وزارة الصحة
Ministry of Health

FAMILY PLANNING

National Guidelines for Health Care Providers

First Edition 2023

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Evidence-Based Guidance

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FOREWORD

It is a matter of great satisfaction for us to endorse the first edition of "Family Planning National Guidelines for Health Care Providers - 2023" which has been developed by Ministry of Health with the support of other stakeholders and partners.

Saudi Arabia recognizes family planning as a basic human right for individuals, families and communities and flash on its contribution to social and economic development. Therefore, this issue is considered as one of the top priorities of Kingdom's vision 2030, which aims toward creating a vibrant society in which all citizens can thrive and pursue their passions.

As part of Saudi Arabia's agenda and the global family planning goals, we are committed in ensuring access to high-quality family planning services at all levels of healthcare, particularly primary healthcare, in order to achieve universal health coverage.

We are encouraging the application of standard practices and enabling the healthcare providers to continue offering comprehensive care to clients who need family planning services. We stand by women and men at reproductive age to satisfy their needs for family planning, choose their contraceptive methods and receive effective counseling on the safe use of these methods.

In KSA, we are determined to achieve sustainable development goals 2030, and we believe scaling up and re-prioritizing resources for family planning is a key factor to achieve those goals.

H. E.

Minister of Health

Fahd Al-Jalajel

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The First Edition of “Family Planning National Guidelines for Health Care Providers -2023” was developed by adapting the World Health Organization (WHO) “Family Planning: A Global Handbook for Providers,” that was published in 2018 and 2022 by the Ministry of Health in collaboration with various health programs and related partners. These guidelines sure will certainly assist in the ongoing efforts to improve the standard of family planning services that provided by healthcare facilities to the target group.

The Ministry of Health (MoH) would like to express its sincere gratitude to the members of the technical working group and peer-reviewed group for their crucial contributions during the development and review process of the guidelines. The names of the members in each group are mentioned on the following page.

The Directorate of Health Programs and Chronic Diseases provided outstanding technical leadership and coordination throughout the consultation process and the official submission of this guidance, for which the Ministry of Health is highly appreciative. Furthermore, the World Health Organization, Saudi Health Council, Public Health Authority, Ministry of Economy and Planning, and Family Affair Council are particularly appreciated by MoH for their excellent contributions towards the development of these guidelines.

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What Are These Guidelines?

The guidelines offer up-to-date information on clinical practice and serves as guidance on the operational concepts, protocols, instructions, administration norms and management that govern family planning services as well as the standards of achievement and expectations for services provision in Saudi Arabia.

Objective of the Guidelines

The aims of these guidelines are to increase access to family planning services and their quality by equipping healthcare providers with recent information that will enable them to implement and deliver family planning programs efficiently and effectively.

Structure of the Guidelines

This document aims to give a general overview of family planning and its different methods. The principles, availability, and counseling of family planning are covered in the first section. The different types of family planning methods—oral contraceptive pills, injectables, intrauterine devices, patches, vaginal rings, barriers, natural contraception, and voluntary surgical sterilization techniques—are discussed in the subsequent chapters. These chapters presenting comprehensive information on every method, covering its benefits, disadvantages as well, standard operating procedure, restrictions, and how-to use each one appropriately, in addition to step-by-step instructions. Chapter twelfth addresses specific family planning issues for a variety of clients, including adolescents, men, women approaching menopause, and clients with disabilities. A thorough understanding of certain reproductive related topics as well as sexually transmitted infections and HIV are given in the final chapters.

Target Audience

The guidelines are intended to be used by all health service providers offering family planning services at all levels of the health system. The guidelines ensure that implementers are informed and follow these rules and to deliver high-quality family planning services.

CONTENT

ABBREVIATIONS

ARV	Antiretroviral
CICs	Combined injectable contraceptives
COC	Combined oral contraceptives
DMPA	Depot medroxyprogesterone acetate
ECPs	Emergency contraceptive pills
FABs	Fertility awareness based
HIV	Human immunodeficiency virus
IM	Intramuscular
IUD	Intrauterine device
KSA	Kingdom of Saudi Arabia
LNG-IUD	Levonorgestrel intrauterine device
MoH	Ministry of Health
MPA	Medroxyprogesterone acetate
NET-EN	Norethisterone enanthate
NSAIDs	Non-steroidal anti-inflammatory drugs
PID	Pelvic inflammatory disease
POP	Progestin-only pill
SC	Subcutaneous
STIs	Sexually transmitted infections
UPA	Ulipristal acetate
UPA-EC	Ulipristal acetate-emergency contraceptive pills
VTE	Venous thromboembolism
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

Family Planning

What is Family Planning?

It is the ability of a couple to anticipate and attain the desired number of children, and the spacing and timing of their births. It is achieved through the use of contraceptive methods and the treatment of involuntary infertility.

Principles of Family Planning

Family planning services are guided by nine human rights principles. As health provider of family planning, you contribute to all of them. These include:

- **Principle 1: Non-discrimination**
  Should be provided without discrimination of any kind based on race, national or social origin, or other status such as disability, family status, health status, economic and social situation.

- **Principle 2: Availability of contraceptive information and services**
  Functioning health and health-care facilities, goods and services, as well as programs, have to be available in sufficient quantity.

- **Principle 3: Accessible information and services**
  Also required to ensure that health-care facilities, commodities and services are accessible to everyone. This includes physical and economic accessibility, as well as access to information.

- **Principle 4: Acceptable information and services**
  All provision of health-care facilities, commodities and services must be acceptable to those who are their intended beneficiaries. They must be provided in a manner respectful of medical ethics and of the culture of individuals and communities must be designed to respect confidentiality, and improve the health status of those concerned.

- **Principle 5: Quality**
  Health-care facilities, commodities and services be of good quality, including scientifically and medically appropriate. This requires, among other things, skilled medical personnel, scientifically approved and unexpired drugs and medical equipment.

- **Principle 6: Informed decision-making**
  It is giving each person the opportunity to make autonomous reproductive choice. The principle of autonomy, expressed through free, full and informed decision-making.

- **Principle 7: Privacy and confidentiality**
  When an individual accessing health information and services, they should not be subject to interference with their privacy.

- **Principle 8: Participation**
  Have an obligation to ensure active, informed participation of individuals in decision-making that affects them, including on matters related to their health.

- **Principle 9: Accountability**
  Effective accountability mechanisms are key to ensuring that the agency and choices of individuals are respected, protected and fulfilled, including when seeking and receiving health care.

Family Planning Methods

There are many classifications contraceptive methods: hormonal and non-hormonal, temporal and long-term, as well as modern and traditional contraceptive methods, which are considered to be the most frequently used category.

Type of Family Planning Methods

- **Modern contraceptive methods:**
  These include oral contraceptive pills, emergency contraception, injectables, intrauterine device (IUD), implants, male and female condoms, vaginal barrier methods (including the diaphragm, cervical cap and spermicidal) and other barrier methods such as (diaphragm, cervical cap, and spermicidal) as well as other hormonal methods like (patches, vaginal rings), in addition to voluntary surgical sterilization for both sexes.

- **Traditional contraceptive methods:**
  These include fertility awareness-based methods, withdrawal and other traditional methods.

Effectiveness of Family Planning Methods

For the majority of clients, the effectiveness of family planning methods is crucial and varies substantially. It might be more useful to compare the effectiveness of methods and talk about if the client feels competent to use the method well rather than discussing pregnancy rates, which can be difficult to understand. There are four groups of methods based on effectiveness (see annex 2).

- **Very effective** – In general, methods that require little or no action by clients are the most effective. The four most effective methods are implants, IUDs, female sterilization, and vasectomy.

- **Effective** – Methods when used correctly and consistently can be highly effective. They require some repeated action by the user, however—some seldom, such as getting 4 injections a year, and some often, such as taking a pill every day, 365 days a year. Pregnancy rates for these methods range from (2 to 7) pregnancies in (100) women in a year.

- **Moderately effective** – Commonly used. The pregnancy rates for these methods range from (10 to 19) pregnancies in (100) women in a year.

- **Less effective** – These methods usually have much higher pregnancy rates—as high as 20 or more pregnancies in (100) women in one year of use.

For a comparison of the effectiveness of family planning methods, (see annex 1).

Provision of Family Planning

Family planning provision might be summarized in the following steps:

Step One: Counsel the Client for Informed Choice

Counseling clients about family planning methods allows the client to make an informed choice of their preferred method according to their interest and goals. The service provider should give an overview of available methods and provide more detailed as needed on any specific method(s) the client may be interested in. During counseling sessions, the provider should follow the concepts of counseling for informed choice as instructed in these guidelines and use the information in the appropriate way.

Step Two: Screen Client for Medical Eligible Criteria for Contraceptive Method of Choice

The second step is to check for medical eligibility for the contraceptives after the client has chosen their preferred method. The screening procedure ensures that the client will use the selected method in a safe and efficient manner. The provider must adhere to the medical eligibility criteria for the relevant method in these guidelines that the client has chosen.

Step Three: Start Use of Method

The next step is to provide the method after the client has been assessed to ensure that can utilize the chosen method in a safe and appropriate way. Depending on the client's circumstances, method provision includes assessing when the client can begin using the method of choice, giving advice on side effects, explaining how to use the method, and supporting the user. The provider must follow the information and instructions as mentioned in respective method section relevant in order to give the client the preferred method of choice.

Step Four: Plan for Follow Up and Return Visit

The last step is to arrange for the next appointment and discuss the benefits of a return visit after the client has been provided the preferred method of choosing. Provider should provide precise information on when to return and the reasons for return as instructed in the respective method section.

Who Provide Family Planning Services?

Many different people can learn to inform and advise people about family planning and to provide family planning methods. When more types of health workers are authorized and trained to provide family planning methods, more people have access to them.
The types of health providers who can and do provide family planning include the following:

Type of Health Provider	Examples
Specialist doctor	Gynecologist, obstetrician
Specialist doctor	Family doctor, general practitioner
Midwife	Registered midwife, nurse-midwife
Nurse	Registered nurse , clinical nurse specialist
Pharmacist	Pharmacist, clinical pharmacist
Pharmacy worker	Pharmacy technician dispenser, pharmacist aide

Client Assessment for Family Planning Methods

All women at the reproductive age and married are eligible to access family planning services, as are men. Many actions should be taken to provide family planning methods;

Client Assessment

The process through which clients are assessed to:

- Ensure that the client is not pregnant (see job aid - Pregnancy checklist p.239).
- Assess whether the client has any conditions that prohibit the use of a particular method.
- Identify any special problems that require further assessment, treatment, or regular follow-up.

Steps in Client's Assessment

- **History taking -** This is an essential component in client assessment as it provides basic information about the client, which helps the service provider to discuss appropriate family planning options for the couple.
- **Physical, Medical, and Investigation Procedures -** When providing family planning methods, service providers should know the standard and recommended screening procedures, like physical and medical examinations, as well as laboratory tests (such as breast, pelvic, and genital examinations, cervical cancer screenings, hemoglobin tests, and blood pressure measurements), are not necessary unless clinically indicated for specific contraceptive methods. For example, pelvic exams are mandatory for the provision of intrauterine devices (IUDs) and tubal ligation (see annex 3).

Medical Conditions That Make Pregnancy Especially Risky

Some common medical conditions make pregnancy riskier to a woman's health. The effectiveness of her contraceptive method thus has special importance.

Reproductive Tract Infections and Disorders

- Breast cancer.
- Endometrial cancer.
- Ovarian cancer.
- Some sexually transmitted infections (gonorrhea, chlamydia).
- Some vaginal infections (bacterial vaginosis).
- Malignant gestational trophoblastic disease.

Cardiovascular Disease

- High blood pressure (systolic blood pressure higher than 160 mm Hg or diastolic blood pressure higher than 100 mm Hg) .
- Complicated valvular heart disease.
- Ischemic heart disease (heart disease due to narrowed arteries) Stroke.
- Thrombogenic mutations.

Other Infections

- HIV (see Chapter 14).
- Tuberculosis.
- Schistosomiasis with fibrosis of the liver.

Endocrine Conditions

- Diabetes if insulin dependent, with damage to arteries, kidneys, eyes, or nervous system (nephropathy, retinopathy, neuropathy), or of more than 20 years' duration.

Anemia

- Sickle cell disease.

Gastrointestinal Conditions

- Severe (decompensated) cirrhosis of the liver.
- Malignant (cancerous) liver tumors (hepatoma) and hepatocellular carcinoma of the liver.

Neurologic Conditions

- Epilepsy.

Rheumatic Conditions

- Systemic lupus erythematosus.

Medical Eligibility Criteria for Contraceptive Methods

All clients should be screened before initiating a method of choice to ensure that it is medically appropriate for safe and effective use. The tables below provide a summary of the World Health Organization's (2015) Fifth Edition Medical Eligibility Criteria for Contraceptive Use. The majority of the family planning methods chapters in this guidelines are based on the Medical Eligibility Criteria checklists.

Using Clinical Judgment in Special Cases

Usually, a woman with any serious conditions should not use family planning methods. In special circumstances, however, when other, more appropriate methods are not available or acceptable to her, a qualified provider who can carefully assess the specific woman's condition and situation may decide that she can use them. The provider needs to consider the severity of her condition and, for most conditions, whether she will have access to follow-up, according to WHO recommendations for serious conditions (annexes 4,5). Category 3 and 4 conditions are shaded to indicate that the method should not be provided where clinical judgment is limited.

WHO Categories for Temporary Contraceptive Methods

Categories	Description
1	A condition for which there is no restriction for the use of the contraceptive method, use the method.
2	A condition where the advantages of using the 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.
3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method. 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. Do not use the method.
4	A condition which presents an unacceptable health risk if the contraceptive method is used.

Family Planning Counseling

Counseling refers to a process of interactions, a two-way communication, between a skilled provider, and the client in which unbiased information is given to the client about all available methods so that she or he can make a free, well-informed decision. Counseling is one of the most important components of family planning. It is the responsibility of service providers at all levels to offer effective counseling on family planning methods in order to increase client satisfaction and ensure continuity in their method of choice.

Who Provides Counseling?

Providers of service who have received training in family planning counseling and who should be aware of the basic principles of counseling in order to provide a comprehensive counseling service regarding all available family planning methods.

General Tips for Successful Counseling

A good counsellor is trained to;

- Show every client respect, and help each client feel at ease.
- Encourage the client to explain needs, express concerns, ask questions but prefer not to ask question with just “yes” or “no” answered.
- Let the client’s wishes and needs guide the discussion.
- Talk with the client in a private place, where no one else can hear.
- Assure the client of confidentiality— that you will not tell others about your conversation or the client’s decisions.
- Listen carefully. Listening is as important as giving correct information.
- Give just key information and instructions. Use words the client knows.
- Respect and support the client’s informed decisions.
- Bring up side effects, if any, and take the client’s concerns seriously.
- Check that the client understands.
- Invite the client to come back any time for any reason.

Counseling has succeeded When:

- Clients feel they got the help they wanted.
- Clients know what to do and feel confident that they can do it.
- Clients feel respected and appreciated.
- Clients come back when they need to.
- And, most important, clients use their methods effectively and with satisfaction.

Types of Clients Seeking Counseling

- New clients with no method in mind or new clients with method in mind.
- Returning clients with no health problems (satisfied returning for follow-up) or returning clients with health problems.

Figure 1: New Clients Choosing Method

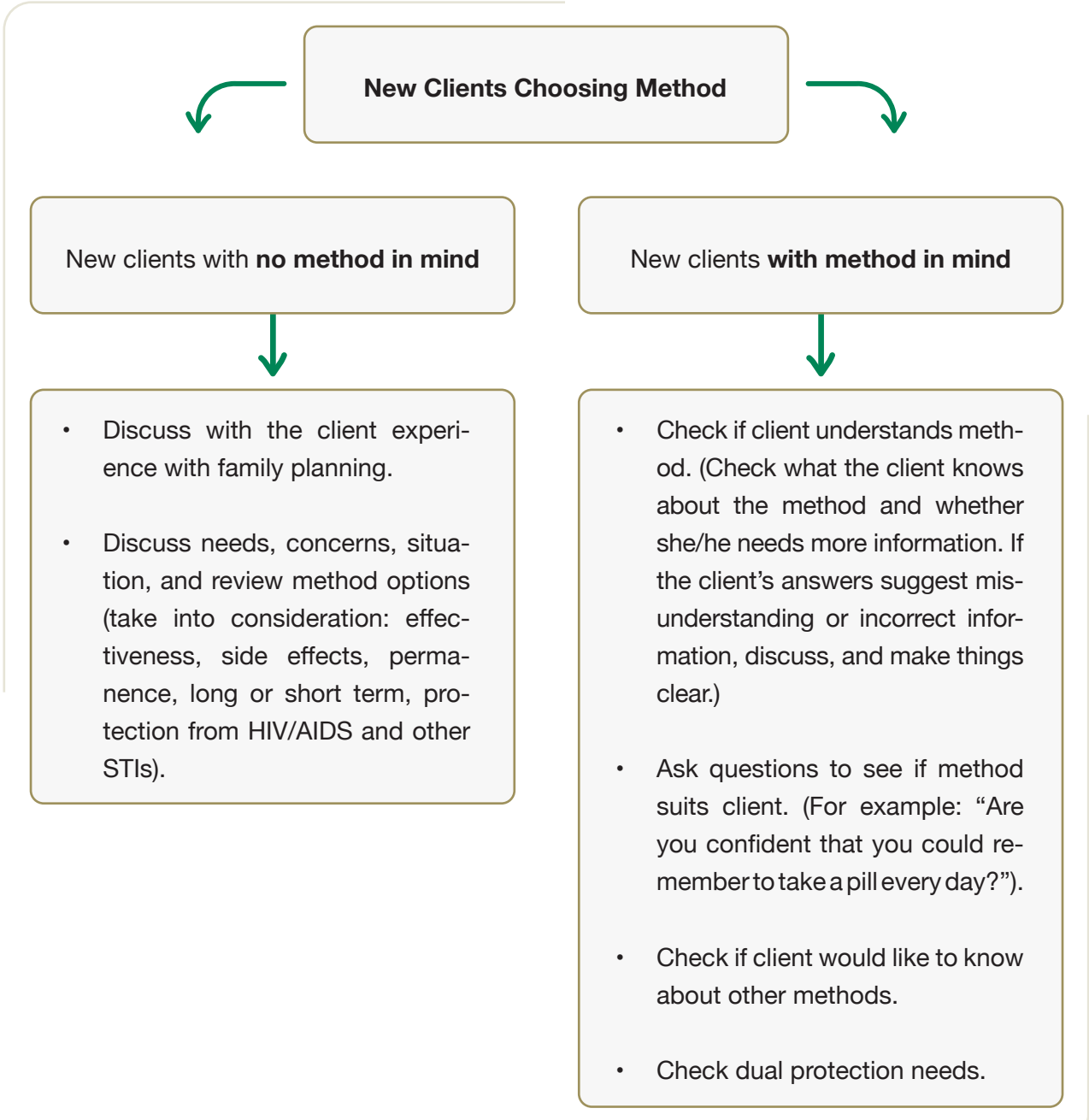
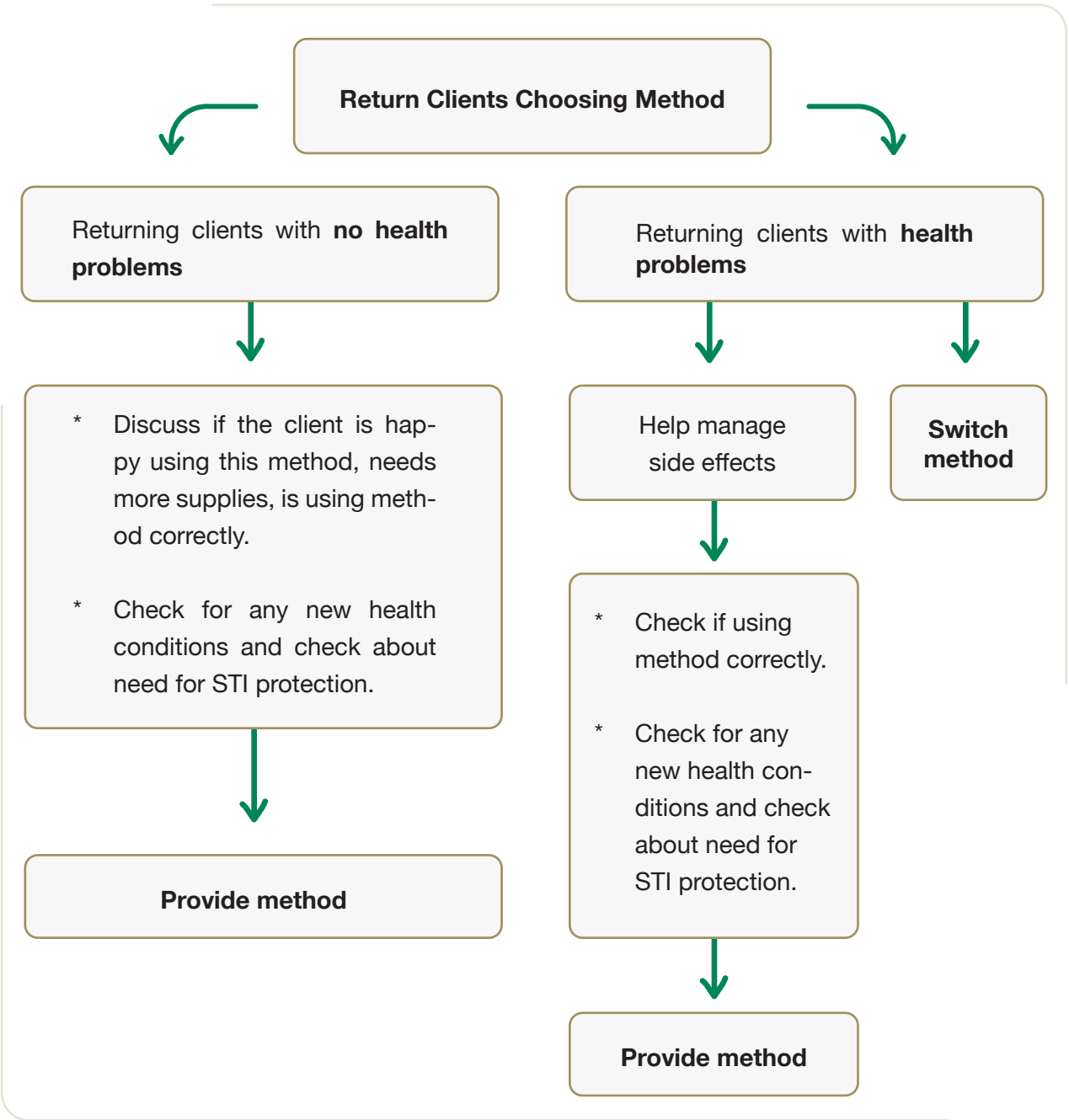


Figure 2: Return Client Choosing Method



Provision of Family Planning Services during an Epidemic

Access to an effective use of family planning services by clients is time-sensitive since improper or delayed contraceptive use significantly affects effectiveness.

During an epidemic, providers of family planning services should:

- Screen clients for symptoms of the epidemic disease and—if symptoms are present—manage or refer the client in accordance with local protocols.

- Protect their own and their client's safety during interactions by following rules of infection prevention appropriate to the type of epidemic, including sanitizing equipment and rooms using the correct protocols.

- Ensure that the client makes a voluntary and informed method choice, and that privacy and confidentiality are respected.

- Provide the full range of methods when resources and circumstances permit, but be open about what is not available, and when additional methods may become available. Offer the client a "bridging" method if their method of choice is not available.

- Provide multi-month supplies of contraceptives methods that the client used and multiple doses of emergency contraceptive pills (ECPs), as needed, to cover a longer duration of use.

- Discuss and counsel on IUDs (see job aid p.243) and implants (see job aid p.244) that may be effective beyond the labelled duration of use.

Safe Use of Contraceptive Methods in an Epidemic

To provide safe family planning care during an epidemic, providers should:

- The medical eligibility criteria (MEC) for contraceptive use do not change during an epidemic, use WHO's Medical Eligibility Criteria for Contraceptive Use (MEC) and the MEC wheel or app to evaluate the safety of contraceptive methods for each client (see Digital Health Tools p.16).

- Recognize health risks, including signs and symptoms of serious health conditions that may be more common during a protracted epidemic. If a client reports such signs or symptoms, refer them for care or manage the conditions.

- Reassess the safety of contraceptive methods for clients who develop serious health conditions. (see annex 7 – Signs and Symptoms of Serious Health Conditions).

SelfCare for Contraception

- Many contraceptive methods can be safely and effectively self-administered without a physical exam.

- Combined oral contraceptives (COCs), progestin only pills (POPs), emergency contraceptive pills (ECPs), spermicides, some diaphragms, male and female condoms, fertility awareness-based methods, and lactational amenorrhea are all methods that clients can self-administer.

- Clients can initiate and continue these methods with or without the support of a health worker.

In providing family planning services during an epidemic, providers should:

- Dispense DMPA-SC, COCs, POPs, ECPs, spermicides, flexible diaphragms, and male and female condoms in pharmacies or drug stores without a prescription, where allowed by national regulations.

- Distribute these methods in community outreach programs without a prescription, where allowed by national regulations.

Use of Digital Health Technologies

Digital health technology can assist health care providers in ensuring that patients have access to family planning even in an epidemic. Digital health technologies come in a wide variety of forms and applications, and they can be especially helpful during an epidemic when clinic-based services are limited.

Examples of some of the technologies used in a digital health framework to connect providers with clients include: SMS or text messaging, phone or video “visits”, mobile apps, and web-based tools such as email or open medical records (medical records that clients can directly review or access themselves).

With the exception of IUDs, implants, some diaphragms, and permanent methods (male and female sterilization), contraceptive methods do not require a physical exam prior to initiation.

In an epidemic, health care providers offering family planning services should:

- Use digital health technologies to connect with clients, counsel them, and prescribe methods that do not require physical examination.

- Leverage digital health technologies to share important information on the safety of contraceptive methods, and how to access services and self-administer selected methods.

Digital Health Tools

A. Contraceptive delivery tool for humanitarian settings

- To access and install the Android or Apple App, follow this link for information:

B. Medical eligibility criteria for contraceptive use app

- To access and install the Android or Apple App, follow this link for information:

CHAPTER 2

ORAL CONTRACEPTIVE PILLS

Combined Oral Contraceptives

Combined oral contraceptive pills (COCs) are composed of low doses of 2 synthetic hormones (progestin and an estrogen) that are similar to a woman's natural hormones progesterone and estrogen. They are safe, easy to use, controlled by the client, and do not interfere with sexual desire. For recommended COCs in KSA, (see annex 8).

Main Characteristics

- **Mechanism of action:**
  - Involves thickening of the cervical mucus which could prevent sperm transport, and inhibits ovulation (the release of egg from the ovaries).

- **Effectiveness:** *Depends on user:*
  - As high as 99.7% effective over the first year, if no pill taking mistakes are made.
  - As commonly used, it is about 93%.

- **Common side effects:**
  - Changes in bleeding patterns, including: Lighter and fewer days of bleeding, irregular bleeding, infrequent bleeding, and no monthly bleeding.
  - Systemic side effects: Headaches, dizziness, nausea, breast tenderness, weight changes, mood changes, acne (can worsen or improve acne, but usually improves), mild blood pressure elevation.

- **Protection against STIs:** Has no effect.

- **Fertility return:** Immediately after the cessation of COCs.

- **Known Health Benefits:**
  - Helps protect against: Risks of pregnancy, cancer of the lining of the uterus (endometrial cancer), cancer of the ovary, symptomatic pelvic inflammatory disease.
  - May help protect against: Ovarian cysts, Iron-deficiency anemia.
  - Reduces: Menstrual cramps, menstrual bleeding problems, ovulation pain, excess hair on face or body, symptoms of polycystic ovarian syndrome (irregular bleeding, acne, excess hair on face or body), symptoms of endometriosis (pelvic pain, irregular bleeding).

- **Known Health Risks:**
  - Very rare: Blood clot in deep veins of legs or lungs (deep vein thrombosis or pulmonary embolism).
  - Extremely rare: Stroke, and heart attack.

Medical Eligible Criteria for Combined Oral Contraceptives

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 COCs if she wants. If she answers **"yes"** to a question, follow the instructions. In some cases, she can still start COCs.

A Client's assessment for the use of Combined Oral Contraceptives based on WHO Medical Eligible Criteria

1. **Is the client 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. **Has she had a baby in the last 3 weeks and she is not breastfeeding?**
   No ( ) Yes ( )
   - Give her COCs now and tell her to start taking them 3 weeks after childbirth.
   - If there is an additional risk that she might develop DVT or VTE, then she should not start COCs at 3 weeks after childbirth, but start at 6 weeks instead. The additional risk factors include previous VTE, thrombophilia, cesarean delivery, blood transfusion at delivery, postpartum hemorrhage, pre-eclampsia, obesity (≥30 kg/m^2), smoking, and being bedridden for a prolonged time).

3. **Does she smoke cigarettes?**
   No ( ) Yes ( )
   - Do not provide COCs if she is 35 years of age or older and smokes or uses other types of tobacco. Urge her to stop smoking and help her choose another method, but not patch or ring if she smokes fewer than 15 cigarettes a day, and also not monthly injectables if more than 15 cigarettes a day.

(Continue to next page)

A Client's assessment for the use of Combined Oral Contraceptives based on WHO Medical Eligible Criteria

4. Does she have cirrhosis of the liver, a liver infection, or a liver tumor? Has she ever had jaundice when using COCs?

No ( ) Yes ( )

- Do not provide COCs if she reports one of the mentioned conditions, and help her to choose another method without hormones. (She can use monthly injectables if she has had jaundice only with past COC use.)

5. Does she have high blood pressure?

No ( ) Yes ( )

If not possible to check blood pressure:

- If 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 up if possible or help her choose a method without estrogen.

Check the blood pressure if possible:

- If her blood pressure is below 140/90 mm Hg, provide COCs. No need to retest before starting COCs.
- If blood pressure is 160/100 mm Hg or higher, do not provide COCs. Help her choose a method without estrogen, but not a progestin-only injectable.
- If blood pressure is 140–159/90–99 mm Hg, one measurement is not enough to diagnose high blood pressure. Give her a backup methods* (see p. 23) to use until she can return for another blood pressure measurement, or help her choose another method.

  - If her next blood pressure measurement is below 140/90 mm Hg, she can start COCs.
  - However, if her next blood pressure measurement is 140/90 mm Hg or higher, do not provide COCs. Help her choose a method without estrogen, but not a progestin-only injectable if systolic blood pressure is 160 or higher or diastolic pressure is 100 or higher.

(Continue to next page)

A Client's assessment for the use of Combined Oral Contraceptives based on WHO Medical Eligible Criteria

6. **Has she had diabetes for more than 20 years or has damage to her 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 injectable.

7. **Does she have gallbladder disease now or take medication for gallbladder disease?**

   No ( ) Yes ( )

   - Do not provide COCs. Help her choose another method but not the combined patch or combined vaginal ring.

8. **Has she ever had a stroke, blood clot in her leg or lungs, heart attack, or other serious heart problems?**

   No ( ) Yes ( )

   - If she reports heart attack, ischemic heart disease, 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 (not superficial clots) or lungs, help her choose a method without hormones.

9. **Does she have or has she ever had breast cancer?**

   No ( ) Yes ( )

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

10. **Does she sometimes see a bright area of lost vision in the eye before a very bad headache (migraine aura)? Does she get 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 made worse by light, noise, or moving about.**

    No ( ) Yes ( )

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

(Continue to next page)

A Client's assessment for the use of Combined Oral Contraceptives based on WHO Medical Eligible Criteria

11. Is she taking medications for seizures? Is she taking rifampicin or rifabutin for tuberculosis or another illness?

No ( ) Yes ( )

- If she is taking barbiturates, carbamazepine, lamotrigine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, or rifabutin, do not provide COCs. They can make COCs less effective. Help her choose another method but not progestin-only pills, patch, or combined ring.
- If she is taking lamotrigine, help her choose a method without estrogen.

12. Is she planning a major surgery that will keep her from walking for one week or more?

No ( ) Yes ( )

- If so, she can start COCs 2 weeks after she can move about again. Until she can start COCs, she should use a backup method.

13. Does she have several conditions that could increase her chances of heart disease (coronary artery disease) or strokes, such as older age, smoking, high blood, pressure, or diabetes?

No ( ) Yes ( )

- Do not provide COCs. Help her choose a method without estrogen but not progestin only injectables.

Note: Also, women should not use COCs if they report having thrombogenic mutations or lupus with positive (or unknown) antiphospholipid antibodies. For complete classifications, (see annex 4).

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

Providing Combined Oral Contraceptives

A. When to Start Using

A woman can start using COCs at any time, once she is certain she is not pregnant. To be reasonably certain, use the Pregnancy Checklist (see job aid p.239).

Client's Situation	When to Start
Having menstrual cycles or switching from a non-hormonal method	• *If she is starting Within the first 5 days after the start of her monthly bleeding,* no need for a backup method. • *If it is more than 5 days after the start of her monthly bleeding,* she can start COCs any time if she is not pregnant. She will need a backup methods* (see p. 26) for the first 7 days of taking pills or should advise her to avoid having sex. • If she is switching from an IUD, she can start COCs immediately, (see Chapter 5 - p.93-94).
Switching from a hormonal method	• Immediately, as long as she was using a hormonal method consistently and correctly before and she is not pregnant. *No need to wait for her next monthly bleeding*. No need for a backup method. • If she is switching from injectables, she can begin taking COCs when the repeat injection would have been given. No need for a backup method.
Fully or nearly fully breastfeeding	**Less than 6 months after giving birth** • 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. **More than 6 months after giving birth** • *If her monthly bleeding has not returned,* she can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills. • *If her monthly bleeding has returned,* she can start COCs as advised for women having menstrual cycles (see the first row of this table). *(Continue to next page)*

Client's Situation	When to Start
Partially breastfeeding	**Less than 6 weeks after giving birth** • Give her COCs and tell her to start taking them 6 weeks after giving birth. • *If her monthly bleeding returns before this time,* give her a backup method to use until 6 weeks since giving birth. **More than 6 weeks after giving birth** • *If her monthly bleeding has not returned,* she can start COCs any time if she is not pregnant. She will need a backup method for the first 7 days of taking pills. • *If her monthly bleeding has returned,* she can start COCs as advised for women having menstrual cycles.
Not breastfeeding	**Less than 4 weeks after giving birth** • *She can start COCs at any time on days 21-28 after giving birth. No need for backup method.* • *If there is an additional risk factor for VTE,* wait until 6 weeks after childbirth, and advise her to use another method until this time. **More than 4 weeks after giving birth** • *If her monthly bleeding has not returned,* and she is not pregnant, she can start COCs at any time, but advise her to avoid sex or use a backup method for the first 7 days of taking pills. • *If her monthly bleeding has returned,* she can start COCs as advised for women having a menstrual cycle.
No monthly bleeding (not related to childbirth or breastfeeding)	• Start COCs at any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills.
After miscarriage or abortion	• *Within 7 days* after first- or second trimester miscarriage or abortion, start COCs immediately. No need for a backup method.

(Continue to next page)

Client's Situation	When to Start
	• *More than 7 days* after first- or second-trimester miscarriage or abortion, start COCs at any time if it is reasonably certain that she is not pregnant, but advise her to avoid sex or use a backup method for the first 7 days of taking pills.
After taking emergency contraceptive pills (ECPs)	**After taking progestin-only or combined ECPs:** • She can start or restart COCs immediately after she takes the ECPs. *No need to wait for her next monthly bleeding.* - A continuing user who needed ECPs due to pill taking errors can continue where she left off with her current pack. • If she does not start immediately but returns for COCs, she can start at any time if it is reasonably certain she is not pregnant. • All women will need to use a backup method for the first 7 days of taking pill. **After taking ulipristal acetate (UPA) ECPs:** • She can start or restart COCs on the 6th day after taking UPA-ECPs. *No need to wait for her next monthly bleeding.* COCs and UPA interact. If COCs are started sooner, and thus both are present in the body, one or both may be less effective. • Give her a supply of pills and tell her to start them on the 6th day after taking the UPA-ECPs. • She will need to use a backup method from the time she takes the UPA-ECPs until she has been taking COCs for 7 days. • If she does not start on the 6th day but returns later for COCs, she may start at any time if it is reasonably certain she is not pregnant.

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

B. Explaining How to Use

It is important to give the client clear and practical instructionson on how to utilize the COCs. The following **five steps** are required to be able to use COCs:

1. Give pills

- Give up to 3 months' supply depending on the woman's preference and planned use.
- Show the client a sample packet of the same type of COC that she will use.

2. Explain the pill pack

- Show which kind of pack (21 pills or 28 pills). With the 28-pill packs, point out that the last 7 pills are a different color and do not contain hormones (inactive pills).
- Show how to take the first pill from the pack, and then How to follow the directional arrows on the pack to take the rest of the pills.

3. Give key instruction

- Take one pill each day at the same time until the pack is empty, and link the pill taking to a daily routine activity.

4. Explain starting the next pack

- 28-Pill packs: She should take the first pill of the new pack the day after she finishes the previous pack.
- 21-Pill packs: Require only a 7-day break between the previous and the next pack. So, she should wait 7 days—no more—and then take the first pill from the next pack.
- The pill is often started >5 days after the onset of menses. When this occurs, we recommend backup contraception for the first 7 days of the cycle.
- It is very important to start the next pack on time if starting a pack late risks pregnancy.

5. Provide a backup method and explain use

- If she misses pills, she may need to use a backup method such as abstinence, male or female condoms, spermicides, or withdrawal.
- If she misses 3 or more hormonal pills, she can consider ECPs.

Managing Missed Pills of COCs

Instruction on what to do if pills with 30–35 µg Estrogen* missed or taken late

Missed 1 or 2 pills? Started new pack 1 or 2 days late?	**Missed pills 3 or more days in a row in the first or second week? Started new pack 3 or more days late?**	**Missed 3 or more pills in the third week?**
• Take the late or missed hormonal pill as soon as possible. • Little or no risk of pregnancy.	• Take the late or missed hormonal pill as soon as possible. • Use a backup method for the next 7 days. • Also, if she had sex in the past 5 days, she can consider ECPs (see Chapter 3).	• Take the late or missed hormonal pill as soon as possible. • Finish all hormonal pills in the pack. Throw away the 7 nonhormonal pills in a 28-pill pack use back-up. • Start a new pack the next day. • Use a backup method for the next 7 days. • Also, if she had sex in the past 5 days, she can consider ECPs (see Chapter 3).

For pills with 20 µg of estrogen or less, women missing one pill should follow the same guidance as for missing one or two 30–35 µg pills. Women missing 2 or more pills should follow the same guidance as for missing 3 or more 30–35 µg pills.

Note:

If missed any hormonal pills? (last 7 pills in 28-pill pack)

- Discard the missed nonhormonal pill(s).
- Keep taking COCs, one each day. Start the new pack as usual.

In a case of severe vomiting or diarrhea

- If she vomits within 2 hours after taking a pill, she should take another pill from her pack as soon as possible, then keep taking pills as usual.
- If she has vomiting or diarrhea for more than 2 days, follow the above instruc¬-tions for 3 or more missed pills.

Managing Any Problems

Problems reported as side effects or problems with use.

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

- Reassure her that many women using COCs experience irregular bleeding. It is not harmful and usually becomes less or stops after the first few months of use.
- Exclude other possible causes of irregular bleeding such as missed pills, taking pills at different times each day, vomiting, diarrhea, and taking anticonvulsants, rifampicin, or rifabutin.
- To reduce irregular bleeding:
  - Urge her to take a pill each day at the same time each day.
  - Teach her to make up for missed pills properly, including after vomiting or diarrhea, (see p.28).
  - For modest short-term relief, she can try (800mg) ibuprofen 3 times daily after meals for 5 days, or another NSAID, beginning when irregular bleeding starts.
  - If she has been taking the pills for more than a few months and NSAIDs do not help, Give her a different COC formulation, if available. Ask her to try the new pills for at least 3 months.
- Another genital tract pathology should be considered if irregular bleeding continues or starts after several months and is not related to COC use, and when it is identified, manage or refer for treatment.

No monthly bleeding

- Ask if she is having any bleeding at all. If she is, reassure her.
- Reassure her that some women using COCs stop having monthly bleeding, and this is not harmful.
- Ask if she has been taking a pill every day. If so, reassure her that she is not likely to be pregnant. She can continue taking her COCs as before.
- Did she skip the 7-day break between packs (21-day packs) or skip the 7 non-hormonal pills (28-day pack)? If so, reassure her that she is not pregnant. She can continue using COCs.
- If she has missed hormonal pills or started a new pack late:
  - She can continue using COCs.
  - Tell a woman who has missed 3 or more pills or started a new pack 3 or more days late to return if she has signs and symptoms of early pregnancy.

Ordinary headaches (nonmigrainous)

- To relieve pain, suggest aspirin (325–650mg), ibuprofen (200–400mg), paracetamol (325–1000mg), or another pain reliever.
- Some women get headaches during the hormone-free week (the 7 days a woman does not take hormonal pills). Consider extended use for 12 weeks without a break, followed by one week of non-hormonal pills.
- Any headaches that get worse or occur more often during COC use should be evaluated.

Nausea or Dizziness

- Advise her to take pills with meals, and preferably at bedtime.
- Cosider locally available remedies if symptoms contiue.

Breast tenderness

- Recommend that she wear a supportive bra and try to use hot or cold compresses.
- For tenderness and pain suggest aspirin (325–650mg), ibuprofen (200–400mg), paracetamol (325–1000mg), or other pain reliever.

Weight change

- Review diet and counsel as needed.

Mood changes or changes in sex drive

- Give her support as appropriate if she complains of changes in her life that could affect her mood or sex drive.
- Clients with serious mood changes such as major depression should be referred for care.

Acne

- Acne usually improves with COC use. It may worsen for a few women.
- If acne persists, give her a different COC formulation, if available.
- Ask her to try the new pills for at least 3 months.
- Consider the locally available remedies

New Problems That May Require Switching Methods

May or may not be due to the method use.

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

- The woman should be referred or evaluated by history and pelvic examination, diagnose and treat as appropriate.
- She can continue using COCs while her condition is being evaluated.
- If bleeding is caused by STDs or PID, she can continue using COCs during treatment.

Starting treatment with anticonvulsants, rifampicin, or rifabutin

- Barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, rifabutin, or ritonavir may make COCs, patch, and combined vaginal ring less effective. If using these medications long term, she may want a different method, such as progestin-only injectables, implants, a Cu-IUD or LNG-IUD.
- If using these medications short-term, she can use a backup method along with COCs for greater protection from pregnancy.

Migraine headaches

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

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

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

Certain serious health conditions (suspected heart or serious liver disease, high blood pressure, blood clots in deep veins of legs or lungs, stroke, breast cancer, damage to arteries, vision, kidneys, or nervous system caused by diabetes, or gallbladder disease). See annex 7 - Signs and Symptoms of Serious Health Conditions.

- Tell her to stop taking COCs.
- Give her a backup method to use until the condition is evaluated.
- Refer for diagnosis and care if not already under care.

Suspected pregnancy

- Assess for pregnancy, including ectopic pregnancy.
- Tell her to stop taking COCs if pregnancy is confirmed.
- There are no known risks to a fetus conceived while a woman is taking COCs.

Progestin Only Pills

Progestin-only pills (POPs) are estrogen-free oral contraceptives that only have extremely small amounts of a synthetic progestogen which is a hormone that is similar to progesterone in women. POPs are useful alternatives for women who cannot use methods containing estrogen and are effective at preventing pregnancy, especially for breastfeeding women. They are also referred to as “minipills” and “oral contraceptives with progestin alone. For the KSA’s recommended POPS, (see annex 8).

Main Characteristics

- **Mechanism of action:**
  - Thickening of the cervical mucus (this blocks sperm from meeting an egg).
  - Disrupting the menstrual cycle, including preventing the release of eggs from the ovaries (ovulation).

- **Effectiveness:** *Depends on the user:*
  Breastfeeding women:
  - As commonly used, about 99% effective over the first year.
  - When pills are taken every day, more than 99% effective over the first year.

  Less effective for women not breastfeeding:
  - As commonly used, about 93% effective over the first year.
  - When pills are taken every day at the same time, less than 1 pregnancy per 100 women using POPs over the first year (3 per 1,000 women).

- **Common side effects:**
  - Changes in bleeding pattern: Frequent bleeding, irregular bleeding, infrequent bleeding, prolong bleeding, and no monthly bleeding.
  - Systemic side effects: Headaches, dizziness, nausea, breast tenderness, mood changes, and abdominal pain.

- **Protection against STIs:** Has no effect.

- **Fertility return:** Immediately return after POPs are stopped.

- **Known health benefits:** Helps to reduce the risk of pregnancy.

- **Known health risks:** None.

Medical Eligible Criteria for Progestin Only Pills

Most women can use POPs safely, especially those who are breastfeeding. However, assessing a client's medical condition before starting POPs is mandatory. This is done using the Medical Eligibility Criteria assessment form for POP use. If she answers **"no"** to all of the questions, then she can start POPs if she wants. If she answers **"yes"** to a question, follow the instructions. In some cases, she can still start POPs.

A Client's assessment for the use of Progestin Only Pills based on WHO Medical Eligible Criteria

1. **Does the client have severe cirrhosis of the liver or a severe tumor?**
   No ( ) Yes ( )
   - If she has severe cirrhosis or a severe liver tumor, such as liver cancer, do not provide POPs. Help her choose a method without hormones.

2. **Does she have a serious problem now with a blood clot in her leg or lungs?**
   No ( ) Yes ( )
   - If she reports a current blood clot in a leg (affecting deep veins, not superficial veins) or in a lung, and she is not on anticoagulant therapy, do not provide POPs. Help her choose non-hormonal methods.

3. **Is she taking medication for seizures? Is she taking rifampicin or rifabutin for tuberculosis or other illness?**
   No ( ) Yes ( )
   - If she is taking barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, or rifabutin, do not provide POPs. They can make POPs less effective. Help her choose another method, but not COCs.

4. **Does she have or has she ever had breast cancer?**
   No ( ) Yes ( )
   - If she has, do not provide POPs, and help her choose non-hormonal methods.

Note: ***Also, women should not use POPs if they report having thrombogenic mutations or lupus with positive (or unknown) antiphospholipid antibodies, (see annex 4).***

Providing Progestin Only Pills

A. When to Start Using

A woman can start using POPs at any time, once she is certain she is not pregnant. To be reasonably certain she is not pregnant, use the Pregnancy Checklist (see p.239).

Client's Situation	When to Start
Fully or nearly fully breastfeeding	**Less than 6 months after giving birth** • *If her monthly bleeding has not returned,* she can start POPs any time between giving birth and 6 months. No need for a backup method. • *If her monthly bleeding has returned,* she can start POPs as advised for women having menstrual cycles. **More than 6 months after giving birth** • *If her monthly bleeding has not returned and she is not pregnant,* she can start POPs any time but advise her to avoid sex or use a backup method for the first 2 days of taking pills. • *If her monthly bleeding has returned,* she can start POPs as advised for women having menstrual cycles see next page.
Partially breastfeeding	• *If her monthly bleeding has not returned and she is not pregnant,* she can start POPs any time but she will need a backup method for the first 2 days of taking pills. • *If her monthly bleeding has returned,* she can start POPs as advised for women having menstrual cycles.
Not breastfeeding	**Less than 4 weeks after giving birth** • She can start POPs at any time. No need for a backup method. **More than 4 weeks after giving birth** • *If her monthly bleeding has not returned and she is not pregnant,* she can start POPs at any time, *(Continue to next page)*

Client's Situation	When to Start
Not breastfeeding (continued)	but advise her to avoid sex or use a backup method for the first 2 days of taking pills. • *If her monthly bleeding has returned,* she can start POPs as advised for women having menstrual cycles.
Switching from a hormonal method	**If she has been using the hormonal method consistently and correctly or if she is not pregnant** • She can immediately start POPs, and no need to wait for her next monthly bleeding. No need for a backup method. **If she is switching from injectables** • She can begin taking POPs when the repeat injection would have been given. No need for a backup method.
Having menstrual cycles or switching from a non -hormonal method	**At any time of the month** • *If she is starting within 5 days after the start of her monthly bleeding,* no need for a backup method. • *If it is more than 5 days after the start of her monthly bleeding,* she can start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking pills. • If she is switching from an IUD, she can start POPs immediately, (see Chapter 5 - p.93-94).
No monthly bleeding (not related to childbirth or breastfeeding)	• Start POPs at any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking pills.
After miscarriage or abortion	• *Start immediately within 7 days* after first or second trimester miscarriage or abortion. No need for a back-up method. • *If more than 7 days* after a first- or second-trimester miscarriage or abortion, she can start POPs at any time if it is reasonably certain that she is not pregnant. Advise her to avoid sex or use a backup method for the first 2 days of taking pills. *(Continue to next page)*

Client's Situation	When to Start
After taking emergency contraceptive pills (ECPs)	**After taking progestin-only or combined ECPs:** • She can start or restart POPs immediately after she takes the ECPs. *No need to wait for her next monthly bleeding.* - A continuing user who needed ECPs due to pill taking errors can continue where she left off with her current pack. • If she does not start immediately but returns for POPs, she can start at any time if it is reasonably certain she is not pregnant. • All women will need to use a backup method for the first 2 days of taking pill. **After taking ulipristal acetate (UPA) ECPs:** • She can start or restart POPs on the 6th day after taking UPA-ECPs. *No need to wait for her next monthly bleeding.* • POPs and UPA interact. If POPs are started sooner, and thus both are present in the body, one or both may be less effective. • She will need to use a backup method from the time she takes the UPA - ECPs until she has been taking POPs for 2 days. • If she does not start on the 6th day but returns later for POPs, she may start at any time if it is reasonably certain she is not pregnant.

B. Explaining How to Use

To use POPs effectively, it's crucial to give the client clear step-by-step instructions.

1. **Give pills**
   - Give up to 3 months' supply depending on the woman's preference and planned use.

2. **Explain the pill pack**
   - Show which kind of pack - 28 pills or 35 pills.
   - Explain that all pills in POP packs are the same color and all are active pills, containing a hormone that prevents pregnancy.
   - Show how to take the first pill from the pack and then how to follow the directions, or arrows, on the pack to take the rest of the pills.

3. **Give key instruction**
   - Take one pill each day at the same time until the pack is empty, and link the pill taking to a daily routine activity.
   - Women who are not breastfeeding should take a pill at the same time each day. Taking a pill more than 3 hours late makes it less effective.

4. **Explain starting the next pack**
   - When she finishes one pack, she should take the first pill from the next pack on the next day.
   - It is very important to start the next pack on time. Starting a pack late risks pregnancy.

5. **Provide a backup method and explain use**
   - Sometimes she may need to use a backup method, if she misses or is late taking a pill.
   - Backup methods include abstinence, male or female condoms, spermicides, and withdrawal.

6. **Explain that effectiveness decreases when breastfeeding stops**
   - Without the additional protection of breastfeeding itself, POPs are not as effective as most other hormonal methods.
   - When she stops breastfeeding, she can either continue taking POPs if she is satisfied with the method, or consider switching to another method.

Managing Missed Pills

Instruction on what to do if progestin only pills missed or taken late

If menses have returned and the woman misses 1 or more pills by more than 3 hours (or 12 hours in the case of the 75mg desogestrel-containing pills), regardless of whether or not she is breastfeeding

- Take a missed pill as soon as possible and continue taking the pills as usual, one each day.
- Abstain from sex or use a back-up method for the next 2 days.
- Also, if she had sex in the past 5 days, she can consider taking ECPs.
- Generally, if she vomits within 2 hours after taking a pill, she should take another pill from her pack as soon as possible, and keep taking pills as usual.

If the woman is breastfeeding and has amenorrhea, and she misses 1 or more pills by more than 3 hours (or 12 hours in the case of 75mg desogestrel pills)

- Take 1 pill as soon as possible and continue taking the pills as usual, one each day.
- If she is less than 6 months postpartum, no backup method is needed.

Key massage: ***Take a missed pill as soon as possible and keep taking pills as usual, one each day. (she may take 2 pills at the same time or on the same day).***

Managing Any Problems

Problems reported as side effects or problems with use.

Missed pills

- See Managing Missed Pills, previous page.

No monthly bleeding

- Breastfeeding women:
  - Reassure her that this is normal during breastfeeding. It is not harmful.
- Women not breastfeeding:
  - Reassure her that some women using POPs stop having monthly bleeding, and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not pregnant or infertile. Blood is not building up inside her.
  - Check the woman's age; she may be going into menopause or early menopause.

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

- Reassure her that many women using POPs experience irregular bleeding—whether breastfeeding or not. It is not harmful and sometimes becomes less or stops after the first several months of use. Some women have irregular bleeding the entire time they are taking POPs, however.
- Other possible causes of irregular bleeding including:
  - Vomiting or diarrhea.
  - Taking anticonvulsants or rifampicin.
- To reduce irregular bleeding:
  - Teach her to make up for missed pills properly, including after vomiting or diarrhea.
  - For modest short-term relief she can try (800mg) ibuprofen 3 times daily after meals for 5 days, or another NSAID, beginning when irregular bleeding starts. NSAIDs provide some relief of irregular bleeding for implants, progestin-only injectables, and IUDs, and they may also help POP users.
  - Ask her to try the new pills for at least 3 months.
- If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.

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

- Reassure her that some women using POPs experience heavy or prolonged bleeding. It is generally not harmful and usually becomes less or stops after a few months.
- For modest short-term relief she can try NSAIDs, beginning when heavy bleeding starts. Try the same treatments as for irregular bleeding, (see previous page).
- To help prevent anemia, suggest she take iron tablets and tell her it is important to eat foods containing iron.
- If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.

Ordinary headache (nonmigrainous)

- Suggest aspirin (325–650mg), ibuprofen (200–400mg), paracetamol (325–1000mg), or another pain reliever.
- Any headaches that get worse or occur more often during POP use should be evaluated.

Mood change or change in sex drive

- Ask about changes in her life that could affect her mood or sex drive, including changes in her relationship with her husband. Give her support as appropriate.
- Some women experience depression in the year after giving birth. This is not related to POPs. Clients who have serious mood changes such a major depression should be referred for care.
- Consider locally available remedies.

Breast tenderness

- If breastfeeding women, and her breast is full, tight, and painful; lump or blocked duct or infected breast should be rule out. Treat breast infection with antibiotics according to clinical guidelines. Advise her to:
  - Continue to breastfeed often.
  - Massage her breasts before and during breastfeeding.
  - Apply heat or a warm compress to breasts.
  - Try different breastfeeding positions.
  - Ensure that the infant attaches properly to the breast.
  - Express some milk before breastfeeding.

- If women not breastfeeding:
  - Recommend that she wear a supportive bra (including during strenuous activity and sleep).
  - Try hot or cold compresses.
  - Suggest aspirin (325–650mg), ibuprofen (200–400mg), paracetamol (325–1000mg), or another pain reliever.
  - Consider locally available remedies.

Nausea or dizziness

- For nausea, suggest taking POPs at bedtime or with food.
- If symptoms continue, consider locally available remedies.

Severe pain in the lower abdomen

- May be due to various problems, such as enlarged ovarian follicles or cysts.
  - A woman can continue to use POPs during evaluation and treatment.
  - There is no need to treat enlarged ovarian follicles or cysts unless they grow abnormally large, twist, or burst. Reassure the client that they usually disappear on their own. To be sure the problem is resolving, see the client again in 6 weeks.
- With severe abdominal pain, be particularly alert for additional signs or symptoms of ectopic pregnancy, which is rare and not caused by POPs, but can be life-threatening.
- In the early stages of ectopic pregnancy, symptoms may be absent or mild, but eventually they will become severe. A combination of the following signs or symptoms should increase suspicion of ectopic pregnancy:
  - Unusual abdominal pain or tenderness.
  - Abnormal vaginal bleeding or no monthly bleeding, especially if this is a change from her usual bleeding pattern.
  - Light-headedness or dizziness.
  - Fainting.
- If ectopic pregnancy or other serious health condition is suspected, refer for immediate diagnosis and care.

New Problems That May Require Switching Methods

May or may not be due to the method use.

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

- A woman should be referred or evaluated by history and pelvic examination. Diagnose and treat as appropriate.
- She can continue using POPs while her condition is being evaluated.
- If bleeding is caused by STDs or PID, she can continue using POPs during treatment.

Starting treatment with anticonvulsants, rifampicin, or rifabutin

- Barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, rifabutin, or ritonavir may make POPs less effective. If using these medications long term, she may want a different method, such as progestin-only injectables or a Cu-IUD or LNG-IUD.
- If using these medications short-term, she can use a backup method along with POPs.

Migraine headaches (see Identifying Migraine Headaches and Auras, p.246-248)

- A woman who has migraine headaches with or without aura can safely start POPs.
- If she develops migraine headaches without aura while taking POPs, she can continue to use POPs if she wishes.
- If she develops migraine aura while using POPs, stop POPs. Help her choose a method without hormones.

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

- A woman who has one of these conditions can safely start POPs. If, however, the condition develops after she starts using POPs, she should stop. Help her choose a method without hormones.
- Refer for diagnosis and care if not already under care.

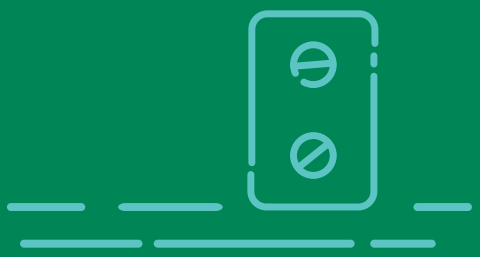
Suspected pregnancy

- Assess for pregnancy, including ectopic pregnancy.
- Tell her to stop taking POPs if pregnancy is confirmed.
- There are no known risks to a fetus conceived while a woman is taking POPs.

Certain serious health conditions (suspected blood clots in deep veins of legs or lungs, liver disease, or breast cancer). See annex 7 – Signs and Symptoms of Serious Health Conditions.

- Tell her to stop taking POPs.
- Give her a backup method to use until the condition is evaluated.
- Refer for diagnosis and care if not already under care.

CHAPTER 3



EMERGENCY CONTRACEPTIVE PILLS

Emergency Contraceptive Pills

Emergency contraceptive pills (ECPs) may help a woman avoid pregnancy after having sex without contraception if used up to five days after unprotected sex. They are safe and suitable for all women, even women who cannot use ongoing hormonal contraceptive methods, usually were taken in high doses and in different ways to those used for regular contraception.

Although they are typically called "morning after" pills or post-coital contraceptives, these names do not accurately describe when they should be used. Progestin only contraceptives pills, and combined oral contraceptives are dedicated product for emergency use.

Pill Formulations and Dosing for Emergency Contraception

Pill Type and Hormone	Formulation	Pills to Take	
		Initially	12 hours later
Dedicated ECP Products			
Progestin-only	1.5mg LNG	1	0
	0.75mg LNG	2	0
Ulipristal acetate	30mg UPA	1	0
Oral contraceptive Pills Used for Emergency Contraception			
Combined (estrogen-progestin) **oral contraceptives**	0.02mg EE + 0.1mg LNG	5	5
	0.03mg EE + 0.15mg LNG	4	4
	0.03mg EE + 0.125mg LNG	4	4
	0.05mg EE + 0.25mg LNG	2	2
	0.03mg EE + 0.3mg norgestrel	4	4
	0.05mg EE + 0.5mg norgestrel	2	2
Progestin-only pills	0.03mg LNG	50*	0
	0.0375mg LNG	40*	0
	0.075mg norgestrel	40*	0

* Many pills, but safe LNG = levonorgestrel EE = ethinyl estradiol

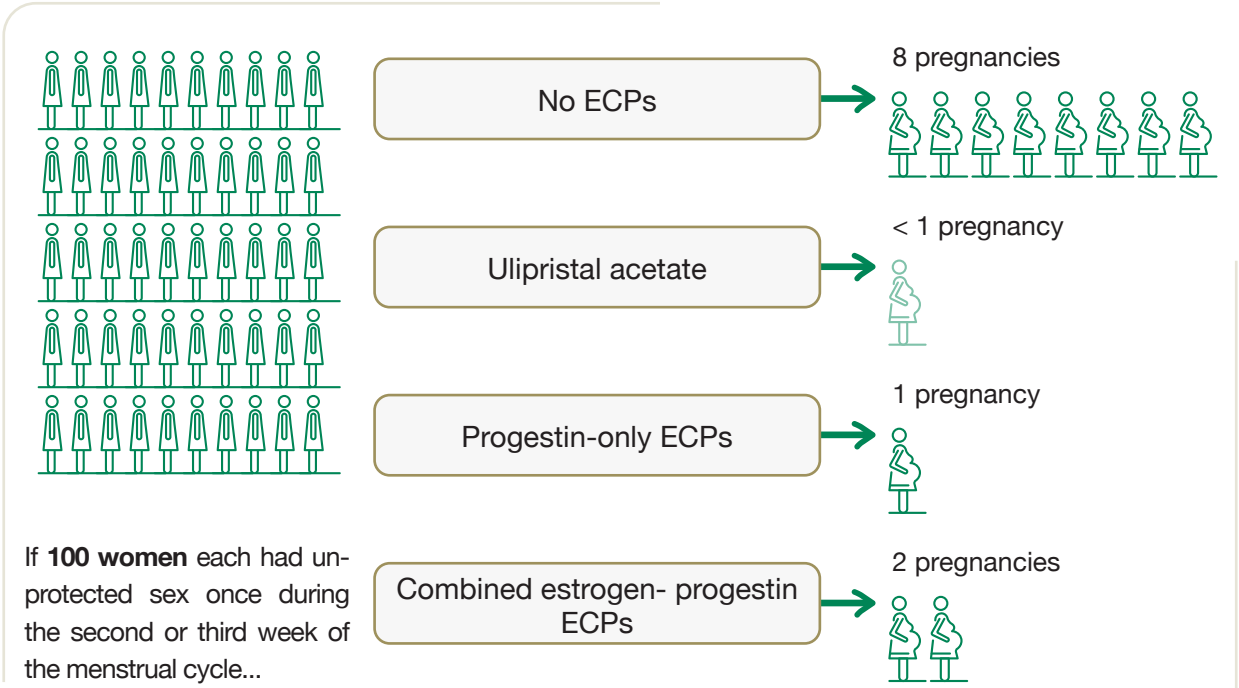
Note: ***For information on brands of ECPs and oral contraceptive pills, see the International Consortium for Emergency Contraception (http://www.cecinfo.org).***

Main Characteristics

- **Mechanism of action:**
  - Work by preventing or delaying the release of of egg from ovaries (ovulation).
  - They do not work if a woman is already pregnant.

- **Effectiveness:** *Depends on when the dose is taken:*
  - If women had sex once during the second or third week of their menstrual cycle without use of contraception, effectiveness would be about 92%.
  - If women used ulipristal acetate ECPs, effectiveness would be above 99%.
  - If women used progestin-only ECPs, effectiveness would be at 99%.
  - If women used combined estrogen and progestin ECPs, effectiveness would likely 98%.

Effectiveness of Emergency Contraceptive Pills



- **Common side effects:**
  - Changes in bleeding pattern: Slight irregular bleeding for 1-2 days after taking ECPs, monthly bleeding may start earlier or later than expected.
  - Systemic side effects: Nausea, abdominal pain, fatigue, headaches, breast tenderness, dizziness, vomiting.

- **Protection against STIs:** None.
- **Fertility return:** Immediately after ECPs are stopped.
- **Known health benefits:** Helps protect against risks of pregnancy.
- **Known health risks:** None.

Medical Eligible Criteria for Emergency Contraceptive Pills

All women can use emergency contraceptive pills safely and effectively, including women who cannot use ongoing hormonal contraceptive methods. Because of the short-term nature of their use, there are no medical conditions that make ECPs unsafe for any woman.

Providing Emergency Contraceptive Pills

A. When to Start Using

The ECPs can be used by women when ever they are worried about becoming pregnant. For example, after:

- Any unprotected sex.
- Mistakes using contraception, such as:
  - Condom was used incorrectly, slipped, or broke.
  - Couple incorrectly used a fertility awareness method (for example, failed to abstain or to use another method during the fertile days).
  - Man failed to withdraw, as intended, before he ejaculated.
  - Woman has had unprotected sex after she has missed 3 or more combined oral contraceptive pills or has started a new pack 3 or more days late.
  - IUD has come out of place.
  - Woman has had unprotected sex when she is more than 4 weeks late for her repeat injection of DMPA, more than 2 weeks late for her repeat injection of NET-EN, or more than 7 days late for her repeat monthly injection.
- Sexual assault.

B. Explaining How to Use

There are some steps that must be taken when using ECPs:

1. **Explain when to take the pills**

- She can take the pill or pills immediately.
- If she is using a 2-dose regimen, tell her to take the next dose in 12 hours.

2. **Tell her about common side effects**

- Nausea, abdominal pain, possibly others.
- Slight bleeding or change in timing of monthly bleeding.
- Side effects are not signs of illness and they do not last long.

3. **Explain how to manage the side effects**

- **Nausea:**
  - Routine use of anti-nausea medications is not recommended.
  - Women who have had nausea with previous ECP use or with the first dose of a 2-dose regimen can take anti-nausea medication such as 25–50mg meclizine hydrochloride, 30-60 minutes before taking ECPs.

- **Vomiting:**
  - If the woman vomits within 2 hours after taking progestin-only or combined ECPs, she should take another dose.
  - If she vomits within 3 hours of taking ulipristal acetate ECPs, she should take another dose. (She can use anti-nausea medication with this repeat dose, as above.)
  - If vomiting continues, she can take a repeat dose of progestin-only or combined ECPs by placing the pills high in her vagina.
  - If vomiting occurs more than 2 hours after taking progestin-only or combined ECPs, or 3 hours after taking UPA-ECPs, then she does not need to take any extra pills.

4. **Encourage her to start an ongoing method of contraception**

- If she is not pregnant at the time of taking ECPs, encourage her to choose a regular contraceptive method as soon as possible.
- If possible, give her more ECPs to take home in case she needs them in the future.

5. **Ask her to come for follow-up**

- Tell her to return if her next monthly cycle is delayed more than 7 days in order to do an early pregnancy test.

When to Start or Restart Contraception after ECP Use

Method	When to start or restart
Hormonal methods: combined oral contraceptives, progestin-only pills, progestin-only injectables, monthly injectables, implants, combined patch, combined vaginal ring	**After taking progestin-only or combined ECPs:** • Can start or restart any method immediately after she takes the ECPs. *No need to wait for her next monthly bleeding.* - The continuing user of oral contraceptive pills who needed ECPs due to error can resume use as before. She does not need to start a new pack. - Patch users should begin a new patch. - Ring users should follow the instructions for late replacement or removal (see p.129,132). • All women need to abstain from sex or use a backup method* (see p.53) for the first 7 days of using their method. • If she does not start immediately, but instead returns for a method, she can start any method at any time if it is reasonably certain she is not pregnant. **After taking ulipristal acetate (UPA) ECPs:** • She can start or restart any method containing progestin on the 6th day after taking UPA-ECPs. *No need to wait for her next monthly bleeding.* (If she starts a method containing progestin earlier, both the progestin and the UPA could be less effective). - If she wants to use oral contraceptive pills, vaginal ring, or patch, give her a supply and tell her to start on the 6th day after taking UPA-ECPs. If she wants to use injectables or implants, give her an appointment to return for the method on the 6th day after taking UPA-ECPs or as soon as possible after that. - All women need to use a backup method from the time they take UPA-ECPs until they have been using a hormonal method for 7 days (or 2 days for progestin-only pills). • If she does not start on the 6th day, but instead returns later for a method, she may start any method at any time if it is reasonably certain she is not pregnant. *(Continue to next page)*

Method	When to start or restart
Copper-bearing intrauterine device	**After taking progestin-only, combined, or UPA-ECPs:** • If she decides to use a copper-bearing IUD after taking ECPs, she can have it inserted on the same day she takes the ECPs. No need for a backup method. • If she does not have it inserted immediately, but instead returns for the method, she can have the copper-bearing IUD inserted any time if it can be determined that she is not pregnant. **Note:** *The Cu-IUD can be used for emergency contraception. A woman who wants to use the IUD for regular contraception can have it inserted for emergency contraception within the first 5 days after unprotected sex and then the woman continues using it,* (see Chapter 5).
Levonorgestrel intrauterine device	**After taking progestin-only or combined ECPs:** • She can have the LNG-IUD inserted at *any time it can be determined that she is not pregnant* (see Pregnancy checklist p.239). • She should use a backup method* (see p.53) for the first 7 days after LNG-IUD insertion. **After taking UPA-ECPs:** • She can have the LNG-IUD inserted on the 6th day after taking UPA-ECPs *if it can be determined that she is not pregnant.* - If she wants to use the LNG-IUD, give her an appointment to return to have it inserted on the 6th day after taking UPA-ECPs or as soon as possible after that. • She will need to use a backup method from the time she takes UPA-ECPs until 7 days after the LNG-IUD is inserted. • If she does not have the LNG-IUD inserted on the 6th day, but instead returns later, she can have it inserted at any time if it can be determined she is not pregnant. *(Continue to next page)*

Method	When to start or restart
Barrier methods: Male and female condoms, spermicides, diaphragms, cervical caps	• Immediately after taking progestin-only, combined, or UPA-ECPs.
Natural method: Fertility awareness methods and withdrawal	**After taking progestin-only, combined, or UPA-ECPs:** • Standard Days Method: With the start of her next monthly bleeding. • Symptoms-based methods: Once normal secretions have returned. • Give her a backup method to use until she can begin the method of her choice. • Withdrawal: Immediately after taking progestin-only, combined, or UPA-ECPs.
Female sterilization	**After taking progestin-only, combined, or UPA-ECPs:** • The sterilization procedure can be done *within 7 days after the start of her next monthly bleeding or any other time if she is not pregnant.* Give her a backup method to use until she can have the procedure.
Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.	

Managing Any Problems

Problems reported as side effects, may or may not be due to the method.

Slight Irregular Bleeding

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

Change in timing of the next monthly bleeding or suspected pregnancy

- Monthly bleeding may start a few days earlier or later than expected. This is not a sign of illness or pregnancy.
- If her next monthly bleeding is more than 7 days later than expected after she takes ECPs, assess for pregnancy. There are no known risks to a fetus conceived if ECPs fail to prevent pregnancy.

CHAPTER 4

INJECTABLES CONTRACEPTIVE METHODS

Progestin-Only Injectables

The injectable contraceptives depot medroxyprogesterone acetate (DMPA) and norethisterone enanthate (NET-EN) are highly effective estrogen-free contraceptives containing synthetic progestogen. They are suitable for most women and are given periodically, every three or two months, by deep intramuscular injection. They do not interfere with sexual desire or disrupt an existing pregnancy. For a list of the progestin-only injectables that are recommended in KSA, (see annex 8).

Main Characteristics

- **Mechanism of action:**
  - Act primarily by preventing the release of ova from the ovaries (ovulation).

- **Effectiveness:** *Depends on getting injections regularly:*
  - As it is commonly used, effectiveness within the first year is approximately 96%.
  - When women have injections on time, effectiveness would be more than 99% over the first year.

- **Common side effects:**
  - Monthly bleeding changes are normal and not harmful.
    With DMPA, these typically include:
    - first 3 months: Irregular bleeding and prolonged bleeding.
    - At and after 1 year: No monthly bleeding, infrequent bleeding, and irregular bleeding.

    With NET-EN, bleeding patterns are less affected than DMPA:
    - First 6 months: Fewer days of bleeding.
    - After 1 year: More likely to have monthly bleeding than DMPA user.
  - Systemic side effects: headaches, dizziness, nausea, weight gain, mood changes, and abdominal bloating and discomfort.
  - Physical changes there is possibility of losing bone density, but most of it reversible.

- **Protection against STIs:** None.

- **Fertility return:** After injections are stopped there is a delay of about 4-months for DPMA, and 1-month delay for NET-EN.

- **Known health benefits:**

  With DMPA:

  - Helps protect against: Pregnancy and associated risks, Cancer of the lining of the uterus (endometrial cancer), Uterine fibroids.
  - Also, may help prevent iron-deficiency anemia.
  - Decrease symptoms of endometriosis (pelvic pain, irregular bleeding) as well as sickle cell crises in women with sickle cell anemia.

  With NET-EN:

  - Helps protect against: Pregnancy and associated risks, and iron-deficiency anemia.

- **Known health risks**: None.

Medical Eligible Criteria for Use of Progestin-Only Injectables

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 progestin-only injectables if she wants. If she answers **"yes"** to a question, follow the instructions; in some cases, she can still start progestin-only injectables.

A Client's Assessment for the use of Progestin-Only Injectables based on WHO Medical Eligible Criteria

1. **Is she 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. **Does she have severe cirrhosis of the liver or a severe liver tumor?**

   No ( ) Yes ( )

   - If she reports severe cirrhosis or a severe liver tumor, such as liver cancer, do not provide progestin-only injectables. Help her choose a method without hormones.

3. **Does she have high blood pressure?**

   No ( ) Yes ( )

   Check her blood pressure if possible

   - If she is currently being treated for high blood pressure and it is adequately controlled, or her blood pressure is below 160/100 mm Hg, provide progestin-only injectables.

(Continue to next page)

A Client's Assessment for the use of Progestin-Only Injectables based on WHO Medical Eligible Criteria

- If systolic blood pressure is 160 mmHg or higher or diastolic blood pressure is 100 mmHg or higher, do not provide progestin-only injectables. Neither progestin-only injectables nor any methods containing estrogen are appropriate for client; help her to choose another method.
- If she reports having high blood pressure in the past, and you cannot check blood pressure, provide progestin-only injectables.

4. Has she had diabetes for more than 20 years or does she have damage to her arteries, vision, kidneys, or nervous system caused by diabetes?

No ( ) Yes ( )

- Do not provide progestin-only injectables. Neither progestin-only injectables nor any methods containing estrogen are appropriate for the client; help her choose another method.

5. Has she ever had a stroke, blood clot in her leg 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 different method that does not contain estrogen.
- If she reports a current blood clot in one of her legs (affecting deep veins, not superficial veins) or in a lung and she is not on anticoagulant therapy, help her choose a method without hormones.

6. Is she having vaginal bleeding that is unusual for her?

No ( ) Yes ( )

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

(Continue to next page)

A Client's Assessment for the use of Progestin-Only Injectables based on WHO Medical Eligible Criteria
7. Does she have or has she ever had breast cancer? **No ( ) Yes ( )** • Do not provide progestin-only injectables. Help her choose a method without hormones.
8. Does she have several conditions that could increase her 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 a method without estrogen.

Providing Progestin-Only Injectables

A. When to Start Using

May be initiated at any time, once the client is proven not pregnant.

Client's Situation	When to Start
Having menstrual cycles	**At any time of the month.** • *If she is starting within 7 days after the start of her monthly bleeding,* she can start immediately and there is no need for a backup method. • *If it is more than 7 days after the start of her monthly bleeding,* she can start any time if not pregnant, she will need a backup method* for the first 7 days after the injection. • If she is switching from an IUD, she can start injectables immediately.
Switching from another hormonal method	• Immediately, as long as she was using a hormonal method consistently and correctly before and she is not pregnant. No need to wait for her next monthly bleeding and no need for a backup method. • If she is switching from injectables, she can have the new injectable when the repeat injection would have been given. No need for a backup method.

(Continue to next page)

Client's Situation	When to Start
Fully or nearly fully breastfeeding	**Less than 6 months after giving birth** • If she gave birth less than 6 weeks ago, delay her first injection until at least 6 weeks after giving birth. • *If her monthly bleeding has not returned,* she can start injectables any time between 6 weeks and 6 months, if she is not pregnant. No need for a backup method. • *If her monthly bleeding has returned,* she can start injectables as advised for women having menstrual cycles (see the first row of this table). **More than 6 months after giving birth** • *If her monthly bleeding has not returned,* she can start injectables any time if she is not pregnant. She will need a backup method (see p.63) for the first 7 days after the injection. • *If her monthly bleeding has returned,* she can start injectables as advised for women having menstrual cycles. (See the first row of this table).
Partially breastfeeding	**Less than 6 weeks after giving birth** • Delay her first injection until at least 6 weeks after giving birth. **More than 6 weeks after giving birth** • *If her monthly bleeding has not returned,* she can start injectables any time if she is not pregnant. She will need a backup method (see p.63) for the first 7 days after the injection. • *If her monthly bleeding has returned,* she can start injectables as advised for women having menstrual cycles. (See the first row of this table).
Not breastfeeding (after giving birth)	**Less than 4 weeks after giving birth** • Start injectables at any time. No need for a backup method. *(Continue to next page)*

Client's Situation	When to Start
Not breastfeeding (after giving birth) (continued)	**More than 4 weeks after giving birth** • She can start injectables at any time *if her monthly bleeding has not returned,* and it is reasonably certain she is not pregnant, but advise her to avoid sex or use a backup method (see p.63) for the first 7 days after the injection. • *If her monthly bleeding has returned,* she can start injectables as advised for women having menstrual cycles, (see the first row of this table).
No monthly bleeding (not related to childbirth or breastfeeding)	• Start injectables at any time, if she is not pregnant. She will need a backup method* for the first 7 days after the injection.
After miscarriage or abortion	• If she is *starting within 7 days* after first- or second-trimester miscarriage or abortion, she can start immediately and there is no need for a backup method. • If it is *more than 7 days* after first- or second trimester miscarriage or abortion, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method* for the first 7 days after the injection.
After taking emergency contraceptive pills (ECPs)	**After taking progestin-only or combined ECPs:** • She can start or restart injectables on the same day as taking the ECPs. *No need to wait for her next monthly bleeding to have the injection.* She will need to use a backup method* for the first 7 days after the injection. • If she does not start immediately but returns for injectables, she can start at any time if it is reasonably certain she is not pregnant. **After taking ulipristal acetate UPA-ECPs:** • A woman can start or restart injectables on the 6th day after taking UPA-ECPs, so make an appointment for her to return for the injection on the 6th day or as soon as possible after that. *(Continue to next page)*

Client's Situation	When to Start
After taking emergency contraceptive pills (ECPs) (continued)	*No need to wait for her next monthly bleeding to have the injection.* The progestin in the injectables and UPA interact with each other. If injectables are started sooner, and thus both are present in the body, one or both may be less effective. • She will need to use a backup method from the time she takes UPA-ECPs until 7 days after the injection. • If she does not start on the 6th day but returns later for injectables, she may start at any time if it is reasonably certain she is not pregnant.
Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.	

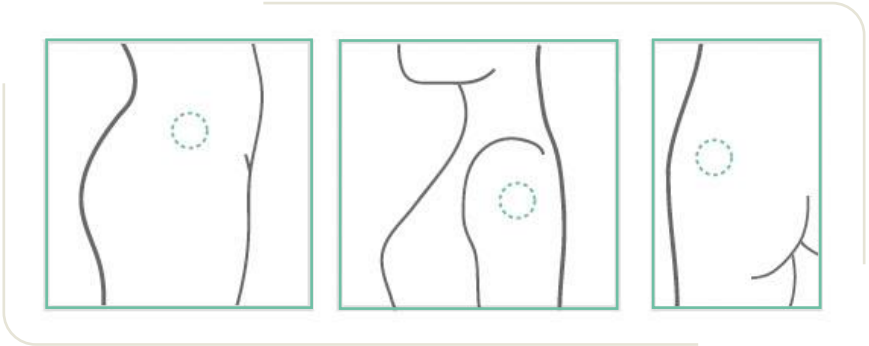
B. Explaining How to Use

1. Show the client

- The type and name of the planned injection.

2. Describe how the injection is given

- Under aseptic conditions, it is administered intramuscularly into the buttock or upper arm, depending on the client's preference.



3. Give specific instructions

- Advice her not to massage the injection site.
- Tell her the name of the injection and agree on a date for her next injection.

4. Describe the most common side effects (see p.57)

- Side effects are common, but some women do not have them.
- They usually become less or stop within few months after receiving the injection.

5. Explain that effectiveness decreases when breastfeeding stops

- Without the additional protection of breastfeeding itself, progestin-only injectables are not as effective as most other hormonal methods.
- Consider changing to another method.
- Sometimes she may need to use a backup method, if she misses or is late taking a pill.

6. Plan for the next injection

- Agree on a date for the client's next injection:
  - 3 months (13 weeks) for DMPA, but she may come up to 4 weeks after the scheduled injection date and still get an injection.
  - 2 months (8 weeks) for NET-EN, but she may come up to 2 weeks after the schedules injection date and still get an injection.
- With either DMPA or NET-EN, she can come up to 2 weeks before the scheduled injection date.
- She should come back no matter how late she is for her next injection (see - managing late injection p.65).

7. Information card

- As a reminder, give her a card with information about injection type and date written on it.

The example of Injectable Contraceptive Reminder Card

Injectable Contraceptive Reminder Card	
Client's name:	
Type of injection:	
Date of injection:	
Date of next injection:	
If you have any problems or questions, go to:	
(Name and location of health facility)	

Managing Late Injection of Progestin-Only Injectables

Instruction on what to do if progestin only injectable taken late

If more than 4-weeks late for DMPA, or more than 2-weeks late for NET-EN, she can receive her next injection, if:

- She has not had sex since 2 weeks after the scheduled date of injection.
- She has used a backup method or taken ECPs after any unprotected sex since 2 weeks after the scheduled injection's date, or She is fully or nearly fully breast-feeding and gave birth less than 6 months ago.
- In all three conditions above She will need a backup method for the first 7 days after the injection.

If up to 4-weeks late for a repeat injection of DMPA, or up to 2-weeks late for repeat injection of NET-EN

- A woman can receive her next injection, without the need for tests, evaluation, or a backup method.

Managing Any Problems

Women's satisfaction maybe be affected by these problems, so the provider should follow the instructions on how to treat any side effects and specific conditions that have been reported.

No monthly bleeding (amenorrhea)

- Reassure her that most women using progestin-only injectables stop having monthly bleeding over time, and this is not harmful.
- If not having monthly bleeding bothers her, she may want to switch to monthly (combined) injectables, if available (see p. 69).

Irregular bleeding (bleeding at unexpected times)

- Reassure her that most women using progestin-only injectables stop having monthly bleeding over time, and this is not harmful.
- For modest short-term relief, she can take (500mg) mefenamic acid twice daily after meals for 5 days, or (40mg) of valdecoxib daily for 5 days, beginning when irregular bleeding starts.
- If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use (see the row on Unexplained vaginal bleeding p. 68).

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

- Reassure her that bleeding It is not harmful and usually becomes less or stops after a few months.
- For modest short-term relief she can try (one at a time), beginning when heavy bleeding starts: 500mg of mefenamic acid twice daily after meals for 5 days, or (40mg) of valdecoxib daily for 5 days, or (50 µg) of ethinyl estradiol daily for 21 days.
- If bleeding becomes a health threat or if the woman wants, help her choose another method.
- To help prevent anemia, suggest she take iron tablets and tell her it is important to eat foods containing iron, such as meat, poultry, green leafy vegetables, and legumes.
- If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.

Ordinary headaches (nonmigrainous)

- Suggest aspirin (325–650mg), ibuprofen (200–400mg), paracetamol (325–1000mg), or other pain reliever.
- Any headaches that get worse or occur more often during use of injectables should be evaluated.

Mood changes or change in sex drive

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

Weight gain

- Review the client's diet with her and counsel as needed.

Abdominal bloating and discomfort

- Consider locally available remedies.

Dizziness

- Consider locally available remedies.

New Problems That May Require Switching Methods

Problems that may or may not be due to the use of progestin-only injectables.

Migraine headaches (see the job aid on Identifying Migraine Headaches and Auras, p.246-248)

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

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

- Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate.
- If no cause of bleeding can be found, stop injectables and provide another method of her choice to use (but not implants or a copper-bearing or hormonal IUD) until the condition is evaluated and treated.
- If bleeding is caused by STI or pelvic inflammatory disease, she can continue using progestin-only injectables during treatment.

Certain serious health conditions (suspected blocked or narrowed arteries, serious liver disease, severe high blood pressure, blood clots in deep veins of legs or lungs, stroke, breast cancer, or damage to arteries, vision, kidneys, or nervous system caused by diabetes). See annex 7 – Signs and Symptoms of Serious Health Conditions.

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

Suspected pregnancy

- Assess for pregnancy.
- Stop injections if pregnancy is confirmed.
- There are no known risks to a fetus conceived while a woman is using injectables or to a woman who receives an injection while pregnant.

Monthly Injectables

Monthly injectables are combined injectable contraceptives containing two hormones, a progestin and an estrogen, similar to the natural hormones progesterone and estrogen in a woman's body.

There are two types: medroxyprogesterone acetate (MPA)/estradiol cypionate and norethisterone enanthate (NET-EN)/estradiol valerate. They are given monthly, every 3 to 4 weeks (+/- 7 days), and they do not interfere with sex or disrupt an existing pregnancy. See annex 8 for the recommended monthly injectables in KSA.

Main Characteristics

- **Mechanism of action:**
  - Act primarily by preventing the release of ova from the ovaries (ovulation).

- **Effectiveness:** *Depends on getting injections regularly:*
  - As commonly used, effectiveness about 97% for women using monthly injectables over the first year.
  - When women have injections on time, the effectiveness would exceed 99% over the duration of the first year.

- **Common side effects:**
  - Changes in bleeding pattern: Lighter bleeding, fewer days of bleeding, irregular or prolonged bleeding, infrequent and no monthly bleeding.
  - Systemic side effects: Headaches, dizziness, weight gain, and breast tenderness.

- **Protection against STIs:** None.

- **Fertility return:** After injections are stopped: An average of about 5-months, one month longer than with most other methods.

- **Known health benefits and risk:**
  - Long-term studies of the monthly injectable are limited, but researchers expect that its health benefits and risks are like those of combined oral contraceptives (COCs), (see p.19-20).

Medical Eligible Criteria for Use of Monthly Injectables

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 wants. If she answers **"yes"** to a question, follow the instructions; in some cases, she can still start monthly injectables.

A Client's Assessment for the use of Monthly Injectables based on WHO Medical Eligible Criteria

1. **Is she breastfeeding a baby less than 6 months old?**
   No ( ) Yes ( )
   - If fully or nearly fully breastfeeding, she can begin 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 monthly injectables as soon as 6 weeks after childbirth.

2. **Has she had a baby in the last 3 weeks and is not breastfeeding?**
   No ( ) Yes ( )
   - She can begin monthly injectables as soon as 3 weeks after childbirth.
   - If there is an additional risk that she might develop DVT or VTE, then she should not start monthly injectables at 3 weeks after childbirth, but start at 6 weeks instead. The additional risk factors include previous VTE, thrombophilia, cesarean delivery, blood transfusion at delivery, postpartum hemorrhage, pre-eclampsia, obesity (≥ 30 kg/m2).

3. **Does she smoke 15 or more cigarettes a day?**
   No ( ) Yes ( )
   - Do not provide monthly injectables, if she is 35 years of age or older and smokes more than 15 cigarettes a day. Urge her to stop smoking and help her choose another method.

4. **Does she have severe liver disease—active hepatitis, severe cirrhosis, or liver tumor?**
   No ( ) Yes ( )
   - Do not provide monthly injectables, if she reports one of the mentioned conditions, and help her to choose another method without hormones.

(Continue to next page)

A Client's Assessment for the use of Monthly Injectables based on WHO Medical Eligible Criteria

5. Does she have high blood pressure?

No ( ) Yes ( )

If not possible to check blood pressure

- If 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 a method without estrogen.

Check the blood pressure if possible

- If blood pressure is below 140/90 mm Hg, provide monthly injectables.
- If systolic blood pressure is 140 mm Hg or higher or diastolic blood pressure is 90 or higher, do not provide monthly injectables. 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/ 90–99 mmHg is not enough to diagnose high blood pressure. Provide a backup method to use until she can return for another blood pressure check, or help her choose another method now if she prefers. If blood pressure at next check is below 140/90, she can use monthly injectables.

6. Has she had diabetes for more than 20 years or has damage to her arteries, vision, kidneys, or nervous system caused by diabetes?

No ( ) Yes ( )

- Do not provide monthly injectables. Help her choose a method without estrogen but not progestin-only injectable.

7. Has she ever had a stroke, blood clot in her leg or lungs, heart attack, or other serious heart problems?

No ( ) Yes ( )

- If she reports heart attack, ischemic heart disease, 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 (not a superficial clot) or in the lungs, help her choose a method without hormones.

(Continue to next page)

A Client's Assessment for the use of Monthly Injectables based on WHO Medical Eligible Criteria

8. **Does she have or has she ever had breast cancer?**
   No ( ) Yes ( )
   - Do not provide monthly injectables. Help her choose a method without hormones.

9. **Does she sometimes see a bright area of lost vision in the eye before a very bad headache (migraine aura)? Does she get 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)?**
   No ( ) Yes ( )
   - If she has migraine aura at any age, do not provide monthly injectables.
   - If she has migraine headaches *without aura and is aged 35 or older,* do not provide monthly injectables. Help these women choose a method without estrogen.
   - If she is under 35 and has migraine headaches without aura, she can use monthly injectables (see Identifying Migraine Headaches and Auras, p. 246-248).

10. **Is she planning major surgery that will keep her from walking for one week or more?**
    No ( ) Yes ( )
    - If so, she can start monthly injectables 2 weeks after she can move about again. Until she can start monthly injectables, she should use a backup method.

11. **Does she have several conditions that could increase her chances of heart disease (coronary artery disease) or strokes, such as older age, smoking, high blood, pressure, or diabetes?**
    No ( ) Yes ( )
    - Do not provide monthly injectables. Help her choose a method without estrogen but not progestin only injectables.

12. **Is she taking lamotrigine?**
    No ( ) Yes ( )
    - Do not provide monthly injectables. Monthly injectables can make lamotrigine less effective. Help her choose a method without estrogen.

Providing Monthly Injectables

A. When to Start Using

The starting time for monthly injectables is almost the same as that for progestin-only injectables for regular contraception, (see p.60-63) with the exceptions mentioned in the table below.

Client's Situation	When to Start
Fully or nearly fully breastfeeding	**Less than 6 months after giving birth** • Delay her first injection until 6 months after giving birth or when breast milk is no longer the baby's main food—whichever comes first. **More than 6 months after giving birth** • *If her monthly bleeding has not returned,* she can start injectables any time if she is not pregnant. She will need a backup method (see p.74) for the first 7 days after the injection. • *If her monthly bleeding has returned,* she can start injectables as advised for women having menstrual cycles (see p.60).
Partially breastfeeding	**Less than 6 weeks after giving birth** • Delay her first injection until at least 6 weeks after giving birth. **More than 6 weeks after giving birth** • *If her monthly bleeding has not returned,* she can start injectables any time if she is not pregnant. She will need a backup method* for the first 7 days after the injection. • *If her monthly bleeding has returned,* she can start injectables as advised for women having menstrual cycles (see p.57). *(Continue to next page)*

Client's Situation	When to Start
Not breastfeeding (after giving birth)	**Less than 4 weeks after giving birth** • Start injectables at any time on days 21–28 after giving birth.No need for a backup method. If additional risk for VTE, wait until 6 weeks. **More than 4 weeks after giving birth** • *If her monthly bleeding has not returned,* she can start injectables at any time, and it is reasonably certain she is not pregnant, but advise her to avoid sex or use a backup method* for the first 7 days after the injection. • *If her monthly bleeding has returned,* she can start injectables as advised for women having menstrual cycles.

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

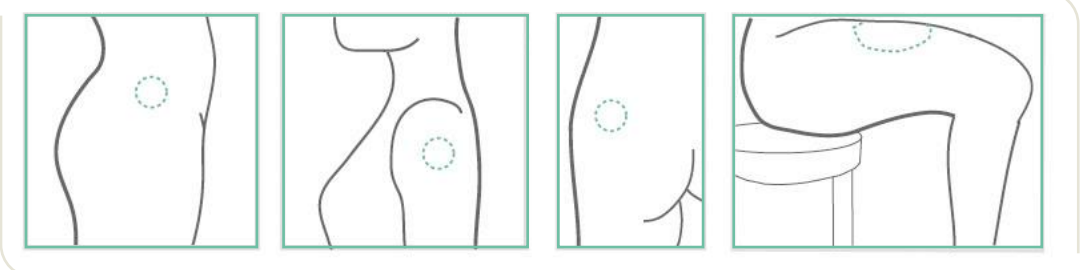
B. Explaining How to Use

1. Show the client

- The type and name of the planned injection.

2. Describe how the injection is given

- Under aseptic conditions, it is administered intramuscularly into the hip, the outer thigh, the buttock or upper arm, depending on where the woman prefers.



3. **Give specific instructions**

- Tell her not to massage the injection site.
- Tell her the name of the injection and agree on a date for her next injection in about 4 weeks.

4. **Describe the most common side effects**

- Side effects are common, but some women do not have them.
- They usually become less or stop within few months after receiving the injection.

5. **Plan for the next injection**

- Agree on a date for her next injection in 4 weeks.
- Ask her to come on time, but she may come up to 7 days before or after the scheduled date and still get an injection.
- She should come back no matter how late she is for her next injection. If more than 7 days late, she should abstain from sex or use backup methods until she can get an injection.
- She can also consider ECPs if she is more than 7 days late and has had unprotected sex in the past 5 days (see p.50).

6. **Information card**

- Give her an information card with the injection type and date written on it (see p.65).

Managing Any Problems

Note: Management of the most common side effects from monthly injectables use is similar to that for combined oral contraceptives (COCs), (see p.19,20).

Managing Late Injection of Monthly Injectables

Instruction on what to do if monthly injectable taken late

If the client is less than 7 days late for a repeated injection →

- she can receive her next injection. No need for tests, evaluation, or a backup method.

A client who is more than 7 days late can receive her next injection if: →

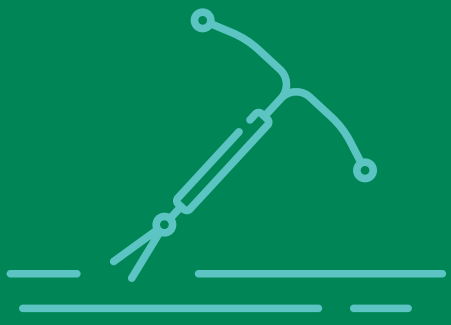
- She has not had sex since 7 days after the scheduled date of her injection, or
- She has used a backup method or has taken emergency contraceptive pills (ECPs) after any unprotected sex since 7 days after the scheduled date of her injection.
- She will need a backup method for the first 7 days after the injection.

If the client is more than 7 days late and does not meet these criteria →

- Additional steps can be taken to be reasonably certain she is not pregnant (see the job aid Pregnancy checklist, p.239).

Key massage: ***Discuss why the client was late and solutions. If coming back on time is often a problem, discuss using a backup method when she is late for her next injection, taking ECPs, or choosing another method.***

CHAPTER 5



INTRAUTERINE DIVICES

Copper – Bearing Intrauterine Device

The copper-bearing intrauterine device is a small, flexible contraceptive device made of a plastic frame with copper sleeves or wire around it.

Almost all types of IUDs have one or two strings, or threads, tied to them. The strings hang through the cervix into the vagina. A specifically trained health care provider inserts it into a woman's uterus through her vagina and cervix. The recommended IUD in KSA is listed in (annex 8).

Main Characteristics

- **Mechanism of action:**
  - Act primarily by preventing fertilization and causing a chemical change that damages sperm and eggs before they can meet.

- **Effectiveness:** *One of the most effective and long-lasting method:*
  - Its > 99% effective over the first year (6 per 1,000 women who use the IUD perfectly, and 8 per 1,000 women as commonly used). This means that 992 to 994 of every 1,000 women using IUDs will not become pregnant.
  - A small risk of pregnancy remains beyond the first year of use and continues as long as the woman is using the IUD. Over 10 years of IUD use about 2 pregnancies per 100 women.

- **Common side effects:**
  - Changes in bleeding pattern: Bleeding may be heavier and longer, or irregular, with more cramps and pain (especially in the first 3 to 6 months).
  - Systemic side effects: Perforation of the uterine wall and usually heals without treatment, as well as miscarriage, preterm birth, or infection in the rare case that the woman becomes pregnant with the IUD in place.

- **Protection against STIs:** Has no effect.

- **Fertility return:** Immediately after IUDs removed.

- **Known Health Benefits:**
  - Reduce incidence of endometrial cancer and cervical cancer.
  - Reduces the risk pregnancy and ectopic pregnancy.

- **Known Health Risks:**
  - Uncommon: May contribute to anemia if the woman already has low iron blood stores before IUD insertion.
  - Rarely: May lead to plevic inflammatory disease (PID) if the woman has chlamydia or gonorrhea at the time of IUD insertion.

Medical Eligible Criteria for Copper-Bearing IUDs

Ask the client the questions given below to know about here medical conditions. If she answers **"no"** to all of the questions, then she can have IUD inserted if she wants. If she answers **"yes"** to a question, follow the instructions below.

A Client's Assessment for the use of Copper – Bearing intrauterine device based on WHO Medical Eligible Criteria

1. **Does the client think she is pregnant?**
   No ( ) Yes ( )
   - Ask the client the questions in the Pregnancy Checklist (see job aid p.239). If she answers "yes" to any of these questions, you can be reasonably certain that she is not pregnant, and she can have an IUD inserted. If the Pregnancy Checklist cannot rule out pregnancy, use the job aid Ruling Out Pregnancy before inserting an IUD.

2. **Did she give birth more than 48 hours but less than 4 weeks ago?**
   No ( ) Yes ( )
   - Delay inserting an IUD until 4 or more weeks after childbirth.

3. **Does she have an infection following childbirth or abortion?**
   No ( ) Yes ( )
   - Do not insert the IUD if she currently has infection of the reproductive organs during the first 6 weeks after childbirth or abortion (puerperal sepsis) or she just had an abortion-related infection in the uterus (septic abortion). Treat or refer her if she is not already receiving care. Help her choose another method or offer a backup method. After treatment, re-evaluate for IUD use.

(Continue to next page)

A Client's Assessment for the use of Copper – Bearing intrauterine device based on WHO Medical Eligible Criteria

4. **Does she have vaginal bleeding that is unusual for her?**
   No ( ) Yes ( )
   - If she has unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition, use of an IUD could make diagnosis and monitoring of any treatment more difficult. Help her choose a method to use while being evaluated and treated (but not a hormonal IUD, progestin-only injectables, or implants). After treatment, re-evaluate for IUD use.

5. **Does she have any female conditions or problems (gynecologic or obstetric conditions or problems), such as genital cancer or pelvic tuberculosis? If so, what problems?**
   No ( ) Yes ( )
   - Do not insert an IUD if she has any of these conditions. 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.

6. **Does she have HIV or AIDS? Does she have any health conditions associated with HIV infection?**
   No ( ) Yes ( )
   - Do not insert an IUD if she has HIV infection with severe or advanced clinical disease. In contrast, a woman living with HIV who has mild or no clinical disease can have an IUD inserted, whether or not she is on antiretroviral therapy.

7. **Assess whether she is at very high individual risk for STIs.**
   No ( ) Yes ( )
   - Women who have a very high individual likelihood of STI infection should not have an IUD inserted unless gonorrhea and chlamydia are ruled out by lab tests.

Note: ***Also, women should not use the IUD if they report having systemic lupus erythematosus with severe thrombocytopenia. For complete classifications, (see annex 4 - Medical Eligibility Criteria for Contraceptive Use).***

Pelvic Screening and Examination

For performing the pelvic examination and STI risk assessment, the questions below help you to check for signs of conditions that would rule out IUD insertion. If the answer to all of the questions is **"no,"** then the client can have an IUD inserted. If the answer to any question is **"yes,"** refer for diagnosis and treatment as appropriate. Help the client choose another method and counsel her about condom use if she faces any risk of STIs.

Screening Questions for Pelvic Examination and STI Risk Assessment Before IUD Insertion
1. Does the client have any type of ulcer on the vulva, vagina, or cervix? **No ( )** **Yes ( )** • Possible STI if she has.
2. Does she feel pain in her lower abdomen when you move the cervix? **No ( )** **Yes ( )** • If the client feels pain, possible PID.
3. Does she have tenderness in the uterus, ovaries, or fallopian tubes (adnexal tenderness)? **No ( )** **Yes ( )** • If she has tenderness, possible PID.
4. Does she have a purulent cervical discharge? **No ( )** **Yes ( )** • If she has purulent cervical discharge, possible STI or PID.
5. Does the cervix bleed easily when touched? **No ( )** **Yes ( )** • If the cervix bleeds easily on touch, possible STI or cervical cancer.

(Continue to next page)

Screening Questions for Pelvic Examination and STI Risk Assessment Before IUD Insertion
6. Is there an anatomical abnormality of the uterine cavity that will prevent correct IUD placement? **No ( ) Yes ( )** • If an anatomical abnormality distorts the uterine cavity, proper IUD placement may not be possible. Help her to choose another method.
7. Were you unable to determine the size and/or position of the uterus? **No ( ) Yes ( )** • Determining the size and position of the uterus before IUD insertion is essential to ensure high placement of the IUD and to minimize risk of perforation. If size and position cannot be determined, do not insert an IUD. Help her choose another method.

Providing Copper-Intrauterine Device

A. When to Start Using

In many cases a woman can start the IUD at any time if it is reasonably certain she is not pregnant. To be reasonably certain she is not pregnant, use the Pregnancy Checklist (see p.239).

Client's Situation	When to Start
Having menstrual cycles	**At any time of the month** • *If she is starting within 12 days after the start of her monthly bleeding,* no need for a backup method. • *If it is more than 12 days after the start of her monthly bleeding*, she can have the IUD inserted any time if it is reasonably certain she is not pregnant. No need for a backup method.
Switching from a hormonal method	• Immediately, if she has been using the method consistently and correctly or she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. *(Continue to next page)*

Client's Situation	When to Start
Switching from a hormonal method (continued)	• If she is switching from an injectable, she can have the IUD inserted when the next injection would have been given. No need for a backup method.
Soon after childbirth (regardless of breastfeeding status)	• *At any time within 48 hours* after giving birth including caesarean delivery. • *If it is more than 48 hours* after giving birth, delay until 4 weeks or more after giving birth.
Fully or nearly fully breastfeeding	**Less than 6 months after giving birth** • If the Cu-IUD is *not inserted within the first 48 hours and her monthly bleeding has not returned,* she can have the IUD inserted any time between 4 weeks and 6 months after giving birth. No need for a backup method. • *If her monthly bleeding has returned,* she can have the IUD inserted as advised for women having menstrual cycles (see the first row of this table). **More than 6 months after giving birth** • *If her monthly bleeding has not returned,* she can have the IUD inserted any time if she is not pregnant. No need for a backup method. • *If her monthly bleeding has returned,* she can have the IUD inserted as advised for women having menstrual cycles.
Partially or not breastfeeding	**More than 4 weeks after giving birth** • *If her monthly bleeding has not returned,* she can have the IUD inserted if she is not pregnant. No need for a backup method. • *If her monthly bleeding has returned,* she can have the IUD inserted as advised for women having menstrual cycles (see the first row of this table).
No monthly bleeding (not related to childbirth or breastfeeding)	• Any time if it can be determined that she is not pregnant (see Ruling Out Pregnancy, p.239). No need for a backup method.

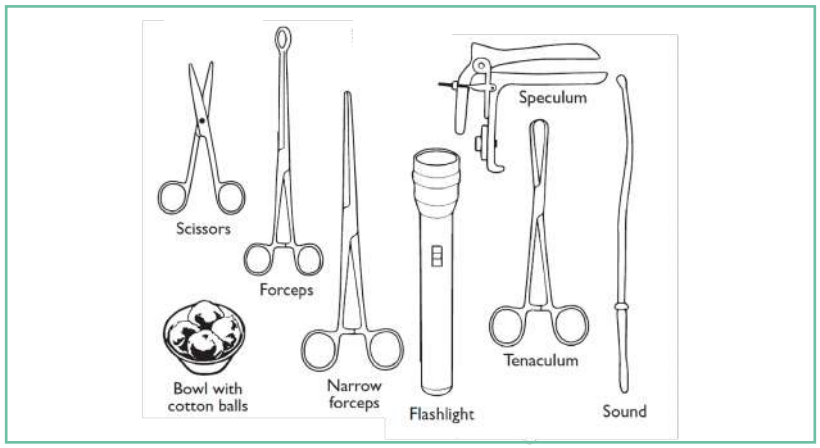
(Continue to next page)

Client's Situation	When to Start
After miscarriage or abortion	• The Cu-IUD may be *inserted immediately, or within 12 days* after first- or second-trimester miscarriage or abortion and if no infection is present. No need for a backup method. • *If it is more than 12 days* after first- or second-trimester miscarriage or abortion and no infection is present, she can have the Cu-IUD inserted at any time if she is not pregnant. No need for a backup method. • If infection is present, treat or refer, and help the client choose another method. If she still wants the Cu-IUD, it can be inserted after the infection has completely cleared. • IUD insertion after second-trimester abortion or miscarriage requires specific training. If not specifically trained, delay insertion until at least 4 weeks after miscarriage or abortion.
For emergency contraception	• *Within 5 days* after unprotected sex. • When the time of ovulation can be estimated, *she can have an IUD inserted up to 5 days* after ovulation. Sometimes this may be more than 5 days after unprotected sex.
After taking emergency contraceptive pills (ECPs)	• The IUD can be inserted on the same day that she takes the ECPs (progestin-only, combined, or UPA-ECPs). No need for a backup method. • If she does not have it inserted immediately but returns for an IUD, she can have it inserted any time if it can be determined that she is not pregnant.

B. Explaining How to Insert and Remove the Cu-IUD

Only a healthcare practitioner who has received comprehensive IUD training and has practiced under close supervision is qualified to insert and remove IUDs in a sterile setting. As shown in the following illustration, specific instruments and insurance should be used during the insertion and removal process.

The Necessary Instruments Required for IUD Insertion and Removal



Inserting the IUD

If a woman decides to use an IUD, she should be informed of what will happen during insertion.

Talk with the client before the procedure

- Explain the insertion process. (see p.87).
- Show her the speculum, tenaculum, and the IUD and inserter in the package.
- Tell her that she will experience some discomfort or cramping during the procedure, and that this is to be expected.
- Ask her to tell you any time that she feels discomfort or pain. Ibuprofen (200–400mg), paracetamol (325–1,000mg), or other pain reliever may be given 30 minutes before insertion to help reduce cramping and pain. Do not give aspirin, which slows blood clotting.

Talk with the client during the procedure

- Tell her what is happening, step by step, and reassure her.
- Alert her before a step that may cause pain or might startle her.
- Ask from time to time if she is feeling pain.

Talk with the client after the procedure

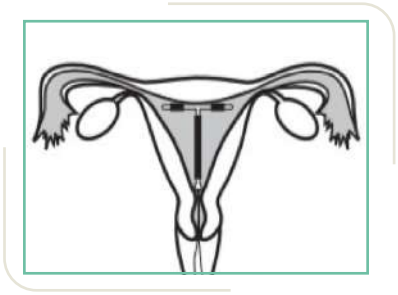
- Ask her how she is doing.
- Tell her that the procedure was successful and that the IUD is in place.
- Tell her that she can rest for a while and then slowly sit up before getting up and dressing.
- Remind her that the two of you will be discussing next steps and follow-up.

Insertion Procedure

Throughout the insertion procedure, the health care provider must follow these instructions:

1. Uses proper infection prevention procedures.
2. Conducts a pelvic examination to determine the position of the uterus and assess eligibility (see Screening Questions for Pelvic Examination and STI Risk Assessment Before IUD Insertion, p.82-83). The provider first does the bimanual examination and then inserts a speculum into the vagina to inspect the cervix.
3. Cleans the cervix and vagina with appropriate antiseptic.
4. Slowly inserts the tenaculum through the speculum and closes the tenaculum just enough to gently hold the cervix and uterus steady.
5. Slowly and gently passes the uterine sound through the cervix to measure the depth and position of the uterus.
6. Loads the IUD into the inserter while both are still in the unopened sterile package.
7. Slowly and gently inserts the IUD into the uterus and removes the inserter.
8. Cuts the strings on the IUD, leaving about 3 cm hanging out of the cervix.
9. After the insertion, the woman rests. She remains on the examination table until she feels ready to get dressed.

The following illustration shows the IUD after being inserted into female uterus



Removal Procedure

When removing an IUD, the practitioner should take these steps and inform the client about what will happen:

1. Inserts a speculum to see the cervix and IUD strings and carefully cleans the cervix and vagina with an antiseptic solution such as iodine.
2. Asks the woman to take slow, deep breaths and to relax. The woman should say if she feels pain during the procedure.
3. Using narrow forceps, the provider pulls the IUD strings slowly and gently until the IUD comes completely out of the cervix.

Supporting the user

Specific instructions are given to client when using Cu-IUD

Expect cramping and pain

- She can expect some cramping and pain for a few days after insertion.
- Suggest ibuprofen (200–400mg), paracetamol (325–1000mg), or other pain reliever as needed.
- Also, she can expect some bleeding or spotting immediately after insertion. Irregular spotting can continue during the first month after insertion.

Length of pregnancy protection

- Discuss how to remember the date to return for removal or replacement.
- Give each woman the following information in writing on a reminder card, like the one shown below, if possible, and explain:
  - The type of IUD she has.
  - Date of IUD insertion.
  - Month and year when the IUD will need to be removed or replaced.
  - Where to go if she has problems or questions about her IUD.

Follow-up visit

- A follow-up visit after her first monthly bleeding or 3 to 6 weeks after IUD insertion is recommended. No woman should be denied an IUD, however, because follow-up would be difficult or not possible.

The example of IUD Reminder Card

IUD Reminder Card		
Client's name:		
Type of IUD:		
Date inserted:		
Remove or replace by:	Month:	Year:
If you have any problems or questions, go to:		
(Name and location of health facility)		

Managing Any Problems

Problems reported as side effects or complications.

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

- Reassure her that many women using Cu-IUDs eventually experience heavy or prolonged bleeding. It is generally not harmful and usually becomes less or stops after the first several months of use.
- For modest short-term relief she can try (one at a time):
  - Tranexamic acid (1500mg), 3 times daily for 3 days, then (1000mg) once daily for 2 days, beginning when heavy bleeding starts.
  - Nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen (400mg) or indomethacin (25mg), 2 times daily after meals for 5 days, beginning when heavy bleeding starts. Other NSAIDs, except aspirin, also may be provided.
- To prevent anemia, provide iron tablets, if possible, and tell her it is important for her to eat foods containing iron (see "Possible anemia", next page).
- If heavy or prolonged bleeding continues or starts after several months of normal bleeding or long after the IUD was inserted, or if you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use (see "Unexplained vaginal bleeding", p.92).

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

- Reassure her that many women using Cu-IUDs eventually experience irregular bleeding, and it is not harmful.
- For modest short-term relief she can try NSAIDs such as ibuprofen (400mg) or indomethacin (25mg) twice daily after meals for 5 days, beginning when irregular bleeding starts.
- If it continues or starts after several months of normal bleeding, consider underlying conditions unrelated to method use (see "Unexplained vaginal bleeding", p.92).

Cramping and pain

- She can expect some cramping and pain for the first day or two after IUD insertion.
- Explain that some cramping is common in the first 3 to 6 months of IUD use, particularly during monthly bleeding, and it is not harmful and usually decreases over time. Suggest aspirin (325–650mg), ibuprofen (200–400mg), paracetamol (325–1000mg), or other pain reliever.
- If sever cramping continues beyond the first 2 days, evaluate for partial expulsion or perforation.

Possible anemia

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

Severe lower abdominal pain (suspected pelvic inflammatory disease [PID] and suspected ectopic pregnancy)

- Some common signs and symptoms of PID often also occur with other abdominal conditions, such as ectopic pregnancy. If ectopic pregnancy is ruled out, assess for PID.
- If possible, do abdominal and pelvic examinations (see annex 7 – Signs and Symptoms of Serious Health Conditions for signs from the pelvic examination that would indicate PID).
- If a pelvic examination is not possible, and she has a combination of the following signs and symptoms in addition to lower abdominal pain, suspect PID:
  - Unusual vaginal discharge.
  - Fever or chills.
  - Pain during sex or urination.
  - Bleeding after sex or between monthly bleeding.
  - Nausea and vomiting.
  - A tender pelvic mass.
  - Pain when the abdomen is gently pressed (direct abdominal tenderness) or when gently pressed and then suddenly released (rebound abdominal tenderness).
- Treat PID or immediately refer for treatment.
  - There is no need to remove the IUD if she wants to continue using it. If she wants it removed, take it out after starting antibiotic treatment.
  - If the infection does not improve, consider removing the IUD while continuing antibiotics. In both cases the woman's health should be closely monitored.
- If ectopic pregnancy or other serious health condition is suspected, refer at once for immediate diagnosis and care (see p.184,185 female sterilization, and for ectopic pregnancies).
- If the client does not have these additional symptoms or signs, assess for pelvic inflammatory disease.

Suspected uterine puncturing (perforation)

- If puncturing is suspected at the time of insertion or sounding of the uterus, stop the procedure immediately (and remove the IUD if inserted). Observe the client in the clinic carefully:
  - For the first hour, keep the woman at bed rest and check her vital signs (blood pressure, pulse, respiration, and temperature) every 5 to 10 minutes.
  - If the woman remains stable after one hour, check for signs of intra-abdominal bleeding, such as low hematocrit or hemoglobin or rebound on abdominal examination, if possible, and her vital signs. Observe her for several more hours. If she has no signs or symptoms, she can be sent home, but she should avoid sex for 2 weeks, and help her choose another method.
  - If she has a rapid pulse and falling blood pressure, or new pain or increasing pain around the uterus, refer her to a higher level of care.
  - If uterine perforation is suspected within 6 weeks or more after insertion based on clinical symptoms, refer for evaluation of her condition and removal of the IUD.

IUD partially comes out (partial expulsion)

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

IUD completly comes out (complete expulsion)

- If complete expulsion is suspected (for example, strings cannot be found on pelvic exam) and the client does not know whether or not it came out, refer for ultrasound or (x-ray, if pregnancy can be ruled out) to assess whether it might have moved to the abdominal cavity. Give her a backup method to use in the meantime.
- Discuss with the client whether she wants another IUD or a different method.
  - If she wants another IUD, she can have one inserted right away if she is not pregnant.
  - If the client does not want to continue using an IUD, help her choose another method.

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

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

New Problems That May Require Switching Methods

May or may not be due to the method.

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

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

Suspected Pregnancy

- Assess for pregnancy, including ectopic pregnancy.
- Explain that an IUD in the uterus during pregnancy increases the risk of preterm delivery or miscarriage, including infected (septic) miscarriage during the first or second trimester, which can be life-threatening.
- If the woman does not want to continue the pregnancy, counsel her according to program guidelines.
- If she continues the pregnancy:
  - Advise her that it is best to remove the IUD.
  - Explain the risks of pregnancy with an IUD in place. Early removal of the IUD reduces these risks, although the removal procedure itself involves a small risk of miscarriage. If she agrees to removal, gently remove the IUD or refer for removal.

- Explain that she should return at once if she develops any signs of miscarriage or septic miscarriage (vaginal bleeding, cramping, pain, abnormal vaginal discharge, or fever).
- If she chooses to keep the IUD, a nurse or doctor should follow her pregnancy closely. She should see a nurse or doctor at once if she develops any signs of septic miscarriage.

• If the IUD strings are not visible and cannot be found in the cervical canal, the IUD cannot be safely retrieved. Refer for ultrasound, if possible, to determine whether the IUD is still in the uterus. If it is, or if ultrasound is not available, her pregnancy should be followed closely. She should seek care at once if she develops any signs of septic miscarriage.

Switching from the IUD to Another Method

Switching to	When to Start
A hormonal method: combined oral contraceptives (COCs), progestin only pills (POPs), progestin-only injectables, monthly injectables, combined patch, combined vaginal ring, or implants	• *If starting during the first 7 days* of monthly bleeding (first 5 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 7 days* of monthly bleeding (after the first 5 days for COCs and POPs) and she has had sex since her last monthly bleeding, start the hormonal method now. It is recommended that the IUD be kept in place until her next monthly bleeding. • *If starting after the first 7 days* of monthly bleeding (after the first 5 days for COCs and POPs) and she has not had sex since her last monthly bleeding, the IUD can stay in place and be removed during her next monthly bleeding, or the IUD can be removed and she can use a backup method* for the next 7 days (2 days for POPs).
Barrier methods: Male or female condoms, spermicides, diaphragms, cervical caps	• The next time she has sex after the IUD is removed.

(Continue to next page)

Switching to	When to Start
Natural method: Fertility awareness methods and withdrawal	• In the same cycle that the IUD is removed. • The next time she has sex after the IUD is removed.
Female sterilization	• *If during the first 7 days* of monthly bleeding, remove the IUD and perform the female sterilization procedure. No need for a backup method. • *If after the first 7 days* of monthly bleeding, perform the sterilization procedure. Ideally, the IUD can be kept in place until her follow-up visit or her 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.
Vasectomy	• Any time. • The woman can keep the IUD until a test of her husband's semen shows that the vasectomy is working, or for 3 months, when the vasectomy will be fully effective.
Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.	

Levonorgestrel Intrauterine Device

The levonorgestrel intrauterine device (LNG-IUD) is a T-shaped plastic device that steadily releases a small amount of levonorgestrel (a progestin hormone) each day. Also called the levonorgestrel-releasing intrauterine system, LNG-IUS, or hormonal IUD.

Marketed under such brand names as Mirena, Liletta, Levosert, Kyleena, Skyla, and Jaydess. The Kyleena, Skyla, and Jaydess IUDs and their inserters are slightly smaller than the Mirena, Liletta, and Levosert. For a recommended one in KSA, (see annex 8).

Main Characteristics

- **Mechanism of action:**
  - Work primarily by preventing the sperm from fertilizing an egg.

- **Effectiveness:** *One of the most effective and long-lasting methods:*
  - Its > 99% effective over the first year (2 per 1,000 women). This means that 998 of every 1,000 women using LNG-IUDs will not become pregnant.
  - A small risk of pregnancy remains beyond the first year of use and continues as long as the woman is using the LNG-IUD.
    - » Over 5 years of use of the Mirena LNG-IUD: Less than 1 pregnancy per 100 women (5 to 8 per 1,000 women).
  - Mirena and Kyleena are approved for up to 5 years of use. Research shows that Mirena remains highly effective for 7 years. Levosert and Liletta are approved for up to 4 years of use. Research supports up to 5 years of use of Levosert and Liletta. Skyla and Jaydess are approved for up to 3 years of use.

- **Common side effects:**
  - Changes in bleeding pattern including: Lighter and fewer days of bleeding, infrequent, irregular or prolonged bleeding and even no monthly bleeding.
  - Systemic side effects include: Acne, headaches, nausea, dizziness, breast tenderness or pain, weight gain, mood changes, ovarian cysts.

- **Protection against STIs:** Has no effect.

- **Fertility return:** Immediately after IUDs removed.

- **Known Health Benefits:**
  - Helps protect against: Risks of pregnancy and iron-deficiency anemia.

- May help protect against: Endometrial cancer and cervical cancer.
- Reduces: Menstrual cramps, heavy monthly bleeding, symptoms of endometriosis (pelvic pain, irregular bleeding) and risk of ectopic pregnancy.

- **Known Health Risks:**
  - Rarely in the short term, PID may occur if the woman has gonorrhea or chlamydia at the time of insertion.

- **Complications:**
  - Rarely: Perforation of the uterine wall by the LNG-IUD may occur; usually heals without treatment.
  - Very rarely: Miscarriage, preterm birth or infection in the rare case that the woman becomes pregnant with the LNG-IUD in place.

Medical Eligible Criteria for LNG-IUDs

Ask the client the questions given below to about her medical conditions. If she answers **"no"** to all of the questions, then she can have LNG-IUD inserted if she wants. If she answers **"yes"** to a question, follow the instructions. The client assessment for LNG-IUD use is almost the same as the assessment for Cu-IUDs for regular contraception (see p. 80,81) with the exceptions shown below.

A Client's Assessment for the use of Levonorgestrel Intrauterine Device based on WHO Medical Eligible Criteria
1. Does the client have or has she ever had breast cancer? **No ( )** **Yes ( )** • Do not insert the LNG-IUD if she has. Help her choose a method without hormones.
2. Does she now have a blood clot in the deep veins of her leg or lungs? **No ( )** **Yes ( )** • If she was recently diagnosed with a blood clot in legs (affecting deep veins, not superficial veins) or in a lung, and she is not on anticoagulant therapy, help her choose a method without hormones.
3. Does she have severe cirrhosis or a severe liver tumor? **No ( )** **Yes ( )** • If she reports severe cirrhosis or a severe liver tumor such as liver cancer, do not provide the LNG-IUD. Help her choose a method without hormones.

Pelvic Screening and Examination

Client screening, which includes pelvic examination and STI risk assessment for LNG-IUD use, is almost the same as for Cu-IUD use for regular contraception (see p. 82-83).

Providing Levonorgestrel-Intrauterine Device

A. When to Start Using

In many cases a woman can start the LNG-IUD at any time if it is reasonably certain she is not pregnant.

Client's Situation	When to Start
Having menstrual cycles or switching from a non-hormonal method	**Any time of the month** • *If Within 7 days after the start of her monthly bleeding.* No need for a backup method. • *If more than 7 days after the start of her monthly bleeding* and she is not pregnant, she can have the LNG-IUD. She will need a backup method for the first 7 days after insertion.
Switching from a hormonal method	• Immediately if she has been using the method consistently and correctly and she is not pregnant. No need to wait for her next monthly bleeding. • *If she is starting within 7 days after the start of her monthly bleeding,* no need for a backup method. • *If it is more than 7 days after the start of her monthly bleeding,* she will need a backup method* for the first 7 days after insertion. • If she is switching from an injectable, she can have the LNG-IUD inserted when the repeat injection would have been given. No need for a backup method.
Soon after childbirth (regardless of her breastfeeding status)	• *Any time within 48 hours* after giving birth. This requires a provider with specific training in postpartum insertion (by hand or using a ring forceps). • *If more than 48 hours,* delay until at least 4 weeks.

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Client's Situation	When to Start
Fully or nearly fully breastfeeding	**Less than 6 months after giving birth** • If the LNG-IUD is not inserted *within the first 48 hours and her monthly bleeding has not returned,* she can have the LNG-IUD inserted any time between 4 weeks and 6 months. No need for a back-up method. • *If her monthly bleeding has returned,* she can start have the LNG-IUD inserted as advised for women having menstrual cycles, (see previous page). **More than 6 months since giving birth** • If her monthly bleeding has not returned, she can have the LNG-IUD inserted any time if she is not pregnant. She will need a backup method* for the first 7days after insertion. • If her monthly bleeding has returned, she can have the LNG-IUD inserted as advised for women having menstrual cycles.
Partially or not breastfeeding	**Less than 4 weeks after giving birth** • If the LNG-IUD is not inserted *within the first 48 hours,* delay insertion until at least 4 weeks after giving birth. **More than 4 weeks after giving birth** • *If her monthly bleeding has not returned,* she can have the LNG-IUD inserted any time if she is not pregnant. She will need a backup method (see p.99) for the first 7 days after insertion. • *If her monthly bleeding has returned,* she can have the LNG-IUD inserted as advised for women having menstrual cycles.
No monthly bleeding (not related to childbirth or breastfeeding)	• The LNG-IUD can be inserted at any time if she is not pregnant. She will need a backup method (see p.99) for the first 7 days after insertion.

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Client's Situation	When to Start
After miscarriage or abortion	• Immediately if the LNG-IUD is inserted *within 7 days* after first- or second -trimester abortion or miscarriage without indications of infection present. No need for a backup method. • *If it is more than 7 days* after first- or second -trimester abortion or miscarriage without indications of infection present, she can have the LNG-IUD inserted at any time if she is not pregnant. She will need a backup method* for the first 7 days after insertion. • If infection is present, treat or refer, and help the client choose another method. If she still wants the LNG-IUD, it can be inserted after the infection has completely cleared. • LNG-IUD insertion after second-trimester abortion or miscarriage requires specific training. If not specifically trained, delay insertion until at least 4 weeks after miscarriage or abortion.
After taking progestin-only, combined, or ulipristal acetate (UPA) emergency contraceptive pills (ECPs)	• She can have the LNG-IUD inserted if she is not pregnant, for example, after the start of her next monthly bleeding. Give her a backup method or oral contraceptive pills to use until she can have the LNG-IUD inserted. • She should not have the LNG-IUD inserted in the first 6 days after taking UPA-ECPs. This leads to drugs interaction. If the LNG-IUD is inserted sooner, and thus both LNG and UPA are present in the body, one or both may be less effective.
Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.	

B. Explain the Insertion and Removal Procedures of LNG – IU

Instructions for the client on LNG-IUD insertion and removal procedures are similar to those for the Cu-IUD (see p.87).

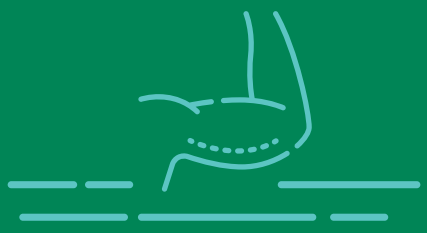
Managing Any Problems

The management of the LNG-IUD's common side effects is almost the same as that of the Cu-IUD and COCs for regular contraception (see p.29,89).

Switching from the LNG-IUD to Another Method

The guidelines for switching from LNG-IUD to another method are similar to those when switching from a copper-bearing IUD to another method. see also when to start for each method (see p.93-94).

CHAPTER 6



IMPLANTS

Implants

Implants are small plastic rods, each about the size of a matchstick, that release a progestin, which is similar to the natural hormone progesterone in a woman's body. They are estrogen free, and so can be used throughout breastfeeding and by women who cannot use methods with estrogen. There are two main types of implants either with 1 or 2 rods. In KSA, one rod implant is recommended (see annex 8).

Main Characteristics

- **Mechanism of action:** *Act primarily by:*
  - Preventing the release of eggs from the ovaries(ovulation).
  - Thickening cervical mucus (this blocks sperm from reaching an egg).

- **Effectiveness:**
  Implants are one of the most effective and efficient methods. its effectiveness last from 3 to 5 years, depending on the type of implant.
  - As high as > 99 % effective within the first year of implant's use.
  - A small risk of pregnancy remains beyond the first year of use and continues as long as the woman is using implants.

- **Common side effects:**
  - Changes in bleeding patterns even after about 1 year: Lighter bleeding and fewer days of bleeding, irregular bleeding, prolonged bleeding, infrequent bleeding, and no monthly bleeding.
  - Systemic side effects: Headache, dizziness, nausea, abdominal pain, breast tenderness, acne, weight and mood changes.
  - Other possible physical changes: Enlarged ovarian follicles.

- **Protection against STIs:** Has no effect.

- **Fertility return:** Immediately after implants are stopped.

- **Known health benefits:**
  - Helps protect against: Risks of pregnancy, including ectopic pregnancy.
  - May help protect against: Iron-deficiency anemia.
  - Reduces: Risk of ectopic pregnancy.

- **Known health risks:** None

- **Complications:**
  - Uncommon: Infection at insertion site and Difficult removal.
  - Rare: Expulsion or migration of implant.

Medical Eligible Criteria for Implants

Ask the client the questions given below. Examinations and tests are not necessary. If she answers **"no"** to all of the questions, then she can have implants inserted if she wants. If she answers **"yes"** to a question, follow the instructions. In some cases, she can still using implants.

A Client's Assessment for the use of Implants based on WHO Medical Eligible Criteria
1. Does the client have severe cirrhosis of the liver or a severe tumor? **No ( )** **Yes ( )** • Do not provide implants, if she reports severe cirrhosis or a severe liver tumor. Help her choose a method without hormones.
2. Does she have a serious problem now with a blood clot in her leg or lungs? **No ( )** **Yes ( )** • Do not provide implants, if she reports a current blood clot in one of her legs (affecting deep veins, not superficial veins) or in a lung and she is not on anticoagulant therapy. • Help her choose a method without hormones.
3. Is she having vaginal bleeding that is unusual for her? **No ( )** **Yes ( )** • If she has unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition, implants could make diagnosis and monitoring of any treatment more difficult. • Help her choose method to use until the condition is evaluated and treated, but not progestin-only injectables or a copper-bearing or hormonal IUD. After treatment, reconsider the use of implants.
4. Does she have or has she ever had breast cancer? **No ( )** **Yes ( )** • If yes, do not provide implants. Help her choose a method without hormones.

Providing Implants

A. When to Start

Client's Situation	When to Start
Having menstrual cycles or switching from a non-hormonal method	**Any time of the month** • *If she is starting within 7 days after the start of her monthly bleeding,* she can have implants inserted immediately and there is no need for a backup method. • *If it is more than 7 days after the start of her monthly bleeding,* she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup methods for the first 7 days. • If she is switching from an IUD, (see Switching from IUD to Another Method, in Chapter 5 - Copper-Bearing Intrauterine Device, p. 93-94).
Switching from another hormonal method	• Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant, (no need to wait for her next monthly bleeding). No need for a backup method. • If she is switching from a progestin-only or combined monthly injectable, she can have an implants inserted when the repeat injection would have been given. No need for a backup method.
Fully or nearly fully breastfeeding	**Less than 6 months after giving birth** • *If her monthly bleeding has not returned,* she can have implants inserted any time between giving birth and 6 months. No need for a backup method. • *If her monthly bleeding has returned,* she can have implants inserted as advised for women having menstrual cycles (see the first row of this table). *(Continue to next page)*

Client's Situation	When to Start
Fully or nearly fully breastfeeding (continued)	**More than 6 months after giving birth** • *If her monthly bleeding has not returned,* she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method (see p.107) for the first 7 days after insertion. • *If her monthly bleeding has returned,* she can have implants inserted as advised for women having menstrual cycles.
Partially breastfeeding	• *If her monthly bleeding has not returned,* she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method (see p.107) for the first 7 days after insertion. • *If her monthly bleeding has returned,* she can have implants inserted as advised for women having menstrual cycles (see the first row of this table).
Not breastfeeding (after giving birth)	**Less than 4 weeks after giving birth** • She can have implants inserted at any time and there is no need for a backup method. **More than 4 weeks after giving birth** • *If her monthly bleeding has not returned,* she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method (see p.107) for the first 7 days after insertion. • *If her monthly bleeding has returned,* she can have implants inserted as advised for women having menstrual cycles (see the first row of this table).
No monthly bleeding (not related to childbirth or breastfeeding)	• She can have implants inserted any time if it is reasonably certain she is not pregnant. • She will need a backup method for the first 7 days after insertion.

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Client's Situation	When to Start
After miscarriage or abortion	• *If implants are inserted within 7 days* after a first- or second-trimester miscarriage or abortion, she can have implants inserted immediately and there is no need for a backup method. • *If it is more than 7 days* after a first- or second-trimester miscarriage or abortion, she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion.
After taking emergency contraceptive pills (ECPs)	**After taking progestin-only or combined ECPs** • Implants can be inserted on the same day as she takes the ECPs. *There is no need to wait for the next monthly bleeding.* She will need to use a backup method* for the first 7 days. • If she does not start immediately but returns for an implant, she can start at any time if it is reasonably certain she is not pregnant. **After taking ulipristal (UPA) ECPs** • Implants can be inserted on the 6th day after taking UPA-ECPs. *So there is no need to wait for her next monthly bleeding.* Implants and UPA interact. If an implant is inserted sooner, and thus both are present in the body, one or both may be less effective. • She will need to use a backup method from the time she takes UPA-ECPs until 7 days after the implant is inserted. • If she does not start on the 6th day but returns later for implants, she can start at any time if it is reasonably certain she is not pregnant.

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

B. Explain the Insertion and Removal Procedures for Implants

Inserting Implants

Implant insertion and removal require training as well as supervised practice. Implant insertion normally takes a few minutes, while it occasionally can take longer depending on the provider's skill. Related complications are uncommon and also depend on the provider's competency.

The essential equipment, supplies required for Implants Insertion and Removal

The provider ensures that the implant itself, along with all other required equipment and supplies are available, and should adhere to the appropriate infection control measures throughout the procedures.

The essential equipment and supplies for the insertion process are listed below

- Antiseptic solution with bowl
- Gloves
- Local anesthetic (1% concentration with or without epinephrine)
- Syringe
- Sterile drape
- Sterile gauze
- Sterile skin closure
- Pressure bandage
- Implant pre-loaded inside needle

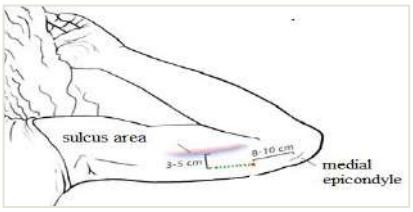
In addition, the removal process needs the following instruments

- Scalpel
- Curved mosquito forceps
- Straight mosquito forceps

Steps for the Insertion Procedure for 1-Rod Implants

1. Place a clean, dry cloth under the woman's arm and position the non-dominant arm with elbow flexed and hand behind ear.

   Mark position on arm for insertion of rod, 8–10cm from the medial epicondyle and 3–5cm below the sulcus area.



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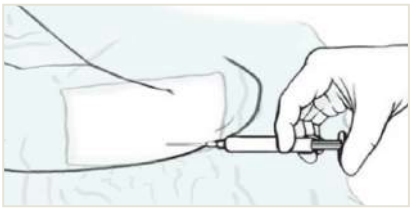
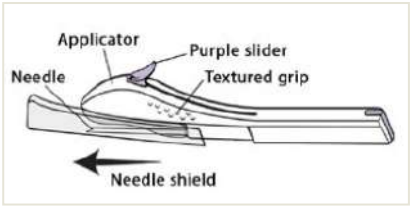
2. Prep insertion site with antiseptic solution and drape.

   Inject 1–2 mL of 1% lidocaine just under the skin, raising a wheal at the insertion point and advancing up to 5 cm along the insertion track.



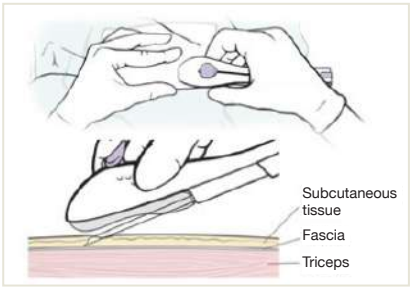
3. Using the no-touch technique, remove the sterile disposable 1-rod applicator from blister pack. Hold it at the textured surface area.
   Visually verify presence of implant inside of needle. Remove needle shield.



4. Provider should be situated to visualize the insertion and ensure it is subcutaneous and parallel to the arm.

   Stretch skin near insertion site with thumb and index finger.

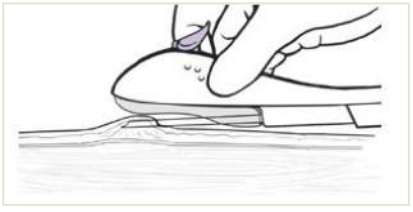
   Puncture skin with applicator at a 30° angle and insert only the bevel of the needle.

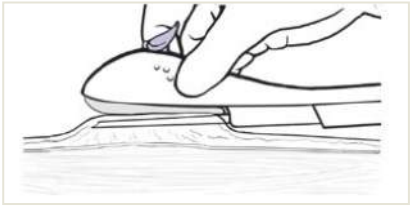


5. Visualizing the needle, lower the applicator until parallel with surface of skin and gently advance, while lifting skin upwards to ensure superficial placement.

   Insert entire length of the needle without using force.

   Verify entire length of the needle has been inserted in the skin before the next step.





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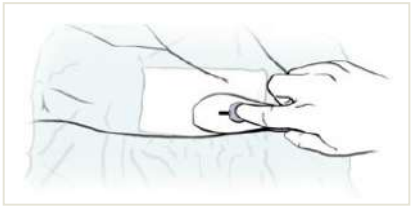
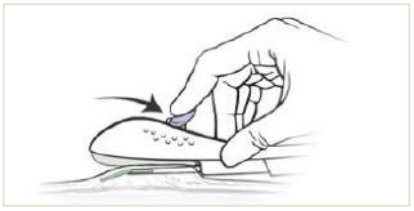
6. Hold the applicator in this position and press the purple slider downwards until it stops.

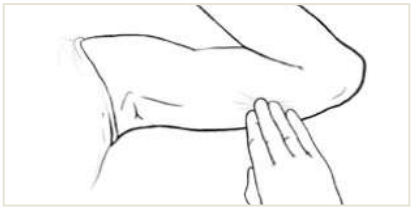
   This action will retract the needle into the body of the applicators.





7. Gently remove applicator, leaving the implant in place.

8. Palpate to check the implant is in place. Ask the woman to palpate the implant to confirm its presence.

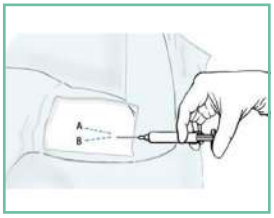


9. Close the incision site with a sterile skin closure.

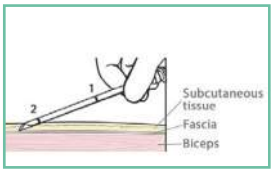
10. Apply pressure bandage dressing to minimize bleeding and bruising.

Steps for the Insertion Procedure for 2-Rod Implants

1. Place a clean, dry cloth under the woman's arm and position the non-dominant arm with elbow flexed and hand parallel to ear. Mark positions (A) and (B) on arm for insertion of rods, 6–8 cm above the medial epicondyle.



2. Prep insertion site with antiseptic solution and drape. Inject 1–2 mL of 1% lidocaine just under the skin raising a wheal at the insertion point and advancing up up to 5 cm along the insertion tracks (A&B).



3. Stretch skin near insertion site with thumb and index finger. Puncture skin with trocar at a 20° angle and insert only the bevel of the needle.

4. Lower the applicator until parallel with surface of the skin and gently advance, while lifting skin upwards to ensure superficial placement. Advance trocar and plunger to mark (1) nearest the hub of the trocar.

5. Remove plunger while holding trocar in place. Load first rod (A) into trocar with tissue forceps.

6. Reinsert plunger, advancing until resistance is felt.

7. Hold plunger firmly in place with one hand, and slide the trocar out of the incision until it reaches the plunger handle. Withdraw trocar and plunger together until mark (2) nearest the trocar tip (do not remove the trocar from the incision).

8. At mark (2), redirect the trocar about 15° away from the first rod inserted (A). Advance trocar and plunger toward (B) up to mark (1) and insert second rod (B) using the same technique (repeat steps 5–7).

9. Palpate to check the implants are in place. Ask the woman to palpate the implants to confirm their presence.

10. Close the incision site with a sterile skin closure.

11. Apply pressure bandage dressing to minimize bleeding and bruising.

Removing Implants

Explain the Removal Procedure to a Client

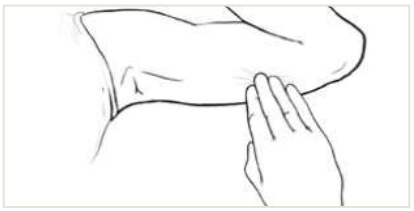
A woman needs to know what will happen during removal. The following description can help explain the procedure to her. The provider should ask whether the woman wants to continue preventing pregnancy and discuss her options. If she wants new implants, they should be placed above or below the site of the previous implants or in the other arm.

Steps for the Removal Procedure

1. Locate 1- rod implant by palpation and pressing down. Refer for further examination if not located.

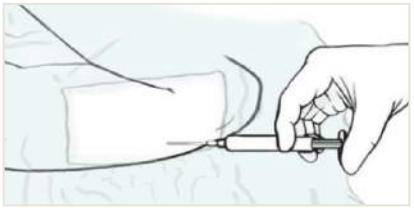
   Determine location of the distal end of the implant by palpation and mark this as the incision site.

   If the implant cannot be located, check both of the possible insertion sites (A and B), as well as both arms. If it is not possible to find the implant, refer the woman for further examination.

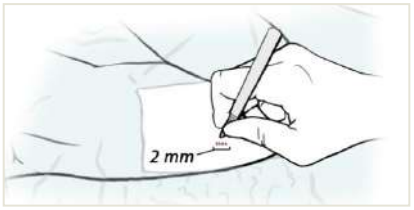


2. Prep insertion site with antiseptic solution and drape.

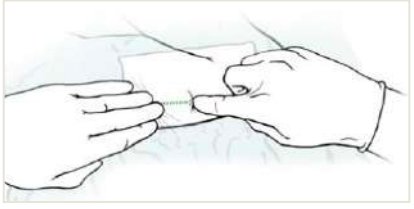
   Inject 1–2 mL of 1% lidocaine just under the implant so as not to obscure it. If this is a 2-rod system, inject between the 2 rods.



3. Make a small (2 mm) stab incision, at the tip(s) of and parallel to the implants.



4. Push the implant(s) toward the incision until the tip is visible. If this a 2-rod system, remove them one at a time.



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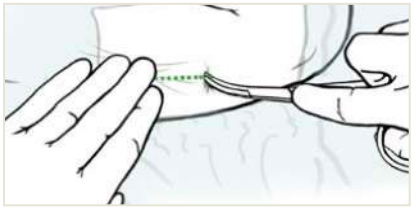
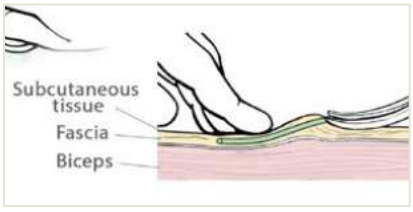
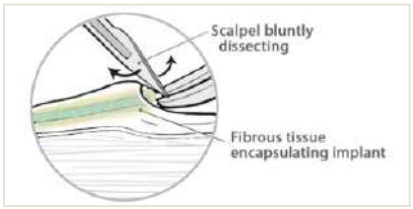
5. Grasp implant with a curved mosquito forceps and gently remove it.

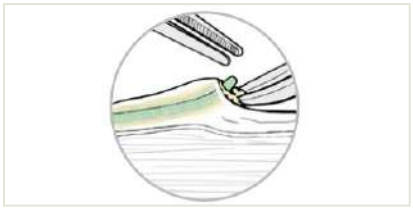




6. If the tip of the implant does not become visible in the incision, insert a forceps tip into the incision, grasp the implant and remove fibrous tissue with back of scalpel blade and/or gauze.

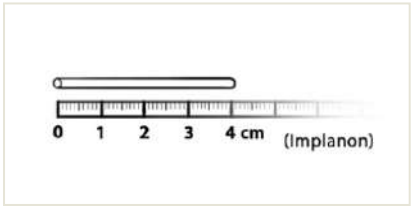


7. After the implant is exposed, grasp with second pair of mosquito foceps and gently remove it.

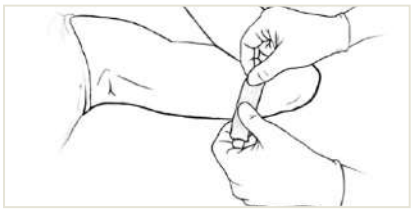


8. Ensure that the complete rod has been removed; show it to the client.

   If this is a 2-rod system, repeat steps 4–7 to remove the second rod.



9. Close the incision site with sterile skin closure.



10. Apply pressure bandage dressing to minimize bleeding and bruising.

Managing Any Problems

Problems reported as side effects or complications

Pain after insertion or removal

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

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

- Keep the implants in place, use an antiseptic to clean the infected area, and provide oral antibiotics for 7 to 10 days.
- Ask the client to come back after completing a course of antibiotics, and if the infection has not subsided, remove the implants or refer for removal.
- Expulsion or partial expulsion frequently occurs after infection. Ask the client to return if she notices an implant coming out.

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

- Do not remove the implants, and clean the area with antiseptic.
- Incise the abscess and drain it, treat the wound, and give oral antibiotics for 7–10 days.
- Ask the client to return after taking all antibiotics if she has heat, redness, pain, or drainage of the wound. If infection is present when she returns, remove the implants or refer for removal.

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

- This is rare, and usually occurs within a few months of insertion or with infection.
- If no infection is present, after explanation and counseling replace the expelled rod or capsule through a new incision near the other rods or capsules, or refer for replacement.

Change in Bleeding Pattern

No monthly bleeding

- If the client has no monthly bleeding soon after implant insertion, rule out pregnancy (see p.239). She might have been pregnant at the time of insertion. If she is pregnant, remove the implant.
- If she is not pregnant, reassure her that some women stop having monthly bleeding when using implants, and this is not harmful.

Irregular bleeding (bleeding at unexpected Times)

- Reassure her that many women using implants experience irregular bleeding. It is not harmful and usually becomes less or stops after the first year of use.
- For modest short-term relief, she can try (800mg) ibuprofen or (500mg) mefenamic acid 3 times daily after meals for 5 days, beginning when irregular bleeding starts.
- If these drugs do not help her, she can try one of the following, beginning when irregular bleeding starts:
  - Combined oral contraceptives that contain the progestin levonorgestrel. Ask her to take -1 pill daily for 21 days.
  - COCs containing 50 µg ethinyl estradiol -1 pill daily for 21 days.
- If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use (see the row on “Unexplained vaginal bleeding”, p.117).

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

- Reassure her that some women using implants experience heavy or prolonged-bleeding. It is generally not harmful and usually becomes less or stops after a few months.
- For modest short-term relief, she can try any of the treatments for irregular bleeding, as suggested above, beginning when heavy bleeding starts. COCs with (50 µg) of ethinyl estradiol may work better than lower-dose COCs.
- To prevent anemia, suggest iron tablets, and advise eating foods containing iron such as meat and poultry.
- If irregular, heavy, or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use (see the row on “Unexplained vaginal bleeding”, p.117).

Abdominal pain

Mild abdominal pain

- Suggest paracetamol (325–1000mg), aspirin (325–650mg), ibuprofen (200–400mg), or other pain reliever.
- Consider locally available remedies.

Severe lower abdominal pain

- May be due to various problems, such as enlarged ovarian follicles or cysts.
  - A woman can continue to use implants during evaluation.
  - There is no need to treat enlarged ovarian follicles or cysts unless they grow abnormally large, twist, or burst.
  - Reassure the client that they usually disappear on their own. To be sure the problem is resolving, see the client again in 6 weeks, if possible.
- Be particularly alert for additional signs or symptoms of ectopic pregnancy. Ectopic pregnancy is rare and not caused by implants, but it can be life-threatening. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy:
  - Unusual abdominal pain or tenderness.
  - Abnormal vaginal bleeding or no monthly bleeding—especially if this is a change from her usual bleeding pattern.
  - Light-headedness or dizziness.
  - Fainting.
- If ectopic pregnancy or other serious health condition is suspected, refer at once for immediate diagnosis and care.

Acne

- Consider locally available remedies.
- If client wants to stop using implants because of acne, she can consider switching to COCs. For many women, acne gets improved with COC use.

Breast tenderness

- Consider applying warm or cold compresses.
- Recommend that she wear a supportive bra all the times even (even during strenuous activity and sleeping).
- Offer aspirin (325–650mg), ibuprofen (200–400mg), paracetamol (325–1000mg), or other pain reliever, also may consider using locally available medicines.

Weight change

- Discuss the client's diet with her and counsel as needed.

Mood changes or changes in sex drive

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

Nausea or dizziness

- Consider locally available remedies.

Ordinary headaches (nonmigrainous)

- Suggest aspirin (325–650mg), ibuprofen (200–400mg), paracetamol (325–1000mg), or other pain reliever.
- Any headaches that get worse or occur more often during use of implants should be evaluated.

New Problems That May Require Switching Methods

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

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

Migraine headaches (see Identifying Migraine Headaches and Auras, p.246-248)

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

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

- A woman who has one of these conditions can safely start implants. If, however, the condition develops while she is using implants:
  - Remove the implants or refer for removal.
  - Help her choose a method without hormones.
  - Refer the client for diagnosis and care if she is not already under care.

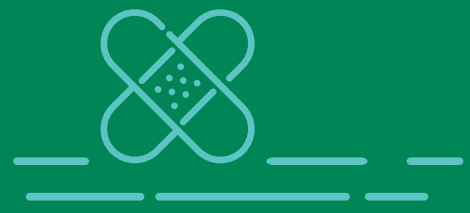
Certain serious health conditions (suspected blood clots in deep veins of legs or lungs, serious liver disease, or breast cancer). See annex 7 - Signs and Symptoms of Serious Health Conditions.

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

Suspected pregnancy

- Assess the client for pregnancy, including ectopic pregnancy (see “Severe lower abdomen pain”, p.116).
- Remove the implants or refer for removal if she will carry the pregnancy to term.
- There are no known risks to a fetus conceived while a woman has implants in place.

CHAPTER 7



COMBINED PATCH

Combined Patch

Combined patch is a small, thin square of flexible plastic worn on the body, continuously releases 2 hormones—a progestin and an estrogen, like the natural hormones progesterone and estrogen in a woman's body—directly through the skin into the bloodstream. See annex 8, for the recommended combined patch in KSA.

The woman puts on a new patch every week for 3 weeks, then no patch is used during the fourth week. During this week the woman will have her monthly bleeding.

Main Characteristics

- **Mechanism of action:**
  - Act primarily by preventing the release of ova from the ovaries (ovulation).

- **Effectiveness:** *Depends on the user:*
  - More than 99% effective over the first year, if no mistakes are made with use of the patch.
  - As commonly used, it is about 93% effective over the first year.

- **Common side effects:**
  - Changes in bleeding pattern: Lighter bleeding and fewer days of bleeding, irregular bleeding, prolonged bleeding, or no monthly bleeding.
  - Systemic side effects: Headaches, nausea, vomiting, abdominal pain, breast tenderness and pain, flu symptoms/upper respiratory infection, and vaginitis.

- **Protection against STIs:** Has no effect.

- **Fertility return:** Immediately, after stop applying the combined patch.

- **Known health benefits and risks:**
  - Long-term studies of the patch are limited, but researchers expect that its health benefits and risks are like those of combined oral contraceptives (COCs), (see p.19-20).

Medical Eligible Criteria for Combined Patch

Note: Medical Eligibility Criteria guidelines for when to start, and helping continuing users for the combined patch are the same as for combined oral contraceptives and the combined vaginal ring (see p.20,128).

Providing Combined Patch

A. Explaining How to Use the Combined Patch

1. **Explain how to remove the patch from its pouch and remove backing**
   - Tell the user that she should tear the foil pouch along the edge.
   - Then pull out the patch and peel away the backing without touching the sticky surface.

2. **Show her where and how to apply the patch**
   - Explain that she can apply it on the upper outer arm, back, stomach, abdomen, or buttocks, wherever it is clean and dry, but not on the breasts.
   - She must press the sticky, medicated part against her skin for 10 seconds. She should run her finger along the edge to make sure it sticks.
   - The patch will stay on even during work, exercise, swimming, and bathing.

3. **Explain when to change and restart the patch**
   - She must change the patch every week for 3 weeks in a row.
   - She should apply each new patch on the same day of each week—the "patch-change day." For example, if she puts on her first patch on a Sunday, all of her patches should be applied on a Sunday.
   - Explain that to avoid irritation, she should not apply the new patch to the same place on the skin where the previous patch was.

4. **Ask her not to wear a patch on the fourth week**
   - She should not wear a patch on the 4th week.
   - She will probably have monthly bleeding this week.

5. **Talk to her after the patch-free week, she should apply a new patch**
   - She should never go without wearing a patch for more than 7 days. Doing so risks pregnancy.

B. Instructions for Late Replacement or Removal, or if the Patch Comes Off

1. **Explain how to apply a new patch if she forgot to after the 7-day patch-free interval**
   - Apply a new patch as soon as possible.
   - Keep the same patch-change day.

- If late by only 1 or 2 days (48 hours or less), there is no need for a backup method.
- If more than 2 days late (more than 48 hours) and (that is, no patch was worn for 10 days or more in a row), use a backup method for the first 7 days of patch use.
- Also, if more than 2 days late and unprotected sex occurred in the past 5 days, consider taking ECPs (see Chapter 3).

2. **Describe what to do in case of being late changing the patch at the end of the first or second week**
   - If late by only 1 or 2 days (48 hours or less), apply a new patch as soon as possible. Keep the same patch-change day. No need for a backup method.
   - If more than 2 days late (more than 48 hours), apply a new patch as soon as possible. This patch will begin a new 4-week patch cycle, and this day of the week will become the new patch-change day. She needs to use a backup method for the next 7 days.
   - Also, if more than 2 days late and unprotected sex occurred in the past 5 days, consider taking ECPs (see Chapter 3).

3. **Explain what to do in case of being late taking off the patch at the end of the third week**
   - Remove the patch.
   - Start the next cycle on the usual patch-change day.
   - No need for a backup method.

4. **Describe what to do if the patch came off and was off for less than 2 days (48 hours or less)**
   - Apply a new patch as soon as possible. (The same patch can be re-used if it was off less than 24 hours).
   - No need for a backup method.
   - Keep the same patch change day.

5. **Explain what to do if the patch came off and was off for more than 2 days (more than 48 hours)**
   - Apply a new patch as soon as possible, with the same patch-change day.
   - Use a backup method for the next 7 days.
   - Keep the same patch-change day.

- If during third week, skip the patch-free week and start a new patch immediately after same week. If a new patch cannot be started immediately, use a backup method and keep using it through the first 7 days of patch use.
- If during first week and unprotected sex occurred in the past 5 days, consider taking ECPs (see Chapter 3).

CHAPTER 8

HORMONAL VAGINAL RINGS METHODS

Combined Vaginal Ring

Combined vaginal ring is a small, flexible ring that a woman places in her vagina. Continuously releases 2 hormones - a progestin and an estrogen, like the natural hormones progesterone and estrogen in a woman's body—from inside the ring. Hormones are absorbed through the wall of the vagina directly into the bloodstream.

A client leaves the ring in place for 3 weeks, then takes it out during her monthly period around the fourth week. Seven days later, she puts in a new ring, (see annex 8).

Main Characteristics

- **Mechanism of action:**
  - Act primarily by preventing the release of eggs from the ovaries (ovulation).

- **Effectiveness:** *Depends on the user:*
  - When no mistakes are made with use of the combined vaginal ring, less than 1 pregnancy per 100 women using the combined vaginal ring over the first year (3 per 1,000 women).
  - As commonly used, it is about 93% effective over the first year.

- **Common side effects:**
  - Changes in bleeding pattern: Lighter and fewer days of bleeding, irregular bleeding, infrequent bleeding, prolonged bleeding, or no monthly bleeding.
  - Systemic side effects: Headaches, white vaginal discharge, vaginitis.

- **Protection against STIs:** Has no effect.

- **Fertility return:** Immediately, after stop applying the combined vaginal ring.

- **Known health benefits and risks:**
  - Long-term studies of the vaginal ring are limited, but researchers expect that its health benefits and risks are like those of combined oral contraceptives (COCs), (see p.19-20).

Medical Eligible Criteria for Combined Vaginal Ring:

Note: Medical Eligibility Criteria guidelines for when to start, and helping continuing users for the combined vaginal ring are the same as for combined oral contraceptives and combined patch (see p.20,121).

Providing Combined Vaginal Ring

A. Explaining How to Use the Combined Vaginal Ring

1. Explain how to insert the ring

- The user can choose the position most comfortable for her—for example, standing with one leg up, squatting, or lying down.
- Then she should press opposite sides of the ring together and gently push the folded ring entirely inside the vagina. Vaginal muscles naturally keep the ring in place.

2. Explain how long she can use the ring

- She should keep the ring in place at all times, every day and night for 3 weeks.
- She can take the ring out at the end of the third week.

3. Describe when to take out the ring

- At the fourth week, she should remove the ring.
- To remove the ring, she can hook her index finger inside it, or squeeze the ring between her index and middle fingers, and pull it out.
- She will probably have monthly bleeding at the fourth week.
- If she forgets and leaves the ring in for as long as a fourth week, no special action is needed.

4. **Advise the client**
   - Never leave the ring out for more than 48 hours until the fourth week.
   - If the ring slips out, she should rinse it in clean water and immediately reinsert it.

B. Instructions for Late Replacement or Removal of the Combined Vaginal Ring

1. **If a client left the ring out for 48 hours or less during weeks 1 through 3**
   - Put the ring back in as soon as possible.
   - No need for a backup method.

2. **If she left the ring out for more than 48 hours during week 1, 2 or 3**
   - Put the ring back in as soon as possible.
   - Use a backup method for the next 7 days.
   - If the ring was left out for more than 48 hours in the first week and unprotected sex occurred in the previous 5 days, consider taking emergency contraceptive pills (ECPs), (see Chapter 3).
   - Start a new ring at the end of the third week and skip the ring-free week. If unable to start the new ring at the end of the third week, use a backup method and keep using it through the first 7 days after starting a new ring.

3. **If she forgot to insert a new ring at the beginning of the cycle**
   - Insert a new ring as soon as possible. If late by only 1- or 2 days (48 hours or less), that is - the ring is left out no longer than 9 days in a row - no need for a backup method.
   - Keep the same ring-removal day.
   - If the new ring is inserted more than 2 days (more than 48 hours) late - that is, the ring is left out 10 days or more in a row - use a backup method for the first 7 days of ring use.
   - Also, if unprotected sex occurred in the past 5 days, consider taking emergency contraceptive pills (ECPs), (see Chapter 3).

4. **If a ring is kept in longer than 3 weeks**
   - If the same ring is used for up to 28 days (4 weeks), no backup method is needed. She can take a ring-free week or start a new ring immediately.
   - If the same ring is used for 28 to 35 days (more than 4 weeks but less than 5 weeks), insert a new ring and skip the ring-free week. No backup method is needed.

Progesterone - Releasing Vaginal Ring

The progesterone - releasing vaginal ring is a small, smooth, soft flexible silicone ring placed in the vagina to prolong lactional amenorrhea (postponing the return of monthly bleeding). Continuously releases natural progesterone hormone - like that in woman's body - from inside the ring.

A client can start using the ring at 4 to 9 weeks after giving birth, and it remains in place for total of 90 days. A woman can start each new ring immediately afte removal of the previous ring for greatest effectiveness. The recommended progesterone - releasing vaginal ring in KSA, (see annex 8).

Main Characteristics

- **Mechanism of action:**
  - Act primarily by preventing ovulation. Progesterone extends the postpartum amenorrhea of the breastfeeding woman. That is, it delays the return of monthly bleeding.

- **Effectiveness:** *Depends on the user:*
  - Over a year, one or two pregnancies out of every 100 women who used the progesterone-releasing vaginal ring. This corresponds to an effectiveness rate of 98-99%.

- **Common side effects:**
  - Changes in bleeding pattern: Spotting or irregular bleeding.
  - Systemic side effects: Breast pain, lower abdominal pain, and vaginal discharge.

- **Protection against STIs:** Has no effect.

- **Fertility return:** Immediately after stop applying the progestrone – releasing vaginal ring.

- **Known health benefits and risks:**
  - No change in breast milk production or composition; the method supports continued breastfeeding and healthy infant nutrition.
  - Safe and effective, based on several 1-year studies. Its health risks may be like those of progestin-only pills (see p.33).
  - Women who are actively breastfeeding and are at least 4 weeks postpartum can safely use the progesterone-releasing vaginal ring (MEC Category 1).

Medical Eligible Criteria for Progestron – Releasing Vaginal Ring

Note: Medical Eligibility Criteria guidelines for when to start, and helping continuing users for the progesterone-releasing vaginal ring are the same as for progestin only pills (POPs),(see p.34).

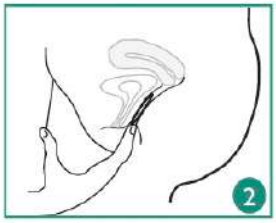
Providing Progestron – Releasing Vaginal Ring

A. Explaining how to use the Progestron – Releasing Vaginal Ring

1. Describe how to insert the ring in

- The client can choose the position most comfortable for her—for example, standing with one leg up, squatting, or lying down.
- Then she should press opposite sides of the ring together and, with her index finger, gently push the folded ring entirely inside the vagina as far as she can (see picure1). Vaginal muscles naturally keep the ring in place.

- The exact position of the ring in the vagina is not important, but inserting it deeply helps it to stay in place (see picture 2), and the user is less likely to feel it. The muscles of the vagina naturally keep the ring in place.



- She should not feel the ring after she places it into her vagina. If she feels the ring in her vagina, she has a sensation of it slipping, or it feels uncomfortable, she may not have pushed it back into her vagina far enough. Instruct her to use a clean finger to gently push the ring as far as she can into her vagina. There is no danger of the ring being pushed too far up in the vagina, breaking during insertion, or getting lost.

2. Inform her how long she should wear the ring

- She should keep the ring in place for 90 days at all times to maintain effectiveness.
- To contiue avoiding pregnancy, she can take the ring out at the end of the 90 days and replace it immediately with a new ring. She can use 4 rings, for up to one year of use in the postpartum period.

3. **Advise the client**
    - Never leave the ring out for more than 2 hours.
    - If the ring slips out completely, she should rinse it in clean water and immediately put it back in place.
    - A ring does not interfere with sex or decrease sexual pleasure.
    - Tell her that there's a possibility her husband may have felt the ring.

B. Instructions for Late Replacement or Removal of the Progestron – Releasing Vaginal Ring

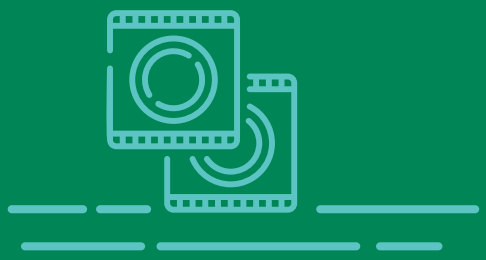
1. **If a client left her ring out for more than 2 hours**
    - Insert the ring back as soon as possible.
    - Contact your health care provider to discuss any concerns.

2. **If she left the ring out for more than 24 hours**
    - Insert the ring back as soon as possible.
    - Use a condom if you have sex in the next 48 hours.
    - Contact your health care provider to discuss any concerns.

3. **If she feels the ring slipping**
    - Use a clean finger to push the ring up as far into the vagina as possible.

4. **After one year of use or if no longer breastfeeding at least 4 times per day**
    - For longer birth spacing, she can plan ahead to switch to another family planning method.

CHAPTER 9



BARRIER CONTRACEPTIVE METHODS

Male Condoms

The male condom is a thin latex rubber sheath or covering that fits over a man's erect penis to prevent sperm from entering the female genital tract. STIs and HIV can also be prevented by using it. Male condoms are available over-the-counter and don't require a doctor's prescription. It is controllable by the user and can serve as a backup, temporary, or regular technique.

Main Characteristics

- **Mechanism of action:**
  - Act primarily by forming a physical barrier that keeps sperm out of the vagina, and preventing pregnacny. In addition, prevent infections in the vagina, penis, or semen from transmitting to other partner.

- **Effectiveness:** *Depends on the user:*
  - When used correctly with every act of sex, its effectiveness over the first year is 98%.
  - As commonly used, its effectiveness over the first year is 87%.

- **Common side effects:** None.

- **Protection against STIs and HIV:**
  - Male condoms significantly reduce the risk of becoming infected with HIV when used correctly with every act of sex.
  - When used consistently and correctly, condom use prevents 80% to 95% of HIV transmission that would have occurred without condoms.
  - Condoms reduce the risk of becoming infected with many STIs when used consistently and correctly during sexual practice.
    - Protect best against STIs spread by discharge, such as HIV, gonorrhea, and chlamydia.
    - Also protect against STIs spread by skin-to-skin contact, such as herpes and human papillomavirus.

- **Fertility return:** Immediately return.

- **Known health benefits:**
  - Help protect against: Risks of pregnancy and STIs, including HIV.
  - May help protect against conditions caused by STIs such as: Recurring pelvic inflammatory disease and chronic pelvic pain, cervical cancer and infertility (male and female).

- **Known health risks:**
  - Extremely rare: Severe allergic reaction (among people with latex allergy).

Medical Eligible Criteria for Male Condoms

All men can safely use latex male condoms except those with:

- Severe allergic reaction to latex rubber.
- Some time may be restricted in case of an erectile dysfunction.

Providing Male Condoms

A. When to start Using

Any time, whenever a man or a couple wants protection from pregnancy or STIs.

B. Explaining how to Use

There are **five steps** to using a male condom

1. Ensure that the client use a new condom for each act of sex

- Tell the client to check the condom package: If torn or damaged or date expired, do not use it.
- The man should wash his hands with mild soap and clean water before putting the condom on.

2. Explain to the client when to use the condom

- Before any physical contact, place the condom on the tip of the erect penis with the rolled side out.
- For the most protection, put the condom on before the penis makes any genital contact.

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3. Explain how to unroll the condom all the way to the base of the erect penis

- The condom should unroll easily. Forcing it on could cause it to break during use.
- If the condom does not unroll easily, it may be on backwards, damaged, or too old. Throw it away and use a new condom.
- If the condom is on backwards and another one is not available, turn it over and unroll it onto the penis.

4. Explain what to do after ejaculation

- Immediately after ejaculation, hold the rim of the condom in place and withdraw the penis while it is still erect.
- Slide the condom off, to avoid spilling semen.
- If having sex again, should use a new condom.

5. Discuss about the safest way to dispose of used condoms

- Wrap the condom in its package and put it in the rubbish pin.

Note: ***Some practices can increase the risk of condom breaks and should be avoided, such as unrolling the condom before putting on the penis, use of oilbased lubricants, reusing, use of more than one condom at the same time, or having dry sex.***

Managing Any Problems

Problems with use may or may not be due to the method.

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

- ECPs can help prevent pregnancy in such cases (see Chapter 3).
- Refer for possible post-exposure prophylaxis against HIV and possible presumptive treatment against other STIs. If the client has signs or symptoms of STIs after having unprotected sex, assess or refer.
- Ask clients to show you how they use the condom. Correct any errors in application or use.

Difficulty putting on the condom

- Ask clients to show you how they put the condom on, using a model or other item. Correct any errors.
- Ask the client if any lubricants are being used. the wrong lubricant or too little lubricant can increase the breakage while too much lubricant can cause the condom to slip off. it is better to use the lubricant packaged with condoms are usually made of silicone. Clean water and saliva can be used for lubrication.
- Avoid lubricants made with any oils, petroleum jell, lotions, cold creams, cocoa butter, and butter.

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

- Suggest trying another brand of condoms. A person may be more sensitive to one brand of condoms than to others.
- Suggest putting lubricant or water on the condom to reduce rubbing that may cause irritation.
- If symptoms persist, assess or refer for possible vaginal infection or STI as appropriate.
  - If there is no infection and irritation continues or recurs, the client may have an allergy to latex.
  - If not at risk of STIs, including HIV, help the client choose another method.
  - If the client or partner is at risk for STIs, suggest using female condoms or plastic male condoms, if available. If not available, urge continued use of latex condoms. Tell the client to stop using latex condoms if symptoms become severe.
  - If neither partner has an infection, a mutually faithful sexual relationship provides STI protection without requiring condom use but does not protect against pregnancy.

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

- Discuss ways to talk about condoms with partner (see Bringing Up Condom Use, p.136-137) and also dual protection rationales (see Choosing a Dual Protection Strategy, p.210).
- Consider combining condoms with:
  - Another effective contraceptive method for better pregnancy protection.
  - If no risk of STIs, a fertility awareness method, and using condoms only during the fertile time. (see p.161-169).
- Especially if the client or partner is at risk for STIs, encourage continued condom use while working out problems.

New Problems That May Require Switching Methods

May or may not be due to the method.

Female client is using Miconazole or Econazole (for treatment of vaginal infections)

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

Severe allergic reaction to condom (hives or rash over much of body, dizziness, difficulty breathing, or loss of consciousness during or after condom use). See annex 7 - Signs and Symptoms of Serious Health Conditions.

- 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.
- If the client or partner cannot avoid risk of STIs, suggest they use female condoms or plastic male condoms, if available.

Female Condoms

The female condom is a sheath made of thin, transparent, soft film that is inserted inside the vagina before or at the time of intercourse to prevent pregnancy, STIs, and HIV. It has 2 flexible rings, an inner ring at the closed end helps to insert the condom, and an outer ring at the open end holds the condom in position outside the vagina.

Main Characteristics

- **Mechanism of action:**
  - Act primarily by forming a physical barrier that prevents sperm from entering the vagina.

- **Effectiveness:**
  - When used correctly with every act of sex, it is 95% effective throughout the first year.
  - As commonly used, its effectiveness over the first year is 79%.

- **Common side effects:** None.

- **Protection against STIs and HIV:**
  - Female condoms reduce the risk of infection with STIs, including HIV, when used correctly with every act of sex.

- **Fertility return:** Immediately return.

- **Known health benefits:**
  - Help protect against: Risks of pregnancy, and STIs, including HIV.

- **Known health risks:** None.

Medical Eligible Criteria for Female Condoms

No Medical conditions restrict a client's eligibility to use the female condom, except those with severe allergic reaction to latex should not use latex female condoms. However, consideration should be given to the fact that there is a higher failure rate with condoms compared with other methods if not used correctly and consistently.

Providing female condoms

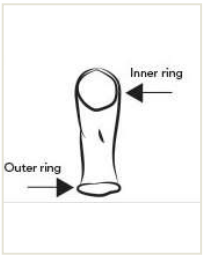
A. When to start Using

Any time, whenever a woman or a couple wants protection from pregnancy or STIs.

B. Explaining how to Use

There are **five steps** to using a female condom.

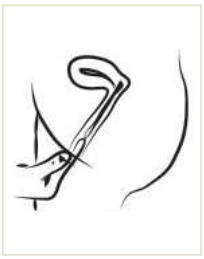
1. Ensure use of a new female condom for each act of sex



- Tell the client to check the condom package: if torn or damaged or date expired, do not use it.
- She should wash her hands with mild soap and clean water before putting the condom on.

2. Explain to the client when to insert the condom into the vagina

- For the most protection, insert the condom before intercourse by 8 hours.
- Choose a position that is comfortable for insertion—squat, raise one leg, sit, or lie down.
- Rub the sides of the female condom together to spread the lubricant evenly.



- Grasp the ring at the closed end, and squeeze it so it becomes long and narrow. With the other hand, separate the outer lips (labia) and locate the opening of the vagina.
- Gently push the inner ring into the vagina as far up as it will go. Insert a finger into the condom to push it into place. About 2 to 3 centimeters of the condom and the outer ring remain outside the vagina.

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3. Explain how the penis enters into the condom and stays inside it during intercourse

- The tip of the husband's penis should be carefully guided to enter inside the condom.
- If the condom is accidentally pulled out of the vagina or the outer ring is pushed into it during sex, put the condom back in place.

4. Explain what to do after the man withdraws his penis

- Remove the condom before standing up, to avoid spilling semen.
- If the couple has sex again, they should use a new condom.
- Reuse of female condoms is not recommended.
- Tell the client to 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.

5. Explain how to dispose of the used condom safely

- Wrap the condom in its package and put it in the rubbish pin.

Note: ***Explain about ECPs in case of errors in condom use to help prevent pregnancy.***

Managing Any Problems

The common side effects may or may not be due to the method.

Difficulty inserting the female condom

- Ask the client how she inserts the female condom. If a model is available, ask her to demonstrate and let her practice with the model. If not, ask her to demonstrate using her hands. Correct any errors.

Inner ring uncomfortable or painful

- Suggest that she reinsert or reposition the condom so that the inner ring is tucked back behind the pubic bone and out of the way.

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

- Usually goes away on its own without treatment.
- Suggest adding lubricant to the inside of the condom or onto the penis to reduce rubbing that may cause irritation.
- If symptoms persist, assess and treat for possible vaginal infection or STI, as appropriate.
  - If there is no infection, help the client choose another method unless the client is at risk for STIs, including HIV.
  - For clients at risk for STIs, including HIV, suggest using male condoms. If using male condoms is not possible, urge continued use of female condoms despite discomfort.
  - If neither husband has an infection, a mutually faithful sexual relationship provides STI protection without requiring condom use but does not protect against pregnancy.

Condom slips, is not used, or is used incorrectly

- ECPs can help prevent pregnancy (see Chapter 3).
- Refer for possible post-exposure prophylaxis for HIV and possible presumptive treatment for other STIs. If the client has signs or symptoms of STIs after having unprotected sex, assess or refer.

Condom squeaks or makes noise during sex

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

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

- Discuss ways to talk with her husband about the importance of the condom use for protection from pregnancy and STIs.

Suspected pregnancy

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

New Problems That May Require Switching Methods

Severe allergic reaction to condom (hives or rash over much of body, dizziness, difficulty breathing, or loss of consciousness during or after condom use). See annex 7 - Signs and Symptoms of Serious Health Conditions.

- Stop using latex condoms. Non-latex female condoms may be available.
- Refer for care, if necessary. Severe allergic reaction to latex could lead to life- threatening anaphylactic shock. Help the client choose another method.
- If the client or her husband cannot avoid risk of STIs, suggest they use non-latex female condoms or plastic male condoms, if available. If neither her husband has an infection, a mutually faithful sexual relationship provides STI protection without requiring condom use but does not protect against pregnancy.

Spermicides

Spermicides are sperm-killing substances inserted deep into the vagina, near the cervix, before sex. They are available as foaming tablets, melting or foaming suppositories, cans of pressurized foam, melting film, jelly, and cream are the least effective family planning methods.

Main Characteristics

- **Mechanism of action:**
  - Act primarily by causing the membrane of sperm cells to break, killing them or slowing their movement. This keeps sperm from meeting an egg.

- **Effectiveness:** *Depends on the user:*
  - When used correctly with every act of sex, its effectiveness over the first year is 84%.
  - As commonly used, its effectiveness over the first year is 79%.

- **Common side effects:**
  - Some users report irritation in or around the vagina and penis.
  - Possibly physical changes may occur likes vaginal lesions.

- **Protection against STIs:** None.

- **Fertility return:** Immediately.

- **Known health benefits:** Helps to protect against pregnancy.

- **Known health risks:**
  - Uncommon: Urinary tract infection, especially when using spermicides 2 or more times a day.
  - Rare: Frequent use of nonoxynol-9 may increase risk of HIV infection.

Medical Eligible Criteria for Spermicides

All women can safely use spermicides except those who:

- Are at high risk for HIV infection.
- Have HIV infection.

Those women who are at high risk for HIV infection or who have HIV should use another method.

Providing Spermicides

A. When to start Using

Any time the client wants to use spermicides, she can start using them.

B. Explaining how to use

It is important to give the client clear and practical instructions for spermicide use.

1. Give spermicide

- Give as much spermicides as possible - even as much as a year's supply, if available.

2. Explain how to insert the spermicide into the vagina

- Check the expiration date and avoid using the spermicide past its expiration date. If possible, wash hands with mild soap and clean water.
- Foam or cream: Shake cans of foam hard. 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.
- Tablets, suppositories, and jellies: Insert the spermicide deep into the vagina, near the cervix, with an applicator or with fingers.
- Film: Fold film in half and insert with fingers that are dry (or else the film will stick to the fingers and not the cervix).

3. Explain when to insert the spermicide into the vagina

- Foam or cream: Any time less than one hour before sex.
- Tablets, suppositories, jellies, and film: Between 10 minutes and one hour before sex, depending on type.

4. Explain about multiple acts of sex

- Insert additional spermicide before each act of sex.

5. Ensure that she does not wash the vagina (douching) after sex.

- Douching is not recommended because it will wash away the spermicide and also increase the risk of sexually transmitted infections.
- If you must douche, wait for at least 6 hours after sex before doing so.

Diaphragms

The diaphragm is a soft latex cup that covers the cervix. The rim contains a firm, flexible spring that keeps the diaphragm in place. It is better to be used with spermicides to improve effectiveness.

Main Characteristics

- **Mechanism of action:**
  - Act primarily by blocking sperm from entering the cervix; spermicide kills or disables sperm. Both keep sperm from meeting an egg.

- **Effectiveness**: *Depends on the user:*
  - When used correctly with spermicide in every act of sex, its effectiveness over the first year is 84%.
  - As commonly used with spermicide, its effectiveness over the first year is 83%.

- **Common side effects:**
  - Some users report irritation in or around the vagina and penis.
  - Possibly physical changes may occur likes vaginal lesions.

- **Protection against STIs:** None.

- **Fertility return:** No delay.

- **Known health benefits:**
  - Help protect against: Risks of pregnancy.
  - May help protect against: Certain STIs (chlamydia, gonorrhea, pelvic inflammatory disease, trichomoniasis), and cervical precancer or cancer.

- **Known health risks:**
  - Common to uncommon: Urinary tract infection.
  - Uncommon: Bacterial vaginosis and Candidiasis.
  - Rare: Frequent use of nonoxynol-9 may increase risk of HIV infection.
  - Extremely rare: Toxic shock syndrome.

Medical Eligible Criteria for diaphragms

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, she can start using the diaphragm if she wants.If she answers **"yes"** to a question, follow the instructions. In some cases, she can still start using the diaphragm.

A Client's Assessment for the use of Diaphragm based on WHO Medical Eligible Criteria
1. Has the client recently had a baby or second-trimester abortion? **No ( ) Yes ( )** • The diaphragm should not be fitted until 6 weeks after childbirth or second-trimester abortion, when the uterus and cervix have returned to normal size. Give her a backup method to use until then.
2. Is she allergic to latex rubber? **No ( ) Yes ( )** • She should not use a latex diaphragm if she has allergy to it. She can use a diaphragm made of plastic.
3. Does she have HIV infection? Does she think she is at high risk for HIV infection? (Discuss what places a woman at high risk for HIV—for example, her husband has HIV.) **No ( ) Yes ( )** • Do not provide a diaphragm. For HIV protection, recommend using condoms alone or with another method.

Providing Diaphragms

A. When to start using

Client's Situation	When to Start
Any time	**Any time** • If she has had a full-term delivery or second-trimester spontaneous or induced abortion less than 6 weeks ago, give her a backup method* to use, if needed, until 6 weeks have passed.

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Client's Situation	When to Start
Special advice for women switching from another method	• Suggest that she try the diaphragm for a time while still using her method. This way she can safely gain confidence that she can use the diaphragm.
Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.	

B. Explaining how to use

Whenever possible, show the woman the location of the pubic bone and cervix with a model or a picture. Explain that the diaphragm is inserted behind the pubic bone and covers the cervix. The steps below describe how to insert the diaphragm.

1. **Squeeze a spoonful of spermicidal cream, jelly, or foam into the diaphragm and around the rim**

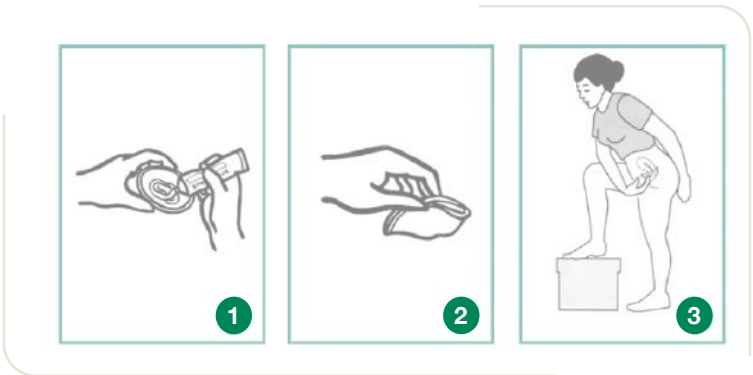
- With clean hands hold the diaphragm and check for holes, cracks, or tears and the expiration date.

2. **Explain how to press the rim together and push the diaphragm into the vagina as far as it goes**

- Insert the diaphragm less than 6 hours before having sex. Choose a position that is comfortable for insertion, squatting, raising one leg, sitting, or lying down.

3. **Explain how to feel the diaphragm to make sure it covers the cervix**

- Through the dome of the diaphragm, the cervix feels like the tip of the nose.
- If the diaphragm feels uncomfortable, take it out and insert it again.



4. **Describe how the diaphragm should remain in place for at least 6 hours following sex**

- Leave the diaphragm in place at least 6 hours after having sex but no longer than 24 hours.
- Leaving the diaphragm in place for more than one day may increase the risk of toxic shock syndrome. It also cause a bad odor and vaginal discharge.
- For multiple acts of sex, make sure that the diaphragm is in the correct position, and also insert additional spermicide in front of the diaphragm before each act of sex.

5. **Explain how to remove, slide a finger under the rim of the diaphragm and pull it down and out**

- With a clean hand insert a finger into the vagina until the rim of the diaphragm is felt, then gently slide the finger under the rim and pull the diaphragm down and out. Wash the diaphragm and keep it clean and dry after each use.

Managing Any Problems

The common side effects may or may not be due to the method. The health provider advises and supports the client.

Difficulty inserting or removing diaphragm

- Give advice on insertion and removal. Ask client to insert and remove the diaphragm in the clinic.
- Check its placement after she inserts it. Correct any errors.

Discomfort or pain with diaphragm use

- A diaphragm that is too large can cause discomfort. Check if it fits well.
  - Fit her with a smaller diaphragm if it is too large.
  - If fit appears proper and different kinds of diaphragms are available, try a different diaphragm.
- Ask her to insert and remove the diaphragm in the clinic. Check the diaphragm's placement after she inserts it. Give further advice as needed.
- Check for vaginal lesion:
  - If vaginal lesions or sores exist, suggest she use another method temporarily (condoms or oral contraceptives) and give her supplies. Lesions will go away on their own if she switches to another method.

- Assess for vaginal infection or sexually transmitted infection (STI). Treat or refer for treatment as appropriate.

Irritation in or around the vagina or penis (she or her partner has itching, rash, or irritation that lasts for a day or more)

- Check for vaginal infection or STI. Treat or refer for treatment as appropriate.
- If no infection, suggest trying a different type or brand of spermicide.

Urinary tract infection (burning or pain with urination, frequent urination in small amounts, blood in the urine, back pain)

- Treat with cotrimoxazole (240mg) orally once a day for 3 days, or trimethoprim (100mg) orally once a day for 3 days, or nitrofurantoin (50mg) orally twice a day for 3 days.
- If infection recurs, consider refitting the client with a smaller diaphragm.

Bacterial vaginosis (abnormal white or gray vaginal discharge with unpleasant odor; may also have burning during urination and/or itching around the vagina)

- Treat with metronidazole (2g) orally in a single dose, or metronidazole (400–500mg) orally twice a day for 7 days.

Candidiasis (abnormal white vaginal discharge that can be watery or thick and chunky; may also have burning during urination and/or redness and itching around the vagina)

- Treat with fluconazole (150mg) orally in a single dose, miconazole (200mg) vaginal suppository once a day for 3 days, or clotrimazole (100mg) vaginal tablets twice a day for 3 days.
- Miconazole suppositories are oil-based and can weaken a latex diaphragm. Women using miconazole vaginally should not use latex diaphragms or condoms during treatment. They can use a plastic female or male condom or another method until all medication is completed.

Suspected pregnancy

- Assess for pregnancy.
- There are no known risks to a fetus conceived while a woman is using spermicides.

New Problems That May Require Switching Methods

May or may not be due to the method.

Recurring urinary tract infections or vaginal infections (such as bacterial vaginosis or candidiasis)

- Consider refitting the client with a smaller diaphragm.

Latex allergy (redness, itching, rash, and/or swelling of genitals, groin, or thighs [mild reaction]; or hives or rash over much of the body, dizziness, difficulty breathing, loss of consciousness [severe reaction])

- Tell the client to stop using a latex diaphragm. Give her a plastic diaphragm, or help her choose another method, but not latex condoms.

Toxic shock syndrome (sudden high fever, body rash, vomiting, diarrhea, dizziness, sore throat, and muscle aches). See annex 7 – Signs and Symptoms of Serious Health Conditions.

- Treat or refer for immediate diagnosis and care. Toxic shock syndrome can be life-threatening.
- Tell the client to stop using the diaphragm. Help her choose another method but not the cervical cap.

Cervical Caps

The cervical cap is a soft, deep, latex or plastic rubber cup that snugly covers the cervix. It comes in different sizes and requires fitting by a specifically trained provider.

Main Characteristics

- **Mechanism of action:**
  - Act primarily by forming a physical barrier that prevents sperm from entering the female genital tract.

- **Effectiveness:** *Varies according to women birth status:*

  Women who give birth:
  - One of the least effective methods, as commonly used.
  - As commonly used with spermicide, its 68% over the first year.
  - When used correctly with every act of sex, its 74% over the first year.

  Women who not give birth:
  - One of the more effective methods, as commonly used.
  - As commonly used, its 84% effective during the first year especially if use with spermicide.
  - When used correctly with every act of sex, its 91% effective over the first year.

- **Protection against STIs:** None.

- **Fertility return:** No delay.

- **Side effects, health benefits and health risks:** Same as for diaphragm (see p.147).

Medical Eligible Criteria for cervical caps

As it is similar to the diaphragm, ask the client the same medical eligibility criteria questions for diaphragm use (see p.148), if she has cervical precancer or cancer do not provide cervical cap.

A Client's Assessment for the use of Cervical Cap based on WHO Medical Eligible Criteria

1. **Has the client been treated or is going to be treated for cervical pre-cancer (cervical intraepithelial neoplasia, [CIN]) or cervical cancer?**
   No ( ) Yes ( )
   - Do not provide her with a cervical cap.

Providing cervical caps

A. When to start Use

Providing the cervical cap is similar to providing diaphragms (see p.148-150).

B. Explaining how to Use

It is important to give the client clear and practical instructions for cervical cap insertion and removal procedures.

Cervical cap insertion procedure

- Fill one-third of the cap with spermicidal cream, jelly, or foam.
- Press the rim of the cap around the cervix until it is completely covered, pressing gently on the dome to apply suction and seal the cap.
- Insert the cervical cap any time up to 42 hours before having sex.

Cervical cap removing procedure

- The client should leave the cervical cap in for at least 6 hours after her husband's last ejaculation, but not more than 48 hours from the time it was put in.
- Leaving the cap in place for more than 48 hours may increase the risk of toxic shock syndrome and can cause a bad odor and vaginal discharge.
- Tip the cap rim sideways to break the seal against the cervix, and then gently pull the cap down and out of the vagina.

CHAPTER 10

NATURAL CONTRACEPTIVE METHODS

Lactational Amenorrhea Method

The lactational amenorrhea method (LAM), a temporary family planning method based on the natural effect of breastfeeding on fertility. This method performs effectively if the nursing woman meets the following criteria:

- The mother has amenorrhea – her monthly bleeding has not returned.
- She is fully or nearly fully breastfeeding, and fed often, day and night.
- The baby is less than 6 months old.

Note: To continue preventing pregnancy, a woman must switch to another method as soon as any one of the three LAM criteria no longer applies.

Main Characteristics

- **Mechanism of action:**
  - Act primarily by preventing the release of ova from the ovaries (ovulation). Frequent breastfeeding temporarily prevents the release of the natural hormones that cause ovulation.

- **Effectiveness:** *Depends on user:*
  - As commonly used, it might reach up to 98% within the first 6 months after childbirth.
  - When used correctly more than 99% effective within the first 6 months after childbirth.

- **Protection against STIs:** None.

- **Fertility return:** Depends on how long the woman continues to breastfeed.

- **Side effects:** None.

- **Known health risks:** None.

- **Known health benefits:**
  - Help protect against: Risks of pregnancy.
  - Encourages: The best breastfeeding patterns, with health benefits for both mother and baby.

Medical Eligible Criteria for Lactational Amenorrhea Method

All breastfeeding women can safely use the LAM, but a woman with the following circumstances may need to consider other contraceptive methods.

A Client's Assessment for the use of Lactational Amenorrhea Method based on WHO Medical Eligible Criteria
1. **Has HIV infection:** Should use condoms along with the LAM to prevent transmission of HIV and other STIs. If she is not taking ART therapy, she will transmit HIV to her infant through breastfeeding.
2. **Is using certain medications during breastfeeding:** Including mood-altering drugs, reserpine, ergotamine, anti-metabolites, cyclosporine, high-dose corticosteroids, bromocriptine, radioactive drugs, lithium, and certain anticoagulants.
3. **The newborn has a condition that makes it difficult to breastfeed:** Including being small-for-date or premature and needing intensive neonatal care, unable to digest food normally, or having deformities of the mouth, jaw, or palate.

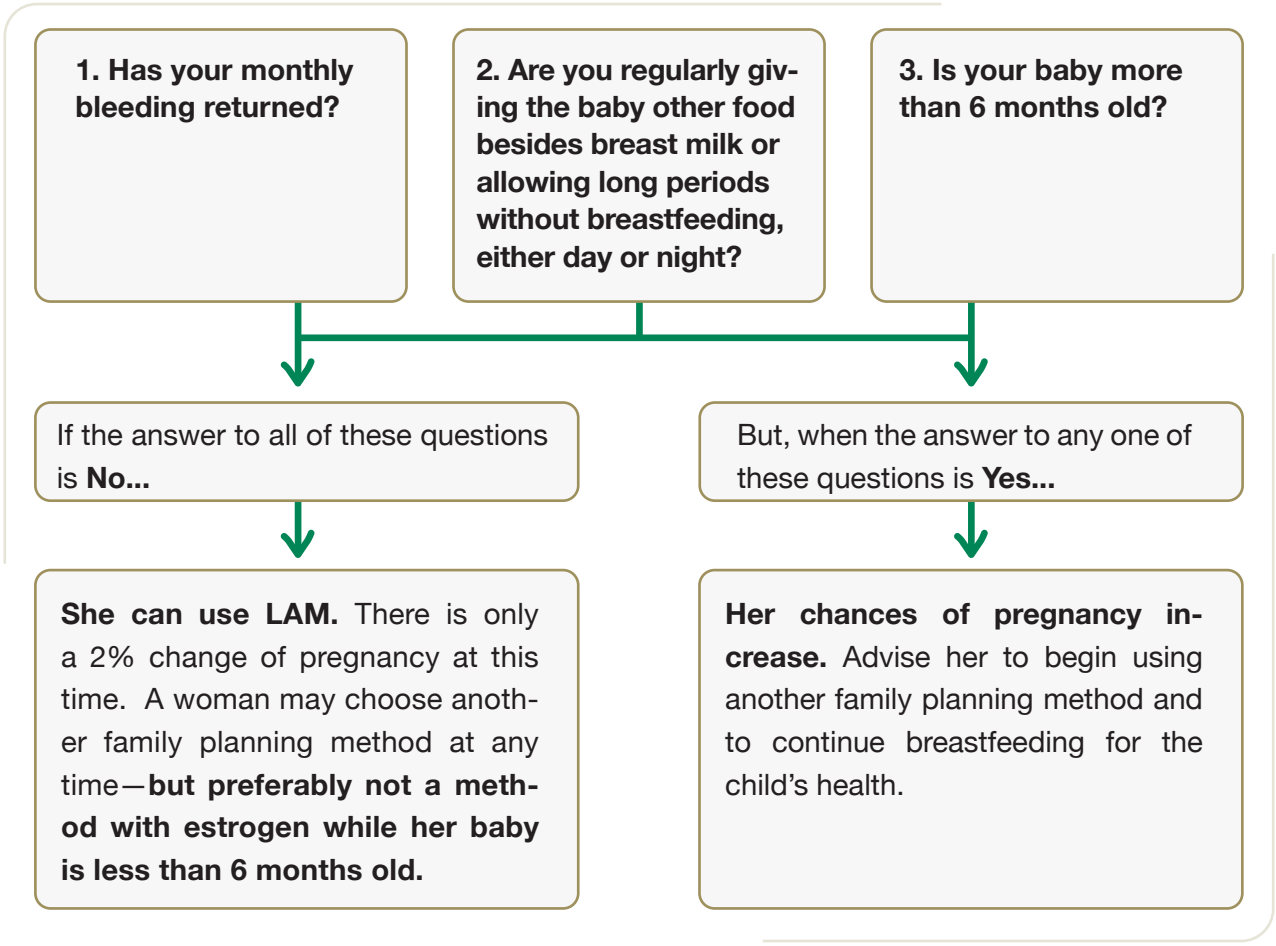
Providing Lactational Amenorrhea Method

A. When to Start Use

Client's Situation	When to Start
Within 6 months after childbirth	• Start breastfeeding immediately (within one hour) or as soon as possible after the baby is born. In the first few days after childbirth, the yellowish fluid produced by mother's breast (colostrum) contain substances very important to baby's health. • Any time, if she has been fully or nearly fully breastfeeding her baby since birth and her monthly bleeding has not returned.

When Can a Woman Use LAM?

Ask the mother these three questions:



B. Explaining How to Use

1. If a client is breastfeeding often

- An ideal pattern is feeding on demand and at least 10 to 12 times a day in the first few weeks after childbirth and thereafter 8 to 10 times a day, including at least once at night in the first months.
- Daytime feedings should be no more than 4 hours apart, and night-time feedings no more than 6 hours apart.
- Some babies may not want to breastfeed 8 to 10 times a day and may want to sleep through the night. These babies may need gentle encouragement to breastfeed more often.

2. Start other foods at 6 months

- She should start giving other foods in addition to breast milk when the baby is 6 months old. At this age, breast milk can no longer fully nourish a growing baby.

3. Plan follow-up visit

- Plan for the next visit while the LAM criteria still apply, so that she can choose another method and continue to be protected from pregnancy.
- If possible, give her condoms or POPs now (if the baby is no longer fully or nearly fully breastfeeding, if her monthly bleeding returns, or if the baby reaches 6 months of age before she can come back for another method).

Managing Any Problems

If a client reports any of these common problems, listen to her concerns and give advice and support. Make sure she understands the advice and agrees.

Breast tender or sore

- If her breasts are full and painful/tender, she may have engorged breasts.
- If one breast is tender with painful lumps, she may have blocked ducts. Engorged breasts or blocked ducts may progress to red and tender infected breasts. Treat infected breasts with antibiotics according to clinical guidelines.

  To aid healing, advise her to:
  - Continue to breastfeed often.
  - Massage her breasts before and during breastfeeding.
  - Apply heat or a warm compress to breasts.
  - Try different breastfeeding position.
  - Ensure that the infant latches properly to the breasts.
  - Express some milk before breastfeeding.

Nipples cracked or sore

- If her nipples are cracked, she can continue breastfeeding.
- Assure her that they will heal over time. To aid healing, advise her to:
  - Apply drops of breast milk to the nipples after breastfeeding and allow them to air-dry.
  - After feeding, use a finger to break suction first before removing the baby from the breast.
  - Do not wait until the breast is full to breastfeed. If full, express some milk first.
- Teach the woman about proper attachment and how to check for signs that the baby is not attaching properly.
- Tell her to clean her nipples with water only, once a day, and to avoid soaps and alcohol-based solutions.
- Examine her nipples and the baby's mouth and buttocks for signs of fungal infection (thrush).

Fertility Awareness - Method

The fertility awareness - method is based on the woman's identification of her naturally occurring signs and symptoms of the fertile and infertile phases of her menstrual cycle. It is sometimes called periodic abstinence or natural family planning. A woman can use several ways, alone or in combination, to tell when her fertile time begins and ends. There are main two types of fertility awareness-method:

- **Calendar-based methods:** Involve keeping track of days of the menstrual cycle to identify the start and end of the fertile time. Example include:
  - Standard Days Method, which avoids unprotected vaginal sex on days 8 through 19 of the menstrual cycle.
  - Calendar rhythm method.

- **Symptoms-based methods:** Depend on observing signs of fertility such as:
  - Cervical secretions: A woman sees or feels cervical secretions, or may feel just a little vaginal wetness.
  - Basal body temperature (BBT): A woman's resting body temperature goes up slightly after the release of an egg (ovulation). She is not likely to become pregnant from 3 days after this temperature rise through the start of her next monthly bleeding. Her temperature stays higher until the beginning of her next monthly bleeding.
  - Examples: TwoDay Method, BBT method, ovulation method (also known as Billings method or cervical mucus method), and symptothermal method.

Main Characteristics

- **Mechanism of action:**
  - Act primarily by avoiding unprotected sex during the fertile days—usually by abstaining or using condoms or a diaphragm. Some couples use spermicides or withdrawal, but these are among the least effective methods.

- **Effectiveness:**
  - As commonly used, about 85% depending on the woman's ability to identify her fertile phase.
  - Pregnancy rates with consistent and correct use vary for different types of fertility awareness methods (see table below).

Method	Pregnancies per 100 Women Over the First Year of Use	
	Consistent and correct use	As commonly used
Calender-based methods		
Standard Days Method	5	12
Symptoms-based methods		
Two Day Method	4	14
Ovulation method	3	23
Symptothermal method	<1	2

- **Protection against STIs:** None.
- **Fertility return:** No delay.
- **Side effects:** None.
- **Known health risks:** None.
- **Known health benefits:**
  - Help protect against: Risks of pregnancy.

First type: Calendar-Based Methods

Medical Eligible Criteria for Calendar-Based Methods

All women can use calendar-based methods. No medical conditions prevent the use of these methods, but some conditions can make them harder to use effectively. In the following situations, a woman may use it with caution or delay to ensure correct use of the method (see definition of caution and delay in annex 4).

A Client's Assessment for the use of Calendar-Based Methods based on WHO Medical Eligible Criteria
1. In the following situation, use caution with calendar-based methods: • Menstrual cycles are irregular. (For example, menstrual cycle irregularities are common in young women in the first several years after their first monthly bleeding and in older women who are approaching menopause. Identifying the fertile time may be difficult).
2. In the following situations, delay starting calendar-based methods: • Recently gave birth or is breastfeeding. (**Delay** until she has had at least 3 menstrual cycles and her cycles are regular again. For several months after regular cycles have returned, use with **caution**). • Recently had an abortion or miscarriage. (**Delay** until the start of her next monthly bleeding). • Irregular vaginal bleeding. (**Delay** until cycles have become more regular).
3. In the following situation, delay or use caution with calendar-based methods: • Taking drugs that can make the menstrual cycle irregular, (for example, certain antidepressants, thyroid medications, long-term use of certain antibiotics, or long-term use of any NSAID, such as aspirin or ibuprofen).

Providing Calendar-Based Method

A. When to start use

Once trained, a woman or couple usually can begin using calendar-based methods at any time. Give clients who cannot start immediately another method to use until they can start.

Client's Situation	When to Start
Having regular menstrual cycles	**Any time of the month** • No need to wait until the start of next monthly bleeding.
No monthly bleeding	• Delay calendar-based methods until monthly bleeding returns.

(Continue to next page)

Client's Situation	When to Start
After childbirth (whether breastfeeding or not)	• Delay the Standard-Day-Method until she has had 4 menstrual cycles and the last one was 26 – 32 days long. • Regular cycles will return later in breastfeeding women than in women who are not breastfeeding.
After miscarriage or abortion	• Delay the Standard-Day-Method until the start of her next monthly bleeding, when she can start if she has no bleeding due to injury to the genital tract.
Switching from a hormonal method	• Delay starting the Standard-Day-Method until the start of her next monthly bleeding. • If she is switching from injectables, delay the standard-days method at least until her repeat injection would have been given, and then start it at the beginning of her next monthly bleeding.
After taking emergency contraceptive pills	• Delay the Standard-Day-Method until the start of her next monthly bleeding.

B. Explaining How to Use the Calender-based Method

Standard Days Methods

Note: This method is appropriate for women whose menstrual cycles are usually between 26 and 32 days long.

1. Keep track of the days of the menstrual cycle

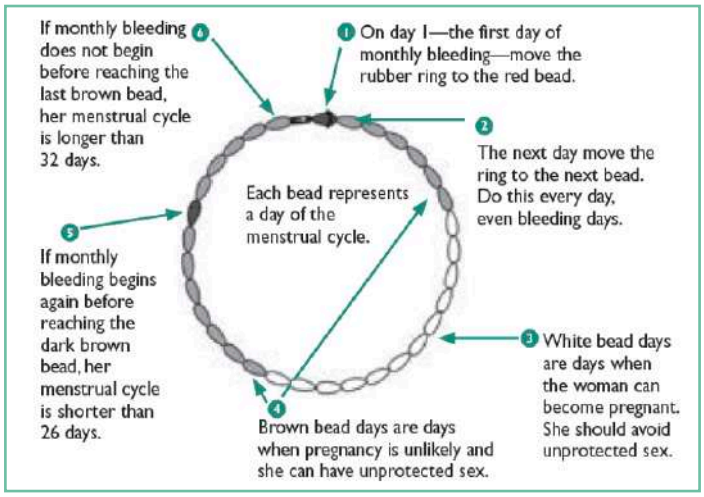
- A woman keeps track of the days of her menstrual cycle, counting the first day of monthly bleeding as day 1.

2. Avoid unprotected sex on days 8–19

- Days 8 through 19 of every cycle are considered fertile days for all users of the standard days method.
- The couple avoids sex or uses condoms or a diaphragm during days 8 through 19.
- The couple can have unprotected sex on all other days of the cycle-days 1 through 7 at the beginning of the cycle and from day 20 until her next monthly bleeding begins.

3. Use memory aids if needed

- The couple can mark a calendar or use other memory aids.



Calendar-Rhythm Method

1. Keep track of the days of the menstrual cycle

- Before relying on this method, a woman records the number of days in each menstrual cycle for at least 6 months. The first day of monthly bleeding is always counted as day 1.

2. Estimate the fertile time

- The woman subtracts 18 from the length of her shortest recorded cycle. This tells her the estimated first day of her fertile time. Then she subtracts 11 days from the length of her longest recorded cycle. This tells her the estimated last day of her fertile time.

3. Avoid unprotected sex during the fertile time

- The couple avoids sex or uses condoms or a diaphragm during the fertile time.

4. Update calculations monthly

- She updates these calculations each month, always using the 6 most recent cycles. Example:
  - If the shortest of her last 6 cycles was 27 days, (27–18=9). She starts avoiding unprotected sex on day 9.
  - If the longest of her last 6 cycles was 31 days, (31–11= 20). She can have unprotected sex again on day 21.
  - Thus, she must avoid unprotected sex from day 9 through day 20 of her cycle (see job aid Menstrual Cycle p. 245).

Second type: Symptoms-Based Method

Medical Eligible Criteria for Symptoms-Based Method

All women can use symptoms-based methods. No medical conditions prevent the use of these methods, but some conditions can make them harder to use effectively. In the following situations, the woman may use it with **caution** or **delay** to ensure correct use of the method (see definition of caution and delay in annex 4).

A Client's Assessment for the use of Symptoms-Based Methods based on WHO Medical Eligible Criteria

1. **In the following situation, use caution with symptoms-based method**
   - Recently had an abortion or miscarriage
   - Menstrual cycles have just started or have become less frequent or stopped due to older age. (Menstrual cycle irregularities are common in young women in the first several years after their first monthly bleeding and in older women who are approaching menopause. Identifying the fertile time may be difficult).
   - A chronic condition that raises her body temperature (for basal body temperature and symptothermal methods).

2. **In the following situations, delay starting symptoms-based method**
   - Recently gave birth or is breastfeeding. (**Delay** until normal secretions have returned—usually at least 6 months after childbirth for breastfeeding women and at least 4 weeks after childbirth for women who are not breastfeeding. For several months after regular cycles have returned, use with **caution**).
   - An acute condition that raises her body temperature (for basal body temperature and symptothermal methods).
   - Irregular vaginal bleeding.
   - Abnormal vaginal discharge.

3. **In the following situation, delay or use caution with symptoms-based method**
   - Taking any drugs that change cervical secretions, (for example, antihistamines, or drugs that raise body temperature, antibiotics).

Providing Symptoms-Based Method

A. When to start use

Once trained, a woman or couple usually can begin using symptoms -based methods at any time. Women not using a hormonal method can practice monitoring their fertility signs before they start using symptoms-based methods. Give clients who cannot start immediately another method to use until they can start.

Client's Situation	When to Start
Having regular menstrual cycles	**Any time of the month** • No need to wait until the start of next monthly bleeding.
No monthly bleeding	• Delay symptoms-based methods until monthly bleeding returns.
After childbirth (whether breastfeeding or not)	• She can start symptoms-based methods once normal secretions have returned. • Normal secretions will return later in breastfeeding women than in women who are not breastfeeding.
After miscarriage or abortion	• She can start symptoms-based methods immediately with special counseling and support if she has no infection-related secretions or bleeding due to injury to the genital tract.
Switching from a hormonal method	• She can start symptoms-based methods in the next menstrual cycle after stopping a hormonal method.
After taking emergency contraceptive pills	• She can start symptoms-based methods once normal secretions have returned.

B. Explaining How to Use Symptoms-Based Method

Two-Day Method

Note: If a woman has a vaginal infection or other condition that changes cervical mucus, the Two Day Method will be difficult to use.

1. Check for secretions

- A woman checks for cervical secretions every afternoon and/or evening, on fingers, underwear, or tissue paper or by sensation in or around the vagina.
- As soon as she notices any secretions of any type, color, or consistency, she considers herself fertile that day and the following day.

2. Avoid sex or use another method on fertile days

- The couple avoids vaginal sex or uses condoms or a diaphragm on each day with secretions and on each day following a day with secretions. They can also use withdrawal or spermicides, but these are less effective.

3. Resume unprotected sex after 2 dry days

- The couple can have unprotected sex again after the woman has had 2 dry days (days without secretions of any type) in a row.

Basal Body Temperature (BBT) Method

Note: If woman has fever or other changes in the body temperature, the BBT method will be difficult to use.

1. Take body temperature daily

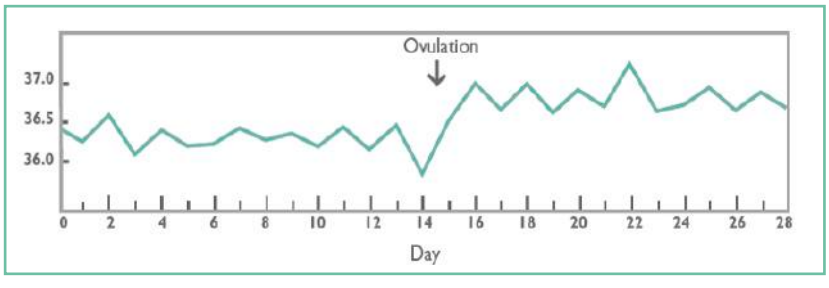
- A woman takes her body temperature at the same time each morning before she gets out of bed and before she eats anything. She records her temperature on a special graph.
- She watches for her temperature to rise slightly-0.2 °C to 0.5 °C (0.4 °F to 1.0 °F) just after ovulation (usually about midway through the menstrual cycle).

2. Avoid sex or use another method until 3 days after the temperature rise

- Avoid sex or use another method from the first day of monthly bleeding until 3 days after the woman's temperature has risen above her regular temperature.

3. Resume unprotected sex until next monthly bleeding begins

- When the woman's temperature has risen above her regular temperature and stayed higher for 3 full days, ovulation has occurred and the fertile period has passed.
- The couple can have unprotected sex on the fourth day and until her next monthly bleeding begins.



Ovulation Method

Note: If a woman has a vaginal infection or another condition that changes cervical mucus, this method may be difficult to use.

1. **Check cervical secretions daily**

- The woman checks every day for any cervical secretions on fingers, underwear, or tissue paper or by sensation in or around the vagina.

2. **Avoid unprotected sex on days of heavy monthly bleeding**

- Ovulation might occur early in the cycle, during the last days of monthly bleeding. Heavy bleeding could make mucus difficult to observe.

3. **Resume unprotected sex until secretions begin**

- Between the end of monthly bleeding and the start of secretions, the couple can have unprotected sex, but not on 2 days in a row. (Avoiding sex on the second day allows time for semen to disappear and for cervical mucus to be observed).
- It is recommended that they 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 check for cervical mucus.

4. **Avoid unprotected sex when secretions begin and until 4 days after "peak day"**

- As soon as she notices any secretions, she considers herself fertile and avoids unprotected sex.
- She continues to check her cervical secretions each day. The secretions have a "peak day"—the last day that they are clear, slippery, stretchy, and wet. She will know this has passed when, on the next day, her secretions are sticky or dry, or she has no secretions at all. She continues to consider herself fertile for 3 days after that peak day and avoids unprotected sex.

5. **Resume unprotected sex**

- The couple can have unprotected sex on the 4th day after her peak day and until her next monthly bleeding begins.

Withdrawal

Just before ejaculation, the man withdraws his penis from his partner's vagina and ejaculates outside the vagina, keeping his semen away from her external genitalia. Also known as coitus interruptus and "pulling out." One of the least effective contraceptive methods. Some men use this method effectively, however. Offers better pregnancy protection than no method at all. Always available in every situation. Can be used as a primary method or as a backup method. Requires no supplies and no clinic or pharmacy visit.

Main Characteristics

- **Mechanism of action:**
  - Works by keeping the sperm out of woman's body.

- **Effectiveness:** *Depends on the user:*
  - Risk of pregnancy is greatest when the man does not withdraw his penis from the vagina before he ejaculates with every act of sex.
  - When used correctly with every act of sex, it is 96% effective over the first year for the women whose partners use withdrawal.
  - As commonly used, it is 80% effective over the first year for the whose partners use withdrawal.

- **Protection against STIs:** None.

- **Fertility return:** Never Suppressed.

- **Side effects, known health risks, and known health benefits:** None.

Medical Eligible Criteria for Withdrawal

- All men can use withdrawal. No medical conditions restrict a client's eligibility to use.
- Withdrawal may be especially appropriate for couples who:
  - Have no other method available at the time.
  - Are waiting to start another method.
  - Have sex infrequently.
  - Have objections to using other methods.

Providing Withdrawal Method

A. When to Start Using

- Can be used at any time.
- Effectiveness depends on the willingness and ability of the couple to use withdrawal with every act of intercourse.

B. Explaining How to Use

1. When the man feels close to ejaculating

- He should withdraw his penis from the woman's vagina and ejaculate outside the vagina, keeping his semen away from her external genitalia.

2. If the man has ejaculated recently

- Before sex he should urinate and wipe the tip of his penis to remove any remaining semen.

3. Giving advice on use

- Inform the client that he can use the withdrawal method at any time, and that there is no contraindication to its use.
- Tell him that if he wants to increase the effectiveness of withdrawal, he may combine it with other methods.
- Explain that in case ejaculation takes place before withdrawing, ECP should be used (see Chapter 3).

C. Giving Advice on Use

1. Learning proper use can take time

- Suggest the couple also use another method until the man feels that he can use withdrawal correctly with every act of sex.

2. Greater protection from pregnancy is available

- Suggest an additional or alternative family planning method. (Couples who have been using withdrawal effectively should not be discouraged from continuing.)

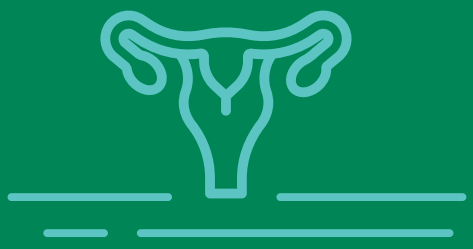
3. Some men may have difficulty using withdrawal

- Men who cannot sense consistently when ejaculation is about to occur.
- Men who ejaculate prematurely

4. Can use emergency contraceptive pills (ECPs)

- Explain ECP use in case a man ejaculates before withdrawing (see Chapter 3). Give ECPs if available.

CHAPTER 11



VOLUNTARY SURGICAL STERILIZATION METHODS

Female Sterilization (Tubal Ligation)

Female sterilization is a permanent surgical method of contraception for women to avoid having childern in the future. It provides irreversible protection against pregnancy. It has no adverse effects on the menstrual cycle, sexual desire, or even sexual intercourse. The two most common surgical approaches used are:

- **Mini-laparotomy:** Involves making a small incision in the abdomen. The fallopian tubes are brought to the incision to be cut or blocked.
- **Laparoscopy:** Involves inserting a long, thin tube containing lenses into the abdomen through a small incision. This laparoscope enables the doctor to reach and block or cut the fallopian tubes in the abdomen.

Alternative names for female sterilization are tubal sterilization, tubectomy, bi-tubal ligation, tying the tubes, mini-lap, and “the operation”.

Main Characteristics

- **Mechanism of action:**
  - Act primarily by cutting or blocking the fallopian tubes, which prevent ova and sperm from uniting.

- **Effectiveness:** *Varies slightly depending on how the tubes are blocked, but pregnancy rates are low with all techniques*
  - Most effective contraceptive methods, more than 99% effective over the first year after having the sterilization procedure.
  - A small risk of pregnancy remains beyond the first year after the procedure and until the woman reaches menopause.

- **Protection against STIs:** None.

- **Fertility return**: Never return.

- **Side effects**: None.

- **Known health risks:**
  - Uncommon to extremely rare: Complications of surgery and anesthesia (see the next page).

- **Known health benefits:**
  - Helps protect against: Risk of pregnancy, Pelvic inflammatory disease (PID).
  - May help protect against: Ovarian cancer.
  - Reduces: Risk of ectopic pregnancy.

Complications of Surgery (Uncommon to extremely rare)

- Complications can be kept to a minimum if appropriate techniques are used and if the procedure is performed in an appropriate setting by a skilled provider.
- Like other minor surgeries, female sterilization carries some risks, such as infection or abscess of the wound. Serious complications are uncommon. Death, due to the procedure or anesthesia, is extremely rare.
- The risk of complications with local anesthesia, with or without sedation and analgesia, is significantly lower than with general anesthesia.

Note: For female sterilization a pelvic examination and blood pressure screening are essential. When available, a hemoglobin test can contribute to safe and effective use.

Medical Eligible Criteria for Female sterilization

Ask the client the questions below to know about her medical conditions that may limit when, where, or how the sterilization procedure should be performed.
If she answers **"no"** to all of the questions, 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, (see annex 4)

A Client's Assessment for the use of Female Sterilization based on WHO Medical Eligible Criteria

1. **Does she have or has she ever had any female conditions or problems, such as infection or cancer? If so, what problems?**

   No ( ) **Yes ( )**

   If she has any of the following, use caution:
   - Previous abdominal or pelvic surgery.
   - Past pelvic inflammatory disease since last pregnancy.
   - Uterine fibroids.
   - Breast cancer.

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

   Related to pregnancy
   - current pregnancy.
   - 7–42 days postpartum.
   - Postpartum after a pregnancy with severe pre-eclampsia or eclampsia.

(Continue to next page)

A Client's Assessment for the use of Female Sterilization based on WHO Medical Eligible Criteria

- Serious postpartum or post-abortion complications (such as infection, hemorrhage, or trauma) except uterine rupture or perforation (special; see below).
- Hematometra (a large collection of blood in the uterus).

Unrelated to Pregnancy

- Unexplained vaginal bleeding that suggests an underlying medical condition.
- Purulent cervicitis, chlamydia, or gonorrhea.
- Pelvic inflammatory disease.
- Pelvic cancers (treatment may make her sterile in any case).
- Malignant trophoblast disease.

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

- Fixed uterus due to previous surgery or infection.
- Endometriosis.
- Hernia (abdominal wall or umbilical).
- Postpartum or post-abortion uterine rupture or perforation.

2. Does she have any heart problems, stroke, high blood pressure, diabetes, or complications of diabetes? If so, what?

No ( ) Yes ( )

If she has any of the following, use caution:

- Controlled high blood pressure.
- Mild high blood pressure (140/90 to 159/99 mmHg).
- Past stroke or heart disease without complications.
- Diabetes without damage to arteries, vision, kidneys, or nervous system.

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

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

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

- Several conditions together that increase chances of heart disease or stroke, such as older age, smoking, high blood pressure, or diabetes.
- Moderately high or severely high blood pressure (160/100 mm Hg or higher).
- Diabetes for more than 20 years or damage to arteries, vision, kidneys, or nervous system caused by diabetes.
- complicated valvular heart disease.

(Continue to next page)

A Client's Assessment for the use of Female Sterilization based on WHO Medical Eligible Criteria

3. Does she have any lingering, long-term diseases or any other conditions? If so, what?

No ( ) Yes ( )

If she has any of the following, use caution:

- Moderate iron-deficiency anemia (hemoglobin 7–10 g/dl).
- Severe lack of nutrition.
- Sickle cell disease.
- Inherited anemia (thalassemia).
- Diaphragmatic hernia.
- Epilepsy.
- Hypothyroidism.
- Mild cirrhosis of the liver, liver tumors, or schistosomiasis with liver fibrosis.
- Kidney disease.
- Obesity.
- Elective abdominal surgery at time sterilization is desired.
- Depression.
- Young age.
- Uncomplicated lupus with negative antiphospholipid antibodies.

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.
- HIV with advanced or severe clinical disease.
- Lupus with positive (or unknown) antiphospholipid antibodies, with severe thrombocytopenia, or on immunosuppressive treatment.

Providing Female Sterilization Method

A. When to Perform the Procedure

If there is no medical reason to delay, a woman can have the female sterilization procedure any time she wants if she is not pregnant and there are no medical conditions that limit when, where, or how the female sterilization procedure should be performed.

Client's Situation	When to Start
Having menstrual cycles or switching from another methods	**Any time of the month** • *Any time within 7 days after the start of her monthly bleeding.* No need to use another method before the procedure. • *If it is more than 7 days after the start of her monthly bleeding,* she can have the procedure any time. Make sure she is not pregnant. • If she is switching from oral contraceptives, she can continue taking pills until she has finished the pill pack to maintain her regular cycle. • If she is switching from an IUD, she can have the procedure immediately (see p.94).
No monthly bleeding	• Any time as long as she is not pregnant.
After childbirth	• *Immediately or within 7 days after giving birth,* if she has made a voluntary, informed choice in advance. • *Any time 6 weeks or more after childbirth* if it is certain she is not pregnant.
After miscarriage or abortion	• *Within 48 hours after uncomplicated abortion,* if she has made a voluntary, informed choice in advance.
After using emergency contraceptive pills (ECPs)	• The sterilization procedure can be done *within 7 days* after the start of her next monthly bleeding or any other time if she is not pregnant. • Give her a backup method or oral contraceptives to start the day after she finishes taking the ECPs, to use until she can have the procedure.

Ensuring Informed Choice

Note: The health care provider should listen carefully to the client's concerns, and gives adequate, clear and practical information about the sterilization procedure - especially its permanence-will help the client make an informed choice and be a successful and satisfied user, without later regret. Involving her husband in counseling can be helpful but is not necessary or required.

The 7 Points of Informed Consent
Counseling must cover all **7** points of informed consent. In some programs the client and the counselor also sign an informed consent form. To give informed consent to sterilization, the client must understand the following points:
1. Temporary contraceptives also are available to the client, including long-acting reversible contraceptives.
2. Voluntary sterilization is a surgical procedure.
3. There are certain risks of the procedure as well as benefits. (Both risks and benefits must be explained in a way that the client can understand.)
4. If successful, the procedure will prevent the client from ever having any more children.
5. The procedure is considered permanent and probably cannot be reversed.
6. The client can decide against the procedure at any time before it takes place (without losing rights to other medical, health, or other services or benefits).
7. The procedure does not protect against sexually transmitted infections, including HIV.

B. Performing the Sterilization Procedure

Explaining the procedure

There are two methods available for female sterilization procedures. The following description is for procedures done more than 6 weeks after childbirth. The procedure used up to 7 days after childbirth is slightly different.

The Minilaparotomy Procedure

1. The provider uses proper infection-prevention procedures at all times.
2. The provider performs a physical examination and a pelvic examination. The pelvic examination is to assess the condition and mobility of the uterus.
3. The provider inserts a special instrument (uterine elevator) into the vagina, through the cervix, and into the uterus to raise each of the 2 fallopian tubes so they are closer to the incision. This may cause discomfort.
4. The woman usually receives light sedation and analgesia to relax her. She stays awake. Local anesthetic is injected above the pubic hair line. She will not experience serious pain.
5. The provider makes a small horizontal incision (2–5 centimeters) in the anesthetized area. This usually causes little pain. (For women who have just given birth, the incision is made at the lower edge of the navel.)
6. Each tube is tied and cut or else closed with a clip or ring.
7. The provider closes the incision with stitches and covers it with an adhesive bandage.
8. The woman receives instructions on what to do after she leaves the clinic or hospital, (see Explaining Self Care for Female Sterilization on next page) usually she can leave in a few hours.

The Laparoscopy Procedure

1. The provider uses proper infection-prevention procedures at all times.
2. The provider performs a physical examination and a pelvic examination. The pelvic examination is to assess condition and mobility of the uterus.
3. The woman usually receives light sedation and analgesia to relax her. She stays awake. Local anesthetic is injected under her navel. She will not experience serious pain.
4. The provider places a special needle into the woman's abdomen and, through the needle, inflates (insufflates) the abdomen with gas or air. This raises the wall of the abdomen away from the pelvic organs.
5. The provider makes a small incision (about one centimeter) in the anesthetized area and inserts a laparoscope. A laparoscope is a long, thin tube containing lenses. Through the lenses the provider can see inside the body and find the 2 fallopian tubes.
6. The provider inserts an instrument through the laparoscope (or, sometimes, through a second incision) to close off the fallopian tubes.
7. Each tube is closed with a clip or a ring, or by electric current applied to block the tube (electrocoagulation).
8. The provider then removes the instrument and laparoscope. The gas or air is let out of the woman's abdomen. The provider closes the incision with stitches and covers it with an adhesive bandage.

9. The woman receives instructions on what to do after she leaves the clinic or hospital (see Explaining Self Care for Female Sterilization below). She usually can leave in a few hours.

C. Explaining Self-Care for Female Sterilization

1. Before the procedure the woman should

- Use another contraceptive until the procedure.
- She should not eat anything for 8 hours before surgery, but she can drink clear liquids until 2 hours before surgery.
- Not take any medication for 24 hours before the surgery (unless she is told to do so).
- Wear clean, loose-fitting clothing to the health facility if possible.
- Not wear nail polish or jewelry.
- If possible, bring her husband, relative or friend to help her go home afterwards.

2. After the procedure the woman should

- Rest for 2 days and avoid vigorous work and heavy lifting for a week.
- Keep the incision clean and dry for 1 to 2 days.
- Avoid rubbing the incision for 1 week.
- Abstinence from sex for at least 1 week, and then only when she feels comfortable having sex.

3. What to do about the most common problems

- She may have some abdominal pain and swelling after the procedure. It usually goes away within a few days. Suggest ibuprofen (200–400mg), paracetamol (325–1,000mg), or other pain reliever. She should not take aspirin, which slows blood clotting. If she had laparoscopy, she may have shoulder pain or feel bloated for a few days.

4. Plan the follow-up visit

- Following up within 7 days or at least within 2 weeks is strongly recommended.
- A health care provider checks the site of the incision, looks for any signs of infection, and removes any stitches.

Managing Any Problems

If the client reports complications of female sterilization, listen to her concerns, give advice and support, and, if appropriate, treat. Make sure she understands the advice and agrees.

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

- Clean the infected area with antiseptic, and give oral antibiotics for 7 to 10 days.
- Ask the client to return after taking all antibiotics if the infection has not cleared.

Abscess (a pocket of pus under the skin caused by infection)

- Clean the area with antiseptic.
- Cut open (incise) and drain the abscess.
- Treat the wound.
- Give oral antibiotics for 7 to 10 days.
- Ask the client to return if not improved after taking all antibiotics, and still has heat, redness, pain, or drainage of the wound.

Severe lower abdominal pain

- If the surgical procedure was recently performed, assess for any other problem that may indicate that the condition is related to the surgery, such as bleeding, lack of appetite, lack of bowel transit, lack of urination, or fever. If any of these are present, rapidly refer the client to a higher-level facility with surgical capability.
- If the surgery took place some months or years ago, suspect an ectopic pregnancy.

Ectopic pregnancy

- Ectopic pregnancy is a life-threatening condition requiring immediate surgery:
  - If ectopic pregnancy is suspected, perform a pelvic examination only if facilities for immediate surgery are available.
  - Otherwise, immediately refer and/or transport the woman to a facility where definitive diagnosis and surgical care can be provided.

Suspected pregnancy

- Assess for pregnancy, including ectopic pregnancy.

Male Sterilization (Vasectomy)

The Vasectomy is a permanent contraceptive method for men intended to provide life-long, and irreversible protection against pregnancy. It does not interfere with sexual desire, function, or appearance. It is also called male sterilization and male surgical contraception.

Main Characteristics

- **Mechanism of action:**
  - Act primarily by preventing sperm from mixing with semen during ejaculation. (Semen is ejaculated, but it does not contain sperm), because both vasa deferentia are surgically closed.

- **Effectiveness:**
  - Most effective contraceptive methods, more than 99% effective over the first year after having the sterilization procedure.
  - Vasectomy is not fully effective for 3 months after the procedure.
    - » Some pregnancies occur within the first year because the couple does not use condoms or another effective method consistently and correctly in the first 3 months before the vasectomy is fully effective.
  - A small risk of pregnancy remains beyond the first year after the procedure and until the woman reaches menopause.
    - » Over 3 years of use: About 4 pregnancies per 1,000 women.
  - If the wife of a man who has had a vasectomy becomes pregnant, it may be because:
    - » The couple did not always use another method during the first 3 months after the procedure.
    - » The cut ends of the vas deferens grew back together.
    - » The provider made a mistake.

- **Protection against STIs:** None.

- **Fertility return:** Never return.

- **Side effects:** None.

- **Known health risks:** None.

- **Known health benefits:**
  - Helps protect against: Risk of pregnancy in his wife.

- **Complication:**
  - Uncommon to rare: Severe scrotal or testicular pain that lasts for months or years.
  - Uncommon to very rare: Infection at the incision site or inside the incision (uncommon with conventional incision technique; very rare with no-scalpel technique).
  - Rare: Bleeding under the skin that may cause swelling or bruising (hematoma).

Medical Eligible Criteria for Male sterilization

Ask the client the questions below to know his medical conditions that may limit when, where, or how the vasectomy procedure should be performed. If he answers **"no"** to all of the questions, the vasectomy procedure can be performed in a routine setting without delay. If he answers **"yes"** to a question, follow the instructions, which recommend caution, delay, or special arrangements.

A Client's Assessment for the use of Male Sterilization based on WHO Medical Eligible Criteria

1. **Does he have any problems with his genitals, such as infections, swelling, injuries, or lumps on his penis or scrotum? If so, what problems?**

   No ( ) Yes ( )

   If he has any of the following, use caution:
   - Previous scrotal injury.
   - Swollen scrotum due to 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, the other side must be done, too).

   If he has any of the following, delay male sterilization:
   - 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 at the same time as repairing the hernia. If this is not possible, the hernia should be repaired first).
   - Undescended testicles—both sides.

(Continue to next page)

A Client's Assessment for the use of Male Sterilization based on WHO Medical Eligible Criteria

2. Does he have any other conditions or infections? If so, what?

No ( ) Yes ( )

If he has any of the following, use caution:

- Diabetes.
- Depression.
- Young age.
- Lupus with positive (or unknown) antiphospholipid antibodies or is 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:

- HIV with advanced or severe clinical disease.
- Coagulation disorders (blood does not clot).
- Lupus with severe thrombocytopenia.

Providing Male Sterilization Method

A. When to Perform the Procedure

Any time a man requests it (if there are no medical reasons to delay).

Ensuring Informed Choice

Apply the same criteria used for female sterilization when making a well-informed choice (see p.180).

B. Performing the Sterilization Procedure

Explaining the procedure

The following description can help to explain the procedure to the man who has chosen a vasectomy. This description is summary not detailed instructions.

1. The provider uses proper infection-prevention procedures at all times.
2. The man receives an injection of local anesthetic in his scrotum to prevent pain. He stays awake throughout the procedure.
3. The provider feels the skin of the scrotum to find each vas deferens—the 2 tubes in the scrotum that carry sperm.

4. The provider makes a puncture or incision in the skin:
   - Using the no-scalpel vasectomy technique, the provider grasps the tube with specially designed forceps and makes a tiny puncture in the skin at the midline of the scrotum with a special sharp surgical instrument.
   - Using the conventional procedure, the provider makes 1 or 2 small incisions in the skin with a scalpel.
5. The provider lifts out a small loop of each vas from the puncture or incision. Most providers then cut each tube and tie one or both cut ends closed with thread. Some close off the tubes with heat or electricity. They may also enclose one end of the vas in the thin layer of tissue that surrounds the vas.
6. The puncture is covered with an adhesive bandage, or the incision may be closed with stitches.
7. The man receives instructions on what to do after he leaves the clinic or hospital (see Expaining Self-Care for Vasectomy below). The man may feel faint briefly after the procedure. He should stand first with help, and he should rest for 15 to 30 minutes. He usually can leave within an hour.

Explaining Self-Care for Male Sterilization

1. Before the procedure the man should

- Wear clean, loose-fitting clothing to the health facility.

2. After the procedure the man should

- Rest for 2 days, if possible.
- Put cold compresses on the scrotum for the first 4 hours, which may decrease pain and bleeding.
- Wear snug underwear or pants for 2 to 3 days to help support the scrotum.
- Keep the puncture/incision site clean and dry for 2 to 3 days. He can use a towel to wipe his body clean but should not soak in water.
- Should not have sex for at least 2 to 3 days.
- Use condoms or another effective family planning method for 3 months after the procedure.

3. What to do about the most common problems

- Discomfort in the scrotum usually lasts 2 to 3 days. Suggest ibuprofen (200–400mg), paracetamol (325–1000mg), or other pain reliever. He should not take aspirin, which slows blood clotting.

4. Plan the follow-up visit

- Ask him to return in 3 months for semen analysis, because at this time it should become sperm free.

Managing Any Problems

If the client reports complications of vasectomy, listen to his concerns, give advice and support, and, if appropriate, treat.

Bleeding or blood clots after the procedure

- Reassure the client that minor bleeding and small uninfected blood clots usually go away without treatment within a couple of weeks.
- Large blood clots may need surgical drainage.
- Infected blood clots require antibiotics and hospitalization

Infection at the puncture or incision site (redness, heat, pain, pus)

- Clean the infected area with soap and water or antiseptic.
- Give oral antibiotics for 7 to 10 days.
- Ask the client to return after taking all antibiotics if the infection has not cleared.

Abscess (a pocket of pus under the skin caused by infection)

- Clean the area with antiseptic.
- Cut open (incise) and drain the abscess.
- Treat the wound.
- Give oral antibiotics for 7 to 10 days.
- Ask the client to return after taking all antibiotics if he has heat, redness, pain, or drainage of the wound.

Pain lasting for months

- Suggest elevating the scrotum with snug underwear or pants or an athletic supporter.
- Suggest soaking in warm water.
- Suggest aspirin (325–650mg), ibuprofen (200–400mg), paracetamol (325–1000mg), or other pain reliever.
- Provide antibiotics if infection is suspected.
- If pain persists and cannot be tolerated, refer for further care.

CHAPTER 12

SERVING DIVERSE GROUPS

Serving Diverse Groups

Clients are considered to have special needs for family planning if they are at high risk of an unintended pregnancy or have physical, social-cultural, or biological conditions that could make it difficult for them to access family planning services. Young clients, older women, men, postpartum women, post-abortion, client living with HIV, and people with disabilities. Regardless of their circumstances, all of these clients are entitled to the same family planning information and services as the other clients.

Adolescents

- All contraceptives are safe for young people.
  - They can safely use any contraceptive method. Age is not a medical reason for denying any method to adolescents.
  - Young women are often less tolerant. However, with counseling, they will be a-ware of what to expect and may be less likely to stop using their methods.
  - It is important when counseling young people to consider sexually transmitted infections (STIs) risk and how to reduce it.

Women Near Menopause

- Pregnancy is possible right up to menopause, but it carries greater risks for the woman and her baby.

- **All methods are safe for healthy older women, but:**
  - Older women who are at risk for heart disease (who have high blood pressure or diabetes or who smoke) should not use the pill or monthly injectables. Help her choose another method.
  - Users of fertility-awareness-based methods should switch to another method as they approach menopause. Their irregular periods can make fertility-awareness-based methods hard to use.
  - If an older woman is already having heavy bleeding problems, IUD use may increase them further.
  - Female sterilization may be a good choice for older couples who do not want any more children.
  - Bone mineral density decreases slightly during DMPA use, but increases again after stopping. It is not known whether this leads to an increased risk of fractures.

- **When to stop using family planning methods**
  - IUDs can be left in place until after menopause. They should be removed at least 1 year after the last menstrual period.
  - Hormonal methods (pills, injectables, and implants) affect bleeding. It may be difficult to know if the woman has reached menopause. After stopping a hormonal method, she can use condoms for one year. If she has no menstrual periods during that time, she no longer needs contraception.

- **Protecting herself from STIs and HIV/AIDs**
  - Sexually active older women can still be at risk for STIs or HIV infection, even if they no longer need contraception (see Dual Protection - see p.210).

Men

- **Important supporters, important clients**
  - They influence women. Many men care about their spouses' reproductive health and support them.
  - Men are also important as clients. Important family planning methods— male condoms and vasectomy—are used by men.

- **Many ways to help men**
  - Providers can give support and services to men both as supporters of women and as clients.

- **Encourage couples to talk**
  - Coach men and women on how to talk with their spouses about sex, family planning, and STIs.
  - Encourage joint decision-making about sexual and reproductive health matters.
  - Invite and encourage women to bring their husbands to the clinic for joint counseling, decision-making, and care.
  - Encourage the man to understand and support his wife to choose the contraceptive method she prefers.
  - Encourage the man to consider taking more responsibility for family planning-for example, by using condoms or vasectomy.
  - Suggest to female clients that they tell their husbands about health services for men. Give informational materials to take home, if available.

- **Provide accurate information**

  To inform men's decisions and opinions, they need correct information and correction of any misperceptions. Topics important to men include:

  - Family planning methods, both for men and for women, including safety and effectiveness.
  - STIs including HIV—how they are and are not transmitted and the signs and symptoms, testing, and treatment.
  - The benefits of waiting until the youngest child is 2 years old before a woman becomes pregnant again.
  - Male and female sexual and reproductive anatomy and function.
  - Safe pregnancy and delivery.

- **Offer services or refer**

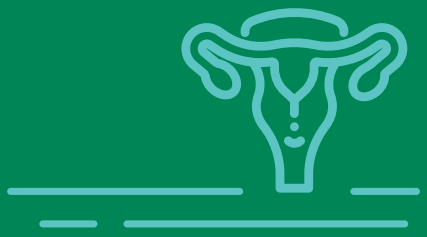
  Important services that many men want include:
  - Male condoms and vasectomy services.
  - Information and counseling about other contraceptive methods, particularly methods that must have the male cooperation, such as fertility-awareness-based methods and female condoms.
  - Counseling and help for sexual problems.
  - STI/HIV counseling, testing, and treatment.
  - Infertility counseling.
  - Screening for penile, testicular, and prostate cancer.

Clients with Disabilities

- People with disabilities should be treated in the same way as people without disabilities.
- To counsel clients with disabilities, health care providers need to consider their preferences and the nature of their disability.
  - For example, barrier methods may be difficult for some people with a physical disability, and women with an intellectual disability may have trouble remembering to take a pill each day or dealing with changes in monthly bleeding.
- Like all clients, people with disabilities need sexual and reproductive health education to make informed choices.
- Facilities should be made physically accessible—for example, with ramps for wheelchairs and large bathrooms with grab bars.

- Learning to respect the rights of people with disabilities and to care for them should be part of pre-service training for health care providers, and it should be reinforced with in-service training periodically.

CHAPTER 13



REPRODUCTIVE HEALTH ISSUES

Family Planning in Post Abortion Care

Post-abortion care includes any or all of the following, as needed or desired:

An optional post abortion follow-up visit 7–14 days after the procedure, management of persistent side effects or complications, and contraceptive services. Immediately after an abortion, before the client leaves the facility, it's crucial to provide family planning information and also to offer counseling and methods of contraception. Family planning services can be offered by different health workers, including those who carry out abortions and provide post-abortion care. When such services are provided immediately after an abortion and are included in post abortion care, women are more likely to use contraception to reduce the risk of an unintended pregnancy.

Help Women Obtain Family Planning

Provide Important Information

A woman has important choices and opportunities, before, during, and after abortion care. To make decisions about her health and fertility, she needs to know the following:

- Fertility returns quickly. Following an abortion, ovulation can return as early as 8–10 days later and usually within 1 month. Hence, initiating a family planning method immediately after abortion if possible, or as soon as possible within the first month, is important for women who desire to delay or prevent a future pregnancy.
- All contraceptive options may be considered after an abortion. The client's wishes and her future plans for childbearing are paramount and the woman should be empowered to make an informed choice.
- If the woman decides to wait before choosing a contraceptive method for ongoing use, she should consider using a backup method in the meantime if she has unprotected sex. The client should be informed that spermicides and withdrawal are the least effective contraceptive methods, and if possible, she should be given condoms and emergency contraceptive pills.
- If the woman decides not to use contraception at this time, providers can offer information on her fertility condition, the most appropriate available methods, and where to obtain them.
- If being treated for infection or vaginal or cervical injury, the woman should wait until she has completed treatment/management of the infection/injury before having sex again.

- If a woman who has suffered a miscarriage wants to become pregnant again soon, the provider should encourage her to wait at least 6 months as this may reduce the risks of low birth weight, premature birth, maternal anemia, and a repeat miscarriage.
- A woman receiving postabortion care may need other reproductive health services. In particular, a provider can help her consider if she might have been exposed to STIs.

When to Start Contraceptive Methods

After ruling out the presence of any medical conditions that may affect medical eligibility the following methods may be started immediately, (see annex 4).

Contraceptive method	First trimester medical/ surgical abortion	Second trimester medical/ surgical abortion	Special considerations
Reversible methods (in order of effectiveness)			
Intrauterine device (IUD)	Can insert at the time success of abortion is determined	Can insert at the time success of abortion is determined, but insertion must be done by a specially trained person	Avoid after septic abortion
Implant, Progestin-only injectables, Combined injectable contraceptives (monthly), Combined patch, Combined ring, Combined oral contraceptives, Progestin-only pills	Can start immediately after abortion; in the case of medical abortion, can start immediately after the first pill of the medical abortion regimen		Injectable can be considered
Diaphragm and cap	Can start immediately after abortion	Wait for 6 weeks	

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Contraceptive method	First trimester medical/ surgical abortion	Second trimester medical/ surgical abortion	Special considerations
Reversible methods (in order of effectiveness)			
Fertility awareness-based methods (FABs)	Can start when regular menstrual cycles return		Special counseling may be needed to ensure correct use of FABs
Irreversible (permanent) methods			
Female sterilization	Can have this surgery immediately after abortion		The decision to have this surgery must be made in advance of the abortion

Additional considerations:

- IUD insertion immediately after a second-trimester abortion is associated with a higher risk for expulsion, which the woman should be informed about, and the insertion requires a specially trained provider.
- If pills are the chosen method, provide up to 3 month's supply of pills, depending on the woman's preference and anticipated usage.
- Clients who choose to start the contraceptive ring should be instructed to check for expulsion in the event of residual or heavy bleeding during / after the medical abortion process.
- The diaphragm must be refitted after uncomplicated first-trimester miscarriage or abortion. After uncomplicated second-trimester miscarriage or abortion, refitting of the diaphragm should be delayed 6 weeks to allow the uterus to return to normal size.
- Sterilization is permanent and must be decided upon in advance of the abortion, and not while a woman is sedated, under stress, or in pain. Counsel carefully and be sure that the client understands they have the option to choose a reversible method (see p.175-183).
- Fertility awareness-based methods (FABs):
  - A woman can start symptoms based methods once she has no infection-related secretions or bleeding due to injury to the genital tract.
  - She can start calendar-based methods with her next monthly bleeding, if she is not having bleeding due to injury to the genital tract (see p.161-167).

Cervical Cancer

Cervical cancer results from uncontrolled, untreated growth of abnormal cells in the cervix as result of Human papillomavirus (HPV), an STI infections. HPV is found on skin in the genital area in addition to the tissues of the vagina, cervix, and mouth.

It is primairly transmitted through skin-to-skin contact, and vaginal sex can also spread HPV.Over 40 types of HPV can infect the cervix but only 14 of them can cause pre-cancer changes to the cell of cervix. Most sexually active women are infected with at least one type of HPV throughout their lives. In most cases the HPV infection clears (goes away) on its own. However, in some clients, HPV is still existing and results in pre-cancerous lesions on the cervix that can progress to cancer.

Cancer of the cervix usually takes at least 10 to 20 years to develop. This means there is a long period of opportunity to detect and treat early cervical cell changes before they become cancer.

Who Is Most at Risk of Having Cervical Cancer?

Some factors make clients more likely to be infected by HPV. Other factors contributed to the persistence of high-risk HPV infection and cervical cancer progression. Every client benefits from cervical pre-cancer lesion screening and treatment, although the following factors and characteristics enhance the risk of being infected with HPV, developing a persistent HPV infection, and developing cervical pre-cancer or cancer:

- Having multiple sexual partners and/or having a partner who has multiple sexual partners.
- Having had many sexual partners over the years, and/or having a sexual partner who has had many sexual partners over the years.
- Having a weakened immune system (including those living with HIV, who have 6 times the risk of developing cervical cancer compared with those who don't have HIV).
- Having other STIs, such as genital herpes, chlamydia, or gonorrhea.
- Being young at the time of first intercourse/first birth.
- Being a tobacco smoker.
- Having a partner who is not circumcised.

Screening Tests

There are three different screening tests that can be used:

1. Cytology test is (conventional Papanicolaou [Pap] smear or liquid-based cytology [LBC]) requires collecting a small amount of cells from the cervix. The sample is sent to a laboratory for analysis. Using cytology requires a well-functioning lab that has quality assurance systems in place.

2. Primary screening test is an HPV DNA nucleic acid amplification test (HPV NAAT), detect the presence of a virus by detecting the viral DNA.

3. Co-testing (Pap and Primary and HPV DNA testing).

4. Visual Inspection with Acetic Acid (VIA) – performed by looking at the cervix with the naked eye 1 minute after applying a weak vinegar (3–5% acetic acid) solution to it. Maintaining a well-functioning VIA screening program requires training and supervision of providers and ongoing quality control.

Starting Age and Interval of Screening

- Pre-cancer screening for the cervical lesion is quick, easy, and usually painless.
- Cervical screening is recommended for women at the following conditions;
  - Women aged 21 to 29: Starting cervical cancer screening at the age of 21 or 22 years after starting sexual activity (whichever comes later), with Pap smear test every 3 years.
  - Women aged 30 to 65: Continue cervical cancer screening with any of the following strategies:
    - » Primary HPV DNA testing every five years; or
    - » Co-testing (Pap and primary HPV DNA testing) every five years; or
    - » Pap test alone every three years.
- Depending on the screening test performed and if a client has HIV, the recommended frequency.

Treatment Methods

Cervical precancerous lesions can be treated by ablative methods, which include destruction of abnormal tissue by burning or freezing (thermal ablation or cryotherapy), or by excisional treatment by large-loop excision of the transformation zone (LLETZ) or cold knife conization (CKC) in women not eligible for ablative treatment.

Vaccine Available for Prevention

The Saudi government's food and drug authorities have given their approval to a cervical cancer vaccine that had been recommended by the health minister. A vaccine against HPV (types 6, 11, 16, and 18) can prevent the majority of cervical cancers.

The quadrivalent Human Papillomavirus (types 6, 11, 16, and 18) recombinant vaccine, known as GARDASIL, is most effective when administered to clients before they start having sexual activity. The deltoid region of the upper arm or the higher anterolateral region of the thigh are the ideal sites for the intramuscular injection method of vaccine administration.

The following vaccines are given to women:

- Girls between the ages of 9 and 15 should receive two doses (for a period of 6 to 12 months).
- Girls and women over the age of 15 should take three doses. The third dose is given six months after the first two, which are spaced out by one to two months.

CHAPTER 14

SEXUAL TRANSMITTED INFECTIONS, Including HIV

Sexually Transmitted Infections, Including HIV

Sexually Transmitted Infections

Sexually transmitted infections (STIs) are caused by bacteria, viruses, and parasites that are spread through sexual contact. These organisms can be found in vaginal fluids and in semen, on the skin of the genitals and areas around them, and in the mouth, throat, and rectum. Most STIs either cause no symptoms or show symptoms that can easily go unnoticed. Others can cause pain and physical and psychological discomfort. If not treated, some STIs can cause pelvic inflammatory disease, chronic pelvic pain, infertility, and cervical cancer in women, and some STIs can cause infertility, and anorectal and prostate cancer in men. Some STIs can also greatly increase the chance of becoming infected with HIV.

Who Is at Risk for STIs?

There are some sexual practices and other behaviors that increase the risk of getting an STI, Including HIV such as;

- Any sexual practice with a partner who has STI symptoms, or who has been diagnosed or treated for an STI in the past 6 months.
- Any sexual practice extra-marital relationship without condoms in the past 6 months—the more partners, the greater the risk.
- Exposure to contaminated needles from injection drug use or other (such as occupational exposure).

Some groups (known as “key populations”) are at higher risk of HIV and other STIs, regardless of the prevalence in the general population. These include:

- Anyone with extramarital sexual relationships (e.g. multiple partners, male sex with male).
- People who inject drugs.
- The sexual partners of these individuals.

STIs Causes

STIs are caused on by a variety of pathogens. Most illnesses brought on by bacteria or parasites are curable. In most cases, STIs caused on by viruses cannot be cured, although their symptoms can be managed with treatment. The majority of STIs are spread through sexual activity, and a significant proportion of this spread can be prevented by using condoms properly and regularly. However, some individuals can gain a STI through other methods. The table below gives more information.

STI Types, Causes, Cures, and How They Are Spread

STI	Type	Curable	Sexual spread	Nonsexual Spread
Chancroid	Bacterial	Yes	Any sexual practice	None.
Chlamydia	Bacterial	Yes	Any sexual practice	From mother to child during delivery.
Gonorrhea	Bacterial	Yes	Any sexual practice	From mother to child during delivery, or through breast milk. Contaminated blood transfusion.
Hepatitis B	Viral	No	Any sexual practice	From mother to child during delivery, or through breast milk. Contaminated blood transfusion.
Herpes	Viral	No	Any sexual practice	From mother to child during pregnancy or delivery.
HIV	Viral	No	Any sexual practice	From mother to child during pregnancy or delivery, or through breast milk. Contaminated blood transfusion. Injection drug use with nonsterile needles.
Human papilloma-virus (HPV)	Viral	No	Any sexual practice	From mother to child during delivery.

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STI Types, Causes, Cures, and How They Are Spread

STI	Type	Curable	Sexual spread	Nonsexual Spread
Human T-lymphotropic virus	Viral	No	Any sexual practice	From mother to child during pregnancy or delivery, or through Breast milk. Contaminated blood transfusion.
Syphilis	Bacterial	Yes	Any sexual practice	From mother to child during pregnancy or delivery. Contaminated blood transfusion.
Trichomoniasis	Parasitic	Yes	Any sexual practice	From mother to child during delivery.

STI Signs and Symptoms

In the table below, common symptoms and signs that indicate to a STI are listed along with their possible causes.

Symptoms	Possible cause
Discharge from the penis: pus, clear or yellow - green drip	Chlamydia, gonorrhea, trichomoniasis.
Abnormal vaginal discharge	Cervical STI: Chlamydia, gonorrhea. Vaginal STI: Trichomoniasis. Non-STI vaginal infection: Bacterial vaginosis, candidiasis.
Anorectal discharge	Chlamydia, gonorrhea.
Lower abdominal pain (possible pelvic inflammatory disease)	Chlamydia, gonorrhea, trichomoniasis.

(Continue to next page)

Symptoms	Possible cause
Swollen and/or painful testicles	Chlamydia, gonorrhea.
Warts on the genitals, anus, or surrounding areas	HPV, especially types 6 and 11.
Ulcers on the genitals, anus, or surrounding areas	Genital herpes, syphilis, chancroid.

Early detection of STIs

Ideally, an STI must be detected (and treated) as soon as possible to prevent problems and stop the infection from spreading. In order to aid in the early detection of STIs, a provider should:

- Ask about the client's sexual history and assess their risk of getting an STI.
- Ask about the existence of STI symptoms in the client or partner, such as genital sores / pain / swelling, abnormal genital or anorectal discharge, or lower abdomen pain.
- Look for signs of STIs when doing a pelvic or genital examination.
- If a client develops signs and/or symptoms of a STI, make a timely syndromic diagnosis and provide the proper care. In some settings, perform STI testing as necessary rapid or laboratory testing, based on availability-see below or refer the client to another facility for appropriate care.
- For clients without STI signs or symptoms but who are at high risk for acquiring STIs, encourage them to get screened for syphilis and, when feasible, also for gonorrhea and chlamydia.

In addition, a family planning provider should

- Advise on condom and lubricant use, as appropriate to the client's needs.
- Assist all clients who have had a STI diagnosis or who show STI symptoms or to inform their sexual partners.

In settings where STI testing is available, providers should, where appropriate:

- Offer hepatitis B testing, preferably using rapid screening tests that can be conducted in the same visit, and: If the test is positive, the client should be referred for an assessment of treatment eligability; if negative, the client should consider hepatitis B vaccination when recommended and available.

- Offer tests for gonorrhea and chlamydial infections, if available. Based on the history and risk, collect samples from the throat, vagina, and anus. If possible, offer the client the opportunity to collect samples themselves (self-collection), as some find this more acceptable.
- Inform clients at high risk of STI exposure that syphilis and HIV testing should be done regularly—at least once a year.
- Tell clients to keep an eye out for any genital sores, warts, or unusual discharge in themselves or their partner and, if present, seek medical care as soon as possible.

Avoiding STIs

Family planning providers can assist their clients in various ways to prevent STIs, including HIV.

Prevention measure	Notes
HPV vaccine	See Vaccine Available for Prevention (see Cervical Cancer, p. 200-202).
Hepatitis B vaccine	Hepatitis B infection is prevented by vaccines, which are usually given to newborns and children. Adolescents and adults at increased risk of infection (see the section Who Is at Risk for STIs? p.205) are also recommended for vaccination, including people living with HIV, household and sexual contacts of people with chronic hepatitis B virus infection, persons in prisons, and persons who inject drugs.
Condoms	The correct and consistent use of male or female condoms offers effective protection against STIs, including HIV (see p.135,140).
Pre-Exposure Prophylaxis (PrEP)	PrEP can be an effective tool to prevent HIV when taken as prescribed.
Post-Exposure Prophylaxis (PEP)	PEP can be offered to prevent HIV infection after exposure, for emergency situations. It must be started within 72 hours after the possible exposure.
Lubricant	Lubricants prevent micro tears in the mucosa, which can create entry points for STIs. **Water-based lubricants are recommended when used with condoms.**

(Continue to next page)

Prevention measure	Notes
Male circumcision	Male circumcision can reduce men's risk of HIV infection by 50%– 60% when having vaginal sex with a female partner. Male circumcision can also reduce a female partner's risk of acquiring STIs.
Preventing and treating STIs	Diagnosing and treating STIs helps prevent the client from acquiring additional STIs; this is because sores or ulcers associated with existing STIs can make it easier for other STIs (including HIV) to infect the person. For example, herpes simplex virus 2 (HSV-T) infection (genital herpes) increases the risk of acquiring HIV 3-fold, syphilis 2-fold, and trichomoniasis 1.5-fold.

Choosing a Dual Protection Strategy

Family planning providers can talk to clients about how they can protect themselves both from STIs, including HIV, and from pregnancy (known as "dual protection"). The decision to use particular prevention measure(s) should be an informed choice, made voluntarily by the client. Providers should not allow their personal views to influence clients' prevention choices. It is important to remember that clients might choose to use different strategies in different situations as well as at different times in their lives.

The best strategy is the one that a person can practice effectively.

Strategy 1: Use male or female condoms consistently (with every sex act) **and correctly.**

- One method is used to help protect against both pregnancy and STIs.

Strategy 2: Use male or female condoms consistently and correctly plus another family planning method.

- Using two methods provides extra protection from pregnancy in case the condom is not used, is used incorrectly, or breaks.
- This strategy may be a good choice for those who want to feel reassured about avoiding pregnancy if they cannot always be sure of consistent and correct condom use.

Strategy 3: If both partners know that they are not infected with any STIs, or if one partner is living with HIV but has achieved viral suppression through ART, then use any family planning method to prevent pregnancy and agree to stay in a mutually faithful relationship.

- Many family planning clients believe they are in this group and thus feel protected from STIs, including HIV, without using condoms.
- This strategy depends on good communication and trust between partners.

Contraceptives for Clients with STIs, Including HIV

Clients with STIs and HIV can start and keep using the majority of contraceptive methods safely, whether or not they are using ART. There are a few limitations, however, as described in the table below.

Special Family Planning Considerations for Clients with STIs, including HIV

Method	Has STIs	Has HIV
Intrauterine device (IUD): Copper-Bearing IUD (Cu-IUD) or Levonorgestrel Containing IUD (LNG-IUD)	• Do not insert an IUD in a client who is at very high individual risk for gonorrhea and chlamydia, or who currently has gonorrhea, chlamydia, purulent cervicitis, or pelvic inflammatory disease (PID).	• A client living with HIV clinical disease that is mild or with no symptoms (WHO Stages 1 or 2), including a client on antiretroviral therapy (ART), can have an IUD inserted. • Generally, a client should not have an IUD inserted if they have HIV clinical disease that is severe or advanced (WHO Stages 3 or 4). *(Continue to next page)*

Method	Has STIs	Has HIV
Intrauterine device (IUD): Copper-Bearing IUD (Cu-IUD) or Levonorgestrel Containing IUD (LNG-IUD) (continued)	• However, a current IUD user who becomes infected with gonorrhea or chlamydia or develops PID can safely continue using the IUD during and after treatment for the infection.	• A current IUD user who becomes infected with HIV or whose HIV clinical disease becomes severe or advanced (WHO Stages 3 or 4) can safely continue using the IUD. • A client using an IUD can keep the IUD in place when they start ART.
Female sterilization	• If the client has gonorrhea, chlamydia, purulent cervicitis, or PID, delay sterilization until the condition has been treated.	• Clients living with HIV, including those on ART, can safely undergo female sterilization. • The procedure may need to be delayed in clients with severe or advanced HIV clinical disease (WHO Stages 3 or 4) if the client currently has an HIV-related illness.
Vasectomy	• If the client has scrotal skin infection, active STI, or swollen, tender tip of penis, sperm ducts, or testicles, delay vasectomy until the condition has been treated.	• Clients living with HIV, including those on ART, can safely undergo vasectomy. • The procedure may need to be delayed in clients with severe or advanced HIV clinical disease (WHO Stages 3 or 4) if the client currently has an HIV-related illness.

(Continue to next page)

Method	Has STIs	Has HIV
Spermicides	• Can be used.	• Generally, clients living with HIV should not use spermicides (the risks usually outweigh the advantages).
All hormonal methods (except hormone-releasing IUDs) Can be used by any client with STIs, including HIV.		

What Family Planning Methods can be used by Men and Women at High Risk for HIV?

All forms of contraception can be safely used by adolescents and women at high risk for HIV, in the absence of any other medical or physiological contraindications, with the exception of spermicides.

HIV testing and prevention services to be routinely offered to clients presenting for family planning (FP) services, by setting

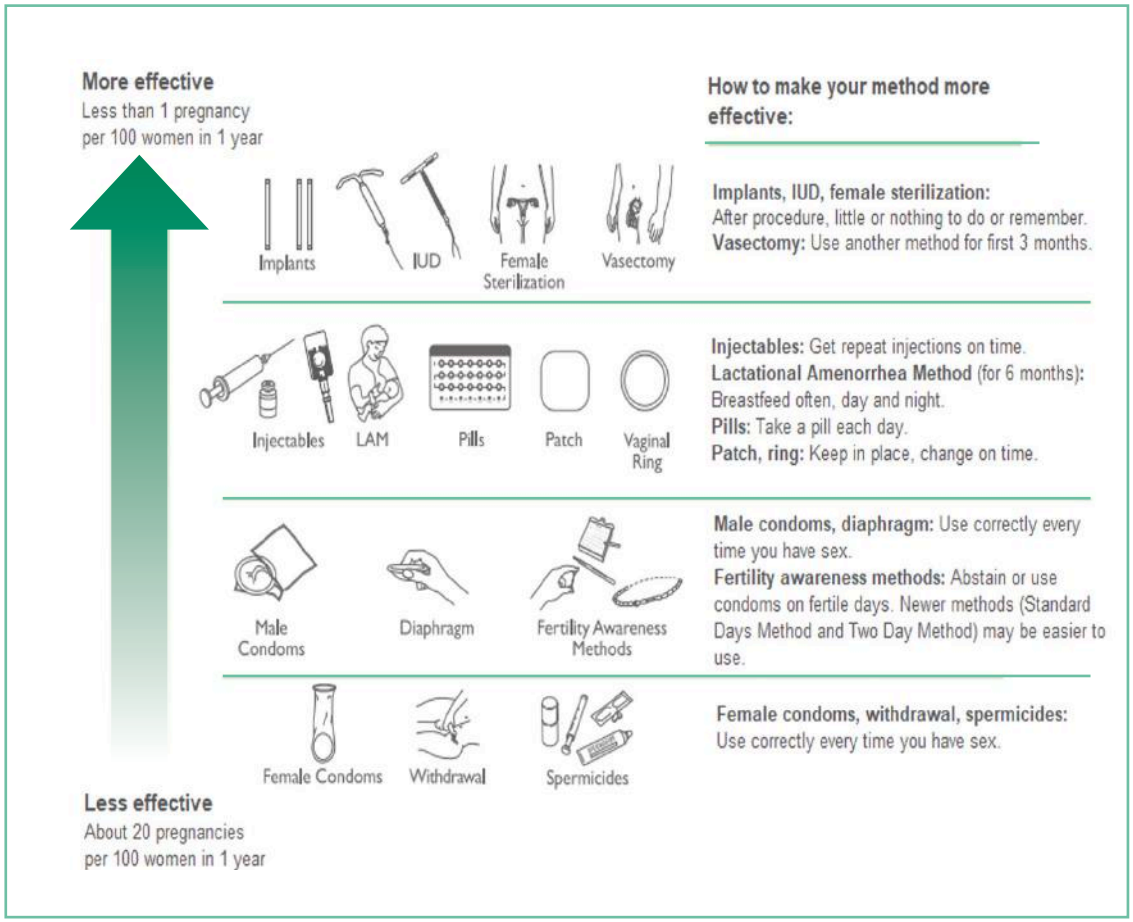
	Low and medium HIV burden settings (HIV prevalence < 5%)		High HIV burden settings (HIV prevalence ≥ 5%)
HIV service	**FP clients not at high risk for HIV**	**FP clients at high risk for HIV**	**All FP clients**
Male and female condoms and lubricant	Yes	Yes	Yes
Discussion to assess HIV risk before offering (or referring for) HIV testing (see section above on who is at high risk?)	Yes	Yes	*Not mandatory — HIV testing should be a routine offer*

(Continue to next page)

	Low and medium HIV burden settings (HIV prevalence < 5%)		High HIV burden settings (HIV prevalence ≥ 5%)
HIV service	**FP clients not at high risk for HIV**	**FP clients at high risk for HIV**	**All FP clients**
Offer or refer for HIV testing and provide information about HIV testing	*Not a routine offer*	Yes	Yes
For women testing positive during the FP consultation: post-test counseling, provision of or referral for antiretroviral therapy (ART), and supported linkage to care	Yes	Yes	Yes
For women testing negative during the FP consultation: HIV risk-reduction counseling, and supported linkage to pre-exposure prophylaxis (PrEP) screening and provision	*Not a routine offer*	Yes	Yes
Partner testing (or partner referral) or couples' HIV testing and counseling	*Not a routine offer*	Yes — if both partners consent	Yes — if both partners consent
Condom promotion for male partners	Yes	Yes	Yes

ANNEXES

Annex (1): Comparing Effectiveness of Family Planning Methods



Annex (2): Contraceptive Effectiveness

Rates of Unintended Pregnancies per 100 Women

Family planning method	First-Year Pregnancy Rate [a] (Trussell & Aikenb [b])		12-Month Pregnancy Rate [c] (Polis et al.[d])
	Consistent and correct use	As commonly used	As commonly used
Implants	0.1	0.1	0.6
Vasectomy	0.1	0.15	
Female sterilization	0.5	0.5	
Levonorgestrel IUD	0.5	0.7	
Copper-bearing IUD	0.6	0.8	1.4
LAM (for 6 months)	0.9[e]	2[e]	
Monthly injectable	0.05[e]	3[e]	
Progestin-only injectable	0.2	4	1.7
Combined oral contraceptives	0.3	7	5.5
Progestin-only pills	0.3	7	
Combined patch	0.3	7	
Combined vaginal ring	0.3	7	
Male condoms	2	13	5.4
Standard-Days Method	5	12	
Two-Day Method	4	14	
Ovulation method	3	23	
Other fertility awareness methods		15	
Diaphragms with spermicide	16	17	
Withdrawal	4	20	13.4
Female condoms	5	21	
Spermicide	16	21	
Cervical capf	26[g], 9[h]	32[g], 16[h]	
No method	85	85	

Key			
Very effective	Effective	Moderately effective	Less effective
0–0.9	1–9	10–19	20+

a *Rates largely from the United States. Data from best available source as determined by authors.*

b *Trussell J and Aiken ARA, Contraceptive efficacy. In: Hatcher RA et al. Contraceptive Technology,21st revised edition. New York, Ardent Media, 2018.*

c *Rates from developing countries. Data from self-reports in population-based surveys.*

d *Polis CB et al. Contraceptive failure rates in the developing world: an analysis of Demographic and Health Survey data in 43 countries. New York: Guttmacher Institute, 2016.*

e *Source: Hatcher R Et al. Contraceptive technology. 20th ed. New York, Ardent Media, 2011.*

f *Source: Trussell J. Contraceptive failure in the United States. Contraception. 2004:70(2): 89–96.*

g *Pregnancy rate for women who have given birth.*

h *Pregnancy rate for women who have never given birth.*

Annex (3): Importance of Selected Procedures for Providing Family Planning Methods

Key to the chart:

- **Class A:** Essential and mandatory in all circumstances for safe and effective use of the contraceptive method.
- **Class B:** Contributes substantially to safe and effective use.
- **Class C:** Does not contribute substantially to safe and effective use of the contraceptive method.

Specific situation	Combined oral contraceptives*	Monthly injectables	Progestin-only Pills	Progestin-only injectables	Implants	Cu- and LNG-IUDs	Male and female condoms	Diaphragms and cervical caps	Spermicides	Female sterilization	Vasectomy
Breast examination by provider	C	C	C	C	C	C	C	C	C	C	NA
Pelvic/genital examination	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 laboratory 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: medical history and physical examination	C	C	C	C	C	A**	C	C†	C†	C	C
STI/HIV screening: laboratory tests	C	C	C	C	C	B**	C	C†	C†	C	C
Blood pressure screening	‡	‡	‡	‡	‡	C	C	C	C	A	C§

Note: No tests or examinations are needed before using fertility awareness-based methods, lactational amenorrhea method, or emergency contraceptive pills.

NA *Not applicable*

* *Includes patch and combined vaginal ring.*

** *If a woman has a very high individual likelihood of exposure to STIs, she generally should not have an IUD inserted unless other methods are not available or not acceptable. If she has current purulent cervicitis, gonorrhea, or chlamydia, she should not have an IUD inserted until these conditions are resolved and she is otherwise medically eligible.*

† *Polis CB et al. Contraceptive failure rates in the developing world: an analysis Women at high risk of HIV infection should not use spermicides. Using spermicides alone or diaphragms or cervical caps with spermicides is not usually recommended for women with HIV infection unless other, more appropriate methods are not available or acceptable.*

‡ *Desirable, but in settings where the risks of pregnancy are high, and hormonal methods are among the few methods widely available, women should not be denied use of hormonal methods solely because their blood pressure cannot be measured.*

§ *For procedures performed using only local anesthesia*

Annex (4): WHO Medical Eligibility Criteria for Contraceptive use for Client with certain Health Conditions

Categories for Temporary Methods

Category	With Clinical Judgment	With Limited Clinical Judgment
1	Use method in any circumstances	Yes (Use the method)
2	Generally use method	
3	Use of method not usually recommended unless other more appropriate methods are not available or not acceptable	No (Do not use the method)
4	Method not to be used	

Categories for Female Sterilization and Vasectomy

Accept (A)	There is no medical reason to deny the method to a person with this condition or in this circumstance.
Caution (C)	The method is normally provided in a routine setting, but with extra preparation and precautions.
Delay (D)	Use of the method should be delayed until the condition is evaluated and/or corrected. Alternative, temporary methods 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. The capacity to decide on the most appropriate procedure and anesthesia support also is needed. Alternative, temporary methods of contraception should be provided if referral is required or there is otherwise any delay.

(continued)

= *Use the method*
= *Do not use the method*
I = *Initiation of the method*
C = *Continuation of the method*
\- = *Condition not listed; does not affect eligibility for method*
NA *Not applicable*

Conditions	COCs	Monthly Injectable	Patch & Ring	POPs	Progestin- only injectable	Implants	Emergency Contraceptive Pills*	CU-IUD	LNG-IUD	Female Sterilization*
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY										
Pregnant	NA	NA	NA	NA	NA	NA	NA	4	4	D
Age	Menarche to < 40 years			Menarche to < 18 years				Menarche to < 20 years		Young age
	1	1	1	1	2	1	-	2	2	C
	≥ 40 years			18 to 45 years				≥ 20 years		
	2	2	2	1	1	1	-	1	1	
				> 45						
				1	2	1	-			
PARITY										
Nulliparous (has not given birth)	1	1	1	1	1	1	-	2	2	A
Parous (has given birth)	1	1	1	1	1	1	-	1	1	A
BREASTFEEDING										
< 6 weeks postpartum	4	4	4	2	3[a]	2	1 UPA=2	b	b	*
≥ 6 weeks to < 6 months postpartum (primarily breastfeeding)	3	3	3	1	1	1	1 UPA=2	b	b	A
≥ 6 months postpartum	2	2	2	1	1	1	1 UPA=2	b	b	A
POSTPARTUM (NOT BREASTFEEDING)										
< 21 days	3	3	3	1	1	1	-	b	b	
With other added VTE risk factors	4	4	4							*
21–42 days	2	2	2	1	1	1	-	b	b	
With other added VTE risk factors	3	3	3							
> 42 days	1	1	1	1	1	1	-	1	1	A
POSTABORTION										
First trimester	1	1	1	1	1	1	-	1	1	
Second trimester	1	1	1	1	1	1	-	2	2	*
Immediate post-septic abortion	1	1	1	1	1	1	-	4	4	
Past ectopic pregnancy	1	1	1	2	1	1	1	1	1	A
History of pelvic surgery	1	1	1	1	1	1	-	1	1	C*

*For additional conditions relating to emergency contraceptive pills and female sterilization.

a *In settings where pregnancy morbidity and mortality risks are high and this method is one of few widely available contraceptives, it may be made accessible to breastfeeding women immediately postpartum.*

b *Postpartum IUD use: For the copper-bearing IUD, insertion at <48 hours is category 1. For the LNG-IUD, insertion at <48 hours is category 2 for breastfeeding women and category 1 for women not breastfeeding. For all women and both IUD types, insertion from 48 hours to <4 weeks is category 3; ≥4 weeks, category 1; and puerperal sepsis, category 4.*

= *Use the method*

= *Do not use the method*

I = *Initiation of the method*

C = *Continuation of the method*

\- = *Condition not listed; does not affect eligibility for method*

NA *Not applicable*

Conditions	COCs	Monthly Injectable	Patch & Ring	POPs	Progestin- only injectable	Implants	Emergency Contraceptive Pills*	CU-IUD	LNG-IUD	Female Sterilization*
SMOKING										
Age < 35 years	2	2	2	1	1	1	-	1	1	A
Age >= 35 years										
<15 cigarettes/day	3	2	3	1	1	1	-	1	1	A
>=15 cigarettes/day	4	3	4	1	1	1	-	1	1	A
OBESITY										
>= 30 kg/m2 body mass index	2	2	2	1	1†	1	1	1	1	C
Blood pressure measurement unavailable	NA[c]	NA[c]	NA[c]	NA[c]	NA[c]	NA[c]	-	NA	NA	NA
CARDIOVASCULAR DISEASE										
Multiple risk factors for arterial cardiovascular disease (older age, smoking, diabetes, and hypertension)	3/4[d]	3/4[d]	3/4[d]	2	3	2	-	1	2	S
HYPERTENSION[e]										
History of hypertension, where blood pressure CANNOT be evaluated (including hypertension in pregnancy)	3	3	3	2[c]	2[c]	2[c]	-	1	2	NA
Adequately controlled hypertension, where blood pressure CAN be evaluated	3	3	3	1	2	1	-	1	1	C

(continued)

† *From menarche to age <18 years, >30 kg/m2 body mass index is category 2 for DMPA, category 1 for NET-EN.*

c *In settings where pregnancy morbidity and mortality risks are high and this method is one of few widely available contraceptives, women should not be denied access simply because their blood pressure cannot be measured.*

d *When multiple major risk factors exist, any of which alone would substantially increase the risk of cardiovascular disease, use of the method may increase her risk to an unacceptable level. However, a simple addition of categories for multiple risk factors is not intended. For example, a combination of factors assigned a category 2 may not necessarily warrant a higher category.*

e *Assuming no other risk factors for cardiovascular disease exist. A single reading of blood pressure is not sufficient to classify a woman as hypertensive.*

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C = *Continuation of the method*
\- = *Condition not listed; does not affect eligibility for method*
NA *Not applicable*

Conditions	COCs	Monthly Injectable	Patch & Ring	POPs	Progestin- only injectable	Implants	Emergency Contraceptive Pills*	CU-IUD	LNG-IUD	Female Sterilization*
ELEVATED BLOOD PRESSURE (PROPERLY MEASURED)										
Systolic 140–159 or diastolic 90–99	3	3	3	1	2	1	-	1	1	C[f]
Systolic >= 160 or diastolic >= 100[g]	4	4	4	2	3	2	-	1	2	S[f]
Vascular disease	4	4	4	2	3	2	-	1	2	S
History of high blood pressure during pregnancy (where current blood pressure is measurable and normal)	2	2	2	1	1	1	-	1	1	A
DEEP VENOUS THROMBOSIS (DVT)/PULMONARY EMBOLISM (PE)										
History of DVT/PE	4	4	4	2	2	2	*	1	2	A
Acute DVT/PE	4	4	4	3	3	3	*	1	3	D
DVT/PE and on anticoagulant therapy	4	4	4	2	2	2	*	1	2	S
Family history of DVT/PE (first-degree relatives)	2	2	2	1	1	1	*	1	1	A
MAJOR SURGERY										
With prolonged immobilization	4	4	4	2	2	2	-	1	2	D
Without prolonged immobilization	2	2	2	1	1	1	-	1	1	A
Minor surgery without prolonged immobilization	1	1	1	1	1	1	-	1	1	A
Known thrombogenic mutations (e.g., factor V Leiden, prothrombin mutation; protein S, protein C, and antithrombin deficiencies)[g]	4	4	4	2	2	2	*	1	2	A

f *Elevated blood pressure should be controlled before the procedure and monitored during the procedure.*

g *This condition may make pregnancy an unacceptable health risk. Women should be advised that because of relatively higher pregnancy rates, as commonly used, spermicides, withdrawal, fertility awareness methods, cervical caps, diaphragms, or female or male condoms may not be the most appropriate choice.*

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I = *Initiation of the method*
C = *Continuation of the method*
\- = *Condition not listed; does not affect eligibility for method*
NA *Not applicable*

Conditions	COCs	Monthly Injectable	Patch & Ring	POPs	Progestin- only injectable	Implants	Emergency Contraceptive Pills*	CU-IUD	LNG-IUD	Female Sterilization*
SUPERFICIAL VENOUS DISORDERS										
Varicose veins	1	1	1	1	1	1	-	1	1	A
Superficial venous thrombosis	2	2	2	1		1	1	-	1	A
Ischemic heart diseases [g]				I C		I C			I C	
Current	4	4	4	2	3	3	2	*	1	D
History of										C
Stroke (History of cerebrovascular accident)[g]	4	4	4	2 3	3	2 3	*	1	2	C
Known dyslipidemias without other known cardiovascular risk factors [h]	2	2	2	2	2	2	-	1	2	A
VALVULAR HEART DISEASE										
Uncomplicated	2	2	2	1	1	1	-	1	1	C[i]
Complicated [‡, g]	4	4	4	1	1	1	-	2[i]	2[i]	S*
Systemic Lupus Erythematosus					I C			I C		
Positive (or unknown) antiphospholipid antibodies	4	4	4	3	3 3	3	-	1 1	3	S
Severe thrombocytopenia	2	2	2	2	3 2	2	-	3 2	2	S
Immunosuppresive treatment	2	2	2	2	2	2	-	2 1	2	S
None of the above	2	2	2	2	2	2	-	1 1	2	C

(continued)

g *This condition may make pregnancy an unacceptable health risk. Women should be advised that because of relatively higher pregnancy rates, as commonly used, spermicides, withdrawal, fertility awareness methods, cervical caps, diaphragms, or female or male condoms may not be the most appropriate choice.*

h *Routine screening is not appropriate because of the rarity of the condition and the high cost of screening.*

‡ *Pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis.*

i *Prophylactic antibiotics are advised before providing the method.*

= Use the method
= Do not use the method
I = Initiation of the method
C = Continuation of the method
- = Condition not listed; does not affect eligibility for method
NA Not applicable

Conditions	COCs		Monthly Injectable		Patch & Ring		POPs		Progestin- only injectable		Implants		Emergency Contraceptive Pills*	CU-IUD	LNG-IUD		Female Sterilization*
NEUROLOGICAL CONDITIONS																	
Headaches[j]	I	C	I	C	I	C	I	C	I	C	I	C			I	C	
Nonmigrainous (mild or severe)	1	2	1	2	1	2	1	1	1	1	1	1	-	1	1	1	A
Migraine													2				
Without aura	I	C	I	C	I	C	I	C	I	C	I	C			I	C	
Age < 35	2	3	2	3	2	3	1	2	2	2	2	2	-	1	2	2	A
Age >= 35	3	4	3	4	3	4	1	2	2	2	2	2	-	1	2	2	A
With aura, at any age	4	4	4	4	4	4	2	3	2	3	2	3	-	1	2	3	A
Epilepsy	1[k]	1[k]	1[k]	1[k]	1[k]	1[k]	1[k]	1[k]	1[k]	1[k]	1[k]	1[k]	-	1			C
DEPRESSIVE DISORDERS																	
Depressive Disorders	1[l]	1[l]	1[l]	1[l]	1[l]	1[l]	1[l]	1[l]	1[l]	1[l]	1[l]	1[l]	-	1	1[l]		C
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS																	
Vaginal Bleeding Patterns															I	C	
Irregular pattern without heavy bleeding	1		1		1		2		2		2		-	1	1	1	A
Heavy or prolonged bleeding (including regular and irregular patterns)	1		1		1		2		2		2		-	2	1	2	A
Unexplained vaginal bleeding (suspicious for serious condition), before evaluation	2		2		2		2		3		3		-	I	C	I	C	D
Endometriosis	1		1		1		1		1		1		-	2	1		S
Benign Ovarian Tumors (including cysts)	1		1		1		1		1		1		-	1	1		A
Severe dysmenorrhea	1		1		1		1		1		1		-	2	1		A
GESTATIONAL TROPHOBLASTIC DISEASE																	
Decreasing or undetectable ß-hCG levels	1		1		1		1		1		1		-	3	3		A
Persistently elevated ß-hCG levels or malignant disease[g]	1		1		1		1		1		1		-	4	4		D

k *If taking anticonvulsants, refer to section on drug interactions, p. 428.*

l *Certain medications may interact with the method, making it less effective.*

= *Use the method*
= *Do not use the method*
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NA = *Not applicable*

Conditions	COCs	Monthly Injectable	Patch & Ring	POPs	Progestin- only injectable	Implants	Emergency Contraceptive Pills*	CU-IUD		LNG-IUD		Female Sterilization*
Cervical ectropion	1	1	1	1	1	1	-	1		1		A
Cervical Intraepithelial Neoplasia (CIN)	2	2	2	1	2	2	-	1		2		A
Cervical cancer (Awaiting Treatment)	2	2	2	1	2	2	-	I 4	C 2	I 4	C 2	D
Breast Disease												
Undiagnosed mass	2	2	2	2	2	2	-	1		2		A
Benign breast disease	1	1	1	1	1	1	-	1		1		A
Family history of cancer	1	1	1	1	1	1	-	1		1		A
BREAST CANCER												
Current[g]	4	4	4	4	4	4	-	1		4		C
Past, no evidence of disease for at least 5 years	3	3	3	3	3	3	-	1		3		A
Endometrial Cancer[g]	1	1	1	1	1	1	-	I 4	C 2	I 4	C 2	D
Ovarian Cancer[g]	1	1	1	1	1	1	-	3	2	3	2	D
Uterine Fibroids												
Without distortion of the uterine cavity	1	1	1	1	1	1	-	1		1		C
With distortion of the uterine cavity	1	1	1	1	1	1	-	4		4		C
ANATOMICAL ABNORMALITIES												
Distorted uterine cavity	-	-	-	-	-	-	-	4		4		-
Other abnormalities not distorting the uterine cavity or interfering with IUD insertion (including cervical stenosis or lacerations)	-	-	-	-	-	-	-	2		2		-
PELVIC INFLAMMATORY DISEASE (PID)												
Past PID (assuming no current risk factors for STIs)								I	C	I	C	
With subsequent pregnancy	1	1	1	1	1	1	-	1	1	1	1	A
Without subsequent pregnancy	1	1	1	1	1	1	-	2	2	2	2	C
Current PID	1	1	1	1	1	1	-	4	2[m]	4	2[m]	D

(continued)

m *Treat PID using appropriate antibiotics. There is usually no need to remove the IUD if the client wishes to continue use.*

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NA Not applicable

Conditions	COCs	Monthly Injectable	Patch & Ring	POPs	Progestin- only injectable	Implants	Emergency Contraceptive Pills*	CU-IUD		LNG-IUD		Female Sterilization*
SEXUALLY TRANSMITTED INFECTIONS (STIS)[g]								I	C	I	C	
Current purulent cervicitis, chlamydia, or gonorrhea	1	1	1	1	1	1	-	4	2	4	2	D
Other STIs (excluding HIV and hepatitis)	1	1	1	1	1	1	-	2	2	2	2	A
Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	1	1	1	1	1	1	-	2	2	2	2	A
Increased risk of STIs	1	1	1	1	1	1	-	2/ 3n	2	2/ 3n	2	A
HIV/AIDS[g]												
								I	C	I	C	
High risk of HIV	1	1	1	1	1	1	-	1	1	1	1	A
Asymptomatic or mild HIV clinical disease (WHO stage 1 or 2)	1	1	1	1	1	1	-	2	2	2	2	A
Severe or advanced HIV clinical disease (WHO stage 3 or 4)	1	1	1	1	1	1	-	3	2	3	2	S[o]
ANTIRETROVIRAL THERAPY												
Treated with nucleoside reverse transcriptase inhibitors (NRTIs)**	1	1	1	1	1	1	-	2/ 3p	2	2/ 3p	2	-
TREATED WITH NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIS)												
Efavirenz (EFV) or nevirapine (NVP)	2	2	2	2	DMPA 1 NET-EN 2	2	-	2/ 3p	2	2/ 3p	2	-
Etravirine (ETR) or rilpivirine (RPV)	1	1	1	1	1	1	-	2/ 3p	2	2/ 3p	2	-
Treated with protease inhibitors (PIs)[††]	2	2	2	2	DMPA 1 NET-EN 2	2	-	2/ 3p	2	2/ 3p	2	-
Treated with integrase inhibitors (raltegravir [RAL])	1	1	1	1	1	1	-	2/ 3p	2	2/ 3p	2	-

††PIs include: ritonavir-boosted atazanavir (ATV/r), ritonavir-boosted lopinavir (LPV/r), ritonavir-boosted darunavir (DRV/r), ritonavir (RTV).

***NRTIs include: abacavir (ABC), tenofovir (TDF), zidovudine (AZT), lamivudine (3TC), didanosine (DDI), emtricitabine (FTC), stavudine (D4T).*

n The The condition is category 3 if a woman has a very high individual likelihood of STIs.

o Presence of an AIDS-related illness may require a delay in the procedure.

p Condition is category 2 for IUD insertion for asymptomatic or mild HIV clinical disease (WHO stage 1 or 2), category 3 for severe or advanced HIV clinical disease (WHO stage 3 or 4).

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NA *Not applicable*

Conditions	COCs	Monthly Injectable	Patch & Ring	POPs	Progestin- only injectable	Implants	Emergency Contraceptive Pills*	CU-IUD		LNG-IUD		Female Sterilization*
OTHER INFECTIONS												
Schistosomiasis												
Uncomplicated	1	1	1	1	1	1	-	1		1		A
Fibrosis of liver (if severe, see cirrhosis, next page)[g]	1	1	1	1	1	1	-	1		1		C
Tuberculosis[g]								I	C	I	C	
Non-pelvic	1	1	1	1	1	1	-	1	1	1	1	A
Known pelvic	1	1	1	1	1	1	-	4	3	4	3	S
Malaria	1	1	1	1	1	1	-	1		1		A
ENDOCRINE CONDITIONS												
Diabetes												
History of gestational diabetes	1	1	1	1	1	1	-	1		1		A[q]
Non-vascular diabetes												
Non-insulin dependent	2	2	2	2	2	2	-	1		2		C[i,q]
Insulin dependent[g]	2	2	2	2	2	2	-	1		2		C[i,q]
With kidney, eye, or nerve damage[g]	3/4[r]	3/4[r]	3/4[r]	2	3	2	-	1		2		S
Other vascular disease or diabetes of > 20 years' duration[g]	3/4[r]	3/4[r]	3/4[r]	2	3	2	-	1		2		S
THYROID DISORDERS												
Simple goiter	1	1	1	1	1	1	-	1		1		A
Hyperthyroid	1	1	1	1	1	1	-	1		1		S
Hypothyroid	1	1	1	1	1	1	-	1		1		C
GASTROINTESTINAL CONDITIONS												
Gallbladder Disease												
Symptomatic												
Treated by cholecystectomy	2	2	2	2	2	2	-	1		2		A
Medically treated	3	2	3	2	2	2	-	1		2		A
Current	3	2	3	2	2	2	-	1		2		D
Asymptomatic	2	2	2	2	2	2	-	1		2		A

q *If blood glucose is not well controlled, referral to a higher-level facility is recommended.*

r *Assess according to severity of condition.*

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= *Do not use the method*
I = *Initiation of the method*
C = *Continuation of the method*
\- = *Condition not listed; does not affect eligibility for method*
NA *Not applicable*

Conditions	COCs	Monthly Injectable	Patch & Ring	POPs	Progestin- only injectable	Implants	Emergency Contraceptive Pills*	CU-IUD	LNG-IUD	Female Sterilization*
History of cholestasis										
Pregnancy-related	2	2	2	1	1	1	-	1	1	A
Past combined oral contraceptives related	3	2	3	2	2	2	-	1	2	A
Viral Hepatitis	I C	I C	I C							
Acute or flare	3/4r 2	3 2	3/4r,s 2	1	1	1	2	1	1	D
Carrier	1	1	1	1	1	1	-	1	1	A
Chronic	1	1	1	1	1	1	-	1	1	A
Cirrhosis										
Mild (compensated)	1	1	1	1	1	1	-	1	1	A
Severe (decompensated)[g]	4	3	4	3	3	3	-	1	3	S[t]
LIVER TUMORS										
Focal nodular hyperplasia	2	2	2	2	2	2	-	1	2	A
Hepatocellular adenoma	4	3	4	3	3	3	-	1	3	C[t]
Malignant (hepatoma)[g]	4	3/4	4	3	3	3	-	1	3	C[t]
ANEMIAS										
Thalassemia	1	1	1	1	1	1	-	2	1	C
Sickle Cell Disease[g]	2	2	2	1	1	1	-	2	1	C
Iron-Deficiency Anemia	1	1	1	1	1	1	-	2	1	D/C[u]
DRUG INTERACTIONS (FOR ANTIRETROVIRAL DRUGS, SEE HIV/AIDS)										
Anticonvulsant Therapy										
Certain anticonvulsants (barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate)	3[l]	2	3[l]	3[l]	DMPA 1 NET-EN 2	2[l]	-	1	1	-
Lamotrigine	3[§]	3[§]	3[§]	1	1	1	-	1	1	-
Antimicrobial Therapy										
Broad-spectrum antibiotics	1	1	1	1	1	1	-	1	1	-
Antifungals and antiparasitics	1	1	1	1	1	1	-	1	1	-
Rifampicin or rifabutin therapy	3[l]	2	3[l]	3[l]	DMPA 1 NET-EN 2	2	-	1	1	-

s *In women with symptomatic viral hepatitis, withhold these methods until liver function returns to normal or 3 months after she becomes asymptomatic, whichever is earlier.*

t *Liver function should be evaluated.*

u *For hemoglobin < 7 g/dl, delay. For hemoglobin > 7 to <10 g/dl, caution.*

§ *Combined hormonal contraceptives may reduce the effectiveness of lamotrigine.*

Annex (5): WHO Medical Eligibility Criteria for Conditions relating to Barriers Methods

= *Use the method*
= *Do not use the method*
I = *Initiation of the method*
C = *Continuation of the method*
\- = *Condition not listed; does not affect eligibility for method*
NA *Not applicable*

Condition	Male and female condoms	Spermicides	Diaphragms	Cervical caps	Lactational amenorrhea method #
REPRODUCTIVE HISTORY					
Parity					
Nulliparous (has not given birth)	1	1	1	1	-
Parous (has given birth)	1	1	2	2	-
< 6 weeks postpartum	1	1	NA[v]	NA[v]	-
CARDIOVASCULAR DISEASE					
Complicated valvular heart disease (pulmonary hypertension, risk of atrial fibrillation, history of subacute bacterial endocarditis)[g]	1	1	2	2	-
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS					
Cervical intraepithelial neplasia	1	1	1	4	-
Cervical cancer	1	2	1	4	-
Anatomical abnormalities	1	1	NA[w]	NA[x]	-
HIV/AIDSg					
High risk of HIV	1	4	4	4	-
Asymptomatic or mild HIV clinical disease (WHO stage 1 or 2)	1	3	3	3	C[y]
Severe or advanced HIV clinical disease (WHO stage 3 or 4)	1	3	3	3	C[y]
OTHERS					
History of toxic shock sydrome	1	1	3	3	-
Urinary tract infection	1	1	2	2	-
Allergy to latex[z]	3	1	3	3	-

v *Wait to fit/use until uterine involution is complete.*

w *Diaphragm cannot be used in certain cases of uterine prolapse.*

x *Cap use is not appropriate for a client with severely distorted cervical anatomy.*

y *Caution: Women living with HIV should receive appropriate antiretroviral therapy (ART) and exclusively breastfeed for the first 6 months of a baby's life, introduce appropriate complementary foods at 6 months, and continue breastfeeding through 12 months. (See Chapter 24 – Maternal and Newborn Health, Preventing Mother-to-Child Transmission of HIV.*

z *Does not apply to plastic condoms, diaphragms, and cervical caps.*

*For additional conditions relating to the lactational amenorrhea method, see next page.*

Annex (5.1): Additional Conditions Relating to the Lactational amenorrhea Method

Conditions affecting the newborn that may make breastfeeding difficult: Congenital deformities of the mouth, jaw, or palate; newborns who are small-for-date or premature and needing intensive neonatal care; and certain metabolic disorders.

Medication used during breastfeeding: To protect infant health, breastfeeding is not recommended for women using such drugs as anti-metabolites, bromocriptine, certain anticoagulants, corticosteroids (high doses), cyclosporine, ergotamine, lithium, mood-altering drugs, radioactive drugs, and reserpine.

Annex (5.2): Conditions Relating to Fertility Awareness Methods

A = Accept C = Caution D = Delay

Condition	Symptoms-based methods	Calendar-based methods
Age: post menarche or perimenopause	C	C
Breastfeeding < 6 weeks postpartum	D	D[aa]
Breastfeeding => 6 weeks postpartum	C[bb]	D[bb]
Postpartum, not breastfeeding	D[cc]	D[aa]
Postabortion	C	D[dd]
Irregular vaginal bleeding	D	D
Vaginal discharge	D	A
Taking drugs that affect cycle regularity, hormones, and/or fertility signs	D/C[ee]	D/C[ee]
Diseases that elevate body temperature		
Acute	D	A
Chronic	C	A

aa *Delay until she has had 3 regular menstrual cycles.*

bb *Use caution after monthly bleeding or normal secretions return (usually at least 6 weeks after childbirth). cc Delay until monthly bleeding or normal secretions return (usually < 4 weeks postpartum).*

dd *Delay until she has had one regular menstrual cycle.*

ee *Delay until the drug's effect has been determined, then use caution.*

Annex (5.3): Conditions Relating to the Progesterone-Releasing Vaginal Ring

Pregnancy	N/A
Breastfeeding > 4 weeks postpartum	1

Annex (6): Contraceptives for Clients with STIs, Including HIV

Method	Has STIs	Has HIV
Intrauterine device (Cu- IUD or LNG-IUD)	Do not insert an IUD in a woman who is at very high individual risk for gonorrhea and chlamydia, or who currently has gonorrhea, chlamydia, purulent cervicitis, or PID. A current IUD user who becomes infected with gonorrhea or chlamydia or develops PID can safely continue using an IUD during and after treatment.	• Disease that is mild or with no symptoms, including a woman on ARV therapy, can have an IUD inserted. • Generally, a woman should not have an IUD inserted if she has HIV clinical disease that is severe or advanced (WHO Stages 3 or 4). • A woman using an IUD who becomes infected with HIV or whose HIV clinical disease becomes severe or advanced (WHO Stages 3 or 4) can safely continue using the IUD. • A woman using an IUD can keep the IUD in place when she starts ARV therapy.
Female sterilization	If client has gonorrhea, chlamydia, purulent cervicitis, or PID, delay sterilization until the condition is treated and cured.	• Women with HIV, including women on ARV therapy, can safely undergo female sterilization. • The procedure may need to be delayed if she currently has an HIV-related illness.
Vasectomy	If client has scrotal skin infection, active STI, or swollen, tender tip of penis, sperm ducts, or testicles, delay sterilization until the condition is treated and cured.	• Men who are living with HIV, including men on ART therapy, can safely undergo vasectomy. • The procedure may need to be delayed if he currently has an HIV-related illness.
Spermicides (Including when used with diaphragm or cervical cap)	Safely use spermicides.	• Should not use spermicides if at high risk of HIV. Generally, should not use spermicides if she has HIV • infection.
All hormonal methods (except hormone-releasing IUDs) can be used by any client with STIs, including HIV.		

Annex (7): Signs and Symptoms of Serious Health Conditions

The table below lists signs and symptoms of some serious health conditions. These conditions are mentioned under Health Risks or Managing Any Problems in the chapters on contraceptive methods. These conditions occur rarely to extremely rarely among users of the method. They also occur rarely among people of reproductive age generally. Still, it is important to recognize possible signs of these conditions and to take action or refer for care if a client reports them. In some cases clients who develop one of these conditions may need to choose another contraceptive method.

Condition	Description	Signs and Symptoms
Deep vein thrombosis	A blood clot that develops in the deep veins of the body, generally in the legs.	Persistent, severe pain in one leg, sometimes with swelling or red skin.
Ectopic pregnancy	Pregnancy in which the fertilized egg implants in tissue outside the uterus, most commonly in a fallopian tube but sometimes in the cervix or abdominal cavity.	In the early stages of ectopic pregnancy, symptoms may be absent or mild, but eventually they become severe. A combination of these signs and symptoms should increase suspicion of ectopic pregnancy: • Unusual abdominal pain or tenderness • Abnormal vaginal bleeding or no monthly bleeding—especially if a change from her usual bleeding pattern. • Light-headedness or dizziness. • Fainting.
Heart attack	Occurs when the blood supply to the heart is blocked, usually due to a build-up of cholesterol and other substances in the coronary arteries.	Chest discomfort or uncomfortable pressure; fullness, squeezing, or pain in the center of the chest that lasts longer than a few minutes or that comes and goes; spreading pain or numbness in one or both arms, back, jaw, or stomach; shortness of breath; cold sweats; nausea.
Liver disorders	Infection with hepatitis inflames the liver; cirrhosis scars tissue, which blocks blood flow through the liver.	Yellow eyes or skin (jaundice) and abdominal swelling, tenderness, or pain, especially in the upper abdomen.
Pelvic inflammatory disease (PID)	An infection of the upper genital tract, caused by various types of bacteria.	Lower abdominal pain; pain during sex, pelvic examination, or urination; abnormal vaginal bleeding or discharge; fever; cervix bleeds when touched. In a pelvic examination, signs of PID include tenderness in the ovaries or fallopian tubes, yellowish cervical discharge containing mucus and pus, bleeding easily when the cervix is touched with a swab, or a positive swab test, and tenderness or pain when moving the cervix and uterus during pelvic examination.

Condition	Description	Signs and Symptoms
Pulmonary embolism	A blood clot that travels through the bloodstream to the lungs.	Sudden shortness of breath, which may worsen with a deep breath, cough that may bring up blood, fast heart rate, and a light-headed feeling.
Ruptured ectopic pregnancy	When a fallopian tube breaks due to an ectopic pregnancy.	Sudden sharp or stabbing pain in lower abdomen, sometimes on one side. Possible right shoulder pain. Usually, within hours the abdomen becomes rigid and the woman goes into shock.
Severe allergic reaction to latex	When a person's body has a strong reaction to contact with latex.	Rash over much of the body, dizziness brought on by a sudden drop in blood pressure, difficult breathing, loss of consciousness (anaphylactic shock).
Stroke	When arteries to the brain become blocked or burst, preventing normal blood flow and leading to the death of brain tissue.	Numbness or weakness of the face, arm or leg, especially on one side of the body; confusion or trouble speaking or understanding; trouble seeing in one or both eyes; trouble walking, dizziness, loss of balance or coordination; severe headache with no other known cause. Signs and symptoms develop suddenly.
Toxic shock syndrome	A severe reaction throughout the body to toxins released by bacteria.	High fever, body rash, vomiting, diarrhea, dizziness, muscle aches. Signs and symptoms develop suddenly.

Annex (8): Family Planning Drugs Registered in Saudi Food and Drug Authority (SFDA)

Type of Methods	Medication Description	Trade Name Examples
Oral Contraceptives	Desogestrel 75 microgram tablet *	CERAZETTE ®
		DESIRETT ®
		DESOGEST ®
	Levonorgestrel 30 microgram tablet *	MICROLUT ®
	Levonorgestrel 1.5 mg tablet	NAVELA ®
	Levonorgestrel 0.75 mg tablet	POSTINOR-2 ®
	Drospirenone 4 mg Film-coated tablet	SLINDA ®
	Desogestrel 150 microgram + ethinylestradiol 30 microgram tablet *	REGULON ®
		MARVELON ®
		CYBELLE ®
	Desogestrel 25 microgram + ethinylestradiol 30 microgram tablet	GRACIAL ®
	Ethinylestradiol 30 microgram, gestodene 75 microgram film coated tablet	GYNERA ®
		LINDYNETTE ®
		LUTTAGEN ®
	Drospirenone 3 mg, ethinylestradiol 30 microgram film coated tablet	YASMIN ®
		MIDIANA ®
		ZAHRA ®
		DIVA ®
	Cyproterone acetate 2 mg + ethinylestradiol 35 microgram tablet *	DIANE ®
	Ethinylestradiol 30 microgram, levonorgestrel 125 microgram tablet	LOGYNON ®
	Drospirenone 3 mg + ethinylestradiol 20 microgram + levomefolic calcium 451 microgram tablet *	YAZ PLUS ®
	Chlormadinone acetate 2 mg, ethinylestradiol 30 microgram film-coated tablet	BELARA ®
Implants	Etonogestrel 68 mg Implant	IMPLANON NXT ®
	Etonogestrel 11 mg, ethinylestradiol 3.474 mg Implant	ORNIBEL ®
Intrauterine Device	Levonorgestrel 52 mg drug delivery system: intrauterine, 1 system *	MIRENA ®
	cu380 a copper intra-uterine device: contraceptive, 1 device *	SLIVER LINE ®
		Safeload ®
Ring / Barrier Methods	Etonogestrel 11.7 mg , ethinylestradiol 2.7 mg Vaginal Ring	NUVARING ®
Patches	Ethinylestradiol 6 mg/24 hours + norelgestromin 0.6 mg/24 hours patch *	EVRA TRANSDERMAL ®
Injection	Medroxyprogesterone acetate 150 mg/ml injection, 1 ml vial *	DEPO-PROVERA ®

*Available within the Ministry of Health Formulary.

Note: This list is subject to regular updates, trade names are only an example of registered generics available in SFDA.

JOB AID

JOB AID

Pregnancy Checklist

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

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

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

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

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

Comparing Contraceptives Methods

Comparing Combined Methods

Characteristic	Combined Oral Contraceptives	Monthly Injectables	Combined Patch	Combined Vaginal Ring
How it is used	Pill taken orally.	Intramuscular (IM) injection.	Patch worn on upper outer arm, back, abdomen or buttocks. Not on breasts.	Ring inserted in the vagina.
Frequency of use	Daily.	Monthly: Injection every 4 weeks.	Weekly: Patch is changed every week for 3 weeks. No patch worn 4th week.	Monthly: Ring kept in place for 3 weeks and taken out during 4th week.
Effectiveness	Depends on user's ability to take a pill every day.	Least dependent on the user. User must obtain injection every 4 weeks (plus or minus 7 days).	Requires user's Attention once a week.	Depends on user keeping the ring in place, not leaving it out for more than 48 hours at a time.
Bleeding patterns	Typically, irregular bleeding for the first few months and then lighter and more regular bleeding	Irregular bleeding or no monthly bleeding is more common than with COCs. Also, some have pro-longed bleeding in the first few months	Similar to COCs, but irregular Bleeding is more common in the first few cycles than with COCs.	Similar to COCs, but ir-regular bleeding is less common than with COCs.
Privacy	No physical signs of use but others may find the pills	No physical signs of use.	Patch may be seen by spouse or others.	Spouse may be able to feel the ring

Comparing Injectables

Characteristic	DMPA	NET-EN	Monthly Injectables
Time between injections	3 months.	2 months.	1 month.
How early or late a client can have the next injection	2 weeks before or 4 weeks after scheduled injection date.	2 weeks before or after scheduled injection date.	7 days before or after scheduled injection date.
Injection technique	Deep intramuscular (IM) injection into the hip, upper arm, or buttock. Subcutaneous injection into back of upper arm, abdomen, or front of thigh.	Deep IM injection into the hip, upper arm, or buttock. May be slightly more painfulthan DMPA-IM.	Deep intramuscular (IM) injection into the hip, upper arm, buttock, or outer thigh.
Typical bleeding patterns in first year	Irregular and prolonged bleeding at first, then no bleeding or infrequent bleeding. About 40% of users have no monthly bleeding after 1 year.	Irregular or prolonged bleeding in first 6 months but shorter bleeding episodes than with DMPA. After 6 months bleeding patterns are similar to those with DMPA. 30% of users have no monthly bleedingafter 1 year.	Irregular, frequent, or prolonged bleeding in first 3 months. Mostly regular bleeding patterns by 1 year. About 2% of users have no monthly bleeding after 1 year.
Average weight gain	1–2 kg per year.	1–2 kg per year.	1 kg per year.
Pregnancy rate, as Commonly used.	About 4 pregnancies per 100 women inthe first year.	Assumed to be similar to DMPA.	About 3 pregnancies per 100 women in the first year.
Average delay in time to pregnancy after stopping injections	4 months longer than for women who used other methods.	1 month longer than for women who used other methods.	1 month longer than for women who used other methods.

Comparing Condoms

Characteristic	Male Condoms	Female Condoms
How to wear	Rolled onto man's penis. Fits the penis tightly.	Inserted into the woman's vagina. Loosely lines the vagina and does not constrict the penis.
When to put on	Put on erect penis right before sex.	Can be inserted up to 8 hours before sex.
Material	Most made of latex; some of synthetic materials or animal membranes.	Most made of a thin, synthetic film; a few are latex.
How they feel during sex	Change feeling of sex.	Fewer complaints of changed feeling of sex than with male condoms.
Noise during sex	May make a rubbing noise during sex.	May rustle or squeak during sex.
Lubricants to use	Users can add lubricants: • Water-based or silicone-based only. • Applied to outside of condom.	Users can add lubricants: • Water-based, silicone-based, or oil-based (but not with latex condoms). • Before insertion, applied to outside of condom. • After insertion, applied to inside of condom or to the penis.
Breakage or slippage	Tend to break more often than female condoms.	Tend to slip more often than male condoms.
When to remove	Require withdrawing from the vagina before the erection softens.	Can remain in vagina after erection softens. Requires removal before woman stands.
What they protect	Cover and protect most of the penis, protect the woman's internal genitalia.	Cover both the woman's internal and external genitalia and the base of the penis.
How to store	Store away from heat, light, and dampness.	Plastic condoms are not harmed by heat, light or dampness.
Reuse	Cannot be reused.	Reuse not recommended.
Cost and availability	Generally low cost and widely available.	Usually more expensive and less widely available than male condoms.

Comparing IUDs

Characteristic	Copper-Bearing IUD	Levonorgestrel IUD
Effectiveness	Nearly equal. Both are among the most effective methods.	
Length of use	Approved for 10 years.	Approved for 3 to 5 years.
Bleeding patterns	Longer and heavier monthly bleeding, irregular bleeding, and more cramping or pain during monthly bleeding.	More irregular bleeding and spotting in the first few months. After 1 year no monthly bleeding is more common. Causes less bleeding than copper-bearing IUDs over time.
Anemia	May contribute to iron-deficiency anemia if a woman already has low iron blood stores before insertion.	May help prevent iron-deficiency anemia.
Main reasons for discontinuation	Increased bleeding and pain.	No monthly bleeding and hormonal side effects.
Non-contraceptive benefits	May help protect against endometrial cancer.	Effective treatment for long and heavy monthly bleeding (alternative to hysterectomy). May also help treat painful monthly bleeding. Can be used to provide the progestin in hormone replacement therapy.
Postpartum use	Can be inserted up to 48 hours postpartum. After 48 hours, delay until 4 weeks or more.	
Use as emergency contraception	Can be used within 5 days after unprotected sex.	Not recommended.
Insertion	Requires specific training.	
Cost	Less expensive.	More expensive.

Comparing Implants

Characteristic	Jadelle	Implanon NXT	Levoplant
Type of progestin	Levonorgestrel	Etonogestrel	Levonorgestrel
Number	2 rods	1 rod	2 rods
Approved lifespan	5 years	3 years	4 years

The Menstrual Cycle

Stage	Description
Days 1–5: Monthly bleeding	*Usually lasts from 2–7 days, often about 5 days* If there is no pregnancy, the thickened lining of the womb is shed. It leaves the body through the vagina. This monthly bleeding is also called menstruation. Contractions of the womb at this time can cause cramps. Some women bleed for a short time (for example, 2 days), while others bleed for up to 8 days. Bleeding can be heavy or light. If the egg is fertilized by a man's sperm, the woman may become pregnant, and monthly bleeding stops.
Day 14: Release of egg	*Usually occurs between days 7 and 21 of the cycle, often around day 14* Usually, one of the ovaries releases one egg in each cycle (usually once a month). The egg travels through a fallopian tube towards the womb. It may be fertilized in the tube at this time by a sperm cell that has traveled from the vagina.
Days 15–28: Thickening of the womb lining	*Usually about 14 days long, after ovulation* The lining of the uterus (endometrium) becomes thicker during this time to prepare for a fertilized egg. Usually there is no pregnancy, and the unfertilized egg cell dissolves in the reproductive tract.

Identifying Migraine Headaches and Auras

Identifying women who suffer from migraine headaches and/or auras is important because migraines, and aura in particular, are linked to higher risk of stroke. Some hormonal contraceptives can increase that risk further.

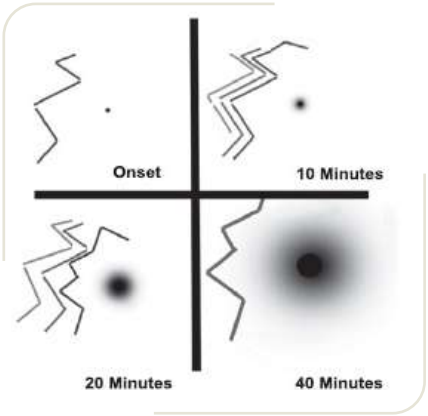
Migraine Headaches

- Recurring, throbbing, severe head pain, often on one side of the head, that can last from 4 to 72 hours.
- Moving about often makes the migraine headache worse.
- Nausea, vomiting, and sensitivity to light or noise may also occur.

Migraine Auras

- Nervous system disruptions that affect sight and sometimes touch and speech.
- Almost all auras include a bright area of lost vision in one eye that increases in size and turns into a crescent shape with zigzag edges.
- About 30% of auras also include a feeling of “pins and needles” in one hand that spreads up the arm and to one side of the face. Some auras also include trouble with speaking. Seeing spots or flashing lights, or having blurred vision, which often occurs during migraine headaches, is not aura.
- Auras develop slowly over several minutes and go away within an hour, typically before the headache starts. (In contrast, a sudden blackout in one eye, particularly with a feeling of “pins and needles” or weakness in the opposite arm or leg, may indicate a stroke.)

- *People describe visual auras as bright, shimmering lines or waves around a bright area of lost vision that increase in size and turn into a crescent shape with zigzag edges. The black spot represents how the area of lost vision increases in size over time*



Identifying Migraine Headaches

For women who want a hormonal method[‡,§] or are using one.
If a woman reports having very bad headaches, ask her these questions to tell the difference between a migraine headache and an ordinary headache. If she answers "yes" to any 2 of these questions, she probably suffers from migraine headaches. Continue to Identifying Migraine Auras, below.

1. Do your headaches make you feel sick to your stomach?
2. When you have a headache, do light and noise bother you a lot more than when you do not have a headache?
3. Do you have headaches that stop you from working or carrying out your usual activities for one day or more?

Identifying Migraine Auras

Ask this question to identify the most common migraine aura. If a woman answers "yes," she probably suffers from migraine auras.

1. Have you ever had a bright light in your eyes lasting 5 to 60 minutes, loss of clear vision usually to one side, and then a headache? (Women with such aura often bring one hand up beside their heads when describing the vision change. In some cases the bright light is not followed by a headache.)

If her headaches are not migraines and she does not have aura, she can start or continue hormonal methods if she is otherwise medically eligible. Any later changes in her headaches should be evaluated, however.

(continued)

Can a Woman with Migraines and/or Aura Use a Hormonal Method?

In situations where clinical judgment is limited:

Yes = Yes, can use

No = No, don't use

I = Initiation

C = Continuation

	Combined methods†		Progestin-only methods§	
Migraine headaches	I	C	I	C
Without aura				
Age < 35	Yes	No	Yes	Yes
Age ≥ 35	No	No	Yes	Yes
With aura, at any age	No	No	Yes	No

† *Methods with estrogen and progestin: combined oral contraceptives, monthly injectables, combined patch, and combined vaginal ring.*

§ *Methods with progestin only: progestin-only pills, progestin-only injectables, and implants.*

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GLOSSARY

Abscess A pocket of pus surrounded by inflammation, caused by a bacterial infection and marked by persistent pain.

Acquired Immunodeficiency Syndrome (AIDS) A condition, due to infection with human immunodeficiency virus (HIV), in which the body's immune system breaks down and is unable to fight certain infections.

AIDS See acquired immunodeficiency syndrome.

Amenorrhea See vaginal bleeding.

Anemia A condition in which the body lacks adequate **hemoglobin**, commonly due to iron deficiency or excessive blood loss. As a result, tissues do not receive adequate oxygen.

Antiretroviral (ARV) therapy A group of drugs used to treat HIV infection. There are several ARV classes, which work against HIV in different ways. Patients take a combination of several drugs at once.

Backup method A contraceptive method used when mistakes are made with using an on-going method of contraception, or to help ensure that a woman does not become pregnant when she first starts to use a contraceptive method. Include abstinence, male or female condoms, spermicides, and withdrawal.

Bacterial vaginosis A common condition caused by overgrowth of bacteria normally found in the **vagina.**

Benign ovarian tumor Noncancerous growth that develops on or in the ovary.

Blood pressure The force of the blood against the walls of blood vessels. Generally, normal systolic (pumping) blood pressure is less than 140 mm Hg, and normal diastolic (resting) blood pressure is less than 90 mm Hg (see hypertension).

Breast cancer A malignant (cancerous) growth that develops in breast tissue.

Breastfeeding Feeding an infant with milk produced by the breasts. Breastfeeding patterns include:

- **Exclusive breastfeeding;** Giving the infant only breast milk with no supplementation of any type—not even water—except for perhaps vitamins, minerals, or medication.
- **Fully breastfeeding;** Giving the infant breast milk almost exclusively but also water, juice, vitamins, or other nutrients infrequently.
- **Nearly fully breastfeeding;** Giving the infant some liquid or food in addition to breast

milk, but more than three-fourths of feedings are breastfeeding.

» **Partially breastfeeding;** Any breastfeeding less than nearly fully breastfeeding, giving the infant more supplementation with other liquids or food. Less than three-fourths of feedings are breastfeeds.

Cervical cancer A malignant (cancerous) growth that occurs in the **cervix,** usually due to persistent infection with certain types of **human papillomavirus.**

Cervical ectropion A nonserious condition in which the mucus-producing cells found in the cervical canal begin to grow on the area around the opening of the **cervix.**

Cervical intraepithelial neoplasia (CIN) Abnormal, precancerous cells in the cervix. Mild forms may go away on their own, but more severe abnormalities may progress to **cervical cancer** if not treated. Also called cervical dysplasia or precancer.

Cervical mucus A thick fluid plugging the opening of the **cervix.** Most of the time it is thick enough to prevent **sperm** from entering the **uterus.** At the midpoint of the **menstrual cycle,** however, the mucus becomes thin and watery, and sperm can more easily pass through.

Cervical stenosis When the cervical opening is narrower than normal.

Cervix The lower portion of the **uterus** extending into the upper **vagina.**

Chancroid A **sexually transmitted infection** caused by a bacterium, which causes an ulcer to grow on the genitals.

Chlamydia A **sexually transmitted infection** caused by a bacterium. If left untreated, it can cause infertility.

Cirrhosis (of the liver) See Liver disorders, Annex ....

Deep vein thrombosis See Deep vein thrombosis, Annex ....

Depression A mental condition typically marked by dejection, despair, lack of hope, and sometimes either extreme tiredness or agitation.

Diabetes (diabetes mellitus) A chronic disorder that occurs when blood glucose levels become too high because the body does not produce enough insulin or cannot use the insulin properly.

Dual protection Avoiding both pregnancy and **sexually transmitted infections.**

Dysmenorrhea Pain during vaginal bleeding, commonly known as menstrual cramps.

Eclampsia A condition of late pregnancy, labor, and the period immediately after delivery characterized by convulsions. In serious cases, sometimes followed by coma and death.

Ectopic pregnancy See Ectopic pregnancy, Annex ....

Ejaculation The release of **semen** from the **penis** at orgasm.

Embryo The product of fertilization of an egg **(ovum)** by a **sperm** during the first 8 weeks of development.

Endometrial cancer Malignant (cancerous) growth in the lining of the **uterus.**

Endometrium The membrane that lines the inner surface of the **uterus.** It thickens and is then shed once a month, causing **monthly bleeding.** During pregnancy, this lining is not shed but instead changes and produces hormones, helping to support the pregnancy.

Epididymis A coiled tube (duct) attached to and lying on the **testes.** Developing **sperm** reach maturity and develop their swimming capabilities within this duct. The matured sperm leave the epididymis through the **vas deferens.**

Epididymitis Inflammation of the **epididymis.**

Epilepsy A chronic disorder caused by disturbed brain function. May involve convulsions.

Estrogen Hormone responsible for female sexual development. Natural estrogens, especially the **hormone** estradiol, are secreted by a mature ovarian **follicle,** which surrounds the egg **(ovum).** Also, a group of synthetic drugs that have effects similar to those of natural estrogen; some are used in some hormonal contraceptives.

Expulsion When a contraceptive implant or intrauterine device fully or partially comes out of place.

Fallopian Tube Either of a pair of slender ducts that connect the **uterus** to the region of each **ovary**. Fertilization of an egg **(ovum)** by **sperm** usually takes place in one of the fallopian tubes.

Fertilization Union of an **ovum** with **a sperm.**

Genital herpes A disease caused by a virus, spread by sexual contact.

Genital warts Growths on the **vulva,** the vaginal wall, and the **cervix** in women, and on the **penis** in men. Caused by certain types of **human papillomavirus.**

Gonorrhea A **sexually transmitted infection** caused by a bacterium. If not treated, can cause **infertility**.

HIV See human immunodeficiency virus.

Hormone A chemical substance formed in one organ or part of the body and carried in the blood to another organ or part, where it works through chemical action. Also, manufactured chemical substances that function as hormones.

Human Immunodeficiency Virus (HIV) The virus that causes **acquired immunodeficiency syndrome** (AIDS).

Human Papillomavirus (HPV) A common, highly contagious virus spread by sexual activity and skin-to-skin contact in the genital area. Certain subtypes of HPV are responsible for most cases of **cervical cancer;** others cause **genital warts.**

Hydrocele The collection of fluid in a body cavity, especially in the **testes** or along the **spermatic cord.**

Hyperlipidemia High level of fats in the blood that increases the risk of heart disease.

Hypertension Higher **blood pressure** than normal; 140 mm Hg or higher (systolic) or 90 mmHg or higher (diastolic).

Hyperthyroidism. Too much production of thyroid **hormones.**

Hypothyroidism Not enough production of thyroid **hormones.**

Implantation The embedding of the **embryo** in the **endometrium** of the **uterus,** where it establishes contact with the woman's blood supply for nourishment.

Infertility The inability of a couple to produce living children.

Informed choice A freely made decision based on clear, accurate, and relevant information. A goal of family planning counseling.

Inguinal Hernia A **hernia** in the groin.

Ischemic heart disease Ischemia is reduced blood flow to tissues of the body. When this reduced flow is in the arteries of the heart, it is called ischemic heart disease.

Jaundice Abnormal yellowing of the skin and eyes. Usually a symptom of **liver disease.**

Labia The inner and outer lips of the **vagina,** which protect the internal female organs.

Laceration A wound or irregular tear of the flesh anywhere on the body, including the **cervix** and **vagina.**

Latex Allergy When a person's body has a reaction to contact with latex, including persistent or recurring severe redness, itching, or swelling. In extreme cases, may lead to anaphylactic shock.

Lesion A disturbed or diseased area of skin or other body tissue.

Mastitis An inflammation of breast tissue due to infection that may cause fever, redness, and pain.

Menarche The beginning of cycles of **monthly bleeding.** Occurs during puberty after girls start producing **estrogen** and **progesterone.**

Menopause The time in a woman's life when monthly bleeding stops permanently. Occurs when a woman's **ovaries** stop releasing eggs (ova). A woman is considered menopausal after she has had no bleeding for 12 months.

Menorrhagia See **vaginal bleeding.**

Menses, **menstrual period**, **menstruation**. See **monthly bleeding**.

Menstrual cycle A repeating series of changes in the **ovaries** and **endometrium** that includes **ovulation** and **monthly bleedin**g. Most women have cycles that each last between 24 and 35 days.

Migraine aura A nervous system disturbance that affects sight and sometimes touch and speech

Migraine headache A type of severe, recurrent headache

Minilaparotomy A female sterilization technique performed by bringing the **fallopian tubes** to a small incision in the abdomen and then usually tying and cutting them.

Miscarriage Natural loss of pregnancy during the first 20 weeks.

Monthly bleeding Monthly flow of bloody fluid from the **uterus** through the **vagina** in adult women, which takes place between **menarche** and **menopause.** Also, the monthly vaginal flow of bloody fluid that women have while using combined hormonal contraceptives (a withdrawal bleed).

Non-steroidal anti-inflammatory drug (NSAID) A class of drugs used to reduce pain, fever, and swelling.

Orchitis Inflammation of **a testis.**

Ovarian cyst Fluid-filled sac that develops in the **ovary** or on its surface; usually disappears on its own but may rupture and cause pain and complications.

Ovaries A pair of female sex glands that store and release ova (see **ovum**) and produce the sex **hormones estrogen** and **progesterone.**

Ovulation The release of an **ovum** from an **ovary.**

Ovum Reproductive egg cell produced by the **ovaries.**

Pelvic inflammatory disease See Pelvic inflammatory disease.

Pelvis The skeletal structure located in the lower part of the human torso, resting on the legs and supporting the spine. In females, also refers to the hollow portion of the pelvic bone structure through which the **fetus** passes during birth.

Penis The male organ for urination and sexual intercourse.

Perforation A hole in the wall of an organ or the process of making the hole, as with a medical instrument.

Placenta The organ that nourishes a growing **fetus.** The placenta (afterbirth) is formed during pregnancy and comes out of the **uterus** within a few minutes after the birth of a baby.

Postpartum (after childbirth) The first 6 weeks after childbirth.

Pre-eclampsia Hypertension with either excess protein in the urine or local or generalized swelling, or both (but without convulsions) after 20 weeks of pregnancy. May progress to **eclampsia.**

Premature Birth A birth that occurs before 37 weeks of pregnancy.

Preventive Measures Actions taken to prevent disease, such as washing hands or providing drugs or other therapy.

Progesterone A steroid **hormone** that is produced by the **ovary** after **ovulation.** Prepares the **endometrium** for **implantation** of a fertilized egg **(ovum)**, protects the embryo, enhances development of the **placenta,** and helps prepare the breasts for **breastfeeding.**

Progestin (progestogen) Any of a large group of synthetic drugs that have effects similar to those of **progesterone.** Some are used in hormonal contraceptives.

Prostate Male reproductive organ where some of the **semen** is produced.

Puerperal Sepsis Infection of the reproductive organs during the first 42 days **postpartum** (puerperium).

Purulent cervicitis Inflammation of the **cervix** accompanied by a pus-like discharge. Often indicates infection with gonorrhea or chlamydia.

Pus A yellowish-white fluid formed in infected tissue.

Scrotum The pouch of skin behind the **penis** that contains the **testes.**

Semen The thick, white fluid produced by a man's reproductive organs and released through the **penis** during **ejaculation.** Contains sperm unless the man has had a vasectomy.

Seminal Vesicles Male organs where **sperm** mixes with **semen.**

Sepsis The presence of various **pus**-forming and disease-causing organisms, or poisonous substances that they produce, in the blood or body tissues.

Septic Abortion Induced or **spontaneous abortion** involving infection.

Sex, sexual intercourse Sexual activity in which the penis is inserted into a body cavity. Vaginal sex involving the vagina.

Sexually transmitted infection (STI) Any of a group of bacterial, fungal, and viral infections and parasites that are transmitted during sexual activity.

Sickle cell anemia, sickle cell disease A hereditary, chronic form of **anemia.** Blood cells take on an abnormal sickle or crescent shape when deprived of oxygen.

Speculum A medical tool used to widen a body opening to better see inside. A speculum is inserted into the vagina to help see the cervix.

Sperm The male sex cell. Sperm are produced in the **testes** of an adult male, mixed with **semen** in the **seminal vesicles,** and released during **ejaculation.**

Spermatic Cord A cord consisting of the vas **deferens,** arteries, veins, nerves, and lymphatic vessels that passes from the groin down to the back of each **testis.**

Syphilis A **sexually transmitted** infection caused by a bacterium. If untreated, may progress to systemic infection, causing general paralysis and dementia. May be transmitted to the fetus during pregnancy or childbirth.

Testes, testicles The two male reproductive organs that produce **sperm** and the **hormone** testosterone; located in the **scrotum.** (Testis refers to one of the testes.)

Thalassemia An inherited type of **anemia.**

Thromboembolic disorder (or disease) Abnormal clotting of blood in the blood vessels.

Thrombogenic mutations Any of several genetic disorders that cause abnormal thickening or clotting of the blood.

Thrombophlebitis Inflammation of a vein due to the presence of a blood clot.

Thrombosis Formation of a blood clot inside a blood vessel.

Urethra The tube through which urine is released from the body. In men **semen** also passes through the urethra.

Uterine fibroid Noncancerous tumor that grows in the muscle of the **uterus.**

Uterine perforation Puncturing of the wall of the **uterus,** which may occur during an induced abortion or with insertion of an intrauterine device.

Uterine rupture A tear of the **uterus,** typically during labor or late pregnancy.

Uterus The hollow, muscular organ that carries the **fetus** during pregnancy. Also called the womb.

Vagina The passage joining the outer sexual organs with the **uterus** in females.

Vaginal bleeding Any bloody vaginal discharge (pink, red, or brown) that requires the use of sanitary protection (pads, cloths, or tampons). Different vaginal bleeding patterns include:

- **Amenorrhea** No bleeding at all at expected bleeding times.
- **Breakthrough bleeding** Any bleeding outside of expected bleeding times (i.e., outside of regular monthly bleeding) that requires use of sanitary protection.
- **Heavy bleeding (menorrhagia)** Bleeding that is twice as heavy as a woman's usual bleeding.
- **Infrequent bleeding** Fewer than 2 bleeding episodes over 3 months.
- **Irregular bleeding** Spotting and/or breakthrough bleeding that occurs outside of expected bleeding times (i.e., outside of regular monthly bleeding).
- **Menstrual bleeding monthly bleeding** Bleeding that takes place, on average, for 3–7 days about every 28 days.
- **Prolonged bleeding** Bleeding that lasts longer than 8 days.
- **Spotting** Any bloody vaginal discharge outside of expected bleeding times that requires no sanitary protection.

Vaginal Mucus The fluid secreted by glands in the **vagina.**

Vaginitis Inflammation of the **vagina.** May be due to infection by bacteria, viruses, or fungi, or to chemical irritation. Not a sexually transmitted infection.

Valvular heart disease Health problems due to improperly functioning heart valves.

Varicose veins Enlarged, twisted veins, most commonly seen in veins just beneath the skin of the legs.

Vas deferens (vas, vasa) Two muscular tubes that transport **sperm** from the **testes** to the seminal vesicles. These tubes are cut or blocked during a vasectomy.

Vascular Disease Any disease of the blood vessels.

Vulva The exterior female genitals.

Warts See **genital warts.**

FAMILY PLANNING

National Guidelines for Health Care Providers

Evidence-Based Guidance

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