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Jhpiego

an affiliate of Johns Hopkins University

Post Partum Family Planning Contraceptive Technology Update

Participant's Handbook

2012

Strengthening Post Partum Family Planning in Punjab

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for

Strengthening Post Partum Family Planning in Punjab

Department of Health & Population Welfare
Government of Punjab.

Jhpiego is an international, non-profit health organization affiliated with The Johns Hopkins University. For more than 36 years, Jhpiego has empowered front-line health workers by designing and implementing effective, low-cost, hands-on solutions to strengthen the delivery of health care services for women and their families. By putting evidence-based health innovations into everyday practice, Jhpiego works to break down barriers to high-quality health care for the world's most vulnerable populations.

This product was made by Jhpiego for FALAH project and it is adapted by incorporating updates on Postpartum Family Planning under the project of Strengthening Postpartum Family Planning Services in Punjab.

POST PARTUM FAMILY PLANNING CONTRACEPTIVE TECHNOLOGY UPDATES

Participant's Handbook

WORKSHOP POWERPOINT HANDOUTS

ABBREVIATIONS AND ACRONYMS

CIC	Combined injectable contraceptive
COC	Combined oral contraceptive
DMPA	Depot-medroxyprogesterone acetate
EC	Emergency contraception
ECP	Emergency contraception pill
EE	Ethinyl estradiol
FP	Family planning
PPFP	Postpartum Family Planning
IP	Infection prevention
IUCD	Intrauterine contraceptive device
LAM	Lactational amenorrhea method
LMP	Last menstrual period
LNG	Levonorgestrel
Mcg	Microgram
ML	Multiload
ml	milliliter
Net-en	Norethisterone enanthate
NSV	No-scalpel vasectomy
PIC	Progestin-only injectable contraceptive
PID	Pelvic inflammatory disease
POP	Progestin-only pill
PPT	PowerPoint
RHC	Rural health center
STI	Sexually transmitted infection
VSC	Voluntary surgical contraception

OVERVIEW

The Post Partum Family Planning Contraceptive Technology Update Course aims to update the service providers about significance of post partum family planning to be used as a strategy for saving mothers lives . A two days workshop based on these technical updates is designed to train the health services providers from the field to provide them the latest advancement in use of modern contraceptive methods and thereby improving the access and quality of FP/PPFP service provision at the primary health care facilities.

These update includes information on the following topics :

- Quality and access in Post partum family planning
- Healthy Timing and Spacing of Pregnancy (HTSP)
- Use of modern contraceptives : combined oral contraceptives (COCs), emergency contraception (EC), injectable contraceptives, intrauterine contraceptive devices (IUCDs), barrier methods , LAM and permanent/surgical contraception
- Best Practices in FP: Use of WHO Medical Eligibility Criteria
- Post Partum IUCD : timings ,benefits
- Contraception for special situations (post-pregnancy and post-miscarriage, women over 35)

Participant's handbook includes pre and post questionnaire, case studies, role plays and power point presentations to be used during the workshop.

POST PARTUM FAMILY PLANNING CONTRACEPTIVE TECHNOLOGY UPDATES

AGENDA

DAY 1	DAY 2
(09:00-15:00)	**(09:00-15:00)**
Welcome Overview of the Workshop Setting Norms & Expectations Pre Course Questionnaire What is Post Partum Family Planning? Why Family Planning is Important?	Agenda of Day 2 Reflections Emergency Contraception IUCD
TEA BREAK	
Healthy Timing & Spacing Of Pregnancy PPFP Counseling Natural Birth spacing Methods-LAM Barrier Method	Voluntary Surgical Contraception Infection Prevention Demonstration of Injection Technique Contraceptive Needs for Post partum Women
LUNCH	
Medical Eligibility Criteria (MEC) Hormonal Contraceptives Group Work Group Presentations	Post course questionnaire Discussion on post course questionnaire Certificate distribution Closing

POST PARTUM FAMILY PLANNING CONTRACEPTIVE TECHNOLOGY UPDATES

Pre Course Knowledge Needs Assessment Questionnaire

Name: _____ **Date:** _____

Instructions:

Attempt all questions. Identify each of the statement either as True (by encircling **"T"**) **OR** as False (by encircling **"F"**), whichever is the appropriate response.

Example:
Mumbai is the capital of Kenya

T	(F)

COUNSELING			
1	The best way to correct a Family Planning rumor is to ignore it.	T	F
2	The doctor should prescribe Family Planning as per his/her best judgment.	T	F
3	It is important to discuss misconceptions and rumors about Family Planning methods with the client	T	F
HEALTHY TIMING AND SPACING OF PRAGNANCY			
4	Pregnancy before the age of 18 years has no adverse effects on the clients health	T	F
5	Recommended interval before attempting the next pregnancy is at least 24 months in order to reduce the health risk to mother and the child	T	F
COCs			
6	Oral contraceptive method is the best method of contraception for a woman who is breast-feeding her infant age 3 months.	T	F
7	Oral contraceptive Pills are also used as emergency contraception	T	F
8	Combined oral contraceptive Pills regularize the menstrual period	T	F
9	Combined Oral contraceptive Pills have protective effect on ovarian cancer.	T	F
10	COCs decreases menstrual cramps	T	F
11	COCs is the combination of estrogen and progesterone.	T	F
12	The mechanism of action of COCs is to prevent the release of the ovum (or egg).	T	F
13	COC pills can be started only during the menstrual period	T	F
14	COCs benefit the breast feeding mothers by increasing the quantity of milk	T	F
15	Excessive bleeding is the most common side effect experienced by the pill users	T	F
MEDICAL ELIGIBILITY CRITERIA			
16	When a contraceptive method is safe to use for the client, it will be in the category number 1	T	F

17	When the use of a particular contraceptive is absolutely contraindicated, it will fall in the category number 2	T	F
18	Nulliparous woman can use the IUCD as a method of contraception	T	F
	EMERGENCY CONTRACEPTIVES		
19	Emergency contraceptive pills (ECPs) are effective if taken within 120 hours of unprotected intercourse	T	F
20	Emergency Contraceptive Pills should be used if the client forgot to take the Oral contraceptive (brown Pills) on the 24th day of menstrual cycle	T	F
21	After the use of ECP, menstrual cycle gets 3 week late	T	F
	INJECTABLE CONTRACEPTIVES		
22	If the client is on injectable contraceptive (3 months), she comes one week later than the schedule time, she should be given second injection	T	F
23	Since the women are familiar with injections, they do **not** need to have counseling.	T	F
24	If the patient develops bleeding P/V following Contraceptive injection, next injection should not be given.	T	F
25	Changes in bleeding pattern is the major reason of the discontinuation of injectables	T	F
	CONDOMS		
26	It is preferable to lubricate condoms before use	T	F
27	Condoms protects from sexually transmitted infections	T	F
	INFECTION PREVENTION		
28	Standard precautions are the guidelines designed to create the barriers between A healthy person and microorganisms	T	F
29	Decontamination of needle and syringe must be done before destroying it in destruclip	T	F
	IUCDs		
30	Copper T 380 IUCD is not recommended for nulliparous women	T	F
31	As long as a woman is not pregnant, Multiload Copper 375 IUCD can be inserted anytime in her cycle	T	F
	VOLUNTARY SURGICAL CONTRACEPTION		
32	Vasectomy is effective immediately after the surgery	T	F
33	Minilap tubal ligation is performed 7 days after delivery of the baby	T	F
	LACTATIONAL AMMENNORHOEA METHOD(LAM)		
34	One of the three criteria for effective lactational amenorrhea (LAM) is that the baby is exclusively breast fed	T	F
35	LAM can be effective for up to 6 months after childbirth	T	F

WORKSHOP ACTIVITIES

ROLE PLAY ON COUNSELING

Directions for the Participants

The trainer and one volunteer from the group will conduct this activity. One will be a clinician, the other a client. Each participant who has a part in the role play should take a few minutes to read the background information and prepare. The observers in the group also should read the background information so that they can participate in the small group discussion following the role play.

Time Allotted: 10 minutes

Participant's Role

Clinician: The physician is a health care provider providing services at a rural health center (RHC).

Client: The client is 25 years of age and has four children, the youngest being 8 months old. She comes to RHC for contraception. She has heard from someone that pills are very effective but she is, at the same time, afraid of the side effects.

Focus of the Role Play

The focus of the role play is on the interaction between the physician and the client. The physician must counsel and reassure the client. The client should continue to be nervous until the physician chooses the appropriate words and expressions that will inform and calm the client.

Discussion Questions

1. Did the provider approach the client in a positive, reassuring manner?
2. Did the physician's approach have the planned effect on the client? What other approaches would have been effective?
3. Were the client's fears realistic?
4. How could this problem have been avoided?

PPFP OPTIONS THAT CAN BE PROVIDED AT DIFFERENT STAGES AFTER DELIVERY

1. FAMILY PLANNING METHOD OPTIONS	2. FULLY OR NEARLY FULLY BREASTFEEDING*	3. PARTIALY BREASTFEEDING OR NOT BREASTFEEDING
Lactational Amenorrhea Method(LAM)	This option can be exercised immediately after delivery	Not applicable
IUCD	Options are: • Post placental insertion within 10 minutes of delivery • Immediate Postpartum insertion within 48 hours of delivery • Postpartum insertion at or after 6 weeks of delivery	
Female Sterilization	Options are: • Abdominal Tubectomy (Minilap) within 7 days of delivery • Laproscopic and Abdominal (Minilap)Tubectomy after 6 weeks	
Progestin-Only Pills, Progestin only Injectables, Implants	This option can be exercised 6 months after childbirth	This option can be exercised immediately if not breastfeeding or 6 weeks after childbirth if partially breastfeeding
Combined Oral Contraceptives and Combined Injectables	This option can be exercised 6 months	This option can be exercised 21 days after childbirth if the mother is not breastfeeding
Male Condom	This option can be exercised whenever sex is resumed	
Vasectomy	This option can be exercised at anytime.	

*at least 75% of the feeds

FIVE QUESTIONS ABOUT LACTATIONAL AMMENORRHOAEA METHOD (LAM):

1. Can LAM be an effective method for birth spacing?

2. Can only well-educated couples use fertility awareness methods?

3. List the hormonal contraceptive methods which are compatible with breastfeeding?

4. What are the 4 messages that a health provider should include during postnatal care that will support the successful use of LAM?

5. List 3 ways that a service provider can promote LAM during antenatal period?

BARRIER METHODS (CONDOMS) QUESTIONNAIRE

1. What are the different types of barrier methods in use?

2. There are different types of male condoms (made of the different materials), such as:
   a. _____
   b. _____
   c. _____

3. How do condoms protect against pregnancy? Do all types protect against STIs?

4. What are other benefits associated with the use of condoms?

5. Allergic reaction to condoms is uncommon. In case of local irritation, what advice will you give to the client?

6. What are the limitations of condom use?

7. What instructions will you give to the client when advising about how to use condoms?

8. What are the lubricants that should be avoided with condoms use?

9. How can you avoid condom rupture during use?

10. What will you advise the client to do if a condom breaks or slips off during intercourse?

CASE STUDY ON PILLS

Rashida is a 30-year-old mother of three children. Her youngest child was delivered about 6 months earlier. Today, she has come to your clinic to get some family planning pills (specifically, combined oral contraceptives [COCs]). Rashida's menses have not yet returned because she has been exclusively breastfeeding her infant. Three days ago, she was at another health center for some medical problems. She is taking antibiotics for a urinary tract infection and ferrous sulfate for anemia.

- During the counseling, Rashida wants to learn more about the pill and ask the following questions:
  1. What is the difference between low-dose and high-dose pills? Are high-dose pills better than the low-dose?
  2. What are some of the advantages of taking the pill?
  3. How about disadvantages—are there any?
- During the screening, there are several considerations:
  4. Given her condition, how does breastfeeding affect her eligibility to use COCs?
  5. How about her medical problems? What antibiotics will affect the effectiveness of the COCs? How about anemia and her intake of ferrous sulfate?
  6. What other pieces of information should you ask Rashida to help her make a decision about whether to use COCs? How would this additional information help?
- Toward the end of the counseling, she also asks about how to use the pill.
  7. Given her situation, 6 months postpartum and no menses, when can she start taking the pill?
  8. Aside from doing a pregnancy test, what can you do to be reasonably sure she is not pregnant? What questions should you ask?
  9. What should you tell her about what to do if she misses pills?
  10. How about if she forgets to start her new pack on time?

After all of Rashida's questions have been answered, you instruct her to return to the clinic for resupply or if there are problems related to using the pill. Three months later, Rashida returns to the clinic to get more pills. During her consult, she says that in the first 2 months of using the pills, she had 1–2 days of spotting in the middle of her cycle. She was not too concerned but would like to know if this is going to happen every time she is on pills. Rashida also mentions that she experienced nausea and some vomiting in the first month but presently gets nausea very infrequently.

11. Are her symptoms normal with pills? What other conditions may cause spotting?
12. What would you advise Naseeb bi about the spotting?
13. Will this spotting continue while she is on pills?
14. What should you advise Rashida about the nausea and vomiting? When should this information have been provided and what advice would have been appropriate at that time?

CASE STUDY ON INJECTABLES

Naima is 36 years old and has three children. She is using Famila, a low-dose COC, and has been using it for the last 2 years. Naima is having headaches and is concerned that they may be related to her use of Famila. She wants to shift to an injectable (progestin-only injectable contraception [PIC]). Naima has come to the family planning clinic today to get an injection. She tells you she is not presently having her menses, and that she has been taking medications for epilepsy.

1. During the counseling, Naima wants to learn more about injectable contraceptives:
   - What are DMPA (Depot-Medroxyprogesterone Acetate, or Depo-Provera) and Net-en (Norethisterone enanthate)? What are their similarities and differences?
   - What are some of the advantages of using injectables?
   - How about disadvantages—are there any?
   - What other information should you share with Naima about PICs?
2. During screening, there are several considerations:
   - Do you think Naima's fears about her headaches being related to her use of Famila are valid? Why?
   - Given her age and headaches, do these factors affect her eligibility to use PICs?
   - How about the medical problem of headaches? How would you further evaluate her complaint of headaches? How about epilepsy? Do medications for epilepsy affect the effectiveness of DMPA?
   - What other conditions should you check out to see if she is eligible?
3. Toward the end of the counseling, Naima also asks about how she can get started on DMPA:
   - Given her condition (not presently having her menses), when can she start receiving Depo-Provera? If, for example, Naima just had a delivery, can she receive an injection before discharge?
   - Aside from doing a pregnancy test, what can you do to be reasonably sure she is not pregnant? What questions should you ask?
   - What should you tell her about returning for reinjection?
   - How about warning signs indicating that she should return to the clinic immediately?

Naima has come back to the clinic for a reinjection. You check her records and note that she is 2½ weeks late. Naima reports that she experienced two episodes of 1–2 days of spotting in the past 2 months. Moreover, Naima is complaining that she has gained about 1.5 kilograms since she started the PIC.

- What should you Naima advise about spotting?
- Does her spotting need to be treated using other hormones? When is it appropriate to give additional hormones?
- How should you address the weight gain?
- What about the delay in returning for injection? Should you give her the injection? Will she need additional protection because of the delay?
- What will you advise her regarding the next follow-up visit?

EXERCISE ON PROGESTIN-ONLY PILLS (POPS)

1. Can a woman who is breastfeeding safely use POPs?

2. How long does it take to become pregnant after stopping POPs?

3. Is it important for a woman to take her POP at the same time each day?

4. Do POPs cause cancer?

5. Can POPs be used as emergency contraceptive pills (ECPs) after unprotected sex?

CASE STUDY ON EMERGENCY CONTRACEPTION

Situation

Warda is 24 years old. She is a student of medical science and was married about 6 months ago. She had unprotected sexual intercourse last night, and has come to you seeking advice about emergency contraception.

Activity

Working in small groups, participants will discuss and decide how they—as health care providers—would deal with this situation. For each small group, there are additional guidelines provided below.

Small Group 1: Before you can advise Warda about EC pills, what do you need to tell her about EC in general? (Be sure to consider different types of methods available. Also describe how you will counsel the client [mention the steps].)

Small Group 2: Warda has chosen to use POPs, and wants to know more about the safety and success rate of the method. What information will you give to her?

Small Group 3: In case of COCs, how are they used as a method of emergency contraception? Can Warda take COCs as needed for emergency contraception in the future? What advice will you give regarding future use?

Small Group 4: How effective are the IUCDs as an EC method? How do they work?

CHECKLIST FOR DMPA CLINICAL SKILLS

(To be completed by the Participants during demonstration by the Trainer)

Place a "✓" in the "YES" or "NO" observation box if the step is performed or not.

STEP/TASK	OBSERVATIONS	
	YES	NO
GETTING READY		
1. Check expiration date on DMPA single-dose vial.		
2. Ensure arm or buttocks are clean for giving IM injection.		
PREPARING THE INJECTION SITE		
1. Wash hands with soap and water and dry them with a clean, dry towel or air dry.		
2. Check that injection site is clean.		
3. If a single-use cotton swab is used to prepare the skin, allow skin to dry before giving the injection.		
PREPARING THE INJECTION		
1. Shake the vial of DMPA thoroughly before withdrawing the dose.		
2. Attach and tighten the needle to the syringe.		
3. Insert the needle through the rubber stopper.		
4. Draw up complete contents of the DMPA vial.		
5. Remove the needle from the vial.		
6. Expel any air bubbles by gently depressing the plunger.		
7. Carefully push the plunger to the dose mark 1.0 mL.		
GIVING THE INJECTION		
1. Insert the needle deep into the muscle (deltoid in arm or upper outer quadrant of gluteal area).		
2. Inject the full dose of DMPA slowly and remove the needle.		
POST-INJECTION TASK		
1. Apply pressure to injection site with cotton, but do not rub.		
2. Discard needle and syringe in a puncture-proof container without recapping or breaking or bending the needle.		
3. Wash hand with soap and water and dry them on a clean towel or air dry.		

Counseling Guide for PPFP Counseling

(To be completed by the Participants during Role Play)

Place a "✓" in the "YES" or "NO" observation box if the step is performed or not.

STEP/TASK	OBSERVATIONS	
	YES	NO
GREET—***Establish good rapport and initiate counseling on PPFP.***		
• Greets the woman, using her name and introducing self.		
• Shows respect for the woman and helps her feel at ease.		
Encourages the woman to explain her needs and concerns and ask questions.		
• Listens carefully and supports the woman's informed decisions.		
• Includes woman's partner or important family member in the discussion, as the woman desires and with her consent.		
ASK—***Determine reproductive intentions, knowledge of pregnancy risk and use of various contraceptives.***		
• Explores woman's knowledge about the return of fertility and the benefits of pregnancy spacing or limiting (as desired).		
• Asks whether she has had prior experience with family planning methods, any problems, reasons for discontinuing, etc.		
• Explores partner's/family's knowledge about the return of fertility and the benefits of pregnancy spacing/limiting.		
• Asks about desired number of children, desire to space or limit births, desire for long-term family planning, etc.		
• Explores woman's need for protection from STIs, including HIV.		
• Explains and supports condom use, as a method of dual protection.		
• Asks whether she has a preference for a specific method, based on prior knowledge or the information provided.		
TELL—***Provide the woman with information about PPFP methods***		
• Advises that to ensure her health and the health of her baby (and family), she should wait at least 2 years after this birth before trying to get pregnant again.		
• Advises about the return of fertility postpartum and the risk of pregnancy. **Advises how LAM and breastfeeding are different.**		
• Advises about the health, social and economic benefits of healthy pregnancy spacing (or limiting, if desired).		
– LAM – Condoms – POPs, COCs – Contraceptive Injectables – PPIUCD		

STEP/TASK	OBSERVATIONS	
	YES	NO
– Vasectomy – Postpartum tubal ligation		
• Shows the methods (using poster or wall chart) and allows the woman to touch or feel the items, including the IUCD, using a contraceptive tray.		
• Corrects any misconceptions about family planning methods.		
HELP—*Assist the woman in making a choice; give her additional information that she might need to make a decision.*		
• Gives woman additional information that she may need and answer any questions.		
• Assesses her knowledge about the selected method; provides additional information as needed.		
• Acknowledges the woman's choice and advises her on the steps involved in providing her with her chosen method.		
EVALUATE and EXPLAIN—*Determine whether she can safely use the method; provide key information about how to use the method*		
• Asks the woman about her medical and reproductive history.		
• Effectiveness: Prevents almost 100% of pregnancies		
• Mechanism for preventing pregnancy: Causes a chemical change that damages the sperm BEFORE the sperm and egg meet		
• Duration of IUCD efficacy: Can be used as long (or short) as woman desires, up to 12 years (for the Copper T 380A)		
• Removal: Can be removed at any time by a trained provider with immediate return to fertility		
• Simple and convenient IUCD placement, especially immediately after delivery of the placenta		
• No action required by the woman after IUCD placement (although one routine follow-up visit is recommended)		
• Immediate return of fertility upon removal		
• Does not affect breastfeeding or breast milk		
• Long-acting and reversible (as described above)		
• Heavier and more painful menses for some women, especially first few cycles after interval IUCD (less relevant or noticeable to postpartum women)		
• Does not protect against STIs, including HIV		
• Higher risk of expulsion when inserted postpartum (though less with immediate postpartum insertion)		
• Bleeding or foul-smelling vaginal discharge (different from the usual lochia)		
• Lower abdominal pain, especially if the first 20 days after		

STEP/TASK	OBSERVATIONS	
	YES	NO
insertion—accompanied by not feeling well, fever or chills		
● Concerns she might be pregnant		
● Concerns the IUCD has fallen out		
● Encourages the woman to ask questions.		
● Asks the woman to repeat key pieces of information.		
<u>RETURN</u>—*Plan for next steps and for when she will arrive to hospital for delivery.*		
● Makes notation in the woman's medical record about her PPFP choice or which methods interest her.		
● If the woman cannot arrive at a decision at this visit, asks her to plan for a follow-up discussion at her next visit; advises her to bring partner/family member with her.		
● Provides information about when the woman should come back, as appropriate.		

ROLE PLAYS: PRACTICING COUNSELING (GATHER) TECHNIQUES

Directions

Two participants in each group will assume (or be assigned) roles, as shown in "Participant Roles." One will be the clinician, the other the client. Participants taking part in the role play should spend a few minutes reading the background information ("Participant Roles" and "Situation") and preparing for the exercise. The observers in the group also should read the background information so that they can participate in the small group discussion following the role play. "Focus of the Role Play" and "Observer Discussion Questions" can be used to guide or generate this discussion.

Combined Oral Contraception (COCs)

Participant Roles

Provider: The clinician is an experienced family planning provider who is skilled in counseling.

Client: Client A is 31 years old and began taking COCs after the birth of her fifth child 2 years ago. At that time, she was screened for medical conditions that might be a precaution for COC use, but none were found. She has had no problems with COCs, once she got over the initial nausea and breast tenderness. She has had to take a job to contribute to the household income. Because of the job and work at home she has never gotten more than 4 hours of sleep on any night for the last 4 months.

Situation

Client A has now returned to the clinic complaining of headaches that she believes are caused by the COCs. She is very nervous. Her mother-in-law told her about someone who died after using COCs for years and suffering bad headaches, because the COCs caused something in her head to burst.

Focus of the Role Play

The focus of the role play is on the interaction between the clinician and the client. The clinician needs to assess the extent of the client's headaches and their possible relationship with COCs. She needs to counsel and reassure the client and recommend a plan of management. The client should remain adamant in her belief that the COCs are causing her headaches until the clinician provides her with the information and management plan that will calm her concerns.

Observer Discussion Questions

1. How did the clinician approach the client?
2. How did the client respond to the clinician? Did the clinician change her approach based on this response? If so, was it appropriate?
3. Did the clinician accurately assess the relationship between the headaches and the COCs? Did she outline an appropriate management plan?
4. How might the clinician improve her interaction with the client?

Voluntary Surgical Contraception

Participants Roles

Provider: A medical practitioner has basic knowledge about family planning and counseling.

Client: Client B is 34 years old and has five living children. She has also had two abortions and one baby that died in infancy. Her last pregnancy, 3 years ago, was extremely difficult and both she and the baby almost died during delivery. The doctors have told her that it would be very dangerous for her to get pregnant again.

Situation
The client and her husband agree that sterilization is a good option for them, but are unsure which of them should be sterilized. They have come to the clinic today to get more information so that they can make a decision as soon as possible. The client is worried that if she is sterilized she will become fat and lazy and unable to care for all of her children. Her husband has heard that vasectomy will make him weak and unable to work in the fields or support his family.

Focus of the Role Play
The focus of the role play is on the interaction between the medical practitioner and the clients. The provider needs to provide information on tubal occlusion and vasectomy that will address the clients' misconceptions and assist them in making a decision. The discussion should continue until a decision is reached.

Observer Discussion Questions

1. How did the provider approach the clients?
2. How did he access the current situation?
3. How did the provider help the couple in reaching a decision?

Young Married Female Seeking Family Planning

Participant Roles

Provider: The clinician is an experienced family planning service provider. She does not, however, fully believe that a teenaged married woman should use any family planning method other than condoms, even though national policies state that adolescents may also use COCs and Norplant.

Client: Client C is a 16-year-old girl. She was married at the age of 13 years and now has two sons. The youngest child is 6 months old. She and her husband have tried to use condoms, but the husband doesn't like them and they really don't know how to use them.

Situation
Client C now comes to the clinic looking for another family planning method because she is afraid of getting pregnant. Several of her friends are using oral contraceptives and they haven't gotten pregnant yet. She thinks pills would be good for her too, but she is nervous and ill at ease.

Focus of the Role Play
The focus of the role play is on the interaction between the clinician and the client. The clinician needs to assess the client's knowledge and understanding of family planning, specifically COCs and condom use. She needs to assess the appropriateness of these methods for the client. The clinician, because of her personal feelings, should focus more on condoms and their correct use. The interaction should continue until the client decides to try condoms again, now that she knows how to use them effectively.

Observer Discussion Questions

1. How did the service provider approach the client? How effectively did the service provider overcome her personal biases?
2. How did the client respond to the service provider?
3. Did the service provider help the client to make the best decision for her? Did she provide the client with all of the information she needed?
4. How might the service provider improve her interaction with the client?

Male Voluntary Sterilization

Participant Roles

Provider: The clinician is an experienced family planning service provider. He is calm and knowledgeable when counseling clients.

Client: Client D is a 38-year-old man with five children: three sons and two daughters. Because he and his wife have limited resources, he is certain that it would be very difficult for them to raise any more children. He plans to be sterilized.

Situation

Client D has now come to the clinic to get more information on sterilization. He says that he does not want to have any more children, and repeatedly asks about the permanent nature of sterilization.

Focus of the Role Play

The focus of the role play is on the interaction between the clinician and the client. The clinician needs to assess the client's understanding of vasectomy. The clinician needs to give the client the information he needs in an impartial manner. He needs to pay particular attention about the permanence of vasectomy and what this implies.

Observer Discussion Questions

1. How did the clinician approach the client?
2. How did the client respond to the clinician?
3. How might the clinician improve her interaction with the client?
4. Was the decision reached an appropriate one? If yes, why? If not, what would have been better?

Depo-Provera Counseling: Side Effects

Participant Roles

Provider: The clinician is an experienced family planning service provider. She/he is calm and knowledgeable when counseling clients.

Client: Client E is a 29-year-old woman with six children. She has been using Depo-Provera since 6 weeks after the birth of her youngest child, 2½ years ago. She says that she had trouble breastfeeding her child because of the Depo-Provera. She kept taking the Depo-Provera, however, because she was more concerned about another pregnancy than about her problems with breastfeeding.

Situation
Client E has come to the clinic complaining of feeling very tired and unable to do her work for the past several months. She is sure it is because she has been taking Depo-Provera for such a long time. She thinks it would be a good idea to take a rest period from Depo-Provera.

Focus of the Role Play
The focus of the role play is on the interaction between the clinician and the client. The clinician needs to assess the relationship between the client's problems and her use of Depo-Provera. She/he also needs to counsel and reassure the client regarding her misconceptions about Depo-Provera. The client should remain firm in her wish to take a rest from Depo-Provera until the clinician provides her with the information that will calm her fears and concerns.

Observer Discussion Questions

1. What were strengths and weakness of the interaction?
2. How might the service provider improve her interaction with the client?
3. Are the client's past or present problems related to her use of Depo-Provera? Did the service provider explain this in an appropriate and convincing manner?
4. What might be better or alternative contraceptive choices for her? Why?

WORKSHOP POWERPOINT HANDOUTS

Postpartum Family Planning

Best Practices/Quality and Access

Healthy Timing and Spacing of Pregnancy

Postpartum Family Planning Counseling

Best Practices in Family Planning- WHO Medical Eligibility Criteria

Lactational Amenorrhea Method (LAM)

Barrier Methods: Male Condoms

Oral Contraceptives (Combined Oral Contraceptives and Progestin-Only Pills)

Emergency Contraception

Injectable Contraceptives

Intrauterine Contraceptive Devices (IUCDs)

Voluntary Surgical Contraception (Tubal Ligation Procedure and Vasectomy Procedure)

Essential Infection Prevention Practices

Contraception for Postpartum Period

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Post partum Family Planning Contraceptive Technology Update

Objectives

By the end of this session, participants will be able to discuss:

- The importance of postpartum family planning and HTSP
- Importance of LAM in Postpartum Period
- The benefits, limitations and counseling considerations for using:
  - Progestin-only pills
  - Progestin-only injectables
  - Combined oral contraceptives (COCs)
  - Emergency contraception (EC)

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Objectives (*cont.*)

- The benefits, limitations, and counseling considerations for using
  - Intrauterine contraceptive devices (IUCDs)
  - Condoms
  - Female sterilization
  - Vasectomy
- Effective counseling

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Post partum Contraception

A
Better
Choice for mothers

What is Postpartum Family Planning?

PPFP is a subset of FP for the prevention of unintended pregnancies through the first year postpartum.

- **Post-Placental** within 10 minutes of placental delivery
- **Immediate Post Partum** within 48hrs after delivery (e.g. voluntary sterilization)
- **Early Post Partum** 48 hrs- 6weeks
- **Extended Post Partum** 6 weeks to 1 year

Rationale for including postpartum family planning in MNCH and FP Programs

- To achieve healthy maternal ,perinatal, newborn, infant and child health outcomes, including reduction of maternal and neonatal mortality
- To address the unmet need for FP among Postpartum women

Unmet need : Fertility Preferences of Post Partum Women

According to PDHS :

- 34% of births occur within short birth interval of less than 24 months
- 34% occur within 24-35 months
- Only 22% use any FP method
- 12% desire another birth within 2 years

Barriers to PPFP Services

Lack of Information

- Lack of awareness of health benefits of spacing
- Shifts in traditions that protected from pregnancy- Post partum abstinence
- Lack of knowledge about fertility return

Misconceptions

- Misconceptions about BF as a method of FP
- Misconceptions about FP for Breastfeeding women

Social Support

- Spousal Permission
- Co-wife competition
- Lack of support from Mother In Law

Barriers to PPFP Services

Access to Services

- Low mobility particularly for low parity women-40 days period after birth
- Non availability of support influence access
- Referrals

Supportive Environment

- Religious beliefs

Risk of Pregnancy May Return Soon after Birth

- For the non-breastfeeding mother:
  - The mean average for first ovulation is 45 days after delivery
  - Return to fertility occurs prior to the return of menses in two out of three women.
- Once menses return, a woman is at as high risk for pregnancy as before conception.

Key Content for PPFP messages

- Healthy spacing of pregnancies
- Mother's risk for unintended pregnancy after a birth and abortion
- LAM and the transition
- Methods for Breastfeeding mothers
- Discussing and choosing a family planning methods within the first month postpartum(couples communication)
- Importance of PPFP services-Referral

HEALTHY TIMING AND SPACING OF PREGNANCY (HTSP)

What Is HTSP?

Healthy Timing Spacing of Pregnancy

Delaying pregnancy until age 18

Healthy pregnancy spacing (after live birth/miscarriage/induced abortion)

Interventions to help women and families:

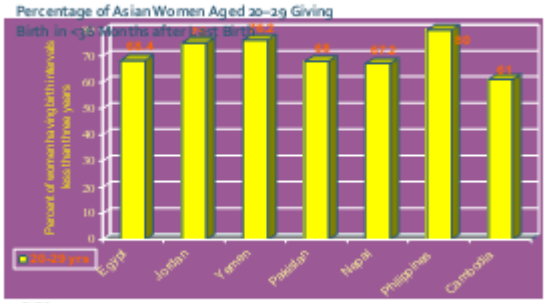
- Make informed decisions about delay/spacing
- Achieve healthiest maternal/newborn outcomes

DEMAND FOR HTSP

- Large generation of adolescents
- Main FP demand for <29 age group is for spacing methods
- High percentages of births occur after too-short intervals
- Even higher percentages of young women with short birth intervals also desire longer birth intervals
- Only 3–5% of postpartum women want another child within 2 years
- Significant service delivery gaps

Ross and Winfrey 2001; Jansen, 2004; Rutstein, 2005

Birth Interval: Selected Asian Countries



Source: DHS Surveys.

Perinatal Outcomes

Birth to pregnancy (BTP) interval of <18 months is associated with increased risk of:

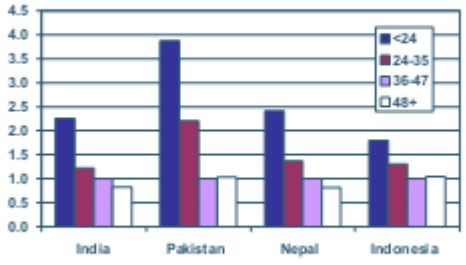
- Maternal mortality
- Induced abortion
- Miscarriage
- Pre-term birth
- Small size for gestational age
- Low birth weight

Perinatal Outcomes *(cont'd)*

- BTP interval of >59 months is associated with increased risk of:
  - Pre-eclampsia
  - Abortion/miscarriage
- Pregnancy interval of <6 months is associated with increased risk of:
  - Premature rupture of membranes, maternal anemia
  - Pre-term birth, low birth weight, small for gestational age

Source: Conde-Agudelo, A. et al. "Effect of the interpregnancy interval after an abortion on maternal and perinatal health in Latin America," International Journal of Gynecology and Obstetrics, Vol. 89, Supplement No. 1, April 2005.

Birth Intervals Associated with Lower Mortality Risk for Infants (Asian Countries)



Birth Interval Recommendations

- Recommendation for spacing after a live birth:
  - Recommended minimum interval before attempting the next pregnancy is at least 24 months in order to reduce the risk of adverse maternal, perinatal and infant outcomes.
- Recommendation for spacing after miscarriage or induced abortion:
  - Recommended minimum interval to next pregnancy should be at least 6 months in order to reduce risks of adverse maternal and perinatal outcomes
  - First Pregnancy should not be before the age of 18 years as it results in maternal and neonatal complications

Source: World Health Organization, 2006 *Report of a WHO Technical Consultation on Birth Spacing*

Postpartum Family Planning Counseling

IT IS IMPORTANT TO AID, NOT PERSUADE, THE CLIENT IN CHOOSING A CONTRACEPTIVE

Counseling: Pregnancy Risk

When a woman can become pregnant after delivery depends on:

- Breastfeeding practices
- Return of menses
- Return to sexual activity

Counseling: Return to Fertility for Breastfeeding Women

- Period of infertility longer with only/exclusive breastfeeding:
  - **Likelihood of menses and ovulation is low during first six months**
  - **After six months, even if her period has not returned, she is at risk of pregnancy**
  - **Women can ovulate before menses if she is on longer only breastfeeding or the baby is more than six months old**

Counseling: Return of Fertility

- Every pregnancy is different. A woman cannot predict fertility from previous pregnancies.
- No woman has a specific "set point" for return of fertility:
  - Return of fertility is unpredictable. If she doesn't want to get pregnant, she needs contraception.

Counseling: Return of Fertility (*cont.*)

- Counsel women using LAM about return of fertility and risk of pregnancy
- Counsel women about return of fertility and risk of pregnancy during antenatal, postpartum, newborn and child care visits—or at any contact
- Inform colleagues—many healthcare workers are unaware of risk of pregnancy during the postpartum

Counseling: Women Who Want to Limit Pregnancies

- Some couples do not want to become pregnant now or in the future.
- For them, there are long-term contraceptive options (male or female sterilization, IUDs and Implants)
- While they are deciding or in process of reaching long-term contraception services, she should use a short-term method to prevent pregnancy until she can get the long-term method.

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Role Play

Let's go through the counseling checklist and follow the guidelines

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Best Practices in Family Planning

Medical Eligibility Criteria for Contraceptive Methods

Medical Eligibility Criteria

- Covers 17 contraceptive methods, 120 medical conditions
- Addresses *who* can use contraceptive method based on medical methods
- Gives guidance to providers for clients with medical problems or other special conditions

Purpose of the Medical Eligibility Criteria (MEC)

- To guide family planning practices based on the best available evidence
- To address and change misconceptions about who can and cannot safely use contraceptive methods
- To reduce medical policy and practice barriers (i.e., not supported by evidence)
- To improve quality, access, and use of family planning services

What Is Answered by MEC?

Identifies which contraceptive or FP method can be safely used in the presence of a given individual characteristic or medical condition

Identification of Conditions

- CONDITIONS represent either:
  - An individuales characteristics (e.g., age, parity)
  - Known pre-existing medical conditions (e.g., hypertension)
  - Use of medications

WHO Medical Eligibility Criteria Classification Categories

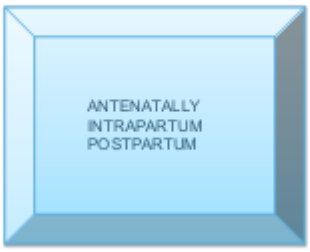
Classification	With clinical judgment	With limited clinical judgment
1	Use method in any circumstances	Yes Use the method
2	Generally use: advantages outweigh risks	Yes Use the method
3	Generally do not use: risks outweigh advantages	No Do not use the method
4	Method not to be used	No Do not use the method

Exercise – Let's Find Out !

- Case 1 – 26 years old, 2 children, smokes about 1 cigarette pack per day and wants to use combined oral contraceptives.
- Case 2 – 36 years old, 1 child and on Depo provera, found hypertensive at 150/90 mm Hg, and wants to continue to use Depo Provera.
- Case 3 – 30 years old, 7 days post elective early abortion and wants a copper T 380 A IUCD
- Case 4 – 20 years old, delivered a baby 3 weeks ago and wants to start POP

REVITALIZING THE LACTATIONAL AMENORRHOEA METHOD

When the LAM can be offered?

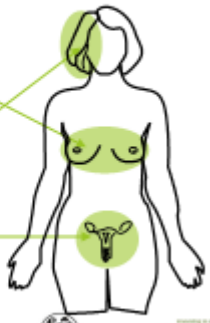


LAM requires 3 conditions

- Exclusive Breastfeeding on demand
- The mother's monthly bleeding has not returned
- The baby is less than 6 months old

LAM: Mechanisms of Action

- Frequent intense suckling disrupts secretion of gonadotrophin-releasing hormone (GnRH)
- Irregular secretion of GnRH interferes with release of follicle-stimulating hormone (FSH) and leutinizing hormone (LH)
- Decreased FSH and LH disrupts follicular development in the ovary to suppress ovulation



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Contraceptive Benefits of LAM

- Effective (1–2 pregnancies per 100 women during first 6 months of use)
- Effective immediately
- Does not interfere with sexual intercourse
- No systemic side effects
- No medical supervision necessary
- No supplies required
- No cost involved

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Non-Contraceptive Benefits of LAM

- For the child:
  - Passive immunization and protection from infections
  - Best source of nutrition
  - Decreased exposure to contaminants in water, in other milk or formulas, or on utensils
- For the mother:
  - Decreased postpartum bleeding

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Limitations of LAM

- User dependent
- May be difficult to practice because of social circumstances
- Highly effective only until menses return or up to 6 months
- Does not protect against STIs

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"Transition" in Relationship to LAM

- Move from the use of LAM to the use of another modern method of contraception
- Can occur at any time:
  - When any one of the three criteria is no longer met
  - When the woman/couple chooses to use another method

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Importance of Transition—Need Contraception for at Least Two years

- The maximum length of time that LAM may offer protection from pregnancy is six months.
- For best maternal and newborn health outcomes, a couple needs to wait at least two years after a birth before attempting to become pregnant again.

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Importance of Transition: Maternal Mortality—FP Saves Lives

"Promotion of family planning in countries with high birth rates has the potential to . . . avert 32% of maternal mortality."

- 90% of abortion-related mortality and morbidity
- 20% of obstetric-related mortality and morbidity

Source: Cleland et al. 2006.

Importance of Transition: Child Mortality—FP Saves Lives

Conservatively, "2 million of the 11 million deaths in children <5 could be averted by elimination of inter-birth intervals of less than 3 years. Effective use of postpartum family planning is the most obvious way in which progress should be achieved."

Source: Cleland et al. 2006.

Initiation of Post-LAM Contraception

- You do NOT need to wait for the woman to have her menses in order to initiate another modern method of contraception
- You can initiate a modern contraceptive method at ANY TIME you are reasonably sure that a woman is not pregnant
- If a woman has been using LAM, you can be reasonably sure she is NOT pregnant

When can various methods be introduced to the mother who is "transitioning" from LAM?

Time for an EXERCISE…

Postpartum Contraceptive Options

In your experience, what factors may be barriers to prevent a woman from transitioning to another method of contraception?

Time for a DISCUSSION…

What factors affect the choice of contraceptive methods?

Factors Affecting Method Choice

- Reproductive goals of woman or couple (spacing or limiting births)
- Personal factors including client preference, time, travel costs, discomfort associated with FP method
- Accessibility and availability of products that are necessary to use method
- Medical factors

What are progestin-only pills (POPs)?

Progestin-Only Pills (POPs): What Are They?

- Pills that contain a very low dose of a progestin like the natural hormone progesterone in a woman's body
- Does not contain estrogen
- Also called "mini-pills"
- Work primarily by:
  - Thickening the cervical mucus (this blocks sperm from meeting egg)
  - Disrupting the menstrual cycle, including preventing ovulation

Progestin-Only Pills: Key Benefits

- Safe for breastfeeding women—No effect on breastfeeding, milk production or infant growth and development after infant is six weeks old
- Adds to the contraceptive effect of breastfeeding—Together, if taken correctly, failure rate less than 1% during first year of use
- Does not interfere with sex

Progestin-Only Pills: Limitations

- Less effective for non-breastfeeding mother—If taken correctly, 3–10 women/100 will become pregnant first year
- Pill must be taken every day
- Bleeding changes (more frequent, irregular) are common but not harmful
- A few women may have headaches, dizziness or breast tenderness

Progestin-Only Pills: Key Counseling Considerations

- Discuss limitations (bleeding irregularities)
- Can be given to a woman at any time to start later
- Discuss tips to help woman remember to take pill every day—link to a daily activity, such as brushing teeth; take same time every day; etc.
- Provide back-up method (e.g., condoms) to use if/when pill is missed

Progestin-Only Injectables

- The injectable contraceptive DMPA (depot medroxyprogesterone acetate) contains a progestin similar to the progesterone naturally in a woman's body
- Does not contain estrogen
- Also known as "the shot" or the injection
- Given by injection into the muscle
- Works primarily by preventing the release of eggs from the ovary

What are some key benefits of injectables?

Progestin-Only Injectables: Key Benefits

- No effect on breastfeeding, milk production or infant growth and development; safe for use after infant is 6 weeks
- When women have injections on time, failure rate less than 1% during first year of use
- Does not require daily action
- Are private
- Do not interfere with sex

Progestin-Only Injectables: Key Benefits (*cont.*)

Helps protect against:

- Cancer of lining of uterus (endometrial cancer)
- Uterine fibroids
- Iron-deficiency anemia

Progestin-Only Injectables: Limitations

- Bleeding irregularities for first two to three months (usually no bleeding at one year)
- Some women may have weight gain, headaches, dizziness, mood changes
- Should wait until six weeks to give first injection to the breastfeeding woman (who is not using LAM)

Progestin-Only Injectables: Counseling Considerations

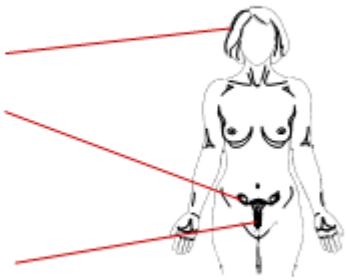
- Discuss limitations (side effects)
- If the client is less than 4 weeks late for repeat injection of DMPA or less than 2 weeks late for a repeat injection of NET-EN, she can receive her next injection.
- She should come back no matter how late she is for her next injection; if reasonably sure she is not pregnant, can give injection any time
- Assure her that she is welcome to return any time she has questions, concerns or problems

What are combined oral contraceptives?

COCs: What Are they?

- Pills that contain low doses of two hormones—a progestin and an estrogen
- Also called "the pill"
- Work primarily by:
  - Preventing the release of eggs from the ovary
  - Thickening cervical mucus so that sperm cannot penetrate

COCs: Mechanisms of Action



You are counseling a woman who is transitioning from LAM to COCs. What will you tell her are the benefits of COCs?

COCs: Key Benefits

- Highly effective when taken daily (failure rate 0.1–0.5 % during first year of use)
- Controlled, and can be stopped, by the woman
- Does not interfere with sex
- Pelvic examination or routine labs for hormonal levels not required to initiate use
- Helps protect against cancer of the uterine lining, cancer of the ovary, symptomatic pelvic inflammatory disease (PID) and anemia

COCs: Limitations

- User-dependent (require continued motivation and daily use); forgetfulness increases method failure
- Some nausea, dizziness, breast tenderness, headaches, spotting or depression may occur (but usually stop after three to four months of use)
- Effectiveness may be lowered when certain drugs are taken
- Re-supply must be readily and easily available
- Do not protect against STIs (e.g., HBV, HIV/AIDS)

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COCs: Who Should Not Use (WHO Category 4)

COCs should not be used if a woman:

- Has migraine headaches with aura
- Has BP 160/100 (140–159/90–99 is Category 3)
- Is breastfeeding (less than six weeks postpartum)
- Is jaundiced (symptomatic viral hepatitis or cirrhosis)
- Has ischemic heart disease or stroke
- Has complicated valvular disease
- Has blood clotting disorders (deep vein thrombophlebitis or pulmonary embolus)

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COCs: Who Should Not Use (WHO Category 4) (*cont.*)

COCs should not be used if a woman:

- Has breast cancer
- Is 35 years old or older and smokes 15 cigarettes/day
- Has diabetes (>20 years duration)
- Has breast cancer
- Has liver tumors
- Has to undergo major surgery with prolonged bed rest

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COCs: Conditions Requiring Precautions (WHO Category 3)

COCs are not recommended unless other methods are not available or acceptable if a woman:

- Is more than six weeks but less than six months postpartum and is primarily breastfeeding
- Is less than three weeks postpartum if not breastfeeding
- Has high blood pressure (140–149/90–99)
- Has a history of breast cancer and no evidence of current disease in last five years

Source: WHO 2004.

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COCs: Conditions Requiring Precautions (WHO Category 3) (*cont.*)

COCs are not recommended unless other methods are not available or acceptable if a woman:

- Develops migraines without aura while on COCs
- Has current gall bladder disease
- Is taking drugs for epilepsy (phenytoin or barbiturates) or tuberculosis (rifampin)

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COCs: Conditions for Which There Are No Restrictions (Category 1)

- Age
- Diabetes (uncomplicated or less than 20 years duration)
- Endometriosis
- Genital tract cancers (cervical, endometrial or ovarian)
- Pregnancy-related benign jaundice (cholestasis)

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COCs: Counseling Considerations

- Discuss limitations (side effects)
- Can start three weeks after delivery if not breastfeeding; six months after delivery if breastfeeding
- Can start even if menses has not started, as long as you are reasonably sure she is not pregnant, but will need to use condoms or abstain for the first week of use

COCs: Counseling on What to Do for Missed Pills (*cont.*)

- Take a missed hormonal/active pill as soon as possible
- Keep taking pills as usual, even if this means she will take 2 pills on same day
- If missed 1 or 2 pills:
  - Take pill as soon as possible
- If missed 3 or more pills in Week 1 or 2:
  - Take pill as soon as possible and use back-up method for seven days
  - Use EC in case of unprotected contact

COCs: Counseling on What to Do for Missed Pills (*cont.*)

- If missed 3 or more pills in Week 3:
  - Take a hormonal pill as soon as possible
  - Finish all hormonal pills in pack and throw away all non-hormonal pills
  - Start a new pack the next day
  - Use a back-up method for seven days
  - If she had sex in the past 5 days, can consider ECPs
- If missed non-hormonal pills discard the missed non-hormonal pills and continue COCs, one a day

COCs: Counseling on Danger Signs

- Return immediately to healthcare provider or clinic if you develop any of the following problems:
  - Severe chest pain or shortness of breath
  - Severe headaches or blurred vision
  - Severe leg pain
  - Absence of any bleeding or spotting during pill-free week (21-day pack) or while taking seven inactive pills (28-day pack)—may be a sign of pregnancy

Emergency Contraception (EC)

Questions for Small Group Activity:

- What is "emergency contraception"?
- What EC's key benefits?
- What are EC's limitations?

Emergency Contraception (EC): What Is It?

- Methods that *prevent* pregnancy after unprotected sexual intercourse has occurred
- Regular contraceptive pills (COCs or POPs) used in a special way.
  - Used in higher dosages
  - Used as soon as possible after unprotected sex (within 120 hours or five days)

NOTE: Emergency contraception does not stop a pregnancy that has started!

Effectiveness

- Progestin-only OCs
  - →If all 100 women used Progestin only ECPs, one would likely become pregnant (1/100 will get pregnant)
- Combined OCs: ethinyl estradiol (EE) and levonorgestrel (LGN)
  - → If all 100 women used Progestin only ECPs, two would likely become pregnant (2/100 will get pregnant)

Types of EC Pills (ECPs)

ECP Type	Dosage
Levonorgestel dedicated product	Singe dose of 1.5 mg of LNG
Estrogen-progestin dedicated product	Ethinyl estradiol (EE) 0.1 mg + LNG 0.5 mg 1 dose and repeated after 12 hours
Progestin only	Single dose of 1.5 mg LNG or 3.0 mg of Norgestrel
COC	EE 0.1 mg+ LNG 0.5 mg (1 dose and repeat after 12 hours) EE 0.1 mg + Norgestrel 1.0 (1 dose and repeat after 12 hours) EE 0.1 mg + Norethindrone 2.0 (1 dose and repeat after 12 hours)

When to START regular contraception after using an emergency contraception?

- COCs – Provide a pack and instruct to start the next day*
- DMPA - Can be given on the same day as ECP is used*
- IUDs - can be used as emergency contraception * and kept up to 12 years as long as contraception is needed

*Family Planning A Global Handbook for Providers 2011

EC: Key Benefits

- Again, EC is the only method that prevents pregnancy after unprotected sex.
- EC could avert:
  - Millions of unintended pregnancies and abortions
  - At least 20 million unsafe abortions and the deaths of 80,000 women
- Woman can have EC on hand in case of emergency.

EC: Key Benefits (*cont.*)

- COCs and POPs are most effective if used as soon as possible after unprotected sex and up to 120 hours (five days)
- Progestin-only regimen safe for breastfeeding woman, but breastfeeding should be delayed (8–24 hours) after EC

(Source: Gainer et al. 2007)

EC: Limitations

A woman using EC may experience the following side effects, none of which indicate illness:

- Nausea and vomiting
  - Less common with POPs
  - May take anti-nausea medicine
- Changes in bleeding pattern
- Abdominal pain, fatigue, headaches, dizziness or nausea in the week after taking the EC pills

EC: Counseling Considerations

- Be sure that client does not want to be pregnant
- Take as soon as possible after unprotected intercourse
- Explain:
  - Correct use—more effective when taken sooner
  - EC is not suitable for regular use because not as effective as other routine methods
  - Nausea and vomiting are common with COCs; significantly less common with POPs
  - EC pills will not cause menses to come immediately
  - EC pills do not provide protection against STIs (e.g., HIV/AIDS, HPV)

EC can be used multiple times in the same month

- For women who have unprotected sex several times during the month
  - Taking emergency contraception several times is not dangerous
  - May cause break-through bleeding and irregular menses
  - Using emergency contraception is not as effective as using modern contraception continuously
    - For a woman who is sexually active, encourage her to initiate modern contraception.

What is an intrauterine contraceptive device (IUCD)?

The IUCD: What Is It?

- The IUCD is a small T-shaped plastic device with fine copper wire wrapped around it; it is inserted into the uterus through the vagina.
- Most IUCDs have one or two strings tied to them that hang through the cervix.
- IUCDs work primarily by causing a chemical change that damages the sperm and egg before they can meet.

Postpartum Insertion of IUCDs (PP-IUCD)

- IUCDs can be inserted:
  - Immediately after delivery of the placenta
  - During cesarean section
  - Within 48 hours of childbirth
- If not inserted within 48 hours of delivery, insertions should be delayed for at least four weeks

NOTE: An IUCD can be inserted immediately after first-trimester abortion.

Risk of Expulsion and Timing of Insertion Postpartum

IUD Expulsion Rates by Timing of Insertion

Time Of IUD Insertion	Definition	Expulsion Rate	Observations
Postplacental	Within 10 minutes after delivery of placenta	9.5–12.5%	Ideal; low expulsion rates
Immediate Postpartum	After 10 minutes to 48 hours post delivery	10-15%	Still safe
Late Postpartum	After 48 hours to 4 weeks post delivery	NOT RECOMMENDED	Increased risk of perforation and expulsion
Interval-Extended Postpartum	After 4 weeks post delivery	3–13%	Safe

Time for a debate…

Participants will be divided into two groups to hold a debate.

- One side will argue for benefits of using an IUCD
- Other side will argue for limitations and reasons not to use an IUCD

IUCDs: Key Benefits

- Highly effective (failure rate <1% in first year of use)
- Very safe (WHO Category 1) from 4th week postpartum
- Effective immediately
- Long-term method (up to 12 years with Copper T 380A)
- Immediate return to fertility upon removal

IUCDs: Key Benefits (*cont.*)

- Do not affect quantity or quality of breast milk; can be used by postpartum women whether or not they are breastfeeding
- Few side effects
- Do not interfere with intercourse

IUCDs: Limitations

- Requires a trained healthcare provider to insert
- Some users report:
  - Changes in bleeding patterns, especially during first three months of use
  - More cramping and pain during monthly menses

NOTE: None of these side effects indicate illness.

- Counseling clients and obtaining informed consent should be done during ANC

PP-IUCDs: Who Should Not Use (WHO Category 4)

Woman with the following should not use the IUD:

- Current puerperal sepsis/endometritis/pelvic inflammatory disease (PID)
- Membranes ruptured >18 hours before delivery (for immediate PP insertion)
- Unexplained vaginal bleeding, which may indicate serious condition
- Cervical or endometrial cancer

PP-IUCDs: Conditions Requiring Precautions (WHO Category 3)

- Insertion from 48 hrs to less than four weeks postpartum
- Woman with AIDS who are not clinically well

PP-IUCDs: Method May Not Be Best Choice if Other Methods Available (WHO Category 2)

- HIV infected but clinically well
- High risk of HIV or STIs
- Vaginitis (trichomoniasis or bacterial vaginosis)
- Anatomic abnormalities of uterus
- Endometriosis
- Complicated valvular heart disease (use prophylactic antibiotic if insertion)
- Less than 20 years of age

IUCDs: Counseling Considerations

- Discuss limitations (note that cramping occurs during involution even without IUD insertion)
- Explain procedure prior to insertion
- Talk with client during the procedure to tell her what is happening and reassure her
- Advise return after three to six weeks or any time she has questions or concerns

What are some benefits of male condoms?

Male Condoms: Benefits

- When used consistently and correctly, male condoms are highly effective against pregnancy (97%) and STIs/HIV
- Can be used soon after childbirth (as soon as intercourse is resumed)
- Protects against STIs/HIV AIDS

Male Condoms: Limitations

- Moderately effective (three to 14 pregnancies per 100 women during the first year) with typical use; with perfect use, 97% effective
- Effectiveness as contraceptives depends on willingness to follow instructions
- User-dependent (require continued motivation and consistent use with each act of intercourse)
- May reduce sensitivity of penis, making maintenance of erection more difficult

Male Condoms: Counseling Considerations

- Explain limitations and discuss need to use for every act of intercourse
- Ensure that client knows how to correctly use condoms, demonstrating on model, banana or cucumber as needed
- Ask client how many condoms are needed—provide plenty of condoms, as well as information on where more can be purchased
- Discuss skills and techniques for negotiating condom use with partner

What is postpartum female sterilization and when can it be done?

Postpartum (PP) Female Sterilization

- Permanent contraception for women who want no more children
- Performed by minilaparotomy, which involves small incision in abdomen
- Works because fallopian tubes are blocked or cut so egg cannot move down tube and reach sperm

PP Female Sterilization (*cont.*)

- Ideally done within 48 hours after delivery
- May be performed immediately following delivery or during cesarean section
- If not performed within one week of delivery, delay for six weeks
- Follow local protocols for counseling clients and obtaining informed consent in advance
  - Must be done during antenatal care for immediate PP sterilization

PP Female Sterilization: Key Benefits

- Highly effective (99.5%); comparable to vasectomy, implants, IUDs
- No long-term side effects
- No need to worry about contraception again
- Is easy to use; nothing to remember or do

PP Female Sterilization: Limitations

- Involves a physical examination and surgery
- Cannot be reversed or stopped if couple changes their mind about wanting another pregnancy
- Rare complications of surgery, such as wound infection or anesthesia complication

Female Sterilization: Who Should Not Use (WHO Category 4)

While contraindications are rare, surgery should be delayed for:

- Women with symptomatic systemic infection (AIDS*, malaria, etc.)
- Women who are more than one week and less than six weeks postpartum

*Minilap may be performed on women with AIDS if in a specialized facility

What is a "vasectomy"?

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Vasectomy (Male Sterilization): What Is It?

- Permanent contraception for men who want no more children
- A safe, convenient, highly effective and simple contraceptive procedure for men that is provided under local anesthesia in an out-patient setting
- Surgery through a small incision in the scrotum that closes off the vas deferens, keeping sperm out of semen

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Vasectomy: Key Benefits

- No serious side effects
- Vasectomy is safer, simpler, less expensive and equally effective as female sterilization (tubal ligation)
- Can be timed to coincide with the breastfeeding woman's postpartum period when fertility is reduced
- Does not affect male sexual performance

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Vasectomy: Key Benefits (*cont.*)

- After first 3 months, highly effective in preventing pregnancy (99.6 to 99.8% effective)
- Is safe, permanent and convenient
- Allows man to take responsibility for contraception
- Increases enjoyment and frequency of sex

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Vasectomy: Limitations

- Is not effective for three months after procedure
  - Need backup method—LAM may be appropriate
- Cannot be reversed if man changes his mind
- Rarely man may have
  - Severe scrotal or testicular pain
  - Infection at the incision site
  - Bleeding under the skin
  - Vans deferens grow back together after some time

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Contraception during Special Periods

Teenagers
Post-Pregnancy and Miscarriage
Women over 35

Contraceptive Options for Teens and Young Women

METHOD	REMARKS
OCs	■ Precautions in young women are rare ■ Most popular among young women ■ Lifestyle may increase missed intake ■ Used for EC also
Implants	■ Side effects (spotting, acne and weight gain) are potential issues

Source: Pocketguide for FP Service Providers, 1996-1998;Global FP Handbook 2007

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Contraceptive Options for Teens and Young Women (cont'd)

METHOD	REMARKS
PICs	■ Side effects (spotting, acne and weight gain) are potential issues ■ Highly recommended for young woman requiring intermediate-duration contraception
IUDs	■ Not recommended for woman with increased risk of STIs
Condoms	■ Provide immediate protection ■ Protects against STIs

Source: Pocket guide for FP Service Providers, 1996-1998;Global FP Handbook 2007

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Additional Points to Tell Teens and Young Women

- Caution that OCs do not prevent STIs
- Discuss condom use: "How are you protecting yourself from AIDS?"
- Ask how he/she plans to discuss condom use with her partner
- Discuss EC

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Contraception for Women 35 Years and Older

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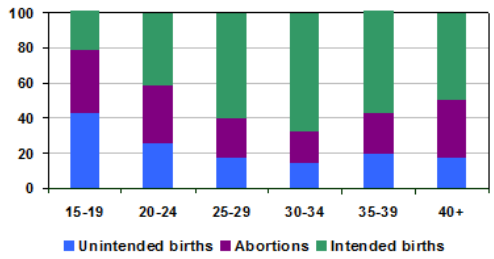
Do Women > 35 Still Need Contraception ?



*Does not include miscarriages.

Source: Lynch, C, Contraception for Women 35 and older, 2001

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Contraceptive Options for over 35 Women

METHOD	REMARKS
COCs and CICs	▪ Women over 35 who smoke > 15 cigarettes/day (Class 4) ▪ Low-dose COCs source of estrogen for perimenopause ▪ ECPs can be used
POCs (implants, PIC and POPs)	▪ POCs can be used in perimenopausal years (40s-50s) ▪ Safely used by older women who smokes (Class 1)
IUDs	▪ Safely used by older women if not at risk for STIs ▪ Possibly preferred method because it is long-term and effective
Condoms	▪ Best used by women with predictable intimacy acts ▪ Only method protecting against STIs
Surgical Contraception	▪ Appropriate for clients/couples who are certain about limiting pregnancies

Source: Pocket guide for FP Service Providers, 1996-1998;Global FP Handbook 2007

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Post-Pregnancy Contraception

Postpartum and Postabortion Periods

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Why Postpartum Contraception?

- Women in the first year postpartum have higher unmet need for FP than the general population of women.
- Demographic and Health Survey data show that very few women (3%-8%) want another child within two years after giving birth; 40% of women in the first year postpartum intend to use a FP method but are not doing so (MAQ*).

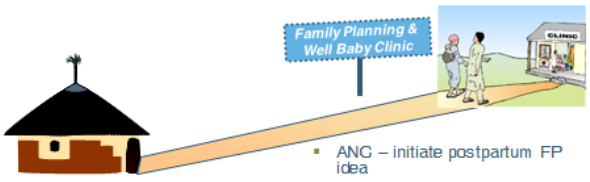
*Data from-Maximizing Access and Quality-Global Health Technical Briefs-USAID

Postpartum FP Goals

- Reduce unmet need for FP
- Improve contraceptive choice
- Promote optimum health through breastfeeding
- Counsel on return to fertility
- Promote health of mothers and their newborns through pregnancyspacing
- Integrate with maternal, newborn and infant services

Stephenson & MacDonald, "FP for Postpartum Women: Seizing a Missed Opportunity" 2005

FP Opportunities for Postpartum Woman



- ANC – initiate postpartum FP idea
- Discharge – counsel
  - Breastfeeding – LAM
  - Non-breastfeeding
    - 6-week postpartum visit
    - Immunization visits
    - Sick and well-child visits

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Need for Postabortion FP Services

- Unsafe abortion is a prime indicator of unmet need for FP
- Failure to provide FP is a major contributor to the problem of unsafe abortion
- Emergency treatment is not linked to FP counseling or services

Risk Factors for Repeat Unsafe Abortion

- Lack of understanding of patients' reproductive health needs (provider)
- Lack of FP services for some groups of women (e.g., adolescents, single women)
- Separation of emergency services from FP services
- Misinformation about which FP methods are appropriate postabortion (provider and patient)
- Lack of recognition of problem of unsafe abortion and patient FP needs (provider)

2007

Why Start Postabortion FP Immediately?

- Increased risk of repeat pregnancy because:
  - Ovulation may occur by day 11 postabortion
  - 75% of women will have ovulated within 6 weeks postabortion

Source: Lähteenmäki 1993; Lähteenmäki et al 1980.

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Postabortion Contraception

METHOD	WHEN TO START	REMARKS
Hormonal Contraception (COCs, DMPA)	Immediate	Effective immediately Can be used even if infection present
IUCDs: First trimester Second trimester	Immediate or delayed 4 to 6 weeks postabortion	No infection present Similar to postpartum
Tubal Ligation/ Vasectomy	Immediate Delayed	Clean procedure Allow infection/injury to resolve

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