

MANAGEMENT of Common Contraceptive Problems

A Problem Solving Reference
Manual for Service Providers in Africa



Pathfinder International

Pathfinder International improves access to and use of quality family planning and reproductive health information and services, including STD and HIV/AIDS prevention, and postpartum and post-abortion care, with a focus on adolescents and young adults. Working with local organizations on three continents, Pathfinder builds their capacity to advocate for and to provide quality services.

A nonprofit, non-government organization established in 1957, Pathfinder International has a multinational Board of Directors; its Boston headquarters supports a global network of regional and country offices. The sub-Saharan Africa Regional Office operates out of Nairobi, Kenya, to serve projects and programs throughout the subregion.

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Management of Common Contraceptive Problems: A Problem Solving Reference Manual for Service Providers in Africa

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LIST OF ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
BBT	Basal body temperature
BID	Twice a day
BP	Blood pressure
BTB	Break-through bleeding
CBS	Community-based service
CBSA	Community-based service agent
CIC	Combined injectable contraceptive
CMM	Cervical mucus method
COCs	Combined oral contraceptives
CS	Child spacing
DMPA	Depot medroxy progesterone acetate (Depo-Provera)
CPR	Contraceptive prevalence rate
ECP	Emergency contraception pill
EE	Ethinyl estradiol
FP	Family planning
HIV	Human immunodeficiency virus
IEC	Information, education, and communication
IPPF	International Planned Parenthood Federation
IUCD	Intrauterine contraceptive device
IUD	Intrauterine device
LH	Leuteinizing hormone
LMP	Last menstrual period
Net-EN	Norethisterone enanthate (or norethindrone)
NFP	Natural family planning
NSAID	Non-steroidal anti-inflammatory drugs
OC	Oral contraceptive
Pap smear	Papanicolaou cervical smear
PID	Pelvic inflammatory disease
POP	Progestin-only pill
PRN	As needed
RTI	Reproductive tract infection
SSA	Sub-Saharan Africa
STD	Sexually transmitted disease
TSS	Toxic shock syndrome
UTI	Urinary tract infection
VSC	Voluntary surgical contraception
WBC	White blood cells

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INTRODUCTION

In some ways the 1990s were the best of times for family planning programs in Africa south of the Sahara. After decades of information, education, communication (IEC), and service delivery, the gap between the knowledge of family planning and the use of contraceptives started to narrow, as evidenced by a modest increase in contraceptive prevalence rates (CPR). However, several studies have shown that ever-use rates among married women of reproductive age remain high compared with current user rates.

Although there has been increase in access to and use of contraceptives, quality of care (QOC) for FP/RH clients has remained a great concern to FP/RH managers, providers, and clients. Concerns have been expressed about, among others, the quality of provider/client interaction, provider competence, client choice of contraceptives, and quality of management of contraceptive problems when they occur, as well client continuation rates.

Assessments of QOC in various programs in Africa have shown that FP service providers do not have standardized procedures for managing contraceptive side effects and other contraceptive related problems. This has led to confusion and deficiencies in the management of such side effects. Dropouts often result, as clients become concerned and hence discontinue FP services.

Thus, as we enter the 21st century—with clients increasingly demanding quality service and aware of their rights in the face of limited resources—programs have to focus on total quality management by meeting clients' expectations of quality and safety at minimum cost.

This handbook focuses on the care and safety of clients and on reducing the negative impact contraceptive side effects and problems have on FP programs. The purpose of the book is to improve the technical capacity of service providers to manage contraceptive side effects and provide information to family planning users.

The material is based on current international standards and is consistent with Pathfinder International's *Comprehensive Reproductive Health and Family Planning Training Curriculum* and standard resources on service provision, including *The Essentials of Contraceptive Technology*, among others.

The book also addresses the client's rights of choice, safety, and correct information, as well as the service provider's need for information and clear, relevant, objective guidance on managing contraceptive related problems.

It is Pathfinder's intention that the publication of the handbook should be only the beginning of a dynamic process. We intend to distribute the book as widely as resources allow. And we ask service providers to keep us advised of their experience in using the book. Is it understandable? User-friendly? Is it on the desk within easy reach because it's indispensable? Or on a shelf somewhere because it's not really that appropriate? What changes should we make in future editions? Your advice, as a user, would be most appreciated. Please send your comments and suggestions to:

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HOW TO USE THIS BOOK

This book is a how-to-book for family planning and reproductive health care providers who work in clinics and other health care facilities. It contains practical information about contraceptive side effects and other problems, how to help the client cope with them, how to manage them, and thus how to improve care of clients and their continuation of contraceptive use.

You can use this book:

- To look up information in order to counsel your client on possible side effects resulting from contraceptive use.
- To look up information in order to help your client come to terms with the common side effects.
- To look up information to assist you in managing your client's side effects.
- For background information and study on your own.

Carry it with you and consult it often!

Audience for the Book

Many different types of people can use this book to help clients come to terms with common contraceptive side effects and continue using their preferred family planning methods. Please share it with clients, volunteers, and other health care providers.

The book is intended to empower service providers in the service delivery room—nurses, doctors, assistant medical officers, and clinical officers—to diagnose and manage the problems and side effects of contraceptive methods. It will also assist the service managers to inform clients about those side effects and to help clients cope with the side effects when they occur.

The book will also be helpful to reproductive health trainers and service delivery supervisors. It is written in simple, clear language in order to extend its readership to literate clients and field workers, for example, community-based service agents (CBSA). The intent is to improve the management of contraceptive side effects and address client concerns, thereby enhancing quality of care and contributing to client satisfaction and continuation.

How To Find Information in This Book

Finding the right chapter. There are nine chapters in this book; each chapter corresponds to a major group of family planning methods. The contraceptive methods are listed in the table of contents.

Finding information in the chapter. All chapters have a brief introduction describing how the method works and its effectiveness. The common problems or side effects of the methods

are listed alphabetically and marked with a “sad face” to make it easier to find them. The most common problems are highlighted by two stars (**).

Each side effect or problem contains information under two subheadings:

- FINDING OUT THE POSSIBLE CAUSE
- HOW TO MANAGE

For example: A client comes to you with specific complaint of “Y.” You determine that she is using POPs (progestin-only pills). You then turn to the chapter on POPs and quickly go down the list of PROBLEMS/CONCERNS until you get problem/concern “Y.” In the category of “Y” there will be subheadings on POSSIBLE CAUSE and HOW TO MANAGE. Sometimes the advice on cause and how to manage is the same for other concerns associated with other methods. In these cases you will be referred to a similar concern in another chapter.

Using the annexes. Besides the bibliography, which contains a wide range of reference material, the handbook contains two annexes that provide useful details for service providers. Annex A presents the WHO Medical Eligibility Criteria for Starting Contraceptive Methods. The criteria are intended to guide service providers in prescribing the appropriate family planning method for a particular client. Annex B guides the service provider in determining that a woman is not likely to be pregnant, given her answers to a specific set of questions. Both annexes are from Hatcher et al., 1997.

The Role of Community-Based Service Agents

Most problems/concerns included in this handbook can be managed by a community-based service agent (CBSA) except where a clinical examination or a referral is necessary. In the interests of continuity of care from the clinic to primary level within the community, some sections indicate what CBSAs can do for the client. Where the possible cause can be investigated by the CBSA or the whole management can be handled by the CBSA, the designation “CBS” has been put after the subheading. Where the CBS agent can only handle part of the management, the designation “CBS” has been put at the end of the paragraph or sentence.

The assumption is that CBSAs have been well trained and receive active support from clinical staff. While it is recognized that not all CBSAs will be able to carry out all the functions indicated, with appropriate training more CBSAs can fit into the continuity of care network more effectively. The idea is to help clinical service providers recognize areas that can generally be managed by CBS agents at village level. In a program with a well-established referral system, with referral forms from the clinic to the CBS agent, instructions can be written on the referral form in a language the CBSA can understand.

Definitions Commonly Used in Describing Contraceptive Side Effects

Bleeding: Any bleeding from the vagina requiring use of sanitary protection (pads, cotton wool, cloths, tampons). This includes moderate, heavy, and prolonged bleeding. In this context “bleeding” refers only to bleeding from the vagina and not to other types of bleeding, e.g., wounds.

Spotting or light bleeding:	Lighter than regular menstruation; minimal pink, brown, or red. Requires no sanitary protection. Is not harmful even if it persists for several weeks.
Moderate bleeding:	Equivalent to a menstrual period, except longer in duration. May last up to twice as long as normal menstruation.
Heavy bleeding:	Greater than regular menstruation for more than 8 days.
Prolonged bleeding:	More than 8 days duration.
Normal side effects:	Symptoms attributed to the contraceptive method that do not require medical intervention for safety, but may require attention and possible intervention to ensure client satisfaction.
Complications:	Problems directly related to the contraceptive method that require medical intervention and management.

1. ORAL HORMONAL CONTRACEPTIVES

LOW-DOSE COMBINED ORAL CONTRACEPTIVES

What they are and how they work

Common problems/concerns

- Acne
- Amenorrhea
- Appetite, loss of
- Bleeding between monthly periods
- Bleeding, scanty
- Bloating, abdominal
- Breast fullness or tenderness
- Chloasma
- Depression
- Dizziness
- Headache, mild
- Headache, severe
- High blood pressure
- Libido, loss of
- Missed pills
- Nausea
- Vomiting
- Weight gain
- Weight loss

PROGESTIN-ONLY ORAL CONTRACEPTIVES (POPS)

What they are and how they work

Common problems/concerns

- Acne
- Amenorrhea
- Bleeding between monthly periods
- Bleeding, heavy
- Bleeding, moderate/prolonged, during the first few months of use for non-breastfeeding women
- Depression and decreased libido
- Dizziness/Nausea
- Ectopic pregnancy
- Enlarged persistent ovarian follicles
- Hair growth, excessive, or hair loss
- Headache
- High blood pressure
- Jaundice
- Missed pills
- Weight gain

1.

ORAL HORMONAL CONTRACEPTIVES

LOW-DOSE COMBINED ORAL CONTRACEPTIVES

What They Are and How they Work

Combined oral contraceptives (COCs/OCs) are pills containing synthetic estrogen and progesterone (progestins) similar to natural hormones in a woman's body. These are the contraceptives commonly referred to as "The Pill." The pills are taken daily to prevent pregnancy.

Today the doses of hormones in combined oral contraceptives are generally lower and safer than the 150mcg of ethinyl estradiol (EE) common in the 1960s. The occurrence of side effects seen earlier has also drastically decreased.

High-dose combined oral contraceptives are now defined as those containing 50mcg or more of ethinyl estradiol.

The low-dose combined oral contraceptives contain less than 50mcg of EE or other estrogen (such as mestranol) with equivalent strength. The most common available COCs in sub-Saharan Africa contain 30 to 35mcg of estrogen. Some common brand names are Microgynon, Lo-Femenal, Nordette, Marvelon, Logynon, and Trinordial.

Pills come in packets of 21 or 28. In the 28-pill packet the first 21 are active pills (they contain hormones) and the remaining 7 contain iron or are spacing pills.

The low-dose pill comes in three types:

- **Monophasic:** Each active pill contains the same amount of estrogen and progestin. Examples are Microgynon, Lo-Femenal, Nordette, Marvelon.
- **Biphasic:** The active pills in the packet (one cycle) contain 2 different combinations of estrogen and progestin in 2 phases. (Out of a cycle of 21 active pills, 10 pills may contain one combination while 11 pills contain another.) Examples are Anteovin, Biphasil, Ovanon, and Normovlar.
- **Triphasic:** The active pills contain 3 different combinations of estrogen and progestin. (Out of a cycle of 21 active pills, 6 may contain one combination, 5 another combination, while 10 pills contain other combinations of the same 2 hormones.) Examples are Logynon and Trinordial.

In general, biphasic and triphasic pills have little or no advantage over monophasic pills.

COCs prevent pregnancy by:

- Suppressing ovulation.
- Thickening the cervical mucus, thereby preventing sperm penetration.
- Changing the endometrial lining, making implantation less likely.
- Reducing sperm transport in the Fallopian tubes.

COCs are highly effective. The pregnancy rate is about 8% in the first year for typical users. The rate can be much lower—less than 1%—with correct and consistent use or much higher than 8% with less than typical consistency and correctness of use.

Common Problems/Concerns

A woman on low-dose combined oral contraceptives may return to the clinic with multiple concerns. These concerns may or may not relate to contraceptive use, but all are important to her and require your attention, counseling, and management. Thorough detailed counseling is very important before starting the method since almost half of clients stop using the method within the first year because of side effects.

Inform the client before starting COCs of the common side effects and how she can deal with them. These include: nausea, breast tenderness, headaches, spotting and breakthrough bleeding, and slight weight change. This will help the client recognize and cope with common minor side effects and help ensure continued use. If the client complains of any of the common side effects do not dismiss her concerns or worries. Reassure her and urge her to continue taking the COC each day. If she is not satisfied after counseling, help her choose another method.



Acne

Finding out possible cause (CBS)

COCs generally improve acne, although some progestins are slightly androgenic and can contribute to acne. Ask which COC she is taking.

Take history to find out about her personal hygiene and how often she cleans her face. Find out if she had acne before starting use of contraceptives or whether it developed after. Also ascertain if she has

changed the cosmetics she had been using, especially to heavy creams, or whether she has undergone any drug treatment.

How to manage (CBS)

If acne is related to COCs, advise client to use a different pill. COCs with low androgen progestin, norethisterone, ethynodiol diacetate, or, if available, one of the newer progestins, norgestimate or desogestrel, may be a good option. If low androgen COCs are not available, try an increase in estrogen dose (to a maximum of 50mcg) or try progestin-only pills (because the dose of progestin is so low).

Counsel and let her know that pills in most instances do not induce acne. Advise to:

- Clean her face twice a day using medicated soap or an astringent like lemon.
- Avoid using heavy facial creams and attempt to limit to one brand.

If she is not comfortable and there is no change after these measures, advise and help the client take an alternative non-hormonal method of her own choice.



**Amenorrhea (No bleeding or spotting at all for several months)

Finding out possible cause (CBS)

Find out if she has seen any sign of bleeding however little, including a stain on her underclothing.

Enquire and confirm that she has been taking active COCs every day. Is she taking the COCs correctly? If she was on a packet of 21 pills, did she start on the next packet without a rest period? Find out if she might have missed 2 or more active pills in a row.

Rule out pregnancy by finding out if she has any of the following: nausea, vomiting, breast fullness/tenderness, and loss of appetite, dizziness, weight change, mood

change or frequent urination or constant fatigue, mild headache, or chloasma. Find out if she has had vaginal sex since her last menstrual period. (CBS) (Refer to Annex B, How To Tell That a Woman Is Not Pregnant.)

If screening is likely to improve client satisfaction, do a complete physical and pelvic (including speculum) examination to find out if there is enlargement of breasts, cervical softening, uterine softening and enlargement, and change of cervical color to dusky blue. If still not sure whether she is pregnant, do a pregnancy test if available.

How to manage (CBS)

If she has been taking the pills correctly, reassure her that she is unlikely to be pregnant and that she should start taking the next packet of COCs on time. If not sure whether pregnant, advise to stop taking the COCs and change method to condoms and/or spermicides until either her next period comes or pregnancy is confirmed. (CBS)

If she is not pregnant but has recently stopped taking oral contraceptives, advise that her periods may take a few months to return. If she does not intend to conceive let her use barrier methods until her menses resume. Then she may start COCs again. (CBS)

If she is not pregnant but had irregular periods before using low-dose combined oral contraceptives, reassure her and let her know that her period may become irregular again when she stops use of COCs.

If client is pregnant, refer according to her preference. Advise her to stop taking COCs if she intends to continue with pregnancy.



Appetite, loss of

Finding out possible cause (CBS)

Enquire when the client started on the pill and how she has been taking it (see *nausea*, page 7).

How to manage (CBS)

Advise the client to take small meals at regular intervals. Let her eat foods of her liking and avoid constipation by taking plenty of fluids, fruits, and vegetables. Encourage her to come back for help in case loss of appetite gets worse, or if she loses significant weight or has any other problem.



Bleeding between monthly periods (spotting or breakthrough bleeding) or light but prolonged bleeding

Finding out possible cause (CBS)

Take history to ascertain whether she has missed taking active pills, whether she has had vomiting or diarrhea, or whether she has been on treatment with medicines for seizures.

How to manage (CBS)

Counsel and reassure client. Let her know that:

- It is not a sign of serious sickness.
- Missing pills can cause bleeding between periods; she should take pills at the same time every day.
- Vomiting and diarrhea may also cause bleeding between periods because of reduced absorption of the hormones, leading to reduced hormone levels in the blood.
- Anti-epileptic medication and rifampicin reduce effectiveness of the pills. Advise the client to use any barrier method of her own choice for backup if she is taking any of the anti-epileptics or rifampicin.

Let her know that she may require a higher dose COC, or help her change her method.



****Bleeding, scanty (reduced menstrual flow)**

Finding out possible cause (CBS)

Enquire about her menstrual history and COC use as in *amenorrhea* (see page 4).

How to manage

Counsel the client and let her know that (CBS):

- Menstrual bleeding is normally reduced when using COC.
- Low-dose combined oral contraceptives have no negative effect on hemoglobin and in most instances help prevent iron-deficiency anemia.
- A few clients do miss their menses; this is normal. Reduced menstrual flow is common and is not usually a sign of pregnancy.
- She should start taking the next packet of pills on time.

If she was on a packet of 21 pills, started on the next packet on schedule, and has been taking COCs correctly and consistently for the past 2 months, reassure her that she is not likely to be pregnant.



Bloating, abdominal

Finding out possible cause

Rule out constipation, pregnancy (see Annex B), and tumor.

How to manage

If not pregnant and no other cause is found, reassure the client. Instruct on diet with plenty of roughage and fluids, and request her to reduce the amount of starchy foods she eats.

If client is very uncomfortable and constipated, give laxatives such as milk of magnesium. If a tumor is found, refer for further investigation and management.



****Breast fullness or tenderness**

Finding out possible cause

Determine as for *nausea*, page 9. Enquire when the client started on COC and how she has been taking it. (CBS)

How to manage

If the cause of breast fullness or tenderness is not clear, rule out pregnancy (see Annex B).

If related to particular phase of the cycle, reduce estrogen dose to lowest level or change to progestin-only brand.

If not pregnant or not sure whether pregnant, advise to keep using her contraceptive method if she can until either her next period comes or pregnancy is confirmed.

If pregnant, find out her current fertility preference and refer to appropriate clinic for further services. Advise to discontinue contraceptive use.

Encourage the client to come back for assistance in case she cannot tolerate the breast fullness/tenderness or has any other problem. Inform the client that she is free to switch to any other method of her own choice any time she wishes. (CBS)

If breastfeeding, COCs may be used at 6 months or more after delivery even though they are not the first choice for any breastfeeding woman. Advise the client to wear a well fitting bra (for symptomatic relief). Advise to continue breastfeeding and to use warm compresses, if appropriate.

Some women have benefited from decreasing their intake of coffee, tea, chocolate, and soft drinks. Vitamin E, 400 to 600iu at 2 per day, has also been shown to relieve the symptoms of fibrocystic breast tenderness. (CBS)

Inform the client that she is free to switch to any other method any time she wishes. (CBS)



Chloasma (mask of pregnancy—a symmetrical dark area across nose and cheeks)

Finding out possible cause (CBS)

Take history of recent pregnancy. Ask about the use of skin lightening creams, including specific brands (some contain mercury) and recent sunburns. Rule out tinea versicolor or other skin disease.

How to manage (CBS)

If recently pregnant counsel and advise the client to be patient for at least 3 months to assess the improvement.

If sunburned, advise to avoid sun and to wear a hat when she is outdoors. If related to cream, advise to stop use of current cream. If no cause is found, and the client thinks it is related to COCs and she cannot tolerate the changes, advise and help her switch to a non-hormonal method of her own choice.



Depression (mood change)

Finding out possible cause

Take history and explore psychosocial problems, abuse, or stress that the client may be going through. If no other cause is found, explore if she had the problem before starting contraceptive use. If so, is it worse now? Does she think the contraceptives caused the problem or made it worse?

How to manage

Counsel, reassure, and inform the client that it may be a temporary situation not related to the contraceptive method. Help the couple overcome their psychosocial differences, if any. If client thinks COCs have made the depression worse, advise to switch to another method of her own choice among the non-hormonal contraceptives, but schedule next visits for close counseling and monitoring.

If depression is due to alcoholism or drug abuse, refer to a drug counseling service or psychiatrist for management.



Dizziness

Finding out possible cause (CBS)

Enquire when the client started on COC and how she has been taking it.

How to manage (CBS)

Manage like *nausea* (see page 9).



Headache, mild

Finding out possible cause (CBS)

Take history to establish the nature and type of headache, when it occurs, part of the head most affected, severity of the headache, whether relieved by analgesics or if persistent the whole day. Ask the client's drinking and eating habits.

How to manage (CBS)

Counsel and reassure the client that it is not a sign of serious sickness, especially when the headache occurs in the morning and mostly on the frontal part of the head. Let her know that it usually becomes less severe or stops within 3 months of starting COC use.

Advise to keep taking the pills and explain that skipping pills may result in pregnancy, which may make the headaches more severe. (CBS)

Advise her to take 1 to 2 (500–1000mg) paracetamol tablets 3 times per day (every 8 hours) for 5 days or one ibuprofen 400mg 3 times per day for 5 days, or 1–2 aspirin 400–800mg on full stomach 3 times per day for 5 days. (Aspirin is not recommended for bleeding disorders or those with bleeding tendencies.)

If headaches are related to hunger pangs, counsel the client in relation to perceived cause of the headache. If headache is not

related to pills, manage as per the specific cause. If the headache occurs during a particular time of the day, advise the client to take analgesic tablets when necessary.

If the headache is continuous throughout the day, advise the client to take analgesic (see dose above). Consider lowering the dose of estrogen or progestin. Advise the client that the headache may or may not have been caused by pills. Advise the client to keep taking pills. If she is not happy, help her choose a non-hormonal method.



Headache, severe

Finding out possible cause

Establish the nature and type of headache, when it occurs, part of the head most affected, severity of the headache, whether relieved by analgesics or if persistent the whole day.

Try to differentiate between tension headaches (muscle contraction) and migraine (vascular headaches). Tension headaches are usually bilateral, pressure like, or dull in nature. They affect the frontal part or base of the head and may be associated with sore neck muscles. Migraine headaches are throbbing in nature and in most instances affect the temporal areas (sides of the head, especially around the upper edge of the ear). They may be preceded by warning signs of speech or memory problems, vision changes (such as flashing lights, double vision, or loss of vision), or numbness, tingling, or weakness in arms or legs.

Though complete physical examination may generally not be necessary, it may make the client be more assured that all is well. Do physical examination; check the blood pressure, and find out the client's drinking and eating habits and whether the headache has any relationship to hunger pangs.

Check nostrils for signs of infection, including purulent nasal discharge and tenderness in sinus area.

How to manage

Counsel the client in relation to perceived cause of the headache. If due to sinusitis, refer for treatment and advise to continue taking COCs.

If headache is not related to contraceptive method, manage as per the specific causes or refer appropriately.

If client has **high blood pressure**, manage as advised below.

If headache is migraine in nature, stop the contraceptive method. Help client choose a non-hormonal method. Refer or manage as appropriate.

If headache is worse since the start of COC use, advise the client to change to another method of her own choice, preferably a non-hormonal contraceptive, or you may try a progestin-only method.



High blood pressure

Finding out possible cause

Take history to rule out any underlying conditions, including whether this is the first time she has been found to have high blood pressure. Do complete physical examination including blood pressure to establish that blood pressure really is elevated.

If systolic BP is 160mmHg or over on this visit or 140 to 159mmHg on 2 successive visits, the client has high blood pressure. If diastolic blood pressure is 100mmHg or more on this visit or 90 to 99mmHg on 2 successive visits, the client has high blood pressure.

How to manage

If BP is below 140/90 mmHg, continue COCs.

If blood pressure is 140–159/90–99mmHg, the client may continue COCs, but if pressure is not below 140/90mmHg on subsequent visit, advise the client to change to another method of her own choice including progestin-only contraceptives.

If the blood pressure is 160/100mmHg or higher, advise the client that COCs are not appropriate for her and let her choose another method.

If the blood pressure is more than 160/100mmHg or the client has vascular problems (stroke or kidney disease), advise the client to stop using all hormonal contraceptives and take an alternative method of her own choice. Take blood pressure monthly (or fortnightly) to ensure it returns to normal. Refer the client to a physician for further investigation and management.



Libido, loss of

Finding out possible cause

See the couple together; explore the couple's relationship and any psychosocial problems that they may be going through. Find out from the couple if the problem may be due to dry vagina, painful intercourse, alcoholism, marriage problems, or other underlying problems. Then explore the same issues individually.

How to manage

If no other cause is found, reassure the client. Inform her that it is usually a temporary situation most likely brought about by mood change as a result of the progestin. If loss of libido is severe, advise the couple to change to another non-hormonal method of their own choice to see if libido returns.



**Missed pills

How to manage

If the client has missed one COC, advise her to take it (yesterday's COC) as soon as she remembers. She should also take the next COC at the regular time, even if that means taking 2 COCs in one day, and complete the pack as usual. Backup method is not necessary. (CBS)

If the client has missed 2 or more COCs in a row she should take 2 COCs per day until she is on schedule. She should use a backup method if she has sex during the next 7 days. (CBS)

She should stop taking COCs until 7 days from the onset if she has started bleeding. (CBS) If her menstrual period does not begin within 4–6 weeks (if regular before starting COCs), rule out pregnancy. (See Annex B.)

If pregnant, refer her according to her preference. Advise her to stop taking COCs.

If not pregnant, reassure and let her continue with low-dose COCs.



**Nausea (upset stomach)

Finding out possible cause (CBS)

Occurs most often during the first cycle of birth control pills or during the first few pills of each new package. Enquire if the client was started on contraceptives within the last 3 months.

Find out if the client missed taking a pill and took 2 at the same time to catch up.

If nausea occurs after a problem-free period of pill use, find out if the client is taking the pills correctly (every day, same time).

Assessment for pregnancy is generally not needed unless the woman has missed pills and had no withdrawal bleeding or if the woman thinks she may be pregnant. However, assessment may reassure the client that all is well.

If the cause of nausea is still not clear, client may be pregnant. Rule out uterine or ectopic pregnancy by finding out if client has nausea, vomiting, breast fullness/tenderness, loss of appetite, dizziness, weight change, mood change, frequent urination, mild headache, and chloasma. (Refer to Annex B.)

If client satisfaction can be improved by assessment, do a complete physical and pelvic (including speculum) examination to

find out if there is enlargement of breasts, cervical softening, uterine softening and enlargement, and change of cervical color to dusky blue.

If still not sure whether she is pregnant, do a pregnancy test if available.

Consider other causes of nausea such as flu or other infections.

How to manage

Reassure the client and let her know that (CBS):

- It is usually temporary and is not a sign of serious sickness.
- It usually becomes less or stops within 3 months of starting.

Inform the client that skipping pills:

- May make the side effect worse.
- May lead to method failure and pregnancy.

Advise client to take pill on a full stomach, after meal or with milk, and to take the pills at the same time every day, preferably at bedtime. (CBS)

If pregnant, refer client according to her preference. If she intends to continue with the pregnancy advise to discontinue the pills. Should miscarriage occur, then there is no need to stop the contraceptive method.

If not pregnant or not sure whether pregnant, advise to keep taking the pills if she can until either her next period comes or pregnancy is confirmed. Encourage the client to come back for assistance if she cannot tolerate the side effect or has any other problem. Inform the client that she is free to switch to any other method of her own choice any time she wishes. (CBS)

If no cause is found and if the client attributes it to the method, advise and help the client take another method of her own choice, preferably non-hormonal. Refer for further investigation and management of the other causes.



Vomiting

Finding out possible cause (CBS)

Enquire if the client was started on pills within the last 3 months. Enquire whether the client missed taking a pill and took 2 at the same time to catch up.

How to manage

Reassure and let her know that (CBS):

- It is not a sign of serious sickness.
- It usually becomes less or stops within 3 months of starting.

Inform the client that skipping the pill may make the side effect worse or may lead to method failure and pregnancy.

If vomiting occurs within one hour of taking the pill, advise to take another active pill from a separate packet. (CBS)

If vomiting is severe and continues for more than 24 hours, advise to keep taking her pills if she can and to either use condoms or avoid sex until she has taken a pill each day for 7 days after vomiting has stopped. (CBS)

If vomiting occurs after a problem-free period of pill use, find out if the client is taking the pill correctly (every day, same time). Advise to take pills on a full stomach, after a meal or with milk, at the same time every day, preferably at bedtime. (CBS)

If the cause of vomiting is still not clear, client may be pregnant. Rule out pregnancy. (See Annex B.)

If not pregnant or not sure whether pregnant, advise to keep taking the pills if she can until either her next period comes or pregnancy is confirmed. Encourage the client to come back for assistance if she cannot tolerate the side effect or has any other problem. Inform the client that she is free to switch to any other method of her own choice any time she wishes. (CBS)

If pregnant, find out her current fertility preference and refer to appropriate clinic for further services. If she intends to con-

tinue with the pregnancy, advise her to discontinue the pills.



**Weight gain

Finding out possible cause (CBS)

Approximately as many women lose weight as gain weight when taking COCs. Take weight to establish the magnitude of weight gain from the start of contraceptive use.

How to manage

Counsel the client and let her know that (CBS):

- All hormonal contraceptives may have a slight effect on weight, but the dose of hormones in COCs is very low and should have only a modest effect.
- Weight gain may have been caused by sodium and water retention.
- Weight gain usually lessens or stops within 3 to 6 months after starting contraceptive use.

If weight gain is less than 2kg, reassure her that it is not a health problem. Fluctuation of 1–2kg (2–4lbs) is normal. Establish the client's eating habits.

If weight gain is more than 2kg and appears to be predominantly due to client's increased appetite or nature of food being eaten (CBS), advise the client on non-weight increasing diet and regular exercise. Advise to take less fat and carbohydrate, adequate protein, and plenty of roughage, fruits, and vegetables.

If eating habits are normal and weight gain is excessive, or if the client feels that the weight is unacceptable, advise the client to change to another method of her choice.

If weight gain is more than 2kg and the cause is not clear, rule out pregnancy. If client is pregnant, refer according to her preference. Advise her to stop using the contraceptives if she intends to continue with the pregnancy.



**Weight loss

Finding out possible cause (CBS)

Approximately as many women lose weight as gain weight by taking COCs. This is rarely caused by hormonal contraceptives. Establish the onset of weight loss in relation to the start of contraceptive use. Rule out any possible underlying illness or pathological cause (e.g., HIV/AIDS, TB), including stress. Establish the rate of weight loss by weighing the client and comparing with previous weight in record. Enquire about the client's diet and eating habits.

How to manage (CBS)

Reassure the client and counsel on nutrition. Advise her to take a balanced diet with plenty of fruits. If client has lost appetite, advise to take foods of her liking in small quantities but at regular intervals. Advise to continue with the contraceptive.

Treat the specific cause that has been identified. If eating habits are normal and weight loss is gross and no specific cause can be identified, advise the client to change to a non-hormonal method of her own choice.

PROGESTIN-ONLY ORAL CONTRACEPTIVES (POPS)

What They Are and How They Work

Progestin-only oral contraceptives do not contain estrogens; therefore, they do not cause many of the side effects or concerns more commonly associated with the estrogens in combined oral contraceptives. Progestins do not suppress production of milk in breastfeeding mothers, and have no documented side effects on the baby, which makes the POPS an ideal contraceptive for breastfeeding women.

However, even more significantly than with COCs, POPs must be taken at the same time every day to avoid side effects and pregnancy.

POPs prevent pregnancy by:

- Making the cervical mucus so thick that sperm cannot pass through it.
- Suppressing ovulation in many cycles.
- Making the lining of the uterus too thin for the fertilized egg or embryo to implant in.
- Reducing sperm transport in the Fallopian tubes.

For breastfeeding women, POPs are very effective as commonly used: 1 pregnancy per 100 women in the first year of use. For non-breastfeeding women, POPs are less effective as commonly used since as many as 9–12 pregnancies per 100 women may occur in the first year of use.

Common Problems/Concerns

Thorough detailed counseling is very important before starting this method since almost half of clients stop using it within the first year due to side effects, particularly bleeding irregularities. Inform the client before starting the progestin-only oral contraceptive of the common side effects and how she can deal with them. This will help the client cope with common minor side effects and ensure continued use. If the client complains of any of the common non-harmful side effects, do not dismiss her concerns or worries: reassure her and urge her to continue taking the pill each day.

If she is not satisfied after counseling, help her choose another method.



Acne

Finding out possible cause

See page 4 under COCs.

How to manage

See page 4 under COCs.



****Amenorrhea (no bleeding or spotting at all for several months)**

Finding out possible cause (CBS)

Take history to establish whether her cycles had been regular and when she started to notice changes. Since many women starting POPs are breastfeeding, amenorrhoea will usually continue. Establish her pattern of taking POPs: how she has been taking them (frequency and timing) and whether she may have missed any pill in the cycle or stopped taking them. Rule out pregnancy. If not pregnant, no treatment is required except counseling and reassurance.

How to manage (CBS)

Let her know that:

- It is not a sign of serious sickness.
- It usually occurs during normal breastfeeding even when a woman is not using a contraceptive.
- It is normal with progestin-only pills.

Advise the client to continue with POPs and to return to the clinic if she continues to be worried about the amenorrhoea.

If the client's worries continue, advise and let her take another method of her own choice, preferably non-hormonal. Do not give hormonal treatment to induce withdrawal bleeding. If pregnant, find out her current fertility preference and refer to appropriate clinic for further services. See page 14, ***ectopic pregnancy***. If she intends to continue with the pregnancy, advise to discontinue the pills. If pregnancy cannot be confirmed, set 2–4-week return date for further examination.



****Bleeding between monthly periods (spotting or break-through bleeding) or light but prolonged bleeding**

Finding out possible cause (CBS)

In the first 3 months of using POPs bleeding or spotting between monthly periods is common and the woman may be reassured that this is normal and may improve over time. If spotting lasts more than 3 months after starting POPs, take history and do a pelvic examination to rule out cervicitis, uterine fibroids, other tumours, pregnancy, abortion, pelvic inflammatory disease (PID), or cervical polyp.

How to manage

If other causes of bleeding are found, counsel the client and treat accordingly or refer to appropriate facility for further investigation and management. Advise the client to continue with POP if the cause of bleeding is PID or abortion.

If no other cause is found, reassure the client. Inform her that light, inter-menstrual bleeding or spotting occurs in 15–20% of POP users during the first 6 to 12 months. It is not serious because the amount of blood lost is usually less than normal monthly blood loss; therefore it does not require treatment. (CBS)

If client wants to continue with method but is unhappy with the bleeding/spotting:

- Advise her to take one active tablet of low-dose combined oral contraceptive (if not breastfeeding) in place of POPs daily for 21 days.
- Let her know that she will get her menses during the next period, and that she should resume taking POPs on the eighth day from the first resting day.
- Alternatively, have the client take ibuprofen tablets 400–800mg 3 times per day for 5 days.



Bleeding, heavy (rare)

Finding out possible cause

Take history to find out the number of pads she uses per hour. If 1–2 pads per hour or if there are clots, do complete pelvic including speculum examination to rule out other causes such as cervicitis, cervical polyp, ectopic pregnancy, abortion, PID, or malignancy. Check for pallor or hemoglobin if facility allows. Keep in mind that heavy bleeding is sometimes an early sign of the approach of menopause, which may begin by the mid 40s.

How to manage

If other gynecological problems are found to be the cause, refer as appropriate for further investigation and management.

If the cause of bleeding is PID or abortion, advise the client to continue with POPs. If no other cause is found, consider switching to COC, if not breastfeeding. Advise on nutrition, i.e., to take meals with iron and folic acid. If hemoglobin is below 9gm/dl, give ferrous sulphate 200mg and folic acid 5mg to take after meals 3 times daily for one month followed by ferrous sulphate 200mg daily for 5 months.



****Bleeding, moderate/prolonged, during the first few months of use for non-breastfeeding women**

Finding out possible cause (CBS)

Take history to determine that she is taking POPs correctly and do a bimanual pelvic including speculum examination to rule out cervicitis, PID, abortion, uterine fibroids, or cervical polyp.

How to manage (CBS)

Counsel and reassure the client if nothing abnormal is detected. Inform the client that:

- The bleeding is not harmful even if it continues for several weeks.
- Bleeding usually becomes shorter and lighter with time.
- In most cases, the amount of blood lost during the prolonged bleeding is usually less than normal menses.

If the client is not satisfied even after reassurance, but wants to continue with POPs, give low-dose COC (if not breastfeeding), one active pill daily for 21 days and then return to POPs or ibuprofen 400–800mg 3 times daily for 5 days.



Depression and decreased libido

Finding out possible cause

See pages 7,9 under COCs.

How to manage

See pages 7,9 under COCs.



Dizziness/Nausea

Finding out possible cause (CBS)

See pages 7,9 under COCs.

How to manage (CBS)

See pages 7,9 under COCs.



Ectopic pregnancy

Finding out possible cause

Suspect ectopic pregnancy in all clients using progestin-only contraceptives who present with symptoms of pregnancy.

If a client reports to the clinic with history of amenorrhoea, irregular bleeding or spotting with abdominal pain, or abnormally light menstrual period, inquire if she has noticed the following symptoms:

- Sudden intense pain.
- Persistent pain or cramping in the lower abdomen usually localized to one side.

- Fainting or dizziness that persists for more than a few seconds, which would indicate internal bleeding.

Rule out pregnancy. (See Annex B.) Find out if there is paleness of the conjunctiva or tongue, abdominal guarding, or tenderness with shifting dullness, which indicates fluid in the abdominal cavity.

How to manage

Urgently start the client on intravenous fluids and refer to the nearest hospital for emergency admission if she has any of the following:

- Moderate to severe lower abdominal tenderness.
- Elevated resting pulse of over 100 beats per minute.
- Decreased blood pressure (less than 90/50mmHg).
- Abdominal tenderness with shifting dullness.
- Suspected or confirmed pregnancy with acute anemia (Hb less than 9gm/dl).



Enlarged persistent ovarian cysts

Finding out possible cause

This condition is usually detected as incidental finding of pelvic exam. Client may complain of pelvic or lower abdominal discomfort. Ovarian cysts may be palpated as abdominal masses during pelvic exam.

How to manage

Counsel and reassure the client. Inform her that they usually disappear on their own.

If they twist or rupture or if they are larger than 3cm (usually causing severe pain), urgently refer the client for surgery.



Hair growth, excessive (hirsutism), or hair loss

Finding out possible cause (CBS)

Take history and find out if there was change in hair distribution after starting POPs. Find out if the client had excess facial or body hair before.

How to manage (CBS)

Counsel and reassure the client that the hormone in the POPs may cause the facial and body hair to increase or decrease. However, these changes are rarely excessive and do improve over time.

No specific treatment is required. There is no need to stop the POPs unless the client requests it.



Headache

Finding out possible cause

See pages 7–8 under COCs.

How to manage

See pages 7–8 under COCs.



High blood pressure

Finding out possible cause

See page 8 under COCs.

How to manage

See page 8 under COCs.



Jaundice

Finding out possible cause

Take history and find out if client has had a similar problem before. Do physical examination to check for active liver disease (hepatitis), gall bladder disease, or benign or malignant liver tumors.

How to manage

If active liver disease, don't use hormones. Refer for treatment as needed. Reassure client that acute jaundice occurring during use of POPs is not related to the method.



**Missed pills

How to manage (CBS)

If client has missed a POP, advise her to take it (yesterday's POP) as soon as she remembers. She should also take the next POP at the regular time even if that means taking 2 POPs in one day. (CBS) If client is more than 3 hours late taking a POP, she should use a backup birth control method for the next 48 hours (2 days). (CBS)

If she has missed 2 or more POPs in a row, there is an increased chance that she will become pregnant. She should immediately start using her backup method for 7 days and restart her POPs right away, by taking 2 POPs (double) per day for 2 days. (CBS)

If her menstrual period does not begin within 4–6 weeks (if regular before missing POPs), rule out pregnancy. (See Annex B.) If pregnant, find out her fertility preference and refer to an appropriate clinic for further services. *See also page 14, ectopic pregnancy.* Advise to discontinue the pills. If not pregnant or not sure whether pregnant, advise to keep taking the pills if she can until either her next period comes or pregnancy is confirmed.



Weight gain

Finding out possible cause (CBS)

See page 11 under COCs.

How to manage (CBS)

See page 11 under COCs.

2. EMERGENCY CONTRACEPTION

EMERGENCY CONTRACEPTION (MORNING AFTER PILLS)

What they are and how they work

Common problems/concerns

- Bleeding, irregular
- Breast tenderness, headache, dizziness, fatigue
- Nausea
- Vomiting

2. EMERGENCY CONTRACEPTION (MORNING AFTER PILLS)

WHAT IT IS AND HOW IT WORKS

This section covers only hormonal emergency contraceptive pills (ECPs) such as the standard oral contraceptives (Yuzpe method) and specially packaged progestins such as Postinor-2.

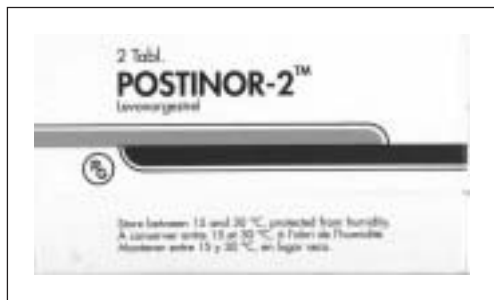
These methods prevent pregnancy from becoming established if the right dosage is taken within 72 hours of intercourse. ECPs do not cause abortion. If taken when the woman is already pregnant, ECPs have no effect on the pregnancy.

The use of emergency contraception during the fertile period reduces the risk of pregnancy by at least 75%. In practice, because the fertile period for a given cycle

can only be estimated, it is often difficult to assess accurately a woman's risk of becoming pregnant. Fortunately, because all emergency contraceptives are quite safe, their use is appropriate any time in the cycle a woman is concerned she might become pregnant.

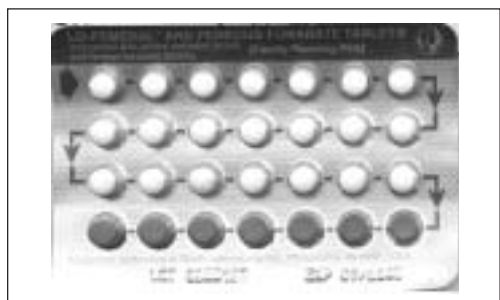
Overall, only 1–3% of women using emergency contraception become pregnant during that cycle. With combined oral contraceptives, 2% become pregnant. With specially packaged progestin-only preparations, such as Postinor-2 (levonorgestrel), 1% become pregnant. The earlier ECPs are taken, the more likely they are to be effective.

Emergency contraception should not be used on a regular basis (from month to month) because it is less effective than other methods.



COMMON PROBLEMS/CONCERNS

COCs taken for a short duration are highly unlikely to cause a serious problem even in women at risk for vascular problems (current or past blood clotting problems, heart attack,



or stroke). They are also unlikely to damage the fetus if a woman is already pregnant.

About 8% of women using COCs for emergency contraception will have spotting during the treatment cycle. About 50% will get their menses at the expected time and most others will start menses earlier than expected. About 25% of women taking Postinor-2 will have nausea, 5% will experience vomiting, and others will experience irregular uterine bleeding, breast fullness, headache, dizziness, and fatigue. These side effects usually do not last more than one day.



Bleeding, irregular

How to manage (CBS)

If no menses within 3 weeks or a delay in the onset of menses of more than one week, the possibility of pregnancy should be ruled out. Advise client to consult clinic or service provider to rule out pregnancy.

If pregnancy is not prevented, counsel client about options.



Breast tenderness, headache, dizziness, fatigue

How to manage (CBS)

Advise the client to take analgesics as

necessary. These side effects usually last no more than 24 hours.



** Nausea

How to manage (CBS)

Nausea occurs in 50% of clients using COCs and 25% of clients using levonorgestrel Postinor-2. Advise client to take each dose with food or take first dose at bedtime. For those clients who have experienced nausea before and are able to afford extra cost, prophylactic anti-emetics may help.



Vomiting

How to manage (CBS)

About 20% of clients using COCs and 5% of clients using levonorgestrel have this problem. If vomiting occurs within 2 hours of taking the first or second dose, the dose should be repeated. Advise to take each dose with food, or take first dose at bedtime. In cases of severe vomiting, the client may administer the dose vaginally. She should place the pill(s) high in the vagina.

3. INJECTABLE HORMONAL CONTRACEPTIVES

COMBINED (ESTROGEN/PROGESTIN) INJECTABLE CONTRACEPTIVES

What they are and how they work

Common problems/concerns

PROGESTIN-ONLY INJECTABLE CONTRACEPTIVES

What they are and how they work

Common problems/concerns

- Acne
- Amenorrhea
- Bleeding between monthly periods
- Bleeding, heavy or prolonged
- Bleeding, moderate
- Breast enlargement
- Chloasma
- Depression
- Dizziness or nausea
- Headache
- High blood pressure
- Late injection
- Libido, loss of
- Pain, severe lower abdominal
- Weight gain
- Weight loss

3.

INJECTABLE HORMONAL CONTRACEPTIVES

COMBINED (ESTROGEN/ PROGESTIN) INJECTABLE CONTRACEPTIVES

What They Are and How They Work

Currently, there are 2 brands of monthly combined injectable contraceptives (CICs):

- Cyclofem, which contains 25mg of depot medroxyprogesterone acetate and 5mg estradiol cypionate, injected intramuscularly once a month.
- Mesigyna, which contains 50mg of norethindrone enanthate and 5mg estradiol valerate, injected intra-muscularly once a month.

Neither is commonly used in Africa. CICs prevent pregnancy by:

- Suppressing ovulation.
- Thickening the cervical mucus, thereby preventing sperm penetration.
- Changing the endometrial lining, making implantation less likely.
- Reducing sperm transport in the Fallopian tubes.

Monthly injectables are highly effective, with a pregnancy rate of less than 1%.

Common Problems/Concerns

Side effects of combined injectable contraceptives are similar to those of

combined oral contraceptives. However, the frequency of occurrence is lower than COCs because there is no fluctuation in the level of hormones, as there is with inconsistent use of oral contraceptives.

Thorough detailed counseling is very important before starting the method since clients often stop using because of side effects.

Inform the client before starting the CIC of the common side effects and how she can deal with them. This will help the client cope with common minor side effects and ensure continued use. Most problems can be managed using the guidance found in Chapter 1, under the section Low-Dose Combined Oral Contraceptives.

If the client complains of any of the common side effects, do not dismiss her concerns or worries; reassure her and urge her to continue with CIC monthly. If she is not satisfied after counseling, help her choose another method.

PROGESTIN-ONLY INJECTABLE CONTRACEPTIVES

What They Are and How They Work

The two most commonly available injectables are depot medroxyprogesterone acetate (DMPA, Depo Provera), 3 months injectable, and norethindrone enanthate (NET-EN, Noristerat), 2 months injectable.

Progestin-only injectables (PIPs) prevent pregnancy by:

- Suppressing ovulation.
- Making the cervical mucus so thick that sperm cannot pass through it.
- Making the lining of the uterus too thin for the fertilized egg to implant in.
- Reducing sperm transport in the Fallopian tubes.

Progestin-only injectables are very effective, with 0.3 pregnancies per 100 women in first year of use when injections are regularly spaced 3 months apart for DMPA and 2 months apart for NET-EN. Pregnancy rates may be higher for women who are late for injection or who miss an injection or if the provider runs out of supplies.

Common Problems/Concerns

Before giving the injection, inform the client of the common side effects and how she can cope with them if they occur. If the client returns complaining of any side effects or concerns:

- Do not dismiss her concerns or worries; counsel and reassure her.
- Help her switch method if this is a real problem or if she wishes to do so.



Acne

Finding out possible cause (CBS)

See page 4 under COCs.

How to manage (CBS)

See page 4 under COCs.



****Amenorrhea (no bleeding or spotting at all for several months)**

Finding out possible cause (CBS)

Enquire and confirm that she has been reporting for injections on time as per

appointments or within the safety window (grace period before or after scheduled appointments).

How to manage

Counsel the client and reassure her that amenorrhea is common, occurs in 90% of women who have been on injectables for at least 3 months, and is not usually a sign of pregnancy. Let her know that (CBS):

- Most clients do miss their menses.
- 40–50% of women on progestin-only injectables stop menstruating within the first 12 months, and 75–80% of those who continue beyond the 12 months do eventually stop menstruating. This is because the lining of the endometrium does not thicken.
- There is no blood retained in the uterus or abdomen at all.

Counsel and give her the next dose of progestin-only injectables.

If the woman has reached age 50, the usual age of menopause, advise to stop using progestin-only injectables and let her take any other non-hormonal method of her choice for 9 months to see if her period returns.

If the client failed to return for injection within the safety window (first 10 days after start of monthly period), rule out pregnancy (see Annex B).

If not sure whether she is pregnant, give her the next dose of progestin-only injectables and review the situation during the subsequent visit.

If pregnant, find out her fertility preference and refer to appropriate clinic for further services. If she intends to continue with the pregnancy, advise to discontinue the method.

If not pregnant but cannot tolerate amenorrhea, help her to take another method of her own choice.



****Bleeding between monthly periods (spotting or break-through bleeding) or light but prolonged bleeding**

Finding out possible cause (CBS)

Take history to find out whether client has missed any injections.

How to manage

Counsel and reassure the client (CBS):

- That irregular bleeding is not a sign of serious sickness.
- That spotting or light prolonged bleeding is normal and usually decreases or stops within a few months.
- That blood loss is usually less than the amount lost with normal menses.

If the bleeding is from other gynecological causes, such as abortion, cervical polyp, or fibroids, refer for further investigations and management, but let the client continue with the injections.

If the concern persists but the client intends to continue with the method, give the client low-dose COCs, to take one active pill daily for 14 to 21 days. (The estrogen in COCs helps rebuild the endometrium and reduce bleeding.) Alternatively, advise the client to take ibuprofen 400–800mg 3 times per day for 5 days or any other non-steroid anti-inflammatory drug (NSAID) but not aspirin. (Aspirin has an anticoagulant effect, which may make the bleeding worse.)

If she had the last injection about 8 weeks ago (4 weeks or less before next appointment), give the next injection now and reschedule her next appointment for 3 months from the date of the current injection.

If client appears to be weak or anemic, give ferrous sulfate 200mg and folic acid 5mg for 1–3 months.

If problem persists and is troublesome to the client, help her switch to another method of her own choice.



Bleeding, heavy or prolonged (rare)

Finding out possible cause

Establish whether the client has been coming regularly for the progestin-only injectables.

Do bimanual pelvic (including speculum) examination to find out if there is any other possible cause such as pregnancy (including ectopic pregnancy), abortion, pelvic inflammatory disease (PID), fibroids, cervical polyp, or other gynecological problems. Enquire if the client feels weak since the onset of heavy bleeding. Check if the conjunctiva or tongue is pale and do hemoglobin test if possible.

How to manage

If no other cause of heavy bleeding is found and the client is less than 8 weeks from the last injection, start on a packet (21 pills) of low-dose combined oral contraceptives. Advise her to take one active pill every day at night before going to bed until she completes the whole cycle (may take for 2 to 3 cycles), or advise to take 30 to 50 micrograms of ethinyl estradiol daily for 7 to 21 days, or ibuprofen 400–800mg 3 times per day for 7 to 14 days.

If bleeding is very heavy or is not reduced, you may give 2 active combined oral contraceptive pills daily for 3–7 days followed by one daily for 11–14 days or injectable estradiol cypronate, 5mg intramuscularly. If not effective within 24 hours, the dose may be repeated once. Let her continue with progestin-only injectables as scheduled. Give 200mg of ferrous sulfate to take at bedtime on full stomach for 3 to 6 months.

If it has been 8 weeks or more since the client's last progestin-only injectables dose,

give another dose of injectable contraceptive and set a new return date based on the current injection.

If the client is on her third or later injection, give low-dose combined oral contraceptive to take one active pill daily for 21 days. Also give iron supplement and let the client know that she will get bleeding during the resting phase at the end of 21 days of COCs.

If bleeding is from other gynecological causes, refer for further investigation and management. However, let the client continue with injections while being assured.

If client is pregnant, stop injections and find out her fertility preference. Manage the pregnancy according to the client's fertility preference or refer for further investigation and management.

If client has low hemoglobin, advise on foods to improve the blood status, such as liver and dark green vegetables. Give ferrous sulfate tablets 200mg 3 times per day (8-hourly) for 3 to 6 months and one 5mg folic acid tablet daily for one month, or one Fefol twice daily for 7–14 days, or one Haeme-up twice daily for 14 days.

If problem persists and is detrimental to the health of the client or is troublesome to the client (interferes with her social or religious life beyond what she can tolerate), help her change to another method of her own choice.



** Bleeding, moderate

Finding out possible cause (CBS)

Take history to determine amount and duration of bleeding. Ask if she missed any injections.

How to manage (CBS)

Counsel and reassure the client. Let her know that this is normal and occurs in 25–30% of women in the first 3 to 6 months of

use. Though the bleeding period may be longer than a normal period, the total blood loss is not more than the loss during the normal menses when on contraceptives. Bleeding becomes shorter and lighter over time.

If client is not satisfied after counseling and reassurance, and it is less than 8 weeks from the last injection, start her on a packet of low-dose combined oral contraceptives. Advise her to take one active pill daily for 7–21 days or to take Premarin 1.25mg daily for 14–21 days or ibuprofen 200–400mg every 4 hours until bleeding subsides or up to 7 days.

If it has been 8 weeks or more since the client's last progestin-only injectables dose, give another dose of injectable contraceptive and schedule a new return date based on the current injection.

If client is weak or anemic, give folic acid tablets 5mg and ferrous sulfate 200mg 3 times per day for one month, then 200mg daily for 2 months.

If bleeding is from other gynecological causes, refer for further investigation and management. However, let the client continue with injections.

If client is pregnant, stop injection and find out her fertility preference. Manage the pregnancy according to the client's preference or refer for further investigation and management.



Breast enlargement/ tenderness, with milk coming out like a lactating mother

Finding out possible cause

Rule out pregnancy.

How to manage

If not pregnant, counsel and help client choose another method, preferably non-hormonal.

**Chloasma (mask of pregnancy)*****Finding out possible cause***

See page 7 under COCs.

How to manage

See page 7 under COCs.

**Depression*****Finding out possible cause***

See page 7 under COCs.

How to manage

See page 7 under COCs.

**Dizziness or Nausea*****Finding out possible cause***

See pages 7, 9 under COCs.

How to manage

See pages 7, 9 under COCs.

**Headache*****Finding out possible cause***

See pages 7–8 under COCs.

How to manage

See pages 7–8 under COCs.

**High blood pressure*****Finding out possible cause***

See page 8 under COCs.

How to manage

See page 8 under COCs.

**Late (more than 2 weeks) injection*****Finding out possible cause***

A woman who is sexually active even though she has not had her injection on time runs the risk of pregnancy. When she comes to the clinic with complaints such as a missed period, the first thing to do is to rule out pregnancy (Annex B).

How to manage

Counsel and reassure the client. Let her know that women using progestin-only injectables often do not have monthly periods. If she is found not to be pregnant, she can continue using injectables if she so wishes.

If not sure, she can use a backup method of her own choice. Schedule appointment for review in one month's time.

**Libido, loss of*****Finding out possible cause***

See page 9 under COCs.

How to manage

See page 9 under COCs.

**Pain, severe lower abdominal*****Finding out possible cause***

Explore any high-risk behavior. Enquire whether she has had unprotected sex with more than one person. Find out if she has noticed any discharge; if so, ask her to describe the nature of the discharge. Do bimanual pelvic including speculum examination. Rule out ectopic pregnancy, acute PID, ovarian tumor or cysts, twisted ovarian follicle, appendicitis, or other abnormality.

How to manage

Reassure the client. If pain is caused by ovarian cysts, inform her that these are common and mostly disappear on their own. Give return date of 3 weeks for re-examination.

If the cause is any of the other gynecological problems, refer immediately for further investigation and management.

Note: Vaginal discharge is not a good indicator of STD. Cervical discharge (identified by speculum examination) along with risk assessment is better.

****Weight gain*****Finding out possible cause (CBS)***

Weight gain with DMPA is common, about 1–2 kg per year, and is due to increased

appetite. Client should be informed about this effect before starting injectables and reminded again at follow-up visits.

How to manage (CBS)

Help client to reduce food intake, especially high calorie fats and oils. If she is not able to avoid weight gain by diet control and she is unhappy about this weight gain, you may need to help her select another method. Some women see weight gain as an advantage.

**Weight loss*****Finding out possible cause (CBS)***

See page 11 under COCs.

How to manage (CBS)

See page 11 under COCs.

4. SUBDERMAL IMPLANTS

What they are and how they work

Common problems/concerns

- Acne
- Amenorrhea
- Bleeding between monthly periods
- Bleeding, heavy
- Bleeding, moderate/prolonged during the first few months of use
- Breast fullness, tenderness, and/or discharge
- Chloasma
- Darkening of the skin over the insertion
- Depression
- Dizziness/Nausea
- Ectopic pregnancy
- Enlarged persistent ovarian follicles
- Expulsion of implants
- Hair growth, excessive
- Headache
- High blood pressure
- Jaundice
- Infection at insertion site
- Libido, loss of
- Pain or itching at insertion site
- Pain, lower abdominal/pelvic, with or without pregnancy symptoms
- Weight gain or loss

4.

SUBDERMAL IMPLANTS

WHAT THEY ARE AND HOW THEY WORK

Progestin-only implants are small hormone-bearing capsules inserted under the skin of a woman's upper arm. They prevent pregnancy by:

- Suppressing ovulation in many cycles.
- Making the cervical mucus so thick that sperm cannot pass through it.
- Making the lining of the uterus too thin for the fertilized egg or embryo to implant in.
- Reducing sperm transport in the Fallopian tubes.

A major advantage of implants is that they do not contain any estrogen, which causes many of the side effects associated with the use of COCs.

COMMON PROBLEMS/CONCERNS

The predominant side effect observed during the use of Norplant (or other implants) is the disruption of the menstrual cycle, which may mean increased or decreased bleeding. Break-through bleeding and spotting are common, especially during the first 6 to 9 months of use. Although initially many women report an increase in the number of bleeding and spotting days while using Norplant implants, research has shown that

the average amount of blood loss is usually less than the loss before using implants.

Clients may come with other problems that may be related to the method such as acne, breast fullness or tenderness, chest pain, depression, excess hair growth, headache, high blood pressure, jaundice, nausea, dizziness, and nervousness.

Despite the fact that most side effects are minor, they may prompt users to stop using implants. Therefore, thorough counseling of potential users before and during insertion has high influence on user satisfaction and continuation rate. Thorough counseling will help clients to cope more effectively with minor side effects. If the client complains of any of the common side effects, do not dismiss her concerns or worries; find out the possible cause and, if appropriate, reassure her and urge her to continue using the implant.

If she is not satisfied after counseling and treatment, help her switch to another method of her own choice.



Acne

Finding out possible cause (CBS)

See page 4 under COCs.

How to manage (CBS)

See page 4 under COCs.



****Amenorrhea (no bleeding or spotting at all for several months)**

Finding out possible cause

Rule out uterine or ectopic pregnancy. Usually this can be done by history. (CBS)

How to manage (CBS)

If not pregnant, counsel and reassure that amenorrhea is normal with implants and is not harmful. Do not give hormonal treatment to induce withdrawal bleeding.

If pregnant, counsel the client about options. If the client decides to continue with the pregnancy, remove the implants and assure her that the small dose of progestin to which she was exposed will have no harmful effect on the fetus. If miscarriage occurs, there will be no need to remove the implants.

If ectopic pregnancy is suspected, refer to the hospital for urgent management. See page 14.

If client is not pregnant but is very uncomfortable with lack of menses, help her switch to another method of her own choice, even COCs if precautions for use of COCs do not apply to the client.



****Bleeding between monthly periods (spotting or break-through bleeding) or light but prolonged bleeding**

Finding out possible cause (CBS)

Find the cause in the same way as for progestin-only injectables (see page 25).

How to manage (CBS)

Manage as for progestin-only injectables (see page 25).



Bleeding, heavy (rare with implants)

Finding out possible cause

Take history to find out the number of pads she uses per hour. If 1–2 pads per hour, or if there are clots, do complete pelvic examination to rule out other causes such as cervicitis, cervical polyp, pregnancy, ectopic pregnancy, fibroids, or malignancy. Check for pallor; measure hemoglobin if facility allows.

How to manage

If no other cause is found, give 2 active tablets of low-dose combined oral contraceptive (if no estrogen-related precautions apply to the client) daily for the remainder of the cycle, or at least 3 to 7 days. This should be followed by one tablet of active low-dose COC per day for 21 days (one cycle). Schedule client to return in 3 days to check if the bleeding has decreased.

If heavy bleeding has not decreased after COC or other estrogen use, refer or assess whether the cause is from another gynecological condition. Remove the implants and advise the client to switch to another method of her own choice. Advise on nutrition: to take foods with iron and folic acid such as liver and green leafy vegetables including spinach, among others.

If hemoglobin is below 9gm/dl, give ferrous sulfate 200mg to take after meals 3 times daily and folic acid 5mg once daily for 1–3 months. This is to be followed by 200mg of ferrous sulfate and 5mg of folic acid daily for 2–6 months.

Uterine evacuation is not necessary unless indicated by other medical condition.

If bleeding is due to other infection or gynecological causes such as PID, manage accordingly or refer for further investigation and management.



Bleeding, moderate/ prolonged during the first few months of use

Finding out possible cause (CBS)

Take history and carry out pelvic examination to rule out cervicitis, uterine fibroids, or cervical polyp.

How to manage (CBS)

If nothing abnormal is detected, counsel client that bleeding is not harmful even if it continues for some weeks. It usually becomes shorter and lighter with time.

If client is not satisfied after reassurance, but wants to continue with implants, give COC one active pill daily for 21 days, or ibuprofen 400–800mg 3 times daily for 5 days.

If the problem is due to other gynecological problem, treat as appropriate or refer for further investigation and management.



Breast fullness, tenderness, and/or discharge (mastalgia)

Finding out possible cause (CBS)

Rule out pregnancy. This can usually be done by history. (See Annex B.)

How to manage (CBS)

If not pregnant, counsel and reassure that condition may be a result of local circulatory changes and tissue fluid retention. It usually becomes less within 3 months of insertion. Do not remove the implants if client is comfortable after reassurance. If on examination breast lump is found to be firm, not tender, and fixed, and if it does not change during the menstrual cycle and the discharge is blood stained (suspicious of cancer), refer immediately for further investigations and management.

If the client is breastfeeding and has breast infection, advise to use warm

compresses and continue breastfeeding. Give appropriate antibiotics.

If the client is pregnant refer according to her preference. Remove implant if she intends to continue with pregnancy.



Chloasma (mask of pregnancy)

Finding out possible cause (CBS)

See page 7 under COCs.

How to manage (CBS)

See page 7 under COCs.



Darkening of the skin over the insertion

How to manage (CBS)

Reassure the client that the darkening will disappear when the implants are removed.



Depression

Finding out possible cause (CBS)

See page 7 under COCs.

How to manage

See page 7 under COCs.



Dizziness/Nausea

Finding out possible cause

See page 7 under COCs.

How to manage

See pages 7, 9 under COCs.



Ectopic pregnancy

Finding out possible cause

See page 14 under POPs.

How to manage

See page 14 under POPs.



Enlarged persistent ovarian follicles (usually detected as incidental finding of pelvic exam)

Finding out possible cause

Perform bimanual pelvic examination to rule out ovarian tumor or cyst, or twisted ovarian follicle.

How to manage

Ovarian follicles develop in some clients on progestin-only contraceptives, and their normal shrinkage (atresia) is sometimes delayed. In these instances, the follicle may continue to grow beyond the size it would attain in the normal cycle. Enlarged follicles cannot be distinguished from ovarian cysts. They usually occur during the first 6 months of progestin-only contraceptive use. They are generally asymptomatic but are often palpable.

Inform client that in most cases the enlarged follicles do disappear spontaneously and should not require stoppage of the progestin-only contraceptives. Give return date of 3 weeks for re-examination.

Rarely, enlarged follicles may twist or rupture, sometimes causing abdominal pain, and surgical intervention may be required.



Expulsion of implants

Finding out possible cause

Check for partial or complete expulsion of capsules.

How to manage

Counsel the client and let her know that this only happens when the capsules are inserted too shallowly, when the tips are too close to

the incision, or when infection is present. Remove all the partially expelled capsules and insert new ones in the other arm.

If the area of insertion is not infected and only one capsule was expelled, open a new package and insert a new capsule. Do not re-use the expelled capsule.

If the area of insertion is not infected and more than one capsule was expelled, remove remaining capsule(s) and re-insert a whole new set.

If the area of insertion is infected, remove the remaining capsules and insert a new set in the other arm. Treat infection. If the client does not wish to continue with implant, advise and help her take an alternative method of her own choice.



Hair growth, excessive (hirsutism), or hair loss

Finding out possible cause (CBS)

See page 15 under POPs.

How to manage (CBS)

See page 15 under POPs.



****Headache**

Finding out possible cause

See pages 7–8 under COCs.

How to manage

See pages 7–8 under COCs.



High blood pressure

Finding out possible cause

See page 8 under COCs.

How to manage

See page 8 under COCs.



Jaundice

Finding out possible cause

Take history and find out if client has had similar problem before. Do complete physical examination including checking for active liver disease (hepatitis), gall bladder disease, and benign or malignant liver tumors.

How to manage

Counsel the client and let her know that the progestin has little effect on liver function and does not increase the risk of gall bladder disease or liver tumors. Implants do not worsen jaundice caused by viral hepatitis.



Infection at insertion site

Finding out possible cause

Inspect the area of insertion for pain, heat, and pus or abscess.

How to manage

If there is infection without abscess, reassure the client. Clean the insertion site with antiseptic lotion and apply dry dressing without removing the implants. Give appropriate antibiotics for 5 to 7 days. Schedule a return date for review. If no improvement on return, remove the implants; if the client is willing to continue, insert new set in the other arm.

If there is an abscess, clean with antiseptic lotion, apply local anesthetic, incise and drain the abscess, and remove all the implants. Dress the wound with normal saline or with antibiotic paraffin/wax gauze (e.g., sofratulle). Give appropriate antibiotics.

If the client is willing to continue the method, insert new set in the other arm. If client is not willing to continue, advise and help her take another method of her own choice. Schedule a return date for review.



Libido, loss of

Finding out possible cause

See page 9 under COCs.

How to manage

See page 9 under COCs.



Pain or itching at insertion site

Finding out possible cause (CBS)

Take history to rule out possible bruise as a result of being hit at insertion site.

How to manage (CBS)

Reassure the client. Advise the client to:

- Ensure the bandage on her arm is not too tight.
- Avoid pressing or rubbing on the implants for a few days.
- Take 1–2 paracetamol tablets 3 times per day for 5 days.

Instruct the client on how to keep the insertion site clean, dry, and protected from accidental injury.



Pain, lower abdominal/pelvic, with or without pregnancy symptoms

Finding out possible cause

Explore any high-risk behavior. Enquire whether she has had unprotected sex with more than one person. Find out if she has noticed any discharge; if so, ask her to describe the nature of the discharge.

Do bimanual pelvic including speculum examination to rule out acute PID, ovarian tumor or cyst, twisted ovarian follicle, appendicitis, or ruptured liver tumor. Rule out abdominal or ectopic pregnancy.

How to manage

Inform the client of findings. If ***ectopic pregnancy***, manage as described above (page 14). Refer to page 34 for management of ***enlarged ovarian follicles***.

If the cause of the pain is any of the other gynecological problems, refer immediately for further investigation and management. See note on page 28.



****Weight gain or loss**

Finding out possible cause (CBS)

See page 11 under COCs.

How to manage (CBS)

See page 11 under COCs.

5. INTRAUTERINE CONTRACEPTIVE DEVICES (IUD/IUCD)

What they are and how they work

Common problems/concerns

- Amenorrhea
- Bleeding, irregular, prolonged or heavy
- Cramping
- Ectopic pregnancy
- Pelvic inflammatory disease (PID)
- Pregnancy
- Strings, missing
- Strings, partner complaints
- Vaginal discharge

5.

INTRAUTERINE CONTRACEPTIVE DEVICES (IUD/IUCD)

WHAT THEY ARE AND HOW THEY WORK

These are small flexible devices inserted into the uterine cavity. Modern IUDs are made of plastic and have copper sleeves on the arms and copper wire wound around the stem. This section applies to the TCu380A (commonly called the Copper-T) and other copper bearing IUDs, the most common IUDs in many settings. IUDs must be inserted by a trained health worker. They do not protect against STD.

IUDs do not suppress production of milk in breastfeeding mothers. They do not cause PID. If the client already has a STD, however, or the service provider inserts the IUD without maintaining sterility, the IUD may make the signs, symptoms, and severity of PID worse, especially in the first three weeks after inserting.

IUDs prevent pregnancy primarily by preventing sperm from fertilizing the egg. They do not cause abortion. IUDs also:

- Interfer with the ability of sperm to pass through the uterine cavity.
- Change the endometrial environment.

IUDs are very effective when inserted correctly. The pregnancy rate can be as low as 0.6 per 100 women in the first year with correct insertion. The pregnancy rate is about 0.8 per 100 women in the first year as typically inserted. The TCu380A is officially approved for 10 years and is highly effective through 12 years, at least.

COMMON PROBLEMS/CONCERNS

Among others, the common side effects are cramping, irregular or absent bleeding, PID, and vaginal discharge. (Cramping and heavier menses usually subside after the first 3 months of use.) Thorough detailed counseling is very important before starting this method since almost half of clients stop using it within the first 3 months because of side effects. Inform the client of the common side effects and how she can deal with them. This will help her cope with minor side effects and ensure continued use.

If the client complains of any of the common side effects, do not dismiss her concerns or worries. Reassure her and urge her to continue using the IUD. If she is not satisfied after counseling, help her choose another method.

IUDs should not be started in women at high risk of STDs and HIV.



Amenorrhea (no bleeding or spotting at all for several months) with IUD in place

Finding out possible cause

Ask client when she had her last menstrual period (LMP) and when she last felt the strings. Rule out pregnancy (see Annex B).

How to manage

If not pregnant, counsel and reassure. If pregnant, manage as described under **pregnancy** below.



****Bleeding, irregular, prolonged or heavy**

Finding out possible cause

Find out how much she has bled. Check for signs of marked anemia (pale conjunctivae or nail beds, low hemoglobin/hematocrit if laboratory is available). Do speculum and bimanual exams to ensure that there is neither cervical pathology nor evidence of intrauterine or ectopic pregnancy or spontaneous abortion.

How to manage

Client has had IUD less than 3 months: If exam is normal, and bleeding is within expected range of IUD users, reassure her that these changes in bleeding are normal and will probably decrease over time. Ask client to return in 3 months for another check. Give ibuprofen 400–800mg 3 times per day for 14 days during bleeding episodes. (CBS)

If bimanual exam shows enlarged or irregular uterus due to fibroids, inform client of the problem and refer for appropriate management.

If client is anemic, give ferrous sulfate 200mg 3 times daily and folic acid 5mg daily for one month then ferrous sulfate 200mg daily for 3 months.

If client does not wish to continue with the method, remove the IUD and help her switch to another method of her own choice.

Client has had the IUD for more than 3 months: If exam is negative and bleeding intervals are short (less than 3 weeks), suspect anovulation.

- If longer intervals (more than 6 weeks), suspect delayed ovulation.
- If there are hot flashes, suspect menopause.
- If client is over age 35, suspect endometrial hyperplasia, or other gynecological endocrine problem.

Refer to specialist, recommend removal.

If severe anemia is present (e.g., less than 9gm/dl Hgb or 30% Hct), help client choose another method. If client has copper IUD, remove and help her select another method. Give 3 more months of iron tablets and re-examine in 3 months time.



****Cramping**

Finding out possible cause

Do abdominal and bimanual pelvic (including speculum) exams to check for PID and other causes of cramping, such as partial expulsion of the IUD, cervical or uterine perforation, or ectopic pregnancy.

How to manage

Inform client that some cramping pain is common in the first 24–48 hours after IUD insertion. Give analgesics. (CBS). If cramping continues and no cause is found within the first 3 months of use, especially in the absence of other symptoms of PID and if cramping is not severe, counsel and reassure the client.

If no cause is found but cramping is severe, provide analgesic and remove the IUD. Let her know that IUD is not suitable for her and advise her to look at the removed IUD for reassurance. Counsel the client and help her switch to another method of her own choice.

If cause is found to be PID, remove IUD and treat accordingly with appropriate antibiotics and analgesics.

If cramping is found to be due to other gynecological causes, manage according to the specific cause.



Ectopic pregnancy

Finding out possible cause

See page 14 under POPs.

How to manage

See page 14 under POPs.

**Pelvic inflammatory disease (PID)**

PID can cause infertility and can be life threatening.

Finding out possible cause

If a client complains of abdominal cramping, abdominal tenderness especially in one or both adnexa, backache, fever, chills, nausea or vomiting, abnormal offensive vaginal discharge, or pain during intercourse (dyspareunia), take history and find out when the IUD was inserted. If within one month, ask:

- If the client has multiple sexual partners or has a partner who has multiple sexual partners.
- If she follows unhygienic practices in her use of tampons or cotton wool during periods.

Do abdominal and bimanual pelvic examination (including speculum). If facilities allow, take a high vaginal swab and cervical smear for gram stain and microscopy, culture, and sensitivity. If not, use syndromic management of abdominal pain.

How to manage

Counsel and reassure the client that antibiotics are usually effective.

If not sure of the findings from the examination (equivocal diagnosis), treat with antibiotics (for gonorrhea, chlamydia, and anaerobic infections) without removing IUD. If condition does not improve in 2 or 3 days, refer client to a facility where she can receive intravenous antibiotics.

If abdominal and pelvic examination confirms PID, remove the IUD (preferably 2–4 days after starting treatment). Treat with antibiotics (for gonorrhea, chlamydia, and anaerobic infection) such as cefoxitin 2g

intramuscularly, or ceftriaxone 250mg plus doxycycline 100mg bid orally for 14 days and metronidazole 400mg 3 times daily for 7 days. If there is no improvement in 48–72 hours, immediately refer to a facility where she can receive intravenous antibiotics.

Advise and help the client to switch to an alternative method of her own choice. The sexual partner should also be treated and condoms provided.

**Pregnancy****Finding out possible cause**

Take history and perform physical and pelvic (including speculum) examination to ascertain pregnancy, gestation age, and whether strings are still visible or can be felt.

How to manage

Counsel the client and inform her of options. Let her know that:

- The pregnancy can continue to term.
- Pregnancy is in most cases due to undetected partial or complete expulsion of the IUD.
- Pregnancy may also occur with the IUD correctly in place.
- The IUD will never go to where the baby is and will not cause the baby to be abnormal, but it can cause spontaneous abortion.
- The strings are likely to carry bacteria from the vagina to the uterus as they are pulled upwards with uterine growth. This may lead to mid-trimester abortion, which in some instances may be associated with septicemia or septic shock and in rare cases death.

If the IUD strings are visible and pregnancy is in the first trimester (less than 13 weeks):

- Inform the client that it is best to remove the IUD.
- Explain that removal of the IUD at this stage has very little adverse effect other

than a somewhat increased risk of spontaneous abortion. However, pregnancy is twice as likely to succeed if the IUD is removed.

- Remove the IUD or refer for removal, if she requests.
- Explain that there will be a good chance for the pregnancy to proceed to term.
- Advise her to report to the nearest hospital if she experiences excessive bleeding, cramping, pain, abnormal vaginal discharge, or fever.

If the strings cannot be found and/or the pregnancy is beyond the first trimester, and the client opts to continue with the pregnancy, counsel the client that there is a risk of mid-trimester spontaneous abortion with infection (sepsis). Advise the client that her pregnancy will have to be followed closely. She should report to the nearest hospital if she experiences excessive bleeding, cramping, pain, abnormal vaginal discharge, or fever.



Strings, missing

Finding out possible cause

Ask the client:

- If the IUD has come out or been expelled. If IUD was expelled, ask her when she had her last menstrual period.
- When she last felt the strings.
- If she has any symptoms of pregnancy.
- If she used a backup method (e.g., condom) from the time she noticed the missing strings.

If client knows the IUD fell out, check for pregnancy; do bimanual pelvic examination including speculum examination.

How to manage

Provide backup method, and reinsert IUD during next period if client desires.

If examination reveals suspected pregnancy but not certain, refer to appropriate

facility for complete evaluation to rule out ectopic pregnancy and management.

If no strings are seen on speculum exam, it may mean that the IUD has fallen out or string may be up in the cervical canal (not visible). Take a sterile cotton swab stick and gently probe the folds of the cervical canal; if strings are not found, client should use a non-hormonal method and return with menses or in four weeks if her period does not start. Strings may come down with menses. If strings are seen, reassure client that strings are present, and help her feel them.

If strings are still not seen, refer to check for IUD either by carefully sounding the uterus, or taking anterior–posterior (AP) and lateral X-ray, or ultrasonography. If IUD is not found on referral, it may have been expelled without being seen. Update the client on the situation and if she wishes, insert another IUD or help her take another method of her own choice.

If she comes back with delayed (greater than 4 weeks) menses check for pregnancy (see Annex B). If pregnant, manage as described under *pregnancy* above.



Strings, partner complaints

Finding out possible cause

Do bimanual pelvic examination (including speculum). Check to ensure that the IUD is in place and not partially expelled.

How to manage

If IUD is in place, counsel the client.

If this has been happening after the periods, teach her how to fold the strings to the posterior fornix using clean fingers.

If it is not related to the periods, inform her that one option would be to cut the string to a length even with the cervical os. Let her know that if this option is followed, she will no longer be able to feel the string. If this is acceptable to her, cut the string even

with the cervical os and enter the information in the client record for future reference.

If the IUD is partially expelled, counsel the client that it will have to be removed and a new one may be inserted. After insertion of the new IUD, inform the client about the new expiry date and record in the client record and card.



Vaginal discharge

Finding out possible cause

Take history and find out if the client has multiple sexual partners or has a partner who

has multiple sexual partners. Do abdominal and bimanual pelvic (including speculum) examinations. If discharge has a bad odor, and if facilities allow, take a high vaginal swab for wet microscopy, gram stain, culture, and sensitivity.

How to manage

If STD is found, treat with antibiotics, or immediately refer for treatment. Advise to choose an alternative method. The sexual partner should also be treated and condoms provided.

6. VOLUNTARY SURGICAL CONTRACEPTION

VASECTOMY

What it is and how it works

Common problems/concerns

- Anesthetic reactions
- Blood pressure, transient drop, or dizziness during or after operation
- Epididymitis
- Hematoma
- Infection, deep, severe
- Granuloma
- Pain, swelling of scrotal tissue, and bruising
- Psychological effects

TUBAL OCCLUSION

What it is and how it works

Common problems/concerns

- IMMEDIATE POST-PROCEDURE:
 - Anesthetic reactions
 - Nausea and vomiting
- FIRST FEW DAYS POST-PROCEDURE:
 - Abscess
 - Bladder injury
 - Bowel injury
 - Hematoma
 - Pain, chest and shoulder
 - Pain, lower abdomen, generalized
 - Wound infection
- LONG-TERM POST-PROCEDURE:
 - Ectopic pregnancy
 - Menstrual disorders

6.

VOLUNTARY SURGICAL CONTRACEPTION

VASECTOMY

What It Is and How It Works

Vasectomy, or male sterilization, is the surgical process of cutting the vas deferens in order to stop the flow of sperm cells. Vasectomy is one of the most effective methods of contraception. Failure rates for vasectomy range from 0 to 2.2% in some large studies, but in most studies the rate is less than 1%. Combining the results of several studies has yielded an overall failure rate of 0.4% among almost 25,000 procedures.

Contrary to the current misinformation and fear of castration, vasectomy is one of the oldest surgical procedures (first introduced in 1775) and has been refined over the years.

Thorough, careful counseling is needed before decision making. The provider should discuss the steps of the procedure, possible side effects and how to manage them, and follow up. Other areas of concern that must be discussed are:

- The procedure is a convenient, effective method of contraception, but it doesn't protect against STD/HIV transmission.
- Side effects are minimal with no-scalpel vasectomy technique. Only local anesthesia is needed.
- Procedure must be considered permanent (reversal can't be assured) and possible future regret should be explored.

- Procedure has no negative effects on sexual functioning.
- The client must use condoms for 20 ejaculations or use another method of family planning for 3 months after the operation to be completely safe.

It is important to identify men who have sexual dysfunction or serious marital or psychological problems during pre-vasectomy counseling as a contraindication to the procedure.

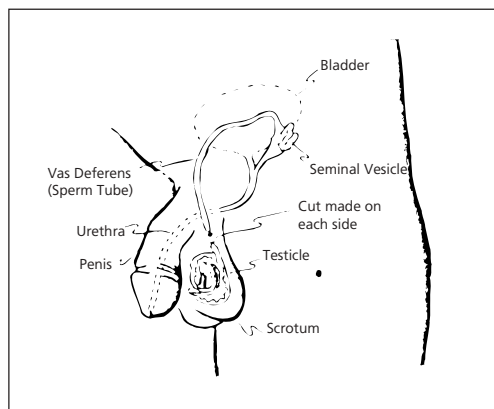
Common Problems/Concerns

Short-term postoperative side effects usually subside within 1–2 weeks. The most common side effects are mild pain and swelling, infection (which occurs in less than 2% of cases), hematoma (in less than 1%), granuloma (in less than 3%), and epididymitis (in 1.5%). Despite the rumors, several studies have confirmed that vasectomized men have no increased incidence of cardiovascular diseases (atherosclerosis) or prostate cancer. It is worth noting that the rate of side effects has decreased tremendously since the introduction of no-scalpel vasectomy.

Anesthesia related problems are also rare. Normally only 5–10cc of 1% lidocaine without epinephrine is used when performing vasectomy and this is far below the anesthetic toxic dose.

Thorough counseling will help the client come to terms with ending fertility and later

to cope with the common minor side effects. If the client returns with a complaint of any of the common side effects or any concern, do not dismiss his worries but counsel and reassure him.



Anesthetic reactions (e.g., loss of sensation on the lips and tongue, followed by convulsions)

Finding out possible cause

Reconfirm the dose of lignocaine (lidocaine, xylocaine) given or if it was accidentally given intravenously.

How to manage

Anesthetic reactions are rare if intravascular injection of lignocaine is avoided and the recommended doses of anesthesia are not exceeded. The condition usually disappears in 1–2 minutes if no more lignocaine is given. Give sedation and controlled ventilation.



Blood pressure, transient drop, or dizziness during or after operation

How to manage

If this situation is prolonged, let the client rest before proceeding. If after the procedure,

help the client lie down with his legs elevated. Intravenous fluids are rarely required.



Epididymitis

How to manage

Reassure the client that this condition is generally not related to bacterial infection and will subside within a matter of weeks. Give the client scrotal support and simple analgesics such as paracetamol, 2 tablets when necessary.



Hematoma

How to manage

Rare, but may result from damage to small vessels that goes unnoticed and is not ligated. Reassure the client that:

- Small hematomas resolve completely with bed rest.
- Big hematomas may be drained, but this must be weighed against infection if sterile procedures are not followed.



Infection, deep, severe

How to manage

Reassure the client and let him know that this is rare but can follow hematoma formation. Clean site with antiseptic solution. May require removal of skin sutures and drainage of incision. Perform wound care. Give 7 to 10 days of appropriate antibiotics.



Granuloma

Finding out possible cause

Rare. May present with testicular pain, inflammation, or small swelling in scrotum on palpation, or it may have no symptoms.

How to manage

Reassure the client that this is a small nodule of collected sperm that has formed at the site of the occluded tube (vas deference). Inform him that the swelling is usually symptomless. Give the client analgesics such as 1–2 (500–1000mg) paracetamol tablets 3 times per day (every 8 hours) for 5 days, or one ibuprofen (400mg) tablet 3 times per day for 5 days, or aspirin on full stomach, 1–2 (400–800mg) tablets 3 times per day for 5 days. (Aspirin is not recommended for people with bleeding disorders or bleeding tendencies.) Very rarely a persistent and painful granuloma may require referral for surgical removal.



****Pain, swelling of scrotal tissue, and bruising**

How to manage

Reassure the client that this has occurred as a result of normal manipulation during the procedure. Advise the client to use ice pack if available and scrotal support. Give analgesic such as 1–2 (500–1000mg) paracetamol tablets 3 times per day (every 8 hours) for 5 days, or one ibuprofen (400mg) tablet 3 times per day for 5 days, or aspirin on full stomach, 1–2 (400–800mg) tablets 3 times per day for 5 days. (Aspirin is not recommended for people with bleeding disorders or bleeding tendencies.)

Superficial skin infections heal with clean, loose dressing.



Psychological effects

How to manage

Counsel and reassure the client. Inform him that the great majority of vasectomized men report no regrets and would recommend the procedure to others. Men usually report no change in sexual desire or performance. Marital relations and sexual satisfaction

sometimes improve, presumably because fears of pregnancy are reduced. When clients come with emotional problems, explore their marital relationship and sexuality and counsel them.

TUBAL OCCLUSION**What It Is and How It Works**

Tubal occlusion, or female sterilization, is the surgical cutting or clamping of the Fallopian tubes in order to prevent the egg (ovum) released by the ovary from being fertilized by sperm and reaching the uterine cavity. It does not cause abortion. It is generally a safe procedure and few women experience side effects or complications. Overall rates of side effects and major complications are very low, in the range of 0.4 to 2.0%.

Female sterilization is a highly effective method of contraception. Sterilization failures (pregnancies after the procedure) occur in less than 1% of women in the first year after surgery. Most reported failure rates for postpartum and interval minilaparotomy procedures using the Pomeroy technique are in the range of 0.2 to 0.4% in the first year.

Due to the permanence of this method, thorough careful counseling is needed before decision making. It is important to discuss the steps of the procedure, possible side effects and how to manage them, and follow up. Other points of concern that must be raised with the client are:

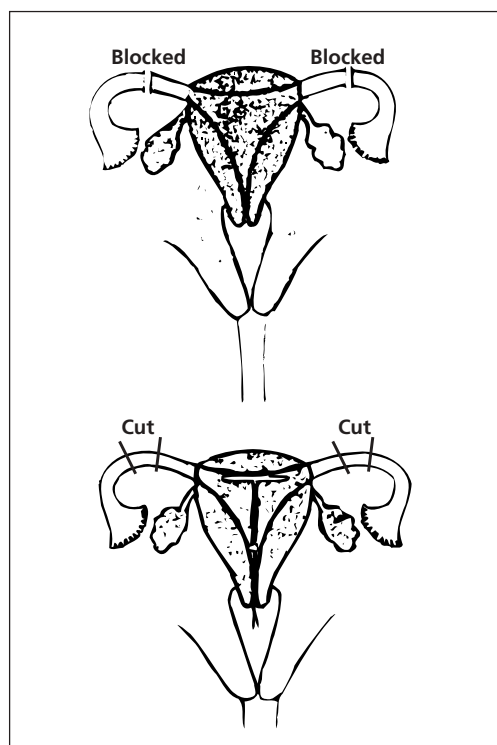
- It is a convenient, effective method; however, it does not protect against STD/HIV transmission.
- Side effects are minimal.
- Procedure must be considered permanent (reversal can't be assured) and possible future regret should be explored.
- Procedure has no negative effects on sexual functioning.

It is important to identify women who have sexual problems or serious marital or psychological problems during counseling before tubal occlusion as a contraindication to the procedure.

Common Problems/Concerns

For the purpose of this discussion, the following definitions have been applied:

- Side effects, or complaints, are symptoms attributable to the surgery that do not require exceptional intervention. These include modest, subsiding pain in the abdomen, shoulder, or chest, and nausea and vomiting.
- Complications are problems directly related to the surgery or the anesthesia that occur within 42 days and that require intervention and management beyond what would normally be provided. These include infection, bleeding, unintended injury, and



depressed respiration or blood pressure due to anesthesia.

If client returns with a complaint of any of the common side effects or concerns, do not dismiss her worries; empathize with her and counsel her. Evaluate carefully to determine if this is a side effect that requires no major intervention or if the woman is having a complication that demands urgent medical attention.

IMMEDIATE POST-PROCEDURE



Anesthetic reactions (e.g., loss of sensation on the lips and tongue, followed by convulsions)

Finding out possible cause

Reconfirm the dose of lignocaine (lidocaine, xylocaine) given or if it was accidentally given intravenously.

How to manage

Anesthetic reactions are rare if intravascular injection of lignocaine is avoided and the recommended doses of anesthesia are not exceeded. This condition usually disappears in 1–2 minutes if no more lignocaine is given. Give sedation and controlled ventilation if the reaction is severe, such as convulsions.



Nausea and vomiting

How to manage

Reassure the client and inform her that this may be the result of anesthesia or of handling the abdominal contents. It will clear in a few hours. If severe, give 1ml of plasil or stemetil intramuscularly. Giving atropine 0.4 to 0.6mg intramuscularly 30 minutes before surgery or intravenously when the client is on the operating table can alleviate this.

FIRST FEW DAYS POST-PROCEDURE

**Abscess****How to manage**

Reassure the client and let her know that it will heal. Clean with antiseptic or eusol (in some rare case hydrogen peroxide). Incise and drain the abscess. Perform wound care. Give 7 to 10 days of appropriate antibiotics. Schedule the client's review date to assess the progress in healing.

**Bladder injury****How to manage**

During postoperative period the following may be observed:

- Hematuria
- Suprapubic pain
- Fever or signs of infection

Refer back to surgery.

**Bowel injury****Finding out possible cause**

See section below, *pain, lower abdomen*.

How to manage

During postoperative period, the following may be observed:

- Abdominal pain
- Vomiting
- Failure to pass gas
- Acute illness
- Fever with rapid pulse (early)
- Temperature returns to normal or subnormal (later)
- Abdominal distension
- Abdominal tenderness

Refer back to surgery.

**Hematoma****How to manage**

Rare, but may result from damage to small vessels that goes unnoticed and is not ligated. Reassure the client and inform her that small hematomas resolve completely with bed rest. Big hematomas may be drained, but this must be weighed against the possibility of infection if sterile procedures are not followed.

**Pain, chest and shoulder****How to manage**

Reassure the client and inform her that this is a result of retained gas used in distending the abdomen during surgery (insufflation during laparoscopy). It will take 1–2 days to disappear. Give analgesics.

****Pain, lower abdomen, generalized****Finding out possible cause**

Take history and do physical examination to rule out warning signs for bowel injury and/or peritonitis.

How to manage

Some postoperative abdominal pain and local tenderness over the wound are normal after tubal occlusion. However, the clinician must take a good history and do a careful examination to ensure that there is not a complication. A complication usually exists if the woman complains of pain that is increasing, if she has fever, pus, or bleeding from the wound, or if there is heat, swelling, or redness of the wound. Complications must be carefully assessed and treated by a clinician familiar with the particular complication. Refer to a higher level if necessary.

Reassure the client that normal pain will usually disappear in a few days. If pain is accompanied by guarding or rebound tenderness, she must be immediately assessed by a surgeon. If mild, may manage with analgesics.



Wound infection

How to manage

If minor, clean with normal saline or antiseptic and apply dry dressing; apply gentian violet if available. If infection is moderate to severe, clean with normal saline, antiseptic, eusol, or hydrogen peroxide. Dress with paraffin wax containing antibiotics (e.g., sofratulle). Give 7 to 10 days of appropriate antibiotics. Schedule the client's review date depending on the severity.

LONG-TERM POST-PROCEDURE



Ectopic pregnancy

Finding out possible cause

Find cause as described on page 14 under POPs.

How to manage

Counsel and reassure the client that overall the incidence of pregnancy following sterilization is very low.

Of these pregnancies, however, over 6% are reported to be ectopic, compared with approximately 1% among women who have not been sterilized. Ectopic pregnancies have been reported as early as 2 months and as late as 8 years after sterilization.

Urgently refer the client to the nearest hospital for emergency admission.



Menstrual disorders

How to manage

Reassure the client and let her know that studies have generally failed to demonstrate any change in bleeding up to 2 years following surgery. Let her know that many reported changes in menstrual patterns after sterilization appear to be related to the discontinuation of methods of contraception that are known to induce changes in the menstrual pattern such as oral contraceptives and IUD.

For postpartum clients, observed changes in menstruation may be related to resumption of normal bleeding patterns following pregnancy.

7. BARRIER METHODS

VAGINAL SPERMICIDES

What they are and how they work

Common problems/concerns

- Failure of vaginal suppositories, foaming tablets, or films to melt
- Heat sensation in the vagina
- Itchiness, skin rash, or lesions on the genitalia or perineum

CONDOMS (MALE)

What they are and how they work

Common problems/concerns

- Breakage or slipping off during sexual act
- Diminished sexual sensitivity or pleasure
- Itchiness, skin rash, or lesions on the genitalia or perineum due to spermicide in condom or latex in condom

DIAPHRAGMS

What they are and how they work

Common problems/concerns

- Discharge and offensive smell from the vagina
- Pain from pressure of diaphragm on bladder or rectum
- Urinary tract infections (UTIs)
- Vaginal irritation especially after intercourse
- Vaginitis

7.

BARRIER METHODS

VAGINAL SPERMICIDES

What They Are and How They Work

Spermicides are chemicals (usually mefegol or nonoxynol-9) that inactivate or kill sperm. They may be in the form of jellies, creams, foaming tablets, suppositories, film, sponges, or aerosols.

Spermicides work by:

- Causing the sperm cell membrane to break.
- Decreasing sperm movement (motility and mobility).
- Reducing sperm's ability to fertilize the egg.

The pregnancy rate is about 26% in the first year for typical users. The pregnancy rate can be as low as 6% with correct and consistent use or it may be higher than 26% when use is highly inconsistent or incorrect.

Common Problems/Concerns

Client concerns and method side effects range from the failure of the suppository or tablet to melt, to possible allergic reactions to the chemicals in the spermicides.



Failure of vaginal suppositories, foaming tablets, or films to melt

Finding out possible cause

Do pelvic examination, including speculum exam, to confirm; remove the unmelted suppository, foaming tablet, or vaginal film.

How to manage (CBS)

If the couple had intercourse with a contraceptive that failed to melt, counsel and advise to use emergency contraceptive pills. Help them select a spermicide with a different chemical composition or use another method of their own choice that fits their needs, values, and preferences.



Heat sensation in the vagina

Finding out possible cause

Do pelvic including speculum examination to find out the cause, whether genital tract infection, mechanical reaction, or allergy.

How to manage (CBS)

If the cause is none of the above, reassure client that a warm sensation is normal with foaming tablets but not with jellies. Advise to continue with the method.

If client is still uncomfortable, advise her to change to a spermicide with a different chemical or to choose another method that fits the couple's needs, values, and preferences.



Itchiness, skin rash, or lesions on the genitalia or perineum

Finding out possible cause

Find out if the client has any past history of allergy. Examine to find out the cause, whether genital tract infection, mechanical reaction, or allergy.

How to manage (CBS)

If due to allergy, advise the client to change to a spermicide with a different chemical or to choose another method that fits the couple's needs, values, and preferences.

CONDOMS (MALE)

What They Are and How They Work

Condoms are thin sheaths made of latex rubber, vinyl, or natural (animal) products. They may be treated with a spermicide for added protection. They are placed on the penis once it is erect.

Condoms:

- Prevent sperm from gaining access to female reproductive tract.
- Prevent microorganisms (HIV, GTIs, other STDs) from passing from one partner to another. (*Note that only latex and vinyl condoms protect against HIV and other STDs.*)

Condoms are moderately effective, with a typical-use pregnancy rate of 14%, and 3% with correct and consistent use during the first year of use.

Common Problems/Concerns

Problems range from possible allergic reactions to condom breakage to complaints of diminished sensitivity.



Breakage or slipping off during sexual act

How to manage (CBS)

Counsel and reassure the client. Advise to use emergency contraceptives.



Diminished sexual sensitivity or pleasure

Finding out possible cause

(CBS)

Enquire whether one or both partners are complaining.

How to manage (CBS)

Counsel and advise that there is advantage of prolonged intercourse and pleasure. Advise to use a small amount of water or water-based lubricant (e.g., KY jelly) on the outside. This may increase sensation and help maintain erection.

Advise to use thinner male condom if not at risk for HIV or female condom, which is known to increase sensation.

If client is not satisfied with the situation, advise to switch to another method of their choice that fits their needs, values, and preferences.

If the man cannot maintain erection while putting on a condom, counsel and reassure that this is mainly due to embarrassment. Assist client through counseling to overcome embarrassment. Advise to have foreplay with condom put on by the woman (partner). If he still has difficulty, advise couple to use female condom.



Itchiness/skin rash/lesions on the genitalia or perineum due to spermicide in condom or latex in condom

How to manage

See *itchiness* under spermicides (page 56).

DIAPHRAGMS

What They Are and How They Work

This method is not commonly used in the Africa region. A diaphragm is a dome-shaped latex (rubber) cup that covers the cervix. It is inserted into the vagina before intercourse.

The diaphragm works by preventing sperm from gaining access to the upper reproductive tract. The pregnancy rate is about 26% in the first year for typical users. However, the pregnancy rate can be as low as 6% with correct and consistent use.

Common Problems/Concerns

The several side effects associated with the use of diaphragms range from infections of the urinary tract to vaginal irritation and pressure pain.



Discharge and offensive smell from the vagina

Finding out possible cause

This may result from retention of the diaphragm for more than 24 hours. Do pelvic examination to rule out presence of other foreign body such as tampon in the vagina.

How to manage

Advise the client to remove the diaphragm as early as is convenient after intercourse, but not less than 6 hours after last act, and to clean it after use.



Pain from pressure of diaphragm on bladder or rectum

Finding out possible cause

The client may complain of vaginal discomfort. Do pelvic examination to assess the correct fit of the diaphragm.

How to manage

Reassure the client and give additional advice on insertion. Have her try insertion in the clinic and then check placement. If the current diaphragm is too large, fit with a smaller one. Schedule a visit to ensure the problem is over and to check client's placement of diaphragm.



Urinary tract infections (UTIs)

Finding out possible cause

Take history to find out if there is frequency of and pain on urination. If possible, take early morning urine specimen for urinalysis and culture and sensitivity.

How to manage

If urinalysis shows more than 10 WBC per high power field in unconcentrated specimen, or culture shows more than 100,000 organisms per milliliter, counsel and reassure the client. Treat with appropriate antibiotics. If the diaphragm remains client's method of choice and she has recurrent urinary tract infections, advise her to void immediately after sexual intercourse. Advise her to drink plenty of fluids and eat foods containing vitamin C, such as oranges, grapefruits, and limes.

If infection is frequent or recurrent, check the diaphragm fit. It may be too big. If problem persists, advise the client to choose another method that fits the couple's needs, values, and preferences.



Vaginal irritation especially after intercourse (from diaphragm or spermicide)

Finding out possible cause

Find cause the same way as for spermicides (*itchiness*, page 56).

How to manage

Manage as for spermicides (*itchiness*, page 56).



Vaginitis (from diaphragm)

How to manage

Counsel the client and advise her to clean her diaphragm thoroughly after use and make sure it is dry before using it again.

8. LACTATIONAL AMENORRHEA METHOD (LAM)

What it is and how it works

Common problems/concerns

- Problems related to the mother
 - Breast engorgement
 - Breast milk, insufficient supply
 - Cesarean section birth and breastfeeding
 - HIV+ mother
 - Malnourished mother
 - Mastitis
 - Medications
 - Nipples, sore/cracked
- Problems related to the baby
 - Baby sleeps too much
 - Cleft palate
 - Premature baby
 - Twins

8.

LACTATIONAL AMENORRHEA METHOD (LAM)

WHAT IT IS AND HOW IT WORKS

The lactational amenorrhoea method (LAM) is a temporary family planning method based on the lack of ovulation resulting from exclusive breastfeeding. “Lactational” means related to breastfeeding and “amenorrhoea” means not having menstrual bleeding.

The lactational amenorrhoea method (LAM) is used during the first 6 months postpartum when fertility is low and the infant is fed solely on breast milk.

LAM is effective—the pregnancy rate is about 2% for typical use in the first 6 months. When used correctly and consistently, the pregnancy rate is 0.5% in the first 6 months after childbirth.

LAM is defined by 3 criteria:

1. the woman’s menstrual periods have not resumed, AND
2. the baby is exclusively or nearly exclusively breastfed, AND
3. the baby is less than 6 months old.

When any one of these 3 criteria is no longer met, another FP method must be introduced in a timely manner to ensure healthy birth spacing.

COMMON PROBLEMS/CONCERNS

Strictly speaking, breastfeeding does not have side effects. However, there are conditions or concerns/worries that may

require management during the course of breastfeeding to ensure that LAM will be effective. These can be conveniently divided into problems related to the mother and problems related to the baby. Family planning providers should encourage breastfeeding and help clients manage the problems.

Problems Related to the Mother



Breast engorgement

Finding out possible cause (CBS)

Take history to establish whether:

- The infant is having difficulty attaching to the breast.
- The feeding is painful.

Observe the mother breastfeeding the infant and perform breast examination for engorgement, which includes:

- Lack of differentiation between the nipple and the areola.
- Firm, tender breasts, with shiny skin and lumpy feeling.
- Slight temperature elevation.

How to manage (CBS)

Counsel and reassure the mother. Let her know that the breast engorgement is a result of congestion and increased vascularity and accumulation of milk in the breast. Advise her to try to soften the areola area so that the infant can attach to the breast correctly

and empty the breast. Let her know that she can do this by applying warm moist towels/cloths to the breast, massaging the breast, and manually expressing milk until the areola can be flattened between her fingers and the infant can take it into its mouth.

Advise her to wear a loose but supportive brassiere, to relieve discomfort with warm showers, to massage the breast/axilla, and to express milk to relieve pressure or breastfeed more frequently. She may use paracetamol to relieve discomfort if necessary.

Let her know that raw cabbage leaves applied to the breast have been associated with relief of engorgement and pain within 2 to 24 hours of application. She should simply place the cabbage leaves inside her bra, against the areola and sore area.



Breast milk, insufficient supply

Finding out possible cause (CBS)

Take history from the mother to find out:

- If she is taking adequate amounts of food and liquids, her eating habits, the kind of diet that she takes, nutritional status, and whether she is getting adequate amounts of rest.
- If she is under unusual stress.
- Why she thinks she does not have enough milk. Probe how frequently the infant suckles (at least every 1–3 hours) and for how long, whether the infant cries too much, or whether the mother feels her breasts are empty.
- How often the infant urinates (infant should urinate pale yellow or colorless urine 6 or more times per day).
- Whether she has started giving other fluids or foods.
- If there are other problems.

Examine and take the infant's weight.

How to manage (CBS)

If the infant is wetting normally, the milk is adequate. If this is not the case, counsel and reassure the mother that the situation may be a result of infrequent infant feeding, not feeding for long enough at a session, or too early introduction of supplemental foods. Advise the mother to feed infant more often (at least every 2 to 3 hours) to build up her supply if wetting is less.

Poor maternal nutrition and dehydration can lead to reduction in breast milk, which may cause early weaning of the baby. Advise the client to take a balanced diet, especially dark green vegetables and fruit, to improve her nutritional and vitamin status. If client has a poor appetite, she should take small amounts of food but frequently throughout the day.

Advise the mother to drink plenty of fluids (at least 6 to 8 glasses per day), and to get adequate rest. If baby is under 6 months of age, advise her to stop giving other foods/fluids and give breast milk only and more frequently to increase her supply. If she is giving other fluids and foods she may need another family planning method.

If infant's weight is appropriate, her milk supply is adequate and she should continue breastfeeding. If baby's weight is low, review with the mother her feeding pattern, frequency, and duration. If feeding is infrequent or of short duration, encourage 6–12 feedings per day, for at least 5–10 minutes per breast. Advise the mother to wake the infant if he falls asleep during feeding and to keep the infant unwrapped while feeding to keep him awake. Have her ensure that the infant is positioned correctly.

If no social, psychological, or physical cause of low milk supply is identified, counsel the client on all methods of family planning and help her to switch to another family planning method of her own choice.



Cesarean section birth and breastfeeding

Assess the woman's ability to handle her infant postoperatively and provide the necessary support for her to successfully breastfeed. She can use LAM if the criteria are met.

How to manage

- Suggest alternative positions to keep infant from resting on the abdominal incision, e.g., side-lying, football hold.
- Help the woman maintain optimal breastfeeding behaviors.



HIV+ mother

Where breastmilk substitutes are not available, not affordable, or not safe:

- Promote exclusive breastfeeding as safer than artificial feeding with early weaning. In this case, LAM can be used, if the woman desires.

Where breast milk substitutes are available, affordable, and safe, and adequate health care is available:

- Encourage the woman to use affordable breast milk substitutes. In this situation, LAM cannot be used as a form of contraception.

How to manage

- Treat mother with antiretroviral drugs, if feasible.
- Help her to choose safest available alternative feeding method.
- Teach mother how to avoid transmission of HIV and repeated exposure to HIV.
- Protect and promote breastfeeding among the rest of the community.

The woman who is HIV+ should use condoms to minimize transmission and protect herself from repeated exposure to infected semen.



Malnourished mother

How to manage

Counsel the mother and advise her that there is not likely to be a significant change in the composition of the milk, although the total volume (amount) of milk may be affected.

She can use LAM if the criteria are met and optimal breastfeeding behaviors are maintained. Advise her to increase her food and liquid intake (one extra serving of staple food), if possible.

If she is severely malnourished, her milk quality may decrease and supply may eventually decrease and stop.



Mastitis (sore breasts)

Finding out possible cause

Take history to find out whether one or both breasts are affected, with accompanying general malaise and fever. (CBS) Do physical examination including examination of the breast, which may be hot, tender, and swollen with localized intense pain.

How to manage

Counsel and encourage the mother to continue breastfeeding on both breasts but start the infant on the unaffected breast first, giving the affected breast a chance to let down. (CBS)

Advise the mother to empty the affected breast by breastfeeding or by pumping or expressing the milk if the infant does not empty the breast during feeding. (CBS)

Advise the mother on strict bed rest. Give antibiotics that are not harmful to the infant such as penicillin, ampicillin, amoxicillin, or erythromycin for 10–14 days.

Advise mother to wear loose but supportive brassiere, apply heat to the breast by using warm cloths, and take plenty of fluids. (CBS) Give mild analgesic such as paracetamol 500–1000mg, 1–2 tablets 3 times per day for 7 days.



Medications

There are three “knowns” about drugs and human milk:

- Most drugs pass into breast milk.
- Almost all medication appears in only small amounts in human milk, usually less than 1% of the maternal dosage.
- Very few drugs are contraindicated for breastfeeding women.

Those drugs that *are* contraindicated for breastfeeding women are: mood-altering drugs, reserpine, ergotamine, antimetabolites, cyclosporine, bromocriptine, radioactive drugs, lithium, and anticoagulants.

How to manage

If a woman is taking these drugs she should not be breastfeeding and thus cannot use LAM.



Nipples, sore/cracked

Finding out possible cause

Take history to ascertain whether feedings are painful, resulting in feeding less often or for shorter periods of time. (CBS) Observe the infant feeding to see if the infant sucks only the tip of the nipple. Ascertain if the breasts are still full after feeding. (CBS)

Do physical examination to determine whether the nipple skin is damaged, fissured, or cracked.

How to manage (CBS)

Counsel the mother and let her know that cracked nipples result from prolonged sucking at incorrect position. Assist her to position the infant correctly on the breast, including infant’s mouth position (wide open, with as much of the breast around the areola in the mouth as possible).

Let her know that the following steps may be helpful:

- Moist heat before feeding: apply warm towels/cloths to the breast or clean with clean water but without soap.
- Brief periods of dry heat after feedings: expose breast to air, thereby allowing the breast milk to dry on the nipple/areola, which promotes healing.

Advise her to avoid use of ointments, which must be removed from the breast before feeding and can add trauma to the area. Vitamin A and D ointment, which does not need to be removed, is occasionally effective.

Encourage the mother to continue breastfeeding on both breasts at each feeding but to start the infant on the unaffected breast first, giving the affected breast a chance to let down. Both breasts should be completely emptied. Give mild analgesic such as paracetamol 500–1000 mg, 1–2 tablets when necessary.

Problems Related to the Baby



Baby sleeps too much

How to manage (CBS)

Advise the mother to unwrap the infant to encourage waking; hold vertically to awaken.

Teach the mother to watch infant’s sleep and wake cycle and feed infant during quiet-alert states. Advise her that crying is the *last sign* of hunger. Cues of hunger include rooting, licking movements, flexing arms and clenching fists, body tension, kicking legs. Advise the mother not to allow baby to sleep for periods greater than 4 hours during the day or 6 hours during the night if she wants to use LAM.



Cleft palate

Breastfeeding is especially advantageous to infants with a cleft palate. The degree of

difficulty in feeding varies with the severity of the defect.

How to manage (CBS)

There is probably a lower efficacy of LAM if suck is weak. Advise mother to abstain or use condom.



Premature Baby

Breastfeeding is advantageous for preterm infants; supportive holds may be required. However, successful breastfeeding requires:

- Motivated mother.
- Motivated and skilled staff.
- Support for correct latch-on.

How to manage

Direct breastfeeding may not be possible for several weeks, but the mother should be encouraged to express the milk and store it for use by infant.

The woman cannot rely on LAM if direct breastfeeding is not possible. There is

probably a lower efficacy of LAM if suck is weak. Advise to abstain or use condom.



Twins

This is mainly a problem of an extra baby. Otherwise, the feeding is much the same as for a single baby.

How to manage (CBS)

The woman can rely on LAM if all of the criteria are met. Advise mother that:

- Breastfeeding twins is not a question of milk supply but of the extra time and the support needed by the mother.
- Breastfeeding infants simultaneously can help diminish time spent feeding.

Adapted from: FAQ Sheet 1, "Frequently Asked Questions on: Breastfeeding and HIV/AIDS," *Linkages*, October 1998, and FAQ Sheet on Amenorrhea Method (LAM), *Linkages*, April 2000.

9. PERIODIC ABSTINENCE (FERTILITY AWARENESS) METHODS

What it is and how it works

Common problems/concerns

- Strained couple relationship

9.

PERIODIC ABSTINENCE (FERTILITY AWARENESS) METHODS

WHAT IT IS AND HOW IT WORKS

Periodic abstinence is the practice of abstaining from intercourse during the fertile period. The fertile period is measured in various ways such as checking physiological cervical mucus changes (Billings or cervical mucus method), measuring changes in body temperature (basal body temperature method), or a combination of both (symptothermal method) for more accurate identification of fertile period.

Fertility awareness or natural family planning (NFP) methods are only somewhat effective. A 20% pregnancy rate occurs in the first year for typical users of most NFP methods. With consistent and correct use, pregnancy rates of 1-9% have been achieved with NFP methods.

COMMON PROBLEMS/CONCERNS

Like lactational amenorrhea, fertility awareness methods do not have side effects as such. However, couples may experience

emotional tension or even estrangement because of the particular stresses the method imposes.



Strained couple relationship

Finding out possible cause (CBS)

Explore the feelings of individual couple members. Try to determine if the difference is caused by prolonged periods of abstinence. See the couple together, then individually, to get the different perspectives on their constraint.

How to manage (CBS)

Counsel and encourage the couple to continue with the method. Assist the couple to identify alternative means of sexual gratification during the abstinence periods. Train the couple on safer sex. If the couple are not satisfied with alternatives to intercourse, advise them to use another method of their choice that fits their needs, values, and preferences.

Annex A

WHO Medical Eligibility Criteria for Starting Contraceptive Methods

The table on the following pages summarizes World Health Organization (WHO) medical eligibility criteria for starting contraceptive methods.

WHO Categories for Temporary Methods

- WHO 1** Can use the method. **No restriction on use.**
- WHO 2** Can use the method. **Advantages generally outweigh theoretical or proven risks.** Category 2 conditions could be considered in choosing a method. If the client chooses the method, more than usual follow-up may be needed.
- WHO 3** **Should not use** the method unless a doctor or nurse makes a clinical judgement that the client can safely use it. **Theoretical or proven risks usually outweigh the advantages** of the method. Method of last choice, for which careful follow-up will be needed.
- WHO 4** **Should not use** the method. Condition represents an **unacceptable health risk** if method is used.

Simplified 2-Category System

Where a doctor or nurse is not available to make clinical judgements, the WHO 4-category classification system can be simplified into a 2-category system as shown in this table:

WHO Category	With Clinical Judgement	With Limited Clinical Judgement
1	Use the method in any circumstances	Use the method
2	Generally use the method	
3	Use of the method not usually recommended unless other, more appropriate methods are not available or acceptable	Do not use the method
4	Method not to be used	

NOTE: In the table that follows, Category 3 and 4 conditions are shaded to indicate the method should not be provided where clinical judgement is limited.

WHO Category for Female Sterilization and Vasectomy

- Accept** No medical reason prevents performing the procedure in a routine setting.
- Caution** The procedure can be performed in a routine setting but with **extra preparation and precautions.**
- Delay** **Delay the procedure.** Condition must be treated and resolved before the procedure can be performed. Provide temporary methods.
- Refer** **Refer client** to a center where an experienced surgeon and staff can perform the procedure. Setting should be equipped for general anesthesia and other medical support. Provide temporary methods. (WHO calls this category “Special.”)

WHO Medical Eligibility Criteria for Starting Contraceptive Methods

CONDITION	Combined OCs	Progestin-Only OCs	DMPA/NET EN	Norplant Implants	Female Sterilization	Vasectomy	Condoms	Tcu-380A IUD	Spermicides	Diaphragm, Cervical Cap	Fertility Awareness-Based Methods	Lactational Amenorrhea Method (LAM)
Pregnant	4	4	4	4	Delay	–	1	4	1	1	–	–
Age												
Less than 16	1	2	2	2	Accept ^a	– ^a	1	2	1	1	1 ^{b,c}	1
16 to 19	1	1	1	1	Accept ^a	– ^a	1	2	1	1	1	1
20 to 39	1	1	1	1	Accept ^a	– ^a	1	1	1	1	1	1
40 and over	2	1	1	1	Accept ^a	– ^a	1	1	1	1	1 ^{b,c}	1
Smoking												
Less than age 35	2	1	1	1	Accept ^a	– ^a	1	1	1	1	1	1
Age 35 and over												
& Light smoker (20 or fewer cigarettes per day)	3	1	1	1	Accept ^a	– ^a	1	1	1	1	1	1
& Heavy smoker (over 20 cigarettes per day)	4	1	1	1	Accept ^a	– ^a	1	1	1	1	1	1
High blood pressure (hypertension)												
Mild (140/90 to 159/99)	2/3 ^d	1	2	1	Caution	–	1	1	1	1	1	1
Moderate (160/ 100 to 179/109)	3/4 ^e	1	2	1	Refer	–	1 ^f	1	1 ^f	1 ^f	1 ^f	1
Severe (greater 180/110) ^g	4	2	3	2	Refer	–	1 ^f	1	1 ^f	1 ^f	1 ^f	1 ^h
Past hypertension where blood pressure cannot be evaluated	3	2	2	2	Caution	–	1	1	1	1	1	1
Diabetes												
Past elevated blood sugar levels during pregnancy	1	1	1	1	Accept	–	1	1	1	1	1	1

^a Sterilization is appropriate for women and men of any age, but only if they are sure they will not want children in the future.

^b This condition may affect ovarian function and/or change fertility signs and symptoms and/or make methods difficult to learn and use.

^c Shortly after menarche (age at first menstrual bleeding) and as menopause approaches, menstrual cycles may be irregular.

^d Category 2 where blood pressure can be monitored periodically. Otherwise, category 3.

^e Category 3 where blood pressure can be monitored periodically. Otherwise, category 4.

^f Higher typical failure rates of this method may expose the user to an unacceptable risk of dangerous unintended pregnancy.

^g With or without vascular disease.

^h Breastfeeding may not be recommended with drugs used to treat this condition.

– Condition not listed by WHO for this method; does not affect eligibility for method use.

Annex B

How To Tell That a Woman Is Not Pregnant

A woman should not start certain family planning methods while she is pregnant. These methods are: combined and progestin-only oral contraceptives, injectables, *Norplant* implants, IUDs, and female sterilization. In contrast, condoms and vaginal methods can and should be used when protection against sexually transmitted diseases is needed during pregnancy.

Although pregnant women should not use some contraceptives, methods other than the IUD probably are not harmful to the mother or the fetus. The best evidence shows that hormonal methods such as oral contraceptives and injectables are not harmful.

A health care provider usually can tell if a woman is not pregnant by asking her questions. Pregnancy tests and physical examinations usually are not needed, they waste resources, and they discourage clients.

- It is reasonably certain that a woman is not pregnant if:
 - Her **menstrual period started within the last 7 days**, OR
 - She **gave birth within the last 4 weeks**, OR
 - She **had an abortion or miscarriage within the last 7 days**, OR
 - She **gave birth within the last 6 months, is breastfeeding often, and has not yet had a menstrual period.**

- If a woman does not fit any of these categories, it is still reasonably certain that she is not pregnant if:
 - She has **not had vaginal sex since her last menstrual period**, OR
 - If she has had sex since her last menstrual period, **she used family planning correctly* and her last menstrual period was less than 5 weeks ago.**

If she has had sex and her last period was 5 weeks ago or more, pregnancy cannot be ruled out, even if she used effective contraception. Has she noticed early signs of pregnancy? If more than 12 weeks since her last menstrual period, has she noticed later signs of pregnancy?

Signs of Pregnancy

Early signs of pregnancy

- Late menstrual period
- Breast tenderness
- Nausea
- Vomiting
- Weight change
- Always tired
- Mood changes
- Changed eating habits
- Urinating more often

Later signs of pregnancy

- Larger breasts
- Darker nipples
- More vaginal discharge
- Enlarged abdomen
- Movements of a baby

If she has had several of these signs, **she may be pregnant**. Try to confirm by physical examination.

- If her answers cannot rule out pregnancy, she should either have a laboratory pregnancy test, if available, or wait until her next menstrual period before starting a method that should not be used during pregnancy. A provider can give her condoms or spermicide to use until then, with instructions and advice on how to use them.

Excerpted from Hatcher et al., 1997.

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