRS utilizes Supply Management Recording as a recording tool to efficiently track the status of commodities at health facilities and hospitals nationwide.

Ovaries. A pair of female sex organs that store and release the ovum or egg. It produces the sex hormones estrogen and progesterone, which prepare the lining of the uterus to receive a fertilized ovum.

Ovulation. The release of an ovum or egg from the ovaries.

Pulmonary embolism. A condition where a part of the clot in DVT may break off and travel through the deep veins back to the heart and eventually be pumped by the heart into the arteries of the lung.

Pelvic inflammatory disease. An infection in the upper genital tract caused by various bacteria. It may present as lower abdominal pain, tenderness of the ovaries or fallopian tubes, yellowish cervical discharge, and bleeding.

Penis. Male organ for urination and sexual intercourse. It is also the passage of semen.

Perfect use. Among couples who initiate use of a method (not necessarily for the first time) and who use it perfectly (both consistently and correctly), the percentage who experience an accidental pregnancy during the first year if they do not stop use for any other reason.

Placenta. The organ that nourishes the fetus. This organ is expelled from the uterus soon after childbirth.

Post-partum. The first six weeks after childbirth.

Progesterone. A hormone produced by the ovaries after ovulation. It causes the endometrium to thicken and prepare for the implantation of a fertilized ovum. It also enhances the development of the placenta and helps prepare the breasts for breastfeeding.

Progestin (a.k.a. progestogen). A group of synthetic drugs that act similarly to progesterone. It is a component of some contraceptives.

Prolonged bleeding. See vaginal bleeding.

Prostate. Part of the male reproductive system. It is located at the base of the urinary bladder and surrounds the urethra. It secretes an alkaline fluid that is part of the semen.

Puberty. A period when the body begins making adult levels of sex hormones and the young person takes on adult body characteristics.

Pulmonary embolism. A blood clot formed elsewhere in the body that has traveled to the lung, causing shortness of breath and pain when taking a deep breath. Can be fatal.

Pus. A whitish to yellowish fluid composed of infected tissues

Scrotum. The pouch of skin behind the penis that contains the testes.

Semen (seminal fluid). Thick white fluid produced partly by the prostate. It is released through the penis. After vasectomy, the semen may no longer contain any sperm.

Seminal vesicles. Male organ where the semen and sperm mixes.

Service Delivery Network (SDN). Network of facilities and providers within the province-wide or city-wide health system offering core package of services, which include modern family planning services, in an integrated and coordinated manner, pursuant to the Maternal, Neonatal, and Child Health and Nutrition Strategy.

Sexually transmitted infection (STI) or sexually transmitted disease (STD). A group of infections caused by various bacteria, viruses, or fungi that are transmitted through oral, anal, or vaginal intercourse.

Sperm. Male sex cell.

Spermicide. Chemical barriers that kill the sperm.

Syphilis. A sexually transmitted infection caused by *Treponema pallidum*. It may be transmitted by sexual contact, mother to fetus while in the womb, and through breaks in the skin that come in contact with the lesions caused by the bacterium.

Testes (testicles). Two male reproductive organs that produce sperm and testosterone. It is found inside the scrotum sac.

Thermal shift. Three consecutive temperatures above the cover line. They are marked as days 1, 2, and 3 in the BBT chart.

Thromboembolic disorder (or disease). Abnormal clotting in the blood vessels.

Thrombophlebitis. The formation of blood clots (thrombi), causing pain and swelling in the leg.

Trichomoniasis. A sexually transmitted infection caused by the protozoan *Trichomonas vaginalis*.

Typical use. Among typical couples who initiate use of a method (not necessarily for the first time), the percentage who experience an accidental pregnancy during the first year if they do not stop use for any other reason.

Unmet need for modern family planning. The number of women who are fecund and sexually active but are not using any modern method of contraception and report not wanting any more children (limiting) or wanting to delay the birth of their next child (spacing).

Urethra. The passage of urine. In men, it is also the passage of semen.

Uterus. A hollow muscular organ that lies between the bladder and the rectum. It carries the fetus during pregnancy.

Vagina. The passage that extends from the external sexual organs to the uterus of females.

Vaginal bleeding, patterns. Any bloody vaginal discharge (pink, red, or brown). Different patterns of vaginal bleeding include the following:

Amenorrhea. Absence of menstrual periods (monthly vaginal bleeding).

Breakthrough bleeding. Any bleeding outside expected bleeding times.

Heavy bleeding. Bleeding that is twice as heavy as the usual bleeding.

Infrequent bleeding. Fewer than two bleeding episodes in three months.

Irregular bleeding. Spotting and/or breakthrough bleeding that occurs beyond expected bleeding times.

Prolonged bleeding. Bleeding lasting for more than eight days.

Vas deferens. Two muscular tubes that serve as storage and passageway for the sperm from the testes to the prostate gland.

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Effectiveness of Modern Family Planning Methods

Mas mabisa

Hindi umaabot sa isa sa bawat 100 babae ang nabubuntis kada taon

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IMPLANTS



IUD



TUBAL LIGATION



VASECTOMY

Paano gawing mas mabisa ang inyong napiling paraan

- **Implants, IUD, Female Sterilization:** Pagkatapos ng operasyon, kaunti na lamang o wala nang kailangan gawin o alalahanin.
- **Vasectomy:** Gumamit ng karagdagang pamamaraan sa unang 3 buwan.



INJECTABLES



LAM



PILLS



PATCH



VAGINAL RING

- **Injectables:** Magpa-ineksyon sa takdang oras
- **Lactational Amenorrhea Method (sa loob ng 6 na buwan):** Magpasuso ng madalas, sa araw at gabi.
- **Pildoras:** Uminom ng isang pildoras araw-araw.
- **Patch, ring:** Itago sa tamang lugar, palitan sa takdang oras.



MALE CONDOMS



DIAPHRAGM



FEMALE CONDOMS



NATURAL FAMILY PLANNING METHODS

- **Condoms, diaphragm:** Gamitin ng tama tuwing nakikipagtalik.
- **Natural Family Planning methods:** Iwasan ang pakikipagtalik kung fertile. Mas madaling gamitin ang mga makabagong pamamaraan (Standard Days Method at Two-Day Method).

Hindi gaanong mabisa

30 sa bawat 100 babae ang nabubuntis kada taon



SPERMICIDE

- **Spermicide:** Gamitin ng tama tuwing nakikipagtalik.

Alamin ang mga Pamamaraan ng Pagpapalano ng Pamilya

Komunsulta sa mga doktor, nars o midwife



PILLS

May dalawang klase:

- Progestin-Only Pills (POPs).

Angkop sa nagpapasung ina dahil hindi nababawasan ang daloy at dami ng gatas.

- Combined Oral Contraceptives (COCs).

Hindi angkop sa mga nagpapasung ina.

Dapat inumin araw-araw sa takdang oras.

Mabisa at pwedeng itigil anumang oras kung gustong magbuntis.

Maaaring gamitin kahit anong edad, may anak man o wala.

Maaaring makaranas ng pagdurugo (spotting), ngunit hindi ito delikado.

May ilan ding makaranas ng pananakit ng ulo, pagbabago ng timbang, pananakit ng sikhura, lalo na sa unang gamit, ngunit madalas na nawawala rin ito.

Nakatutulong sa pag-iwas sa dismorya

(menstrual cramps), malakas na regla at anemia.

Ligtas para sa halos lahat ng babae.

Bihira ang malubhang komplikasyon.



LACTATIONAL AMENORRHEA METHOD (LAM)

Pagpapasung ng gatas ng ina lamang sa sanggol sa loob ng 6 na buwan pagkapanganak.

Maaaring gamitin kung:

- Tanging gatas ng ina lamang ang ibinibigay sa sanggol, at madalas ang pagpapasung, araw-gabi;

- Hindi pa muling bumabalik ang regla; at

- Wala pang 6 na buwan ang sanggol.

Kung hindi na angkop ang mga kondisyong nabanggit sa itaas ngunit ayaw pang mabuntis, gumamit na ng ibang pamamaraan.



CONDOMS

Kung wasto ang paggamit nito tuwing nakikipagtalik, nakatutulong sa pag-iwas sa pagbubuntis at sa pagkahawa sa ilang mga sakit na nakukuha sa pakikipagtalik, kasama na ang HIV/AIDS.

Madaling gamitin at mabisa.

Kung ayaw sa condom dahil nakahahadlang raw ito sa pakikipagtalik at nakababawas ng sensasyon, pag-usapan. May iba't-ibang klase na ng condom na mapagpipilian.



INJECTABLES

May dalawang klase:

- Progestin-Only Injectables (POIs).

Angkop sa nagpapasung ina dahil hindi nababawasan ang daloy at dami ng gatas.

- Combined Injectable Contraceptives (CICs)

Hindi angkop sa nagpapasung ina.

Mabisa at ligtas. Ini-ineksyon sa braso o pige ng babae.

Maaaring i-ineksyon bawat 3 buwan, 2 buwan o buwanan.

Maaaring gamitin kahit anong edad, may anak man o wala.

Maaaring makaranas ng pagdurugo (spotting), o pagtigil ng buwanang regla kung matagal nang ginagamit ito, ngunit hindi ito delikado.

May ilan ding makaranas ng pananakit ng ulo at unti-unting pagtaas ng timbang, ngunit hindi ito delikado.



CONTRACEPTIVE IMPLANTS

Isang mala-posporo kaliti na kapsulang ipinapasok sa ilalim ng balat ng braso ng babae.

Mabisa sa loob ng 3, 5 o 7 na taon, depende sa uri ng implant.

Maaaring gamitin kahit anong edad, may anak man o wala.

Maaaring ipatanggal kahit kailan, at maaaring mabuntis muli pagkatanggal nito.

Ligtas gamitin kahit nagpapasung, basta ilagay 6 na linggo pagkalipas ng panganganak.

Maaaring magkaroon ng pagdurugo (spotting), ngunit hindi ito delikado.



TUBAL LIGATION

Permanenteng pamamaraan para sa babaeng ayaw nang magkaanak.

Mabisa. 99.5% epektibo.

Kailangang magpa-eksamen bago isagawa ang simpleng operasyon. Gising ang pasyente habang inooperahan at hindi masasaktan dahil sa anestisyas.

Maaaring tumagal ang sakit o pamamaga ng sugat o hiwa ng operasyon ng ilang araw pagkatapos ng operasyon.

Walang pangmatagalang side effects.

Walang epekto sa kakayahan o pakiramdam sa pakikipagtalik.



Intra-Uterine Device (IUD)

Ang IUD ay maliit at malambot na plastic na ipinapasok sa matris ng babae.

Mabisa hanggang 12 taon depende sa klase ng IUD. Maaaring ipatanggal kung gusto nang magbuntis.

Maaaring lumakas ang regla sa umpisa.

Bihira ang malubhang komplikasyon.

Minsan kusang lumalabas sa puwerta at nawawala sa ayos ang IUD, lalo na sa una at kung malakas ang regla. Agad komunsulta sa doktor, nars o midwife.



NATURAL FAMILY PLANNING METHODS

Kabilang ang Basal Body Temperature (BBT), Billings Ovulation Method (BOM), Sympto-Thermal Method (STM), Standard Days Method (SDM) at Two-Day Method (TDM). Nangangailangan ng lubos na kaalaman at kakayahang tukuyin kung kailan sa buwanang siklo mabunga (fertile) ang babae, upang iwasan ang pagtatalik sa panahong ito.

Kailangan ang pagsaanay para sa epektibong paggamit.

Nangangailangan ng kooperasyon ng magasawa.

Walang pisikal na side effects.

May ilang pamamaraan na mahirap gamitin kung may lagnat, impeksyon, o katatapos manganak.



VASECTOMY

Permanenteng pamamaraan para sa mga lalaki.

Nagagawa sa isang ligtas, mabilis at simpleng operasyon. Gising ang pasyente habang inooperahan at hindi nasasaktan dahil sa anestisyas.

Maaaring tumagal ng ilang araw ang pamamaga ng sugat ng operasyon. Bihira ang pangmatagalang pananakit.

3 buwan ang lilipas bago maging mabisa (99.9% epektibo) ang vasectomy. Kaya kailangang sabayan ng ibang pamamaraan (condom) hanggang mag-zero sperm count ka na. Walang epekto sa kakayahan o pakiramdam sa pakikipagtalik.