Kiribati National Evidence Based Family Planning Guidelines

Towards a Healthy Family 2015

Contents

Foreword

Te Moan Taeka

E rangi ni kakawaki iroura ngaira ake ti katei Utu bwa ana marurung raoi natira ma ara Utu, ao ea moara riki bon natira ake tina karikia nako aonteaba. E rikirake te botanaomata ao e kakoauaki bwa e uarereke kaubwain abara ni kaitara rikiraken te botanaomata.

E korakora ana tabeaianga te tautaeka iaon te kanganga aio ao e kataia te Botaki ni Kuakua ao Katoki aoraki are tabena aio ni makuri korakora n te aro ba ena uarereke te kanganga ao ena teimatoa te marurung irouia kain Kiribati.

Marurungin te ataei e bon moanaki man te bikoukou ni karokoa 2 ana ririki ao bon te tai ae kakawaki ibukin rikiraken wanawanana. Aio te tai are e na kabatiaki iai te boutoka ma irouia kaaro ibukin natiaa ba ena riki ba te ataei ae marurung ao n wanawana nakon taai aika ana roko.

N ana kai-ni-baire ara Tautaeka, ao e kaungaaki te botanaomata bwa a riai ni karikia natiia nakon korakoraia ao kaubwaia. E rangi ni kakawaki iroun te aine bwa ena marurung raoi ao ni kamaranga ana kariki n te maranga ae uoua te ririki. Kamarangan te kariki e bon angan te tina te marurung ni kona n tararua natina ao ni manga tauraoi rabwatana ni butimwaea te bikoukou ngkana a manga uaia ni iangoia bwa ningai are ana manga karika iai natiia.

Te Tautaeka e rangi ni kaunga bwa 2-3 natim ae tau ibukin korakoran kaubwain te I-Kiribati nakon taai aika ana roko.

E anga na taeka te Botaki ni Kuakua ao Katoki Aoraki ni karabwa te Botaki ae te United Nations Population Fund (UNFPA) ibukin mwanenakin te karikirake aio, ma karekean bwain aoraki ibukin marurungin te Utu.

Karaoan te kai-ni-baire aio, e bon kaota te nano ni boutoka ibukin marurungin te Utu ao ni kaineta ana kouru Kiribati are kangai: “Kauarerekea rikiraken te Botanaomata”.

Honorable Dr. Kautu Tenaua

Minister of Health and Medical Services

Acknowledgements

Thanks to all those who contributed to the development of these guidelines, providing specific input, participating and providing input in workshops as well as review of these guidelines. Following is the list of contributors in alphabetical order with designation and affiliation.

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Abbreviations

AHD	Adolescent Health Development
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Clinic
BP	Blood Pressure
COC	Combined Oral Contraceptives
DMPA/ Depo provera	Depo Medroxy Progesterone Acetate
DPNO	District Principle Nursing Officer
ECP	Emergency Contraceptive Pill
FAB	Fertility Awareness-Based Methods
FP	Family Planning
HB	Haemoglobin
HIC	Health Information Center
HIV	Human Immunodeficiency Virus
IEC	Information, Education & Communication
ICPD	International Conference on Population and Development
IUCD/IUCD	Intra-uterine device/Intra uterine contraceptive device
KFHA	Kiribati Family Health Association
LAM	Lactational Amenorrhoea Method
LMP	Last Menstrual Period
NET-EN	Norethisterone enantate
NSAID	Non-steroidal anti-inflammatory drugs
NSV	No-Scalpel Vasectomy
OC	Oral Contraceptives
POI	Progestogen- only Injectable
POP	Progestogen-only Pill
PNO	Principle Nursing Officer
RH	Reproductive Health
RTI	Reproductive Tract Infection
SDM	Standard Day Method
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
TCH	Tungaru Central Hospital
WHO	World Health Organization
UNFPA	United Nations Population Fund

Executive Summary

Access to family planning is a fundamental human right and is critical to empowering girls and women. The International Conference on Population and Development (ICPD) Programme of Action endorsed by 179 countries in 1994, including Kiribati, called for governments *"to help couples and individuals meet their reproductive goals in a framework that promotes optimum health, responsibility and family well-being, and respects the dignity of all persons and their right to choose the number, spacing and timing of the birth of their children".* (Para 7.14a)

In this regard, the Government of Kiribati is committed to provide good quality and universal access reproductive health services including a full range of family planning methods, to all couples, women and men, including young women and young men.

This document was developed by the Kiribati's Ministry of Health and Medical Services (MHMS) with technical support from the United Nations Population Fund (UNFPA), Pacific Sub-Regional Office. It's an Evidence-Based Guideline developed for helth workers to guide them in the provision of quality family planning and counselling services to clients.

The formulation of the Guideline was inclusive and consultative to ensure contributions of key stakeholders and health care providers were considered.

The finalization was also based on existing practice and adapted from Medical Eligibility Criteria for Contraceptive Use, Four Edition, 2009, The Selection Practice Recommendations for Contraceptive Use, second Edition, 2004, The Global Hand Book for Providers on Family Planning, 2011, and The Population Development Profiles: Pacific Islands Countries, UNFPA, 2014.

The purpose of this comprehensive document is to cover all varieties of family planning methods that will be recommended for use in Kiribati, including Oral methods, Injectable method, Intra-Uterine Contraceptive Device, Implants, Barrier Methods, Sterilization, and others. It also includes other information such as general information on family planning, supply logistic, counselling services, recording, and data collection.

Chapter 1

OVERVIEW OF FAMILY PLANNING METHODS

All individuals and couples should have free access to information as well as family planning (FP) services as they wish and require. Family planning allows family and individuals to achieve their desired number of children and helps them determine the spacing of pregnancies between each other. Thus using appropriate quality contraceptive methods and providing treatment of infertility will be the key factor to achieving family planning.

Access to FP services is a fundamental and principal human right. All individuals should have the basic right to decide freely for themselves of the number of children that they wish to have.

1. Menstrual Cycle and Its Relation to Contraceptive Methods

The menstrual cycle prepares the woman's body for a possible pregnancy. This event occurs every month during the woman's reproductive years. The average range of menstrual cycle is between 26 to 32 days. The length of the menstrual cycle is counted from the first day of menstrual bleeding until the day before the first day of the next menstrual period.

2. What is family planning?

Family Planning is when couples and individuals decide freely and responsibly the number and spacing of their children.

3. Types of Family Planning methods

There are two main categories of family planning methods:

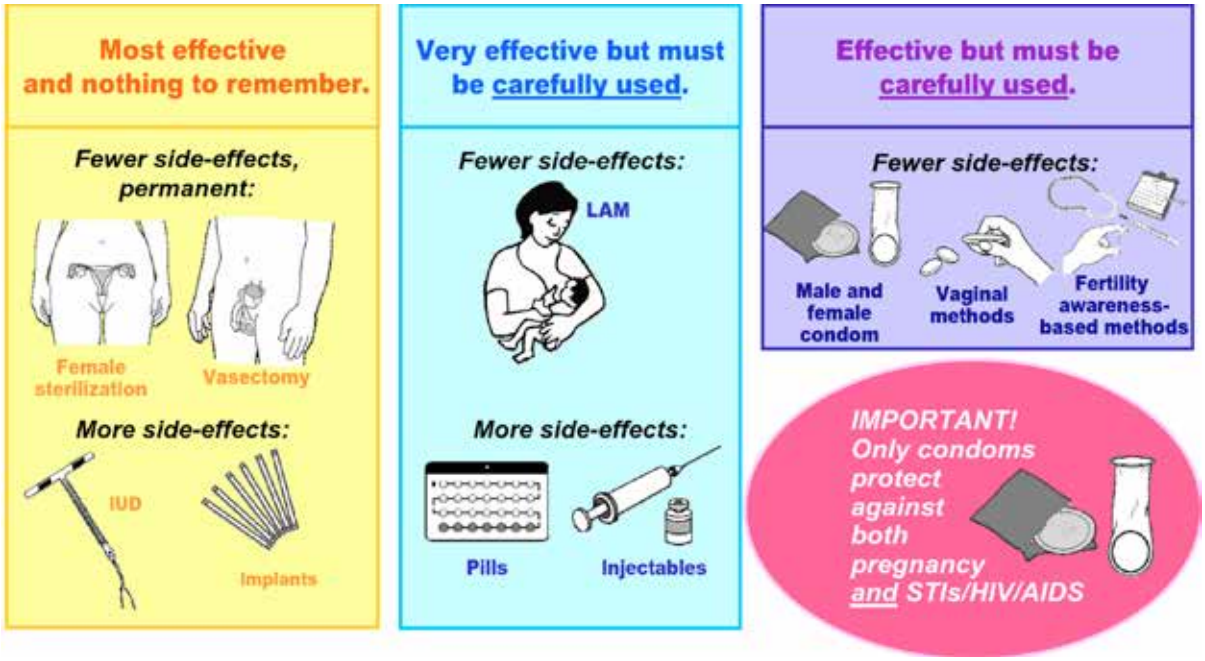
Modern methods:

- Temporary methods such as condoms, oral and injectable hormonal contraceptives, hormonal implants and intrauterine contraceptive devices can be used by couples for spacing births or delay pregnancy.
- Permanent methods such as male (vasectomy) and female (tubal ligation) surgical sterilization can be used by couples who do not wish to have any more children.

Traditional methods:

a. Fertility awareness based methods (Calendar Method, cervical mucus method, temperature method and Sympto-thermal Method) and withdrawal method.

Comparing difference method of FP (Decision making Toll, WHO/ Johns Hopkins, 2005)



4. Benefits of family planning

Family planning has enormous benefits for women; prevents unwanted pregnancies so it eliminates recourse to abortion, saves children's lives, and is a benefit to the family as well as to society.

The following benefits are: (WHO Factsheet, 2013)

- Preventing pregnancy-- it allows women to choose when to become pregnant, and allows spacing between pregnancies
- Reducing infant mortality — it can prevent closely timed pregnancies
- Helping to prevent HIV/AIDS — it helps to prevent unwanted pregnancy among women living with HIV, resulting in fewer infected babies and orphans.
- Empowering people and enhancing education — it allows people to make informed choices on sexual and reproductive health, and is an opportunity for women for enhanced education and participation in public life.
- Reducing adolescent pregnancies —it helps to prevent pregnancy in adolescents which are at higher risk of having complications such as preterm and low birth-weight, and preventing the girl from leaving school because of pregnancy.
- Slowing population growth — which has potential impact on the economy and the environment.

5. Steps in decision making at a Family Planning visit

Clear and concise family planning information should be given to all clients prior to the initiation of any FP methods. The providers should go through a sequence of steps to assist individual clients to reach a decision regarding a particular FP method.

The following steps are:

Step 1: Reason of visit

Client may be present at your clinic for several reasons; en uiring on FP information, post-natal or post-abortion care, recover from miscarriages, or replenish their FP.

Step 2: Determine method of preference:

- Check what the client knows and understand about the method and whether she/he needs more information to make an informed choice
- Assessing contraceptive needs, including need for confidentiality from partner
- Assessing STI protection needs
- Describing options and helping the client make a choice
- Provide appropriate counselling.

Step 3: Clinical assessment including STI/RTI assessment

- Checking the history of the client
- Performing appropriate clinical examination(s)
- Perform laboratory tests if they are needed
- Explain to the client that everyone needs to consider protection from both pregnancy and STIs such as HIV/AIDS and others

Step 4: Review medical eligibility

- There are some restrictions or contradictions in relation to certain FP methods. Therefore, evaluating the client is important to ensure the preferred method is suitable.

Step 5: Method provision

- Performing procedure/providing contraceptive method
- Instructing on the method use and follow up

Chapter 2

COUNSELLING & INFORMED CHOICE

Counselling is a critical element of quality family planning services. Family planning counselling is the process of **two-way face to face communication** by which the counsellor assists the client to make a decision about fertility and contraceptive options. The counsellor need to provides accurate and complete information, addressing the client's particular reproductive health needs, concerns and goals.

Key Messages
a. Good family planning counselling supports informed and voluntary decision-making
b. Counselling requires absolute privacy and confidentiality
c. Effective counselling increases client's satisfaction with family planning methods
d. Provide key information and detailed instructions
e. Listening is as important as giving correct information
f. Integration Counselling Strategy for family planning with STI/HIV counselling

1. Objectives:

- To assist clients to overcome anxieties, clarify any misconceptions and make decisions on whether they need family planning.
- To assist clients with their choice of family planning
- To provide clients information regarding the side effects, advantages and disadvantages of each contraceptive method

2. The counselling process

It's a process where the counselor exchanges information and discusses the specific needs of the client, and through this interaction the client makes a decision. The six elements of counselling process can be summed up in the acronym —"GATHER"

G = Greet client warmly and politely

A = Ask the client about his/her family planning need

T = Tell the client about family planning methods available

H = Help the client decide on the method

E = Explain how to use the method chosen

R = Return visits should be planned

3. The benefits and effectiveness of counselling

In addition to protection of the client's right, counselling will help clients to make informed and voluntary decision-making.

Providing quality of counselling services will help to:

- Increases acceptance of FP services
- Promotes effective use of FP services
- Increases client's satisfaction with FP methods and services
- Enhances continuation of FP services
- Corrects misunderstandings about contraceptive methods

4. Informed choice and decision making

Informed choice is an individual's well-considered, voluntary decision based on options, information, and understanding.

Informed decision-making is the process through which an individual should arrive at a decision about FP.

The decisions that clients make concerning family planning include whether:

- to use contraception to delay, space, or end childbearing
- which method to use
- to continue using contraception if side effects occur from other methods
- to switch methods when the current method is unsatisfactory
- to involve one's partner(s) in decision-making about family planning.

5. Privacy, Confidentiality, and Client Rights

Privacy and confidentiality are essential for all aspects family planning services.

Privacy: This is the client's right and power to control her or his information from being shared in public. Providers must ensure privacy to clients so that unauthorized people are not able to hear their conversation or see the services being provided.

Confidentiality: This means the provider cannot disclose personal health information to anyone else without the patient's consent.

Providers must ensure that no one can gain access to client medical records and other personal information.

Client Rights: Clients have the right to access accurate information, access to safety of services, dignity, expression of opinion, and continuity of care.

6. Client-Provider Interactions

Verbal interactions and sharing of information between the provider and client during each step of a family planning procedure help alleviate client fears and concerns. When a client feels safe and is confident in the provider's skills, the client will be more cooperative. Educating the client about potential side effects and relieving concerns correlate positively with long-term use of temporary family planning methods.

The key principles of effective family planning counselling include the following:

- Show every client with respect
- Ensure visual privacy and confidentiality
- Encourage the client to explain needs, express concerns, and ask questions

- Ensure to related needs such as protection from STIs/HIV, protection from gender-based violence, and support for condom use
- Active listening - as it help to obtain the correct information
- Show empathy for the client's needs
- Remain nonjudgmental about values, behaviors, and decisions that differ from your own
- Use simple words and avoid information overload.
- Respect and support the client's decisions.

7. Communication and Counselling Skills

Both Verbal and Non-verbal skills are very important in counselling; it's allows the counselor to understand and explore for more information, and provide appropriate support to the client's needs.

8. Gender-Sensitive in Counselling

In some circumstances, the counselor may encounter particular problems related to gender that influence clients' decision making on family planning. To address gender-related issues in family planning discussions, the counselor should:

- Discuss with client's on the power to make decisions, and address any gender-related fears and anxieties related to FP use
- Offer clients information related to their reproductive rights
- Encourage the client to make informed choices
- Discuss with client on possibility to bring their partner for counselling
- Based on the client's informed choice of FP, assist them in identifying safe strategies to prevent pregnancy and STIs/HIV

Discuss with young clients how an unplanned pregnancy makes it difficult to continue education and get desired employment.

9. Choosing family planning method

Provider should create the conditions that help client select and decide on a family planning method. The following steps are:

Step 1:	**Listen to the client's contraceptive needs**	Introduce yourself, demonstrate interest, establish eye contact, listen to and answer her/his questions, show support and understanding without judgment, ask questions to encourage participation, ask whether the client would like a FP method.
Step 2:	**Rule-out pregnancy**	Using pregnancy card or pregnancy check list to rule-out pregnancy.
Step 3:	**Display all FP methods using method cards, flip charts, or actual methods**	Show to client the short term methods, long term methods, permanent methods, and fertility awareness methods.
Step 4:	**Set aside methods that are not appropriate for the client**	Check with the following: ❑ Does the client wish to have children in the future ❑ Is she is currently breastfeeding an infant ❑ Does his/her partner support them in FP ❑ Does client have any preference method ❑ Are there any methods that client do not want to use or have not tolerated in the past?
Step 5:	**Give information about the methods including their Effectiveness**	❑ Start with the most effective method ❑ Ensure that the client fully understands each method ❑ Explain that condom (male and female) is the only method that provides dual protection against pregnancy and STIs, including HIV.

Step 6:	**Ask the client to choose the method that is most convenient for her/him**	❑ You may give recommendations, but allow the client to make the final choice ❑ Review the discussion if client is not medically eligible to the selected method ❑ Give the client a back-up method, such as male or female condoms, if the client cannot make up her/his mind.
Step 7:	**Determine client's medical eligibility for the chosen method**	If client is not eligible for the method chosen, explain why and ask her/him to select another method from those that remain
Step 8:	**Give the client complete information about the method that s/he has chosen**	How the method works, side effects, how to use, follow-up (if applicable), when to return to the health care facility.
Step 9: Check that the client understands, and reinforce key information.		
Step 10: Make sure the client has made a definite decision.		

Type of contraceptive	Can start Immediate after birth (Yes/No)	Comments
Combined Oral Contraceptive (COC)	No	Can start COC 6 months after giving birth or when breast milk is no longer the baby's main food
Progesterone Only Pills (POP)	No	Can start POP 6 weeks after giving birth
Progesterone Only Injectables (POI)	No	Can give POI injection at 6 weeks after birth
Hormonal Implants- Jadelle	No	Can start Hormonal Implants with Implants at 6 weeks after given birth
Intrauterine Contraceptive Device (IUCD)	Yes	Can insert IUCD any time within 48 hours after giving birth, including by caesarean delivery.

Chapter 3
CLIENT ASSESSMENT

Client assessment is necessary to ensure that the clients are eligible for the use of the chosen method, to minimize complications and to ensure continuity with the method. Client assessment and subsequently FP use based on eligibility criteria should only be carried out by trained health care workers.

1. History

The aims of history taking are:

- To discover any problems needing treatment or referral
- To record and be aware of client's reproductive health status
- To determine any contraindications to any contraceptive methods
- To discover any complications which may have arisen from any contraceptive method

Gathering information:

The basic information should be gathered during consultation and assessment:

1. **Social History:** Name, Date of Birth, Marital status, and Occupation.
2. **Family History:** whether the client or his/her family has ever had any of the following. history-- High Blood Pressure, Heart Disease, Cancer, Diabetes, Anemia, or Stroke.
3. **Medical and Surgical History:** have client ever had -- significant diseases, past hospitalizations, past surgery, allergic to any medications, any current use of medication.
4. **Menstrual History** (for female client)
   - Age of first menstruation?
   - How long does the period normally last?
   - Is her period regular?
   - Any bleeding between periods?
   - Any severe pain during periods?
   - When was the last menstrual period (LMP)?
5. **Obstetric History:** history of previous pregnancies, including their outcomes such as- live birth, still birth, premature delivery, miscarriage, ectopic pregnancy.

6. Contraceptive History:

- Current use of FP method, if yes, what? Any problem?
- Previous use of FP method? If yes, what? Reason for stopping?
- Does the client wish to space pregnancies or does he/she want to stop having children now?

7. Sexual history:

- Is he/she currently in a sexual relationship? If yes, has the current contraceptive method affected sexual relationship? If so, how?
- Does he/she worry about exposure to STIs, including HIV?

8. Sexually Transmitted Diseases

- Ask if client has any current symptoms or signs of possible STIs such as: vaginal discharge, genital sores, pain on intercourse, lower abdominal pain, etc.
- Any history of previous STIs? if yes, when?

For follow up clients: all revisiting clients, menstrual history, exposure to/risk of STIs, and any new medical problem/treatment and other information as relevant should be asked and recorded.

2. Physical examination

The aims of physical examination are:

- To discover any abnormalities in need of treatment or referral
- To determine if any contraindications to any contraceptive methods exist
- To discover any complications which have occurred from any contraceptive method

Provider should provide a clear explanation to the client about the importance of physical examination and what will be done. It allows the client to understand and become more comfortable with the process.

Examination should be done in a systematic way, and should be checked as the following:

Weight and height:	Underweight or overweight
Blood Pressure (BP):	Elevated BP (systolic over 140-160, diastolic over 90)
Pulse:	Irregularity, weakness
Conjunctivae:	Yellowness (jaundice), pallor (anaemia)
Skin:	Infection, rashes, other problems
Mouth/teeth:	Severe Infection
Thyroid:	Enlargement; nodules
Heart:	Irregular beat, heart murmur, extra heart sounds
Lungs:	Congestion
Breasts:	Masses, tenderness, infection
Abdomen:	Masses, upper or lower abdominal tenderness, liver enlargement

Extremities: Swelling of feet; swelling tenderness of vein

External genitalia and internal genitalia: Infection, other abnormalities

A. Breast Examination

The aim of breast examination is to identify any problem for which the client may need treatment or referral (e.g. mastitis, cracked nipples in breastfeeding women, or tumours). Client should be encouraged to conduct regular breast self-examination.

Five steps for performing breast examination

Step 1: Prepare patient

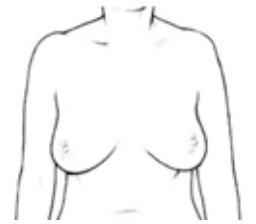
To have more adequate exam, encourage the client to relax and facilitate the client to learn breast self-examination.

Procedure:

- ❑ Explain the process and the important of breast self-examination
- ❑ Explain briefly that you will examine each breast, including the tail of the breast under the arm
- ❑ Wash and dry your hands
- ❑ Ask your client to take off her shirt and bra (should be done in a private area)

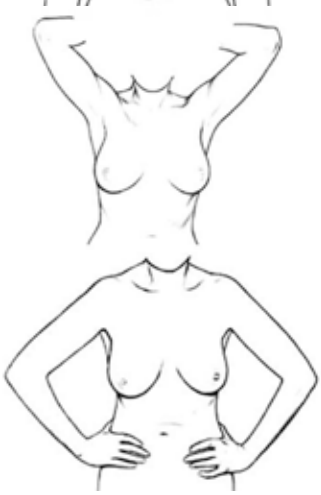
Step 2: Observe (client sitting)

With the client's arms at her side, observe the breasts for any obvious **masses** or any **swelling**, **dimples**, or thickening or discoloured areas of skin.

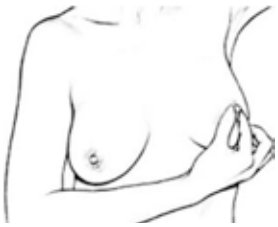


Ask the client to raise her arms over her head, and observe again.

Dimples may indicate cancer under the skin.



Ask her to put her hands on her hips and press against her hips (this tightens the muscles under the breasts). Observe again for dimples or flattened places which look different between the two breasts.



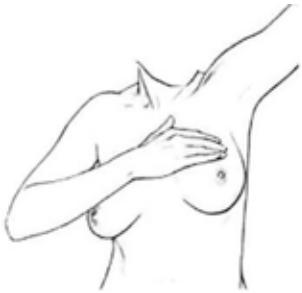
Observe the nipples for any ulcers, rashes or discharge. If one nipple is inverted and the other is not, inquire:

a) Whether the inversion is new? and

b) Whether the inverted nipple can be averted for breastfeeding? (An inversion which is recent, on one side only, or not reversible, is suspicious for an underlying cancer).

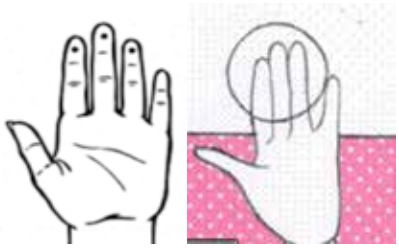
Step 3: Palpation (this step required client to lying down)

Ask her to stretch her arm over her head on the side you are examining (this will spread out the breast tissue and make it easier to detect any masses).

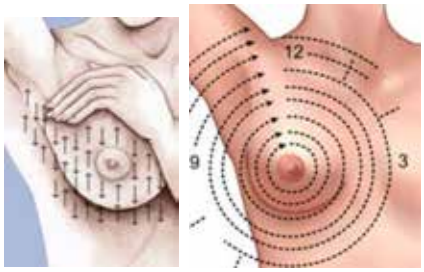


Think of the breast as divided into 4 quadrants, with the tail extending into the axilla (under-arm area).

Examination of the breast must include the tail of the breast, and the lymph nodes which drain the breast. Most breast cancers are found in the upper, outer quadrant of the breast.



Use the pads of the middle 3 fingers to compress and mobilize ("roll") the breast lymph nodes.



Make spiral motions or parallel lines to consistently cover all the breast tissue.

Note down of any abnormalities such as: tenderness or masses (lumps). If you find a mass, gently compress the breast and watch for dimpling of the skin. Compare the mass against characteristics of normal breast tissue.

Normal breast tissues: slightly lumpy feel, symmetric (the lobular tissue is the same in the two breasts), not stuck to the skin overlying the breast or to the muscle underneath the breast, swells just before menses, becoming more tender, and is less full after menses.

Step 4: TEACH breast self-examination

- Ask the client to repeat the procedure
- Watch to see whether she is able to repeat process correctly
- Remind the client to examine her breasts every month after her menses

Step 5: REFER as necessary

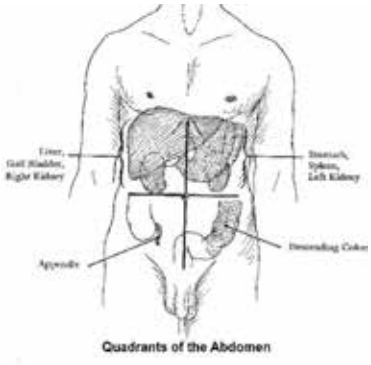
Refer women with any masses suspicious for cancer or other abnormalities to appropriate clinic.

B. Abdominal Examination

The components of abdominal examination include: observation, auscultation, percussion, and palpation. It requires special skills-- looking, listening, feeling and percussing. Imagine the organs in the area that you are examining.

Inspection: Looking for striae, scars, dilated veins, swelling or distension

Palpation



Quadrants of the Abdomen

- Palpation should be done with the flat of the hand rather than the tips
- The abdomen is roughly divided into four quadrants: right upper, right lower, left upper and left lower
- Palpate each quadrant in a systematic manner
- Look for any painful or tender area, then start the palpation at the non-tender areas
- Note down any abnormality, record location, size, texture, mobility

Percussion

To confirm the presence of any masses, organ enlargement, ascites. There are two basic sounds which can be elicited:

- Tympanitic (drum-like) sounds produced by the air filled structures, and
- Dull sounds that occur when a solid structure (e.g. liver) or fluid (e.g. ascites)

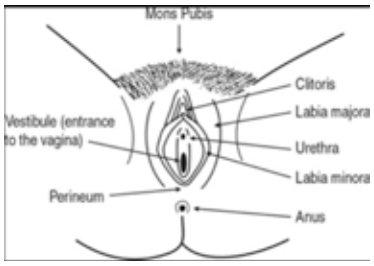
Auscultation

Define if any presence of bowel sounds, fetal heart sounds.. etc.

C. Pelvic Examination

A pelvic examination is a physical examination of the female pelvic organs. It should be performed in dorsal position i.e. patient is lying on a couch on her back with the knees flexed, thus affording a good view of the vulva, it is a convenient position for bimanual examination.

Inspection of External Genitalia



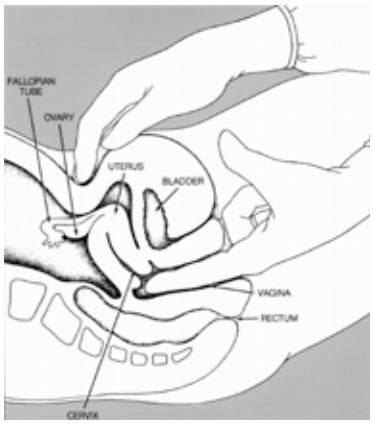
Examination of anatomy, skin lesion, looking for any present of vaginal discharge or bleeding, signs infection, ulceration, growths or swelling.

Internal examination

Speculum Exam:

- Use a speculum to visualize vagina and cervix.
- Duck-bill's (or bivalve) speculum gives an excellent view of the cervix and the vagina
- Insert speculum gently to avoid hurting the client
- Small amount of sterile lubricant is used.
- Look for abnormal discharge/bleeding, any signs of infection, ulceration, lacerations, scars and growth.
- Pap smear and swabs for infection screening should be carried out if needed

Bimanual Exam:



The purpose of the examination is to look at the size and shape of external and internal reproductive organs. It should be done with an empty bladder. Thus, patient needs to void just before the pelvic examination.

Processes:

- Using the right index and middle fingers, guarded with a glove and well lubricated,
- Placing the left hand on the supra-pubic region so that the pelvic organs can be palpated between them.
- Systematically check:
  - vagina and cervix digitally
  - uterus, ovaries and fallopian tubes bimanually
- with the vaginal fingers, push the cervix back and upward so that the fundus can be reached by the abdominal fingers.
- Bimanual palpation of the adnexal area.
- Record of any sign of infection, new growth, swelling or any other abnormalities for further actions.

RECORD

Findings should be recorded legibly in the FP case card and in admission form as appropriate.

RULING OUT PREGNANCY

Pregnancy should be ruled out prior to the provision of contraceptive methods — combined oral contraceptive pills, progesterone only pills, hormonal injectables, hormonal implants, IUCD, surgical sterilization and emergency contraception.

INDICATION FOR PREGNANCY TEST

Pregnancy test is indicated in all clients who have one or more of the following

- Missed her menstrual periods
- Abnormal vaginal bleeding
- Irregular cycles
- Lactating with irregular bleeding or amenorrhea
- Signs and symptoms of pregnancy such as (early morning nausea, vomiting, breast tenderness).

D. STI/RTI Assessment

STI/RTI assessment and prevention should be mentioned at each family planning visit. The opportunities for addressing STIs/ RTIs during the initial (choosing the method) visit and routine follow-up visits are different and should be treated separately.

Women attending a family planning clinic for the first time are usually interested in method for family planning. Client's concern may or may not be about STI/RTI. However this is an opportunity to address STI/RTI.

Initiation of the discussion about STI/RTI should be timed appropriately. If STI/RTI assessment done too early, the woman might feel that her primary concern i.e. family planning, is being overlooked. If brought up too late the choice of the method might have to be reconsidered.

Further evaluation and laboratory tests should be done as indicated by history and clinical examination. The extent of STI/RTI diagnostic or screening work up depends on the resources available at the facility.

Management: Symptomatic women can be managed without laboratory tests i.e. using the syndromic approach. If the client needs further tests then this can be done by referring the client to a specialist.

Chapter 4

ORAL CONTRACEPTIVE METHODS

1. Low Dose Combined Oral Contraceptive Method (COC)

Low dose combined oral contraceptive pills are preparations of synthetic estrogens and progestogens and this form of contraception is highly effective in preventing pregnancy.

A. TYPES OF COMBINED ORAL CONTRACEPTIVE PILLS (COC)

In Kiribati, the combined oral contraceptive pills are low dose monophasic (fixed concentration of estrogen and progesterone) pills and are available as 28 days pills. The COCs are usually supplied in packs, each pack containing 3 'cards' one card for each month.

In 28 days pills one pill containing hormones (active pill) is taken every day for 21 days followed by the 7 placebo (inactive, non-hormonal) pills which are taken one pill each day on the last 7 days.

The low dose COCs commonly available in Kiribati is Microgynon ED. It contains Ethinyl Estradiol 0.03 mgms and Levonorgestrel 0.15 mgms. The seven non hormonal pills contains ferrous fumarate 75 mgms.

B. EFFECTIVENESS AND RETURN TO FERTILITY

Effectiveness

The effectiveness depends on the user: the risk of pregnancy is greatest when a woman starts a new pill pack for 3 or more days late, or misses 3 or more pills near the beginning or end of a pill pack.

Return to fertility

When the woman stops taking the COC, her fertility returns to normal soon after stopping COC. Use of the pill does not alter a woman's capacity for normal fertile cycles. If a woman does not resume normal cycles after stopping the COC, a specific cause other than pill use should be sought.

c. SIDE EFFECTS

The common side effect with COC includes:

- Changes in bleeding patterns: lighter bleeding, irregular bleeding, frequent bleeding, or no monthly bleeding

- Others: - headaches, dizziness, nausea, breast tenderness, weight change, mood changes, acne (can improve or worsen, but usually improves). It's also increases blood pressure.

d. HEALTH BENEFITS AND RISKS

Health Benefits:

If taken correctly, COCs will provide continuous, reversible and very effective[1] protection against pregnancy.

Help protect against---	Risks of pregnancy, cancer of the lining of the uterus (endometrial cancer), cancer of the ovary and symptomatic Pelvic Inflammatory Disease
May help protect against--	Ovarian cysts, Iron-deficiency anemia
Reduce---	Menstrual cramps, menstrual bleeding problems, ovulation pain, excess hair on face or body, symptoms of polycystic ovarian syndrome (irregular bleeding, acne, excess hair on face or body), symptoms of endometriosis (pelvic pain, irregular bleeding)

Health Risks: The health risks due to COC are rare. The possible risks are:

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

e. WHO CAN USE COC

Nearly all women can use COCs safely and effectively, include women who:

- have or have not had children
- not married
- any age, including adolescents and women over 40 years old
- have just had an abortion or miscarriage
- smoke cigarettes—if under 35 years old
- have anemia now or had in the past
- have varicose veins
- infected with HIV, whether or not on antiretroviral therapy, unless that therapy includes ritonavir

Women can begin using COC without: --pelvic examination, blood tests or other routine laboratory tests, cervical cancer screening, breast examination and even when a woman is not having monthly bleeding at the time with pregnancy being ruled out.

f. WHO CAN NOT USE COC

Do not provide COC to women listed below:

- breast feeding a baby less than 6 months old
- 35 years of age or older and smokes
- have cirrhosis of the liver, or a liver infection, or liver tumor

[1] 92 of every 100 women using COCs will not become pregnant (Family Planning, A Global Handbook for Providers, 2011)

- ❑ have high blood pressure
- ❑ had diabetes for more than 20 years or damage to their arteries, vision, kidneys, or nervous system caused by diabetes
- ❑ have gallbladder disease now or take medication for gallbladder disease
- ❑ ever had a stroke, blood clot in their legs or lungs, heart attack, or other serious heart problems
- ❑ have or had breast cancer
- ❑ have migraine
- ❑ taking medications for seizures
- ❑ planning major surgery that will keep her from walking for one week or more
- ❑ have several conditions that could increase chances of heart disease (coronary artery disease) or stroke, such as older age, smoking, high blood pressure, or diabetes

g. WHEN TO START

A woman can start using COCs at any time she wants if pregnancy can be ruled out.

Having menstrual cycles or switching from a non-hormonal method	❑ if she is starting within 5 days after the start of her monthly bleeding, NO need for a backup method ❑ if she start pill more than 5 days after the start of her monthly bleeding, Need a backup method for first 7 days ❑ she can start COC immediately If she is switching from an IUCD
Switching from hormonal method	❑ Can start COC immediately if she has been using the hormonal method consistently and correctly or if confirmed of no pregnancy ❑ If she is switching from injectables,- can start COCs when the repeat injection would have been given. NO need for a backup method
Fully or nearly fully breastfeeding Less than 6 months after giving birth	❑ Can start COC 6 months after giving birth or when breast milk is no longer the baby's main food
More than 6 months after giving birth	❑ If her monthly bleeding has not returned, - can start COCs any time if pregnancy can be ruled out, **Plus**- need a backup method for first 7 days. ❑ If her monthly bleeding has returned, - start COCs as advised for women having menstrual cycles

Partially breastfeeding Less than 6 months after giving birth More than 6 months after giving birth	❑ Can start taking COC after 6 months, Plus - backup method to use 6 weeks after giving birth ❑ If her monthly bleeding has not returned, - can start COCs any time if pregnancy can be ruled out. Plus- need a backup method for first 7 days ❑ If her monthly bleeding has returned, - start COCs as advised for women having menstrual cycles
Not breastfeeding Less than 6 months after giving birth More than 6 months after giving birth	❑ Can start COCs at any time on days 21–28 after giving birth. No need for back up ❑ If her monthly bleeding has not returned, - can start COCs any time if pregnancy can be ruled-out. Plus - backup method for the first 7 days. ❑ If her monthly bleeding has returned, start COCs as advised for women having menstrual cycles
No monthly bleeding (not related to childbirth or breastfeeding) **After miscarriage or abortion**	❑ Can start COCs any time if pregnancy can be ruled out, **Plus**- backup method for first 7 days. ❑ Can start COC Immediately. ❑ If she is starting within 7 days after 1st or 2nd trimester miscarriage or abortion, NO need for a backup method. ❑ If she is starting more than 7 days after 1st or 2nd trimester miscarriage or abortion, Need for a backup method for first 7days.
After taking emergency Contraceptive pills (ECPs)	❑ Can start COCs the day after she finishes taking the ECPs ❑ A new COC user should begin a new pill pack. ❑ A continuing user who needed ECPs due to pill-taking errors can continue where she left off with her current pack. ❑ All women will need to use a backup method for first 7 days.

h. MANAGING PROBLEMS AND SIDE EFFECTES

All women should be counseled and given a clear explanation on the possible side effects prior to starting use of any FP methods.

❍ **Missing Pills** **Missed 1 or 2 pills.** Started new pack 1 or 2 days late	❑ Take a hormonal pill as soon as possible. ❑ Little or no risk of pregnancy
Missed pills 3 or more days in a row in the first or second week. Started new pack, 3 or more days late	❑ Take a hormonal pill as soon as possible ❑ Use a backup method for the next 7 day ❑ if she had sex in the past 5 days, can consider ECPs

Missed 3 or more pills in the third week	❑ Take a hormonal pill as soon as possible ❑ Finish all hormonal pills in the pack. Throw away the 7 non-hormonal pills in a 28-pill pack ❑ Start a new pack the next day ❑ Use a backup method for the next 7 days ❑ Also, if she had sex in the past 5 days, can consider ECPs
Missed any non-hormonal pills (last 7 pills in 28-pill pack)	❑ Discard the missed non-hormonal pill(s) ❑ Start the new pack as usual.
Severe vomiting or diarrhea	❑ If she vomits within 2 hours after taking a pill, she should take another pill from her pack as soon as possible, then keep taking pills as usual. ❑ If she has vomiting or diarrhea for more than 2 days, follow instructions for 3 or more missed pills

❍ **Irregular bleeding**

❑ Provide reassurance to client

❑ Find out the possible cause of bleeding: missed pills, taking pills at different times every day, vomiting or diarrhea, or taking anticonvulsants or rifampicin

❑ Advise client to take pill correctly

❑ Can try with Ibuprofen 800mg 3 times daily after meals for 5 days. If she has been taking the pills for more than a few months and NSAIDs do not help, give her a different COC formulation, if available.

❍ **No monthly bleeding**

❑ Provide reassurance

❑ Check—if she skip any pill

❑ Check if she has missed hormonal pills or started a new pack late

❑ Tell to women who have missed 3 or more pills or started a new pack 3 or more days late --to return if she has signs and symptoms of early pregnancy

❍ **Ordinary headaches** (nonmigrainous)

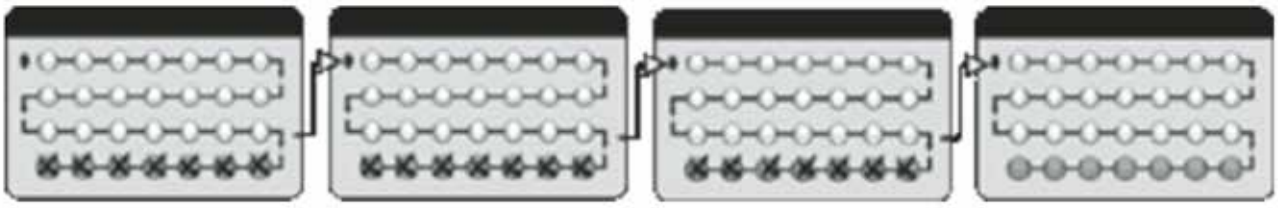
Advise women to try with Aspirin, Ibuprofen, or Paracetamol, and continue with COC as usual. Further investigation should be done if the headache is worst or repeated.

❍ **Nausea or dizziness**

❑ Take COC with food or at bed time

❑ If nausea or dizziness persist: try to take local remedies or try with Extend Use of pills

Extend Use of Pills instruction:



- Skip the last week of pills (without hormones) in 3 packs in a row. (21- day users skip the 7- day waits between the first 3 packs.) No backup method is needed during this time.
- Take all 4 weeks of pills in the 4th pack. (21-day users take all 3 weeks of pills in the 4th pack.) Expect some bleeding during this 4th week.
- Start the next pack of pills the day after taking the last pill in the 4th pack. (21-day users wait 7 days before starting the next pack)

- **Breast Tenderness**

Try to wear a supportive bra, use hot or cold compression, or take Aspirin, Ibuprofen, or Paracetamol.

- **Weight gain**

Review diet, exercise, and counselling if needed.

- **Mood change or change of sex drive**

- Consider Extend Use of Pills
- Ask about changes in her life that could affect her mood or sex drive
- Refer to proper services if symptoms is persist or with severe depression

- **Acne**

If she has been taking pills for more than a few months and acne persists give her a different COC formulation, if available (try with new pill for 3 months).

i. NEW PROBLEM THAT MAY REQUIRE SWITCHING METHODS

- Unexplained vaginal bleeding
- Starting treatment with anticonvulsants, rifampicin, rifabutin
- Migraine headaches or ritonavir
- Un-able to walk for one week or more
- Certain serious health conditions[2]
- Suspect pregnancy

[2]Suspected heart or serious liver disease, high blood pressure, DVT, stroke, breast cancer, diabetes complications, gall bladder disease

2. Progesterone Only Pills (POP)

Progestogen-only Pills (POPs) are oestrogen-free oral contraceptives containing a low dose of progesterone. Progestogen-only pills are also referred to as 'minipills'. POP are good for breast feeding women and can also be taken by non-breast feeding women.

Key Messages

- ❑ Take one pill every day. No breaks between packs
- ❑ Safe for breastfeeding women and their babies
- ❑ Bleeding changes are common but not harmful
- ❑ Can be given to a woman at any time to start later (If pregnancy cannot be ruled out, a provider can give her pills to take later, when her monthly bleeding begins)

a. TYPES OF PROGESTOGEN-ONLY PILLS (POP).

Progesterone -only pills available in Kiribati is Microlut each pill containing active substance i.e.levonorgestrol 0.03 mgms. Each pack has 3 strips/ cycles each strip has 35 tablets.

b. EFFECTIVENESS AND RETURN TO FERTILITY

Effectiveness

Effectiveness depends on the user: For women who have monthly bleeding, risk of pregnancy is greatest if pills are taken late or missed completely.

- ❑ For breast feeding women: when the pills are taken correctly, there are 3 pregnancies per 1000 women using POPs over the first year
- ❑ For non-breast feeding women: POP is less effective. When the pills are taken correctly, there are 9 pregnancies per 1000 women using POPs over the first year

Return to Fertility

When the woman stops taking the POP, her fertility returns to normal soon after stopping POP. Use of the pill does not alter a woman's capacity for normal fertile cycles. If a woman does not resume normal cycles after stopping the POP, a specific cause other than pill use should be sought.

c. SIDE EFFECTS

The possible side effects are:

- ❑ Changes in bleeding patterns including: longer delay in return of monthly bleeding after childbirth for breastfeeding women, frequent bleeding, irregular bleeding, infrequent bleeding, prolonged bleeding, no monthly bleeding.
- ❑ Other side effect includes: headache, dizziness, mood changes, breast tenderness, abdominal pain, and nausea.

d. HEALTH BENEFITS AND HEALTH RISKS

Health Benefits: Help protect against the risks of pregnancy

Health Risks: None

e. WHO CAN USE POPs

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

- breastfeeding (starting as soon as 6 weeks after childbirth)
- have or have not had children
- not married
- any age, including adolescents and women over 40 years old
- just had an abortion, miscarriage, or ectopic pregnancy,
- smoke cigarettes, regardless of woman's age or number of cigarettes smoked
- have anemia now or had in the past
- have varicose veins
- infected with HIV, whether or not on antiretroviral therapy, unless that therapy includes ritonavir

Note:

Women can begin using POPs without: -- pelvic examination, blood tests or other routine laboratory tests, cervical cancer screening, breast examination, even when a woman is not having monthly bleeding at the time, if pregnancy can be ruled out.

POPs with HIV:

POP is safe for all women infected with HIV including women who are on ritonavir. Women and encourage to use condoms along with POPs to prevent transmission of HIV and STIs

f. WHO CAN NOT USE POPs

- Women breastfeeding a baby less than 6 weeks old
- have severe cirrhosis of the liver, a liver infection, or liver tumor
- have a serious problem with a blood clot in your legs or lungs
- taking medication for seizures
- have or have ever had breast cancer

g. WHEN TO START

A woman can start using POPs any time she wants if pregnancy can be ruled out.

Fully or nearly fully breastfeeding	
Less than 6 months after giving birth	❑ Can start 6 weeks after giving birth ❑ If her monthly bleeding has not returned: - start POPs any time between 6 weeks and 6 months. **NO** need for a backup method.
More than 6 months after giving birth	❑ If her monthly bleeding has returned: - start POPs as advised for women having menstrual cycles ❑ If her monthly bleeding has not returned: - can start POPs any time if pregnancy can be ruled out. **Plus**- backup method for first 2 days. ❑ If her monthly bleeding has returned: - start POPs as advised for women having menstrual cycles
Partially breastfeeding	
Less than 6 months after giving birth	❑ Start taking POP 6 weeks after giving birth ❑ If her monthly bleeding returns: - give her a backup method to use until 6 weeks since giving birth
More than 6 months after giving birth	❑ If her monthly bleeding has not returned: - Can start POPs any time if pregnancy can be ruled out, **Plus**- need backup method for first 2 days.
Not breastfeeding	
Less than 6 months after giving birth	❑ Can start POPs at any time, **NO** need for a backup method
More than 6 months after giving birth	❑ If her monthly bleeding has not returned: - Can start POPs any time if pregnancy can be ruled out, **Plus**- backup method for first 2 days ❑ If her monthly bleeding has returned: - start POPs as advised for women having menstrual cycles.
Switching from a hormonal method	❑ Immediately, if she has been using the hormonal method consistently and correctly ❑ If she is switching from injectables: - Can begin taking POPs when the repeat injection would have been given. **NO** need for a backup method.

Having menstrual cycles or switching from a non-hormonal method	❑ At any time ❑ If start POPs within 5 days after her monthly bleeding:- **NO** need for a backup method ❑ If start POPs more than 5 days after her monthly bleeding: - needs a backup method for first 2 days. ❑ If she is switching from an IUCD,: - she can start POPs immediately
No monthly bleeding (not related to childbirth or breastfeeding)	❑ Can start POPs any time if pregnancy can be ruled out, **Plus**- need a backup method for first 2 days.
After miscarriage or abortion	❑ Can start immediately ❑ If she start within 7 days after 1st or 2nd trimester miscarriage or abortion, **NO** need for a backup method ❑ If it is more than 7 days after 1st or 2nd trimester miscarriage or abortion: - start POPs any time if pregnancy can be ruled out, **Plus**- need a backup method for first 2 days
After taking emergency contraceptive pills (ECPs)	❑ Can start POPs the day after she finishes taking the ECPs ❑ A new POP user should begin a new pill pack ❑ A continuing user who needed ECPs due to pill-taking errors can continue where she left off with her current pack. ❑ All women - need backup method for first 2 days.

h. MANAGING PROBLEMS AND SIDE EFFECTS

All women should be counseled and explain on the possible side effects prior to start with any FP methods.

Managing Missed Pills	Take a missed pill as soon as possible, and keep taking pills as usual ❑ If she have regular monthly bleeding:- give backup method for the next 2 days ❑ If she have regular monthly bleeding and had sex in the past 5 days: should consider taking ECPs
Severe vomiting or diarrhea	❑ If vomits within 2 hours after taking a pill: - take another pill from the pack as soon as possible, and keep taking pills as usual. ❑ If vomiting or diarrhea continues: - follow the instructions for making up missed pills above.
No monthly bleeding	Provide Reassurance: - Not having monthly bleeding this is not harmful for women on POPs

Irregular bleeding	Provide Reassurance to client: - Not having monthly bleeding this is not harmful for women on POPs. To reduce irregular bleeding, client should: ❑ Make up for her missing pill(s) ❑ Give Ibuprofen, 800mg, three times per days for 5 days ❑ If she has been taking the pills for more than a few months and NSAIDs do not help, give her a different POP formulation, if available Possible cause of irregular bleeding: ❑ Vomiting or diarrhea ❑ Taking anticonvulsants or rifampicin
Heavy or prolonged bleeding (twice as much as usual or longer than 8 days)	❑ Provide Reassurance to client ❑ Give Ibuprofen, 800mg, three times per days for 5 days ❑ Give Irons tables to prevent anemia ❑ Check for underline condition if bleeding is prolong or heavy
Ordinary headaches (nonmigrainous)	❑ Give Aspirin, or Ibuprofen, or Paracetamol
Mood changes or changes in sex drive	❑ Ask about changes in her life that could affect her mood or sex drive ❑ Refer to proper services if symptoms is persist or with severe depression
Breast tenderness	❑ Recommend that she wear a supportive bra ❑ Try hot or cold compresses ❑ Give Aspirin, or Ibuprofen, or Paracetamol

i. NEW PROBLEMS THAT MAY REQUIRE SWITCHING METHODS

Client may require switching to another family planning method of if she have the following conditions:

- ❑ Unexplained vaginal bleeding
- ❑ Starting treatment with anticonvulsants, rifampicin, rifabutin, or ritonavir
- ❑ Migraine headaches
- ❑ Some serious health conditions[3]
- ❑ Heart disease due to blocked or narrowed arteries or stroke
- ❑ Suspected pregnancy

[3]Suspected DVT, liver disease, breast cancer

3. Emergency Contraceptive Pills

Emergency contraception often called "morning after pills,". It refers to contraceptive methods that can be provided to women following unprotected sexual intercourse to prevent an unintended pregnancy. In Kiribati emergency contraception is available in all health centers. Emergency contraceptive pills are effective and safe for the majority of women who may need them, as well as being simple to use.

The mechanism of action of emergency contraceptive pills depends on the time during the menstrual cycle that they are taken. Emergency contraceptive pills may inhibit or delay ovulation, inhibit tubal transport of the egg or sperm, interfere with fertilization or alter the endometrium, thereby inhibiting implantation of a fertilized egg.

Notes: Emergency contraceptive pills:

- Do not cause abortion
- Do not cause birth defects if pregnancy occurs
- Are not dangerous to a woman's health
- Do not promote sexual risk-taking
- Do not make women infertile

a. TYPES OF EMERGENCY CONTRACEPTION

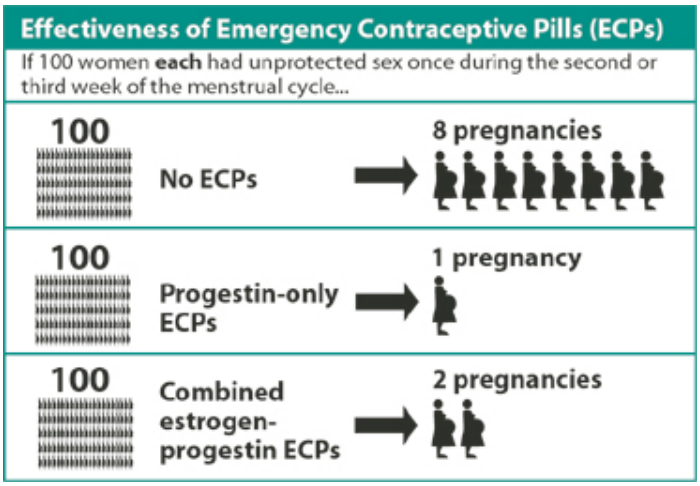
The following are the types of emergency contraceptive pills (ECP)

- Levonorgestrel contraceptive pills (Postinor): Each pack has 2 tablets each tablet containing Levonorgesterol 0.75 mgms. Dedicated packaging is available in Kiribati.
- Combined oral contraceptive pills (Combined ethinylestradiol and levonorgestrel- Microgynon)

b. WHEN TO TAKE

Take **as soon as possible** after unprotected sex. It can also prevent pregnancy when taken any time up to 5 days after unprotected sex. However, the effeteness is better if ECPs can be taken soon after having unprotected sex.

c. EFFECTIVENESS OF EMERGENCY CONTRACEPTIVE PILLS



Source: WHO, FP Guideline 2011

Note:

- All women can use ECPs safely and effectively
- Return of fertility: immediately after taking ECPs
- Protection against sexually transmitted infections (STIs): None

d. ELIGIBILITY FOR EMERGENCY CONTRACEPTION

Emergency contraception is meant to be used only following an unprotected act of sexual intercourse to prevent pregnancy. The following are a number of situations when a woman can use or may need to use emergency contraception:

- When a woman has been a victim of rape/sexual assault.
- After incorrect or inconsistent use of regular contraceptive methods
  - Failed withdrawal method, when ejaculation has occurred in the vagina or on the external genitalia;
  - Miscalculation of the infertile period when using periodic abstinence for e.g. while using cycle beads, failure to abstain from sexual intercourse during the fertile days;
  - Being late for a contraceptive injection;
  - Missed 3 or more active (hormonal) combined oral contraceptive pills in the first week and had unprotected intercourse
  - Missed one or more Progesterone only Pills by more than 3 hours and had unprotected intercourse
  - Unprotected intercourse prior to the effective time of vasectomy
- Accidental failure of other contraceptive methods such as:
  - Condom breakage or slippage
  - IUCD expulsion

e. SIDE EFFECTS

The most common reporting side effect includes:

- **Changes in bleeding patterns:** irregular bleeding for 1–2 days after taking ECPs, or monthly bleeding that starts earlier or later than expected
- **A week after taking ECPs:** nausea, abdominal pain, fatigue, headaches, breast tenderness, dizziness, and vomiting

f. HEALTH BENEFITS AND HEALTH RISKS

Health Benefits	Health Risks
Help protect against risks of pregnancy	None

Dosing Information (FP Global Handbook, 2011)

Pill Type	Total doses need
Levonorgestrel-only	1.5 mg of levonorgestrel in a single dose
Estrogen-progestin	0.1 mg ethinyl estradiol + 0.5 mg levonorgestrel. Follow with same dose 12 hours later
Progestin-only pills with levonorgestrel or norgestrel	❑ Levonorgestrel pills: 1.5 mg levonorgestrel in a single dose. ❑ Norgestrel pills: 3 mg norgestrel in a single dose

Note: Women can take them at once. If she is using a 2-dose regimen, tell her to take the next dose in 12 hours.

g. MANAGING SIDE EFFECTS

Nausea: routine use of anti-nausea medications is not recommended.

Vomiting:

- Should repeat another dose (plus Anti-Nausea medication) if vomits happen within 2 hours after taking ECPs,
- If vomiting continues, she can take the repeat dose by placing the pills high in her vagina

Note: Women should be encouraged in choosing other methods of FP to prevent pregnancy for any future sex.

h. WHEN TO START CONTRACEPTVE AFTER ECPs USE

Combined oral contraceptives, progestin-only pills	Can begin the day after she takes the ECPs. No need to wait for her next monthly bleeding. Plus- need back up method for first 7 days.
Progestin-only injectable	Can start same day as the ECPs. **Plus**- need back up method for first 7 days. Advise client to return if she have any signs or symptoms of pregnancy
Implants	Can start After her monthly bleeding has returned. Give client some back up method while waiting for her monthly period to come.
Intrauterine device (copper-bearing or hormonal IUCDs)	IUCD can be inserted on the same day she takes the ECPs. No need for a backup method.
Male and female condoms, diaphragms, cervical caps, withdrawal	Immediately
Fertility awareness methods	Start with next monthly bleeding. Give client back up method while waiting for her monthly period.

i. MANAGING PROBLEMS

Problems	Management
Slight irregular bleeding	Provide reassurance to client
Change in timing of next monthly bleeding	❑ Provide reassurance to client ❑ Need to assess for pregnancy if her next monthly bleeding is one week later or more than expected after taking ECPs,. **Note: there is no risk to a fetus if ECPs fail to prevent pregnancy.**

Chapter 5

PROGESTERONE ONLY INJECTABLES (POI)

The progestogen-only injectable (POI) contraceptives are synthetic steroid hormones resembling the female hormone progesterone. The injectable hormone is released slowly into the blood stream from the site of the injection.

1. TYPES OF PROGESTOGEN-ONLY INJECTABLE[4] (POI)

Currently depot-medroxyprogesterone acetate (DMPA) known as Depo-Provera® is the injectable contraceptive widely available in Kiribati. Each dose of DMPA/Depo-Provera contains 150 mgms of medroxy progesterone acetate and is given every 3 months (12 weeks) as deep intramuscular injection.

Another type of Progestogen-only injectables is Norethisterone enantate (NET-EN) and each dose of NET-EN contains 200 mgms and is given every 2 months (8 weeks).

Both methods do not contain estrogen, so it can be used throughout breastfeeding and by women who cannot use methods with estrogen.

Key Messages

- ❑ Bleeding changes are common but not harmful
- ❑ Return for injections regularly is very important: every 3 months for DMPA, and every 2 months for NET-EN
- ❑ Repeat injection can be late 4 weeks for DMPA and 2 weeks for Net-En
- ❑ Weight gain is common
- ❑ Return of fertility is often delayed- can take several months after the injection

2. HOW TO GIVE

- ❑ NET-EN: Need to give intramuscular injection. The hormone is then released slowly into the bloodstream.
- ❑ DMPA: Can be injected just under the skin (subcutaneous injection)

[4]NET-EN to be provided when DMPA is not available. Refer recommendation on when to administer if there is a need to switch from DMPA to NET-EN

3. EFFECTIVENESS & RETURN TO FERTILITY

The effectiveness

The effectiveness is depends on the regularity of the injection.

- The risk of pregnancy is about 3 pregnancies per 100 women using progestin-only injectables over the first year.
- If the women follow the regular schedules, the risk of pregnancy is about 3 per 1,000 women over the first year.
- Return average of return fertility is about 4 months for DMPA and 1 month for NET-EN

Return to Fertility

When a client stops taking Progestogen-only injectables (POI), it may take several months for return to fertility. The median delay in return to fertility with DMPA/ Depo-Provera is 10 months and for NET-EN is 6 months from the date of the last injection regardless of the duration of use.

4. SIDE EFFECTS

- Changes in bleeding patterns: NET-EN affects bleeding patterns less than DMPA-
  - First 3 months: Irregular bleeding, or prolonged bleeding
  - At one year: No monthly bleeding, infrequent bleeding, or irregular bleeding
- Other side effects: weight gain, headaches, dizziness, abdominal bloating and discomfort, mood change, or less sex drive.

5. HEALTH BENIFITS

DMPA	NET-EN
Help to protect against: pregnancy, endometrial cancer, and uterine fibroid May help to protect: symptomatic pelvic inflammatory disease, and Iron-deficiency anemia	Help to protect: pregnancy, Iron-deficiency anemia

6. HEALTH RISKS

DMPA and NET-EN has no health risks for women

Note:

- No monthly bleeding during using DMPA and NET-EN is not causing any harm.
- DMPA and NET-EN do not disrupt an existing pregnancy or make women infertile.

7. WHO CAN USE PROGESTIN-ONLY INJECTABLES

Nearly all women can use Progestine-Only, includes women who:

- Have or have not had children
- Are not married
- Are of any age, including adolescents and women over 40 years old
- Have just had an abortion or miscarriage
- Smoke cigarettes

- Are breastfeeding
- Are infected with HIV, whether or not on antiretroviral therapy

Progestin-Only Injectables can be given to women without a pelvic examination, blood tests, cervical cancer screening, breast examination, or to woman who is not having monthly bleeding at the time if pregnancy can be ruled out.

8. THOSE WHO CANNOT USE PROGESTIN-ONLY INJECTABLES

- Who have severe cirrhosis of the liver, a liver infection, or liver tumor
- Who have high blood pressure
- Who have had diabetes for more than 20 years with complications
- Who have had a stroke, blood clot in your legs or lungs, heart attack, or other serious heart problems
- Who have unusual vaginal bleeding
- Who have ever had breast cancer

9. WHEN TO START

Fully or nearly fully breastfeeding	
Less than 6 months after giving birth	❑ Can give injection at 6 weeks after birth ❑ If monthly bleeding has not returned,- can start injection at any time between 6 weeks to 6 months, **NO** need back up method ❑ If monthly bleeding has returned, - can start injectable as advised for women having menstrual cycles
More than 6 months after giving birth	❑ If monthly bleeding has not returned, - can start injectables at any time if pregnancy can be ruled out, **Plus** – backup method for first 7 days ❑ If her monthly bleeding has returned, - can start injectables as advised for women having menstrual cycles
Partially breastfeeding	
Less than 6 months after giving birth	❑ Can give injection at 6 weeks after birth
More than 6 months after giving birth	❑ If monthly bleeding has not returned, - can start injectables at any time if pregnancy can be ruled out, **Plus** – backup method for first 7 days ❑ If her monthly bleeding has returned, - can start injectables as advised for women having menstrual cycles

Not breastfeeding Less than 6 months after giving birth Less than 6 months after giving birth	❑ Can start injectables at any time. **No** need for a backup method ❑ If monthly bleeding has not returned, - can start injectables any time if pregnancy can be ruled out, **Plus** – backup method for first 7 days ❑ If her monthly bleeding has returned, - can start injectables as advised for women having menstrual cycles
No monthly bleeding (not related to childbirth or breastfeeding)	❑ Can start injectables at any time if pregnancy can be ruled out, **Plus** – backup method for first 7 days
After miscarriage or abortion	Can start immediately. ❑ If starting injection within 7 days after first or second-trimester miscarriage or abortion, **NO** need for a backup method. ❑ If starting injection more than 7 days after first or second trimester miscarriage or abortion: - can start injection at any time it pregnancy can be ruled out, **Plus**- backup method for first 7 days
After taking emergency contraceptive pills (ECPs)	❑ Can start injectables on the same day as the ECPs ❑ If injection given within 7 days after the start of her monthly bleeding. She will need a backup method for first 7 days, and advise women to return if she has signs or symptoms of pregnancy

10. GIVING THE INJECTION

Step 1: Get one 1 dose of injectable, needle, and syringe

- ❑ DMPA: 150 mg for intramuscular injection. NET-EN: 200 mg for injections into the muscle
- ❑ Check for expiration date, and make sure that the vial is not leaking
- ❑ For DMPA: use a 2 ml syringe and a 21–23 gauge intramuscular needle
- ❑ For NET-EN: use a 2 or 5 ml syringe and a 19-gauge intramuscular needle (can also use 21-23 gauge)
- ❑ Use a disposable auto-disable syringe and needle from a new sealed package

Step 2: Wash Hands

- ❑ Wash hands with soap and water
- ❑ Wash injection site with soap and water if injection site is dirty
- ❑ No need to wipe site with antiseptic

Step 3: Prepare vial

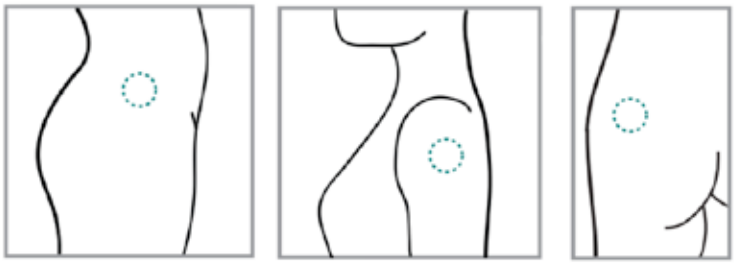
- DMPA: Gently shake the vial
- NET-EN: Shaking the vial is not necessary
- No need to wipe top of vial with antiseptic
- If vial is cold, warm to skin temperature before giving the injection.

Step 4: Fill syringe

Pierce top of vial with sterile needle and fill syringe with proper dose.

Step 5: Inject formula

- Insert sterile needle deep into the hip, or at the upper arm (deltoid muscle), or at buttocks (upper outer portion), whichever the woman prefers.
- Inject the contents of the syringe
- Do not massage injection site.



Step 6: Dispose of disposable syringes and needles safely

- Do not recap, bend, or break needles before disposal
- Place in a puncture-proof sharps container
- Do not re-use disposable syringes and needles

11. MANAGING FOR THE LATE INJECTION

If repeat dose late less than 4 weeks of DMPA, or less than 2 weeks of NET-EN	Can receive her next injection. No need for tests, evaluation, or a backup method.
If repeat dose late more than 4 weeks of DMPA, or more than 2 weeks of NET-EN	Can receive her next injection if: ❑ has not had sex since 2 weeks after her last injection, or ❑ used a backup method or has taken ECPs after any unprotected sex since 2 weeks after her last injection, or ❑ fully or nearly fully breastfeeding and she gave birth less than 6 months ago. Plus - need a backup method for first 7 days after the injection

12. MANAGING PROBLEMS AND SIDE EFFECTS

No monthly bleeding	❑ Provide reassurance to client ❑ If no monthly period is still bothering her, she may wish to switch to another method.
Irregular bleeding	❑ Provide reassurance to client ❑ Provide a short term pain relief with non-steroidal anti-inflammatory drug (e.g 500 mg mefenamic acid 2 times daily after meals for 5 day)—beginning when irregular bleeding starts'
Weight gain	❑ Review diet, physical exercise, and counsel if needed.
Abdominal bloating and discomfort	❑ Try with local available remedies
Heavy or prolonged bleeding (twice as much as usual or longer than 8 days)	❑ Provide reassurance ❑ Try with short term pain relief with non-steroidal anti-inflammatory drug (e.g 500 mg mefenamic acid 2 times daily after meals for 5 day ❑ Give iron tablets and advise on the food intake (food that contain high of iron) – to help with anemia ❑ Choose another method if bleeding becomes a health threat for woman ❑ Consider underline condition if bleeding keeps prolong and heavy
Ordinary headaches	Try with aspirin, ibuprofen, or paracetamol. Should refer client to proper services if headache become prolong or getting worst.
Mood changes or changes in sex drive	Check if she has any changes in her life that could affect her mood or sex drive. Should refer client to proper services if clients have serious mood changes/or depression.
Dizziness	Try with local remedies

13. SWITCH TO OTHER METHODS

Migraine headaches	Help client to choose other method if migraine is prolonged or getting worst.
Unexplained vaginal bleeding	Conduct pelvic examination, and provide treatment appropriately.
Serious health conditions	Refer client to appropriate care services, do not give next injection, and provide backup method to use until the condition is evaluated.
Suspected pregnancy	Stop injection if pregnancy confirmed, do not give next injection, and provide counselling to client. **Note:** There are no risks to a fetus conceived while a woman is using injectables.

Chapter 6

HORMONAL IMPLANTS

Implants are a small capsule, size of a matchstick, containing progestin like the natural hormone progesterone in a woman's body. Since the capsule does not contain estrogen, it can be used throughout breastfeeding and by women who cannot use methods with estrogen. It is a long acting reversible low-dose progestin only method inserted sub-dermally preferably in the inner side of upper arm.

The Implants is one of the most effective and long-lasting methods. It's work primarily by:

- thickening cervical mucus, thus it blocks sperm from meeting an egg
- disturbing the menstrual cycle, plus preventing the release of eggs from the ovaries

Key Messages

- Implants are small flexible capsules that are placed just under the skin of the upper arm
- It provide long-term pregnancy protection
- Need specifically trained skill provider to insert and remove
- Less work for client once implants are in place
- Changing bleeding pattern is comment, but is not harmful

1. TYPES OF IMPLANTS

Jadelle is the hormonal implant that is available in Kiribati. Jadelle has two rods with outer sheaths made of silicon, each rod measures 2.5mm in diameter and 43 mm in length and contains 75mg of levonorgestrel (total 150mgms). Protection from pregnancy is provided within 24 hours when inserted during the first 7 days of a woman's menstrual cycle. Jadelle can be left in place for up to 5 completed years

Jadelle

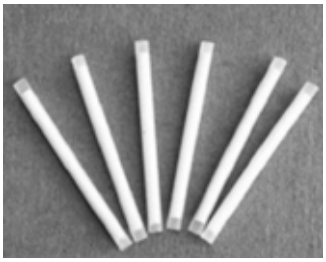
It's 2 rods, effective for 5 years

Implant

1 rod, effective for 3 years

Norplant

6 capsules, effective for 5 years



2. EFFECTIVENESS AND RETURN TO FERTILITY

The effectiveness

Implants is one of the most effective and long-lasting family planning methods.

- Less than 1 pregnancy per 100 women using implants over the first year.
- Jadelle and Norplant start to lose effectiveness sooner for heavier women.

Return to Fertility

When the rods are removed, the return of fertility is immediate; if the client does not want another pregnancy and does not want to use implants any longer, she should begin using another contraceptive method right away.

3. SIDE EFFECTS

Changes in bleeding patterns:

- First several months: lighter bleeding, irregular bleeding, infrequent bleeding, or no monthly bleeding.
- After about one year: lighter bleeding, irregular bleeding, or infrequent bleeding.

Other side effects: headaches, abdominal pain, acne, weight change, breast tenderness, dizziness, mood changes, nausea

4. HEALTH BENEFITS AND HEALTH RISKS

Health Benefits:

- It can help to protect against pregnancy, and symptomatic of pelvic inflammatory disease
- It may help protect against Iron-deficiency anemia

Health Risks: None

Note:

- The effective of Implants will stop working once they are removed
- It can stop monthly bleeding, but this is not harmful
- Implants do not move to other part of the body, and it do not make women infertile

Almost all women can use implants safely and effectively, including women who:

- have or have not had children
- not married
- are of any age
- have just had an abortion, miscarriage, or ectopic pregnancy

- smoke cigarettes
- are 6 weeks after delivery and breastfeeding
- have anemia, varicose veins
- are infected with HIV - with and without ART

5. WHO CANNOT USE IMPLANTS

Implants should not be given to the following women:

- breastfeeding a baby less than 6 weeks old
- have severe cirrhosis of the liver, a liver infection, or liver tumor
- have a serious problem now with a blood clot in your legs or lungs
- have an unusual vaginal bleeding
- have or have ever had breast cancer

6. WHEN TO START THE IMPLANTS

Implant can be given to women at any time if pregnancy can be ruled out.

Having menstrual cycles or switching from a non-hormonal method	Can start at any time of the month ❑ If starting implants within 7 days after the start of her monthly bleeding (5 days for Implanon), - **NO** need for a backup method ❑ If starting implants more than 7 days after the start of her monthly bleeding (more than 5 days for Implanon), and if pregnancy can be ruled out, can Insert Implant at any time **Plus**- need backup method for 7 days
Switching from a hormonal method	Can start with Implants immediately, ❑ If client has been using the hormonal method correctly or if pregnancy can be ruled out, **NO** need for backup method. ❑ If client is switching from injectables, -- can insert Implants when the repeat injection would have been given, **NO** need for a backup method.
Fully or nearly fully breastfeeding Less than 6 months after giving birth	❑ Can start with Implants at 6 weeks after given birth ❑ If monthly bleeding has not returned, - can insert implants at any time between 6 weeks and 6 months, **NO** need for a backup method. ❑ If monthly bleeding has returned, -- can insert implants as advised for women having menstrual cycles
More than 6 months after giving birth	❑ If monthly bleeding has not returned, -- Can insert implants at any time if pregnancy can be ruled out, **Plus** need a backup method for first 7 days. ❑ If monthly bleeding has returned, -- can insert implants as advised for women having menstrual cycles.

Partially breastfeeding Less than 6 weeks after giving birth More than 6 weeks after giving birth	❑ Can start with Implants at 6 weeks after given birth ❑ If monthly bleeding has not returned, -- Can insert implants at any time if pregnancy can be ruled out, **Plus** need a backup method for 7 days ❑ If monthly bleeding has returned, -- can insert implants as advised for women having menstrual cycles
Not breastfeeding Less than 4 weeks after giving birth More than 4 weeks after giving birth	❑ Can insert implants at any time, **NO** need for a backup method ❑ If monthly bleeding has not returned, -- Can insert implants at any time if pregnancy can be ruled out, **Plus** need a backup method for first 7 days ❑ If monthly bleeding has returned, -- can insert implants as advised for women having menstrual cycles
No monthly bleeding (not related to childbirth or breast feeding)	❑ Can insert implants at any time if pregnancy can be ruled out, **Plus** need a backup method for first 7 days
After miscarriage or abortion	Can start with Implants immediately ❑ If implants inserted within 7 days after first or second trimester of miscarriage or abortion, **NO** need for a backup method. ❑ If implants inserted more than 7 days after first or second trimester miscarriage or abortion, -- can Insert Implant at any time, if pregnancy can be ruled out, **Plus** – need a backup method for first 7 days
After ECPs	❑ Can insert Implants within 7 days after the start of her next monthly bleeding (within 5 days for Implanon) or at any time if pregnancy can be ruled out. ❑ Give client a backup method to start the day after she finishes taking the ECPs, to use until the implants are inserted

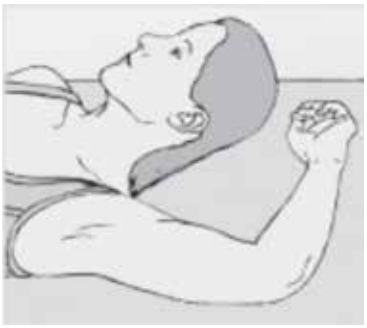
7. INSERTING IMPLANTS

Women should receive details information on the method as well as the insertion procedure.

Note: Implanon is come with a special applicator. Thus, it does not require an incision.

Procedure for insertion:

Step 1: Prepare clients and provide proper infection-prevention procedures.

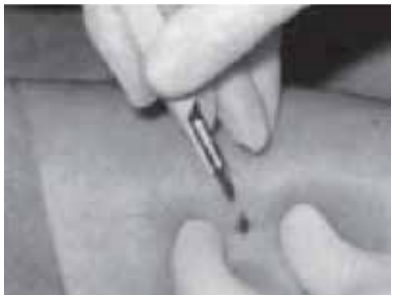


- Check if the client have allergies to any chemical including the antiseptic and anesthetic to be used during insertion
- Have the patient lie on her back on the examination table
- The provider uses proper infection-prevention procedures.

Step 2: Give local anesthesia

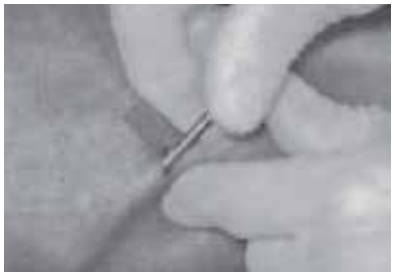
Identify the insertion site; give injection of local anesthetic under the skin of her arm to prevent pain while you insert the implants.

Step 3: Incision



Makes a small incision in the skin on the inside of the upper arm.

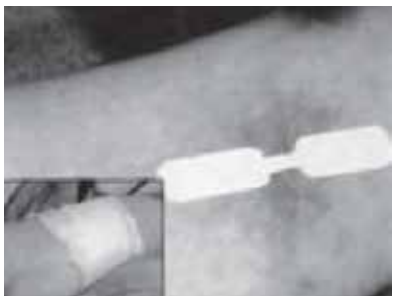
Step 4: Insertion of the implants



Inserts the implants just under the skin using the appropriate applicator.

The woman may feel some pressure or tugging.

Step 5: Closes the incision



- After the implants are inserted, the provider needs to closes the incision with an adhesive bandage. Stitches are not needed.
- The incision is covered with a dry cloth and the arm is wrapped with gauze.

8. FOLLOW UP

All clients provided hormonal implants are advised

- Routine yearly follow-up.
- Return to facility earlier if she has any concerns, side-effects or if she wants to change the method.

Assessment at follow up:

- Assess the client's satisfaction with the method.
- Update the medical history; measure blood pressure, and perform any examination indicated by the history.
- Determine if the client has had any problems or side effects and, if so, record them in the client clinical card/ record.
- Assess for any STI/RTI related concerns or if the client has any symptoms related to STI/RTI.
- Provide appropriate counselling and/or treatment as required.
- Refer client to an appropriate referral facility if any serious problems or side effects cannot be managed at the facility were client has attended for follow up care. Complete and provide the client with referral form.
- Update client's contact information (address, telephone number etc)

9. REMOVING IMPLANTS

Women can request for removal of the implants at any time if she is not happy with the method. Provider should provide details information on removal's procedure.

Procedure for removal:

Step 1: Prepare clients and provide proper infection-prevention procedures

- Have the patient lie on her back on the examination table.
- The provider uses proper infection-prevention procedures

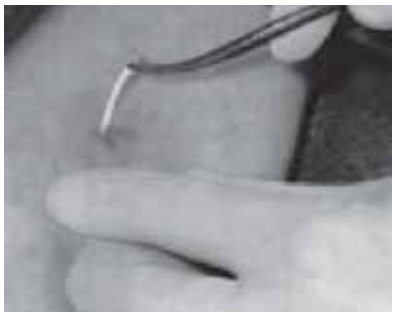
Step 2: Give local anesthesia

Identify the insertion site; give injection of local anesthetic under the skin of her arm to prevent pain while you insert the implants.

Step 3: Incision

Makes a small incision in the skin, - near the site of the incision

Step 4: Pull out the implants



- Using an instrument to pull out each Implant from the forearm.
- A woman may feel slight pain or soreness during the procedure and for a few days after.

Step 5: Closes the incision

- Closes the incision with an adhesive bandage.
- Stitches are not required. An elastic bandage may be placed over the adhesive bandage to apply gentle pressure for 2 or 3 days and keep down swelling.

10. MANAGING WITH SIDE EFFECTS

Irregular bleeding	❑ Provide reassurance to the client ❑ Try with ibuprofen, 800mg, 3 times daily after meals for 5 days, beginning when irregular bleeding starts ❑ If symptom is not improve, give combined oral contraceptive, take one table per day for 21 days ❑ Should check for other underline condition if irregular bleeding does not improve after several months after the insertion.
No monthly bleeding	Provide reassurance to the client
Heavy or prolonged bleeding (twice as much as usual or longer than 8 days)	❑ Provide reassurance to the client ❑ Try with ibuprofen, 800 mg, 3 times daily after meals for 5 days, beginning when irregular bleeding starts ❑ Give iron table to prevent anemia ❑ Should check for other underline condition if heavy bleeding still persist and does not improve after several months after the insertion
Ordinary headaches	❑ Try with aspirin, ibuprofen, or paracetamol ❑ Should check for other underline condition if headache persist or getting worst
Mild abdominal pain	Try with aspirin, ibuprofen, or paracetamol

Acne	Switch to COC can help to improve acne
Weight change	Review diet, physical exercise, and counselling if need it.
Breast tenderness	❑ Wear a supportive bra, or try hot or cold compresses ❑ Try with aspirin, ibuprofen, or paracetamol
Mood changes or changes in sex drive	❑ Check if any changes in her life that could affect her mood or sex drive ❑ Should refer client to proper care if clients have serious mood changes such as major depression
Pain after insertion or removal	❑ Check if the bandage or gauze on her arm is not too tight ❑ Avoid pressing to the insertion place for a few days ❑ Try with aspirin, ibuprofen, or paracetamol
Infection at the insertion site (redness, heat, pain, pus)	❑ Do not remove the implants ❑ Clean the infected areas with antiseptic, or soap and water ❑ Give oral antibiotic for 7 to 10 days ❑ Ask the clients to return if the infection still persist after the course of antibiotic or visible of any expulsion of the implants
Abscess (pocket of pus under the skin due to infection)	❑ Clean the infected areas with antiseptic ❑ Cut open (incise) and drain the abscess and treat the wound. ❑ Give oral antibiotic for 7 to 10 days ❑ Ask the clients to return if the symptoms still persist after the course of antibiotic, and remove the implants
Expulsion (when one or more implants begins to come out of the arm)	❑ Is really rare, however, but it can happen during the infection. ❑ Replace the expelled rod(s) through the new insertion next to the other rods.
Severe pain in lower abdomen	❑ Lower abdomen pain cam due to many reasons including ovarian cysts. ❑ Women can still use implants during medical evaluation

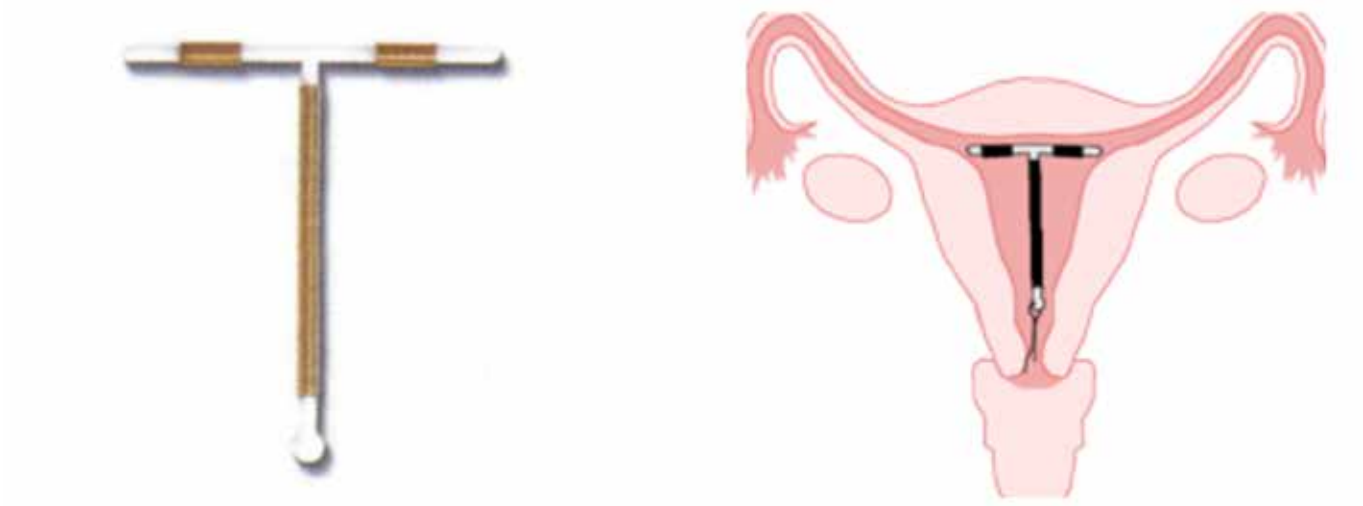
11. SWITCHING METHODS

Consider of switching to other FP method if clients presenting with the following symptoms:

- ❑ Un-explained vaginal bleeding
- ❑ Migraine headaches
- ❑ Certain serious health conditions: suspected blood clots in deep veins of legs or lungs, serious
- ❑ Heart disease due to blocked or narrowed arteries or stroke, liver disease, or breast cancer
- ❑ Suspected pregnancy

Chapter 7

INTRAUTERINE CONTRACEPTIVE DEVICE (IUCD)



The Intra Uterine Contraceptive Devices (IUCD) is a small flexible device that is inserted into the uterus through the vagina. The IUCD is a safe effective long term reversible method for FP.

Key Messages
❑ It provide long-term pregnancy protection
❑ Need to be inserted into the uterus by a specifically trained skill provider
❑ Little required of the client once the IUCD is in place
❑ Bleeding changes are common
❑ Return of fertility after IUCD is removed: no delay

1. TYPES OF IUCD AVAILABLE IN KIRIBATI

The IUCD currently available in Kiribati is the Copper T 380A. The Copper T 380A is small, flexible and shaped like a T with a plastic frame and copper on the stem and the arms, with a total exposed copper area of 380 square mm. It usually has a double stranded white string at its base, which extends through the cervix so that the IUCD can be removed.

2. EFFECTIVENESS AND RETURN OF FERTILITY

Effectiveness

IUCD is one of the most effective and long-lasting methods.

- ❑ Less than 1 pregnancy per 100 women using an IUCD over the first year

- Over 10 years of IUCD use: About 2 pregnancies per 100 women

Return to Fertility

Fertility returns immediately after the removal of IUCD.

3. SIDE EFFECTS

Changes in bleeding patterns are common in the first 3 to 6 months: prolong and heavy bleeding, irregular bleeding, or more cramps or pain during monthly bleeding.

4. HEALTH BENEFITS, HEALTH RISKS AND COMPLICATIONS

Health Benefits	Health Risks
IUCD can help to protect against the risks of pregnancy. It is also may help to protect against endometrial cancer.	Heavy monthly period is comment with women with IUCD. Thus, it may be possible risk of anemia.

Complications

- Complication with IUCD is uncommon.
- Perforation of the wall of the uterus by the IUCD or an instrument used for insertion is very rate, however, it's usually heals without treatment.
- Miscarriage, preterm birth, or infection in women with IUCD is also very rare case.

Note: IUCD Do Not--

- increase the risk of contracting STIs, including HIV
- increase the risk of miscarriage (after the IUCD is removed)
- make women infertile
- cause birth defects
- cause cancer
- move to the heart or brain
- cause discomfort or pain for the woman during sex

5. WHO CAN USE IUCD

Almost all women can use IUCDs safely and effectively, including women who:

- have or have not had children
- are not married
- in any age
- just had an abortion or miscarriage
- breastfeeding
- do hard physical work,
- had ectopic pregnancy
- had pelvic inflammatory disease (PID)
- have vaginal infections, have anemia

- ❑ infected with HIV or on antiretroviral therapy.

Note: Women can start with IUCD without: -- STI/HIV testing or any other routine laboratory tests, cervical cancer screening, or breast examination.

6. WHO CAN NOT USE IUCD

IUCD should not be given to the category of women stated below:

- ❑ give birth more than 48 hours ago but less than 4 weeks
- ❑ have an infection following childbirth or abortion
- ❑ have unusual vaginal bleeding
- ❑ have any gynecologic, obstetric conditions, or problems such as genital cancer or pelvic tuberculosis
- ❑ have AIDS
- ❑ at very high individual risk for gonorrhea or chlamydia
- ❑ suspect of pregnancy

7. WHEN TO START IUCD

Woman can start with IUCD at any time if pregnancy can be ruled out.

Having menstrual cycles	Can start with IUCD at any time. ❑ If IUCD insertion within 12 days after the start of her monthly bleeding, - **NO** need for a backup method. ❑ If IUCD insertion after 12 days after the start of her monthly bleeding, - can start with IUCD any time if pregnancy can be ruled out, **NO** need for a backup method
Switching from another method	Can start with IUCD immediately. ❑ If she has been using the method consistently and correctly or if pregnancy can be ruled out, NO need to wait for her next monthly bleeding and **NO** need for a backup method ❑ If she is switching from injectables, - can insert IUCD at her due day for the next injection, - No need for a backup method.
Soon after childbirth	❑ Can insert IUCD any time within 48 hours after giving birth, including by caesarean delivery. ❑ If it is more than 48 hours after giving birth, - need to delay until 4 weeks or more.

Fully or nearly fully Breast feeding Less than 6 months after giving birth More than 6 months after giving birth	❑ If monthly bleeding has not returned, -- can insert the IUCD at any time between 4 weeks and 6 months after giving birth. **NO** need for a backup method. ❑ If monthly bleeding has returned, -- can have the IUCD inserted as advised for women having menstrual cycles ❑ If monthly bleeding has not returned, -- can insert the IUCD at any time if pregnancy can be ruled out, **NO** need for a backup method. ❑ If monthly bleeding has returned, -- can have the IUCD inserted as advised for women having menstrual cycles
Partially breastfeeding or not breastfeeding More than 4 weeks after giving birth	❑ If monthly bleeding has not returned, -- can insert the IUCD at any time if pregnancy can be ruled out. **NO** need for a backup method. ❑ If monthly bleeding has returned, -- can have the IUCD inserted as advised for women having menstrual cycles.
No monthly bleeding (not related to childbirth or breastfeeding)	Can start with IUCD at any time if pregnancy can be ruled out. **NO** need for a backup method.
After miscarriage or abortion	Can insert IUCD immediately ❑ If the insertion is done within 12 days after first or second trimester abortion or miscarriage, and if no infection is present. NO need for a backup method. ❑ If the insertion is done more than 12 days after first or second trimester miscarriage or abortion, and no infection is present,-- can insert IUCD at any time if pregnancy can be ruled out. **NO** need for a backup method. ❑ If infection is present, treat the infection, and help the client choose another method.
For emergency contraception	Can be inserted within 5 days after unprotected sex
After taking emergency Contraceptive pills (ECPs)	Can be inserted on the same day with ECPs. **NO** need for a backup method.

8. PREVENTING INFECTION AT IUCD INSERTION

Proper technique should be applied at all times during the IUCD insertion. This will help to avoid problems during the insertion as well as prevent complications. The following techniques are:

- ❑ Follow the proper infection control procedures.
- ❑ Always use a proper sterile instruments
- ❑ Always use the new and sterilized IUCD
- ❑ Use " Non-Touch Technique" during the insertion, avoid touching the IUCD directly

9. INSERTING THE IUCD

Explaining to client:

Details information on IUCD should be given to client prior to insertion. The information includes:

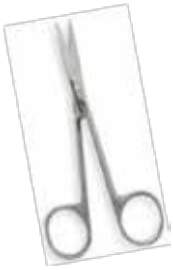
- The insertion procedure
- Show her the instruments: - speculum, tenaculum, sound, including the IUCD and inserter in the package.
- Inform clients that she will be expected some discomfort or cramping during the procedure,
- Ask her to tell you any time when she feels discomfort or pain.
- Some medications such as Ibuprofen, paracetamol, or other pain reliever may be given 30 minutes before insertion to help reduce cramping and pain. (Do not give aspirin, which slows blood clotting)
- Explain about insertion steps

Instruments: below is the list of the instruments need for IUCD insertion

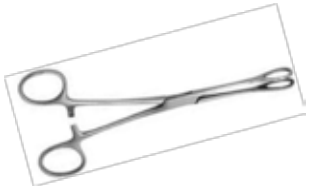
Speculum

Tenaculum

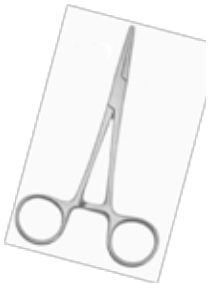
Uterine Sound



Scissor



Forceps



Narrow-Forceps

flashlight

Bowl for cotton balls

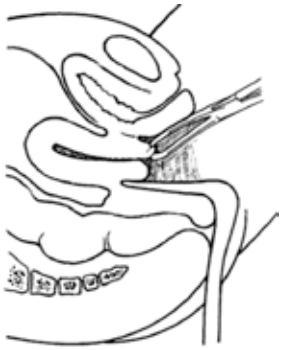
Insertion procedures:

Step 1: Conducts a pelvic examination.

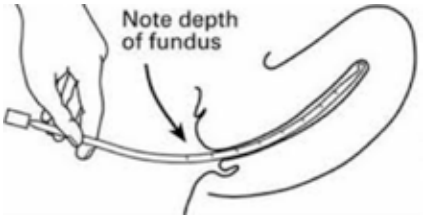
The aim of pelvic examination is to assess the eligibility of the client. Conduct bimanual examination and speculum examination to inspect the vagina and the cervix.

Step 2: cleans the cervix and vagina with appropriate antiseptic

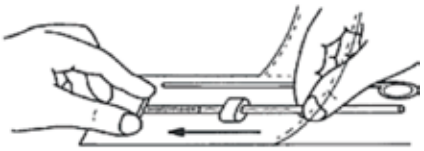
Step 3: slowly inserts the tenaculum through the speculum and closes the tenaculum just enough to gently hold the cervix

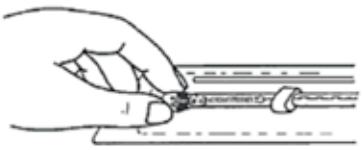


Step 4: slowly and gently passes the uterine sound through the cervix to measure the depth and position of the uterus

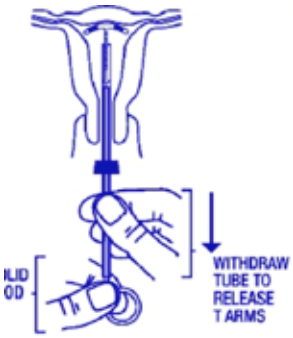


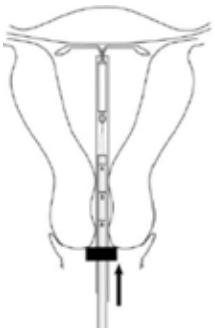
Step 5: loads the IUCD into the inserter while both are still in the unopened sterile package



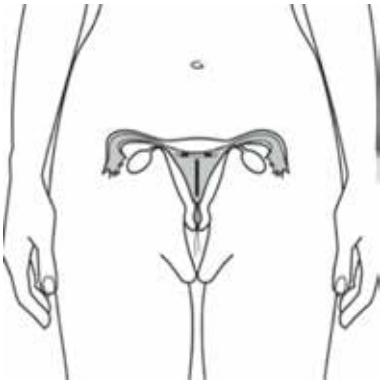


Step 6: slowly and gently inserts the IUCD and removes the inserter.





Step 7: Cuts the strings on the IUCD, leaving about centimeters hanging out of the cervix.



Step 8: Let the client rests until she feel ready to get dress.

Support women after IUCD insertion:

- Advise women to take ibuprofen (200–400 mg), or paracetamol (325–1000 mg) if she feel pain or cramp
- She may expected some small bleeding or spotting immediately after insertion
- She need to check the IUCD's strings from time to time, particularly in the first few months and after monthly bleeding, to confirm that her IUCD is still in place
- Remind women to return for checkup at her first monthly bleeding or 3 to 6 weeks after IUCD insertion
- The following information should be included in the client record card: the type of IUCD she has, date of insertion, when IUCD will need to be removed or replaced, and where to go if she have any problem.

10. REMOVING THE IUCD

Removing an IUCD is usually simple. It can be done at any time of the month. Moreover, it's easier to remove during monthly bleeding, when the cervix is naturally softened.

Procedures:

Step 1: Explain to the client what will happen during removal

Step 2: Inserts a speculum to see the cervix and IUCD's strings and carefully cleans the cervix and vagina with an antiseptic solution.

Step 3: Asks the woman to take deep breaths and to relax

Step 4: Using narrow forceps, the provider pulls the IUCD's strings slowly and gently until the IUCD comes completely out of the cervix

11. SWITCH IUCD TO OTHER METHOD

Switch to COC, POP, or to progestin-only injectables	❑ If starting new method during the first 7 days of monthly bleeding (first 5 days for COCs and POPs), - **NO** need for a backup method. ❑ If starting new method after the first 7 days of monthly bleeding (after first 5 days for COCs and POPs), and if she has had sex since her last monthly bleeding, -- she can start the hormonal method now, but keep IUCD in place until her next monthly bleeding ❑ If starting new method after the first 7 days of monthly bleeding (after first 5 days for COCs and POPs), and if she has no sex since her last monthly bleeding, -- IUCD can be removed at her next monthly bleeding or… she can remove IUCD now but need a backup method for first 7 days
Male or female condoms, spermicides, diaphragms, cervical caps, or withdrawal	She needs to use immediately next time when she have sex after IUCD is removed.
Fertility awareness methods	Immediately after the IUCD is removed

Female sterilization	❑ If remove the IUCD and the female sterilization procedure perform during the first 7 days of monthly bleeding, - **NO** need for a backup method. ❑ If the female sterilization procedure perform after the first 7 days of the month, - the IUCD can be kept in place until her next monthly bleeding
Vasectomy	Keep the IUCD for 3 months after her partner's vasectomy to keep preventing pregnancy until the vasectomy is fully effective

12. MANAGING PROBLEM AND SIDE EFFECTS

Heavy or prolonged bleeding (twice as much as usual or longer than 8 days)	❑ Provide reassurance to client ❑ Give women non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen (400 mg) or indomethacin (25 mg) 2 times daily after meals for 5 days ❑ Provide iron tablets if possible ❑ Look for other underlying conditions if bleeding is still prolong a few months after insertion
Irregular bleeding	❑ Provide reassurance to the client ❑ Give NSAIDs such as ibuprofen (400 mg) or indomethacin (25 mg) 2 times daily after meals for 5 days ❑ Look for other underlying conditions if irregular period is still prolong a few months after insertion
Cramping and pain	❑ Provide reassurance to the client ❑ Give client aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg) If cramp/pain is continues and occurs outside of monthly bleeding: ❑ Look for other underlying conditions ❑ Consider to remove IUCD if the symptoms is still prolong or getting worst
Possible anemia	❑ Give iron table if need it ❑ Advise to client to take food that contains more iron
Partner can feel IUCD strings during sex	This happens sometimes when the strings are too long or cut too short. Try to adjust the strings if possible. If it's not, remove and re-insert a new IUCD.

Severe pain in lower abdomen	If it's possible, do abdominal and pelvic examinations. If it's not possible, check if the client has any symptoms of PID (unusual vaginal discharge, fever or chills, pain during sex or urination, bleeding after sex or between monthly bleeding, nausea and vomiting, tender pelvic mass, or pain when the abdomen is gently pressed). All confirmed or suspect PID should be treated immediately. If ectopic pregnancy or other serious health condition is suspected, refer immediately to appropriate services.
Suspected uterine puncturing (perforation)	Stop the procedure immediately if suspected of perforation at the time of insertion or sounding. ❑ Keep the woman at bed rest and check her vital signs (blood pressure, pulse, respiration, and temperature) every 5 to 10 minutes. ❑ Check for signs of intra-abdominal bleeding, such as low hematocrit or hemoglobin. ❑ Keep her under observe for several more hours. She can go home if there is no more signs or symptoms, -- but she should avoid sex for 2 weeks
IUCD partially comes out (partial expulsion)	Remove the IUCD. Discuss with the client whether she wants another IUCD or a different method. If she still wants to use IUCD, she can insert a new IUCD any time if pregnancy can be ruled out.
IUCD completely comes out (complete expulsion)	Discuss with client whether she wants another IUCD or a different method. If she wants another IUCD, she can have one inserted at any time if pregnancy can be ruled out. If the client does not know whether the IUCD has come out, refer for x-ray or ultrasound to assess whether the IUCD might have moved to the abdominal cavity.
Missing strings	Check with the client: ❑ Whether she saw the IUCD come out ❑ When was the last time felt the strings ❑ When was her last monthly bleeding ❑ If she has any symptoms of pregnancy ❑ If she has used a backup method Use forceps, check for the strings that may folds in the cervical canal

Chapter 8
BARRIER METHODS

Mechanical barriers such as male condoms and female condoms, prevent the sperm from entering the vagina and uterine cavity.

Condoms used correctly and consistently is the only method currently available for **DUAL PROTECTION.** - i.e they prevent pregnancy as well as STIs including HIV/AIDS

TYPES OF BARRIER METHODS:

Male condoms are available in Kiribati. Other barrier contraceptive methods are female condoms.

1. MALE CONDOMS

Male condom is a sheaths, or coverings, that fit over a man's erect penis. It called rubbers, "raincoats," or "umbrellas". It's work by forming a barrier that keeps sperm out of the vagina, preventing pregnancy. Also keep infections in semen, on the penis, or in the vagina from infecting the other partner.

EFFECTIVENESS

Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS, reduces the risk of other sexually transmitted Infections (STIs). Condom use may reduce the risk for genital human papillomavirus (HPV) infection and HPV-associated diseases, e.g., genital warts and cervical cancer (CDC, 2014).

Protection against pregnancy

When used correctly with every act of sex, about 2 pregnancies per 100 women whose partners use male condoms over the first year. Return of fertility after use of condoms is stopped: No delay (WHO, 2011)

Protection against HIV and other STIs

When used consistently and correctly, condom use prevents 80% to 95% of HIV transmission that would have occurred without condoms.

HEALTH BENEFITS AND HEALTH RISKS

Side Effects: Non

Health benefits:

Condoms can help protect against pregnancy, STIs, including HIV. It may help protect again condition cause by STI such as recurring pelvic inflammatory, cervical cancer and Infertility

Health Risks

Severe allergic reaction (among people with latex allergy)

Correcting Misunderstandings

Male condoms:

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

ELIGIBILITY

Barrier methods should be provided to any client who requests it, received appropriate counselling and made an informed decision.

Indication:

Condoms are appropriate for most couples because it rarely causes any side effects. They are also appropriate for couples:

- Where the husband wants to actively participate in family planning.
- Where a client needs or desires protection against STIs, including HIV transmission
- Where the wife has conditions that are considered precautions for other methods of family planning.
- Where the wife is the first 6 months of lactation and wants to use a contraceptive
- Waiting for surgical contraception or IUCD insertion
- Where a client needs a temporary alternative or backup to another method (e.g., for the first 3 months following vasectomy etc.)

Precautions: there is possible of allergy to latex in either man or woman.

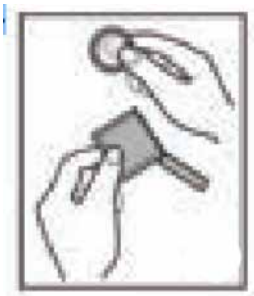
WHAT CONDOM USERS SHOULD NOT DO

Some practices can increase the risk that the condom will break and should be avoided.

- Do not unroll the condom first and then try to put it on the penis
- Do not use lubricants with an oil base because they damage latex
- Do not use a condom if the color is uneven or changed
- Do not use a condom that feels brittle, dried out, or very sticky
- Do not reuse condoms
- Do not have dry sex

Also, do not use the same condom when switching between different penetrative sex acts, such as from anal to vaginal sex. This can transfer bacteria that can cause infection.

EXPPLAIN THE 5 BASIC STEPS OF USING MALE CONDOM

Basic Steps	Important Details	
1. Use a new condom for each act of sex	❑ Check the condom package. Do not use if torn or damaged. Avoid using a condom past the expiration date—do so only if a newer condom is not available. ❑ Tear open the package carefully. Do not use fingernails, teeth, or anything that can damage the condom.	
2. Before any physical contact, place the condom on the tip of the erect penis with the rolled side out	❑ For the most protection, put the condom on before the penis makes any genital, oral, or anal contact.	
3. Unroll the condom all the way to the base of the erect penis	❑ The condom should unroll easily. Forcing it on could cause it to break during use. ❑ If the condom does not unroll easily, it may be on backwards, damaged, or too old. Throw it away and use a new condom. ❑ If the condom is on backwards and another one is not available, turn it over and unroll it onto the penis.	
4. Immediately after ejaculation, hold the rim of the condom in place and withdraw the penis while it is still erect.	❑ Withdraw the penis. ❑ Slide the condom off, avoiding spilling semen. ❑ If having sex again or switching from one sex act to another, use a new condom.	
5. Dispose of the used condom safely	Wrap the condom in its package and put in the rubbish or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing.	

Source: WHO Handbook, 2011

MANAGING PROBLEMS

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

If the Condom breaks, slips off the penis, the client should:

- Use ECPs can help prevent pregnancy
- Assess or refer if the client complain of any symptoms of STIs after the condom break or slips

b. Difficulty putting on the condom

Ask clients to show how they put the condom on, using a model or other item. Correct any errors.

c. Difficulty persuading partner to use condoms

- Discuss ways to talk about condoms with partner
- Consider combining condoms with: Another effective contraceptive method or If no risk of STIs, a fertility awareness method, and using condoms only during the fertile time
- if the client or partner is at risk for STIs, encourage continued condom use while working out problems.

d. Mild irritation in or around the vagina or penis or mild allergic reaction to condom

- Suggest trying another brand of condoms
- Suggest putting lubricant or water on the condom to reduce rubbing that may cause irritation.
- If symptoms persist, assess or refer for possible vaginal infection or STI as appropriate.

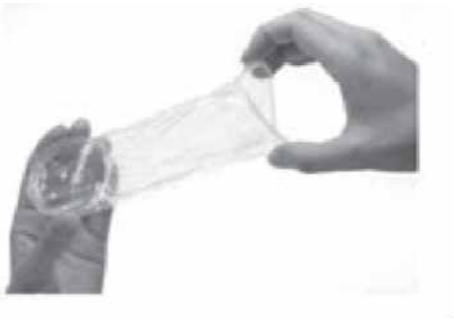
STORAE OF CONDOMS

- Make sure the supplies are adequate. (Keep an extra supply of condoms on hand)
- Store condoms in a cool and dry place and not exposed to sunlight as heat and sunlight cause breakage of condoms.

FOLLOW UP

- No routine follow up visit is required.
- Client can return for further supplies as required.
- Advise client to return at any time if he/she has any concerns or if he/she wants to change the method.

2. FEMALE CONDOMS



A female condom is sheaths, or linings that fit loosely inside a woman's vagina made of thin, transparent, soft plastic film. It have a flexible rings at both ends, one ring at the closed end helps to insert the condom. The ring at the open end holds part of the condom outside the vagina. The product comes with the lubricated with a silicone-based lubricant on the inside and outside.

THE EFFECTIVENESS

- Effectiveness depends on the user: Risk of pregnancy or sexually transmitted infection (STI) is greatest when female condoms are not used with every act of sex.
- When used correctly with every act of sex, about 5 pregnancies per 100 women using female condoms over the first year.
- Return of fertility after use of female condom is stopped: No delay

SIDE EFFECT, HEALTH BENEFITS AND HEALTH RISKS

Side Effects: None

Health benefits: Help protect against the risks of pregnancy, STIs, including HIV

Health Risks: None

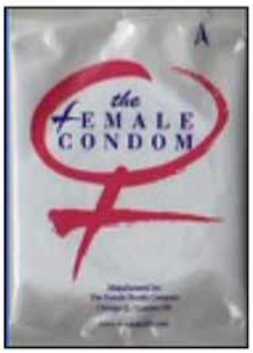
Note: Female condoms--

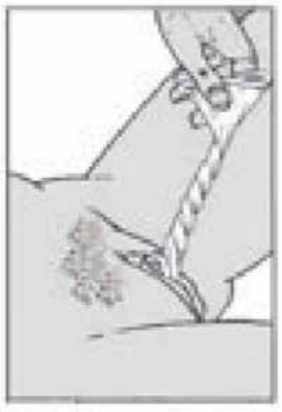
- Cannot get lost in the woman's body.
- Are not difficult to use, but correct use needs to be learned.
- Do not have holes that HIV can pass through.
- Are used by married couples. They are not only for use outside marriage.
- Do not cause illness in a woman because they prevent y semen or sperm from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

WHO CAN USE FEMALE CONDOMS

All women can use plastic female condoms. No medical conditions prevent the use of this method.

THE 5 BASIC STEPS OF USING FEMALE CONDOM

Basic Steps	Important Details	
1. Use a new female condom for each act of sex	❑ Check the condom package. Do not use if torn or damaged. Avoid using a condom past the expiration date—do so only if newer condoms are not available. ❑ If possible, wash your hands with mild soap and clean water before inserting the condom.	

2. Before any physical contact, insert the condom into the vagina	❑ Can be inserted up to 8 hours before sex. For the most protection, insert the condom before the penis comes in contact with the vagina. ❑ Choose a position that is comfortable for insertion—squat, raise one leg, sit, or lie down. ❑ Rub the sides of the female condom together to spread the lubricant evenly. ❑ Grasp the ring at the closed end, and squeeze it so it becomes long and narrow. ❑ With the other hand, separate the outer lips (labia) and locate the opening of the vagina. ❑ Gently push the inner ring into the vagina as far up as it will go. Insert a finger into the condom to push it into place. About 2 to 3 centimeters of the condom and the outer ring remain outside the vagina.	 
3. Ensure that the penis enters the condom and stays inside the condom	❑ The man or woman should carefully guide the tip of his penis inside the condom—not between the condom and the wall of the vagina. ❑ If his penis goes outside the condom, withdraw and try again. ❑ If the condom is accidentally pulled out of the vagina or pushed into it during sex, put the condom back in place.	
4. After the man withdraws his penis, hold the outer ring of the condom, twist to seal in fluids, and gently pull it out of the vagina	❑ The female condom does not need to be removed immediately after sex. ❑ Remove the condom before standing up, to avoid spilling semen. ❑ If the couple has sex again, they should use a new condom. ❑ Reuse of female condoms is not recommended	
5. Dispose of the used condom safely	❑ Wrap the condom in its package and put it in the rubbish or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing.	

SUPPORT THE USER

- Ensure client understands correct use
- Ask the client how many condoms she thinks she will need until she can return
- Explain why using a condom with every act of sex is important
- Explain about emergency contraceptive pills (ECPs)
- Discuss ways to talk about using condoms

TIPS FOR THE NEW USERS

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

HEALPING CONTINUING USERS

- Ask how the client is doing with the method and whether she is satisfied. Ask if she has any questions or anything to discuss.
- Ask especially if she has any trouble using female condoms correctly and every time she has sex
- Give her more female condoms and encourage her to come back for more before her supply runs out
- Ask a long-term client about major life changes that may affect her needs—particularly plans for having children and STI/ HIV risk

MANAGING ANY PROBLEMS

Problems	Management
Difficulty inserting the female condom	Ask the client how she inserts a female condom. If a model is available, ask her to demonstrate and let her practice with the model. If not, ask her to demonstrate using her hands. Correct any errors.
Inner ring uncomfortable or painful	Suggest that she reinsert or reposition the condom so that the inner ring is tucked back behind the pubic bone and out of the way.
Condom squeaks or makes noise during sex	Suggest adding more lubricant to the inside of the condom or onto the penis.
Condom slips, is not used, or is used incorrectly	❑ ECPs can help prevent pregnancy ❑ Little can be done to reduce the risk of STIs if a condom breaks, slips, or is not used. If the client has signs or symptoms of STIs after having unprotected sex, assess or refer. ❑ If a client reports slips, she may be inserting the female condom incorrectly. Ask her to show how she is inserting the condom, using a model or demonstrating with her hands. Correct any errors.

Difficulty persuading partner to use condoms	Discuss ways to talk with her partner about the importance of condom use for protection from pregnancy and STIs.
Mild irritation in or around the vagina or penis	❑ Usually goes away on its own without treatment ❑ Suggest adding lubricant to the inside of the condom or onto the penis to reduce rubbing that may cause irritation. ❑ If symptoms persist, assess and treat for possible causes including vaginal infection or STI.
Suspected pregnancy	❑ Assess for pregnancy. ❑ A woman can safely use female condoms during pregnancy for continued STI protection

Chapter 9
SURGICAL STERILIZATION

Surgical contraceptive methods (female sterilization and male sterilization) are effective permanent methods for family planning available to men and women who desire not to have any more children.

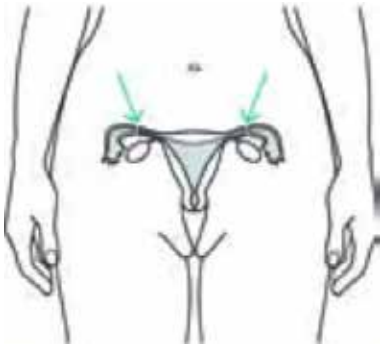
Essential elements of quality sterilization services include counselling and client assessment, informed consent, infection prevention, selection of appropriate procedures, safe anesthesia regimens, and post-operative care and instructions. Strict adherence to infection control practices at all times (before, during and after surgery) is crucial to the safety of the procedure.

Two types of surgical sterilisation:

- Female Sterilization - Tubal Ligation
- Male Sterilization - Vasectomy

1. FEMALE STERILIZATION

Female Sterilization is a permanent contraception for women who will not want more children. The procedure also called: tubal sterilization, tubal ligation, voluntary surgical contraception, tubectomy, bi-tubal ligation, tying the tubes, minilap, and "the operation."



Key Messages
❑ It is a permanent method
❑ Involves a physical examination and surgery
❑ No long-term side effects.

There are 2 surgical approaches most often used:

a. Minilaparotomy involves making a small incision in the abdomen. The fallopian tubes are brought to the incision to be cut or blocked

b. Laparoscopy involves inserting a long thin tube with a lens in it into the abdomen through a small incision. This laparoscope enables the doctor to see and block or cut the fallopian tubes in the abdomen.

The procedure is works because the fallopian tubes are blocked or cut. Eggs released from the ovaries cannot move down the tubes, and so they do not meet sperm.

1. The Effectiveness

It is very effective method, but carries a small risk of failure. Reversal surgery is difficult, expensive, and not available in most areas.

- Less than 1 pregnancy per 100 women over the first year after having the sterilization procedure.
- A small risk of pregnancy remains beyond the first year of use and until the woman reaches menopause.

2. Side Effects: None

3. Health Benefits and Health Risks

Health Benefits

- It's helps to protect against the risks of pregnancy and Pelvic inflammatory disease(PID)
- It may help to protect against ovarian cancer

Health Risks

The health risks are extremely rare.

The complications from surgery and anesthesia are also very uncommon.

Note: Female Sterilization methods do not:

- make women weak
- cause lasting pain in back, uterus, or abdomen
- remove a woman's uterus or lead to a need to have it removed
- cause hormonal imbalances
- cause heavier bleeding or irregular bleeding or otherwise
- change women's menstrual cycles
- cause any changes in weight, appetite, or appearance
- change women's sexual behavior or sex drive

4. Who can have Female Sterilization

Female Sterilization method is safe for all women. Proper counselling and informed consent is needed.

Note: Female Sterilization is also safe for women who are infected with HIV, have AIDS, or on antiretroviral (ARV)

5. Who cannot have Female Sterilization

The woman who cannot have Female Sterilization includes-- women who:

- have any current or past problems with gynecologic, or obstetric conditions, or cancer
- have any cardiovascular conditions, such as heart problems, stroke, high blood pressure, or complications of diabetes

6. When to perform Procedure

Woman can have the female sterilization procedure at any time she wants if she has no medical reason to delay or if pregnancy can be ruled out.

Having menstrual cycles or switching from another method	She can have at any time of the month ❑ Any time within 7 days after the start of her monthly bleeding. **NO** need to use another method before the procedure ❑ If it is more than 7 days after the start of her monthly bleeding, she can have the procedure any time if pregnant can be ruled out. ❑ Switching from oral contraceptives: she can continue taking pills until she has finished the pill pack to maintain her regular cycle ❑ Switching from an IUCD: she can have the procedure immediately
No monthly bleeding	She can have at any time it pregnancy can be ruled out
After childbirth	Immediately or within 7 days after giving birth. OR at any time 6 weeks or more after childbirth if pregnancy can be ruled out.
After miscarriage or abortion	Any time within 48 hours after uncomplicated abortion
After using ECPs	Can be done within 7 days after the start of her next monthly bleeding.--OR at any time other time if pregnancy can be ruled out.

7. Ensuring Informed choice

Women should receive practical information about the procedure, particularly its permanence. It will help woman to make a right informed choice without regret.

A signed Informed Consent should be obtained from client prior to the procedure.

The information should be included in the Informed Consent:

2. Informed about the available of temporary contraceptive
3. Female sterilization is a surgical procedure
4. There are certain risks of the procedure as well as benefits
5. If it is successful, the procedure can prevent client from getting pregnant for life
6. It is an irreversible method
7. Client can decide to not undergo with procedure at any time before it takes place

8. Performing the Sterilization Procedure

Explaining the Procedure

Details information on the procedure should be provided to client prior to the surgical procedure taken place.

Procedures done more than 6 weeks after childbirth

(Note: the procedure used up to 7 days after childbirth is slightly different)

a) Mini-laparotomy Procedure

Step 1: Perform proper infection-prevention procedures.

Step 2: Performs pelvic examination to assess the condition and mobility of the uterus.

Step 3: Local anesthetic is injected above the pubic hair line. The woman usually receives light sedation to relax, she will stay awake at all-time throughout the procedure.

Step 4: A small vertical incision, about 2 to 5 centimeters in the anesthetized area

Step 5: A special instrument (uterine elevator) inserts in to the vagina, through the cervix, and into the uterus to raise each of the 2 fallopian tubes so they are closer to the incision. This may cause discomfort.

Step 6: Each tube is tied and cut or else closed with a clip or ring.

Step 7: Closes the incision with stitches.

Step 8: Provide instructions on what to do after she leaves the clinic or hospital.

b) Laparoscopy Procedure

Step 1: Follow proper infection-prevention procedures at all time.

Step 2: Performs pelvic examination to assess the condition and mobility of the uterus.

Step 3: Local anesthetic is injected under her navel. The woman usually receives light sedation (with pills or into a vein) to relax, she will stay awake at all-time throughout the procedure.

Step 4: The provider places a special needle into the woman's abdomen and, through the needle, inflates (insufflates) the abdomen with gas or air. This raises the wall of the abdomen away from the pelvic organs.

Step 5: Make a small incision (about one centimeter) in the anesthetized area and inserts a laparoscope. A laparoscope is a long, thin tube containing lenses. Through the lenses the provider can see inside the body and find the 2 fallopian tubes.

Step 6: Inserts an instrument through the laparoscope (or sometimes, through a second incision) to close off the fallopian tubes.

Step 7: Each tube is closed with a clip or a ring, or by electric current applied to block the tube (electrocoagulation).

Step 8: Removes the instrument and laparoscope. The gas or air is let out of the woman's abdomen.

Step 9: Closes the incision with stitches and covers it with an adhesive bandage.

Step 10: Provide instructions on what to do after she leaves the clinic or hospital.

Support information for client

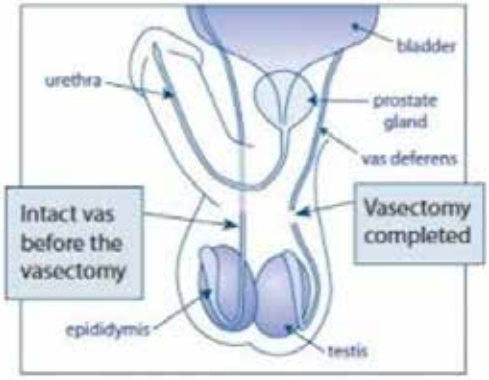
Before the procedure	**Woman should:** ❑ Use another contraceptive until the procedure ❑ Not eat anything for 8 hours before surgery. She can drink clear liquids until 2 hours before surgery ❑ Not take any medication for 24 hours before the surgery (unless she is told to do so) ❑ Wear clean, loose-fitting clothing to the health facility if possible ❑ Not wear nail polish or jewelry ❑ If possible, bring a friend or relative to help her go home afterwards.
After the procedure	**Woman should:** ❑ Rest for 2 days and avoid vigorous work and heavy lifting for a week ❑ Keep incision clean and dry for 1 to 2 days ❑ Avoid rubbing the incision for 1 week. ❑ Not have sex for at least 1 week. Or avoid sex until all pain is gone ❑ Take Ibuprofen (200–400 mg), or paracetamol (325–1000 mg), or other pain reliever if need it (not take aspirin)
Plan the follow-up visit	❑ Following up at 7 to 10 days after the procedure ❑ Checks the site of the incision, looks for any signs of infection, and removes any stitches **Note:** advise the client to come back if she have any of the following symptoms: ❑ bleeding, pain, pus, heat, swelling, or redness of the wound that becomes worse or does not go away ❑ develops high fever (greater than 38° C/101° F) ❑ experiences fainting, persistent light-headedness, or extreme dizziness in the first 4 weeks and especially in the first week

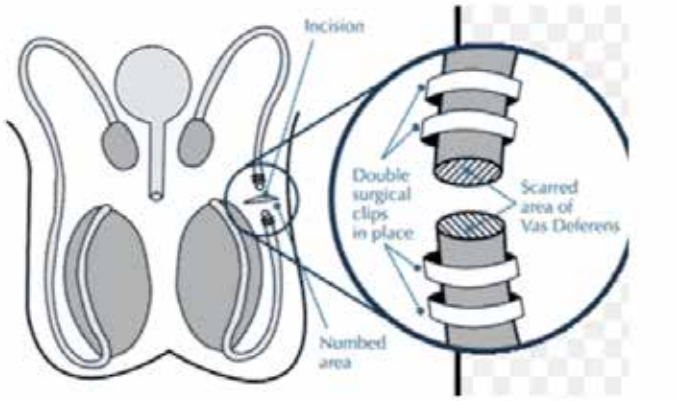
9. Managing Problems

All issues concern by the women needs to be managing carefully and professionally.

Infection at the incision site (redness, heat, pain, pus)	❑ Clean the infected area with soap and water or antiseptic. ❑ Give oral antibiotics for 7 to 10 days. ❑ Ask the client to return after taking all antibiotics if the infection has not cleared
Abscess (a pocket of pus under the skin caused by infection)	❑ Clean the area with antiseptic. ❑ Cut open (incise) and drain the abscess. ❑ Treat the wound. ❑ Give oral antibiotics for 7 to 10 days. ❑ Ask the client to return after taking all antibiotics if she has heat, redness, pain, or drainage of the wound.

2. MALE STERILIZATION (VASECTOMY)





Vasectomy is a simple minor surgical procedure. It can be performed as an outpatient procedure. The vas deferens on each side of the scrotum is identified by palpation before entering the scrotum. The vas deferens on each side is occluded so that the sperm are not released into ejaculation.

It is works by closing off each vas deferens, keeping sperm out of semen. Semen is ejaculated, but it cannot cause pregnancy.

Reversal surgery is difficult, expensive, and not available in most areas.

Key Messages
❑ It is a **Permanent method**, very effective protection against pregnancy. Reversal is usually not possible.
❑ **Involves a safe, simple surgical procedure.**
❑ It takes about **3-month delay in taking effect.**
❑ **Does not affect male sexual performance.**

CATEGORY OF PROVIDERS FOR MALE STERILIZATION

Male sterilization should be performed only by trained and competent medical assistants and doctors. The following additional staffs are required to safely conduct a vasectomy operation:

1. The Effectiveness

Vasectomy is one of the most effective methods but carries a small risk of failure.

- Where men cannot have their semen examined at three months after the procedure, pregnancy rates are about 2 to 3 per 100 women over the first year.
- Where men can have their semen examined after vasectomy, less than 1 pregnancy per 100 women over the first year.
- Vasectomy is not fully effective for 3 months after the procedure.
- A small risk of pregnancy remains beyond the first year after the vasectomy
- Over 3 years of use: about 4 pregnancies per 100 women

2. The side Effects

The side effect is none.

The complication is uncommon. However, possible complication includes scrotal or testicular pain, infection at the incision site, bleeding under the skin that may cause swelling or bruising.

Note: Vasectomy does not:

- remove the testicles
- decrease sex drive
- affect sexual function
- cause a man to grow fat or become weak, less masculine, or less productive
- cause any diseases later in life
- prevent transmission of sexually transmitted infections, including HIV

3. Who can have Vasectomy

Almost all men can have a vasectomy safely, including men who:

- Have no children or few children
- Are not married
- Do not have wife's permission
- Are young
- Are at high risk of infection with HIV or another STI
- Are infected with HIV, whether or not on antiretroviral therapy

Proper counselling and informed consent need to be done prior to the procedure.

Certain medical conditions may need more caution and delay the procedure, or need special arrangements for the clients. Those conditions are:

- have any problems with genitals such as infections, swelling, injuries, or lumps on your penis or scrotum

- have any other medical condition such as: diabetes, depression, young age, lupus with positive (or unknown) antiphospholipid anti-bodies or on immunosuppressive treatment

4. Ensuring Informed choice

Client should receive practical information about the procedure, particularly its permanence. It will help client to make a right informed choice without regret.

The client must understand the following information prior to taking the procedure:

- The availability of temporary contraceptives
- Voluntary vasectomy is a surgical procedure
- There are certain risks of the procedure as well as benefits
- If successful, the procedure will prevent the client from ever having any more children
- The procedure is considered permanent and probably cannot be reversed
- The client can decide to not undergo with the procedure at any time before it takes place (without losing rights to other medical, health, other services or benefits).

5. Technique for Vasectomy

a. Reaching the Vas: No-Scalpel Vasectomy

No-Scalpel Vasectomy is a standard technique. This procedure is to reach each of the 2 tubes in the scrotum (vas deferens) that carry sperm to the penis by:

- Make a small puncture instead of 1 or 2 incisions in the scrotum
- No stitches required to close the skin
- Special anesthesia technique needs only one needle puncture instead of 2 or more.

Advantages:

- Less pain and bruising
- Fewer infections and less collection of blood in the tissue
- short procedure

b. Blocking the Vas

This procedure involves cutting and removing a short piece of each tube and then tying both remaining cut ends of the vas. This procedure has a low failure rate.

6. Performing the Vasectomy Procedure

Explaining the Procedure

Details information on the procedure should be provided to client prior to actual procedure taking place.

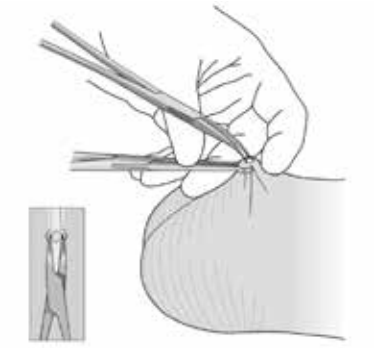
Step 1: Follow proper infection-prevention procedures at all time.

Step 2: Give an injection of local anesthetic in his scrotum to prevent pain. He stays awake throughout the procedure

Step 3: Try to feels the skin of the scrotum to find each vas deferens— the 2 tubes in the scrotum that carry sperm

Step 4: Makes an incision in the skin:

- Using the no-scalpel vasectomy technique, the provider grasps the tube with specially designed forceps and makes a tiny puncture in the skin at the midline of the scrotum with a special sharp surgical instrument.
- Using the conventional procedure, the provider makes1 or 2 small incisions in the skin with a scalpel



Step 5: lifts out a small loop of each vas from the incision, cut each tube and tie one or both cut ends closed with thread (or close off the tubes with heat or electricity)

Step 6: The incision may be closed with stitches or covered with an adhesive bandage

Step 7: Client should receive instructions on what to do after he leaves the clinic. He should rest for 15 to 30 minutes before leaving the clinic.

Support information for client:

Before the procedure	Wear clean, loose-fitting clothing to the health facility.
After the procedure	❑ Rest for 2 days if possible ❑ Put cold compresses on the scrotum for the first 4 hours to help to reduce pain and bleeding. He may experience some discomfort, swelling, and bruising. These should go away within 2 to 3 days ❑ Wear snug underwear or pants for 2 to 3 days to help support the scrotum ❑ Keep the incision site clean and dry for 2 to 3 days. ❑ Not have sex for at least 2 to 3 days ❑ Use condoms or another effective family planning method for 3 months after the procedure. ❑ Suggest ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever if he have any experience of pain or discomfort after the procedure
Plan the follow-up visit	Inform client for come back any time if he has problems. Need to return in 3 months for semen analysis

7. Managing problems

All problems and concerns from clients should be managed appropriately.

Bleeding or blood clots after the procedure	Provide reassure to client. ❑ Normally, minor bleeding and small uninfected blood clots usually go away without treatment within a couple of weeks. ❑ Large blood clots may need to be surgically drained- but really rare ❑ Infected blood clots require antibiotics and hospitalization
Infection at the incision site (redness, heat, pain, pus)	❑ Clean the infected area with soap and water or antiseptic. ❑ Give oral antibiotics for 7 to 10 days. ❑ Ask the client to return after taking all antibiotics if the infection has not cleared.
Abscess (a pocket of pus under the skin caused by infection)	❑ Clean the area with antiseptic ❑ Cut open (incise) and drain the abscess. ❑ Treat the wound ❑ Give oral antibiotics for 7 to 10 days ❑ Ask the client to return after taking all antibiotics if he has heat, redness, pain, or drainage of the wound.
Prolong pain	Advise client to: ❑ Elevating the scrotum with snug underwear or pants or an athletic supporter. ❑ Soaking in warm water. ❑ Try with aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever. ❑ Provide antibiotics if infection is suspected. ❑ Refer for further care if pain persists and cannot be tolerated

Chapter 10

TRADITIONAL FAMILY PLANNING METHODS

The two commonly used traditional methods of family planning are:

1. Fertility awareness based methods (FAB) (standard day method using cycle beads, calendar method, Cervical mucus method)

2. Withdrawal method/ Coitus interruptus

Key Notes

Traditional family planning methods, both fertility awareness- based methods (FAB) and withdrawal method does not protect against STI/HIV. If there is a risk of STI/HIV (including post-partum period) the correct and consistent use of condoms is recommended, either alone or with another contraceptive method.

Women with conditions which make pregnancy an unacceptable risk should be advised that traditional methods of family planning may not be appropriate for them because of their relatively higher typical use failure rates

1. FERTILITY AWARENESS-BASED METHOD (FAB)

There are several fertility awareness-based methods used for family planning. The methods are based on the practice of voluntarily avoiding sexual intercourse during the fertile period of a woman's cycle (i.e. when the ovum is released) to avoid pregnancy. For this method to be effective the following are essential:

- Good communication and understanding should be present between spouses
- Sexual behaviour of couples will have to be modified.

Fertility-awareness based methods can also be used to achieve pregnancy by having intercourse during the fertile phase.

How does FAMs method work?

FAMs work by keeping sperm out of the vagina in the days near ovulation, when a woman is most fertile, and she is most likely to become pregnant.

For this method, women should get very familiar with their own menstrual cycle; she should know when is her fertile days-- so it can help her to avoid a pregnancy.

There are several methods available to help couples know the fertile times:

- Calendar or Rhythm Method
- Standard Days Method (SDM)
- Temperature Method
- Mucus or Billing's Method
- Sympto-thermal Method

TYPES OF FERTILITY AWARENESS-BASED METHODS (FAMs)

a. Calendar Method (Rhythm Method)

It works best in women with regular cycles.

With the calendar method, women need to keep a record of the length of each menstrual cycle in order to determine when they are fertile.

Circle day-one of each cycle, which is the first day of your period. Count the total number of days in each cycle. Propose to do at least for eight cycles.

Chart Your Calendar Pattern

Predict the first fertile day in your current cycle

- Find the shortest cycle in your record
- Subtract 18 from the total number of days
- Count that number of days from day one of your current cycle, and mark that day with an X. Include day one when you count.
- The day marked X is your first fertile

Example:

- Total number of days of her short cycle is 28 days. Thus, 28 subtract 18 = 10
- Count 10 days, starting from first day of her period and mark " X" on that day
- "X" day is the first fertile day of her current cycle

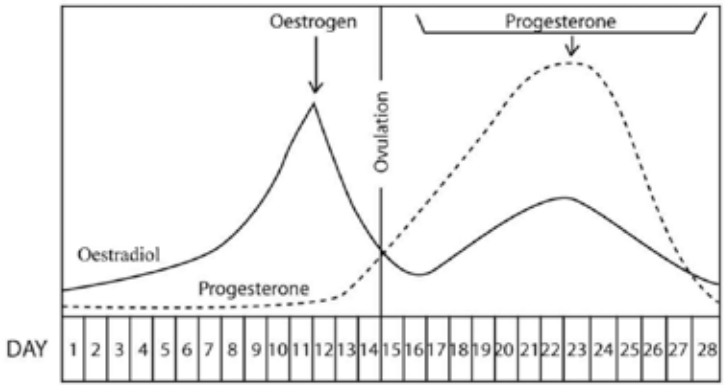
Predict the last fertile day in your current cycle

- Find the longest cycle in your record.
- Subtract 11 days from the total number of days.
- Count that number of days from day one of your current cycle, and mark that day with an X. Include day one when you count.
- The day marked X is the last fertile day.

Example:

- Total number of days of her long cycle is 31. Thus, 31 subtract 11 = 20
- Count 20 days, starting from first day of her period and mark " X"
- The day marked X is the last fertile day

Ovulation chart



b. Standard Days Method (SDM)

CYCLE BEADS

This method relies on a 'standard rule' or a fixed window of fertility that makes it easy for women to know when they are likely to become pregnant. The fertile window is on day 8 to day 19 for women whose cycle lengths range from 26 to 32 days.

This method does not involve calculation or observation and hence it is easy for providers to teach and for women to learn and use. It is easy to incorporate this method into the existing family planning menu as the method has minimal logistical burden and can be offered either in clinics or community based programs. It is important to provide the client with a printed instruction sheet with illustrations along with the cycle beads.

A colour coded string of beads (figure below) called Cycle beads™ can be used by women using SDM as it facilitates in tracking a woman's menstrual cycle and the fertile days. Refer below for description of the cycle beads and how to use cycle beads.

Description of the cycle beads & how to use. The string of 'cycle bead' has 32 tear-drop-shaped coloured beads with no rough edges on a non-detachable double durable string. Each bead represents one day of the menstrual cycle.

First black rubber O-ring, which moves freely from one bead to the next bead. Each string also has a clasp which allows the user to replace the black rubber O- ring if it breaks or is difficult to move over the beads.

The beads are arranged in the following sequence:

- a red bead to signify the start/ first day of the menstrual period
- followed by 6 brown beads, which still signify safe days i.e. when pregnancy is unlikely.
- followed by 12 white beads, which now signify days when the woman is likely to get pregnant. To prevent pregnancy, no unprotected coitus should take place
- followed by 7 brown beads, which refer to days when the woman is not likely to get pregnant
- followed by 1 dark brown bead, which notes if a cycle is less than 26 days
- followed by 5 brown beads, beyond which time, if menses have not begun, the woman has a cycle more than 32 days.
- **Client's can track her cycle days by moving the small black rubber O ring from one bead to the next each day starting with the first day of her menstrual period.**

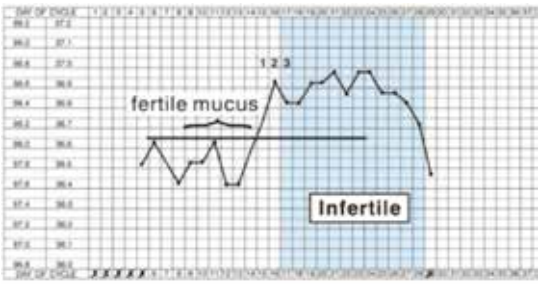
c. Temperature Method

Women's body temperature is lower during the first part of your cycle. It usually rises slightly after ovulation — when an egg is released. The body temperature stays elevated for the rest of women cycle. It falls again just before your next period.

Tracking down the body temperature every day can help women know when she is ovulating. To prevent pregnancy, women should not have unprotected vaginal intercourse until three days after her ovulate each cycle.

For this method, woman is required to record their body temperature on each day and put on the chart. Below is an example of body temperature pattern in women.

The pattern of body temperature may change when women don't get enough sleep, some illness, stress, jet lag, or smoking.

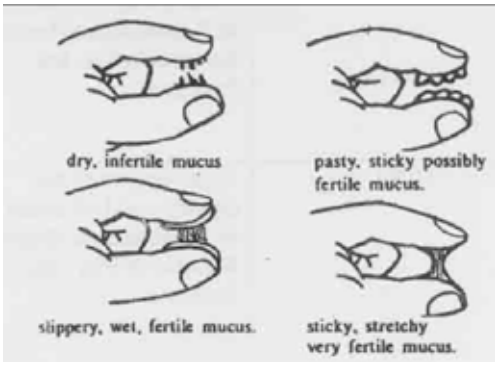


d. Mucus or Billing's Method

The hormones that control women cycle make the cervix produce mucus; it changes in quality and quantity just before and during ovulation. It is important that women can learn to recognize these changes.

- After menstrual period, there are usually a few days without mucus. These are called “dry days.” These may be safe days if the cycle is long.
- When an egg starts to ripen, more mucus is produced. It appears at the opening of the vagina. It is generally yellow or white and cloudy. And it feels sticky or tacky
- Women will have the most mucus just before ovulation. It looks clear and feels slippery — like raw egg white. When it can be stretched between the fingers. These are the “slippery days.” It is the peak of her fertility.
- After about four slippery days, you may suddenly have less mucus. It will become cloudy and tacky again. And then you may have a few more dry days before your period starts. These are also safe days.

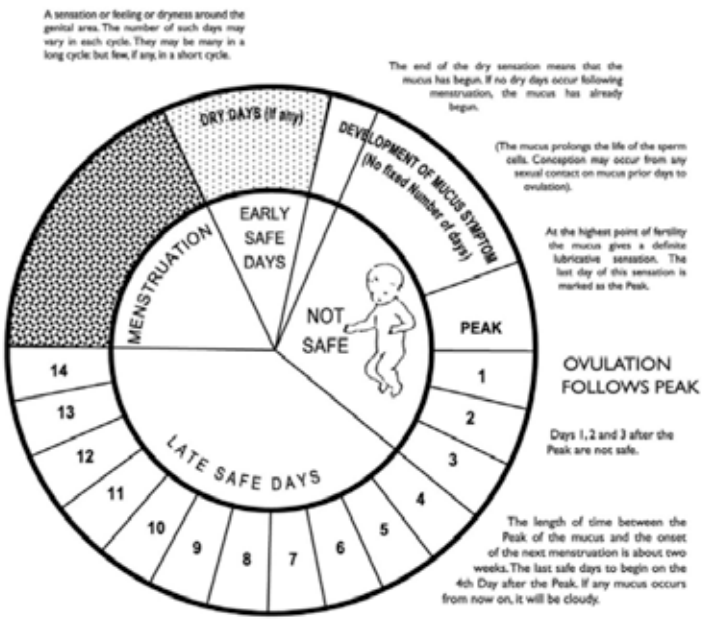
Testing the mucus



To use the Mucus Method correctly a couple must:

- avoid intercourse during a period
- have intercourse only after checking the mucus
- stop having intercourse as soon as fertile mucus is noticed and for 3 days after the fertile mucus has finished - intercourse may be re-started on the 4th day after the “peak”
- any bleeding or spotting during the cycle should be considered potentially fertile and intercourse avoided.

Phases of the menstrual cycle



e. Sympto-thermal Method.

This method uses a combination of calendar, temperature and mucus method to work out the fertile time of the cycle. It has the advantage over using just one method in that a woman can compare symptoms and signs to better pin-point ovulation.

2. WITHDRAWAL METHOD

What is withdrawal?

A man need to pull his penis out of the vagina before ejaculation — the moment when semen spurts out of his penis.

Couples who have great self-control, experience, and trust may use the pull out method more effectively.

Men who use the pull out method must be able to know when they are reaching the point in sexual excitement when ejaculation can no longer be stopped or postponed.

How does withdrawal method work?

Withdrawal prevents pregnancy by keeping sperm out of the vagina. Pregnancy cannot happen if there is no sperm present.

Effectiveness (Planned Parenthood, 2014)

As like other birth control methods, the pull out method is much more effective when you do it correctly.

- 4 out of 100 women will become pregnant each year if they always do it correctly
- 27 out of 100 women will become pregnant each year if they don't always do it correctly.

Benefits

Withdrawal method is simple, and convenient. Women and men like it because it can be used to prevent pregnancy when no other method is available. There are no medical or hormonal side effects. No prescription is necessary.

Disadvantages

- It requires great self-control, experience, and trust
- it does not work for men who ejaculate prematurely
- it does not work for the men who don't know when to pull out

- is not recommended for teens and sexually inexperienced men because it takes lots of experience before a man can be sure to know when he's going to ejaculate

SPECIFIC SITUATIONS

Women post-partum, post-miscarriage and individuals under the age of 18 years are considered as individuals under specific situations. The health care provider should be able to provide the correct advice on use of contraceptives by these individuals.

a. POST-PARTUM FAMILY PLANNING

All post-partum women should be counselled and provided with the family planning method they choose prior to their discharge from the birthing facility. All methods of family planning are appropriate for postpartum women, however the time for starting each method depends on a woman's breastfeeding status.

RETURN TO FERTILITY POST PARTUM

The period of infertility following delivery in non-breastfeeding women is usually around 6 weeks. The period of infertility for breastfeeding mothers is longer than for non- breastfeeding mothers. The return of fertility, however, is not predictable (conception can occur before the woman has signs or symptoms of the first menses). This period of temporary infertility is due to the effect of suckling which causes a surge in Prolactin thereby inhibiting ovulation. Ovulation remains disrupted or suppressed, as long as the frequency, duration and intensity of suckling are high. Ovulation in a lactating woman often naturally resumes around 6 months postpartum

FAMILY PLANNING FOR BREASTFEEDING WOMEN

Breastfeeding women need contraceptive methods before or at the time fertility recovers during lactation. This will depend on personal and social circumstances. It is crucial that contraceptives provided for breastfeeding mothers must be safe and effective without affecting lactation and health.

FAMILY PLANNING FOR NON-BREASTFEEDING WOMEN

Although most non-breastfeeding women will resume menstrual cycles within 4 to 6 weeks after delivery, only about one-third of first cycles will be ovulatory and even fewer will result in pregnancy. In order to avoid all risk of pregnancy, however, family planning method should be started at the appropriate time.

b. LACTATIONAL AMENORRHOE METHOD (LAM)

Criteria:

The clients must be met with the criteria below:

a) amenorrhoea

b) fully or nearly fully breastfeeding

c) less than 6 months postpartum

Breastfeeding shall only be considered an effective natural method of contraception when the baby is fully breast-fed. This means the baby sucks from the breast at least every 3 to 4 hours, day and night for 15 minutes or more, and approximately 8 times a day.

Additional FP methods:

Women shall be recommended to use additional FP to reduce the risk of accidental pregnancy, especially if the:

- mothers periods return
- baby is also artificially fed or started on solid food
- baby is 4 months old or more

Promoting breast feeding: Full and regular breastfeeding should be encouraged women. It's a best method of nutrition for the baby and to promote mother-child bonding.

How does LAM method work

While a woman is continuously breastfeeding, her body does not make a hormone that is necessary for ovulation — the release of an egg from an ovary. Pregnancy cannot happen if an egg is not released. (Planned Parenthood, 2014)

The Effectiveness

As like other FP methods, the effectiveness is depending on the user, breastfeeding is much more effective when client do it correctly.

- Less than 1 out of 100 women who practice continuous breastfeeding perfectly will become pregnant.
- About 2 out of 100 women who use continuous breastfeeding will become pregnant in the first six months if they don't always practice it.

Who can use LAM Method

- When the mother and baby satisfy all the necessary criteria given above
- When other methods of contraception cannot be used

Who cannot use LAM Method

- When the mother and baby cannot satisfy all the above criteria
- When the mother must not get pregnant or does not want to risk another pregnancy, immediately or in the future for medical or social reasons
- When the mother are still on certain medication such as antimetabolites, certain anticoagulants, corticosteroids, lithium, mood-altering drugs, radioactive drugs and reserpine.
- If baby have congenital malformations of the mouth, jaw or palate, newborns that are small for date or premature and need intensive neonatal care.

The benefits of LAM

Breastfeeding is safe, simple, and convenient.

Using breastfeeding as birth control has advantages for mothers. It -

- does not affect a woman's natural hormone balance
- is immediately effective
- is free
- requires no prescription
- needs nothing to be put in place before vaginal intercourse
- reduces bleeding after delivery
- requires no supplies or medical supervision

Breastfeeding also has many health advantages for the baby. It –

- decreases the likelihood of infection via water, other milk, or formula
- increases body contact, enhances increase bonding between mother and child

- passes on some of the mother's antibodies to protect the baby from certain infections
- provides the best nutrition

The advantages of LAM

LAM is available and easy to use, it is free, does not interrupt sexual intercourse, good health benefits to mother and baby, and protection starts immediately after birth.

The disadvantages of LAM

- It's depending on mother's and baby's breastfeeding pattern
- Not an effective method unless all criteria are fulfilled
- Limited duration

c. POST MISCARRIAGE FAMILY PLANNING

Post miscarriage family planning should include the following components:

- Counselling about contraceptive needs in terms of the client's reproductive goals taking into account what is feasible in the community she lives.
- Information and counselling about all available methods, their characteristics, effectiveness and side effects
- Follow-up care
- STI risk assessment.

When to Start

Post- miscarriage FP services need to be initiated immediately because ovulation may occur within 2 weeks (as early as 11 days) following treatment of first trimester incomplete abortion.

At a minimum, all women receiving post-miscarraige need counselling and information to ensure they understand:

- can become pregnant again before the next menses,
- there are safe contraceptive methods to prevent or delay pregnancy, and
- where and how they can obtain FP services and methods.

D. FAMILY PLANNING FOR INDIVIDUALS BELOW 18 YEARS OF AGE

Sexually active young women and men are in need of safe and effective contraception and is available to all ages in Kiribati. Many young women and men do not use effective contraceptive methods, and those who do are likely to use them infrequently or incorrectly. All young women and men need access to FP, and services for them should avoid unnecessary clinical procedures that may embarrass young people and discourage them from using FP services (e.g., pelvic examinations for young women requesting COCs). Furthermore, because adolescents may be less reliable in how they use a method, it is important that they have access to emergency contraceptive services.

Parental consent for provision of contraceptives to under 18s is not mandatory in Kiribati. Providers should have accurate information when making decisions about the use of contraception by people under the age of 18.

Adolescents both married and unmarried often are less tolerant of side effects and therefore have higher discontinuation rates. Proper education and counselling both before, at the time of method selection and follow up can enable adolescents to make informed decisions.

Chapter 11

DATA COLLECTION AND MONITORING SYSTEM

Family planning records and reports are important tools for supervision and monitoring. Two commonly used FP records:

1. FP Case Recording Card

The FP Case Recording Card is a card that records on the socio-demographic, health history, physical examination findings, and current method of use.

- The FP case recording card provides information on past and current use of a FP method and method switch (if any).
- It is an important tool for monitoring the quality of services as it provides information on whether the client has been screened for eligibility to use the method.
- It is useful for follow up of clients.
- When the client cards are organized in a systematic way, it can help to track defaulters.

2. Family Planning Register

This register records relevant information of all the couples eligible for FP in a defined geographical area.

- Provides information on the contraceptive prevalence in a specified geographical area
- Useful tool for tracking clients, especially defaulters
- Provides information on supplies of contraceptives.

Client Reminder Card

Purpose: The Client Reminder Card is used by providers to help their clients keep track of their next appointment date.

At the end of each visit, the provider should schedule the next visit with the client and write the date of the next visit on a reminder card. If the client is using injectables, the provider should also write the type of injectable and the date it was administered

Example of Client Reminder Card:

Stock Tracking Form

Purpose: The Stock Tracking Form allows the provider and the supervisor to monitor the status of commodities. The form provides a summary of the commodities used during the month and supplies the information on quantities remaining for the purpose of re-stocking if needs it.

Monthly Family Planning Recording form

The monthly family recording form is a monthly summary form for FP usage. It provides details of new cases, current cases, and defaulted cases dis-aggregation by family planning method.

Example of Monthly Family Planning Recording form:

	Pill	Depo-Provera	Condom		Natural Method	Sterilization	Patch	Total
			F	M				
Last month total (= current users)								
New (Add)								
Defaulters (Take away)								
TOTAL								

Family Planning Terms

Current: Any man or woman who is currently using a family planning method.

- When a woman is given Depo-Provera, she will be a current user for the next 3 months.
- Similarly for the pill. If you have given a woman 3 months' supply of the pill last month, then she is still currently using family planning this month and will be counted as a current user for three months.
- Any woman fitted with an IUCD, is a current user every month until the loop is removed.
- When a man takes condoms, you count how many months' supply he has (average 12/ month) and count him for that number of months.
- A woman who is taught the natural method, will be current for as long as she uses this method.

New: Any man or woman that has started on a method this month only. For the following months they are counted as current.

Defaulters: Any man or woman that has been using a method and then stops. This includes:

- A woman or man who decides to stop using Family Planning
- A woman or man who does not return for the next appointment
- A woman or man who transfers to another clinic

Reports

Family planning reports provide information on the progress of the various indicators that have been identified by the Ministry of Health. Currently only information of users and discontinuers are recorded. The reports should include complications with use of methods. The reports are important tools for monitoring.

Family planning reporting indicators: MDG 5:

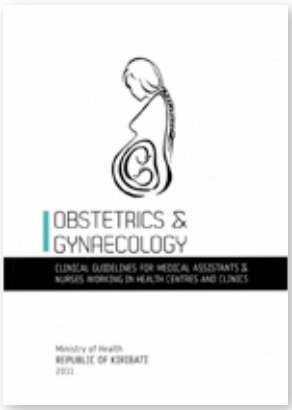
Target 5a: Reduce by three-quarters the maternal mortality ratio

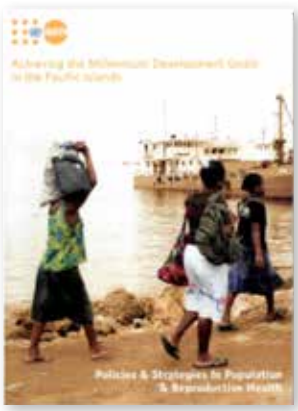
Indicators:	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel

Target 5b: Achieve universal access to reproductive health

Indicators:	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage 5.6 Unmet need for family planning

References & Further Reading





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Appendices

Appendix 1: Contraceptive Logistics (Supplies and Storage)

The objective of this appendix is to orient the health workers about the importance of ensuring regular supplies to avoid stock-outs and about storing contraceptive supplies properly.

Category of Provider responsible: Nurses and Medical Assistants place orders every 2 months in the outer islands and two weekly for clinics in South Tarawa (stocks for additional week sent) along with other RH commodities.

Ensuring Regular Supplies

- Kiribati has a high level of unmet needs of FP. Shortage of supplies is one of the major reasons.
- Regular monitoring of supplies is also an important element of service provision.
- The daily stock report help to monitor the supply level of various contraceptives. It is important to update the daily stock report regularly and to tally the items distributed with the records of the FP register.

Ordering Adequate Supplies

- The need for supplies is estimated based on the records of monthly consumption which in turn is based on either two monthly or weekly (supply) frequency.
- Supply of contraceptives is from the main pharmacy at TCH and the quantity supplied is calculated from stock levels by staff at the Pharmacy at TCH.
- Supplies to the clinics on the outer islands is based on the two monthly order from the outer islands to which an additional 2 months supply (total stock of 4 months so that enough commodities are available even in the event of transport not being available in the interim) is sent from the Pharmacy at TCH to the outer islands. For clinics in S Tarawa the order is made weekly to which an additional supply for a week is sent to the clinics at S.Tarawa.
- Fresh supplies must be ordered according to the existing cycle of ordering taking into account the time lag between indenting (ordering) and receiving of supplies.
- Some factors/conditions which may affect the time lag are seasonality, access, supply levels at the district/central stores

Ensuring Proper Storage of Supplies

- Special attention must be taken to see that the commodities have not reached/exceeded their expiry date.
- Supplies must be stored in cool (temperature 20 to 30° C) and dry place, away from direct sunlight.
- Whenever possible, windows that have screens should be opened and fans should be turned on between 10 AM and 4 PM. However, the supplies are not exposed to too much sunlight.

- Packets of condoms or pills that have their covers torn or discolored or contents seem sticky or oily or brittle should not be accepted or supplied.
- Injections of DMPA should not be discolored or no powder should be sticking to the vials.
- Supplies must be stored in such a way that those with an early expiry date would be used first - first expiry, first out (FEFO).

Logistic responsibilities in a health Facility	
Daily	Regularly (weekly / every two monthly)
Track the number and types of contraceptives dispensed to clients using an appropriate recording manual (daily record/ register)	Count the amount of each method on hand in the facility and check for any damages etc.
Maintain proper storage conditions for all supplies: clean dry storage away from direct sunlight and protected from extreme heat.	Make a list of required contraceptives using the form in the stock report. The quantity ordered should bring the stock up to the level that will meet the expected need until the next order. List sent to Pharmacy at TCH in S.Tarawa and send update report quarterly to UNFPA sub regional office.
Provide contraceptives to client using First Expiry First Out (FEFO) principle.	Check contraceptives received with the list requested.
Source: Adapted from WHO Department of Reproductive Health and Research (WHO/RHR) & Johns Hopkins Bloomberg School for Public Health/Center for Communication Programs (CCP), INFO Project, Family Planning: A Global Handbook for Providers, Baltimore and Geneva: CCP & WHO, 2007	

Appendix 2: Facility, Equipment and Supplies

Clean and well maintained physical facilities with electricity and running water, functioning equipment and continuous reliable supplies are crucial for the provision of quality family planning services.

FACILITY

Health facilities providing family planning services should be clean and well maintained. Facilities should have a waiting room for new and follow up clients. The environment should be consistent with the cultural background and should have educational material such as posters and pamphlets on all family planning methods as well as material on other aspects of reproductive health.

There should be a designated space for counselling ensuring privacy and have appropriat materiel such as flip charts, posters, pamphlets to provide to clients.

Client examination and provision of family planning methods should be done in a room that is clean, well maintained with adequate and appropriate equipment and supplies.

Minimum facilities for providing temporary methods of family planning are: waiting room for clients, a designated area conducive to privacy and confidentiality for counselling, client examination and provision of services.

Facility should also have designated areas for cleaning, sterilizing and disinfecting surgical instruments and materials and storage of processed instruments and supplies. Facilities should be available for storage and retrieval of client records and registers.

Another important requisite is toilet and washing facilities for clients as well as an area for clients to change their clothes depending on the family planning service.

MINIMUM EMERGENCY PROCEDURE REQUIREMENTS

All facilities where surgical procedures are performed MUST:

- have basic emergency equipment

- be able to perform emergency surgical procedures including emergency laparotomy or else an efficient ambulance service for the transport of a patient to the nearest hospital be adequately staffed to perform these emergency procedures.
- have trained personnel in basic resuscitation procedures

EQUIPMENT AND SUPPLIES FOR JADELLE, IUCD AND MALE AND FEMALE SURGICAL STERILIZATION

All equipment, instruments and supplies, must be in optimum working order, available and accessible to the provider. The following tables is a list of equipment and supplies needed for Jadelle insertion and removal, IUCD insertion and for male and female sterilization.

Table 1: Equipment and Supplies for Hormonal implants insertion and removal

Non expendable equipment & supplies	Expendable supplies
Scalpel handle	Instruments Wrapping cloth 18" sq
Syringe 5 ml	Small hand towel
Needle 20 Gauge x 4"	Sterile Gloves various sizes
Mosquito forceps, curved 5"	Gauze 4" X 4"
Dissecting forceps	Zinc oxide plaster
Jadelle trochars with cannula	Jadelle Implants
Sponge holding forceps	Local anaesthetic 1% Xylocaine 30 ml
Small metal bowl/kidney dish	Bar soap
Scalpel blade size 11	Bulbs
Cheatle forcep with jar	Batteries
Spot light	
Torch	

Table 2: Supplies for Hormonal Injectables (POI)

Disposable syringes and needles
Cotton swabs
Antiseptic solution
Soap

Table 3: Equipment and supplies for IUCD insertion and Removal

Non-Expendable Equipment	Expendable Supplies
Vaginal speculum, medium bivalve vaginal speculum	Copper- T 380 A in a pre-sterilized pack.
Sponge holding forceps	Bar soap
Small metal bowl for antiseptic solution	Torch with batteries, appropriate sizes
Vulsellum (small toothed)	Gloves various sizes
Uterine sound	Antiseptic solution/ Betadine (povidone iodine) solution
Scissors, Long Handled	Instrument wrapping cloth 18" sq
Instrument pan and cover	Small hand towel (inside set)
Long curved artery forceps	bulbs
Cheatle forceps	batteries
Cheatle jar	
Kidney Tray (Big size) for keeping used instruments	
Spot light	
Torch	

Table 4: Equipment for vasectomy

Instruments for Vasectomy including special instruments required for No scalpel Vasectomy	Expendable Supplies for Vasectomy
Iodine Cup, 4 oz 1.5" high	Gauze cloth 18 mts X 1 mt
Forceps, Artery, Straight, 51/2"	Sterile Gloves various sizes
Scissors, straight	Liq. Betadine
Sponge Holding Forceps	Xylocaine Inj. 1% 30 ml vial
Ringed Forceps, 4.0 mm ring (NSV)	Disposable Syringe 5 ml with 1.5", gauge 23-24 needle
Ringed Forceps, 3.0 mm ring (NSV)	Black Silk
Dissecting Forceps for NSV	Tab. Paracetamol
	Hypochlorite solution for decontamination
	Dressing
	Adhesive Tape 4" X 5" Roll

ISBN 978-982-520-059-8