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Maternal and Child Survival Program

Long-Acting Reversible Contraceptives Learning Package

Module 1: Introduction to Long-Acting Reversible Contraceptives

Learner Version

The Maternal and Child Survival Program (MCSP) is a global, United States Agency for International Development (USAID) Cooperative Agreement to introduce and support high-impact health interventions with a focus on 24 high-priority countries with the ultimate goal of ending preventable child and maternal deaths within a generation. The Program is focused on ensuring that all women, newborns and children most in need have equitable access to quality health care services to save lives. MCSP supports programming in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment.

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Module 1: Introduction to Long-Acting Reversible Contraceptives

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Module 1: Introduction to Long-Acting Reversible Contraceptives

Module Overview for Learner

Time: 5:40 hours

Module Objectives

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

- Describe family planning (FP) and its benefits
- Define healthy timing and spacing of pregnancy (HTSP)
- Describe different choices of FP methods
- Describe long-acting reversible contraceptive (LARC) methods, mechanism of action, and effectiveness
- Identify common barriers to providing LARCs for adolescents and how to address these barriers at the facility
- Describe LARCs that can be used in the postpartum and post abortion periods
- Identify opportunities for integrating LARCs immediately following the postpartum and post abortion periods

Session Plans

- Session 1: Define family planning, benefits of healthy timing and spacing, and different choices of FP methods available
- Session 2: Introduction to Long-Acting Reversible Contraceptives and its use during postpartum and post abortion period

Sample Schedule

Facility-based delivery: Two consecutive days

Day 1 (2hrs 30min)		Day 2 (3hrs 10min)	
Time	**Session: Activity**	**Time**	**Session: Activity**
10 mins.	One: Introduction Session Objective	40 mins.	Two: LARCs Interactive Presentation & Discussion
10 mins.	One: Pre Test	30 mins.	Two: Barriers to Use of LARCs for Adolescents (Reflection Activity)
30 mins.	One: Discuss Benefits of FP	30 mins.	Two: LARC Methods Used During Postpartum and Post Abortion Period (discussion)
10 mins.	One: Short Quiz	40 mins.	Two: Finding Opportunities for Integration (Facility round)
10 mins.	One: How Contraception Works (discussion)	30 mins.	Two: Action Planning
20 mins.	Healthy Timing and Spacing for Pregnancy (HTSP) (Brainstorming)	10 mins.	Two: Post Test
60 mins.	Contraceptive Updates (Learning Activity)	10 mins.	Two: Summary & Closing

Module 1: Introduction to Long-Acting Reversible Contraceptives

Pre and Post Test Questionnaire

Instructions: Write the letter of the single BEST answer to each question in the blank next to the corresponding number on the answer sheet.

Total time: 10 minutes

1. Long-acting reversible contraceptives (LARCs) are best for a woman who:
   a. Does not want to have any more children
   b. Wants many years of contraception
   c. Has AIDS and is on antiretroviral therapy
   d. Wants to have contraception for 3 months

2. Long-acting reversible contraceptives include:
   a. Combined oral pills
   b. Condoms
   c. IUDs, levonorgestrel-releasing intrauterine system (LNG-IUS), and implants
   d. Rhythm method

3. For a woman in good health, a long-acting reversible contraceptive method is BEST selected by the:
   a. Woman herself
   b. Physician providing health services to the woman
   c. Woman's husband
   d. Woman's mother-in-law

4. LARCs are a good choice for adolescents because:
   a. They are 99% effective
   b. There is no possibility of user error
   c. They can be used by nulliparous women
   d. All of the above

5. Healthy timing and spacing of pregnancy (HTSP) is an approach to family planning that:
    a. Advises women to limit their families
    b. Helps women and families to delay and space their pregnancies
    c. Benefits women who have no children
    d. Helps women to start exercise after pregnancy

6. If a woman does not time and space her pregnancies, risks to newborns include:
    a. Greater risk of newborn death
    b. Less risk of preterm birth
    c. Less risk of being small for gestational age
    d. More likely to be breastfed for 2 years

7. LNG-IUS contraceptive devices are safe for lactating women because they contain:
    a. Both oestrogen and progesterone
    b. Only progesterone
    c. Prolactin
    d. No hormone

8. One of the mechanism of action of progesterone-only implants to prevent pregnancy is by:
    a. Blocking sperm transportation
    b. Damaging sperm
    c. Preventing embedding of fertilized ovum
    d. Causing thickening of cervical mucus

9. When is it safe to insert an IUD during postpartum period:
    a. 2 weeks after delivery
    b. 1 week after delivery
    c. Immediately within 10 minutes of delivery of the placenta
    d. 48 or more hours after delivery

10. After an abortion, fertility can return as soon as:
    a. 2 weeks
    b. 6 weeks
    c. 4 weeks
    d. Menses resume

Module 1: Introduction to Long-Acting Reversible Contraceptives

Pre and Post Test Answer Sheet

Q.1 _____

Q.2 _____

Q.3 _____

Q.4 _____

Q.5 _____

Q.6 _____

Q.7 _____

Q.8 _____

Q.9 _____

Q.10 _____

Module 1: Introduction to Long-Acting Reversible Contraceptives

Handout 1-1: Risks during Pregnancy Family Planning Benefits

Risks during Pregnancy

- Maternal deaths related to pregnancy and childbirth are a significant cause of mortality for adolescents. More than 70,000 maternal deaths occur among 15- to 19-year-olds annually. Adolescents this age are twice as likely to die as women in their twenties.
- The younger a girl is when she becomes pregnant, the greater the health risks. Girls who become pregnant before the age of 15 are five times more likely to die in childbirth than women in their twenties.
- Adolescents are more likely to have pregnancy-related complications such as pre-eclampsia and vaginal fistula, to deliver prematurely, and to have babies that die before their first birthday.
- Adolescents aged 15–19 are estimated to have 2.5 million of the approximately 19 million unsafe abortions that occur annually in the developing world.
- Research has shown that women who become pregnant less than two years after the birth of their last child are more likely to experience adverse maternal, perinatal, newborn, and infant outcomes.
- Women who do not wait six months after an abortion or miscarriage and become pregnant again may experience adverse maternal and perinatal outcomes—such as elevated risks of premature rupturing of membranes, anemia and bleeding, preterm birth, and low birth weight—compared with longer intervals.
- Pregnancy for women over 35 is associated with certain risks that are less common with younger women; older women are more likely to have more children and experience the additional risks associated with high parity. Older women are at least twice as likely to die in pregnancy and childbirth as younger women.
- Bleeding is the most common reason that women over age 35 die during childbirth. The chance of having twins increases with age.
- The risk of developing gestational diabetes or high blood pressure is greater in women over 35. Older mothers have a higher risk of pregnancy-related complications, such as placenta previa, that might lead to a cesarean section delivery.
- The risk of miscarriage or giving birth to a low-birth-weight baby or a baby with a disability also increases in older women.
- Long-acting and permanent family planning (FP) methods that limit childbearing—such as IUDs, implants, tubal ligation, or vasectomy for a partner—can help women avoid an unhealthy or even fatal pregnancy. If older women want to become pregnant, they should be counseled to space their pregnancies and to be sure to use antenatal care and skilled birth attendants at delivery.
- If no other risk factors are involved, the risk of dying continues to increase with each additional pregnancy after the fourth pregnancy. The risk of dying is 1.5 to 3 times higher for women with five or more children than for women with two or three children.
- Some medical conditions may make pregnancy riskier for women. The effectiveness of a contraceptive method is even more important if a woman has one of the following conditions:
    - Reproductive tract infections and disorders such as breast, endometrial, and ovarian cancer; some sexually transmitted infections including gonorrhea and chlamydia; some vaginal infections such as bacterial vaginosis; anomalies among women who have undergone female genital cutting

- Cardiovascular disease such as high blood pressure, complicated valvular heart disease, ischemic heart disease, or stroke
- Insulin-dependent diabetes that damaged the arteries, kidneys, eyes, or nervous system or lasted more than 20 years
- Sickle cell anemia
- Severe cirrhosis of the liver and cancerous liver tumors

- Other infections such as schistosomiasis with fibrosis of the liver, tuberculosis, and HIV/AIDS; although HIV/AIDS is not made worse by pregnancy, HIV disease may increase some health risks of pregnancy and may also affect the health of the infant.

Benefits of Family Planning

- Women who use FP to space, delay, and limit their pregnancies experience many benefits, including:
  - A lower risk of maternal death
  - A lower risk of anemia; lower risk of poor pregnancy outcomes including stillbirth, low birth weight, preterm birth, miscarriage, and complications such as hemorrhage, infection, vaginal fistula, pre-eclampsia, and eclampsia; and a lower risk of complications related to miscarriage or unsafe abortion
  - Additional benefits provided by some contraceptive methods: For example, barrier methods such as male and female condoms provide some protection from STI/HIV transmission between partners. Hormonal contraceptives may protect from acquiring symptomatic pelvic inflammatory disease (PID). In addition, studies have shown that various hormonal methods offer protection from endometrial and ovarian cancer and other gynecological problems such as symptoms of endometriosis and dysmenorrhea.
  - Improved educational and economic opportunities: When given control over their fertility, girls are more likely to stay in school and women are more likely to be employed.
  - It is important to educate all women about the benefits of FP. Targeted messages should be tailored to certain groups. For example, for nulliparous adolescents the message about delaying first pregnancy until at least age 18 should be emphasized to achieve greater benefits. For women who are pregnant, have just given birth, or experienced an abortion, messages about the benefits of healthy timing and spacing of pregnancies are key. For women with several children, messages about limiting are relevant.
  - It may be important to involve a woman's husband or partner, her mother, her mother-in-law, or other key family members in counseling and education about the benefits of FP.
- When women and couples use FP to space, time, and limit their pregnancies, their children also benefit. Better spaced pregnancies allow for longer periods of breastfeeding, which give infants and young children the chance to derive the maximum benefits from the practice of breastfeeding, including better nutrition, protection from childhood diseases, and opportunities for mother and child bonding. Children who are exclusively breastfed are at lower risk of disease, especially diarrhea and respiratory infections.
- Children born to women who use FP to space, time, and limit births are more likely to survive and are less likely to be sick. Research has shown that babies born less than two years after the next oldest sibling are more than twice as likely to die in the first year as those born after an interval of three years. Spacing births could save the lives of more than two million infants and children each year.
- FP gives parents the option to have the number of children they want when they want them, which allows them to meet the varied needs of each individual child. Spacing children allows babies to breastfeed longer, which is healthier for the infant.

- FP allows families to devote more resources to providing their children with food, clothing, housing, and education. When women and couples use FP to space, time, and limit their pregnancies, their children also benefit.
- The reduced risk of death and illnesses among mothers, newborns, infants, and children achieved by healthy timing, spacing, and limiting of pregnancies contributes to reducing the economic strain on a family and helps to ensure family health.
- Reductions in maternal mortality mean that more women are able to care for their children and families, thus improving the quality of life for the entire community.
- Evidence suggests that healthier families and communities contribute to improved planning and development and facilitate preservation of natural resources like forests, water, and land. Moreover, implementing combined interventions in an integrated fashion may yield better results than implementing solely environmental or FP interventions alone.
- Integrated reproductive health services, that include FP counseling and access to contraception, along with HIV care and treatment, can improve the lives of women and couples with HIV and the lives of their families.
- When FP services are easy to access, clients with HIV experience the same health benefits as others in their communities. Couples can limit the size of their families to the number of children they desire and are able to care for. Women are better able to space their children and reduce the risks associated with too many pregnancies or pregnancies spaced too closely.

Source: Benefits of Family Planning. *The Training Resource Package for Family Planning* (USAID, WHO, UNFPA). https://www.fptraining.org

Module 1: Introduction to Long-Acting Reversible Contraceptives

Handout 1-2: World Health Organization (WHO) Definition of Family Planning, Contraception, and Healthy Timing and Spacing of Pregnancy

What is family planning?

According to WHO, "Family Planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through the use of contraceptives and treatment of involuntary infertility."

What is contraception?

Contraception is the intentional prevention of pregnancy by artificial or natural means.

What is healthy timing and spacing of pregnancy?

Healthy timing and spacing of pregnancy (HTSP) is an intervention to help women and families delay or space their pregnancies to achieve the healthiest outcomes for women, newborns, infants, and children, within the context of free and informed choice, taking into account fertility intentions and desired family size.

- Women should delay their first pregnancy until at least age 18;
- After a live birth, women should wait at least 24 months before attempting another pregnancy in order to reduce the risk of adverse maternal, perinatal, and infant outcomes; and
- After a miscarriage or induced abortion, women should wait at least 6 months before attempting another pregnancy to reduce risks of adverse maternal and perinatal outcomes.

Source: World Health Organization, Department of Reproductive Health and Research, K4 Health HTSP toolkit

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Handout 1-3: Barriers to Long-Acting Contraception for Adolescents

Barriers

Barriers to contraception for adolescents may operate at three levels: the individual, the immediate environment, and the wider environment or policy level.

Individual-level factors

Adolescents experience many of the same barriers that adults do in obtaining LARCs at different levels but some may be specific to adolescents at individual level.

Individual-level factors to be considered for adolescents: The stage of brain development in adolescence is linked with risk-taking and short-term thinking. Because of the state of cognitive development and the social changes in adolescence, adolescents are less likely than older adults to be thinking years into the future about their needs. These factors may predispose youth to choose short-acting rather than long-acting methods.

Because many young people lack access to comprehensive sexuality education and have less experience with contraception than older adults, it is common for youth to have heard of no long-acting methods of contraception and to have misconceptions about fertility and the risk of unintended pregnancy.

In many countries adolescents have misconceptions about the immediate and long-term side-effects of long-acting contraceptive methods on their health and on their future ability to bear children. Because of the resulting fears and concerns, adolescents often consider ineffective methods such as withdrawal and traditional remedies to be more acceptable.

Interpersonal

Even when adolescents can obtain long-acting contraceptive methods, social pressure may prevent their use. There are many interpersonal factors in adolescent's life that influence their access or choice to use a LARC:

- Provider bias: health workers in many places refuse to provide unmarried adolescents with contraceptive information and services because they do not approve of premarital sexual activity. Methods are often limited to condoms because providers may wrongly believe that long-acting hormonal methods and intrauterine devices are inappropriate or unsafe for nulliparous women.
- Parents and families: In many communities and families, having sexual relationships at such young age is not acceptable and fear of parents discovering contraceptive use restricts the adolescents to use any family planning method.
- Partners: male partners have significant influence over decisions about contraceptive use and method choice for adolescents, especially married adolescents. Young female is not allowed to consult or use any contraceptive method by his partner mostly.
- Stigma surrounding contraception prevents its use by adolescents who are not in stable relationships. In many places, if a woman carries—or proposes to use—a condom, she may be considered "loose."

Wider Environment/Policy Level

Social and cultural norms: In many societies premarital sexual activity is not considered acceptable, and there is considerable resistance to the provision of contraceptive information and services to unmarried adolescents. Social norms affect contraceptive access and decisions for married adolescents as well. In many places young women are under pressure to conceive and bear children soon after marriage. Contraception is considered only after a first child is born.

Restrictive laws and policies: In many countries, laws and policies restrict the provision of contraception to unmarried adolescents or those below a certain age such as: parental consent or notification requirement and use of outdated medical eligibility criteria. In many cases, the law is not restrictive but providers are not made aware of the current policies around youth reproductive health services or not updated about medical eligibility criteria for adolescents.

Why are LARCs suitable for adolescents?

The WHO medical eligibility criteria show that adolescents and nulliparous clients can safely use LARCs as well as short-acting and barrier methods of contraception. LARCs offer advantages for adolescents that some other contraceptive methods do not offer. For instance, LARCs are easy to use and are extremely effective once in place. Many LARC products are available on the market today (the copper IUD, hormonal intrauterine system [LNG-IUS], and hormonal implants), and they all provide pregnancy protection that is long-acting but not permanent. User error is virtually impossible, and IUDs and implants rank in the top tier of contraceptive methods in terms of effectiveness. The "set and forget" nature of LARCs may also be appealing to teens who do not want to worry about remembering to use a contraceptive.

In addition, once the IUD or implant is in place, it prevents pregnancy for years—during a time when most teens want to avoid childbearing. On average, young people have sex for the first time at about age 17, but do not marry or have a child until their mid-20s. Many adolescents and young adults spend nearly a decade trying to avoid pregnancy. Providing sexual and reproductive health services, including LARC services and comprehensive information on sexual health, will help adolescents improve their health and well-being and reduce the adverse consequences of unsafe abortion, sexually transmitted infections (STIs), HIV infection, and obstetric complications that may lead to death, suicidal tendencies, and depression.

Addressing barriers to use of LARCs by adolescents

Improving adolescents' access to provision of LARC services involves synchronized efforts by family planning providers, family planning service managers, and local and national health officials.

- Strengthening policies related to adolescent reproductive health services and overcoming restrictive laws and policies.
- Communicating these policies to the providers.
- Improving access to a range of LARCs for adolescents: Age alone is not a contraindication for any LARC method; so, adolescents may choose from a number of appropriate LARCs. For example, intrauterine devices or implants can be good choices for adolescents, depending on their needs and preferences.
- Making health centers youth friendly by dedicating special areas of family planning clinics for adolescents, helping to ensure privacy at outreach and mobile clinics, and ensuring that staff are trained to treat clients of all ages with respect and respond to adolescents' needs
- Training providers to offer "youth-friendly" contraceptive counseling: smile, do not judge, keep client's secrets.
- Improving knowledge and addressing misconceptions about use of LARCs by adolescents
- Offering clinic hours convenient for youth, such as after school and during weekends

- Educating community-based contraceptive distributors and primary health workers (extension workers) about adolescents' challenges and needs and how distributors/workers can assist adolescents appropriately
- Correcting providers' misconceptions about use of LARCs by young adults
- If possible, offering services free or at low cost to adolescents

What needs to be done?

- Provide comprehensive sexuality education to young people, both in and out of school, before they begin sexual activity
- Advocate for policies that are supportive of young people's rights and address their needs
- Ensure that providers and services are youth-friendly
- Expand contraceptive options inside and outside of health facilities
- Promote youth-friendly sexual and reproductive health services and refer adolescent clients
- Foster supportive environments for positive youth development, including:
- Educate parents about adolescents' needs and how parents can assist their adolescent children
- Offer life skills education and counseling on sexuality and nutrition during youth outreach

Age alone does not constitute a medical reason for denying any method to adolescents."
– Medical Eligibility Criteria for Contraceptive Use, World Health Organization

Table 1: Adolescent Medical Conditions and LARC

Medical Condition	Implant	LNG-IUD	Cu-IUD
Nulliparity	1	2	2
Following Abortion: **First-Trimester** **Second-Trimester**	 1 1	 2 2	 2 2
Obese	1	1	1
Thrombogenic mutation (Factor V Leiden)	2	2	1
Epilepsy	1	1	1
Past STI/PID	1	1	1
Current Cervicitis/STI	1	4/2*	4/2*
Thalassemia Sickle cell	1	1	2
Depression	1	1	1

Legend: Table 1
1 = A condition for which there is no restriction for the use of the contraceptive method

2 = A condition for which the advantages of using the method generally outweigh the theoretical or proven risks

3 = A condition for which the theoretical or proven risks usually outweigh the advantages of using the method

4= A condition that represents an unacceptable health risk if the contraceptive method is used

* Treatment of STI while IUD/LNG-IUS is in place is usually sufficient; however, insertion of IUD should be deferred if STI is suspected.

Table 2: Contraindications to LARC Use

IUD/LNG-IUS	Implant
Pregnancy	Pregnancy
PID within the previous 3 months	Active liver disease
Active cervicitis	Undiagnosed abnormal uterine bleeding
Postpartum or post abortion sepsis within previous 3 months	History or current breast cancer
Undiagnosed abnormal uterine bleeding	Hypersensitivity to any component of the implant
Genital tract malignancy	
Uterine anomaly	
History or current breast cancer (LNG-IUS)	

Sources: Malawi Ministry of Health (MOH) and IntraHealth International. 2010. Preservice Education Family Planning Reference Guide. Lilongwe, Malawi: MOH. Malawi Ministry of Health (MOH) and IntraHealth International. 2010.

McNicholas C, Peipert JF. 2012. Long-acting reversible contraception (LARC) for adolescent. Current Opinion in Obstetrics and Gynecology 24(5): 293–298. Available at HYPERLINK http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4183267/. Contraception for adolescents in low and middle income countries: Needs, barriers, and access. Reproductive Health 11:1. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3882494/. Chandra-Mouli V, McCarraher DR, Phillips SJ, Williamson NE, Hainsworth G. 2014.

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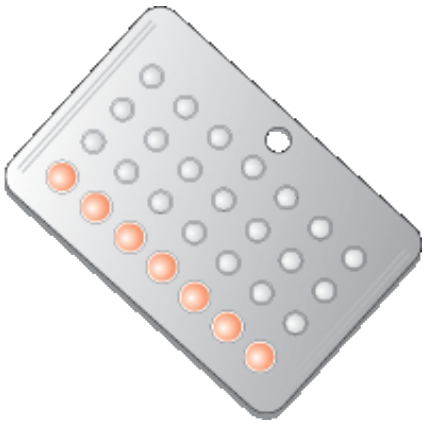
Handout 1-4: Combined Oral Contraceptives (COCs) Fact Sheet

Combined oral contraceptives (COCs) are pills that are taken once per day to prevent pregnancy. They contain the hormones estrogen and progestin.



Primary mechanisms of action

- Prevent ovulation (release of eggs from the ovaries)
- Thicken cervical mucus (make it difficult for sperm to penetrate)

Characteristics of COCs

- Safe and very effective if used consistently and correctly
- Reversible, rapid return to fertility
- Do not interfere with intercourse
- Easy to discontinue use
- Have beneficial non-contraceptive effects (regular menstrual cycles; lighter menses; fewer menstrual cramps; protection from ectopic pregnancy, ovarian and endometrial cancer, and symptomatic pelvic inflammatory disease; possible protection against ovarian cysts and anemia; reduction in symptoms of endometriosis)
- Require daily use
- Incorrect use is common (easy to miss taking a pill)
- Require resupply
- No protection against sexually transmitted infections including HIV
- Have side-effects
- Serious complications are very rare

Side-effects *(generally not signs of a health problem; may diminish or change over time)*

- Headaches, dizziness
- Nausea
- Breakthrough bleeding or spotting
- Breast tenderness
- Mood changes
- Amenorrhea

Who can use COCs

Women of any parity or reproductive age, married or unmarried, who:

- Want to use this method of contraception
- Have no known conditions that preclude safe use

Who should not initiate COCs

(for a complete list, see the World Health Organization Medical Eligibility Criteria)

Women who have the following known conditions (contraindications):

- Breastfeeding during the first six weeks postpartum
- First three weeks postpartum and not breastfeeding (six weeks postpartum if other risk factors for venous thromboembolism)
- Age 35 or older and smoke 15 cigarettes per day or more
- Current breast cancer
- Severe cirrhosis; malignant liver tumors; or benign liver tumors, with the exception of focal nodular hyperplasia (which is a tumor that consists of scar tissue and normal liver cells)
- Cardiovascular conditions (i.e., high blood pressure; diabetes with vascular complications; history of or current deep venous thrombosis, stroke, or ischemic heart disease)
- Migraine with aura or any migraine in women 35 or older
- Taking drugs that affect liver enzymes: rifampicin or rifabutin (for tuberculosis), anticonvulsants (for epilepsy), or ritonavir (as part of an antiretroviral regimen)

COCs use by women with HIV and AIDS

- Women with HIV and AIDS can use COCs without restrictions.
- Women with AIDS who take antiretroviral drugs (ARVs) other than ritonavir can generally use COCs. (There is some evidence that ritonavir reduces the blood levels of contraceptive hormones to a much greater extent than other ARV drugs.)
- Women with HIV who choose to use COCs should be counseled about dual method use and consider using condoms in addition to COCs. In addition to preventing the spread of HIV, condoms may be especially beneficial to women on ARVs because condoms provide additional protection from pregnancy in the event that COC effectiveness is reduced by ARVs.

Provide follow-up and counseling for

- Any client concerns or questions
- Side-effects
- Correct COC use (ability to take pills on schedule, what to do when pills are missed)
- Any signs of complications (thrombosis or thromboembolism); although rare, counsel the woman to come back immediately if any of the following symptoms develop:
    - Severe chest pain or shortness of breath
    - Severe headache with vision problems
    - Sharp pain in leg or abdomen

Dispelling myths regarding COCs

Contraceptive pills **do not:**

- Cause birth defects
- Cause infertility
- Require a rest period
- Decrease sex drive
- Build up in a woman's body

Source: *Training Resource Package for Family Planning* (USAID, WHO, UNFPA). COCs Fact Sheet, 2011, https://www.fptraining.org.

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Handout 1-5: Progestin-Only Injectables Fact Sheet

Progestin-only injectable contraceptives contain the synthetic hormone progestin, similar to the hormone progesterone in a woman's body. They are injected into muscle, which releases progestin into the blood gradually, providing contraception over a period of time. Length of pregnancy protection depends on the type of injectable:

- DMPA (depot medroxyprogesterone acetate), the most widely used progestin-only injectable, is injected every 13 weeks or three months. It is also known as Depo or Depo-Provera.
- NET-EN (norethindrone enanthate, noresthisterone enanthate) is injected every eight weeks or two months.

Primary mechanisms of action

- Prevent ovulation (release of eggs from the ovaries)
- Thicken cervical mucus (make it difficult for sperm to penetrate)

When to start

At any time, if you are reasonably sure the client is not pregnant

During the menstrual cycle

- Within 7 days of menstrual cycle, no need for a backup method;
- If more than 7 days, make sure she is not pregnant, and use a backup method for the first 7 days after injection

Switching from another method

- Immediately, if using the method correctly and consistently; otherwise, make sure she is not pregnant. No need for a backup method.
- If the woman is switching from an IUD, she can start injectable immediately.

More than 6 weeks after child birth (breastfeeding)

- If monthly bleeding has not started then can start injection any time between 6 weeks and 6 months, it is reasonably certain that she is not pregnant.
- If monthly bleeding started, then start within first 7 days of menstrual bleeding
- If it is more than 7 days after the start of monthly bleeding, can start anytime it is reasonably certain she is not pregnant. Use backup method for 7 days after injection.

Less than 4 weeks after child birth (not breastfeeding)

- Start injection at any time, no need for backup method

Post abortion/miscarriage

- Immediately, if she is starting within 7 days or days after a 1st or 2nd trimester abortion,
- If it is more than 7 days, start injection anytime it is reasonably certain she is not pregnant, use a backup method for 7 days

After emergency contraception

- After taking emergency contraceptive pills (ECP), start injection the same day or within 7 days of start of her menstrual period, after she finishes taking the ECPs. Use back up method for 7 days after the injection.

Characteristics of progestin-only injectables

- Highly effective
- Easy to use
- Reversible with some delay in return to fertility (pregnancy occurs on average four months later than with other modern methods)
- Do not interfere with intercourse, private
- Do not affect quality or quantity of breast milk
- Provide non-contraceptive health benefits (protection from endometrial cancer, uterine fibroids, ectopic pregnancy, and symptomatic pelvic inflammatory disease; may reduce sickle crises in women with sickle cell anemia)
- Have side-effects
- Provide no protection from sexually transmitted infections including HIV

Side-effects

(generally not signs of a health problem; may diminish or change over time)

- Irregular menstrual bleeding or spotting*****
- Prolonged or heavy bleeding*****
- Amenorrhea (common, especially after the first year of use)
- Weight gain
- Headaches and dizziness (less common than with combined oral contraceptives)
- Changes in mood and sex drive
- *****(more common during the first few months of use)

Who can use progestin-only injectables

Women of any parity or reproductive age, married or unmarried, who:

- Want to use this method of contraception
- Have no known conditions that preclude safe use (such conditions are rare)

Who should not use progestin-only injectables

Women who have any of the following conditions (contraindications):

- Breastfeeding while less than six weeks postpartum
- Multiple risk factors for cardiovascular disease
- Blood pressure more than 160/100 mmHg
- Acute deep venous thrombosis (unless on established anticoagulant therapy)
- Current or history of ischemic heart disease or stroke
- Unexplained vaginal bleeding (before evaluation)
- History of or current breast cancer
- Diabetes with vascular complications
- Severe cirrhosis; malignant liver tumors; or benign liver tumors, with the exception of focal nodular hyperplasia (a tumor that consists of scar tissue and normal liver cells)

Use of progestin-only injectables by women with HIV and AIDS

- Women with HIV and AIDS who do not take antiretroviral drugs (ARVs) can use progestin-only injectable without restrictions. Women with AIDS on ARVs can generally use DMPA because ARVs do not interfere with its effectiveness.
- Women with AIDS on ARVs can also generally use NET-EN.

Provide follow-up and counseling for

- Any client concerns or questions
- Common side-effects, especially irregular bleeding or spotting, or amenorrhea
- Importance of timely reinjection
- Any signs of complications; although rare, counsel the woman to come back immediately if any of the following symptoms develop:
    - Very bad headaches that start or become worse after initiation
    - Unusually heavy or prolonged bleeding
    - Severe pain in the lower abdomen (ectopic pregnancy)
    - Unusually yellow skin or eyes

Dispel myths regarding progestin-only injectables

Progestin-only injectable:

- Do not cause birth defects
- Do not disrupt an existing pregnancy
- Do not harm a fetus if given to a woman who is already pregnant
- Do not cause permanent infertility
- Can stop monthly bleeding, but this is not harmful. It is similar to not having monthly bleeding during pregnancy. Blood is not building up inside the woman.

Source: *Training Resource Package for Family Planning* (USAID, WHO, UNFPA). Progestin-Only Injectables Fact Sheet, 2011, https://www.fptraining.org.

Module 1: Introduction to Long Acting Reversible Contraceptives

Handout 1-6: Copper Intrauterine Device Fact Sheet

The intrauterine contraceptive device (IUD) is a small plastic device inserted into a woman's uterus to prevent pregnancy. The most commonly used IUDs are shaped like a T and have copper wires or bands on the plastic stem and arms.

The Copper T 380A, or "Copper T," is the most widely used copper IUD in the world. It is effective for up to 12 years.

Primary mechanism of action

Prevents fertilization

The copper ions decrease sperm motility and function by altering the uterine and tubal fluid environment, thus preventing sperm from reaching the fallopian tubes and fertilizing the egg (Rivera et al. 1999).

Timing of Insertion

- At any time, if you are reasonably sure the client is not pregnant
- During the menstrual cycle
  - Within 12 days, no need for a backup method;
  - If more than 12 days, make sure she is not pregnant, and no need for a backup method.
- Switching from another method
  - Immediately, if using the method correctly and consistently; otherwise, make sure she is not pregnant. No need for a backup method.
  - If the woman is switching from an injectable contraceptive, the Copper T 380A can be inserted prior to the next scheduled injection. No backup method is needed.
- Soon after childbirth (breastfeeding or non-breastfeeding)
  - Within 48 hours of delivery, or during a cesarean section
  - If more than 48 hours, then delay until 4 weeks
- Post abortion/miscarriage
  - Immediately or days after a 1st or 2nd trimester abortion, if no infection
  - Delay after medical (non-surgical) abortion until confirmed that the uterus is completely empty
- For emergency contraception

- Within 5 days after unprotected sex.
- After taking emergency contraceptive pills (ECP) the Copper T 380A can be inserted on the same day. No need for back up method.

- No monthly bleeding (amenorrhea that is not related to childbirth or breastfeeding)
  - At any time, if reasonably sure she is not pregnant. No need for a backup method.

Characteristics of Copper IUDs

- Contraceptive Effectiveness: The IUD is effective as soon as it is inserted. The IUD is one of the most effective and long acting contraceptive methods. Its effectivity is comparable to that of female and male sterilization. The failure (pregnancy) rate associated with IUD is:
  - Less than 1% in the first year of use. This means less than 1 pregnancy per 100 women in the first year of use (6 to 8 pregnancies per 1000 women).
  - A very small risk of pregnancy remains beyond the first year of use and continues as long as the woman is using the IUD.
- Effective Lifespan: The Copper T 380A is effective up to 12 years
- Removal or Replacement: Copper T 380A should be replaced or removed no later than the full lifespan of IUD (12 years) from the date of insertion. These can be removed any time when woman wants, before completion of the total duration
- Return to Fertility: A woman's fertility returns promptly after an IUD is removed (Andersson et al. 1992; Belhadj et al. 1986). This message should be made very clear to clients having an IUD removed, and they should have another IUD inserted immediately after removal (if desired and appropriate) or immediately start another contraceptive method, unless they want a pregnancy.

Advantages of IUD

- No constant/daily supplies needed
- Effective immediately upon insertion
- No user action required
- Does not interfere with intercourse
- Long-acting and reversible
- Have beneficial non-contraceptive effects (protection from endometrial cancer and ectopic pregnancy)
- Can be used by postpartum and lactating women
- Does not interact with any medicines the client may be taking
- Fertility returns promptly on removal
- Can be used as an emergency contraceptive if inserted within five days of the first act of unprotected sexual intercourse

Limitations of IUD

- Trained provider needed to insert and remove the IUD
- Pelvic examination before IUD insertion is mandatory, which is not so for other spacing methods
- May cause minor pain or discomfort during insertion and removal procedures

- Has side-effects of changes in menstrual pattern and cramps
- Small risk of expulsion
- Provide no protection from sexually transmitted infections (STIs), including HIV

Side-effects

(generally not signs of a health problem; may diminish or change over time)

- Pain or cramping during menses
- Prolonged and heavy menstrual bleeding
- Bleeding or spotting between monthly periods

Potential Health Risks

- Spontaneous expulsion occurs in about 2-8 % clients (Trieman et al. 1995) and is most likely to occur during the first three months after insertion and during menstrual periods.
- If pregnancy occurs with the IUD in situ, there is a risk of spontaneous abortion, sepsis and ectopic pregnancy; however, IUD is not reported to be having any adverse effects on the fetus.
- Infection following insertion is less than 1%. This minimal risk is highest during the first 20 days after insertion, especially if aseptic precautions have not been taken, rather than because of the device itself. (Hatcher et al, 2004)
- Uterine perforation during insertion is a rare complication, which occurs in 0.5-1.5 per 1000 insertions and is associated with the level of provider's skill and experience (Trieman et al. 1995).

Who can have a copper IUD inserted

- Women of any parity or reproductive age, married or unmarried, including nulliparous women who:
    - Want to use this method of contraception
    - Have no known conditions that preclude safety

Who should not have a copper IUD inserted

- Women who have the following known conditions:
    - Known or suspected pregnancy
    - Sepsis following childbirth or abortion (if insertion is immediately postpartum or post abortion)
    - Unexplained vaginal bleeding
    - Cervical, endometrial, or ovarian cancer
    - Current pelvic inflammatory disease
    - Current purulent cervicitis (gonorrhea or chlamydia)
    - Malignant gestational trophoblastic disease
    - Known pelvic tuberculosis

- Uterine fibroid or other anatomical abnormalities resulting in distortion of the uterine cavity, which is incompatible with IUD insertion

Use of IUDs by women with HIV and AIDS

- An IUD can be provided to a woman with HIV if she has no symptoms of AIDS.
- An IUD generally should not be initiated in a woman with AIDS who is not taking antiretroviral drugs (ARVs).
- A woman who develops AIDS while using an IUD can continue to use the device.
- A woman with AIDS who is doing clinically well on ARV therapy can both initiate and continue IUD use, but follow-up may be required.

Provide follow-up and counseling for

- Any client concerns or questions
- Potential side-effects and reassure her that they are temporary and not a sign of any disease and can be managed easily.
- A woman should return for follow up after her first menses (3-6 weeks following insertion) OR
- At any time, if having any concerns or side-effects related to the IUD
- Any signs of complications; although rare, counsel the woman to come back immediately if any of the following symptoms develop:

Warning Signs

Tell the client to return to the clinic if any of the following signs develop:
PAINS:

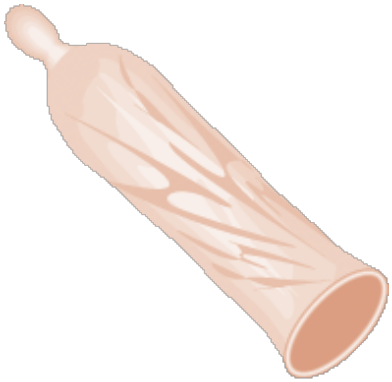
- **P**eriod related problems or pregnancy
- **A**cute abdominal cramping during the first three to five days after insertion (perforation)
- **I**nfection: Fever and chills, unusual vaginal discharge, low abdominal pain (possible infection)
- **N**ot feeling well
- **S**tring-related problems

Source: Adapted from Technical Resource Package for Family Planning, WHO Selected practice recommendations for contraceptive use, Third Edition 2016

Module 1: Introduction to Long-Acting Reversible Contraceptives

Handout 1-7: Male Condoms Fact Sheet

Male condoms are sheaths or coverings that fit over a man's erect penis. Most are made from thin latex rubber; some are polyurethane (plastic).



Primary mechanism of action

- Work by forming a barrier that keeps sperm out of the vagina, preventing pregnancy
- Also keep infectious agents—in semen, on the penis, or in the vagina—from infecting the other partner

Effectiveness

Protection against pregnancy

- As commonly used, about 18 pregnancies per 100 women whose partners use male condoms over the first year
- When used correctly with every act of sex, about 2 pregnancies per 100 women whose partners use male condoms over the first year

Protection against HIV and other sexually transmitted infections (STIs)

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

Characteristics of male condoms

- Safe and easy to use
- Widely available
- Effective if used consistently and correctly
- Provide dual protection (STI/HIV and pregnancy)
- No side-effects
- Can help men with premature ejaculation
- Do not require a provider's help

- Can be used as a temporary backup method of contraception
- Protect women from conditions caused by STIs (pelvic inflammatory disease, cervical cancer, infertility)
- As typically used, less effective than many other family planning methods
- Require partner communication and cooperation
- Latex condoms can be damaged by oil-based lubricants, heat, humidity, or light; polyurethane condoms are not as sensitive to temperature and light
- May reduce sensation

Side-effects of condoms:

None

Who can use condoms

All men and women can safely use male condoms except those with severe allergic reaction to latex (extremely rare).

How to use male condoms

1. Use a new condom for each act of sex. Check the package for damage and check the expiration date. Tear the package open carefully, without using any sharp objects.
2. Before any physical contact, put a condom on the tip of the erect penis with the condom's rolled side out.
3. Unroll the condom all the way to the base of the erect penis.
4. Immediately after ejaculation, hold the rim in place and withdraw the penis while it is still erect. Slide the condom off, avoiding spilling semen.
5. Dispose of the used condom safely.

Practices to avoid

- Unrolling condom before putting it on
- Using oil-based lubricants with latex condoms
- Using condoms that may be old or damaged (e.g., dried out, brittle, sticky)
- Reusing condoms
- Practicing dry sex

Provide follow-up and counseling for

- Any client concerns or questions
- Reinforcing correct condom use and reminding clients that condoms should not be reused
- Allergy to latex

Dispelling myths regarding condoms

Male condoms:

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

Source: *Training Resource Package for Family Planning* (USAID, WHO, UNFPA). Male Condoms Fact Sheet, 2011, https://www.fptraining.org.

Handout 1-8: LAM Decision Making Tool

Handout 1-8: Lactational Amenorrhea Method Decision Making Tool

LAM

Lactational Amenorrhea Method

- **A contraceptive method based on breastfeeding**
  - About LAM:
  - "Lactational"—related to breastfeeding. "Amenorrhea"—not having menstrual bleeding.
  - Using LAM means choosing to breastfeed in a way that prevents pregnancy. It works by stopping ovulation.
- **LAM means breastfeeding often, day and night, and giving baby little or no other food**
  - Giving baby ONLY breast milk (with little or no other food) gives best protection from pregnancy and is best for the baby's health.
  - See page L3 for how to breastfeed for best protection.
  - "How would breastfeeding your baby in this way suit you?"
- **Effective for 6 months after giving birth**
  - If periods have not returned.
  - Very effective when used correctly.
  - But as commonly used it is less effective.
- **Breast milk is the best food for babies**
  - Healthiest way to feed most babies for first 6 months. Breast milk contains the exact nutrients the baby needs and helps protect the baby from infections. Breastfeeding benefits the mother's health too.
  - Breastfeeding should be started within 1 hour after birth, and babies should be given no other food or drink until they are 6 months old.
  - Breast milk can be a major part of the baby's diet for 2 years or more.
- **No protection against STIs or HIV/AIDS**
  - For woman's STI/HIV/AIDS protection, also use condoms.
  - Breastfeeding can pass HIV from mother to baby.

Next Move:

"Do you want to know more about LAM, or talk about a different method?"

If client wants to know more about LAM, go to next page.

To discuss another method, go to a new method tab or to Choosing Method tab.

L1

When you can use LAM

If breastfeeding now, can use LAM if:

- **Baby is less than 6 months old**

  AND
- **Baby gets little or no food or drink except breast milk**

  AND
- **Menstrual periods have not come back**

→
- Breastfeeding women can start LAM at any time if they meet **all 3 conditions**. ✔
- It is best for the baby to breastfeed for at least 2 years.

Once her baby is 6 months or older:
- She should **use another method** of family planning.
- If she continues to breastfeed, non-hormonal methods are best. She can also use progestogen-only methods (mini-pill, long-acting injectable or implants).

→
- Cannot use LAM if she has had 2 or more straight days of menstrual bleeding. (Bleeding in first 8 weeks after childbirth does not count.)

But please tell me if you:
- **Have AIDS? Or are infected with HIV, the AIDS virus?**

→
- New evidence recommends that HIV-positive mothers should breastfeed
- Combination of exclusive breastfeeding and use of antiretroviral treatment can significantly reduce the risk of transmitting HIV to babies
- WHO recommends that HIV-positive mothers or their infants take ARVs throughout the breastfeeding period and until the infant is 12 months old.

Next Move:

If client can start now or when she gives birth, go to instructions on next page.

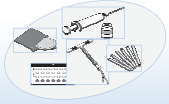
If client can no longer use LAM or is unable to use LAM, help her choose another method.

L2

How to use LAM

- **Can start LAM as soon as baby is born**
- **Breastfeed often**

What to do after LAM:
- **Start giving baby other foods when he/she is 6 months old, but continue to breastfeed**
- **Start another method at the right time**



Are you ready to choose this method?

Start thinking and choosing a transition method and plan

Anything else I can repeat or explain? Any other questions?

How to use LAM

- Can start LAM as soon as baby is born
  - After childbirth, start breastfeeding as soon as possible, for baby's health and best protection from pregnancy.
- Breastfeed often
  - Breastfeed whenever the baby is hungry, both day and night.
  - If feedings become more than 4 hours apart in the day, or more than 6 hours apart at night, consider another method of family planning.
  - Keep breastfeeding even if you or the baby is sick.
  - "Are you ready to keep up this pattern of breastfeeding?"
  - Advise on breastfeeding technique and diet.

What to do after LAM:

- Start giving baby other foods when he/she is 6 months old, but continue to breastfeed
  - When additional foods are introduced, breastfeed before each feeding of other food or drink.
- Start another method at the right time
  - Before or as soon as menstrual periods return (bleeding in first 8 weeks after childbirth not included)
  - OR before stopping fully or nearly fully breastfeeding (baby takes other foods/liquids regularly)
  - OR before baby is 6 months old (about time child starts sitting up)
  - OR when mother no longer wants to use LAM (whichever comes first).

Last Moves:

- Offer supplies now, such as condoms, that she can start using when needed.

"Do you feel confident you can use this method successfully?
Do you need any more advice on breastfeeding?"

Remember to offer condoms for dual protection and/or backup!

Last, most important message: ***"Come back for another method before the baby is 6 months old, or your periods return, or the baby starts taking other food."***

L3

Acknowledgements

Source: Training Resource Package for Family Planning (USAID,WHO,UNFPA). LAM Decision-Making Tool, 2011, https://www.fptraining.org.

Module 1: Introduction to Long-Acting Reversible Contraceptives

Handout 1-9: Postpartum Intrauterine Device (Cu-T380A/LNG-IUS) Fact Sheet

Postpartum IUD insertion refers only to those IUDs/intrauterine systems (LNG-IUSs) inserted during the immediate (within 10 minutes of delivery of placenta), early postpartum period (within 48 hours after delivery), and during cesarean section. Postpartum insertion of an IUD/LNG-IUS, within 10 minutes or up to 48 hours after birth, has been shown to be safe, effective, and convenient for women like the regular or "interval" IUD/LNG-IUS. For many women who rarely access health care services, the insertion of an IUD/LNG-IUS immediately postpartum presents a unique opportunity for them to initiate a long-acting and reversible method of family planning.

Primary mechanism of action

Cu-T380A

- Prevents fertilization
- The copper ions decrease sperm motility and function by altering the uterine and tubal fluid environment, thus preventing sperm from reaching the fallopian tubes and fertilizing the egg (Rivera et al. 1999)

LNG-IUS

- Thickening of cervical mucus
- Interfering with sperm movement
- Thinning the lining of the uterus

Timing of Insertion

The IUD/LNG-IUS can be inserted:

- Postplacental: Immediately (within 10 mins) following the delivery of the placenta, the IUD/LNG-IUS is inserted with long placental forceps (preferably Kelly's Forceps).
- Intra-cesarean: Immediately following the removal of the placenta during a cesarean section, the IUD/LNG-IUS is inserted manually or with a ring forceps before closure of the uterine incision.
- Early postpartum: Within 48 hours of the birth. The IUD/LNG-IUS is inserted with long forceps such as Kelly's Forceps.
- Post abortion: Immediately after an abortion, provided there is no infection or any other contraindication

Characteristics of PPIUD

- Cu-T380A is effective for up to 12 years, LNG-IUS is effective up to 5 years*
- It is immediately effective upon insertion
- Is readily accessible for women who deliver at health care facilities

- Has no effect on the amount or quality of breast milk
- Is safe for use by women living with HIV
- Is reversible and can be removed at any time (with immediate return to fertility) if the woman's contraceptive or reproductive desires change
- Does not require any daily action on the part of the user
- Does not require a separate visit to the facility or, if inserted within 10 minutes of the birth, a separate procedure.
- Postpartum Insertion appears to have a lower rate of uterine perforation, possibly because the insertion instrument used is blunt and the wall of the uterus is thick just after pregnancy. The provider can also be certain that the woman is not pregnant at the time of insertion.
- Saves time for both the woman and provider because the procedure is conducted in the same setting and involves only a few minutes of additional time.
- It is both long-acting and reversible and can be used for a short time or as long as 12 years for Cu-T380A and 5 years for LNG-IUS*. Fertility returns as soon as it is removed.
- * Note: The effectiveness period varies with the type of LNG-IUS used. Studies to confirm the effectiveness period are ongoing

PPIUD Limitations

- Limitations of the PPIUD are minimal and basically the same as for the interval IUD/LNG-IUS
- Trained provider needed to insert and remove the PPIUD
- Does not protect against HIV or other sexually transmitted infections (STIs).
- Menstrual changes are a common side-effect of the IUD, but these may be less bothersome for postpartum women because some cramping and bleeding are expected during the postpartum period.
- Strings will not be initially visible after postpartum insertion, because of the length of the string compared with the length of the postpartum uterus. Usually the strings will descend through the cervix and into the vagina by the time of the first PPIUD follow-up visit (at 4 to 6 weeks).

PPIUD Health Risks

- **Perforation:** Perforation of the uterine wall during PPIUD insertion is rare and is directly related to provider's skill.
- **Infection:** Risk of infection is minimal. It is highest within the first 20 days after IUD insertion, and is thought to be related to either insertion technique (resulting from a lack of proper infection prevention practices) or a pre-existing infection, rather than to the IUD itself. After the first 20 days, the risk of infection among IUD users appears to be comparable to that among non-IUD users.
- **Expulsion:** IUD failure is rare, but the most common cause is spontaneous expulsion of the IUD from the uterus. Spontaneous expulsion appears to be higher with the PPIUD than with interval IUD insertions. Immediate postpartum insertion (within 10 minutes) is associated with a lower risk of expulsion than early postpartum insertion (up to 48 hours). Most expulsions occur within the first 3 months after insertion.

Who can have a PPIUD inserted?

Most women can use the IUD/LNG-IUS in the postpartum period, as well as those who have certain medical conditions such as HIV or diabetes. It is especially well-suited to women who think they are finished having children, but want to delay sterilization until they are certain.

Side-Effects

- Changes in menstrual bleeding may occur for the first 3 to 6 months.
- With Cu-T380A periods may become irregular and the number of bleeding days may increase, or there might be frequent spotting or light bleeding.
- With LNG-IUS periods are irregular and lighter initially or amenorrhea after few months of use
- Bleeding or spotting between monthly periods may occur with LNG-IUS
- Pelvic discomfort and pain can be relieved by mild analgesics.

Most side-effects associated with the use of IUD/LNG-IUS are not serious and will resolve spontaneously. And most IUD/LNG-IUS-related problems can be avoided through:

- Careful screening of clients
- Meticulous attention to appropriate insertion technique
- Strict adherence to correct infection prevention techniques
- Performing PPIUD insertion procedures slowly and gently to assure technical accuracy and client comfort and safety

Woman experiencing the following conditions should not use a PPIUD

- Chorioamnionitis
- Postpartum endometritis/metritis (Category 4)
- Puerperal sepsis (Category 4)
- More than 18 hours from rupture of membranes to delivery of the baby
- Unresolved postpartum hemorrhage
- Extensive genital trauma, the repair of which would be disrupted by postpartum placement of the IUD

When to return for follow-up

- Follow-up for women who receive PPIUD in the immediate or early postpartum period should be integrated with a postpartum care visit at 4-6 weeks.
- Follow up visit at 4 to 6 weeks to reassure the client that the IUD/LNG-IUS is not being expelled.

Warning Signs

Tell the client to return to the clinic as soon as possible for urgent attention and care if any of the following signs develop:

- Foul-smelling vaginal discharge (different from the usual postpartum lochia)
- Heavy vaginal bleeding
- Lower abdominal pain, especially if accompanied by not feeling well, fever, or chills
- Concerns that the IUD/LNG-IUS has fallen out

Source: Adapted from Jhpiego. *Postpartum Intrauterine Contraceptive Device (PPIUD) Services: Learning Resource Package*. Baltimore: Jhpiego Corporation, 2010.

Module 1: Introduction to Long-Acting Reversible Contraceptives

Handout 1-10: Levonorgestrel Intrauterine System (LNG-IUS) Fact Sheet

The Levonorgestrel intrauterine system (LNG-IUS) is a type of hormone-containing intrauterine contraceptive device that is placed in the uterus to prevent pregnancy. It is made up of a "T"-shaped plastic frame and a white cylinder-shaped hormone reservoir around the vertical arm of the frame with two nylon threads at the end for removal.

The vertical stem of the system has the reservoir containing the hormone Levonorgestrel. It contains 52 mg of Levonorgestrel (LNG) and is effective for 5 years. The LNG-IUS can be replaced if continued use is desired.

Note: The effectiveness period varies with the type of LNG-IUS used. Studies to confirm the effectiveness period are ongoing

Mechanism of Action

- Thickening of cervical mucus
- Interfering with sperm movement
- Thinning the lining of the uterus, (making the menstrual cycle lighter)

Timing of Insertion

- At any time, if you are reasonably sure the client is not pregnant
- During the menstrual cycle
    - Within 7 days, no need for a backup method;
    - If more than 7 days, make sure she is not pregnant, and give a backup method.
- Switching from another non-hormonal method
    - Immediately, if using the method correctly and consistently; otherwise, make sure she is not pregnant. Give a backup method for 7 days.
- Switching from another hormonal method
    - If the woman is switching from an injectable contraceptive, the LNG-IUS can be inserted prior to the next scheduled injection. No backup method is needed.
- Soon after childbirth (breastfeeding or non-breastfeeding)
    - Within 48 hours of delivery, or during a cesarean section
    - If more than 48 hours, then delay until 4 weeks
- Post abortion/miscarriage

- Immediately or within 7 days after a 1st or 2nd trimester abortion, if no infection
- Delay after medical (non-surgical) abortion until confirmed that the uterus is completely empty
- After taking emergency contraceptive pills (ECP), give her a backup method to start on the day she finishes taking (ECP) until the LNG-IUS is inserted

- No monthly bleeding (amenorrhea that is not related to childbirth or breastfeeding)
- At any time, if reasonably sure she is not pregnant; give a backup method for the first 7 days.

Characteristics of the LNG-IUS

Contraceptive Effectiveness

Highly effective: Less than 1 pregnancy per 100 women (2 per 1,000 women) using it over the first year. Over 5 years of use, less than 1 pregnancy per 100 women (5–8 per 1,000 women)

Effective Lifespan

The LNG-IUS is effective for 5 years (depending on the type of product)

Removal or Replacement

The LNG-IUS should be replaced or removed no later than the full lifespan of 5 years (depending on the type of LNG-IUS) from the date of insertion. It can be removed any time when woman wants, before completion of the total duration

Return to Fertility

The LNG-IUS does not interfere with normal fertility after removal. The woman can become pregnant in the same menstrual cycle.

Advantages of LNG-IUS

- No constant/daily supplies needed
- No user action required
- Does not interfere with intercourse
- Rapid return to fertility
- Significantly reduces menstrual blood loss; periods become shorter, lighter, or no periods and less painful
- Approved treatment for women suffering from heavy menstrual bleeding
- More cost-effective than oral contraceptives, condoms, and injectable contraception over five years
- Long-acting and reversible
- Can be used by lactating women
- Has minimum systemic hormonal side-effects

Limitations of LNG-IUS

- Trained provider needed to insert and remove the LNG-IUS
- Pelvic examination before LNG-IUS and IUD insertion is mandatory, which is not so for other spacing methods

- May cause pain or discomfort during insertion and removal procedures
- Provide no protection from sexually transmitted infections including HIV

Side-effects *(generally not signs of a health problem; may diminish or change over time)*

- Pain or cramping during menses
- Irregular and lighter menses or amenorrhea
- Bleeding or spotting between monthly periods
- Benign ovarian cysts
- Headache, nausea, breast tenderness, acne
- Mood changes, mild depression (less common)

Health Benefits:

Helps protect against:

- Risk of pregnancy
- Potential reduction of iron deficiency anemia
- Pelvic Inflammatory disease

Reduces:

- Menstrual cramps
- Pelvic pain
- Menstrual bleeding

Who can have the LNG-IUS inserted?

Safe and suitable for almost all women of all ages:

- Young adolescents and nulliparous women
- Women in the immediate postpartum or post abortion period, if not infected
- Breastfeeding women

Who should not have the LNG-IUS inserted?

Women who have the following known conditions:

- Known or suspected pregnancy
- Congenital or acquired uterine anomaly, including fibroids, that distorts the uterine cavity
- Current or recurrent PID
- Postpartum endometritis
- Post abortion sepsis
- Known or suspected uterine or cervical cancer
- Known or suspected breast cancer or other progestin-sensitive cancer, now or in the past
- Abnormal uterine bleeding

- Untreated acute cervicitis or vaginitis, including bacterial vaginosis, known chlamydial or gonococcal cervical infection, or other lower genital tract infections, until the infection is controlled
- Acute liver disease or liver tumor (benign or malignant)
- Acute venous thrombosis (Category 3) if not established on anticoagulation therapy
- A previously inserted LNG-IUS that has not been removed
- Hypersensitivity to any component of the LNG-IUS

When to return for follow-up?

A woman should return for follow up after 4 weeks of insertion **OR**
At any time, if having any concerns or side-effects related to the LNG-IUS

Warning Signs

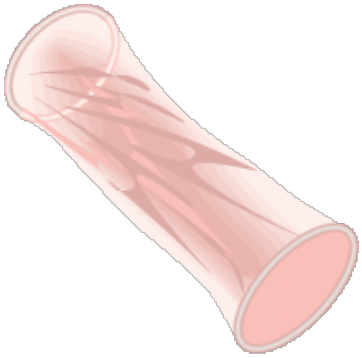
Tell the client to return to the clinic if any of the following signs develop: **PAINS:**

- **P**eriod related problems or pregnancy
- **A**cute abdominal cramping during the first three to five days after insertion (perforation)
- **Infection:** Fever and chills, unusual vaginal discharge, low abdominal pain (possible infection)
- **Not** feeling well
- **S**tring-related problems

Sources: International Contraceptive Access (ICA) Foundation. *LNG-IUS Training Manual for Family Planning*. Turku, Finland: ICA Foundation, 2004; ICA Foundation Levonorgestrel releasing (Actavis & Medicines 360) presentation 2012; Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (JHSPH/CCP) and World Health Organization (WHO). *Family Planning: A Global Handbook for Providers*. 2011 Update. Baltimore, MD, and Geneva: JHSPH/CCP and WHO, 2011.

Module 1: Introduction to Long-Acting Reversible Contraceptives

Handout 1-11: Female Condoms Fact Sheet



Female condoms are sheaths, or linings, that fit loosely inside a woman's vagina

- The most common type is Female Condom Two (FC2)—made of thin, soft, synthetic rubber film, with flexible rings at both ends
- Latex female condoms are available in some countries

Primary mechanism of action

- Work by forming a barrier that keeps sperm out of the vagina, preventing pregnancy
- Also keep infectious agents in semen, on the penis, or in the vagina from infecting the other partner

Effectiveness

Protection against pregnancy

- When used correctly with every act of sex, about 5 pregnancies per 100 women using female condoms over the first year
- As commonly used, about 21 pregnancies per 100 women using female condoms over the first year

Protection against HIV and other sexually transmitted infections (STIs)

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

Characteristics of female condoms

- Safe
- Women can initiate their use
- Have a soft texture that quickly conducts body heat during sex
- Provide dual protection (against STIs/HIV and pregnancy)
- Outer ring provides added sexual stimulation for some women
- Do not require a provider's help
- Can be inserted ahead of time; so they do not interrupt sex
- Are not tight or constricting like male condoms
- Do not dull the sensation of sex like male condoms
- Do not have to be removed immediately after ejaculation

- No side-effects
- Can be used as a temporary backup method of contraception
- Protect women from conditions caused by STIs (pelvic inflammatory disease, cervical cancer, infertility)
- As typically used, less effective than many other family planning methods
- Require partner communication and cooperation
- May be difficult to insert
- Can make noise during sex

Side-effects of female condoms

None

Who can use female condoms

- All men and women can safely use synthetic rubber female condoms.
- All men and women can safely use natural latex female condoms, except those with a severe allergy to latex (extremely rare).

How to use female condoms (FC2)

1. Use a new condom for each act of sex. Check the condom package. Do not use if it is torn, damaged, or past the expiration date. Open the package carefully.
2. Before any physical contact, insert the condom into the vagina. It can be inserted up to eight hours before sex. Find a comfortable position for insertion—squat, raise one leg, sit, or lie down. Grasp the ring at the closed end, and squeeze it so it becomes long and narrow. With the other hand, separate the outer lips and locate the opening of the vagina. Gently insert the inner ring into the vagina as far up as it will go. Insert a finger into the condom to push it into place. (The inner ring should be pushed up just past the pubic bone.)
3. Ensure that the penis enters the condom and stays inside the condom.
4. To remove the condom, hold and twist the outer ring to seal in fluids, and gently pull the condom out of the vagina. The female condom does not need to be removed immediately after sex, but at any time before standing up, to avoid spilling semen.
5. Dispose of the used condom safely.

Tips for new users

- Suggest to a new user that she practice putting in and taking out the condom before the next time she has sex. Reassure her that correct use becomes easier with practice. A woman may need to use the female condom several times before she is comfortable with it.
- Suggest she try different positions to see which one makes insertion easiest for her.
- The female condom is slippery. Some women find insertion easier if they put it in slowly, especially the first few times.
- If a client is switching from another method to the female condom, suggest that she continue with the previous method until she can use the female condom with confidence.

Provide follow-up and counseling for

- Any client concerns or questions
- Correct condom use

Dispelling myths regarding female condoms

Female condoms:

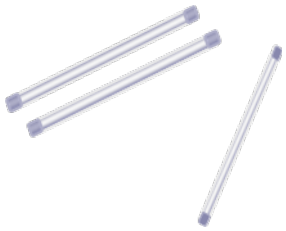
- Cannot get lost in the woman's body
- Are not difficult to use, but correct use needs to be learned
- Do not have holes that HIV can pass through
- Are used by married couples; they are not only for use outside marriage
- Do not cause illness in a woman because they prevent semen or sperm from entering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

Source: *Training Resource Package for Family Planning* (USAID, WHO, UNFPA). Female Condom Fact Sheet, 2011, https://www.fptraining.org.

Module 1: Introduction to Long-Acting Reversible Contraceptives

Handout 1-12: Implants Fact Sheet

Progestin-only implants consist of hormone-filled capsules or rods that are inserted under the skin in a woman's upper arm. They are more than 99% effective, and provide a significant advantage to women in that little to no action is required of the woman once the implants are inserted, except to return to a provider for removal. Hormone passes into the blood stream constantly through the walls of capsule at a steady rate. Implants can be removed at any time by a trained provider with no delay in return to fertility.



Current systems consist of one or two rods:

Type	Number of Rods	Years of Protection	Content
Implanon	1	3 Years	68 mg Etonogestrel
*Implanon NXT	1	3 Years	68 mg Etonogestrel
Jadelle	2	5 Years	75 mg Levonorgestrel
Sino-implant (II)/Levoplant	2	3-4 Years†	75 mg Levonorgestrel

*Implanon NXT: Is radio opaque and the application trocar is different; its contents are the same as Implanon.

†Sino-implant (II)/Levoplant is registered for 3-year use in some countries, and 4-year use in others. Check with your local regulatory body to confirm locally registered duration of use.

Mechanism of action

- Thickens cervical mucus (making it difficult for sperm to penetrate)
- Inhibition of ovulation

Timings of insertion

Implants may be inserted at any time during the menstrual cycle when it is reasonably certain that the client is not pregnant. Post-insertion, the hormone levels in implants rise rapidly and are effective depending on timing of insertion per the woman's menstrual cycle or use of contraception.

- No need of any back up method if insertion is done within 7 days of menstrual cycle.
- If it is more than 7 days (more than 5 days for one rod implant) after the start of monthly bleeding, she can have implant inserted any time if it is reasonably certain that she is not pregnant. She will need a backup method for the first 7 days after insertion.
- If switching from another non-hormonal method, use back up method for 7 days.
- If she is switching from injectables, she can have implants inserted when the repeat injection would have been given. No need for a backup method.
- If switching from IUD/LNG-IUS: starting during the first 7 days of monthly bleeding, insert implant and remove the IUD. No need for a backup method.
- If switching from LNG-IUS and is amenorrheic, rule out possible pregnancy, insert implant and remove LNG-IUS. No need to wait for next monthly bleeding. No need for a backup method.
- Can be inserted during immediate postpartum period (Category 2) or delayed postpartum period.

Characteristics and Benefits of Progestin-only implants

- Highly effective
- Require no further action other than follow-up visits and return for removal
- Do not interfere with normal daily activities
- Long-acting and reversible
- One of the lowest doses of any hormonal contraceptive and contains no estrogen
- Can be used by postpartum women immediately or before going home after delivery
- Have no effect on the quality or quantity of breast milk
- Insertion involves a minor surgical procedure and some discomfort for a day or two
- Comfortable—once the insertion site has fully healed (about 1 week), the rods should not cause any pain and are not noticeable in most women
- Have non-contraceptive health benefits (help prevent ectopic pregnancy and iron deficiency anemia)

Limitations

- Only a trained service provider can provide implant services.
- Changes in menstrual bleeding patterns are common. (Counseling should prepare the woman adequately for this.)
- Insertion and removal are minor surgical procedures and therefore may be associated with bruising (discoloration of the arm), infection, or bleeding.
- A woman cannot discontinue the method on her own.
- The outline of the rod(s) may be visible under the skin of some women, especially when the skin is stretched.
- Contraceptive implants do not protect a woman from genital tract infections (GTIs) and other STIs, including hepatitis B virus (HBV) and HIV/AIDS.

Side-effects

Side-effects, if any, are minor and may diminish or change over time.

Changes in Bleeding Patterns

The most common side-effect with contraceptive implants is a change in the menstrual bleeding pattern. Menstrual bleeding changes are essentially universal, although the pattern in any individual woman cannot be predicted. Typical changes include lighter bleeding, fewer days of bleeding, irregular bleeding, and infrequent or no monthly bleeding (Respond Project 2013). One-rod users are more likely to have infrequent or no monthly bleeding than irregular bleeding (WHO/RHR and Johns Hopkins University School of Public Health Center for Communication Programs, Knowledge for Health Project 2011). Among two-rod implant users, prolonged bleeding and irregular bleeding and spotting are common, especially during the first 6–9 months of use.

Other Possible Side-Effects

- Weight change
- Abdominal pain
- Acne (can improve or worsen)

- Headaches, dizziness, mood changes, nausea, and breast tenderness (less common than with combined oral contraceptives)
- Reduced libido

Who can use progestin-only implants?

Women of any parity or reproductive age (including adolescents), married or unmarried, who:

- Want to use this method of contraception
- Have no known conditions that preclude safe use (such conditions are rare)
- Postpartum women

Who should not initiate progestin-only implants?

Women who:

- Are pregnant (known or suspected)
- Have a history of past or current breast cancer (Category 4)
- Have liver tumor or severe liver disease (Category 3)
- Have acute venous thromboembolism (Category 3)

Who should be advised to discontinue use of progestin-only implants and switch over to a non-hormonal method?

- Women with unexplained vaginal bleeding
- Women with migraine headaches with aura

Use of progestin-only implants by women with HIV and AIDS

- Women with HIV who do not take antiretroviral drugs (ARVs) can use progestin-only implants without restrictions.
- Women with AIDS who take ARVs can generally use progestin-only implants because the effectiveness of implants seems not to be significantly affected by ARVs.
- However, women on Efaverizine (EFVs) should be advised about the possible drug interactions between EFV and implants that may lead to a higher than usual contraceptive failure rate.
- Women with HIV or AIDS who have contraceptive implants should be advised to use condoms.

Provide follow-up and counseling for:

- Any client concerns or questions
- Side-effects, especially irregular bleeding or spotting or amenorrhea
- Any signs of complications (although rare); counsel the woman to come back immediately if any of the following symptoms develop:
    - Infection or pus at the insertion site
    - Unusually heavy or prolonged bleeding
    - Severe pain in the lower abdomen (symptom of ectopic pregnancy)

- Amenorrhea after having regular cycles (signs of pregnancy)
- Expulsion of rod

- Explain to the client that implants can be removed at any time for any reason.

Dispelling myths regarding progestin-only implants

Progestin-only implants do not:

- Break and move around within a woman's body **if inserted correctly.**
- Cause birth defects
- Cause cancer
- Cause abortion if inserted during a pregnancy
- Have any contraindication for use by adolescents, despite myths or fears that adolescents should not use them

Source: Technical Resource Package for Family Planning Contraceptive Implants Module, Family Planning Global Handbook 2011

Module 1: Introduction to Long-Acting Reversible Contraceptives

Handout 1-13: Standard Days Method Fact Sheet

What is it?

The Standard Days Method® (SDM) is an effective, natural method of child spacing used by women and their partners. A couple can use this method if the woman has menstrual cycles 26 to 32 days long. A woman who usually gets her period every month has cycles in this range.

What are CycleBeads®?

CycleBeads® are a string of colored beads that represent the woman's menstrual cycle. A woman moves a ring every day along the necklace to know if she is on a day when she can get pregnant (white beads) or not (brown beads). Women can also use a paper-based version of SDM when CycleBeads® are not available.

How does the SDM work?

The SDM works by helping a woman know which day of her menstrual cycle she is on and whether she is likely to can get pregnant that day. On days she can get pregnant, the woman and her partner either use a condom or do not have sex. Couples practicing the SDM can use either CycleBeads® or the paper-based version of SDM, which is used in a similar way, using an illustration of the beads on paper.

How well does the SDM work to prevent pregnancy?

Using the SDM works very well to prevent pregnancy, especially for women whose menstrual cycles usually are between 26 and 32 days long. For every 100 women who use the SDM correctly for 1 year, fewer than 5 will get pregnant. This is similar to condoms, diaphragms, and other natural methods.

What are some of the advantages of the SDM?

- Does **not** cause any physical side-effects
- Is effective and reversible
- Nothing must be taken daily or at the time of sexual intercourse
- Can be used by women who cannot use, or prefer not to use, methods that contain hormones such as oral contraceptives ("the pill"), contraceptive injection ("the shot") or "the patch"
- Can be used by women who cannot use, or prefer not to use, a birth control method that requires a medical procedure such as the IUD
- Allows both the woman and her partner to be responsible for child spacing

What are some of the disadvantages of the SDM?

- Offers no protection against HIV or other sexually transmitted infections (STIs)
- Requires that the woman remember to move the ring every day if using CycleBeads® or to mark the day on the paper-based version of the SDM.
- Requires cooperation by the male partner (to use a condom or not have sex on white bead days)
- Is not very effective for women with menstrual cycles shorter than 26 days or longer than 32 days

When should a woman contact her health provider?

- More than once in a year her period starts before reaching the darker brown bead or does not start the day after reaching the last brown bead
- She experiences difficulty using a condom or not having sex on days she can get pregnant
- She had unprotected sex on a day she could get pregnant
- She experiences symptoms of, or exposure to, a sexually transmitted infection (STI)
- She wants to stop using the SDM and start another method

Source: Institute for Reproductive Health, Georgetown University | www.irh.org; Training Resource Package for Family Planning, SDM, Fact Sheet, 11/2011 *https://www.k4health.org/toolkits/sdm*.

Module 1: Introduction to Long-Acting Reversible Contraceptives

Handout 1-14: Progestin-Only Pills Fact Sheet

Progestin-only pills (POP), also known as minipills, is an effective method of contraception if used correctly. It is commonly used when the combined pill (which also contains estrogen) is not suitable. They are safe for breastfeeding women and their babies. They contain a very low dose of progestin like the natural hormone progesterone present in a woman's body.

Primary Mechanisms of action

- Prevent ovulation (release of eggs from the ovaries)
- Thicken cervical mucus (make it difficult for sperm to penetrate)

When to start

At any time, if you are reasonably sure the client is not pregnant

During the menstrual cycle

- Within 5 days of menstrual cycle, no need for a backup method;
- If more than 5 days, make sure she is not pregnant, and use a backup method for the first 2 days of taking pill

Switching from another method

- Immediately, if using the method correctly and consistently; otherwise, make sure she is not pregnant. No need for a backup method.
- If the woman is switching from an injectable contraceptive, she can take the pills immediately. No backup method is needed.

Soon after childbirth (breastfeeding or non-breastfeeding)

- Can start POPs any time after giving birth. No need for back up method.

More than 4 weeks after child birth

- If monthly bleeding has not started, then can start POPs any time it is reasonably certain that she is not pregnant.
- If monthly bleeding started, then start within first 5 days of menstrual bleeding.

Post abortion/miscarriage

- Immediately, if she is starting within 7 days after a 1st or 2nd trimester abortion, if no infection

- If it is more than 7 days, start POPs anytime it is reasonably certain she is not pregnant, use a backup method for 2 days

After emergency contraception

- After taking emergency contraceptive pills (ECP), start POPs the day after she finishes taking the ECPs. Use back up method for the first 2 days of taking pills.

Characteristics of progestin-only pills

- Effectiveness depends on the user: For women who have monthly bleeding, risk of pregnancy is high if pills are taken late or missed completely.
    - As commonly used: 1 pregnancy per 100 women using POP over the first year.
    - If pills are taken every day at the same time, less than 1 pregnancy per 100 women using POP.
- Efficacy of progestin-only pills requires consistent use. Women should take the pill at the same time every day.
- If a pill is more than 3 hours late, a backup method of contraception should be used for at least the next 48 hours.
- The POP does not give you a higher risk of blood clots (unlike the combined pill). It can therefore be used by some women who cannot take the combined pill. For example women with migraine, history of high blood pressure
- Do not interfere with intercourse, private
- Do not affect quality or quantity of breast milk
- Bleeding changes are common but not harmful.
- No delay in return of fertility when stopped
- Provide no protection from sexually transmitted infections, including HIV

Side-effects (*generally not signs of a health problem; may diminish or change over time)*

- Changes in bleeding patterns are common such as: prolonged bleeding, frequent bleeding, irregular bleeding, infrequent bleeding, or no monthly bleeding
- Breast tenderness
- Abdominal pain
- Nausea
- Headaches and dizziness (less common than with combined oral contraceptives)
- Changes in mood

Who can use progestin-only pills?

Safe and suitable for nearly all women, including women who are married or unmarried or of any age breastfeeding or not breastfeeding:

- Want to use this method of contraception
- Have no known conditions that preclude safe use (such conditions are rare)

Who should not use progestin-only pills?

Women who have any of the following conditions (contraindications):

- Acute deep venous thrombosis (unless on established anticoagulant therapy)
- Using anticonvulsant drugs (except Lamotrigine) or Rifampicin.
- History of or current breast cancer
- Liver tumor, severe liver disease or infection

Use of progestin-only pills by women with HIV and AIDS

- Women can safely use POPs even if they are infected with HIV and AIDS or are on antiretroviral drugs (ARVs) (except on Ritonavir)

Provide counseling and follow-up for taking pills

- Any client concerns or questions
- Common side-effects, especially irregular bleeding or spotting, or amenorrhea
- Taking pills at the same time every day helps to remember them
- Explain that all pills in POP packs are the same color and all contain a hormone that prevents pregnancy
- Explain that she should take the pill from next pack on the very next day of finishing first pack
- To come back when she stops feeding or wants to switch to another method
- Give as many pills packet as possible.
- Any major change in health status or she thinks she might be pregnant
- Encourage her to come back for more pills before she uses up her supply of pills.
- It is recommended to contact the woman after the first 3 months to check correct use and help with any problems.

Dispel myths regarding progestin-only pills

Progestin-only pills:

- Do not cause a breastfeeding woman's milk to dry up
- Do not cause diarrhea in breastfeeding babies
- Do not cause permanent infertility
- Should be taken every day and not only taken after having sex

Sources: World Health Organization (WHO) Department of Reproductive Health and Research and Johns Hopkins Bloomberg School of Public Health Center for Communications Programs (CCP). Family Planning: A Global Handbook for Providers. 2011 Update. Geneva, Switzerland and Baltimore, Maryland, USA: WHO and CCP; 2007. Available from: http://apps.who.int/iris/bitstream/10665/44028/1/9780978856373_eng.pdf

World Health Organization (WHO). Medical Eligibility Criteria for Contraceptive Use. 5th Edition. Geneva, Switzerland: WHO; 2015. Available from: http://apps.who.int/iris/bitstream/10665/181468/1/9789241549158_eng.pdf?ua=1

Module 1: Introduction to Long-Acting Reversible Contraceptives

Handout 1-15: Emergency Contraceptive Pills (ECPs) Fact Sheet

Emergency contraceptive pills (ECPs) are hormonal methods of contraception that can be used to prevent pregnancy following an unprotected act of sexual intercourse. They contain progestin alone or a progestin and an estrogen together. They are sometimes called "morning after pills" or postcoital contraceptives.

Primary mechanisms of action

- Prevent or delay ovulation (release of eggs from the ovaries)
- ECPs do not inhibit implantation of a fertilized egg.

Characteristics of ECPs

- All women including adolescents can use ECPs safely and effectively, including those who cannot use hormonal contraceptive methods.
- ECPs have no known serious complications.
- Short-term action
- ECPs do not cause abortion of an existing pregnancy
- ECPs are not harmful if taken by a woman who is already pregnant.

Types of ECPs

- Progestin-only pills with levonorgestrel or norgestrel
- Combined oral pills with estrogen and progestin
- Levonorgestrel-only pills or estrogen and levonorgestrel combined, or ulipristal acetate

When to take ECPs?

- As soon as possible after unprotected sex. The sooner they are taken after unprotected sex, the better they prevent pregnancy
- Can prevent pregnancy when taken anytime up to 5 days (120 hrs.) of unprotected sex.

Side-effects *(generally not signs of a health problem; may diminish or change over time)*

ECPs are well tolerated and leave the body within a few days. Some women experience mild and short-term side-effects. These may include:

- Altered bleeding patterns including:
  - Slight irregular bleeding for 1-2 days after taking ECPs
  - Monthly bleeding that starts earlier or later than expected
- Nausea (in up to 20% of women)
- Vomiting (rare)
- Headache
- Abdominal pain
- Breast tenderness
- Dizziness
- Fatigue

Who can use ECPs

Women of any parity or reproductive age, married or unmarried, who:

- Did not use a contraceptive (including cases of rape)
- Used a contraceptive incorrectly
- Used a contraceptive correctly, but it was immediately observed to have failed.

Who should not use ECPs

- Women are able to decide for themselves if they can take ECPs as there are no medical precautions or contraindications to ECPs and do not require a pregnancy test or physical examination before taking ECPs
- ECPs should not be taken if a woman is pregnant because they will not work. However, they will not harm an existing pregnancy.
- ECP effectiveness may be affected by the use of certain medications.

Providing information to ECP client

When providing information about ECP clients:

- Be responsive to the client's needs
- Be supportive of the client's choices
- Be respectful
- Reassure the client that all information she gives you is kept confidential
- Provide a private and supportive environment
- Do not make judgmental comments or indicate disapproval through body language

Dispelling myths regarding ECPs

Emergency contraceptive pills (ECPs) **are not dangerous** and **do not:**

- Increase risky sexual behavior
- Prevent implantation of fertilized ovum
- Cause abortions
- Cause deformed babies

Planning Ongoing Contraception

- Explain that ECPs will not protect her from pregnancy for any future sex. Discuss the need for and choice of contraceptives available.
- If she does not want to start a contraceptive method now, give her condoms or oral contraceptives and ask her to use them if she changes her mind.
- Invite her to come back anytime if she wants another method or has any question or problem.

When to start contraception after ECP use

- **COCs**: Can begin the day after she takes ECPs. No need to wait for monthly bleeding.
- **Progestin-only injectables**: Can start injection on the same day as the ECPs or, if preferred, within 7 days after the start of monthly bleeding (will need a backup method for 7 days)
- **Implants**: After return of her monthly bleeding, give her a backup method or COCs to use until then.
- **Intrauterine Device**: A Copper-bearing IUD can be used as an emergency contraceptive if inserted within 5 days of unprotected coitus. Good option for a woman who wants to use it for long term.
- If she decides to use an IUD after taking ECPs, then IUD can be inserted on the same day she takes ECP (no need of backup method).

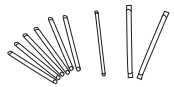
Source: *Training Resource Package for Family Planning* (USAID, WHO, UNFPA). ECP presentation for pharmacist, 2011, https://www.fptraining.org. Family Planning Global Handbook for Providers, revised 2011

Job Aid 1-1: Comparing Effectiveness of Family Planning Methods

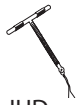
Comparing Effectiveness of Family Planning Methods

More effective

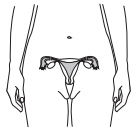
Less than 1 pregnancy per 100 women in 1 year



Implants

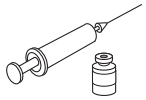


IUD



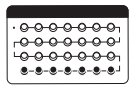
Female sterilization

Vasectomy



Injectables

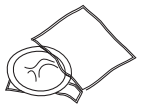
LAM



Pills

Patch

Vaginal ring



Male condoms

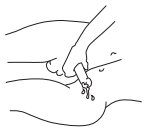
Diaphragm

Female condoms

Fertility awareness methods

Less effective

About 30 pregnancies per 100 women in 1 year



Withdrawal

Spermicides

How to make your method more effective

Implants, IUD, female sterilization: After procedure, little or nothing to do or remember

Vasectomy: Use another method for first 3 months

Injectables: Get repeat injections on time

Lactational amenorrhea method, LAM (for 6 months): Breastfeed often, day and night

Pills: Take a pill each day

Patch, ring: Keep in place, change on time

Condoms, diaphragm: Use correctly every time you have sex

Fertility awareness methods: Abstain or use condoms on fertile days. Newest methods (Standard Days Method and TwoDay Method) may be easier to use.

Withdrawal, spermicides: Use correctly every time you have sex

USAID FROM THE AMERICAN PEOPLE

World Health Organization

Sources:

Steiner MJ, Trussell J, Mehta N, Condon S, Subramaniam S, Bourne D. Communicating contraceptive effectiveness: a randomized controlled trial to inform a World Health Organization family planning handbook. *Am J Obstet Gynecol* 2006;195:85–91.

World Health Organization Department of Reproductive Health and Research (WHO/RHR), Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). *Family Planning: A Global Handbook for Providers*. Baltimore, MD and Geneva: CCP and WHO, 2007.

Trussell J. Choosing a contraceptive: efficacy, safety, and personal considerations. In: Hatcher RA, Trussell J, Stewart F, Nelson AL, Cates W Jr., Guest F, Kowal D, eds. *Contraceptive Technology, Nineteenth Revised Edition*. New York: Ardent Media, Inc., in press.

2007

Job Aid 1-2: WHO MEC Quick Reference Chart

2016 WHO Medical Eligibility Criteria for Contraceptive Use: Quick Reference Chart for Category 3 and 4

to initiate or continue use of combined oral contraceptives (COCs), depot-medroxyprogesterone acetate (DMPA), progestin-only implants, copper intrauterine device (Cu-IUD), levonorgestral intrauterine system (LNG-IUS)

CONDITION	Sub-condition	COC	DMPA	Implants	Cu-IUD	LNG-IUS
Pregnancy		NA	NA	NA		
Breastfeeding	Less than 6 weeks postpartum				See i.	See i.
	6 weeks to < 6 months postpartum					
	6 months postpartum or more					
Postpartum not breastfeeding VTE = venous thromboembolism	< 21days				See i.	See i.
	< 21days with other risk factors for VTE*					
	≥ 21 to 42 days with other risk factors for VTE*					
Postpartum timing of insertion	≥ 48 hours to less than 4 weeks	See i.	See i.	See i.		
	Puerperal sepsis					
Postabortion (immediate post-septic)						
Smoking	Age ≥ 35 years, < 15 cigarettes/day					
	Age ≥ 35 years, ≥ 15 cigarettes/day					
Multiple risk factors for cardiovascular disease						
Hypertension BP = blood pressure	History of (where BP cannot be evaluated)					
	BP is controlled and can be evaluated					
	Elevated BP (systolic 140-159 or diastolic 90-99)					
	Elevated BP (systolic ≥ 160 or diastolic ≥ 100)					
	Vascular disease					
Deep venous thrombosis (DVT) and pulmonary embolism (PE)	History of DVT/PE					
	Acute DVT/PE					
	DVT/PE, established on anticoagulant therapy					
	Major surgery with prolonged immobilization					
Known thrombogenic mutations						
Ischemic heart disease (current or history of)				I C		I C
Stroke (history of)				I C		
Complicated valvular heart disease						
Systemic lupus erythematosus	Positive or unknown antiphospholipid antibodies					
	Severe thrombocytopenia		I C		I C	

CONDITION	Sub-condition	COC	DMPA	Implants	Cu-IUD	LNG-IUS
Headaches	Migraine without aura (age < 35 years)	I C				
	Migraine without aura (age ≥ 35 years)	I C				
	Migraines with aura (at any age)		I C	I C		I C
Unexplained vaginal bleeding (prior to evaluation)					I C	I C
Gestational trophoblastic disease	Regressing or undetectable β-hCG levels					
	Persistently elevated β-hCG levels or malignant disease					
Cancers	Cervical (awaiting treatment)				I C	I C
	Endometrial				I C	I C
	Ovarian				I C	I C
Breast disease	Current cancer					
	Past w/ no evidence of current disease for 5 yrs					
Uterine distortion (due to fibroids or anatomical abnormalities)						
STIs/PID	Current purulent cervicitis, chlamydia, gonorrhea				I C	I C
	Current pelvic inflammatory disease (PID)				I C	I C
	Very high individual risk of exposure to STIs				I C	I C
Pelvic tuberculosis					I C	I C
Diabetes	Nephropathy/retinopathy/neuropathy					
	Diabetes for > 20 years					
Symptomatic gall bladder disease (current or medically treated)						
Cholestasis (history of related to oral contraceptives)						
Hepatitis (acute or flare)		I C				
Cirrhosis (severe)						
Liver tumors (hepatocellular adenoma and malignant hepatoma)						
AIDS	No antiretroviral (ARV) therapy	See ii.	See ii.	See ii.	I C	I C
	Not improved on ARV therapy				I C	I C
Drug interactions	Rifampicin or rifabutin					
	Anticonvulsant therapy **					

Source: Adapted from *Medical Eligibility Criteria for Contraceptive Use, 5th Edition*. Geneva: World Health Organization, 2015. Available: http://www.who.int/reproductivehealth/publications/family_planning/en/index.html

This chart shows a complete list of all conditions classified by WHO as Category 3 and 4. Characteristics, conditions, and/or timing that are Category 1 or 2 for all methods are not included in this chart (e.g., menarche to < 18 years, being nulliparous, obesity, high risk of HIV or HIV-infected, < 48 hours and more than 4 weeks postpartum).

- **Category 1** There are no restrictions for use.
- **Category 2** Generally use; some follow-up may be needed.
- **Category 3** Usually not recommended; clinical judgment and continuing access to clinical services are required for use.
- **Category 4** The method should not be used.

I/C Initiation/Continuation: A woman may fall into either one category or another, depending on whether she is initiating or continuing to use a method. Where I/C is not marked, the category is the same for initiation and continuation.

NA Not Applicable: Women who are pregnant do not require contraception. If these methods are accidentally initiated, no harm will result.

i The condition, characteristic and/or timing is not applicable for determining eligibility for the method.

ii Women who use methods other than IUDs can use them regardless of HIV/AIDS-related illness or use of ART.

* Other risk factors for VTE include: previous VTE, thrombophilia, immobility, transfusion at delivery, BMI > 30 kg/m2, postpartum hemorrhage, immediately post-caesarean delivery, pre-eclampsia, and smoking.

** Anticonvulsants include: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine, and lamotrigine. Lamotrigine is a category 1 for implants.

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Job Aid 1-3: Opportunities for Postpartum Family Planning (Poster)

Pathway of Opportunities for Postpartum Women to Adopt Family Planning

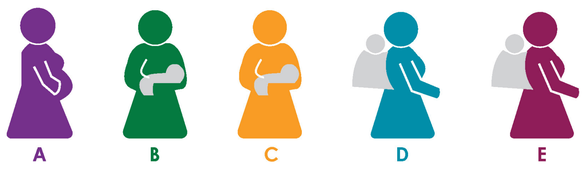
Postpartum Family Planning

Purpose of This Tool

Postpartum Family Planning (PPFP) is a service delivery strategy that expands access to family planning through integration within the existing continuum of maternal, newborn and child health services, resulting in important health benefits by ensuring healthy timing and spacing of pregnancies and the fulfillment of desired family size.

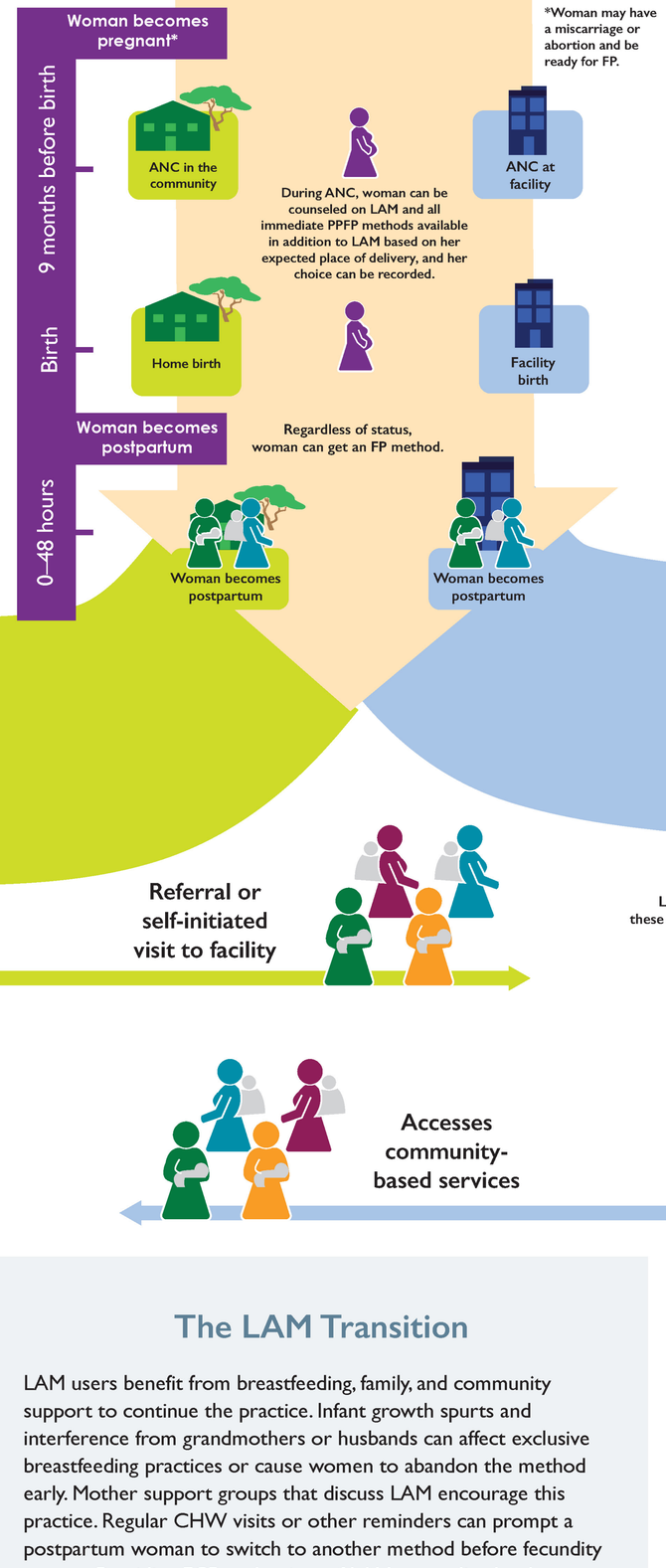
The timing around childbirth and the first two years postpartum (the "extended postpartum period") offers multiple opportunities to deliver family planning services to postpartum women by leveraging their contacts with the health system. This resource demonstrates those opportunities, beginning during antenatal care and continuing through the extended postpartum period. It identifies the types of clients in need of services and the methods available in different settings, scheduled alongside the typical health system contacts that a postpartum woman might experience in her community or at a health facility. Altogether, it serves as a guide for decision-makers in both family planning and maternal and child health sectors to the pathway of opportunities for postpartum women to adopt family planning.

Legend: Types of Postpartum Women

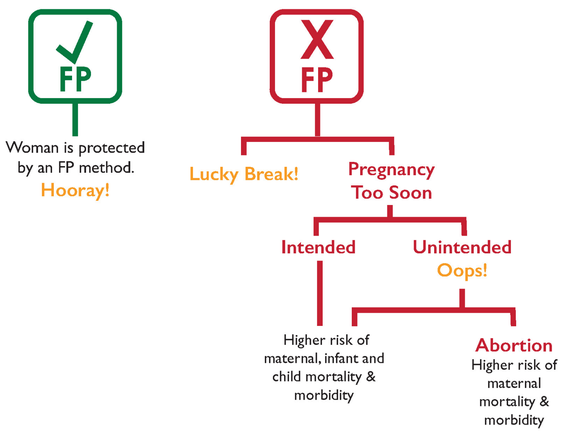


A: Pregnant woman
B: Exclusively breastfeeding with no menses (woman is not at risk of pregnancy)
C: Exclusively breastfeeding and menses have returned
D: Partial or no breastfeeding with no menses
E: Partial or no breastfeeding and menses have returned

The timing of return to sexual activity sometimes occurs soon after birth, even where cultural practices suggest or assume a delay. For this reason, it should be assumed that all postpartum women, even early postpartum women, are potentially at risk of pregnancy in the postpartum period.



Legend: Health Outcomes for Postpartum Women



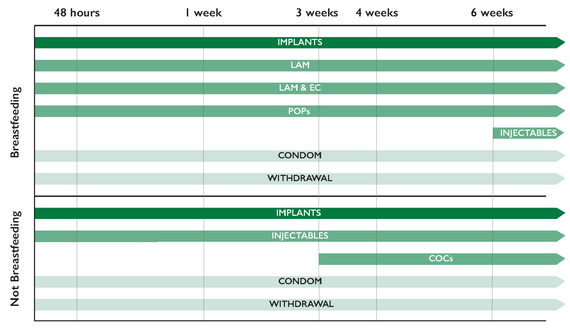
The LAM Transition

LAM users benefit from breastfeeding, family, and community support to continue the practice. Infant growth spurts and interference from grandmothers or husbands can affect exclusive breastfeeding practices or cause women to abandon the method early. Mother support groups that discuss LAM encourage this practice. Regular CHW visits or other reminders can prompt a postpartum woman to switch to another method before fecundity returns. Providing ECP at the time of LAM counseling has been shown to increase timely transition to another method. Also, integrated or linked FP and immunization services can serve as cues to transition from LAM.

Adoption of an FP method requires that the method be:

1. **Offered** by a provider or requested by the client at the point of contact;
2. **Available** at the point of contact on the day of service; and
3. **Appropriate** for the client's medical conditions.

Immediate Postpartum Options: Community



COCs should not be initiated by breastfeeding women until at least 6 months postpartum. In addition, fertility awareness methods, such as Standard Days Method (CycleBeads), require women to chart 4 regular menstrual cycles before beginning this method, so timing varies from one woman to the next.

Acronyms

ANC	antenatal care
CHW	community health worker
COC	combined oral contraceptive
DPT	diphtheria, pertussis and tetanus
ECP	emergency contraception pills
FP	family planning
IUD	intrauterine device
LAM	Lactational Amenorrhea Method
POPs	progestin-only pills
PPFP	postpartum family planning

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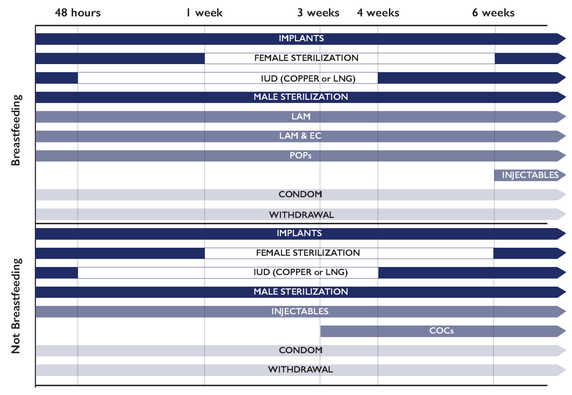
Immediate Postpartum Options: Facility



COCs should not be initiated by breastfeeding women until at least 6 months postpartum. In addition, fertility awareness methods, such as Standard Days Method (CycleBeads), require women to chart 4 regular menstrual cycles before beginning this method, so timing varies from one woman to the next.

Job Aid 1-4: How Contraception Works

How Contraception Works

Texas Women's Healthcare Coalition

Prevents Fertilization
of the Egg by the Sperm

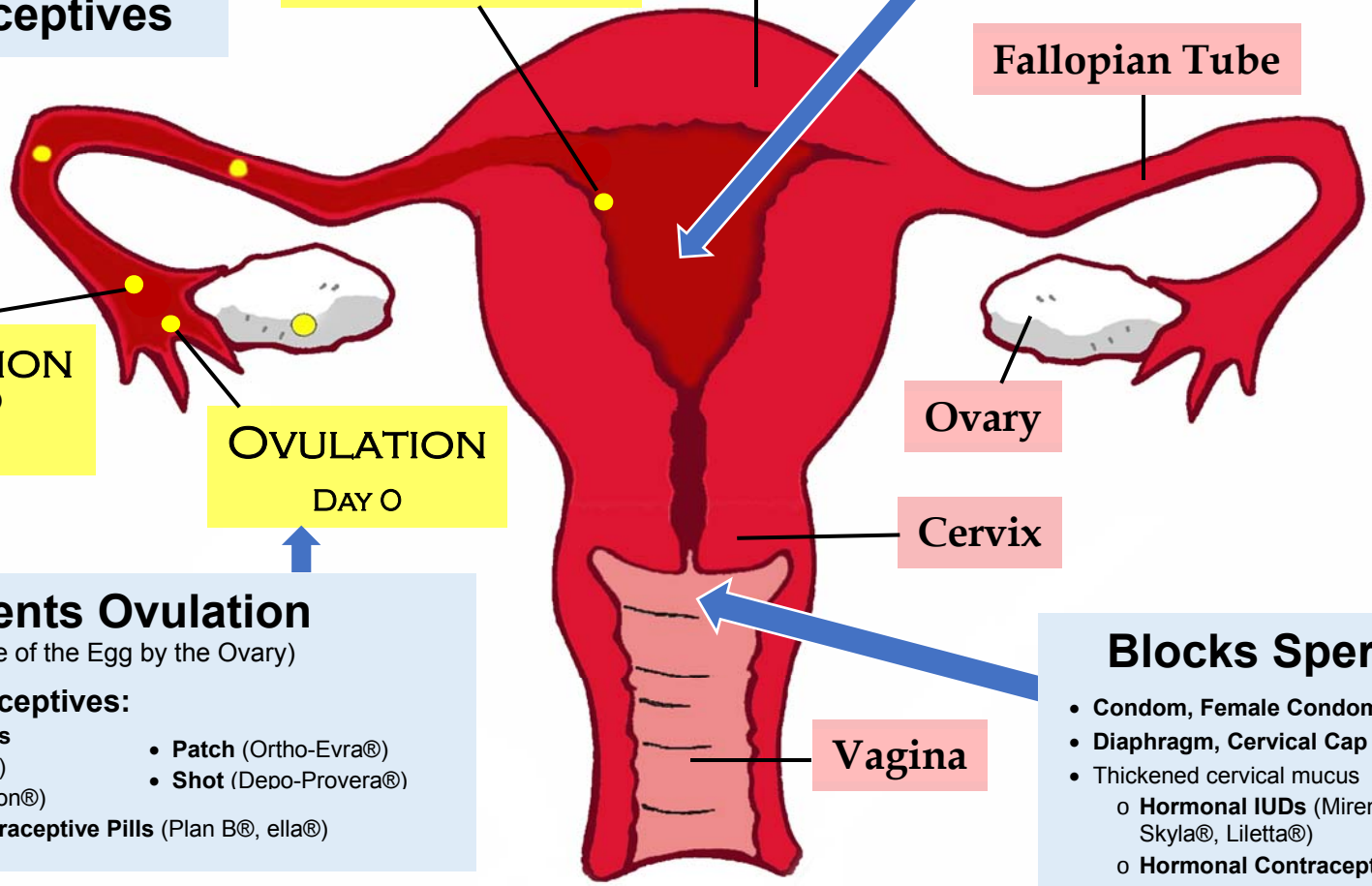
All Contraceptives

Implantation
Day 7

Uterus

Incapacitates Sperm
Primary action of **Copper IUD** ParaGard®)

Fallopian Tube



Fertilization
(Conception)
Day 0 -1

Ovulation
Day 0

Ovary

Cervix

Vagina

Prevents Ovulation
(Release of the Egg by the Ovary)

Hormonal Contraceptives:

- **Birth Control Pills**
- **Ring** (NuvaRing®)
- **Implant** (Nexplanon®)
- **Patch** (Ortho-Evra®)
- **Shot** (Depo-Provera®)
- **Emergency Contraceptive Pills** (Plan B®, ella®)

Blocks Sperm

- **Condom, Female Condom**
- **Diaphragm, Cervical Cap**
- Thickened cervical mucus
  - **Hormonal IUDs** (Mirena®, Skyla®, Liletta®)
  - **Hormonal Contraceptives**

Copper Intrauterine Device (IUD) (ParaGard®) works primarily by **preventing fertilization**, but can prevent implantation of a fertilized egg, e.g., if used as emergency (postcoital) contraception

Healthy Futures of Texas