ESWATINI NATIONAL FAMILY PLANNING SERVICES GUIDELINES

3rd EDITION

UNFPA

World Health Organization

Sexual Reproductive Health Unit

The Kingdom of Eswatini

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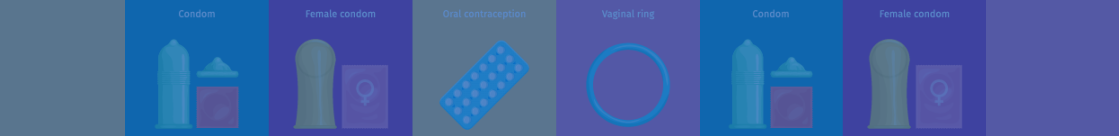
2021



FOREWORD

Family planning (FP) is a human right and a core element of the Essential Health Services in Eswatini. It is a key strategy for reducing maternal and neonatal mortality and attainment of SDGs 3. FP services can also save women's lives by reducing unintended and high-risk pregnancies and unsafe abortions. These services can also help improve the survival rates of new-born and children by lengthening intervals between pregnancies.

According to MICS (2014), the Contraceptive Prevalence Rate (CPR) is at 66.1% while unmet need is at 15.2% and the HIV prevalence remains high at 27%. This exposes the need for FP in the country and thus the need to promote the uptake of FP among women and girls in Eswatini.

Moreover, FP heightens the fact that all couples, individuals and their partners have the right to decide freely and responsibly whether and when to have children, along with their right to attain the highest standard of sexual and reproductive health, and to make decisions free from discrimination, coercion and violence. This right has been reaffirmed and embellished by various bodies in numerous declarations and conventions over the years, notably the 1979 Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) and the 1994 International Conference on Population and Development (ICPD).

This third edition of the Eswatini FP services guidelines is aligned with global FP standards and guidelines, the Medical Eligibility Criteria (MEC) as well as the selected practice recommendations of 2016. It aims to address the recommendations by WHO based on the Evidence for Contraceptive Options and HIV Outcomes study which identified areas for improvement in the provision of FP services, especially for HIV positive individuals.

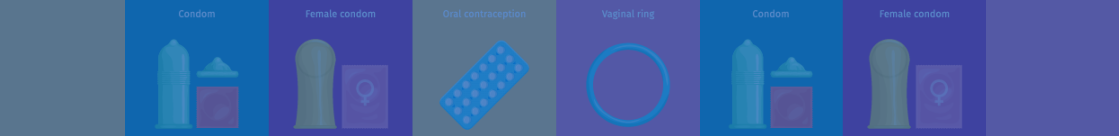
Director of Health Services
Ministry of Health

ACKNOWLEDGEMENTS

The Ministry of Health wishes to acknowledge the technical and financial support from UNFPA in ensuring that the review and validation of these guidelines was a success. The aim of the review of the family planning guidelines was to the provision of standardized contraception services to adolescent girls and young women, including all contraceptive users.

Thanks are due to the Ministry of Health, Sexual Reproductive Health Unit, UN agencies, especially UNFPA and Stakeholders for their support in the review of these guidelines. Many thanks go to the team that was involved in the validation process of the 3rd edition of the guidelines.

Much appreciation is directed to Ms Wendy Gule-Dlamini – the consultant for her wonderful work and guidance during the review, ensuring that the document is distinct.



ACRONYMS AND ABBREVIATIONS

AIDs	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral
BBT	Basal Body temperature
BTL	Bilateral Tubal Ligation
CHC	Combined Hormonal Contraceptives
CI	Coitus interruptus
CICs	Combined Injectable Contraceptives
COCs	Combined Oral Contraceptives
CPR	Contraceptive Prevalence Rate
DPMA	Depo medroxyprogesterone acetate
DVT	Deep vein thrombosis
ECHO	Evidence for Contraceptive Options and HIV Outcomes
ECPs	Emergency Contraceptive Pills
FAM	Fertility awareness method
FP	Family Planning
GBV	Gender Based Violence
HIV	Human Immuno Deficiency Virus
HMIS	Health Management Information System
HTS	HIV Testing Services
IPC	Infection Prevention and Control
IPPF	International Planned Parenthood Federation
IUCD / IUD	Intrauterine contraceptive device / intrauterine device
LAM	Lactational amenorrhea
LGBTIQ	Lesbian, gays, bisexual, transsexuals, intersex and query
LMIS	Logistics Management Information System
LNG	Levonergestrel

MEC	Medical Eligibility Criteria
MICS	Multiple indicator cluster survey
NET-EN	Noresthisterone enathate
NFPM	Natural Family Planning Method
NNRTIs	Non-Necleoside Reverse Transcriptase Inhibitor
NRTI	Nucleoside reverse transcriptase inhibitor
NXT	Nexplanon
OCs	Oral Contraceptives
PAC	Post Abortion Care
PID	Pelvic inflammatory disease
PNC	Post Natal Care
POIs	Progestin Only Injectables
POPs	Progestin only pills
PPE	Personal Protective Equipment
PrEP	Pre-Exposure Prophylaxis
PWDs	People living with Disabilities
SDGs	Sustainable Development Goals
SODV	Sexual Offenses and Domestic Violence Act
SPR	Selected practice recommendations
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually transmitted infections
TB	Ulipristal acetate
UN	World Health Organization
UNFPA	United Nations Population Fund
UPA	Ulipristil acetate
WHO	World Health Organisation

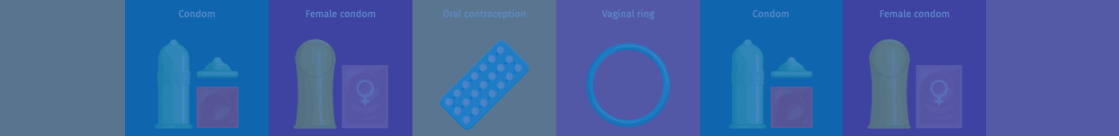
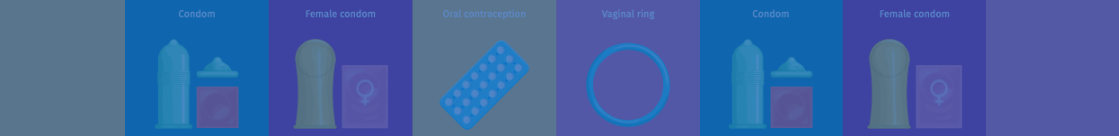
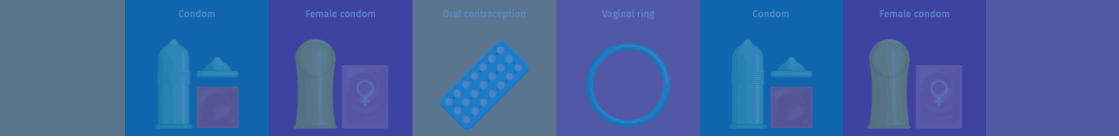


TABLE OF CONTENTS





List of Figures

1. INTRODUCTION AND BACKGROUND TO THE REVIEW

1.1 INTRODUCTION AND BACKGROUND

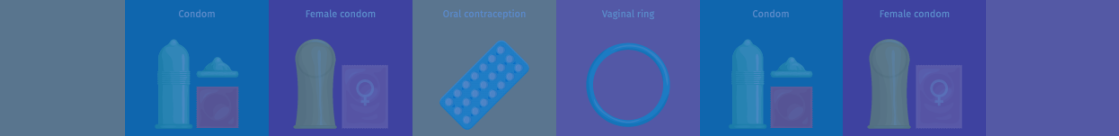
Family planning (FP) is a core element of the Essential Health Services in Eswatini. FP has direct health benefits, such as prevention of unintended pregnancy, sexually transmitted infections including HIV infection in the case of condoms and subsequently it is a key strategy for reducing maternal and neonatal mortality. MICS (2014), states that the Contraceptive Prevalence Rate (CPR) is at 66.1% while unmet need for FP is at 15.2%. Of note is that Eswatini is one of the countries with high HIV prevalence rate at 27%, which further underscores the need to improve access to FP services especially for women living with HIV.

Providing family planning services can include various contraceptive methods as well as meeting the fertility needs of individuals, preconception health services, pregnancy testing and counselling, basic infertility services, and the screening and treatment of sexually transmitted infections, and postpartum family planning.

1.2 AIM OF THE REVIEW

The aim of the review of the Eswatini National FP guidelines 2015 was to come up with an FP guideline document that is aligned with global FP standards and guidelines, the Medical Eligibility Criteria (MEC) as well as the selected practice recommendations. This aims to address the recommendations by WHO and ECHO study which identified areas for improvement in the provision of FP services.

In many countries, women and girls often bear more children than they want, or at times when they are not planned despite possessing these inherent rights



(Starbird, Norton & Marcus 2016). It is against this background that the country prioritizes the review of the FP guidelines to ensure that health care workers are provided with clear guidance in the provision of quality services for FP for the population of Eswatini especially women and girls in hardest to reach areas.

1.3 OBJECTIVES OF THE REVIEW / RATIONALE FOR THE REVIEW

To align the national guidelines with current WHO recommendations and incorporating changes as highlighted by the selected practice recommendations (SPR) 2016.

1.4 THE FAMILY PLANNING PROGRAMME COMPONENT IN ESWATINI

The objective of the FP programme in Eswatini is to:

- Reduce maternal and new-born morbidity and mortality in order to contribute towards the attainment of Sustainable Development Goals (3)
- Provide a voluntary, comprehensive, and well-integrated quality FP service to prevent unintended pregnancies and sexually transmitted infections including HIV.
- Make available a wide range of quality contraceptives to individuals who need them.
- Provide clear, accurate and comprehensible information on contraception.

1.4.1 Policy and Benefits of Family Planning

FP is crucial in ensuring healthy lives and promoting the wellbeing for all at all ages. Starbird, Norton and Marcus (2016) states that investing in FP is a development's best buy. According to Sexual and Reproductive Health Rights (SRHR), partners and individuals have:

- The right to voluntarily decide on whether or not when to have children, the number and spacing of those children, which is attainment of basic human

rights.

- The right to make a decision about a contraceptive method based on free choice and not obtained by any special inducements or forms of coercion.
- The right to comprehensible information on the characteristics (i.e., risks and benefits) of each family planning method available.
- The right to comprehensive, unbiased, and balanced FP counselling, including the right to safe pregnancy/conception counselling for people living with HIV/AIDS.
- Family planning supports the rights of the girl child to remain unmarried and childless, until she is physically, psychologically, and economically ready and desires to bear children.
- It strengthens the rights of women with HIV to decide on future childbearing that is free of coercion.

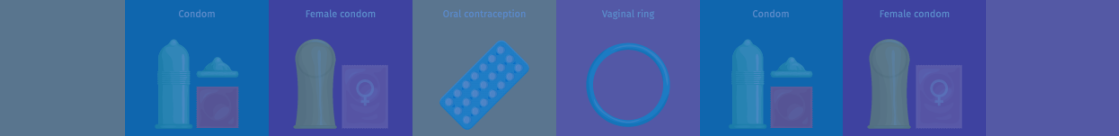
The National Policy on Sexual and Reproductive Health (2013) states that Family planning information and services shall be provided at all levels of care to every individual, their partner or couples according to their needs. The roles and responsibilities of the stakeholders are as follows:

The Ministry of Health shall:

- Create an enabling environment to ensure availability and accessibility of family planning information and voluntary services to all persons regardless of sex, gender, age, status, sexual orientation and religion according to their needs.
- Secure resources for the provision of comprehensive FP services

The SRH programme shall:

- Provide technical guidance and provide tools (standards, guidelines and protocols) to facilitate provision of FP services at all levels of care



- Facilitate integration of HIV/AIDS services into FP services and vice versa.
- Build capacity of health facilities and health care providers to integrate FP and HIV services.
- Ensure voluntarism and informed choice in all government supported family planning activities

The health service providers shall:

- Provide comprehensive FP information and services to all persons according to their needs.

1.5 WHAT'S NEW

This third edition of the Eswatini National FP guidelines has been made to incorporate emerging issues in line with the latest WHO (2015) Medical Eligibility Criteria (MEC), the global FP handbook – WHO (2018), WHO (2016) Selected practice recommendation.

1.5.1 Family Planning in the context of the Sustainable Development Goals (SDGs)

As per the 2030 Agenda, through meeting women's needs for FP, progress towards achieving other targets, concerning health and socioeconomic wellbeing, can be facilitated. FP is important to attain most of the SDGs, however, those more specific to family planning are in Goal 3 on guaranteeing good health and well-being for all at all ages, and in Goal 5 on promoting gender equality and the empowerment of women and girls. The International Planned Parenthood Federation (IPPF) (2020) reveals that FP further ensures achievement of targets 3.1 (reduction of global maternal mortality rate to less than 70 per 100,000 live births); target and target 3.8 – to achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality affordable essential medicines and vaccines

for all.

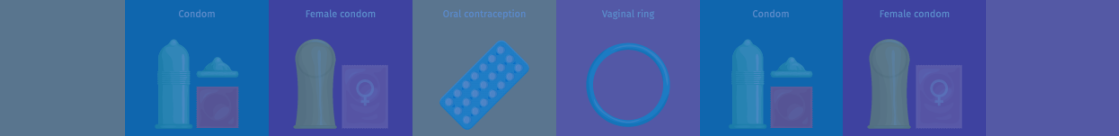
Lastly, target 3.7 and 5.6 that aims at ensuring universal access to SRH services including FP, information and education; and aiming on universal access to SRH and reproductive rights respectively, talks to FP.

1.5.2 Family Planning in the COVID- 19 era

The International Commission of Jurists (ICJ) (2021) reports that the United Nations Population Fund (UNFPA) revealed that there has been a significant drop in family planning services uptake by women since the COVID-19 pandemic in Eswatini. The uptake dropped by 47% compared to the same period the previous year-2020. Of note, the COVID-19 pandemic has placed significant pressure on the health system, however, Eswatini remains obliged to ensure the right to health, including full enjoyment of the right to sexual and reproductive health. Globally, the COVID-19 pandemic has had a disproportionately negative impact on women and girls. Some of the measures put in place by states with the intention to respond to the pandemic have also had a disproportionately negative impact on women and girls.

The Siracusa Principles which may be taken as an authoritative interpretation of the permissible scope of limitations and derogations of rights even in public emergencies and disasters, sets out standards and restrictions for any limitation or derogation of rights in such circumstances. Most importantly in the context of the right to health, the Siracusa principles openly specify that any limitations or derogations of rights in the name of a “public health” emergency must be “specifically aimed at preventing disease or injury or providing care for the sick and injured”. Therefore, it is reasonable to insist that the “public health” objectives in pursuit of which emergency measures and restrictions are purportedly undertaken must, in turn, be specifically aimed at both improving public health and realizing the right to health.

- States have an obligation to ensure that access to reproductive health



services and other essential healthcare services needed by women remain available and unrestricted during this pandemic.

- In particular, comprehensive SRH must be provided as essential services during the COVID-19 pandemic.
- Women's mental and physical health must be protected and adequate healthcare access and sufficient social assistance for women living in poverty must be ensured.
- Pre- and post-natal healthcare services must remain available for women, in a manner that does not risk COVID-19 transmission.
- Survivors of gender-based violence must also have access to comprehensive health services.

In order to realize the right to health of women and girls in Eswatini, the ICJ (2021) recommends that the following measures on SRH:

- Ensure access to family planning health services for all women and girls including LGBTIQ persons;
- Ensure the existence and operation of a functioning public health system, healthcare facilities, goods and services of a sufficient quantity and quality to ensure that every person can fully enjoy the right to health.
- Ensure all health facilities are equipped with all essential medicines including a wide range of contraceptive methods, such as condoms and emergency contraception and medicines for abortions and for post abortion care, as well as HIV related medicines
- Guarantee access to information and education on sex, sexuality, HIV, sexual and reproductive rights especially for adolescents and youth;

1.5.3 Family Planning and Gender Based Violence

Gender-based violence (GBV) continues to be a mishap in Eswatini. The prevalence of GBV is high in Eswatini with 26% of people between 15-49 years reported to experience such violence. This significantly undermines women's

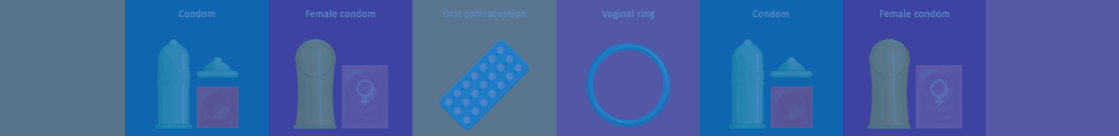
ability to exercise a wide range of human rights, including their right to the highest attainable standard of health, including SRH. Eswatini has enacted legal and policy frameworks aiming to protect women and children (girl child)'s human rights, such as the Sexual Offenses and Domestic Violence Act (SODV Act), which advances already existing protections against gender-based violence, including the Child Protection Act.

The right to sexual and reproductive health includes, among other things: "the right to make free and responsible decisions and choices; and the right to be free from violence, coercion and discrimination, regarding matters concerning one's body and sexual and reproductive health. Some recommendation on GBV by the ICJ (2021) in ensuring attainment of the right to SRH includes:

- Increase access to healthcare services for victims and survivors of GBV, including medical and psychosocial support and ensure adequate rape kits in all health centres;
- Adopt legislation providing for legal aid to enable victims of GBV to be better able to access justice and effective remedies for SGBV, including through courts
- Provide training to public officials, including police, health practitioners and prosecutors and judicial officers on SODV Act on Sexual and Reproductive health rights of victims and survivors of sexual and gender-based violence.
- Ensure comprehensive services for survivors of SGBV are available during the Covid-19 pandemic.

1.5.4 Contraceptive eligibility for women at risk of HIV: Findings from the 'Evidence for Contraceptive Options and HIV Outcomes' (ECHO) Study

The ECHO study findings highlighted the critical need to strengthen and expand HIV and STI prevention services. Testing for HIV and STIs should be part of high-quality family planning services for women at risk.



- The ECHO trial showed high rates of both HIV and STIs in the study sites highlighting the need for appropriate prevention, diagnosis and treatment of all STIs.
- Current HIV prevention measures remain unsatisfactory for many women and adolescent girls living in settings of high HIV incidence.
    - In such areas, the integration of family planning and HIV prevention services for all women is essential if the health of women and adolescent girls is to be improved.
- The ECHO trial further has the following recommendations, based on its findings:
    - STI programmes need to be strengthened, including a move towards diagnostic management.
    - HIV testing and prevention should be included in family planning services.
    - HIV testing should be offered to all women and to partners of all women who are eligible.
    - HIV prevention options should be offered to all women, including pre-exposure prophylaxis (PrEP).
        - The offer of PrEP to women could also be considered where HIV incidence is high.
        - A risk assessment could include: desire to take PrEP (reflecting a self-identified risk); history of an STI; more than one sex partner in the last six months; or women with a sex partner with HIV who is not virally supressed on antiretroviral therapy.

2. SERVING DIVERSE POPULATION

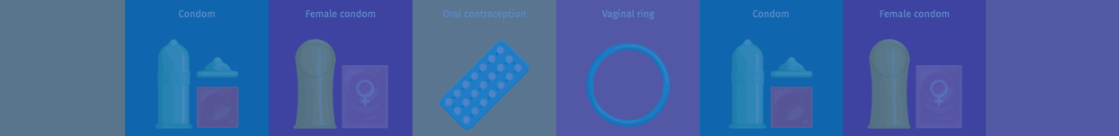
2.1 ADOLESCENTS AND YOUTH

All contraceptives are safe for adolescents and youth. Unmarried and married youth may have different sexual and reproductive health needs. Appropriate sexual and reproductive health services, including contraception, should be available and accessible to all adolescents without requiring authorization from a parent or guardian by law, policy, or practice.

Moreover, social and behavioural issues should be key considerations in the choice of contraceptive methods by adolescents. Method choice can also be influenced by factors such as irregular patterns of intercourse and the need to conceal sexual activity and contraceptive use. Therefore, proper education and counselling, prior to and at the time of method selection can help adolescents meet their specific contraceptive needs, make informed and voluntary decisions.

Youth Friendly services:

- Ensure confidentiality and privacy (however, explain that shared confidentiality may arise if an adolescent is referred for other services to other health care workers or other institutions).
- Respect views and beliefs of adolescent if they are non-detrimental.
- Have enough time to interact with adolescents.
- Have the ability to communicate correct information with adolescents and keep the message simple. Use open communication and allow reflection on issues.
- Be able to use interactive approaches.
- Welcoming partners and include them in counselling, if the client desires
- Speaking without expressing judgment (for example, say “You can” rather than “You should”).
- Being aware of young people’s norms about gender and gently encourage positive, healthful norms.



- Regularly train service providers on emerging issues

2.2 WOMEN NEAR MENOPAUSE

Menopause is reached when a woman ceases to ovulate, usually between the ages of 45 and 55. To be sure to avoid pregnancy, a woman should use contraception until she has had no menses for 12 months in a row.

Special considerations about method choice

- Progestin-only methods (progestin-only pills, progestin-only injectables, implants) are a good choice for women who cannot use methods with estrogen.
- Combined hormonal method
    - Women age 35 and older who smoke regardless of how much should not use Combined Oral Contraceptives (COCs), the patch, or the combined vaginal ring.
    - Women age 35 and older who smoke 15 or more cigarettes a day should not use monthly injectables.
    - Women age 35 or older should not use COCs, monthly injectables, the patch, or the combined vaginal ring if they have migraine headaches (whether with migraine aura or not).

2.3 MEN

Correct information can help men make better decisions about their own health and their partner's health. When partners discuss contraception, they are more likely to make plans that they can carry out. 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, 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

2.4 CLIENTS WITH DISABILITIES

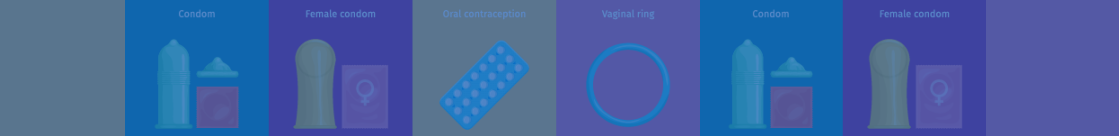
Persons with Disabilities (PWDs) deserve full and sometimes adapted information as well as the same respectful and conscientious care as other clients, since they have the same sexual and reproductive health needs and rights as people without disabilities

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 women with a physical, intellectual and visually impaired disability.
- This may include having trouble remembering to take a pill each day, dealing with changes in menstrual cycle or difficulty with insertion of barrier methods.

Like all clients, PWDs need sexual and reproductive health education to make informed choices.

- People with intellectual disabilities have the same rights as other people to make their own decisions about contraception, including sterilization, however, they may need special support.



3. COMMUNITY INVOLVEMENT

Increasing the involvement of communities in implementing family planning programs is one of the means of increasing acceptability, availability, service uptake, and sustainability of services provided.

Several countries have created ways for communities to participate in their family planning programs. They have found that individuals make better choices about contraception when they participate in the FP program activities in their communities or urban neighbourhoods. Community participation has been recognised as the foundation strategy for Primary Health Care services. It provides a platform for communities to be involved in both activities and decisions that shape their health.

- Community empowerment should be prioritised through education and mobilisation to create demand for services and increase ownership.
- Community activities and platforms should utilised to improve knowledge and clarify myths and misconceptions on contraceptives.
- Community Health care workers should be empowered on contraception in order to bring contraceptive information and methods to women and men.
- Community to facility referral systems should be utilised in referring and linking clients to contraceptive services.
- Collaboration of stakeholders in the community is crucial in standardising messages on contraceptives and increasing coverage of the community with knowledge and services.
- Explore the need to decentralise distribution of contraceptives in the communities.
- Integrate contraceptive service delivery into existing community drug distribution centres.

4. SELECTED PROCEDURES FOR PROVIDING FP METHODS

4.1 COUNSELLING

The key principles for cultivating good client-provider interaction and effective family planning counselling include but not limited to the following:

- Show every client respect, and help each client feel at ease
- Ensure auditory and visual privacy and confidentiality
- Encourage the client to explain needs, express concerns, and ask questions
- Tailor the interaction to the client's needs, circumstances, and concerns
- Be alert to related needs such as protection from STIs/HIV, protection from gender-based violence and support for condom use.
- Listen carefully; Listening is as important as giving correct information
- Show empathy
- Remain non-judgmental about values, behaviours, and decisions that differ from your own
- Remain patient with the client, and express interest
- Give correct and appropriate information and instructions
- Avoid information overload.
- Use words the client knows or can understand
- Demonstrate comfort in addressing sexual and gender issues
- Respect and support the client's informed and voluntary decisions
- Use and provide memory aids.

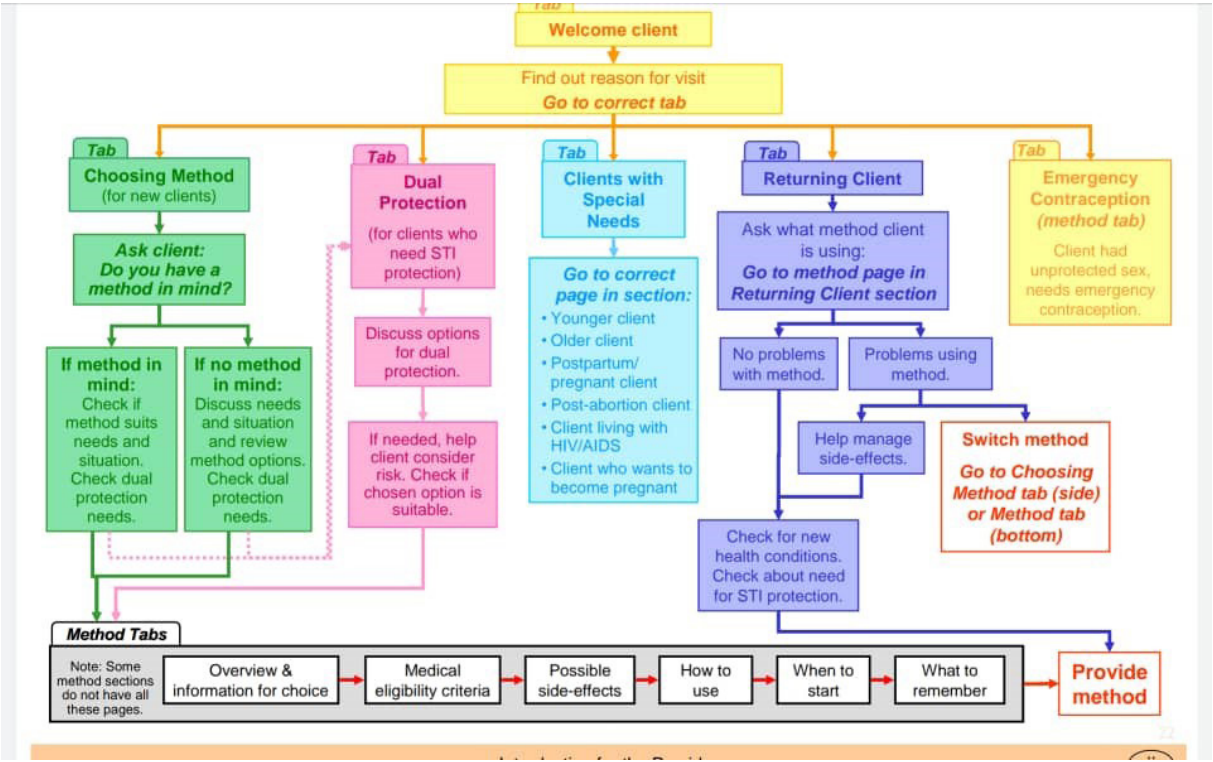


Figure 1: Structured counselling process

4.2 Infection Prevention and Control

Universal Precautions

These are a simple set of effective practices designed to protect health workers and patients from infection with a range of pathogens. Help break the disease-transmission cycle at the mode of transmission step. These practices are used when caring for all patients regardless of diagnosis. Universal precautions include:

- Hand washing
- Use of personal protective clothing (PPE)
- Safe use and disposal of needles and sharps
- Decontamination of equipment and devices.
- Promptly cleaning up blood and body fluid spills.
- Use of safe disposal systems for waste collection and disposal.

4.3 FP COMMODITY LOGISTICS AND MANAGEMENT

High-quality reproductive health care requires a continuous supply and management of contraceptives and other commodities. Of note, Family planning providers are the most important link in the contraceptive supply chain management system that moves commodities from the manufacturer to the client.

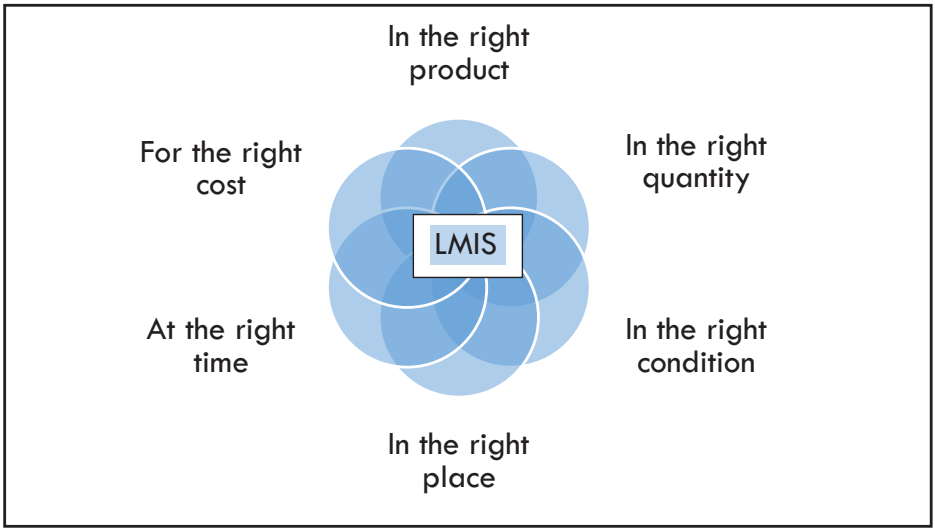
- Accurate and timely reports and orders from providers help supply chain managers determine what products are needed, how much to buy, and where to distribute them.
- Clinic staff members do their part when they:
    - Properly manage contraceptive inventory
    - Accurately record and report what is provided to clients, and
    - Promptly order new supplies.

Clinic staff members need to be familiar with, and work within the system that in place to make sure that they have the supplies they need.

Logistics Management Information System (LMIS) of FP commodities must include:

- Accurate projection of supply needs and cost
- Ordering and procurement
- Appropriate storage facilities at all levels
- Efficient distribution system
- Maintaining good records of supply and utilization
- Monitoring the quality of supplies
- Robust LMIS

The purpose of logistics management information system:



5. NATURAL FAMILY PLANNING METHOD

5.1 OVERVIEW OF NFPM

Natural family planning methods (NFPM) refers to the methods that do not include the use of chemical / hormonal substances or devices for the purpose of preventing pregnancy or achieving pregnancy.

Types of NFPM

1. Abstinence
2. Fertility Awareness Methods (FAM)
3. Lactational Amenorrhea (LAM)
4. Coitus Interruptus (CI)

5.2 ABSTINENCE

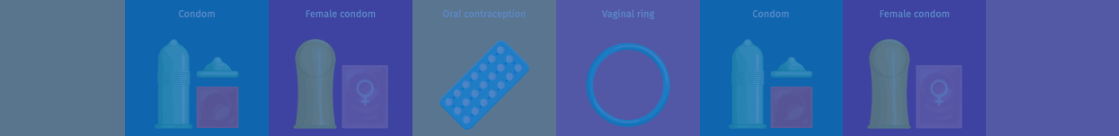
Abstinence is intentionally choosing to avoid all types of intimate genital contact (primary or secondary) for moral, health, religious, ethical or birth control reasons.

Mode of Action

A pregnancy cannot happen if there are no sperms in the vagina. Abstinence needs mental maturity, self-control and commitment from both partners.

Effectiveness

- It is 100% effective if used consistently.
- It is only effective as long as there is full commitment and co-operation between sex partners to remain abstinent.



Advantages and disadvantages

Advantages	Disadvantages
• Encourages partner's communication on contraception • Abstinence has no side effects • It is supported by religious beliefs and socio-cultural norms. • Delays sexual debut for the adolescents and young people • Provides 100% protection against pregnancy and reduces risk of sexually transmitted infections and HIV.	• Both partners must decide, agree and be fully committed to use abstinence. • It requires self-control • It can have a high failure rate, especially if drugs and alcohol are used.

Who can use

- Anyone who chooses to refrain from sexual intercourse. (**Do not use if there is no cooperation from both partners**)

When to start

- It can be started at any time when a person is ready.

5.3 FERTILITY AWARENESS METHODS

Fertility awareness is based on a woman's awareness of the start and end of her fertile period of the menstrual cycle. It is often called the periodic abstinence or natural family planning.

Types of FAM:

- **Calendar-based methods** involve keeping track of days of the menstrual cycle to identify the start and end of the fertile time.
    - E.g. Standard Days Method, which avoids unprotected vaginal sex on days 8 through 19 of the menstrual cycle, and calendar rhythm method. The woman must monitor her menstrual cycle

for 3-6 months so as to determine the ovulation date.

- **Symptoms-based methods** depend on observing signs of fertility.
    - Cervical secretions: cervical mucus increases in amount and becomes thin, stretchy around the time of ovulation. The woman 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.
        - The temperature stays higher until the beginning of her next monthly bleeding

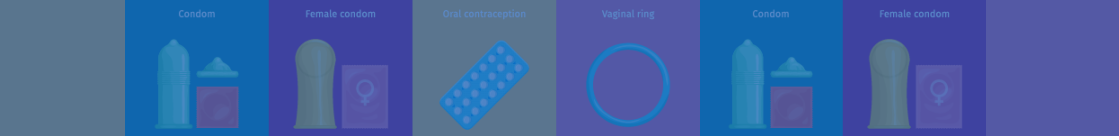
Mode of Action

Helps the woman and her partner identify the fertile phase of each cycle and avoid unprotected vaginal sexual intercourse by either abstaining or using condoms, providing a time barrier between the spermatozoa and ovum.

Effectiveness

Effectiveness depends on the user: risk of pregnancy is greatest when partners have sex on the fertile days without using another method.

- It is 75% if used along with periodical abstinence especially during fertile times
- They are effective if there is co-operation between the partners.

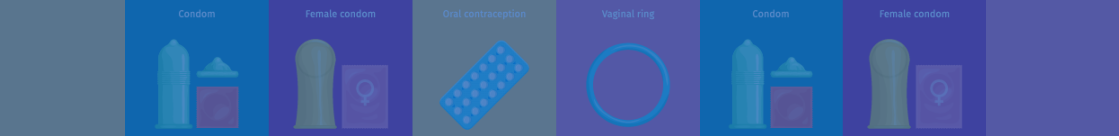


Advantages and disadvantages

Advantages	Disadvantages
• Fertility Awareness methods have no side effects. • Improve knowledge of the reproductive system and understanding of menstrual cycle. • Shared responsibility by partners. • Less expensive. • Do not require procedures and usually do not require supplies • Limited need for professional consultation. • Allows some partners to adhere to their religious or cultural norms • Can assist partners in achieving a wanted pregnancy. • Return to fertility is immediate.	• No protection against sexually transmitted infections including HIV • Need cooperation and commitment by both partners. • Require intensive education and instruction before being confident to use method. • May not be easy to use if menstrual cycle is irregular. • Require accurate record keeping. • Unreliable if client is breastfeeding and has amenorrhea. • Has a high failure rate if client is not well trained and there is no commitment and cooperation between partners.

When to Start

Woman's situation	*Symptoms Based Methods*	*Calendar Method*
Regular menstrual cycles	• Any time of the month. • No need to wait until the start of next monthly bleeding	• Any time of the month • No need to wait until the start of next monthly bleeding.
Amenorrhoea	• Delay until menses return	• Delay until menses return
After childbirth (whether or not breastfeeding)	• She can start symptoms-based methods once normal vaginal secretions have returned. • Normal vaginal secretions will return later in breastfeeding women than in women who are not breastfeeding.	• Delay the method until she has had 3-6 menstrual cycles, and the last one was 26 to 32 days long • Regular cycles will return later in breastfeeding women than in women who are not breastfeeding
After miscarriage or abortion	• She can start immediately with special counselling and support, if she has no infection-related secretions or bleeding due to injury to the genital tract.	• Delay until the start of her next monthly period, if she has no infection-related secretions or bleeding due to injury to the genital tract.



Woman's situation	*Symptoms Based Methods*	*Calendar Method*
Switching from a hormonal method	• She can start symptoms-based methods in the next menstrual cycle after stopping a hormonal method. Use of condom is encouraged while waiting for the next menstrual cycle.	• Delay starting the Standard Days 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 due, and then start it at the beginning of her next monthly bleeding
After taking emergency contraceptive pills	• She can start symptoms-based methods once normal secretions have returned.	• Delay the Standard Days Method until the start of her next monthly bleeding.

5.4 LACTATIONAL AMENORRHEA METHOD

- A temporary family planning method based on the natural effect of breastfeeding on fertility.
- LAM requires 3 conditions that should all be met:
    1. The mother has not resumed menses since delivery
    2. The baby is fully exclusively breastfed as per demand
    3. The baby is less than 6 months' old

Mode of action

- Prevents ovulation

- Hormones released during continuous breastfeeding suppress ovulation which makes pregnancy impossible.

Effectiveness

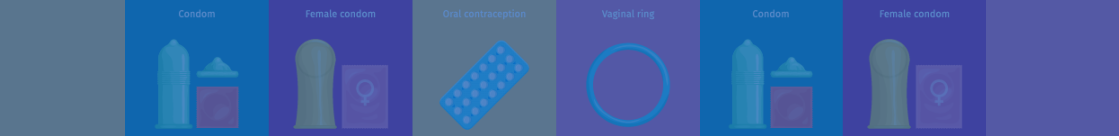
- LAM is up to 98% effective, if practiced during exclusive breastfeeding period.
- Effectiveness is reduced when exclusive breastfeeding is not practiced.

Advantages and disadvantages

Advantages	Disadvantages
• Is universally available and free. • Helps protect against the risk of pregnancy • Encourages exclusive breastfeeding. • It does not interfere with the act of sexual intercourse. • No supplies or procedures needed and has no side effects. • Effective in all women regardless of body weight	• Provides no protection against STI's including HIV. • Effectiveness after exclusive breastfeeding period is not certain. • Frequent breastfeeding may be inconvenient or difficult for some women, especially working mothers. • If the mother is HIV positive there is a risk that the virus will be transmitted to the baby through the breast milk. • If woman develops severe medical breasts conditions, the method can be compromised.

Women Who Can Use LAM

- Women whose babies are less than six-months old, who are exclusively breastfeeding, and are amenorrhoeic can use this method as contraception



When to start

- Start immediately post initiation of breastfeeding

5.5 COITUS INTERRUPTUS

- Coitus Interruptus (CI), also known as male withdrawal, is a method in which the man completely removes the penis from the vagina and away from the external genitalia of the female partner just before he ejaculates.

Mode of action

- CI prevents the sperm from entering the woman's vagina, thus preventing contact between spermatozoa and the ovum.

Effectiveness

It is 80 % effective with correct and consistent use.

Advantages and disadvantages

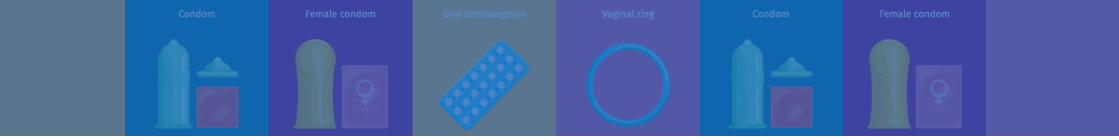
Advantages	Disadvantages
• Can be used at any time • It does not affect breastfeeding. • Always available as a back-up method and no need for professional supervision. • No related cost and no use of chemicals or devices needed. • Accepted by religious, cultural and other beliefs. • Promotes male involvement and partner communication.	• No protection against STI's including HIV. • High failure rate if not used correctly and consistently. • Need for self-control and discipline during sexual intercourse. • Interrupts act of sexual intercourse. • Requires the willingness, commitment of both sexual partners

Who can use Coitus interrupters

- All willing men and their partners
- No medical condition prevents its use
- Is most appropriate for partners who:
    - Have no other method available at the time
    - Are waiting to start another method
    - Have sex infrequently
    - Have objections to using other methods

When to start

It can be started anytime as long as partners is well informed and ready.



6. HORMONAL CONTRACEPTIVES

6.1 OVERVIEW OF HORMONAL CONTRACEPTIVES

There are 5 classes of hormonal methods of contraception;

1. Progesterone-only Oral Pills (POPs)
2. Progesterone-only Injectable Contraceptives (POIs)
3. Combined Oral Contraceptives (COCs)
4. Combined Injectable Contraceptives (CICs)
5. Implants

6.2 PROGESTERONE-ONLY ORAL PILLS (POPS)

- Progestin-only pills (POPs) are also called “minipills” and progestin-only oral contraceptives (OCs).
- Pills that contain a low dose of a progestin similar to the natural hormone progesterone in a woman’s body.
- Do not contain estrogen, thus are safe during exclusive breastfeeding and in women who cannot use methods with estrogen.

Types of POPs

- Microval (containing Levonorgestrel 30mcg) / Microlut

Mode of Action

- Thickens cervical mucus (this blocks sperm from meeting an egg)
- Disrupts the menstrual cycle, including preventing the release of eggs from the ovaries (ovulation)

Effectiveness

- POPs are 99.5% effective when used correctly and consistently.

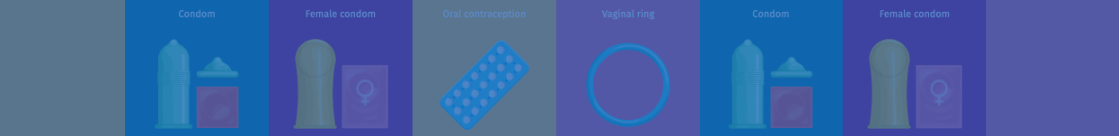
- The effectiveness is dependent on the user:
  - For women who have monthly bleeding, risk of pregnancy is greatest if pills are taken late or missed completely
  - In breastfeeding women are effective within the first 6 months after delivery with exclusive breastfeeding;

When a pill or more is missed;

Number of Missed Pills	**Action to be taken**
1 pill	She should take the pill as soon as she can then continue at the usual time. Use a backup method for 2 days after the missed pill.
2 pills	She should take 2 pills as soon as she can and take another 2 pills the next day then return to her regular schedule on the 3rd day. A backup method of contraception should be used.
3 pills	**Do not attempt to replace as above;** She should use a backup method of contraception and report to the health facility for professional help as soon as possible.

Advantages and disadvantages of POPs

Advantages	Disadvantages
• Can be used during breastfeeding anytime between giving birth and 6 months	• Do not protect against STIs including HIV and AIDS
• Do not affect breast milk production.	• They require strict daily pill-taking, preferably at the same time each day



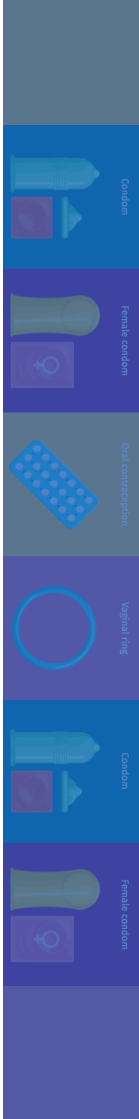
• Suitable for women with risk factors such as heart attack, stroke and thrombosis.	• Irregular bleeding and spotting is common
• Less side effects such as acne and weight gain.	• Less effective in women who are not breastfeeding
• Return to fertility is immediate upon discontinuation.	• Effectiveness may decrease if clients are also taking some other medications (anti-TB drugs, anticonvulsants and antiretroviral (Retinovir boosted and NNRTI based, etc) so a client should use a backup method or change the medication/ method altogether.
• Non contraceptive health benefits which include prevention of endometrial cancer, and anaemia.	• Effectiveness may also be lowered in the presence of diarrhoea and vomiting

Who can use POPs: MEC

Nearly all women can use POPs safely and effectively, including women who:

MEC Category 1	MEC Category 2	MEC Category 3	MEC Category 4
• Are breastfeeding (she can start immediately after childbirth) • Have or have not had children (Parous and nulliparous) • Are married or are not married • Are of any age, including adolescents and women over 40 years old • Have just had an abortion, miscarriage, or ectopic pregnancy • Smoke cigarettes, regardless of woman's age or number of cigarettes smoked • Have anaemia presently or in the past	• Elevated blood pressure (systolic >/= 160, diastolic >/= 100) • History of stroke for initiating clients • History of or current ischaemic heart disease for initiating clients • History of DVT or current DVT on anticoagulant therapy • Major surgery with prolonged immobilization • Systemic lupus erythematous (associated with severe thrombocytopenia or are on Immunosuppressive treatment)	• Acute DVT or pulmonary embolism • History of or current Ischemic heart disease for continuing clients • History of stroke for continuing clients • Systemic Lupus Erythematosus with positive antiphospholipid antibodies • Epilepsy on certain anticonvulsants (phenytoin, carbamazepine, barbiturates etc). • TB patients on Rifampicin or Rifabutin therapy	• Current breast cancer

• Have varicose veins • Are living with HIV, whether or not on antiretroviral therapy	• Irregular, heavy or prolonged vaginal bleeding • Unexplained vaginal bleeding before evaluation • Undiagnosed breast mass	• ARV therapy with Ritonavir-boosted protease inhibitors • Headaches with aura at any age • Severe cirrhosis decompensated.	



When to start POPs

A woman can start using POPs any time she wants if reasonably certain she is not pregnant.

We encourage the use of a back-up method within the first 7 days of using the commodity.

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

Exclusive Breastfeeding

Less than 6 months after giving birth

- If her menses have not returned, she can start POPs any time between giving birth and 6 months.
- No need for a backup method
- If her menses have returned, she can start POPs as advised for women having menstrual cycles

Mixed feeding

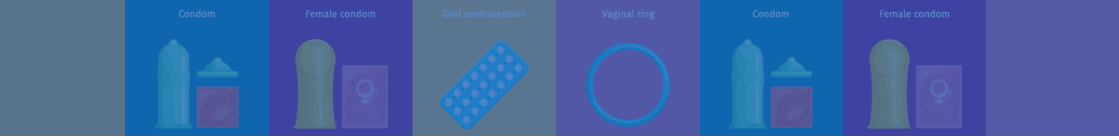
If her menses have not returned

- She can start POPs any time if reasonably certain she is not pregnant.
- She will need a backup method for the first 2 days of taking pills.
- She can start POPs as advised for women having menstrual cycles (see next page)

Not breastfeeding

Less than 6 weeks after giving birth

- She can start POPs at any time.
- No need for a backup method.



More than 6 weeks after giving birth

- If her menses have not returned, she can start POPs any time if reasonably certain she is not pregnant.
- Offer a backup method for the first days of taking pills.
- If her menses have returned, she can start POPs as advised for women having menstrual cycles.

Switching from a hormonal method

- Immediately, if she has been using the hormonal method (POPs) consistently and correctly or if otherwise reasonably certain she is not pregnant.
- No need to wait for her next monthly period.
- No need for a backup method.

Having menstrual bleeding

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 7 days of taking pills

Amenorrhoeac (not related to childbirth or breastfeeding)

- She can start POPs 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

- Start POPs immediately.
    - If she is starting within 7 days after first or second trimester

miscarriage or abortion, no need for a backup method.

- If it is more than 7 days after first or second trimester miscarriage or abortion, she can start POPs any time it is reasonably certain she is not pregnant.
- She will need a backup method for the first 7 days of taking pills.

<u>After taking emergency contraceptive pills (ECPs)</u>

After taking progestin-only or combined ECPs:

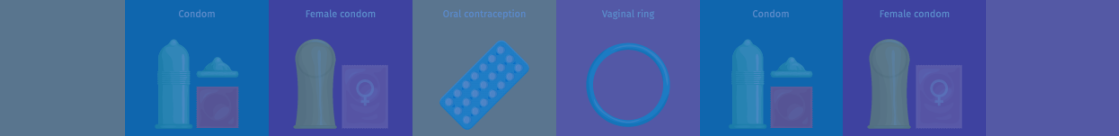
- She can start or restart POPs immediately after she takes the ECPs.
- No need to wait for her next monthly bleeding.
- A continuing user who needed ECPs due to pill-taking errors can continue where she left off with her current pack.
- If she does not start immediately, but returns for POPs, she can 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 7 days of taking pills.

After taking postinor ECPs:

- She can start or restart POPs immediately after taking -ECPs.
- No need to wait for her next monthly bleeding.

Common Side effects

- Changes in bleeding patterns, including:
  - In breastfeeding women there could be a delay in return of monthly bleeding after childbirth (lengthened postpartum amenorrhea)
  - Frequent bleeding
  - Irregular bleeding
  - Infrequent bleeding
  - Prolonged bleeding



- Amenorrhea

NB: Breastfeeding also affects a woman's bleeding patterns.

- Headaches
- Dizziness
- Mood changes
- Breast tenderness
- Abdominal pain
- Nausea
- Other possible physical changes for women not breastfeeding can be enlarged ovarian follicles

6.3 PROGESTON-ONLY INJECTABLE CONTRACEPTIVES (POIs)

- Progestin-only Injectable (POIs) contraceptives contains progesterone only in a smaller varying doses systematically distributed over a specified duration in the body.
- Do not contain estrogen, and so can be used throughout breastfeeding, starting 6 weeks after giving birth, and by women who cannot use methods with oestrogen.

Types of POIs

- Depot medroxyprogesterone acetate (DMPA) – Depo Provera
- Norethisterone enanthate (NET-EN)

Mode of Action

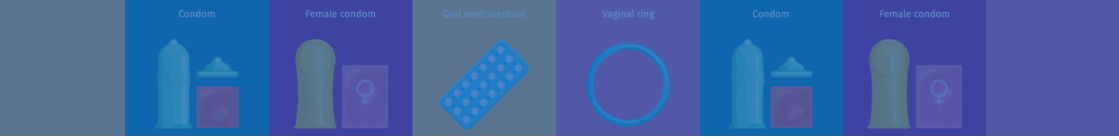
- Suppresses and prevents ovulation
- Thicken cervical mucus thus interfering with sperm transport (spermatozoa are unable to meet the ovum)
- Causes histological changes in the endometrium thus making it unsuitable for implantation

Effectiveness

- Effectiveness depends on getting injections regularly and risk of pregnancy is greatest when a woman misses an injection.
- Above 99% effective

Advantages and disadvantages of POIs

Advantages	Disadvantages
• Can be used during breastfeeding starting after childbirth • Do not affect breast milk production • Suitable for women with risk factors such as heart attack, stroke and thrombosis. • Provides highly effective protection against pregnancy. • Ensures periodic contact with medical or trained health personnel. • Only requires to remember the clinic return dates • It can be confidential: no one else can tell that a woman is using contraception • Non-contraceptive health benefits which include prevention of endometrial cancer, uterine fibroids, endometrial cancers, Pelvic Inflammatory Diseases, endometriosis and anaemia. • Decreases incidence of pre-menstrual or postmenstrual depression and epileptic seizures • Do not make a woman infertile and do not disrupt an existing pregnancy	• Do not protect against STIs including HIV and AIDS • May cause changes in menstrual bleeding patterns. • May cause indirect weight changes and acne. • Requires repeat injection every 2 or 3 months. • There may be delayed return to fertility and cannot be reversed immediately. • May cause headaches, breast tenderness, nausea, hair loss, reduced and changes in libido



Who can use POIs: MEC

MEC Category 1

Nearly all women can use progestin-only injectables safely and effectively, including women who:

- Are of all parity
- Are of any age, including adolescents and women over 40-year-old
- Have just had an abortion or miscarriage
- Smoke cigarettes, regardless of woman's age or number of cigarettes smoked
- Are breastfeeding, starting as soon as 6 weeks after childbirth
- Are living with HIV, whether or not on antiretroviral therapy

When to start POIs?

Regular Menses

- Give the initial injection within the first 7 days of the menstrual bleeding or at any time, if it is reasonably certain that she is not pregnant
- If after 7 days of menstrual bleeding she will need a backup method for the next 7 days.

Amenorrhoeic

- Give anytime if it is reasonably certain that she is not pregnant.
- Use a backup method for the first 7 days of initiating the method

Postpartum client

Breastfeeding:

- Any time within 6 weeks postpartum. With lactational amenorrhea give between 6 weeks and 6 months postpartum, if you can establish that she is not pregnant.

Non breastfeeding:

- Start immediately or at any time within the first 21 days postpartum. After 21 days postpartum and no menses, rule out pregnancy first and initiate but emphasize on the need of a backup method for the next 7 days.

Post abortion

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

Side effects

DMPA

Irregular bleeding } First 3 months
- Prolonged period
- No monthly period } At 1 year
- Infrequent bleeding
- Irregular bleeding

NET-EN

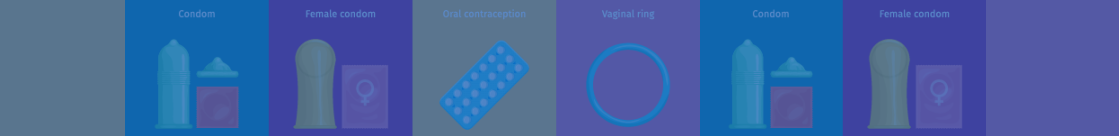
- Weight gain
- Headaches
- Dizziness
- Abdominal bloating and discomfort
- Mood changes
- Low libido
- Loss of bone density

6.4 COMBINED ORAL CONTRACEPTIVES (COCs)

- Pills that contain low doses of 2 hormones, a progestin and an oestrogen; like the natural hormones progesterone and oestrogen in a woman's body.
- Combined oral contraceptives (COCs) are also called "the Pill," low-dose combined pills, OCPs, and OCs.

Types of COCs

- Low dose: Lofemenal or Lucia F containing 0.3mg Norgestrel + 0.03mg Ethinyl Estradiol
- Standard dose: Ovral containing Norgestrel 500µg + 50µg of Ethinyl Estradiol



Mode of action

- Work primarily by preventing the release of eggs from the ovaries (ovulation).
- Thickens the cervical mucus thus interfering with sperm transportation
- Altering the histology of the endometrium that may prevent implantation

Effectiveness

- Effectiveness depends on the user: Risk of pregnancy is greatest when a woman starts a new pill pack 3 or more days late, or misses 3 or more pills near the beginning or end of a pill pack.
- Each pill is effective for 24 hours thus it is taken daily at the same time

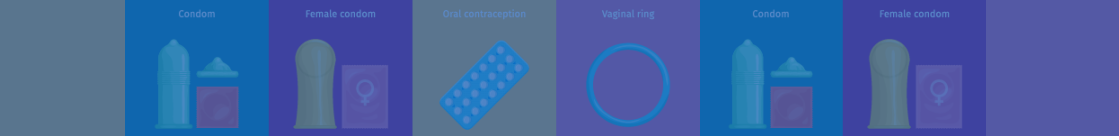
Advantages and disadvantages of using COCs

Advantages	Disadvantages
• Easy to use • Can be used from adolescence to menopause; by nulliparous and multiparous women; provided that no risk factors exist. *Help protect against:* • Risks of pregnancy • Cancer of the lining of the uterus (endometrial cancer) • Cancer of the ovary • Symptomatic pelvic inflammatory disease • Ovarian cysts • Iron-deficiency anaemia • Reduce menstrual cramps • Supresses menstrual bleeding problems • Reduce ovulation pain • Reduce excess hair on face or body • Minimises symptoms of polycystic ovarian syndrome (irregular period, acne, excess hair on face or body) • Reduce symptoms of endometriosis (pelvic pain, irregular bleeding)	• Does not protect against STIs and HIV infection. • Must be taken daily and at the same time • Require an individual to obtain regular supplies. • Effectiveness may be lowered if client is on anti-TB drugs (Rifampicin or Rifabutin therapy), anti-epilepsy treatment and some ARVs indicating a need for a backup method. • Effectiveness may also be lowered in the presence of diarrhoea and vomiting • Reduce milk production in breastfeeding women. • May cause mood changes and low libido to some women • Can increase the risk of Myorcardial Infarction (MI) in women with existing risk factors such as smoking, Diabetes or hypertension.

Who can use COCs:

MEC Category 1	MEC Category 2	MEC Category 3	MEC Category 4
Nearly all women can use COCs safely and effectively, including women who: • Have or have not had children • Are of any age, including adolescents and women over 40 years old • After childbirth and during breastfeeding, after a period of time	• Age above 40 years • Breastfeeding more than 6 months after delivery • Non-breastfeeding women 21 – 42 days with no risk of venous thromboembolism • Smoking and age less than 35 years • Obesity • History of p high blood pressure during pregnancy • Family history of DVT/PE • Major surgery without prolonged immobilization • Superficial thrombophlebitis • Uncomplicated Valvular heart disease	• Breastfeeding 6 weeks to 6 months after delivery • Acute Viral hepatitis • TB patients on Rifampicin or Rifabutin therapy • Anticonvulsant therapy (phenytoin, carbamazepine, barbiturates)	• Breastfeeding less than 6 weeks postpartum • Smoking and age more than 35 year (smoking more than 15 cigarettes/day) • Non-breastfeeding less than 21 days after delivery with or without risk of venous thromboembolism • Symptomatic gall bladder disease (medically treated and current) • Severe hypertension (systolic >160 or diastolic >100 mm Hg) and hypertension with vascular complications • Hypertension (history of hypertension, hypertension controlled on treatment, moderate hypertension)

• Have just had an abortion, miscarriage, or ectopic pregnancy • Smoke cigarettes, if under 35 years old • Have anemia now or had in the past • Have varicose veins • Are living with HIV, whether or not on antiretroviral therapy	• Systemic lupus erythematous (associated with severe thrombocytopenia or are on Immunosuppressive treatment) • Non-migraine headache (mild or severe) in continuing clients • Migraine headache without aura at age less than 35 years for Initiating clients • Unexplained vaginal bleeding before evaluation • Cervical intraepithelial neoplasia or cervical cancer awaiting treatment • Undiagnosed breast mass • Insulin dependent Diabetes Mellitus • Asymptomatic gall bladder disease • HIV treatment with NNRTIs and PIs		• History of DVT/PE or current DVT/PE or DVT/PE on anticoagulant therapy • Major surgery with prolonged immobilization • History of stroke • History of or current ischaemic heart disease • Complicated Valvular heart disease • Systemic Lupus Erythematosus with positive antiphospholipid antibodies • Migraine headache with aura at any age • Severe liver cirrhosis (decompensated) • Current breast cancer • Liver Cancer • Known thrombogenic mutation • Benign liver tumours



When to start

A woman can start using COCs any time she wants if it is reasonably certain she is not pregnant.

Having menstrual cycles or switching from a non-hormonal method

- 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 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 she is switching from an IUD, she can start COCs immediately

Switching from a 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 injectables,
    - Begin taking COCs when the repeat injection would have been given.
    - No need for a backup method.

Exclusive 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 post birth

- If her menses have 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 menses have returned, she can start COCs as advised for women having menstrual cycles.

Mixed feeding

Less than 6 weeks post birth

- Give her COCs and tell her to start taking them 6 weeks after giving birth.
- Give her a backup method to use until 6 weeks since giving birth if her monthly bleeding returns before this time.

More than 6 weeks after giving birth

- If her menses have not returned, she can start COCs any time it is reasonably certain she is not pregnant
- If her menses have returned, she can start COCs as advised for women having menstrual cycles

No monthly period (not related to childbirth or breastfeeding)

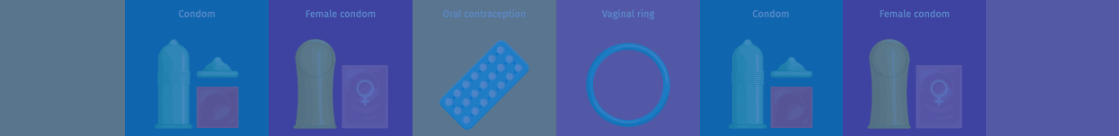
- She can start COCs any time it is reasonably certain she is not pregnant.
- She will need a backup method for the first 7 days of taking pills.

After miscarriage or abortion

- Immediately. If she is starting within 7 days after first or second trimester miscarriage or abortion, no need for a backup method.
- If it is more than 7 days after first or second trimester miscarriage or abortion, 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.

Not breastfeeding

- She can start COCs at any time on days 21–28 after giving birth.
- Give her pills any time to start during these 7 days.
- No need for a backup method.



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 period.
    - A continuing user who needed ECPs due to pill-taking errors can continue where she left off with her current pack.
- If she does not start immediately but returns for COCs, she can start at any time if it is reasonably certain she is not pregnant.
- All women will need to use a backup method for the first 7 days of taking pills.

After taking Postinor or 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 period.
- 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.

6.5 COMBINED INJECTABLES CONTRACEPTIVES (CICs)

These are monthly injectables containing 2 hormones; a progestin and an estrogen, like the natural hormones progesterone and estrogen in a woman's body.

Types of CICs

- Norethisterone enanthate (NET-EN) 50mg +estradiol valerate 5mg (Trade

names: Mesigyna and Norigynon)

Effectiveness

- About 97 % effective
- Effectiveness depends on returning on time: Risk of pregnancy is great when a woman is late for an injection or misses an injection.

Mode of action

- Suppresses ovulation, preventing the release of ovum from ovaries.

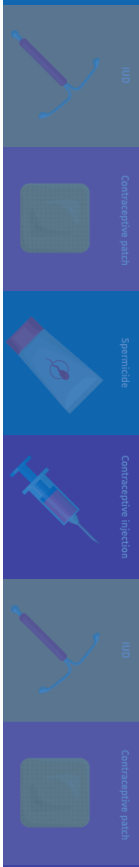
Advantages and disadvantages

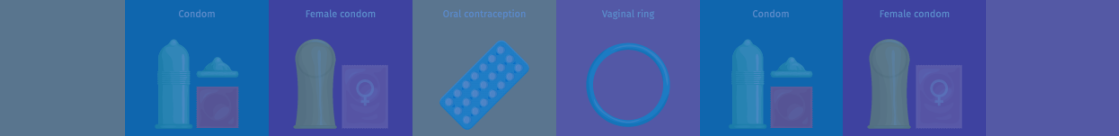
Advantages	Disadvantages
• Do not require daily action • Are private: No one else can tell that a woman is using contraception • Can be stopped at any time • Are good for spacing births	• Does not protect against STIs and HIV infection. • Requires injection monthly • Must be administered by a trained health service provider. • Effectiveness may be lowered if client is on anti-TB drugs (Rifampicin or Rifabutin therapy), anti-epilepsy treatment and some ARVs etc., indicating a need for a backup method. • Cannot be given to breastfeeding women with babies less than six months. It affects the quality and quantity of the milk production among breastfeeding women. • May affect the menstrual cycle

Who can use CICs

MEC Category 1	MEC Category 2	MEC Category 3	MEC Category 4
• Women of any parity • Are of any age, including adolescents and women over 40 years old • Have just had an abortion or miscarriage • Smoke any number of cigarettes daily and are under 35 years old	• Age above 40 years • Breastfeeding more than 6 months after delivery • Non-breastfeeding women 21 – 42 day with no risk of venous thromboembolism • Smoking and age less than 35 years • Obesity • History of high blood pressure during pregnancy where blood pressure is measured and is normal • Family history of DVT/PE • Major surgery without prolonged immobilization • Superficial thrombosis • Uncomplicated Valvular heart disease	• Breastfeeding 6 weeks to 6 months after delivery • Non-breastfeeding less than 21 days after delivery with or without risk of venous thromboembolism • Smoking and age more than 35 years	• Breastfeeding less than 6 weeks postpartum • Severe hypertension (systolic >160 or diastolic >100 mm Hg) and hypertension with vascular complications • History of DVT/PE or current DVT/PE or DVT/PE on anticoagulant therapy • Major surgery with prolonged immobilization • History of stroke • History of or current ischaemic heart disease • Complicated Valvular heart disease • Complicated Diabetes Mellitus (vascular complications e.g. nephropathy, retinopathy)

• Smoke fewer than 15 cigarettes daily and are over 35 years old • Have anaemia or history of anaemia • Have varicose veins • Are living with HIV, whether or not on antiretroviral therapy	• Systemic lupus erythematous (associated with severe thrombocytopenia or are on Immunosuppressive treatment) • Non-migraine headache (mild or severe) • Migraine headache without aura at age less than 35 years for Initiating clients • Unexplained vaginal bleeding before evaluation • Cervical intraepithelial neoplasia or cervical cancer awaiting treatment • Undiagnosed breast mass • Uncomplicated Diabetes Mellitus • Asymptomatic gall bladder disease • • HIV treatment with NNRTIs and PIs	• Hypertension (history of hypertension, hypertension controlled on treatment, moderate hypertension) • Migraine headache without aura at age less than 35 years for continuing clients • Symptomatic gall bladder disease • Acute Viral hepatitis	• HIV/AIDS on treatment Ritonavir boosted PIs • TB patients on Rifampicin or Rifabutin therapy • Systemic Lupus Erythematosus with positive antiphospholipid antibodies • Migraine headache without aura at age more than 35 years for continuing clients • Migraine headache with aura at any age • Severe liver cirrhosis (decompensated) • Current breast cancer • Liver Cancer • Anticonvulsant therapy (phenytoin, carbamazepine, barbiturates) • Multiple risk factors for arterial cardiovascular disease (such as older age, smoking, diabetes and hypertension





When to start CICs

A woman can start injectables any time she wants if it is reasonably certain she is not pregnant.

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, no need for a backup method.
    - If it is more than 7 days after the start of her monthly bleeding, 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.
    - If she is switching from an IUD, she can start injectables immediately

Switching from a 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 another injectable, she can have the new injectable when the repeat injection would have been given.
    - No need for a backup method.

Exclusive breastfeeding

Less than 6 months after giving birth

- Delay 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 monthly bleeding has not returned, start injectables any time if it is reasonably certain woman is not pregnant.
- She will need a backup method for the first 7 days after the injection.

- If her menses have returned, she can start injectables as advised for women having menstrual cycles

Not breastfeeding

- Can start injectables at any time on days 21–28 after giving birth.
- No need for a backup method.
- If seen after 4 weeks and her menses have not returned, she can start injectables any time if reasonably certain she is not pregnant.
- She will need a backup method for the first 7 days after the injection.
- If menses have returned, she can start injectables as advised for women having menstrual cycles

After miscarriage or abortion

- Immediately; if starting within 7 days after first or second trimester miscarriage or abortion, no need for a backup method.
- If it is more than 7 days after first or second trimester miscarriage or abortion, 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.

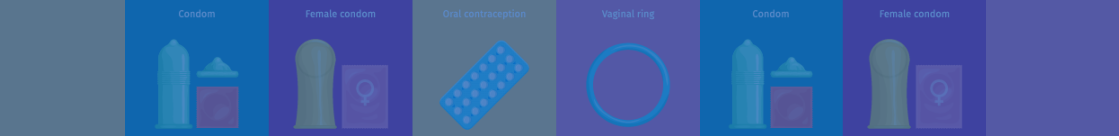
After taking emergency contraceptive pills (ECPs)

After taking progestin-only or combined ECPs:

- Start or restart injectables on the same day as taking the ECPs.
- No need to wait for her next monthly menstrual bleeding to have the injection.
- Give 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 Postinor or ulipristal acetate (UPA) ECPs:

- She can start or restart injectables on the 6th day after taking UPA-ECPs.



- No need to wait for her next monthly bleeding.
- Monthly injectables and UPA interact.
    - If an injectable is started sooner, and thus both are present in the body, one or both may be less effective.
- Make an appointment for her to return for the injection on the 6th day after taking UPA-ECPs, or as soon as possible after that.
- Give 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 6reasonably certain she is not pregnant.

Side effects

- Changes in bleeding patterns, including
    - Lighter bleeding and fewer days of bleeding
    - Irregular bleeding
    - Infrequent bleeding
    - Prolonged bleeding
    - Amenorrhea
- Weight gain
- Headaches
- Dizziness
- Breast tenderness

6.6 IMPLANTS

- Implants are small plastic rods, each about the size of a matchstick, that release a progestin like the natural hormone progesterone in a woman's body.
- Do not contain oestrogen, and so can be used throughout breastfeeding

and by women who cannot use methods with estrogen.

Types of implants

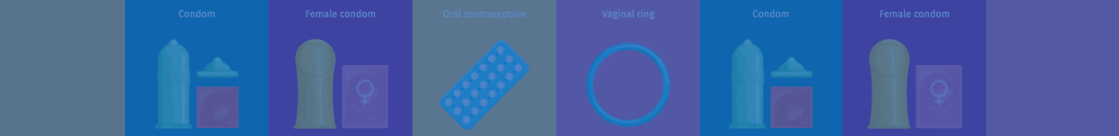
- Jadelle: 2 rods containing levonorgestrel, effective for 5 years
- Implanon NXT (Nexplanon): 1 rod containing etonogestrel, labelled for up to 3 years of use.

Mode of action

- Prevents ovulation
- Thickens cervical mucus on the cervix, which blocks sperm from reaching an egg)

Effectiveness

- Most effective and long lasting reversible method
- About 99% effective
- For heavier women, the effectiveness of Jadelle and Levoplant may decrease near the end of the duration of use stated on the label. These users may want to replace their implants sooner.



Advantages and disadvantages

Advantages	Disadvantages
• Provide long-term pregnancy protection. • Do not require the user to do anything once they are inserted • Are both long-lasting and reversible • Do not interfere with sex • Very effective for 3 to 5 years, depending on the type of implant used. • Immediately reversible. • Avoids user errors and problems with resupply • Helps protect against symptomatic pelvic inflammatory disease (PID) • Reduces risk of ectopic pregnancies • Cut down menstrual pains	• Does not protect against STIs and HIV/ AIDS • Require specifically trained provider to insert and remove. • A woman cannot start or stop implants on her own.

Side effects

- Changes in bleeding patterns, including:
    - Lighter bleeding and fewer days of bleeding

Prolonged bleeding

- Irregular bleeding
- Infrequent bleeding
- Amenorrhea

} First several months to a year

- Lighter bleeding and fewer days of bleeding
- Irregular bleeding, infrequent bleeding and absent monthly bleeding may persist after a year of insertion

- Headaches
- Abdominal pain
- Acne (can improve or worsen)

- Weight change
- Breast tenderness
- Dizziness
- Mood changes
- Nausea
- Enlarged ovarian follicles

Who can use

Nearly all women can use implants safely and effectively

MEC Category 1

- Parous and nulliparas
- Woman of any age, including adolescents and women over 40 years old
- Women who have just had an abortion, miscarriage, or ectopic pregnancy
- Women who smoke cigarettes, regardless of woman's age or number of cigarettes smoked
- Breastfeeding women
- Those with anemia or had history of anaemia
- Those with varicose veins
- Women living with HIV, whether or not on antiretroviral therapy

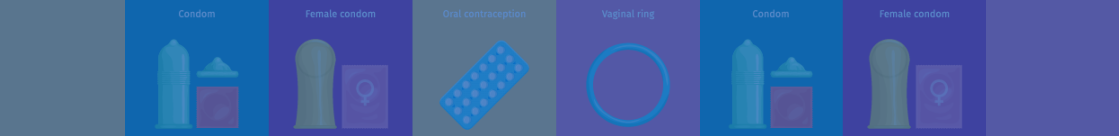
When to start

A woman can start using implants any time she wants if it is reasonably certain she is not pregnant.

<u>Having menstrual cycles or switching from a non-hormonal method</u>

Any time of the month

- 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 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.

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 monthly injectable, she can have implants inserted when the repeat injection would have been given.
  - No need for a backup method

Exclusive breastfeeding

Less than 6 months after giving birth

- If her menses have not returned, she can have implants inserted any time between giving birth and 6 months.
- No need for a backup method.
- If her menses have returned, she can have implants inserted as advised for women having menstrual cycles

More than 6 months after giving birth

- If her menses have not returned, 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.
- If her menses have returned, she can have implants inserted as advised for women having menstrual cycles.

Mixed feeding

- If her menses have not returned 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.
- If her menses have returned, she can have implants inserted as advised

for women having menstrual cycles.

Not breastfeeding

Less than 6 weeks after giving birth

- She can have implants inserted at any time.
- No need for a backup method

More than 6 weeks after giving birth

- If her menses have not returned, 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.
- If her menses have returned, she can have implants inserted as advised for women having menstrual cycles

Amenorrhea (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.

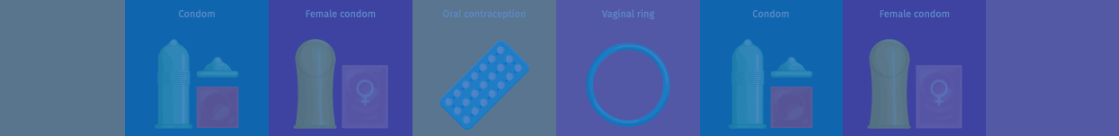
After miscarriage or abortion

- Insert immediately; if inserted within 7 days after first or second trimester miscarriage or abortion, no need for a backup method.
- If it is more than 7 days after first or second trimester miscarriage or abortion, 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.
    - 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 postinor ECPs:

- Implants can be inserted on the 6th day after taking ECPs.
- No need to wait for her next monthly bleeding.
- Make an appointment for her to return on the 6th day to have the implant inserted, 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 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.

7. INTRAUTERINE CONTRACEPTION DEVICE

- An Intrauterine contraceptive device (IUCD), also known as the intrauterine device (IUD) is a tiny device that is inserted into the uterus to prevent pregnancy.
- It is a long acting reversible contraceptive method, and most effective in birth control.
- It should be inserted by competent personnel to reduce chances of perforation of the uterus.

Types of IUDs

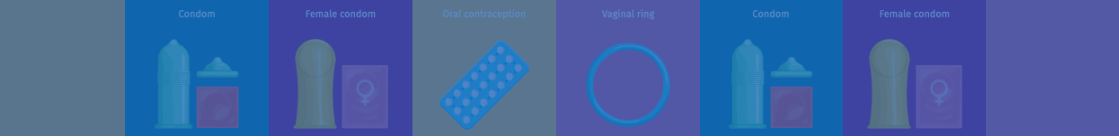
- The copper-bearing intrauterine device (IUD) - a small T- shaped, flexible plastic frame with copper sleeves or wire around it. The CuT-380A gives protection for up to 10 years. The Cu380Ag gives protection for 5 years.
- The Hormonal IUDs (Mirena), giving protection for 5 years. (This commodity is currently unavailable in public health facilities in the country).

Mode of action

- Works by causing a chemical change that damages sperm and egg before they can meet.

Effectiveness

- IUCD is one of the most effective and long- acting methods:
- Less than 1 pregnancy per 100 women using an IUD over the first year (over 99%) effective.
- A small risk of pregnancy remains beyond the first year of use and continues as long as the woman is using the IUCD.



Advantages and disadvantages

Advantages	Disadvantages
• Reliable long term contraceptive method (protection up-to 10 years) • Safe to use during breastfeeding • Does not interfere with sexual intercourse • Has no further costs for supplies after the IUCD is inserted • Does not require client action for efficacy • May help protect against cancer of the lining of the uterus (endometrial cancer) • May help protect against cervical cancer • Reduces the risk of ectopic pregnancy • No hormonal side effects with Copper T • Hormone releasing IUCD may reduce menstrual bleeding and immediate return to fertility	• Does not protect against STIs including HIV • May increase menstrual bleeding and cramping in the first few months of use *Though Uncommon:* • May contribute to anemia if a woman already has low iron blood stores before insertion • May cause Pelvic Inflammatory Disease in woman with chlamydia or gonorrhoea at the time of IUCD insertion.

Who can use IUCDs

- Safe and Suitable for use by nearly all women.
- Suitable to use by women of all different parity
- Suited for use by women of any age, including adolescents and women over 40 years old
- Those who have just had an abortion or miscarriage (if no evidence of infection)
- Those breastfeeding

- Women who does hard physical work
- Have had ectopic pregnancy
- Have had PID
- Have vaginal infections
- Have anaemia
- Have HIV clinical disease that is mild or with no symptoms whether or not they are on antiretroviral therapy

When to start IUCDs

Women can start IUCDs at any time if it is reasonably certain that she is not pregnant.

Having menstrual cycles

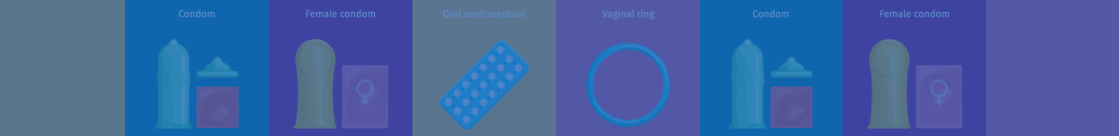
- Any time of the month
    - If she is starting within 12 days after the start of her menstrual period, no need for a backup method.
    - If it is more than 12 days after the start of her menstrual period, she can have the IUCD inserted any time if it is reasonably certain she is not pregnant.
    - No need for a backup method.

Switching from another method

- Immediately, if she has been using the method consistently and correctly or if it is otherwise reasonably certain she is not pregnant.
- If she is switching from an injectable, she can have the IUCD inserted when the next injection would have been given.
- No need to wait for her next menstrual period.
- No need for a backup method.

Soon after childbirth (regardless of breastfeeding status)

- Any time within 48 hours after giving birth, including by caesarean delivery
- If it is more than 48 hours after giving birth, delay until 4 weeks or more after giving birth.



Exclusive Breastfeeding

Less than 6 months after giving birth

- If the IUCD is not inserted within the first 48 hours and her menses have not returned, she can have the IUCD inserted any time between 4 weeks and 6 months after giving birth.
- If her menses have returned, she can have the IUCD inserted as advised for women having menstrual cycles.
- No need for a backup method.

More than 6 months after giving birth

- If her menses have not returned, she can have the IUCD inserted any time it is reasonably certain she is not pregnant.
- If her menses have returned, she can have the IUCD inserted as advised for women having menstrual cycles
- No need for a backup method.

Mixed feeding or not breastfeeding

More than 4 weeks after giving birth

- If her menses have not returned, she can have the IUCD inserted if it can be determined that she is not pregnant
- No need for a backup method.
- If her menses have returned, she can have the IUCD inserted as advised for women having menstrual cycles.

Amenorrhea (not related to childbirth or breastfeeding)

- Any time if it can be determined that she is not pregnant
- No need for a backup method.

After miscarriage or abortion

- Immediately, if the IUCD is inserted within 12 days after first or second trimester abortion or miscarriage and if no infection is present.
- If it is more than 12 days after first or second trimester miscarriage or abortion and no infection is present, she can have the IUCD inserted

any time if it is reasonably certain she is not pregnant.

- If infection is present, treat or refer, and help the client choose another method.
    - If she still wants the IUCD, it can be inserted after the infection has completely cleared.
- IUCD insertion after second-trimester abortion or miscarriage requires specific training. If not specifically trained, delay insertion until at least 4 weeks after miscarriage or abortion
- No need for a backup method.

For emergency contraception

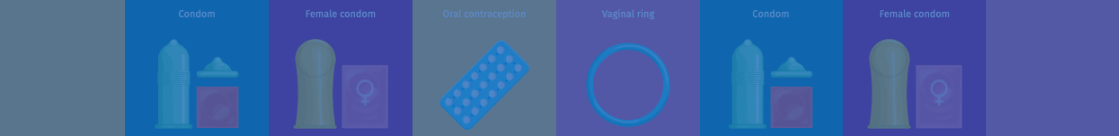
- Within 5 days after unprotected sex.
- When the time of ovulation can be estimated, she can have an IUCD inserted up to 5 days after ovulation.
    - At times this may be more than 5 days after unprotected sex.

After taking emergency contraceptive pills (ECPs)

- The IUCD can be inserted on the same day that she takes the ECPs (progestin-only, combined, or ulipristal acetate ECPs).
- If she does not have it inserted immediately, but returns for an IUCD, she can have it inserted any time if it can be determined that she is not pregnant.
- No need for a backup method.

Side effects

- Changes in bleeding patterns (especially in the first 3 to 6 months), including
    - Prolonged and heavy monthly bleeding
    - Irregular bleeding
    - More cramps and pain during menstrual periods
- Breast tenderness
- Headaches
- Skin and mood changes



8. EMERGENCY CONTRACEPTION

Emergency contraceptive pills (ECPs) help a woman avoid pregnancy after she has sex without contraception (unprotected sexual intercourse). It is not a routine contraceptive but only used in cases of unprotected sex, torn condom or sexual assault.

Types of emergency contraceptives

- Progestogen only pills; these should be given as a single dose regimen. Examples:
  - Postinor or Pregnon (0.75mg Levonorgestrel) given as 2 pill stat.
  - Ulipristal acetate, give 2 pills stat.
  - Microval (0.03mg Levonorgestrel) – 50 pills stat
  - Microlut (0.03mg Levonorgestrel) – 50 pills stat
- Combined hormonal contraceptive pills; these should be given as a two dose regimen 12hrs apart.
  - Lofemenal (0.3 mg norgestrel + 0.03mg ethinyl estradiol) – 4 pills stat then repeat after 12 hours
  - Ovral (norgestrel 500µg + 50 µg of ethinyl estradiol) – 2 pills stat then repeat after 12 hours
- IUCD:
  - The Copper IUCD can be inserted within 5 days of unprotected sex.
  - However, it can only be prescribed and given by a medical doctor after conclusive rule out of potential pregnancy and STI presence.

Mode of action

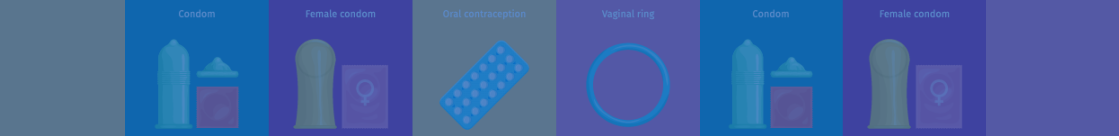
- Work by preventing or delaying ovulation, however do not work once woman is pregnant.
- The ECP's prevents the release of an egg from the ovary or delay its release by 5-7 days. By then any sperm in the woman's reproductive tract will have died, since sperm can survive there for only about 5 days. (If ovulation has

occurred and the egg was fertilized, ECP's do not prevent implantation or disrupt an already established pregnancy).

Effectiveness

Depended on the user;

- It is 92% effective if used during the second or third week of the menstrual cycle. Thus more effective if used within the first week of the menstrual cycle. The earlier the EC is used after unprotected sexual intercourse, the more effective they are.
- It is 99% effective on progestin-only ECPs.
- It is 98% effective on combined contraceptive.
- It is 99% effective on IUCD.



Advantages and disadvantages

Advantages	Disadvantages
• Reduces the risk of pregnancy • Can be used by women of any age, including adolescents • They are not abortifacient • Do not prevent or affect implantation • Do not cause birth defects if pregnancy occurs • Are not dangerous to a woman's health • Do not increase risky sexual behaviour • Do not make women infertile • Can be used more than once in a woman's cycle	• No protection against STIs including HIV • Failure rate of ECPs is higher as compared to other contraceptives • Does not provide long term protection • EC pills do not continue to prevent pregnancy during the rest of the cycle. • EC has the potential for misuse through self-prescription and sharing of pills. • Efficacy depends on the client action. • They can cause nausea (more common for the COC regimen)

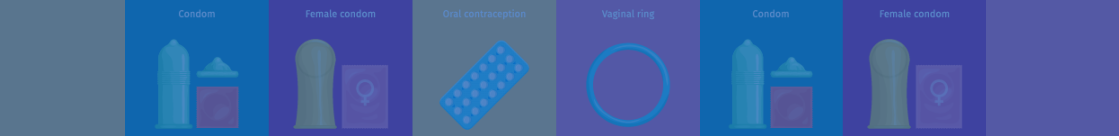
Who can use ECPs

MEC Category 1	MEC Category 2
Emergency contraceptives are safe and suited for use by all women, including: • Breastfeeding women • Past ectopic pregnancy • Rape cases • Obesity (effectiveness is reduced for women who weigh more than 70kg, a copper IUCD is recommended if a woman decides to use ECP) • Clients on anti TB treatment e.g. Rifampicin • Clients on anti-Psychotic treatment e.g. phenytoin, phenobarbital, carbamazepine • Clients on ARV treatment e.g. Efavirenz, nevirapine	• History of severe cardiovascular complications • Angina Pectoris • Migraine • Severe liver disease • Jaundice

When to use

Anytime within 72 hours of unprotected sex, the sooner after unprotected sex that ECPs are taken, the more effective they are. ECPs can be used any time a woman is worried that she might become pregnant, for example:

- After sexual assault
- Within 72 hours of unprotected sex
- When a condom was used incorrectly, slipped, or broke; partners incorrectly used a fertility awareness method e.g. 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; IUCD 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.

Side Effects and management (copy from old guideline)

Some users report the following:

- Changes in bleeding patterns, including:
    - Slight irregular bleeding for 1–2 days after taking ECPs
    - Monthly bleeding that starts earlier or later than expected
- Nausea and Vomiting
- Abdominal pain
- Fatigue
- Headaches
- Breast tenderness
- Dizziness

9. SURGICAL STERILIZATION

9.1 OVERVIEW OF SURGICAL STERILIZATION

Surgical sterilization refers to a surgical contraceptive procedure which is intended to provide permanent contraception. As such, special care must be taken to assure that every client who chooses this method does so voluntarily and is fully informed about the permanence of this method and the availability of alternative, long-acting, highly effective methods. Reversal is usually not possible.

Types of surgical contraception

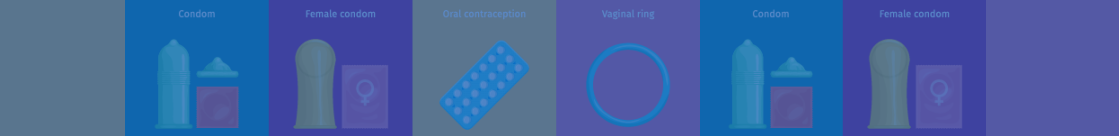
- Bilateral Tubal Ligation (Female sterilization)
- Vasectomy (male sterilization)

9.2 BILATERAL TUBAL LIGATION (BTL)

This is a permanent surgical contraception for women who will not want more children.

Two types of surgical approaches most often 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.
    - It can be conducted under local or general anaesthesia
- Laparoscopy
    - Involves inserting a long, thin tube containing lenses into the abdomen through a small incision.
    - This laparoscope enables easy reach and block or cut of the fallopian tubes in the abdomen.
    - It is conducted under general anaesthesia



Mode of action

The fallopian tubes are blocked or cut, thus the ovum (eggs) released from the ovaries cannot move down the fallopian tubes to be fertilized by the sperm

Effectiveness

- 99.5% effective in preventing pregnancy.

Advantages and disadvantages

Advantages	Disadvantages
• Protects against pregnancy • Is highly effective and safe • Efficacy does not depend on the client's action. • Has no effects on breastfeeding • Does not interfere with act of sexual intercourse. • It is cost effective after the initial procedure • No significant long term side effects or health risks. • It protects against ovarian cancer • It is effective immediately after the procedure • Reduces the risk of ectopic pregnancy.	• Does not protect against STIs and HIV. • Difficult to reverse. • Procedure needs specially equipped facilities and trained personnel. • Failure of procedure pre-disposes to ectopic pregnancy. • Subjects client to pain and leaves permanent scar. • The client /partner needs to sign a consent • There may be complications associated with the surgical procedure such as infection and or bleeding at incision site

Who can have BTL

Any woman can have female sterilization safely, including women who:

- Have no children or few children
- Are married or not
- Do not have husband's permission

- Are at child-bearing age
- Just gave birth (within the last 7 days)
- Are breastfeeding
- Are living with HIV, whether or not on antiretroviral therapy

When to perform BTL

Having menstrual cycles or switching from another method

- 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 it is reasonably certain 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 IUCD, she can have the procedure immediately.

Amenorrhea

- Any time if it is reasonably certain she is not pregnant.

After childbirth

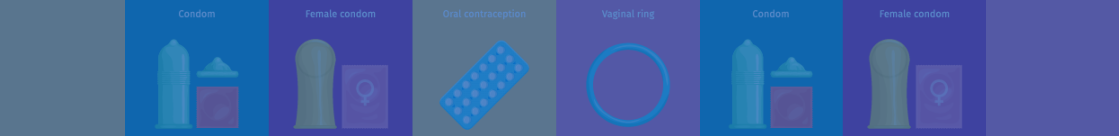
- Immediately or within 7 days after giving birth, if she has made a voluntary, informed choice in advance.
- Any time 6 weeks or more after childbirth if it is reasonably certain she is not pregnant.

After miscarriage or abortion

- Within 48 hours after uncomplicated abortion.

After using emergency contraceptive pills

- The sterilization procedure can be done within 7 days after the start of her next monthly bleeding or any other time if it is reasonably certain she is not pregnant.
- A backup method or oral contraceptives should be given, to start the day after she finishes taking the ECPs, and to use until she has done the procedure.



Side effects

None reported. However, there may be complications on the incision site:

- Wound infection
- Abscess
- Haematoma
- Pain

1.1 VASECTOMY

- This is permanent contraception for men who will not want more children. Through a puncture or small incision in the scrotum, the provider locates each of the 2 tubes that carries sperm to the penis (vas deferens) and cuts or blocks them by cutting and tying them closed or by applying heat or electricity (cautery).
- It can be conducted under local (non-scapel) or general anaesthesia

Mode of action

- Works by closing off each vas deferens, keeping sperm out of semen.

Effectiveness

- Not fully effective for 3 months after procedure
- Otherwise, it is 99.8% effective post the 3 months since procedure.

Advantages and disadvantages

Advantages	Disadvantages
• Highly effective and safe • It is considered safe, permanent and convenient. • Does not affect sexual dysfunction • Does not decrease sex drive • It is not associated with long-term health risks. • Less expensive; easy to perform • The man takes responsibility for contraception	• Does not protect against STIs and HIV. • The procedure is virtually irreversible (i.e. success of reversal surgery cannot be guaranteed) • There are risks associated with surgical procedures • Can only be provided by adequately trained personnel • There is a delay in effectiveness after the procedure has been performed (3 months) hence the necessity for a backup method

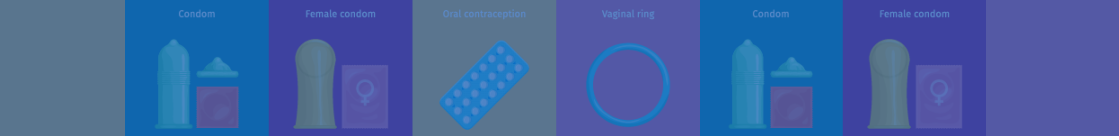
Who can have vasectomy

Any man can have a vasectomy safely, including men who:

- Have no children or few children
- Are married or are not married
- Do not have wife's permission
- Are of child-bearing age
- Have sickle cell disease
- Are at high risk of infection with HIV or another STI
- Are living with HIV, whether or not on antiretroviral therapy

When to start

- The method can be offered anytime a man request if there is no medical reason to delay
- A backup method must be used to ensure efficacy of method, for at least 3



months.

Side effects

None, however there may be complications – rarely – of the following:

- Severe scrotal and testicular pain
- Infection at the incision
- Bleeding under the skin that may cause or bruising

10. BARRIER METHODS

Barrier methods of contraception prevent pregnancy by blocking the entrance of sperm into the uterine cavity; the most common being condoms. They further provide protection against STIs including HIV, as such can be used together with all other methods of contraceptives to provide *dual contraception*.

Types of condoms

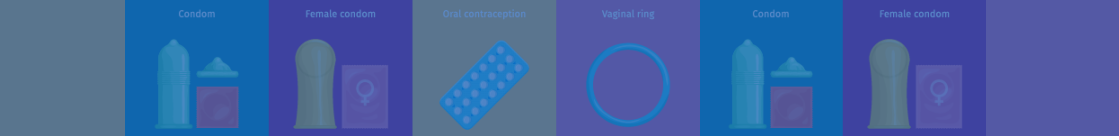
- Male condom
    - Which is a thin sheath or covering made to fit over a man's erect penis before sexual intercourse. Most condoms are made of thin latex rubber. Some are coated with a lubricant or spermicide. Condoms come in different sizes, colours, and textures.
- Female condom
    - Is a sheath made of thin transparent, polyurethane pre-lubricated with a silicone-based substance (dimethicone).

Mode of Action

- Condoms act as a barrier that keeps sperm out of the vagina thereby preventing pregnancy as well as the transmission of most STIs, including HIV/AIDS.

Effectiveness

- The male condom is 98% effective if used correctly and consistently with every act of sexual intercourse.
- The female condom is 95% effective if used correctly and consistently with every act of sexual intercourse.



Advantages and disadvantages

Advantages	Disadvantages
• Prevent most STIs, including HIV/AIDS when used correctly and consistently with every act of sexual intercourse. • They prevent pregnancy. • Encourages involvement of both partners during sexual intercourse. • Can be used with other contraceptive methods (dual method use). • Have no hormonal side effects and may reduce exposure to cervical cancer. • Have no effect on breast milk production. • Relatively easy to use • They are relatively inexpensive and widely accessible. • Do not require medical consultation or contact with health care providers. • Empowers women to protect themselves from pregnancy, STIs including HIV. • No medical conditions appear to limit use. • Promotes good hygiene habbits. • It does not interfere with fertility.	• Efficacy depends on the client's knowledge on condom use and mutual agreement of partners. • Availability has to be ensured by carrying it at all times. • Could slip in or off during sex. • Quality is compromised with poor storage. • Not re-usable. • It interrupts the sexual activity. • Spillage or condom burst.

Who Can Use Condoms (MEC Category 1)

Barrier contraceptives should be accessible to any male or female client who needs them after receiving appropriate counselling and reaching an informed decision.

Barrier contraceptives are especially appropriate:

- When the woman is taking medicines that interfere with hormonal

contraceptive efficacy.

- When there are medical contraindications to other reversible methods and when sterilization is not desired or desirable.
- For clients who have intercourse infrequently thus no desire to commit to a contraceptive commodity
- For protection against STIs including HIV/AIDS.
- During investigation for gynaecological symptoms.
- As a back-up to another method.
- In conjunction with fertility awareness, for use during the fertile phase of the menstrual cycle.
- As an interim form of contraception, e.g. during Lactational amenorrhea or immediately following vasectomy
- Partners living with HIV/AIDS – whether they are discordant or concordant

Contraindications

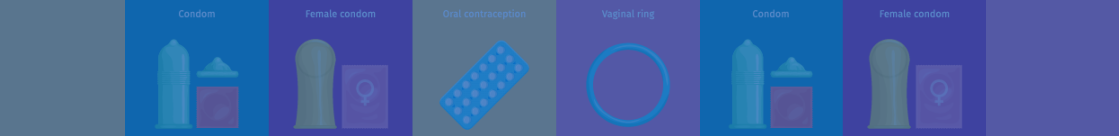
- everyone eligible for condom use.
    - If allergic to latex client can use non-latex condom.

When to Start?

- Any time.

Side effects

- Irritation



11. INTEGRATION OF FP SERVICES

WHO defines integrated service delivery as 'the organization and management of health services so that people get the care they need, when they need it in ways that are user friendly, achieve the desired result and provide value for money. The integration of family planning services into other service points of care is an effective approach to simultaneously reducing vertical transmission of HIV, increasing access to contraception, and reducing maternal deaths. All service areas integrating FP should have access to FP commodities through the normal channels. All the commodities should be accounted for at the end of the month through the accepted structures.

NB: The provision of other health services should never be contingent upon the acceptance of family planning.

11.1 Why integrate FP services?

Importance of integration	Challenges of integration
• Clients benefit from multiple services in one visit • Missed opportunities for some services are minimized • There is increased uptake of services • Minimizes referrals • Integration improves the engagement of both sexes	• Client load can make it difficult to offer comprehensive FP services in some areas • Staff attitude. • Increased waiting time for clients (some may be in a hurry) • Shortage of human resources.

Roles and responsibilities of stakeholders in integration

Central level (Ministry of Health and Partners)

Joint planning and programming	Regular joint reviews and evaluation of programs	Data collection, processing and dissemination of health information	Procurement, management and distribution of selected equipment and supplies including RH commodities	Training of Trainers and health service providers.	Ensuring proper functioning of electronic data collection systems

Regional level (Regional Health Management Team, Regional Mentors, Partners supporting the regions)

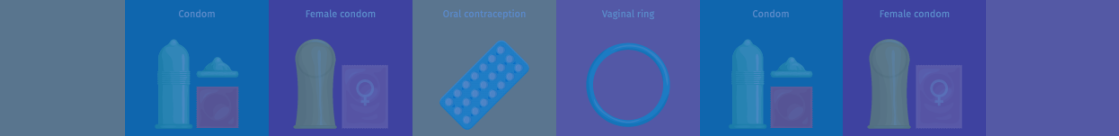
Development of regional work plans	Coordination of training and supervision	monitoring and evaluation of integrated services	Ensure consistent supply of commodities	Sharing of information and resources e.g. transport

Health Care facility Level (Service providers)

Integrate FP activities into health education, MNH, RH, STI/HIV/AIDS, ASRH male involvement, nutrition & curative care services	Counselling on all aspects of sexual and reproductive health	Provision of integrated services based on informed choice	Referral for services including follow up at community level	Operational research for improvement of integrated RH services	Sharing of information and resources on integrated services.

At the Community level (Community Health Committee, Rural Health Motivators, Expert Clients, Community Mentor Mothers, Community Peer Educators, Traditional Healers)

Integrated approach during sensitization and mobilization of the communities	Coordination and collaboration on training and other capacity building activities



Integration of family planning with other services

Any client who is visiting FP clinic could have a need for other services. Service providers should take advantage of the opportunity to discuss matters related to sex and sexuality while counselling clients about FP methods. Services that can be integrated in the family planning service delivery point include:

HTS / STIs and TB services:

Integrated FP and HIV services should include;

- Counselling, testing and ART initiation
- Giving FP information, distribution of IEC materials and distribution of condoms for HIV/STI prevention
- Counselling for family Planning and referral
- Counselling and provision of both short and long acting family planning methods
- Counselling on benefits, advantages, disadvantages, side effects, adherence and compliance for the client to make informed choice.
- Counselling on safe pregnancy
- TB information and screening

HIV positive women should be routinely screen for cancers of the reproductive system especially cervical cancer.

- Educate clients on self-breast examination and cervical cancer.
- Screening and management of cervical cancer (VIA, Pap smear,).
- Refer clients for Cryotherapy, LEEP or with any abnormal findings for further management.

Integration of family planning in maternity

Clients in maternity and immediately post-partum have a high unmet need for family planning. Some may not have attended antenatal clinic hence they may have missed out on family planning information and counselling services.

- FP information and distribution of IEC materials should be prioritized.
- Counselling for FP and offering the services to postpartum clients

Family planning for post abortion

Family Planning information and services provide an important opportunity for clients who just had an abortion. During the post abortion phase fertility resumption is almost immediately (within 2 weeks). Offering FP assist the client in transitioning the grieving period while planning for the next pregnancy. Services that can be offered includes:

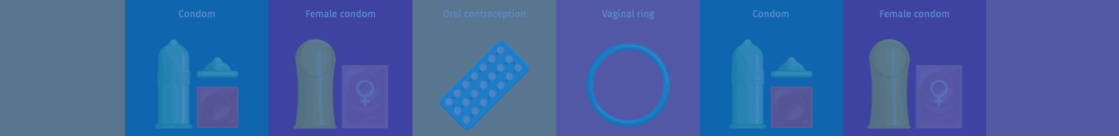
- Giving FP information, distribution of IEC materials and distribution of condoms for HIV/STI prevention
- Counselling for family Planning and referral
- Counselling and provision of both short and long acting family planning methods
- Counselling on benefits, advantages, disadvantages, side effects, adherence and compliance for the client to make informed choice.
- Counselling on safe pregnancy

Post abortion care (PAC) clients can also benefit from other services including counselling and testing for HIV, screening of reproductive organ cancers and STI screening and management.

Integration in the gynaecology departments and any other relevant service entry points

Clients seeking gynaecology services and other inpatient and outpatient services can also benefit from family planning integration, through;

- Receiving information, counselling, and provision of Family Planning services.
- Receiving counselling and testing for HIV as well as screening of reproductive organ cancers and management.
- Dual method use or Dual protection should be encouraged.



11.2 Gender dynamics influence on FP service provision and response management to sexual assault

Clients subjected or exposed to Intimate Partner violence or domestic violence are most likely to default, reject offer for family planning, or receive services secretly thus at risk of getting unwanted pregnancy. It is important for service providers to acknowledge challenges faced by clients that are of social influence and individualize provision of FP that do not expose them to danger or harm from their partners.

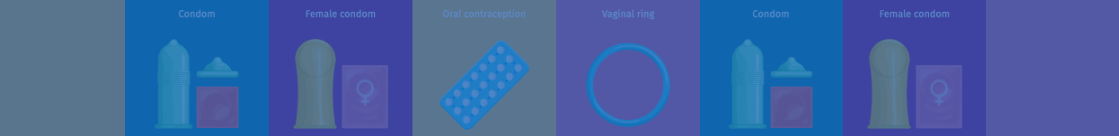
Client who have experienced sexual assault, are also at risk of getting an unwanted pregnancy. Offer them EC and other relevant services within the PEP package as soon as possible (refer to current GBV Health Sector Guidelines). When they are stable they can be counselled for family planning and be offered a regular method of their choice.

12. HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS)

Health Management Information System (HMIS) involves recording and custody of information to facilitate future planning and reference. Reports involve filling out, compiling specific information on data for use at a certain level. the Documentation remains important in FP service provision, for report writing and monitoring purposes as well as research purposes where applicable.

Health provider should ensure that all FP records are fully taken, including;

- Client's demographic details
- Detailed history (past and present); medical, surgical, gynaecological, etc.
- Appointment card which is given to the client for follow up.
- CMIS, FP and PNC registers
- A national referral forms
- A supply stock card which records FP methods and quantity stock balances.
- FP ordering and reporting form
- FP summary reports: monthly, quarterly and annual. This provides a summary of the number and type of clients served, number of contraceptives received and dispensed and the projected requirement of contraceptives by method



Family Planning Indicators

Indicators are measures used to track changes in a programme over time and provide information on the status of programme activities, targets and progress toward achieving programme objectives. They are as follows:

FP indicators

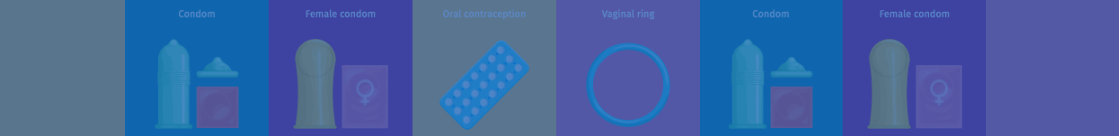
- Number of health facilities providing FP services.
- Total population catchment area.
- Total population of reproductive age.
- Types of FP methods available and offered
- Number of first FP attendance.
- Number of re-attendants.
- Number of FP clients tested for HIV.
- Number of FP clients who tested HIV positive.
- Number of FP clients taking condoms for dual protection.
- Number of FP clients discharged for intended pregnancy
- Number of crude dropouts.
- Number of clients who got pregnant while on contraceptives.
- Number of clients accessing FP services through MNCH services.
- Number of FP commodities distributed.

Challenges in Documentation

- Multiple records (too many registers). Shortage of human resource. · Stock out of the data tools
- Lack of knowledge by staff on the importance of data.
- Continuous increase of workload.
- Poor quality data (sometimes the data collected does not help to inform programmers and policy makers).
- Poor network affects operations of CMIS, thus leading to using down time data forms which are later not captured into the system
- Poor maintenance of computers
- Some information not captured e.g., outreaches, mobile clinics

Monitoring and evaluation

Monitoring	Evaluation
Monitoring data is important for decision making because it can help to: • Assess whether the programme is meeting its established targets during the review period (monthly, quarterly or annually) • Identify and improve problem areas in the Family Planning programme • Improve efficiency of utilization of Family Planning programme resources.	Evaluation helps to: • Account for what has been accomplished • Provide feedback to stakeholders for decision making • Assess cost-effectiveness of the program • Contribute to policy development



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14. APPENDICES

14.1 APPENDIX 1: SUMMARY OF RECOMMENDATION - MEDICAL ELIGIBILITY CRITERIA

TOPIC	MEC RECOMMENDATION	GRADE ASSESSMENT OF QUALITY OF EVIDENCE
1. Recommendations for combined hormonal contraceptive (CHC) use by age group		
(CHCs include combined oral contraceptives, combined injectable contraceptives, combined patch and combined vaginal ring)		
< 40 years	Women from menarche through 40 years of age can use CHCs without restriction (MEC Category 1).	Range: Low to very low
≥ 40 years	Women 40 years and older can generally use CHCs (MEC Category 2).	
2. Recommendations for CHC use among breastfeeding women		
< 6 weeks postpartum	Breastfeeding women < 6 weeks postpartum should not use CHCs (MEC Category 4).	Range: Low to very low
≥ 6 weeks to <6 months postpartum	Breastfeeding women ≥ 6 weeks to < 6 months postpartum (primarily breastfeeding) generally should not use CHCs (MEC Category 3).	
≥ 6 months postpartum	Breastfeeding women ≥ 6 months postpartum can generally can use CHCs (MEC Category 2).	

3. Recommendations for CHC use among postpartum women		
< 21 days postpartum without other risk factors for venous thromboembolism (VTE)	Women who are < 21 days postpartum and do not have other risk factors for VTE generally should not use CHCs (MEC Category 3).	Range: Low to very low
< 21 days postpartum with other risk factors for VTE	Women who are < 21 days postpartum with other risk factors for VTE should not use CHCs (MEC Category 4).	
≥ 21 days to 42 days postpartum without other risk factors for VTE	Women who are ≥ 21 days to 42 days postpartum without other risk factors for VTE can generally use CHCs (MEC Category 2).	
≥ 21 days to 42 days postpartum with other risk factors for VTE	Women who are ≥ 21 days to 42 days postpartum with other risk factors for VTE generally should not use CHCs (MEC Category 3).	
> 42 days postpartum	Women who are > 42 days postpartum can use CHCs without restriction (MEC Category 1).	

4. Recommendations for CHC use among women with superficial venous disorders		
Varicose veins	Women with varicose veins can use CHCs without restriction (MEC Category 1).	Very low
Superficial venous thrombosis (SVT)	Women with SVT can generally use CHCs (MEC Category 2).	

5. Recommendations for CHC use among women with known dyslipidaemias		
Known dyslipidaemias without other known cardiovascular risk factors	Women with known dyslipidaemias without other known cardiovascular risk factors can generally use CHCs (MEC Category 2).	Very low; reviewed for clarity as requested by the GRC

6. Recommendations for progestogen-only contraceptive (POC) and levonorgestrel-releasing intrauterine device (LNG-IUD) use among breastfeeding women		
6a. POC use among breastfeeding women (POCs include progestogen-only pills, implants and injectables)		
< 6 weeks postpartum	Breastfeeding women who are < 6 weeks postpartum can generally use progestogen-only pills (POPs) and levonorgestrel (LNG) and etonogestrel (ETG) implants (MEC Category 2). Breastfeeding women who are < 6 weeks postpartum generally should not use progestogen-only injectables (POIs) (DMPA or NET-EN) (MEC Category 3).	Range: Low to very low
≥ 6 weeks to < 6 months postpartum	Breastfeeding women who are ≥ 6 weeks to < 6 months months postpartum can use POPs, POIs, and LNG and ETG implants without restriction (MEC Category 1).	
≥ 6 months postpartum	Breastfeeding women who are ≥ 6 months postpartum can use POPs, POIs, and LNG and ETG implants without restriction (MEC Category 1).	

6b. LNG-IUD use among breastfeeding women		
< 48 hours postpartum	Breastfeeding women who are < 48 hours postpartum can generally use LNG-IUDs (MEC Category 2).	Very low
≥ 48 hours to < 4 weeks postpartum	Breastfeeding women who are ≥ 48 hours to < 4 weeks postpartum generally should not have an LNG-IUD inserted (MEC Category 3).	
≥ 4 weeks postpartum	Breastfeeding women who are ≥ 4 weeks postpartum can use an LNG-IUD without restriction (MEC Category 1).	
Puerperal sepsis	Breastfeeding (and non-breastfeeding) women with puerperal sepsis should not have an LNG-IUD inserted (MEC Category 4).	
7. Recommendations for use of subcutaneously-administered depot medroxyprogesterone acetate (DMPA-SC) – new method added to the guideline		
All recommendations	Recommendations for DMPA-SC will follow the current recommendations for DMPA-IM (intramuscular).	Very low
8. Recommendations for Sino-implant (II) – new method added to the guideline		
All recommendations	Recommendations for Sino-implant (II) will follow the current recommendations for LNG implants.	Range: Moderate to very low

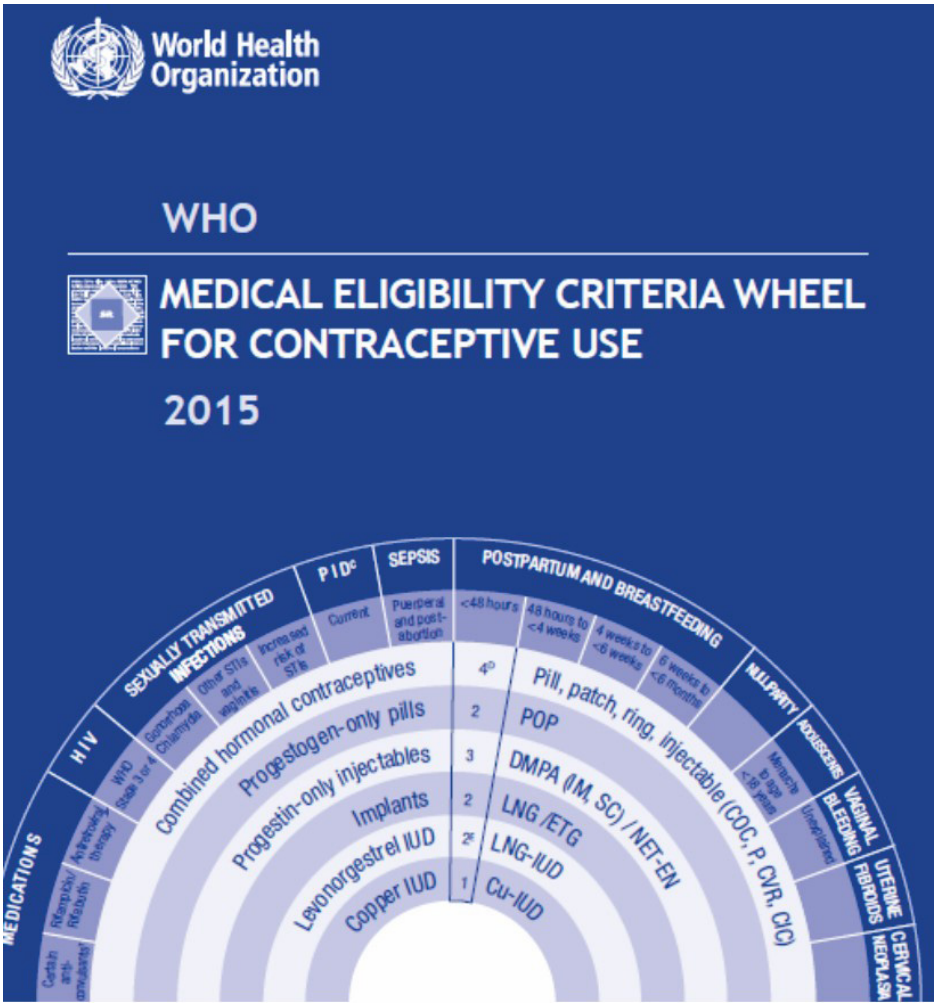
9. Recommendations for emergency contraceptive pills (ECPs) – ulipristal acetate (UPA) as a new method added to the guideline and obesity as a new condition for ECP use		
Pregnancy	For pregnant women, ECP use is not applicable.	
Breastfeeding	Breastfeeding women can use combined oral contraceptive pills (COCs) or LNG for ECPs without restriction (MEC Category 1). Women who are breastfeeding can generally use UPA for ECPs (MEC Category 2).	
Past ectopic pregnancies	Women who have experienced past ectopic pregnancies can use COCs, LNG or UPA for ECPs without restriction (MEC Category 1).	
History of severe cardiovascular disease	Women with history of severe cardiovascular disease, including ischaemic heart disease, cerebrovascular attack or other thromboembolic conditions, can generally use COCs, LNG or UPA for ECPs (MEC Category 2).	Very low
Migraines	Women with migraines can generally use COCs, LNG or UPA for ECPs (MEC Category 2).	
Severe liver disease	Women with severe liver disease, including jaundice (a personal characteristic and sign of liver disease prior to diagnosis), can generally use COCs, LNG or UPA for ECPs (MEC Category 2).	

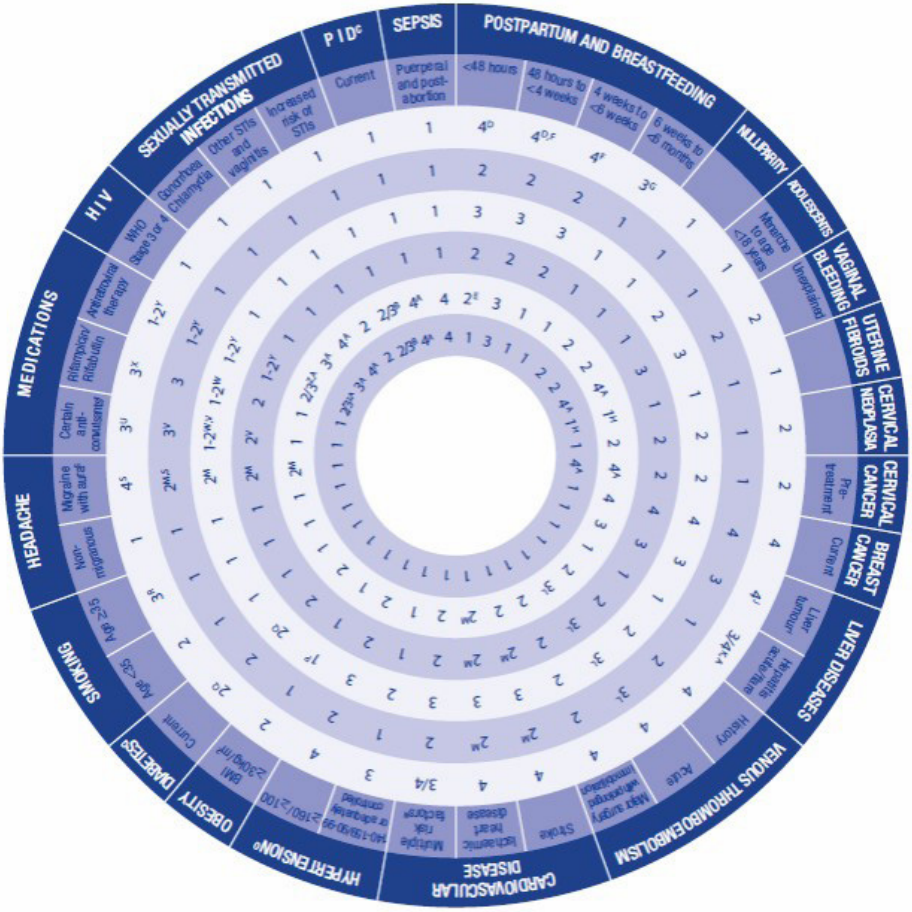
Use of CYP3A4 inducer	Women using CYP3A4 inducers can use COCs, LNG or UPA for ECPs without restriction (MEC Category 1).	
Repeat use of ECP	There are no restrictions on repeated use for COCs, LNG or UPA for ECPs (MEC Category 1).	
Rape	There are no restrictions for use of COCs, LNG or UPA for ECPs in cases of rape (MEC Category 1).	
Obesity	Women who are obese can use COCs, LNG or UPA for ECPs without restriction (MEC Category 1).	Moderate
10. Intrauterine device (IUD) use for women with increased risk of sexually transmitted infections (STIs)		
IUD initiation	Many women with increased risk of STIs can generally undergo either copper-bearing IUD (Cu-IUD) or LNG-IUD initiation (MEC Category 2). Some women at increased risk (very high individual likelihood) of STIs generally should not have an IUD inserted until appropriate testing and treatment occur (MEC Category 3).	No new evidence identified, so quality of evidence not evaluated using GRADE process; reviewed for clarity as requested by the GRC
IUD continuation	Women at increased risk of STIs can generally continue use of either CuIUD or LNG-IUD (MEC Category 2).	

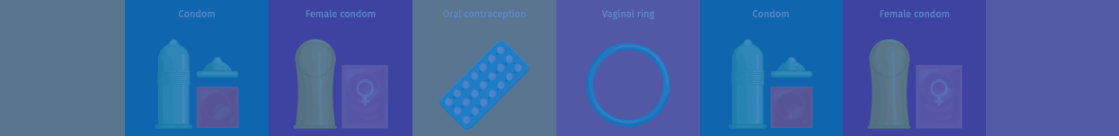
11. Recommendations for use of progesterone-releasing vaginal ring – new method added to the guideline		
Breastfeeding and ≥ 4 weeks postpartum	Women who are actively breastfeeding and are ≥ 4 weeks postpartum can use the progesterone-releasing vaginal ring without restrictions (MEC Category 1).	Low
12. Recommendations for use of hormonal contraception for women at high risk of HIV infection, women living with HIV, and women living with HIV using antiretroviral therapy (ART)		
12a. Women at high risk of HIV infection	Women at high risk of acquiring HIV can use the following hormonal contraceptive methods without restriction: COCs, combined injectable contraceptives (CICs), combined contraceptive patches and rings, POPs, POIs (DMPA and NET-EN), and LNG and ETG implants (MEC Category 1). Women at high risk of acquiring HIV can generally use LNG-IUDs (MEC Category 2).	Range: Moderate to very low
12b. Women living with asymptomatic or mild HIV clinical disease (WHO stage 1 or 2)	Women living with asymptomatic or mild HIV clinical disease (WHO stage 1 or 2) can use the following hormonal contraceptive methods without restriction: COCs, CICs, combined contraceptive patches and rings, POPs, POIs (DMPA and NET-EN), and LNG and ETG implants (MEC Category 1).	

	Women living with asymptomatic or mild HIV clinical disease (WHO stage 1 or 2) can generally use the LNG-IUD (MEC Category 2).	
12c. Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4)	Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4) can use the following hormonal contraceptive methods without restriction: COCs, CICs, combined contraceptive patches and rings, POPs, POIs (DMPA and NET-EN), and LNG and ETG implants (MEC Category 1). Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4) generally should not initiate use of the LNG-IUD (MEC Category 3) until their illness has improved to asymptomatic or mild HIV clinical disease (WHO stage 1 or 2). Women who already have an LNG-IUD inserted and who develop severe or advanced HIV clinical disease need not have their IUD removed (MEC Category 2 for continuation).	Range: Moderate to very low

14.2 APPENDIX 2: WHO MEDICAL ELIGIBILITY CRITERIA WHEEL FOR CONTRACEPTIVE USE



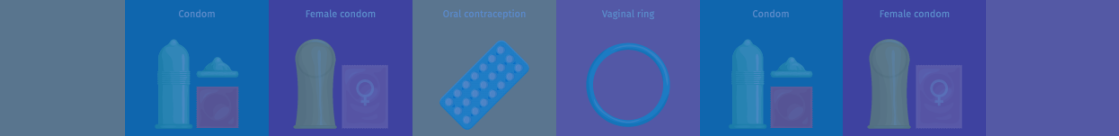

POSTPARTUM AND BREASTFEEDING
<48 hours
48 hours to <4 weeks
4 weeks to <6 weeks
6 weeks to 6 months
FERTILITY
ADOLESCENTS
Menarche to age <18 years
VAGINAL BLEEDING
Unexplained
UTERINE FIBROIDS
CERVICAL NEOPLASIA
CERVICAL CANCER
Pre-treatment
BREAST CANCER
Current
LIVER DISEASES
Tumour
Hepatitis active/flare
Liver
History
VENOUS THROMBOEMBOLISM
Active
Major surgery with prolonged immobilisation
Stroke
CARDIOVASCULAR DISEASE
Ischaemic heart disease
Multiple risk factors
HYPERTENSION
140-159/90-99 or well-controlled
≥160/≥100
OBESITY
BMI ≥30kg/m²
DIABETES
Current
SMOKING
Age ≥35
Age <35
HEADACHE
Migraine with aura
Non-migraine
MEDICATIONS
Certain anti-convulsants
Rifampicin/ Rifabutin
Antiretroviral therapy
HIV
WHO Stage 3 or 4
SEXUALLY TRANSMITTED INFECTIONS
Gonorrhoea Chlamydia
Other STIs and vaginitis
Increased risk of STIs
PID
Current
SEPSIS
Puerperal and post-abortion



14.3 APPENDIX 3: MANAGING SIDE EFFECTS

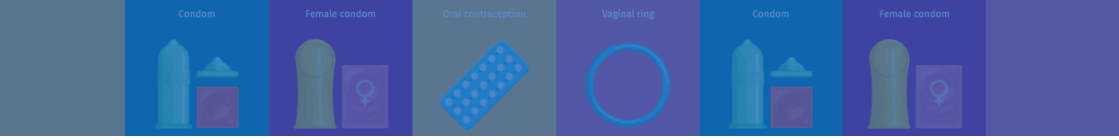
Side effect	Commodity	Management
Irritation	Condom	May result from allergy to latex though this is very rare Advice the couple to use a non-latex brand of condoms Screen for presence of infection and treat, if present
Spillage or breakage of Condom		Offer comprehensive PEP.

Spotting	POPs	Reassure client that this is common with POP use. Determine if client had vomiting or diarrhoea recently or is taking any medicines that might interact with POPs or if not consistently taking pill at the same time If bleeding starts after several months of normal or no monthly bleeding, or there are other reasons to suspect pregnancy (e.g., client has missed pills), assess for pregnancy or other underlying conditions. Manage condition or refer client to appropriate level
	POIs COCs CICs Implants IUCD	Spotting or light bleeding is common during use of these contraceptives, particularly during the first few months of use. It is not harmful. Reassure the client If the bleeding is persistent assess for gynaecological problems and treat accordingly If there is no gynaecological problem treat with non-steroidal anti-in inflammatory drugs (NSAIDs) e.g. Ibuprofen or give a cycle of COCs



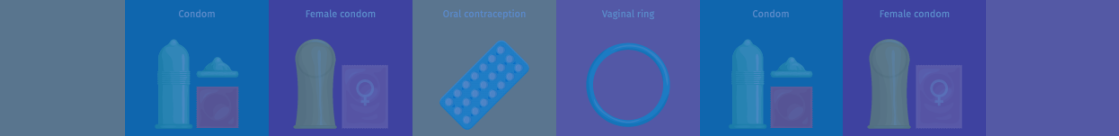
Heavy or prolonged bleeding	POPs POIs CICs Implants	Assess for underlying gynaecological problems and manage accordingly. If there are no underlying gynaecological problems; Give Non – Steriods Anti-in amatory Drugs(NSAIDS) (Ibuprofen 400mg tds) and COCs If bleeding persists and becomes a threat to her life, discontinue clients from method and help her choose another method.

Amenorrhea	POPs	If client is breastfeeding, reassure her that it is normal not to have monthly bleedings while breastfeeding, If not, reassure her that some woman stops having monthly bleeding while taking
	POIs	Counselling and reassurance are sufficient. If in doubt, assess for pregnancy, and manage accordingly. If client is bothered by lack of menses despite reassurance, discontinue injectable, and help her choose another method.
	CICs Implants	Assess for pregnancy; If not pregnant - counsel and reassure, no treatment is required If pregnant, stop injections and refer for ANC
	COCs	If the client is taking COCs correctly, reassure. If she has not been taking the pills correctly assess for pregnancy, If not pregnant advise her to take the pills correctly If pregnant, discontinue COCs and refer for ANC



Headache or dizziness	POPs	If headaches worsen while using POPs (e.g. she develops migraines with aura), discontinue POPs and help client select alternative method. Refer if need be.
	POIs	Assess for other causes including raised blood pressure. Reassure client if symptoms are mild. If severe, discontinue injectable and refer for evaluation. Help client choose another method.
	COCs CICs IUCD	If headaches are mild, treat with analgesics and reassure. If headaches persist or are associated with blurring of vision, discontinue commodity and help the client to choose another method
Breast fullness or tenderness	POPs POIs COCs CICs Implants	Assess for pregnancy. If pregnant, advise to stop POPs / POIs If not pregnant, reassure and give analgesics If physical examination shows signs of sepsis, treat with antibiotics and analgesics Assess for breast cancer; If she has breast lump or other suspicious lesions, refer for further management.
Mood changes or nervousness	POPs	Counsel the clients If the condition worsens, advise client to stop and help her to select an alternative method

Nausea, dizziness, vomiting	COCs	Advice the client that this is a common side effect in COCs users in the 1st few months Advise client to take pill with evening meal or before bedtime. If symptoms persist, assess for pregnancy If pregnant manage appropriately If not pregnant, reassure tenderness
	CICs IUCD	Assess for pregnancy If not pregnant, counsel client that it may decrease after 3 months If problem is intolerable don't give the next injection and assist client to select another method If pregnant refer for ANC
Abdominal cramping and pain	IUCD	Inform client that some abdominal cramping may occur in the 1st 24-48 hours. If cramping continues give analgesics (Ibuprofen 200mg- 400mg, Paracetamol 325mg – 1000mg) If pain and cramping is severe evaluate for underlying conditions including signs of partial IUCD expulsion, PID or ectopic pregnancy and treat accordingly. If pain and cramping persists and no cause is found, remove IUCD, counsel client to select another method



Wound infection	BTL	Treat with antibiotics; If abscess is present, drain and continue with antibiotics
Abscess		Clean the area with antiseptic; Give oral antibiotics; Refer for Incision and drainage
Haematoma		This usually will resolve overtime but may require drainage if extensive.
Pain at incision		Give analgesics ; Assess for infection and manage accordingly
Bleeding at the incision site or inside the incision	Vasectomy	Reassure him that minor blee blood clots usually go away without treatment within a couple of weeks
		Large blood clots may need to surgically drained
		Infected blood clots require antibiotics and hospitalization

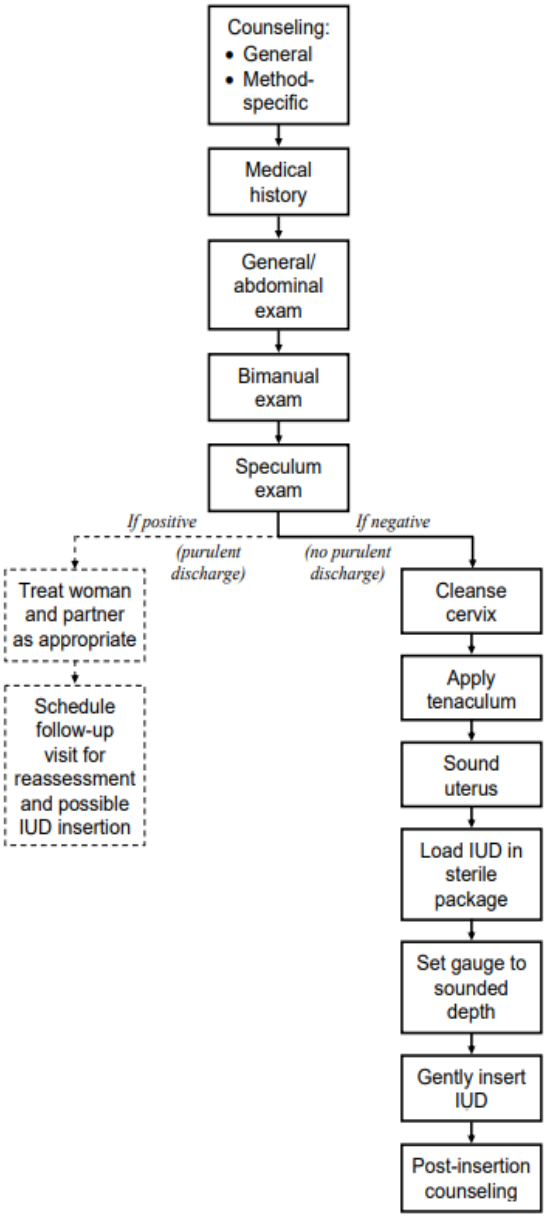
14.4 APPENDIX 4: PREGNANCY CHECKLIST

NO		YES
	1. Did you have a baby less than 6 months ago, are you exclusive breastfeeding, and had amenorrhea since then?	
	2. Have you abstained from sexual intercourse since your last monthly bleeding or delivery?	
	3. Have you had a baby in the last 4 weeks?	
	4. Did your last monthly bleeding start within the past 7 days (or within the past 12 days if the client is planning to use an IUD)?	
	5. Have you had a miscarriage or abortion in the last 7 days (or within the past 12 days if the client is planning to use an IUD)?	
	6. Have you been using a reliable contraceptive method consistently and correctly?	

If the client answered **"yes"** to at least one of the questions, and she has no signs or symptoms of pregnancy, you can give her the method she has chosen

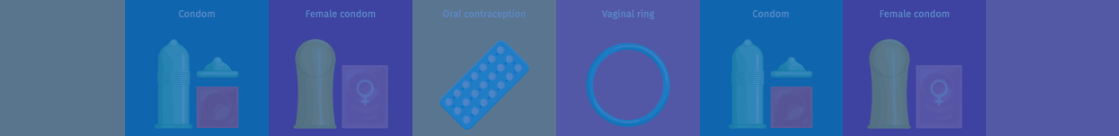
If the client answered **"no"** to all questions, pregnancy cannot be ruled out. The client should wait for her next monthly bleeding or use a pregnancy test.

14.5 APPENDIX 5: ICUD INSERTION PROCEDURE



14.6 APPENDIX 6: EFECT OF SPECIFIC ARVS ON THE EFFECTIVENESS OF HORMONAL CONTRACEPTIVE METHODS

Hormonal contraceptive method	Evidence
Combined oral contraceptives (COCs)	Efavirenz reduces blood progestin levels of COCs, but no efficacy data are available, while other NNRTIs (e.g., nevirapine, etravirine, rilpivirine) do not appear to affect levels or efficacy. Some PIs, particularly ritonavir boosted -PIs, also decrease progestin levels (which could potentially increase pregnancy risk) in COC users. Conversely, cobicistat boosted elvitegravir lowered ethinyl estradiol levels but increased norelgestromin levels (thus contraceptive efficacy is likely maintained).
Progestin-only pills (POPs)	Based on limited data, progestin levels with POPs do not appear to be reduced by some PIs; but no efficacy data are available; and data on POP levels when used with other ARVs (such as efavirenz or nevirapine) are not available.
Progestin-only injectables (e.g., DMPA or Net En)	Levels of DMPA do not appear to be reduced by ARVs (including efavirenz, zidovudine, lamivudine, nevirapine, and nelfinavir). Studies on Net-En when used with ART are not available.



Contraceptive implants	A retrospective chart review suggests that efavirenz may decrease the efficacy of Levonorgestrel implants (e.g., Jadelle), compared to use by women living with HIV not using efavirenz, though additional data are needed. For the 16 women who became pregnant in this study, the mean time elapsed between implant insertion and pregnancy was 16.4 months. Several case reports and a pharmacokinetic study suggest that efavirenz (but not ritonavir -boosted lopinavir) may decrease the efficacy of Etonogestrel implants (e.g., Implanon), though additional data are needed. In a Brazilian study, 79 women living with HIV received Etonogestrel implants and were followed every 6 months for 3 years. Over the course of the study, between 60 percent and 71 percent of women were receiving various ART regimens; no pregnancies were reported.
Levonorgestrel releasing intrauterine devices (IUDs) (e.g., Mirena)	Limited evidence suggests that efficacy of the Levonorgestrel releasing IUD is unlikely to be affected by ART.
Emergency contraceptive pills (ECPs)	Limited evidence suggests that Levonorgestrel levels are signi cantly reduced among women using LNG ECPs and efavirenz, but no effcacy data are available. Data for other types of ECPs (UPA ECPs or Yuzpe regimen) or other ARVs are not available.