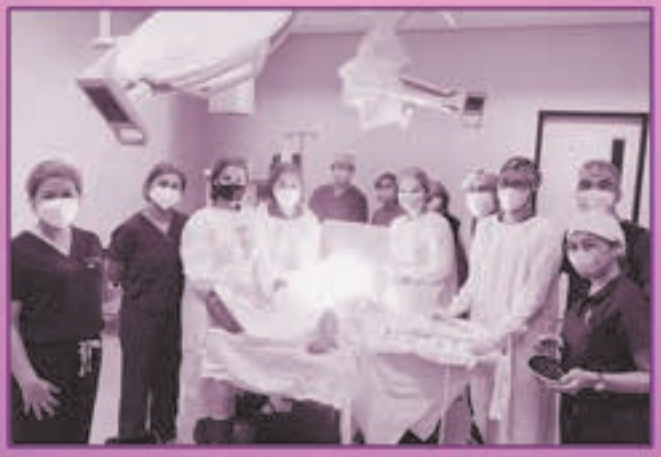
World Health Organization
Philippines

THE PHILIPPINE FAMILY PLANNING HANDBOOK

2023 Edition



The Philippine
FAMILY PLANNING
Handbook

2023 Edition

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Preface

The Philippines commits that all Filipinos enjoy a healthy and productive life and are empowered to make informed decisions in family planning and in their reproductive health and rights. The family planning (FP) Program aims to provide universal access to FP information and services whenever and wherever these are needed, regardless of marital, socioeconomic status, religion, ethnicity, and in any situation. To achieve this goal, the Department of Health will (1) address the need to help couples and individuals achieve their desired family size within the context of responsible parenthood and improve their reproductive health to attain sustainable development, and (2) ensure that quality FP services are available in DOH-retained hospitals, LGU-managed health facilities, non-government organizations (NGOs), and the private sector.

Among the priority strategies is the integration of family planning with other basic services, such as maternal care services (ie. prenatal visits, childbirth and postpartum periods), immunization, pre-marriage orientation and counseling, post-abortion care, among others. Additional high-impact practice in FP is the expansion of FP service coverage through community-based distribution, task-shifting (e.g., distribution of male condoms and resupply of contraceptive pills to current users by community health and population volunteers), outreach services in urban poor communities, and GIDAs through public-private engagement, among others.

The Philippines' Family Planning Handbook 2023 serves to provide the necessary information to guide FP practitioners and program managers in the delivery of quality FP services across the life stages. The Handbook provides updates on the latest contraceptive technology based on the 2022 WHO Global Handbook for Family Planning Providers, as well as other scientific journals.

Furthermore, this version highlights new chapters that discuss and guide FP implementation under the full implementation of the Supreme Court Ruling in relation to the Mandanas-Garcia Petition 2018.

This handbook can be used as a reference in the review and enhancement of training modules and curriculum in relation to building the skills and competencies of FP practitioners and service providers. Moreover, it shall guide the development of the PhilHealth benefit package for women's health, which reflects the current protocols and updated standards vital in achieving the goals of Universal Health Care.

Foreword

Republic Act No. 10354, or the "Responsible Parenthood and Reproductive Health Act of 2012," was considered a landmark legislation towards enhancing access of Filipinos to reproductive health services. The mandate for the full implementation of the RPRH law was further intensified through President Duterte's signing of Executive Order No. 12 entitled "Attaining and sustaining "Zero Unmet Need for Modern Family Planning" through the strict implementation of the Responsible Parenthood and Reproductive Health Act, providing funds therefor, and for other purposes." Another landmark legislation directed towards the achievement of Universal Health Care (UHC) in the Philippines was signed in 2019. The Republic Act No. 11223, or the "Universal Health Care Act," is an important stride towards expanding population, service, and financial coverage through various health sector reforms. The rollout of the UHC Act shall complement the implementation of the RPRH Law in providing responsive family planning services and ensuring access of Filipinos to medically safe, legal, non-abortifacient, effective, and culturally acceptable modern family planning methods.

With distinct honor, I introduce to all frontline health workers the updated Philippine Family Planning Handbook 2023 edition. The Handbook serves as a gold standard for providing family planning and contraceptive services in the country. Referencing the latest local and international literature, the handbook provides updated and relevant information for service providers on existing family planning methods. New family methods that were made available after its last update seven years ago are also included in this Handbook. At the same time, the 2023 Handbook also guides how FP services are delivered under the new UHC framework and during periods of humanitarian emergencies such as times of disasters and pandemics.

Given the recent challenges in the provision of health services brought about by the COVID-19 pandemic, I encourage all health providers to continue upholding the highest standards in delivering family planning services. With the help of this Handbook, I hope that providers will be fully equipped and geared towards reaching the goal of zero unmet need for family planning in the country.

TEODORO J. HERBOSA, MD
Secretary of Health

Message of WHO Representative to the Philippines for the Philippine Family Planning Handbook 2023 Edition

Ensuring access for all people of reproductive age to their preferred family planning methods advances several human rights, such as the right to life, freedom of choice and expression, and the right to work and education. It also brings significant public health benefits, especially in preventing maternal deaths.

The Sustainable Development Goals set for 2030 aim to make sexual and reproductive health services widely available, acceptable, and utilized. These are attainable through supporting and promoting contraceptive services with effective government policies and guidelines. Another equally important aspect is the provision of timely and relevant information and services to individuals seeking them.

The prevention of unintended pregnancies helps in lowering maternal ill-health and the number of pregnancy-related deaths. Modern family planning methods can lower unintended pregnancies, while also reducing HIV transmissions from mothers to newborns and curtailing the need for unsafe abortion. Family planning allows people to attain their desired number of children, if any, and to determine the spacing of their pregnancies.

These benefits could be profound for young girls who are at increased risk of health problems due to early child-bearing. When we delay pregnancies in this age group, they can focus on their education and the opportunities they want to pursue in the future.

The COVID-19 pandemic has made it more challenging to meet the huge needs in family planning services and other essential services. The Philippine Family Planning Handbook 2023 offers clear, accurate, and up-to-date information and advice on modern family planning methods to help providers meet clients' needs in these challenging times.

In addition, this handbook highlights principles on responsible parenthood and reproductive health (RPRH) and contraceptive technology, thus ensuring expanded and continuous access to and financing of family planning services.

I encourage all health service providers to make the most of this handbook to help ensure the provision of quality and safe family planning services.

RUI PAULO DE JESUS, MD
WHO Representative to the Philippines

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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral Drugs
ASC	Ambulatory Surgical Clinic
BBT	Basal Body Temperature
BHERT	Barangay Health Emergency Response Team
BHS	Barangay Health Station
BHW	Barangay Health Worker
BMI	Body Mass Index
BP	Blood Pressure
BCS	Balanced Counseling Strategy PLUS
BTL	Bilateral Tubal Ligation
CHC	Combined Hormonal Contraceptive
CHD	Center for Health Development
CHO	City Health Office
CHT	Community Health Team
CIC	Combined Injectable Contraceptive
CIN	Cervical Intraepithelial Neoplasia
COC	Combined Oral Contraceptive
COCP	Combined Oral Contraceptive Pill
CSO	Civil Society Organization
CVD	Cardiovascular Disease
CWHS	City-Wide Health System
DILG	Department of the Interior and Local Government
DMPA	Depot-Medroxyprogesterone Acetate
DOH	Department of Health
DSWD	Department of Social Welfare and Development
DVT	Deep Vein Thrombosis
EC	Emergency Contraception
ECP	Emergency Contraceptive Pill
EE	Ethinyl Estradiol
EMONC	Emergency Obstetric and Newborn Care
EPI	Expanded Program on Immunization

FAB Method	Fertility Awareness-Based Method
FDA	Food and Drug Administration
FHSIS	Field Health Service Information System
FIC	Fully Immunized Child
FP	Family Planning
FPCBT	Family Planning Competency-Based Training
FSH	Follicle Stimulating Hormone
GAD	Gender and Development
GIDA	Geographically Isolated and Disadvantaged Areas
HCPN	Health Care Provider Network
HIV	Human Immunodeficiency Virus
ICV	Informed Choice and Voluntarism
IEC	Information, Education, and Communication
IM	Intramuscular
IUD	Intrauterine Device
LAM	Lactational Amenorrhea Method
LAPM	Long-Acting Permanent Method
LARC	Long-Acting Reversible Contraception
LCE	Local Chief Executives
LGU	Local Government Unit
LH	Luteinizing Hormone
LHSD	Local Health Systems Development
LNG	Levonorgestrel
MEC	Medical Eligibility Criteria
mFP	Modern Family Planning
MHCS	Mobile Health Care Service
MHO	Municipal Health Office
MISP	Minimum Initial Service Package
NDHS	National Demographic and Health Survey
NET-EN	Norethisterone Enanthate
NFP	Natural Family Planning
NGA	National Government Agency
NGO	Non Government Organization
NHIP	National Health Insurance Program

NHTS-PR	National Household Targeting System for Poverty Reduction
NSV	No-Scalpel Vasectomy
PWHS	Province-wide Health System
PE	Pulmonary Embolism
PCPN	Primary Care Provider Network
PHIC/PhilHealth	Philippine Health Insurance Corporation
PHN	Public Health Nurse
PHO	Provincial Health Office
PID	Pelvic Inflammatory Disease
PMIS	Pharmaceutical Management Information System
PMS	Premenstrual Syndrome
POC	Progestin-Only Contraceptive
POI	Progestin-Only Injectable
POP	Progestin-Only Pill
CPD	Commission on Population and Development
PPE	Personal Protective Equipment
PPIUD	Postpartum Intrauterine Contraceptive Device
PSI	Progestin Subdermal Implant
RHM	Rural Health Midwife
RHU	Rural Health Unit
RPRH	Responsible Parenthood and Reproductive Health
RTI	Reproductive Tract Infections
SDM	Standard Days Method
SC	Supreme Court
SHF	Special Health Fund
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
TCL	Target Client List
UHC	Universal Health Care
VSC	Voluntary Surgical Contraception
VTE	Venous Thromboembolism
WHO	World Health Organization
WRA	Women of Reproductive Age

Introduction

Overview of the Handbook

Under the Philippines' Universal Health Care (UHC) Law, family planning (FP) service has been identified as one of the essential healthcare packages in the health care delivery system. It includes the provision of ethical and medically safe, legal, accessible, affordable, non-abortifacient, effective and quality reproductive health care services, and supplies essential in the promotion of people's right to health, especially those of women, the poor, and the marginalized, and shall be incorporated as a component of basic healthcare.

A Client-Centered Approach to Care, which empowers clients to achieve their reproductive intentions safely and as a means of improving quality of care and service within the context of rights-based FP, was advocated during the Family Planning Summit 2017 (FP2020). It warrants that FP service providers should have the technical knowledge and competencies to ensure that the quality of care being provided is at par with international standards.

Several changes and new trends that have emerged since the last edition of the FP Clinical Standards issued in 2014. There was a call to review and update the standards in line with the WHO 2022 Family Planning Global Handbook for Providers and to focus on strengthening the primary care integration of the Department of Health (DOH) to the UHC Law. Providing the local context in terms of implementing FP services and support activities is likewise given emphasis to enlighten FP providers and program managers on how to ensure and sustain the provision of FP and other Reproductive Health (RH) services under full devolution (Supreme Court Ruling on the Mandanas-Garcia Petition, 2018).

There was a call to review and update the Philippine FP Clinical Standards Handbook issued in 2014 in line with the WHO 2022 Family Planning Global Handbook for Providers, and Omnibus Health Guidelines (OHG). The updated Philippine Family Planning Standards Handbook, 2023 Edition will ensure that FP health care providers are equipped with the latest updates on contraceptive technology and other relevant information on emerging FP concerns. It also provides guidance on implementing and expanding integrated delivery of FP services to ensure the provision of FP and other Reproductive Health (RH) services with the current policy reforms. Furthermore, the revision of the Handbook shall serve as a reference in the development of the PhilHealth benefit package for women's health, which should reflect the current protocols and updated standards vital in achieving the goals of UHC. Moreover, it shall serve as an important source of information for the enhancement of FP training modules and curriculum to improve skills and competencies of FP practitioners.

Objective of the Handbook

This Handbook is intended to be used as a reference guide by FP practitioners and program managers in terms of providing updated, quality modern FP information and services and ensuring that appropriate support systems are established to guarantee non-disruption of FP services in various settings.

User of the Handbook

The Handbook is intended to be used primarily as a reference by FP practitioners in the public and private sectors. It also guides local health management in planning and budgeting, implementing, monitoring and evaluation to ensure that FP services can be readily accessed and are available in all service delivery points within the local health system.

Methodology in the Review and Revision Process

The process in the delivery of the final Handbook entailed the following:

1. Review of literature on current trends in FP referenced from global standards of FP practice, such as but not limited to the following: WHO Global Handbook on Family Planning (2022); the WHO Medical Eligibility Criteria (2015); Selected Practice Recommendations for Contraceptive Use (2016) and latest available scientific journals and articles on contraceptive technology, among others. A summary of the updated key findings was prepared and presented to key stakeholders for discussion.
2. The consultative process included a presentation of the literature review findings and proposed changes and updates in the current version. Furthermore, the suggested content outline included the formatting of the updated version based on the participants' recommendations as well as the feasibility and appropriateness of procedures in the context of the country's moral, civic and religious concerns.
3. Drafting of the Updated Philippine Family Planning Standards Handbook 2023 was based on findings and recommendations from the stakeholders' meeting. A 5-member team of technical writers were assigned specific topics that were initially reviewed and updated by the Technical Editors to include the latest updates from the 2022 WHO Global Handbook.
4. A review of the Updated Philippine FP Standards Handbook 2023 edition was done by the experts panel. The recommendations of the panel were immediately inputted into the draft for the second version.
5. Consultative meetings with relevant DOH units and stakeholders on the draft Updated Philippine Handbook on FP Standards were conducted. The consultative process entailed a full-day workshop to discuss and validate the following: a) Content of the updated version (i.e., clarity; relevance; usefulness, formats, etc.); and b) additional recommendations. The results and agreements during the stakeholders' validation workshop were integrated by the technical writing team in the second draft to produce the revised final version of the Updated Philippine Family Planning Standards Handbook 2023.
6. Final editing and review of the draft document by the technical editors. The final draft of the Updated Philippine FP Standards Handbook 2023 was then submitted to WHO and the DOH.
7. A Department Memorandum on the Adoption of the Updated Philippine Family Planning Standards Handbook 2023 is issued to support the proper dissemination and use of the updated version of the Handbook by all stakeholders, including the FP service providers in the health care provider network.

What are the Updates?

TOPICS	DESCRIPTION
Principles on Family Planning Practice in the Philippines	This section described the various principles (following global standards as defined in the latest WHO Global Handbook for Service Providers, 2022). It also provided a description of the application of these principles in FP Practice.
Informed Choice and Voluntarism	The section provided a description of the principle of Informed Choice and Voluntarism (ICV) as an important component in the practice of FP. It also included examples to illustrate the application of this principle. The use of Informed Consent Forms was also highlighted.
Client Assessment and Counseling	In this section, a full description of how FP clients should be handled by service providers was presented. A new item being introduced in this section is the Balanced Counseling as a new approach/ technique in the provision of FP counseling
Contraceptive Technology	All methods of FP were discussed, providing information on the following, as appropriate: • Name of the method • Introduction (about the method, types) • Reproductive intention: Who can/cannot use? • Mechanism of action • Effectivity (perfect use, typical use) • Advantage and disadvantages • Return to fertility • Side-effects and adverse reaction, and their management • Dispelling myths and misconceptions • Non-contraceptive benefits • How to provide the method (timing) • How to use • Post-insertion support/counseling • Support for continuing users (when to follow-up) • To do prior to provision of the method (specific to LARC and permanent methods) • Summary of key points (3-6) for each method
Ensuring client access to quality FP care under different service delivery settings	1. Three-tier referral with multi-provider/payer setting a. Roles of community health workers and providers in expanding FP reach – along with the areas of conducting demand generation activities/finding women with unmet FP need and providing FP services b. Mechanisms for FP provision under different providers/payers/regulators at the primary, secondary, and tertiary levels of care

	2. GIDA setting a. Criteria for site selection b. Requirements for the provision of itinerant services for FP
	3. Pandemic, disaster, and health emergency setting a. Policies providing standards for FP service delivery under disaster/pandemic/health emergency situations – DOH DM 2020-0222, HEMS handbook b. Adaptations in FP service delivery – teleconsult/ telemed; use of courier services for FP commodity resupply, etc. 4. Health care provider network (HCPN) in a local health system setting a. Types of HCPN under UHC: Public, Private and Public-Private mix b. Client referral pathway and referral arrangements c. HCPN management
Policy shift towards an expanded and integrated delivery of family planning services	This section highlights implications of current policies on the delivery and financing of FP services, highlighting the shift towards a more integrated approach under a province-/city-wide health system setting: 1. Universal Health Care Act 2. SC Ruling on Mandanas-Garcia Petition
Sustaining the provision of Quality FP Services	1. Family Planning Program Management 2. Setting up of HCPNs a. Inventory of public and private FP providers b. Development of HCPN governance structure as well as contracting, referral, claims and reimbursement sharing arrangements 3. Inclusion of FP services in Konsulta Package 4. Contracting of interested providers 5. Network accreditation
Financing FP thru PhilHealth	This includes an update and description on PhilHealth Membership and Eligibility as well as the Benefit Coverage for FP Services

I. RPRH Principles, Client Assessment & Effective Counseling in FP

A. RESPONSIBLE PARENTHOOD AND REPRODUCTIVE HEALTH PRINCIPLES

The country has been continuously implementing the global call for the recognition and application of human rights and gender-based principles in the provision of reproductive health services, including family planning (FP), to ensure that quality and "client-centered" services are being provided by health practitioners. Thus, it is vital to focus on the specific health care needs of the client and help them achieve their reproductive goals.

Table 1 presents these principles as espoused under the Responsible Parenthood and Reproductive Health (RPRH) Act which guides all FP and reproductive health (RH) practitioners in providing RH services.

Table 1. RPRH IRR Principles

HUMAN RIGHTS AND GENDER-BASED PRINCIPLES[1]	WHAT THE RPRH LAW MANDATES[2]
Principle 1. Non-discrimination	The State mandates the recognition of and guarantees: • human rights of all persons (i.e. equality and non-discrimination, including those between married and unmarried individuals); • the right to sustainable human development; • the right to health which includes reproductive health; • the right to education and information; • that reproductive health supplies and health products for the poor shall be the primary responsibility of the national government, LGUs shall endeavor to provide information, services and supplies to poor and non-poor families; and • the eradication of discriminatory practices, laws and policies that infringe on a person's exercise of reproductive health rights.

1 WHO Global Handbook on Family Planning for Providers, 2022 edition
2 RA 10354 or RPRH Law of 2012 Implementing Rules and Regulations

Principle 2. Availability of contraceptive information and service Principle 3. Accessible Information and Services Principle 4. Acceptable information and services	The State guarantees: • Universal access to medically-safe, non-abortifacient, effective, legal, affordable, and quality reproductive health care services, methods, devices, supplies which do not prevent the implantation of a fertilized ovum as determined by the Food and Drug Administration (FDA) and relevant information and education thereon according to the priority needs of women, children and other underprivileged sectors;
	• Promotion and provision of information and access, without bias, to all modern methods of family planning, whether natural or artificial, which have been proven medically safe, legal, non-abortifacient, and effective in accordance with scientific and evidence-based medical research standards such as those registered and approved by the FDA; and • Ensures the provision of funding support to promote all modern natural methods of family planning (i.e. Billing's Ovulation Method, etc.) consistent with the needs of acceptors and their religious convictions.
Principle 5. Quality	• Since human resource is among the principal assets of the country, effective and quality reproductive health care services must be given primacy to ensure maternal and child health, the health of the unborn, safe delivery and birth of healthy children, and sound replacement rate, in line with the State's duty to promote the right to health, responsible parenthood, social justice and full human development; and • While the RPRH IRR recognizes that abortion is illegal and punishable by law, the government shall ensure that all women needing care for post-abortive complications and all other complications arising from pregnancy, labor- and delivery-related issues shall be treated and counseled in a humane, non-judgmental, and compassionate manner in accordance with law and medical ethics.
Principle 6. Informed Decision-Making	• The right to make free and informed decisions, which is central to the exercise of any right, shall not be subjected to any form of coercion and must be fully guaranteed by the State;

	• Informed choice and voluntarism shall be promoted by all public and private health care providers rendering reproductive health care; and • Clients shall not be denied any right or benefit (including the right to avail of any program of general welfare or health care) as a consequence of any decision regarding reproductive health care; neither shall they be coerced nor induced to avail of any particular service or health product.
Principle 7. Gender responsiveness	• The State recognizes the promotion of gender equality, gender equity, women empowerment and dignity as a health and human rights concern and as a social responsibility. Gender equality and women empowerment are central elements of reproductive health and population and development.
Principle 8. Privacy and confidentiality	• Gender-Sensitive Handling of Clients (Section 5.26 of the RPRH Law) stipulated that health care providers shall be provided with training on gender-sensitive handling of clients to ensure nonjudgmental and humane delivery of all reproductive health care services and information, including the respect for the right to privacy and the privilege of confidentiality of clients.
Principle 9. Participation	• Active participation by non-government organizations (NGOs), women's and people's organizations, civil society, faith-based organizations, the religious sector, private sector, and communities is crucial to ensure that reproductive health and population and development policies, plans, and programs will address the priority needs of women, the poor, and the marginalized.
Principle 10. Accountability	• The provision of reproductive health care, information and supplies, and giving priority to poor beneficiaries must be the primary responsibility of the national government in collaboration with the LGUs, consistent with its obligation to respect, protect and promote the right to health and the right to life.

Application of the Human Rights and Gender-Based Principles for FP Practitioners and FP Managers

Table 2. Applying the Human Rights and Gender-Based Principles for FP Practitioners and FP Managers

PRINCIPLE	FOR THE FP PRACTITIONERS	FOR THE FP MANAGERS
Non-Discrimination	• Welcome all clients equally. • Respect every client's needs and wishes. • Set aside personal judgments and any negative opinions. • Promise yourself to give every client the best care you can.	• Ensure that FP information and services are available in both public and private facilities for ALL women of reproductive age regardless of age, marital status, gender, culture, religious convictions, personal circumstances, or nature of work.
Availability of contra-ceptive information and service	• Know the FP methods available and how to provide them. • Help make sure that supplies stay in stock. • Do not rule out any method for a client unless the method is a contraindication. • Do not hold back information.	• Ensure availability of a wide array of modern FP methods (both natural and artificial) that are medically safe, non-abortifacient, effective, legal, affordable, and quality reproductive health care services, devices, and clinic supplies. • Ensure the adequacy of trained and competent providers/assistants to provide FP information and services in the health facilities. • Support the conduct of demand generation activities to promote and disseminate adequate and appropriate FP information. • Ensure that there is no disruption in FP services even during times of pandemic and disasters.

Accessible Information and Services	• Help make sure that everyone can access information and services despite physical disability or health/climate catastrophe. • Participate in outreach, when possible, do home visits or engage the assistance of the community.	• Be responsive to address the special needs of certain population groups. • Support the conduct of itinerant services in GIDA areas. • Engage community members or NGOs to assist in information dissemination.
Acceptable information and services	• Be friendly and welcoming and help make the facility that way. Provide information materials and encourage clients to ask questions. • Not to miss any opportunities to promote FP, include information on FP for every WRA-client who visits the facility particularly those women who may be too shy to ask or request information on family planning. • Put yourself in the client's shoes. • Think of what is important to the clients—what they want and how they want it provided.	• Support and maintain client-centered and friendly facilities to ensure access to available FP information and services.
Quality FP services	• Keep your knowledge and skills up to date. Use good communication skills. • Check that the contraceptives you provide are not out-of-date.	• Support the conduct of competency-based training for service providers. • Build the capacities of service facilities and providers to maintain and sustain quality FP services with adequate and appropriate commodity requirements and medical supplies.

Informed Decision Making	• Explain family planning methods clearly, including how to use them, how they work, how effective they are, and what side effects they may have, if any. • Help clients consider what is important to them in an FP method. • Follow guidelines on Informed Choice of this Handbook (See Informed Choice & Voluntarism page 25).	• Build competencies of FP service providers on counseling (GATHER, BALANCED COUNSELING) and on Informed Choice and Voluntarism approaches.
Gender responsiveness	• Use available tools and instrumentalities in providing gender-responsive FP services. • Ensure gender responsiveness of the FP program.	• Ensure the proper dissemination of appropriate tools and guidelines on gender responsiveness. • Provide training on gender responsiveness (gender sensitivity training of providers and other staff).
Privacy and confidentiality	• Do not discuss your clients with others except with permission and as needed for their care. • When talking with clients, find a place where others cannot hear the conversation. • Do not tell others what your clients have said. • Promptly keep the clients' records in a safe and secured place.	• Provide safety nets that are compliant with the Data Privacy Act.
Participation	• Encourage feedback from clients by: 1. Asking clients what they think about FP services provided to them.	• Encourage public-private partnership and collaborative work in the provision of quality FP services.

	2. Acting on what they say/suggest to improve care.	• Explore mechanisms to entice the participation of private practitioners. • Motivate and reach out to families and individuals (in the community) to participate in FP related planning processes and to improve FP services.
Accountability	• Hold yourself accountable for the care that you give clients while protecting their rights and privacy. • LCEs should have accountability of the FP service provision as well and should be held accountable for the achievement or non-achievement of FP indicators in their jurisdiction.	• Ensure that the provision of FP information and services are supported with adequate funds to support program and service implementation. • LCEs are evaluated on how well they support FP Program In their LGU.

B. INFORMED CHOICE AND VOLUNTARISM & INFORMED CONSENT

What is Informed Choice and Voluntarism?

One of the pillars of quality of care in family planning (FP) is safeguarding that the rights of FP clients are always respected by service providers. The rights of FP clients, especially the right to information and choice, must be honored through appropriate FP counseling to enable clients to make voluntary and informed choices based on accurate, balanced, and complete information.

In compliance with the Implementing Rules and Regulations (IRR) of the RPRH Law of 2012, the Department of Health (DOH) issued Administrative Order No. 2011-0005 that defines Informed Choice and Voluntarism (ICV) as "a standard in the delivery of FP services, ensuring that clients freely make their own decision based on accurate and complete information on a broad range of available modern FP methods, and not by any special inducements or forms of coercion or misinterpretation."

The DOH recognizes that ensuring ICV results in a better and longer method use and improved client compliance and satisfaction who, in turn, encourage others to participate in FP programs. This is effectively done through face-to-face, verbal and nonverbal exchange of information with clients.

Health care providers are responsible for ensuring that the following basic client rights are respected, and FP client makes a voluntary and informed choice:

1. Right to information — To learn about the benefits and availability of FP methods.
2. Right to access — To obtain services regardless of sex, creed, color, marital status, social status, or location.
3. Right to choose — To decide freely on whether to practice FP and which method to use.
4. Right to safety — To be able to practice safe and effective FP.
5. Right to privacy — To be counseled and be provided with services in a private environment.
6. Right to confidentiality — To be assured that personal information is kept between the client and the provider.
7. Right to dignity — To be treated with courtesy, consideration, and attentiveness.
8. Right to comfort — To be provided with utmost care and attention during service.
9. Right to continuity — To receive FP services and supplies, if needed.
10. Right to opinion — To express views on the services offered.

Informed Consent

Informed consent is different from informed choice. Informed consent is a written voluntary decision of an FP client stating that he/she accepts a particular method (e.g., sterilization, IUD, or implant insertion) before undergoing the procedure. The service provider is assumed to have already provided correct information about all FP methods and adequate counseling prior to the acknowledgment of the decision.

The RPRH Law of 2012 IRR includes the following provisions regarding informed consent/ parental consent for minors availing of FP services:

- Any minor availing of FP services must have a written consent of her parent or guardian.
- Any minor who has had a previous pregnancy or is already a parent still requires parental consent prior to availing of FP services.

The following is an example of an Informed Consent Form.

MODEL INFORMED CONSENT FORM *

Name of Facility: _____

Address: _____

I, _____ the undersigned, request that _____
(client's name) *(procedure)*

be performed / be provided on my person. I make this request of my own free will, without having been forced or given any special inducement. I understand the following:

1. There are other permanent, or temporary contraceptive methods available to me and my partner.
2. The procedure to be performed on/method to be provided to me is a permanent/ long-acting reversible procedure, the details of which have been explained to me.
3. The method involves risks, in addition to benefits, both of which have been explained to me.
4. If the procedure/method is successful, I will be unable to have any more children.
5. The effect of the method should be considered permanent (for BTL/Vasectomy) or Long-Acting but Reversible (for IUD and Implant)
6. The method does not protect me or my partner from infection with sexually transmitted infections, including HIV/AIDS.
7. I can decide against the method/procedure at any time before the operation is performed (without losing the right to medical, health, or other services or benefits).

_____ _____
(Signature or mark of client) *(Date)*

_____ _____
(Signature or mark of attending doctor) *(Date)*

**If the client is an adolescent, the parent or guardian must sign the following declaration:

I, _____, the parent or guardian of the (client) give my consent for my adolescent daughter/son to undergo the aforementioned procedure.

_____ _____
(Signature or mark of parent) *(Date)*

** If the method is permanent:

I, _____, the spouse of the (client) agree that my spouse can undergo the aforementioned procedure.

_____ _____
(Signature or mark of spouse) *(Date)*

Ensuring Informed and Voluntary Decisions

Service providers must be aware of the principles of ICV.

Table 3 explains the principles of ICV and provides hypothetical examples of non-compliance or vulnerability. Service providers must be aware that their best interests might violate ICV principles and the rights of the client.

Table 3. Principles of Informed Choice and Voluntarism (ICV)

ICV PRINCIPLE	CLARIFICATION / INTERPRETATION	EXAMPLE OF NON-COMPLIANCE/ VULNERABILITY
No quotas or other numerical targets relative to the total number of births, number of FP acceptors, or acceptors of a particular FP method.	A quota or target is a predetermined number of births, FP acceptors, or acceptors of a particular method that a service provider or a barangay health worker is assigned or required to achieve. Indicators for planning, budgeting, and reporting are exempted.	Dionisia, the midwife–owner of a lying-in, discovers that her employed midwife failed to achieve her required 10 PPIUD insertions per month and thus deducts 5% from her salary.
No payment of incentives, bribes, gratuities, or financial reward to: • An individual in exchange for becoming an FP acceptor • Program personnel for achieving a numerical target or quota relative to the total number of births, number of FP acceptors, or acceptors of a particular FP method.	Provider payments violate the provision only when payment is based on a quota or target set as a predetermined number of total births, number of FP acceptors, or number of acceptors of a particular method. Incentives, bribes, gratuities, and financial rewards should not be a form of inducement to accept a particular method.	The best "performing" health providers in a program receive supplies and/ or equipment as reward based on the number of FP acceptors.
No denial of rights and benefits for those who do not accept FP.	Health facilities shall not deny any right or benefit, including the right to participate in any program of general welfare or the right to access healthcare, as a consequence of the decision not to accept FP services.	Mothers who did not accept any FP method are denied immunization services.

Comprehensible information on chosen FP method. Full disclosure for experimental contraceptive method and procedures.	Clients must receive comprehensible information about the risks, benefits, side effects, and contraindications of the method they want to use in accordance with local standards.	Service providers withhold full information on FP methods from the clients.
Informed consent must be documented prior to permanent methods, namely, bilateral tubal ligation (BTL) or vasectomy.	During counseling, potential FP clients should be made aware of all the modern FP methods. If methods such as intrauterine device and BTL, which require a certain level of skill from providers, are unavailable, the provider should be able to refer the client to a facility where the services are available.	Mara goes to the hospital desiring to have BTL. However, no doctor is available to conduct the procedure. The nurse simply tells her that the method is unavailable and sends Mara home with no alternative method or referral.
No discrimination should be made against applicants for grants or funding because of religious or conscientious commitment to offer only natural FP.		Chastity Foundation was denied funding because it strictly promoted only natural FP methods.
Funding of programs with involuntary sterilization or coercive abortion is not allowed.	Practice of abortion is illegal in the country, as stipulated in the Revised Penal Code. Program beneficiaries are not allowed to join advocacy activities lobbying for abortion as an FP method.	

C. COUNSELING AND CLIENT ASSESSMENT FOR FAMILY PLANNING

FP Counseling

Counseling is an essential part in providing quality FP and RH services. It is a face to face, personal communication in which the counselor helps the client make the right decisions and act on them. It helps the client make informed decisions on suitable FP methods to accept and use. The goal of counseling is to help the client choose a method that will allow her to follow appropriate birth spacing and her reproductive goals which she or her partner can use effectively until the client desires to have another pregnancy or shift to another contraceptive.

The Family Planning Counselor

The role of the FP counselor is to assist the client, ideally with the partner, in making informed decisions about fertility and contraception dependent on the client's values and needs. The FP counselors (physicians, nurses, or midwives) should have attended the "Family Planning Competency-Based Training Module1 (FPCBT 1)," a basic FP training, effective in integrating their skills in the provision of FP services. They should be able to impart their knowledge of the various contraceptive options available and have a good understanding on how to relate to their clients' needs. Although a variety of lay people can learn to motivate and advise people about FP, only trained health workers are authorized to provide FP methods in health facilities.

Trained midwives are usually the FP service providers responsible for attending to FP clients – from counseling to provision of methods like IUD insertion, provision of injectables, pills, and implants. They also conduct counseling and client follow-ups and work under the supervision of a trained FP nurse and medical doctor.

Community Health Workers

Due to a shortage in personnel, task sharing can be resorted to. This refers to expanding the level of health care providers who can appropriately deliver health services as recommended by the World Health Organization (WHO). Task sharing helps address shortages and uneven distribution of health care providers, especially in rural and remote areas, gives specialists more time to use their skills, provides more FP methods at the primary care level, and increases access to safe and timely care. However, it should be noted that at the barangay or village level clinic, barangay health workers (BHWs) are only authorized to resupply commodities like pills or condoms, follow-up with clients, and encourage FP use through IEC activities.

The FP Client

There are different types of clients that the FP counselor can encounter. As a counselor, the provider must take into consideration the following in order to carry out a quality counseling session:

NEW CLIENT		RETURNING CLIENT	
with a method in mind	with no method in mind	with problems	with no problems
Discuss the client's needs and situation including the client's reproductive intent. Since the client already has a method in mind, it is important that the FP provider	The provider must inform and discuss with the client the methods that may be suitable according to his/her characteristics and needs.	Discuss with the client about his/her issue/s on the current method and about the possible options to resolve the problem/s.	Discuss and update the client about his/her current FP method.

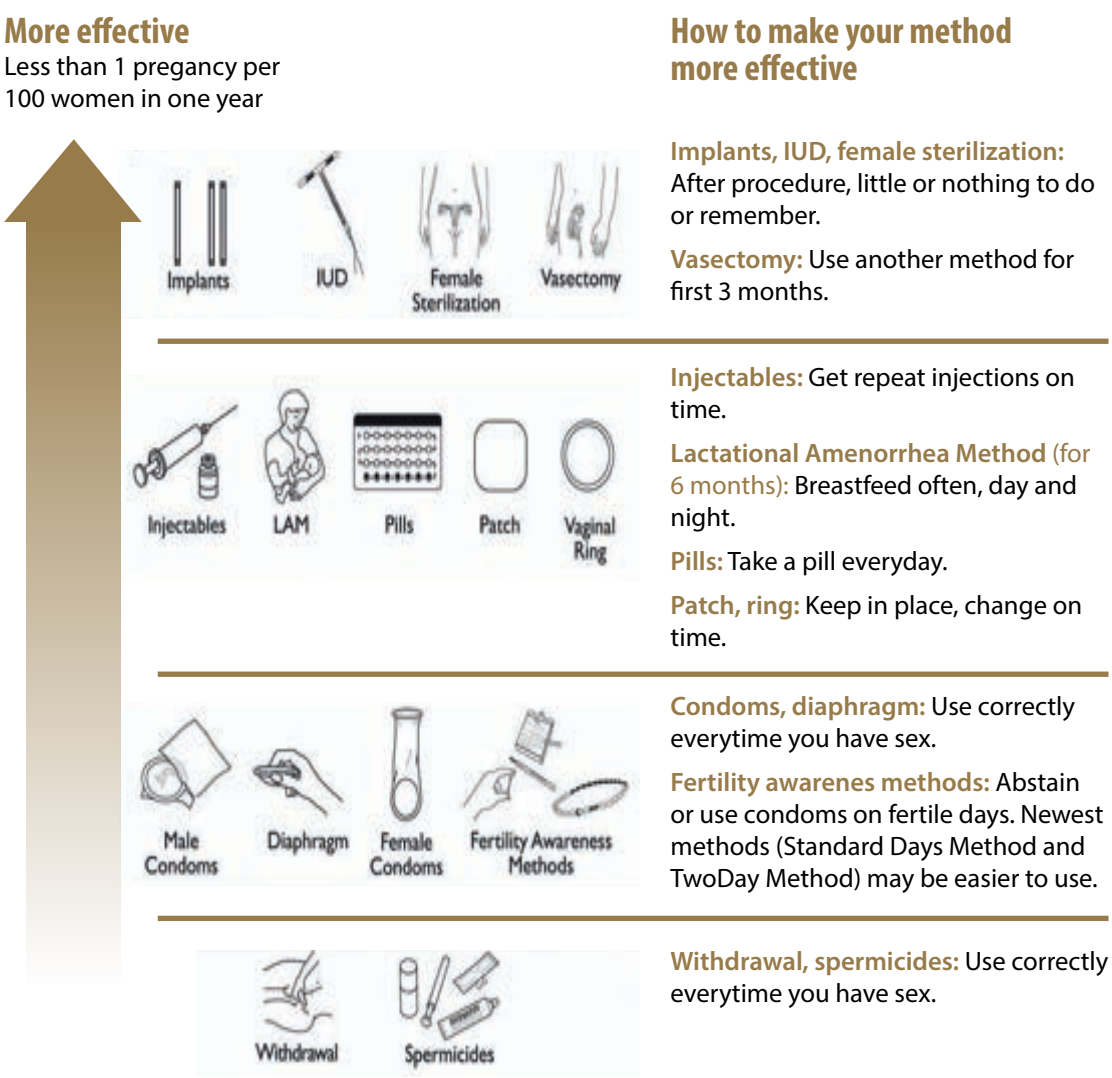
discusses with the client his/her chosen method to check if his/her knowledge on the FP method being considered is correct and if it is medically appropriate for the client to use. If the client is ineligible, discuss the reason for ineligibility, and inform the client about other FP methods. Other FP methods available may be discussed if the client is not medically eligible for the chosen method. The provider should help the client to consider methods appropriate for him/her.	Allow the client to choose the method that would be convenient and medically appropriate for him/her.		

Counseling About Effectiveness

An essential part of FP counseling is a discussion on the comparison of the effectiveness of all FP methods relevant to the client's needs. It is important to consider that certain medical conditions make pregnancy riskier to a woman's health. Thus the effectiveness of her contraceptive method has special importance. The method that requires little or no action by the client may be the most effective for him/her and depending on the client's reproductive intention.

- The four most effective methods are implants, IUD, female sterilization, and vasectomy. Implants and IUDs are highly effective for 3 to 5 years or more while female sterilization and vasectomy are permanent. There is about less than one pregnancy in 100 women in 1st year of use. The Methods in the second row (Figure 1) can be highly effective when used correctly and consistently. They require repeated action from the client. Pregnancy rates for these methods range from 2 to 7 pregnancies in 100 women in a year.
- The methods in the lower row have much higher pregnancy rates, about 20 or more pregnancies in 100 women in 1 year of use.

Figure 1. Comparing Effectiveness of Family Planning Methods



Source: WHO Tiered-Effectiveness Counseling. https://www.ghspjournal.org/content/3/3/352

Basic Contraceptive Information for First Counseling Session

The following essential information should be provided to the clients as part of the basic contraceptive education:

1. **Method effectiveness**
    - It refers to the lowest likelihood of pregnancy when the method is used correctly and consistently, as reported in various studies. This includes how a method works and the rates of unanticipated pregnancy during utilization of a particular FP method.

2. **Advantages and disadvantages**
   - The details about a particular method provided to the client must be provided with consideration to his/her preferences and current conditions.
3. **Side effects and complications**
   - Clients must be informed about the potential side effects of a particular method and advice on what to do and how to lessen the occurrence of the side effects. . The provider should emphasize the possible serious symptoms/side effects of the selected FP method which would require immediate consultation.
   - This discussion should be revisited once a method is chosen during follow-up visits and inform that method switching is an acceptable option.
4. **Use of the chosen method**
   - The information about the use of particular FP methods should be correct and clear, and will help optimize correct use of the chosen method by the client. The client education must include the following:
     a. How the method is used and when to start
     b. What to do if any side effects, problems or other symptoms are noted
     c. What are the danger signs for immediate consultation
     d. What special strategies to be used in order to lower the errors of usage
     e. What to do when errors occur.
     f. What to do for missed pills
5. **When to return**
   - The client must be informed about his/her return visit for follow-up, resupply or assessment and management of symptom/s. The client may return any time and for any reason, but it should be emphasized that return visits are not mandatory unless absolutely needed like in order to get the timely resupply of contraceptives.
6. **Education on the prevention of STI**
   - Educating the clients on STI prevention is an integral part of counseling because of the higher number of STI cases globally. ABCDE (Abstinence, Being mutually faithful, Condom use, Do not share, and Education and information) of sex should also be emphasized.

Family Planning Counseling Approaches

The GATHER Approach

The GATHER Approach is a widely used method of FP counseling that emphasizes providing clients with accurate information about their reproductive health options, helping them to assess their needs and make informed decisions, and supporting them in implementing their chosen methods of contraception. The six steps of the GATHER Approach are:

- Greet: Establish a warm and welcoming atmosphere.
- Ask: Ask open-ended questions to understand the client's needs and preferences.
- Tell: Provide accurate and unbiased information about FP options.
- Help: Help the client to choose the best FP method for them.

- Explain: Explain the chosen method in detail and answer any questions.
- Return/Refer: Schedule a follow-up visit to provide support and monitor the client's progress, or refer them to a facility for services that were unavailable during the client's visit.

The New Counseling Approach: Balanced Counseling Strategy Plus

Balanced Counseling Strategy (BCS) Plus is a practical, interactive, and client-friendly counseling strategy that uses 3 key job aids such as algorithm, counseling cards and brochures for counseling clients about FP. There are different stages involved:

1) **Pre-choice stage,** which uses an algorithm to assist the counselor to determine which FP method/s to amplify in the next stage;
2) **Method choice stage,** which uses counseling cards that contain all relevant aspects of the different contraceptives. Counseling cards contain the description/pictures of the FP methods, method effectiveness, how to use, side effects (if any), brands, protection against HIV and STI, when to return, and contraindications.
3) **Post-choice stage.**

   The BCS Plus is client-centered, assures confidentiality and privacy of the client, and ensures the right of the client to make informed and voluntary decisions. It is made to provide the necessary information and tools for the improvement of consultation's efficiency and effectiveness. It also simplifies the client's decision-making in choosing appropriate methods based on his/her needs during FP counseling sessions.

Steps of the algorithm to guide implementation of BCS Plus within an FP clinic[3]

A. Pre-choice Stage

The FP provider and the client should establish and maintain a warm, cordial relationship. Tell the client and her partner, if present, that their FP and health needs will be addressed during consultation. Using a counseling card, counsel the client on healthy timing and spacing of pregnancy. Rule out pregnancy using a checklist to make sure that a woman is not pregnant. Show all the method cards and ask the client for his/her method of choice. Ask the following questions and set aside method cards based on the client's answers:

DO YOU WANT TO HAVE CHILDREN IN THE FUTURE?	
If yes, set aside vasectomy and ligation cards. Explain why.	If no, keep all cards and continue.

3 Algorithm for Using the Balanced Counseling Strategy Plus, third edition 2015

HAVE YOU GIVEN BIRTH IN THE LAST 48 HOURS?	
If yes, set aside combined oral contraceptive pills and combined injectable. Explain why.	If no, continue with the next question.
ARE YOU BREASTFEEDING AN INFANT LESS THAN 6 MONTHS OLD?	
If yes, set aside combined oral contraceptive pills and combined injectable. Explain why.	If no, or she has begun her monthly bleeding again, set aside the lactational amenorrhea (LAM) card. Explain why.
DOES YOUR PARTNER SUPPORT YOU IN FAMILY PLANNING?	
If yes, continue with the next question.	If no, set aside the barrier methods, FAB methods. Explain why.
DO YOU HAVE ANY MEDICAL CONDITIONS? ARE YOU TAKING ANY MEDICATIONS?	
If yes, ask further about which conditions or medications. Refer to WHO medical eligibility criteria wheel and set aside all contraindicated method cards. Explain why.	

B. Method choice stage

1. Check all the methods that have not been set aside and indicate their effectiveness. Arrange the remaining cards in order of effectiveness.
2. Ask the client to choose the method that is suitable for him/her.
3. Using the method-specific brochure, check whether the client has a medical condition/s wherein the method is not recommended.

C. Post-choice Stage

1. Discuss with the client the chosen method based on the method-specific brochure as a counseling tool. Check the client's knowledge and share key information.
2. Once the client has a decision for his/her chosen method, obtain his/her informed consent by explaining the contents of a prepared document and asking the client to sign.
3. Perform routine physical and pelvic examination as a good public health practice.
4. Give him/her the selected FP method.
5. Answer any questions or apprehensions regarding the accepted contraceptive and give further instructions as necessary and schedule post method follow-up appointment.
6. Encourage the client to involve his/her partner in future FP counseling.

Systematic Screening for other Services Stage

1. Determine the client's need for postpartum, newborn, infant care, well-child services or post-abortion care and other health-related conditions.
2. Ask the client about her previous screening for cervical cancer or breast cancer and perform tests or refer if necessary.
3. Discuss the STI/HIV transmission and prevention and dual protection with the client using counseling cards. Offer and instruct about the correct and consistent use of a condom.
4. Using counseling cards, conduct STI and HIV risk assessment. Do treatment if any symptoms are identified.
5. Ask about the client's HIV status.
6. Thank the client for the visit. Complete the counseling session.

Both the GATHER Approach and BCS Plus are effective methods of FP counseling. The best approach for a particular client will depend on their individual needs and preferences.

Client Assessment

Client Assessment is the process by which the health care provider learns about the client's health status, FP needs, and medical eligibility for FP method use.

Purpose of Client Assessment:

Client history-taking is the process of gathering information through an interview about the client's past and present reproductive health status. It enables the FP provider to evaluate and assess the client's reproductive health status and assess the client's RH needs. It also facilitates the identification of risk factors or areas of precautions in the use of the FP method and enables the health care providers to properly record and identify information gathered in FP Form I. In summary, the client assessment is being done to:

- Establish the client's health status
- Determine the client's eligibility in using a contraceptive method
- Determine whether the client is in good health, needs further examination and management including closer follow-up and/or referral
- Identify the need for additional procedures and/or laboratory examinations

Steps in Client Assessment

1. The client's comfort and privacy should always be considered
    - Greet the client cordially
    - Establish rapport with the client
    - Establish the purpose of the visit
    - Explain to the client the procedures to be performed such as physical and/or laboratory examinations.
    - Encourage the client to ask questions openly and freely.

2. Record the client's medical history using Family Planning Service Record Form I (FP Form I).
3. Have a discussion with the client about the findings based on his/her history, necessary examination (physical and/or laboratory examination), referral for further management if needed, and schedule of follow-up visit.

Only those procedures recommended by the WHO (applicability of procedures and examinations for contraceptive use) should be performed.

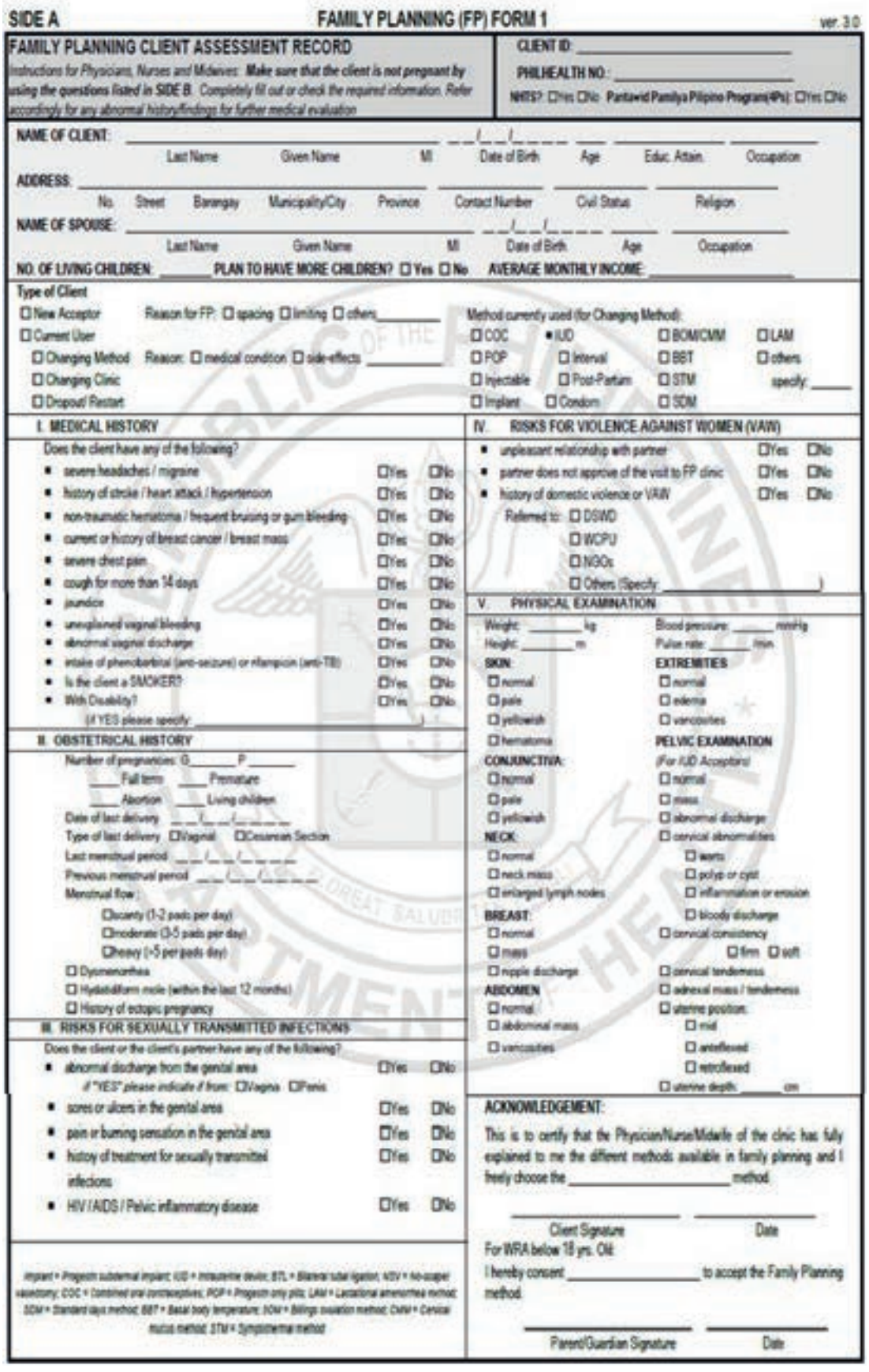
While this is a sound advice to follow as most contraceptives do not require clinical tests and procedures for contraceptive use, it is still recommended to perform basic tests as this is an opportunity to determine the general health status of clients who otherwise would not come for at least a yearly check-up. Physical, pelvic examinations and laboratory tests may be done for STI, cervical cancer, and PTB, which are some of the prevalent conditions in the country. This is to enforce good public health practice.

Accomplishing FP Form 1 (Version 3.0 2016)

Once the provider has done counselling with the client, the FP provider will fill out the FP Form I. The updated version of FP Form I is a two-page form with the front page divided into five sections namely: medical history, obstetrical history, assessment of risk for STI, assessment of risk for violence against women (VAW), and physical examination. It also includes socio-demographic information (client's personal data, type of acceptor, and FP method used) and an acknowledgment section with the client's signature signifying that the client has been counseled.

The form also lists the possible medical conditions relevant to contraceptive method use. It is used to record the result of the assessment and has a section on parental/guardian consent.

The back portion is divided into columns and has the following information: date of visit; medical findings (medical observations, complaints, complications, services rendered/ procedures, lab exams, treatment and referrals); FP method/supplies given (method/brand and number of units); name of provider and signature and date of follow-up visit).



SIDE A

FAMILY PLANNING (FP) FORM 1

ver. 3.0

FAMILY PLANNING CLIENT ASSESSMENT RECORD

Instructions for Physicians, Nurses and Midwives: ***Make sure that the client is not pregnant by using the questions listed in SIDE B.*** *Completely fill out or check the required information. Refer accordingly for any abnormal history/findings for further medical evaluation*

CLIENT ID: _____

PHILHEALTH NO.: _____

NHTS? ☐Yes ☐No Pantawid Pamilya Pilipino Program(4Ps): ☐Yes ☐No

NAME OF CLIENT: _____ __/__/____ ___ _____ _____

Last Name Given Name MI Date of Birth Age Educ. Attain. Occupation

ADDRESS: _____ _____ _____ _____

No. Street Barangay Municipality/City Province Contact Number Civil Status Religion

NAME OF SPOUSE: _____ __/__/____ ___ _____

Last Name Given Name MI Date of Birth Age Occupation

NO. OF LIVING CHILDREN: _____ PLAN TO HAVE MORE CHILDREN? ☐Yes ☐No AVERAGE MONTHLY INCOME: _____

Type of Client

☐New Acceptor Reason for FP: ☐spacing ☐limiting ☐others_____

☐Current User

☐Changing Method Reason: ☐medical condition ☐side-effects _____

☐Changing Clinic

☐Dropout/ Restart

Method currently used (for Changing Method):

☐COC ☐IUD ☐BOM/CMM ☐LAM

☐POP ☐Interval ☐BBT ☐others

☐Injectable ☐Post-Partum ☐STM specify: _____

☐Implant ☐Condom ☐SDM

I. MEDICAL HISTORY

Does the client have any of the following?

- severe headaches / migraine ☐Yes ☐No
- history of stroke / heart attack / hypertension ☐Yes ☐No
- non-traumatic hematoma / frequent bruising or gum bleeding ☐Yes ☐No
- current or history of breast cancer / breast mass ☐Yes ☐No
- severe chest pain ☐Yes ☐No
- cough for more than 14 days ☐Yes ☐No
- jaundice ☐Yes ☐No
- unexplained vaginal bleeding ☐Yes ☐No
- abnormal vaginal discharge ☐Yes ☐No
- intake of phenobarbital (anti-seizure) or rifampicin (anti-TB) ☐Yes ☐No
- Is the client a SMOKER? ☐Yes ☐No
- With Disability? ☐Yes ☐No

(if YES please specify: _____)

II. OBSTETRICAL HISTORY

Number of pregnancies: G_____ P _____

____Full term ____Premature

____Abortion ____Living children

Date of last delivery __/__/____

Type of last delivery ☐Vaginal ☐Cesarean Section

Last menstrual period __/__/____

Previous menstrual period __/__/____

Menstrual flow:

☐scanty (1-2 pads per day)

☐moderate (3-5 pads per day)

☐heavy (>5 pads/day)

☐Dysmenorrhea

☐Hydatidiform mole (within the last 12 months)

☐History of ectopic pregnancy

III. RISKS FOR SEXUALLY TRANSMITTED INFECTIONS

Does the client or the client's partner have any of the following?

- abnormal discharge from the genital area ☐Yes ☐No

  If "YES" please indicate if from: ☐Vagina ☐Penis
- sores or ulcers in the genital area ☐Yes ☐No
- pain or burning sensation in the genital area ☐Yes ☐No
- history of treatment for sexually transmitted infections ☐Yes ☐No
- HIV / AIDS / Pelvic inflammatory disease ☐Yes ☐No

Implant = Progestin subdermal implant; IUD = Intrauterine device; BTL = Bilateral tubal ligation; NSV = No-scalpel vasectomy; COC = Combined oral contraceptives; POP = Progestin only pills; LAM = Lactational amenorrhea method; SDM = Standard days method; BBT = Basal body temperature; BOM = Billings ovulation method; CMM = Cervical mucus method; STM = Symptothermal method

IV. RISKS FOR VIOLENCE AGAINST WOMEN (VAW)

- unpleasant relationship with partner ☐Yes ☐No
- partner does not approve of the visit to FP clinic ☐Yes ☐No
- history of domestic violence or VAW ☐Yes ☐No

Referred to: ☐DSWD ☐WCPU ☐NGOs ☐Others (Specify: _____)

V. PHYSICAL EXAMINATION

Weight: _____ kg Blood pressure: _____ mmHg

Height: _____ m Pulse rate: _____ /min

SKIN: ☐normal ☐pale ☐yellowish ☐hematoma

CONJUNCTIVA: ☐normal ☐pale ☐yellowish

NECK: ☐normal ☐neck mass ☐enlarged lymph nodes

BREAST: ☐normal ☐mass ☐nipple discharge

ABDOMEN: ☐normal ☐abdominal mass ☐varicosities

EXTREMITIES: ☐normal ☐edema ☐varicosities

PELVIC EXAMINATION

(For IUD Acceptors)

☐normal ☐mass ☐abnormal discharge ☐cervical abnormalities ☐warts ☐polyp or cyst ☐inflammation or erosion ☐bloody discharge ☐cervical consistency ☐firm ☐soft ☐cervical tenderness ☐adnexal mass / tenderness ☐uterine position: ☐mid ☐anteflexed ☐retroflexed ☐uterine depth: _____ cm

ACKNOWLEDGEMENT:

This is to certify that the Physician/Nurse/Midwife of the clinic has fully explained to me the different methods available in family planning and I freely choose the _____ method.

_____ _____

Client Signature Date

For WRA below 18 yrs. Old:

I hereby consent _____ to accept the Family Planning method.

_____ _____

Parent/Guardian Signature Date

SIDE B **FP FORM 1**

FAMILY PLANNING CLIENT ASSESSMENT RECORD

DATE OF VISIT (MM/DD/YYYY)	MEDICAL FINDINGS (Medical observation, complaints/ complication, service rendered/ procedures, laboratory examination, treatment and referrals)	METHOD ACCEPTED	NAME AND SIGNATURE OF SERVICE PROVIDER	DATE OF FOLLOW-UP VISIT (MM/DD/YYYY)

How to be Reasonably Sure a Client is Not Pregnant

1. Did you have a baby less than six (6) months ago, are you fully or nearly fully breastfeeding, and have you had no menstrual period since then? ☐ Yes ☐ No
2. Have you abstained from sexual intercourse since your last menstrual period or delivery? ☐ Yes ☐ No
3. Have you had a baby in the last four (4) weeks? ☐ Yes ☐ No
4. Did your last menstrual period start within the past seven (7) days? ☐ Yes ☐ No
5. Have you had a miscarriage or abortion in the last seven (7) days? ☐ Yes ☐ No
6. Have you been using a reliable contraceptive method consistently and correctly? ☐ Yes ☐ No

- If the client answered **YES** to at least one of the questions and she is free of signs or symptoms of pregnancy, provide client with desired method.
- If the client answered **NO** to all of the questions, pregnancy cannot be ruled out. The client should await menses or use a pregnancy test.

The following information is requisite to be filled out in FP Form I by the provider during the client's initial or follow-up visit:

A. Personal Data

1. Complete name of the client. Under the present Family Code of the Philippines, an unmarried pregnant woman, including those with a live-in partner, should retain her Maiden name.
2. Name of the husband/partner/guardian
   - In case of emergency or for the purpose of guardianship or consent.
3. Client's age, sex, marital status, date and place of birth
4. Religion, occupation, average family monthly income
   - To determine the financial capacity for needed examinations and capability in using cheaper forms or methods
5. Educational attainment
   - To be able to adjust the level of communication
   - To determine the ability to follow instructions
6. Address
   - To be able to determine if the client can do a follow-up or to visit the client if needed.

B. Medical History

1. Menstrual History
   - Menarche is the age of onset of menstruation
   - Last menstrual period (LMP) is the first day of the last menstrual period
   - Previous Menstrual period (PMP) is the first day of the menstrual period prior to the mentioned LMP. PMP is used to verify accuracy of the LMP and to establish regularity or irregularity of menses.

C. OB history

In order to evaluate the obstetric history of the client, completing OB score must be done by the provider. OB scores measure the gravidity (G) and parity (P) of a woman. Gravidity (G) refers to the number of pregnancies borne by the mother, irrespective of the pregnancy outcome. Parity (P) refers to the number of pregnancies reaching viability (>20 weeks AOG). Other information needed are the number of full-term pregnancies, preterm pregnancies, abortions or miscarriages (ectopic/molar) and number of current living children.

D. FP history

1. FP method currently being used, if any
   - Duration of use
   - Satisfaction with use
2. FP method previously used
   - Duration of use
   - Reason/s for discontinuation or shifting
3. Reproductive goals/intents
   - To achieve/maintain the desired number of children
   - To limit or to space pregnancy

E. Risk of Sexually Transmitted Infections (STI)

FP clients need to be assessed on the risk of STI. If the client is likely to get infected with STI, the FP counselor must provide the necessary supply of condoms and information about risks, symptoms, and treatment, as well as the correct and consistent use of condoms. FP clients with high individual risk for STIs may need to be referred by the provider to facilities with STI services.

Basic screening history for STI risk:

- Presence of abnormal vaginal or urethral discharge
- Abnormal vaginal bleeding with the last two menstrual periods
- Pain or burning sensation during urination
- History of genital tract problems such as ulcers or skin lesions around the genital area
- Partners of the client who have been treated in the last three months
- Having more than one sexual partners in the last two months and/or their sex partners having other sex partners.

F. Violence against women

It is essential to assess if the FP client is exposed to gender violence since it will affect the support of her partner in using a particular FP method. If the client is experiencing any violence from her partner, she must be referred to the nearest Women's Crisis Center.

Physical Examination

Physical examination ensures the safe use of FP method and should be done for ALL clients. Although the WHO Medical Eligibility Criteria (MEC) does not recommend routine physical and laboratory procedures for FP, it can be performed during wellness visits or annual health examination as recommended by the Omnibus Health Guidelines. FP clinics should be in a good position to assist clients to undergo at least a yearly check-up, other than the routine PE done.

Physical examinations will also help the health care provider to:

- identify any abnormal conditions during history-taking that may affect the suitability of the selected FP method
- evaluate the client's health status while using the FP method to monitor any changes in his/her conditions
- confirm complications from side effects while using a contraceptive method.

It is advisable for the client and provider to have a third person, either a client's companion or a health provider, present during the physical examination. Never examine a patient alone.

Laboratory Examinations

Laboratory tests are not always required. In some instances, information on history taking or findings on the physical examination may require confirmation through laboratory tests. They should be performed as needed.

Importance of Selected Procedures for Providing Family Planning

Some examinations or procedures should be done prior to the provision of an FP method. Clients with known medical problems may need additional tests or examinations prior to being considered as candidates for a specific method. Some FP methods do not require any of the procedures.

Key to Applicability of Procedures or Tests for Contraceptive Methods

Class A: Essential and mandatory in all circumstances for safe and effective use of the contraceptive method. A pelvic or genital examination is essential for IUD insertion, diaphragm use, female sterilization, and vasectomy. STI risk assessment also is essential before IUD insertion. Blood pressure screening is essential before female sterilization.

Class B: Contributes substantially to safe and effective use. If the test or examination cannot be done, however, the risk of not performing it should be weighed against the benefits of making the contraceptive method available. Laboratory screening for STIs and a hemoglobin test would contribute to the safety of IUD insertion. A hemoglobin test also would contribute to the safety of female sterilization.

Class C: Does not contribute substantially to safe and effective use of the contraceptive method. These tests and exams are not required or helpful for hormonal contraceptive methods, male or female condoms, or spermicides.

Table 4. Applicability of Procedures or Tests for Contraceptive Methods

Specific Situation	Combined oral contraceptives*	Monthly injectables	Progestin-only pills	Progestin-only injectables	Implants	Cu- and LNG-IUDs	Male and female condoms	Diaphragm and cervical caps	Spermicides	Female sterilization	Vasectomy
Breast examination by provider	C	C	C	C	C	C	C	C	C	C	NA
Pelvic/genital examination	C	C	C	C	C	A	C	A	C	A	A
Cervical cancer screening	C	C	C	C	C	C	C	C	C	C	NA
Routine laboratory tests	C	C	C	C	C	C	C	C	C	C	C
Hemoglobin test	C	C	C	C	C	B	C	C	C	B	C
STI risk assessment: medical history and physical examination	C	C	C	C	C	A[1]	C	C[2]	C[2]	C	C
STI/HIV screening: laboratory tests	C	C	C	C	C	B[1]	C	C[2]	C[2]	C	C
Blood pressure screening	[3]	[3]	[3]	[3]	[3]	C	C	C	C	A	C[4]

Note: No tests or examinations are needed before using fertility awareness-based methods, lactational amenorrhea method, or emergency contraceptive pills.

NA= Not applicable
* Includes patch and combined vaginal ring.

[1] If a woman has a very high individual likelihood of exposure to STIs, she generally should not have an IUD inserted unless other methods are not available or not acceptable. If she has current purulent cervicitis, gonorrhea, or chlamydia, she should not have an IUD inserted until these conditions are resolved and she is otherwise medically eligible.

[2] Women at high risk of HIV infection should not use spermicides. Using spermicides alone or diaphragms or cervical caps with spermicides is not usually recommended for women with HIV infection unless other, more appropriate methods are not available or not acceptable.

[3] Desirable, but in settings where the risks of pregnancy are high, and hormonal methods are among the few methods widely available, women should not be denied use of hormonal methods solely because their blood pressure cannot be measured.

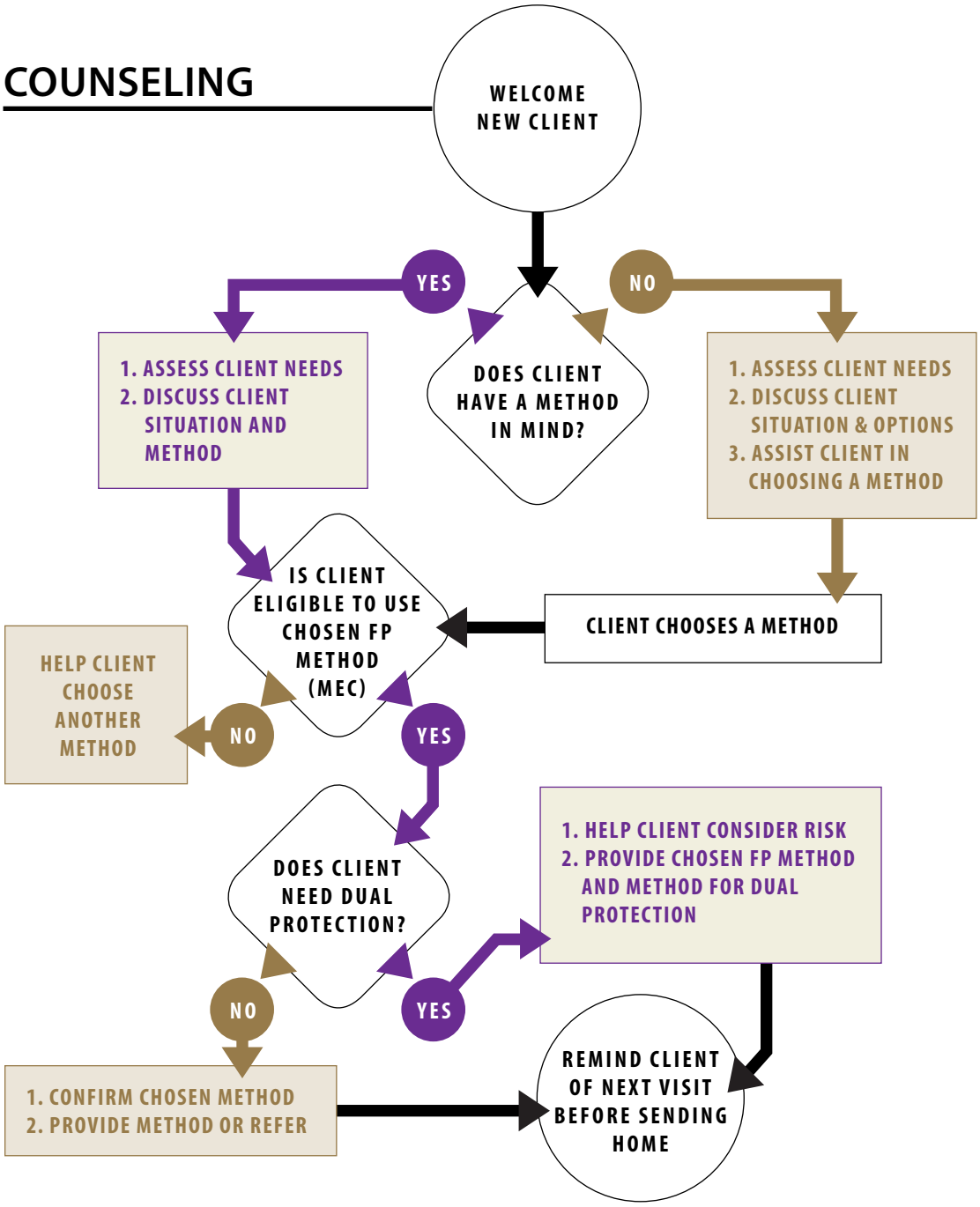
[4] For procedures performed using only local anesthesia.

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

Flow of Activities and Services for Clients in a Given Health Facility

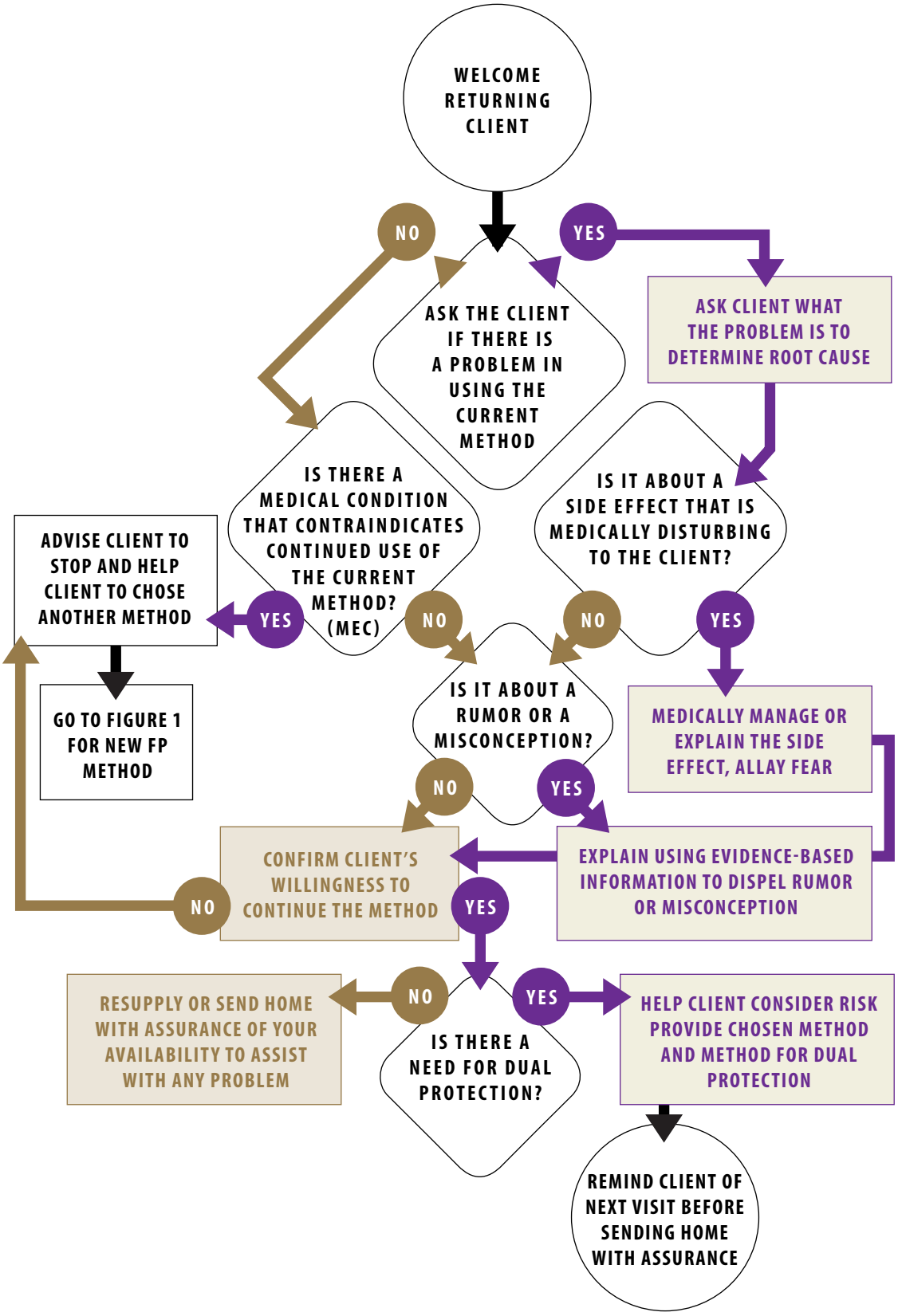
This flow of activities and services reflect the specific steps from the time clients enter the facility up to the provision of the FP method and the key decision points to be made while clients are being served in the facility.

Figure 2. Flow of Activities and Services for a New Family Planning Client



Source: Family Planning Clinical Standards Handbook 2014 edition

Figure 3. Flow of Activities and Services for a Returning Family Planning Client



Source: Family Planning Clinical Standards Handbook 2014 edition

Using the WHO Medical Eligibility Criteria

What is the WHO-Medical Eligibility Criteria (MEC)?

- Medical screening of clients based on the best available evidence on FP practices.
- Recommendations for the use of specific contraceptive methods by women and men

Who have certain characteristics or pre-existing medical conditions?

- Assistance for health care providers who counsel women, men, and couples about the choice of contraceptive method.

What is the purpose of the WHO-MEC?

- To reduce medical barriers for contraception
- To address misconceptions on who can use contraception
- To improve access and quality of care in FP
- To promote safe use of contraceptives

Each condition represents either an individual's characteristics (e.g., age) or a known pre-existing medical or pathological condition (e.g., hypertension). The conditions that affect the eligibility of a client for using each contraceptive method are classified under four categories (Table 5).

Table 5. Simplified 2-Category Classification

WHO CATEGORY	WITH CLINICAL JUDGMENT	WITH LIMITED CLINICAL JUDGMENT
Category 1	Use the method in any circumstances	Use
Category 2	Generally use the method	Use
Category 3	Use of the method is not usually recommended unless other appropriate methods are not available or acceptable	Do not use
Category 4	Method must not be used	Do not use

Conversely, fertility awareness-based methods are classified (Table 6) based on whether a method is safe to use (A); whether extra precautions, preparations, or counseling are required (C); or whether the use of a method should be delayed until circumstances change (D). For female and male sterilization (Table 7), a fourth category (S) signifies that a special arrangement should be made for the procedure.

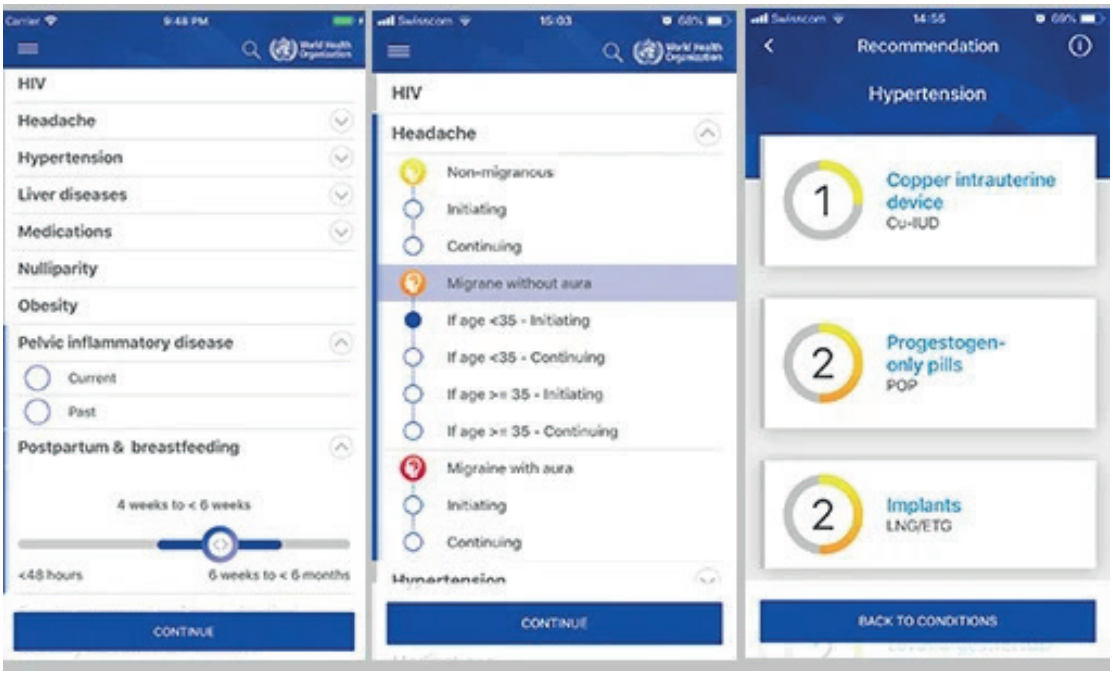
Table 6. MEC for Fertility-based Awareness Methods

MEC CATEGORIES	CONDITIONS/CLASSIFICATIONS CRITERIA
A (Accept)	The method has no restrictions.
C (Caution)	The method requires extra or special counseling to ensure correct use.
D (Delay)	The method should be delayed until a condition is evaluated or corrected. An alternative temporary method of contraception should be offered.

Table 7. MEC for Female and Male Sterilization

MEC CATEGORIES	CONDITIONS/CLASSIFICATIONS CRITERIA
Accept (A)	There is no medical reason to deny sterilization to a person with this condition.
Caution (C)	This procedure is normally conducted in a routine setting but with extra preparation and precautions.
Delay (D)	The procedure is delayed until the condition is evaluated and/or corrected. An alternative temporary method of contraception should be provided.
Special (S)	The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anesthesia, and other backup medical support. For these conditions, the capacity to decide on the most appropriate procedure and anesthesia regimen is also needed. Alternative temporary methods of contraception should be provided if referral is required or there is otherwise any delay.

New App for WHO's Medical Eligibility Criteria for Contraceptive Use



Source: New App for WHO's Medical Eligibility Criteria for Contraceptive Use. https://www.who.int/news/item/29-08-2019-new-app-for-who-s-medical-eligibility-criteria-for-contraceptive-use

This application is a digital tool to facilitate the task of providers in recommending safe, effective and appropriate methods for women with medical conditions or medically relevant characteristics. The app can be accessed and installed in both Android and Apple operating systems. There are nine common types of contraceptive methods that are covered by this app. The clients may easily combine multiple conditions and view guidance on each condition separately or in combination. It has a multiple list of medical conditions for which all the contraceptive methods may be safely recommended to the clients provided there are no additional health problems. It also includes additional information about emergency contraception and graphic representation of the effectiveness of various contraceptive methods.

Ruling Out Pregnancy

Ruling out pregnancy is recommended before starting a hormonal contraceptive and before intrauterine device (IUD) insertion. Family planning providers have 3 tools available for this routine task:

- Medical history (often collected using the Pregnancy Checklist on page 33)
- Pregnancy tests
- Delaying the start of the method until the client's next monthly bleeding.

Which tool should a provider use first and when?

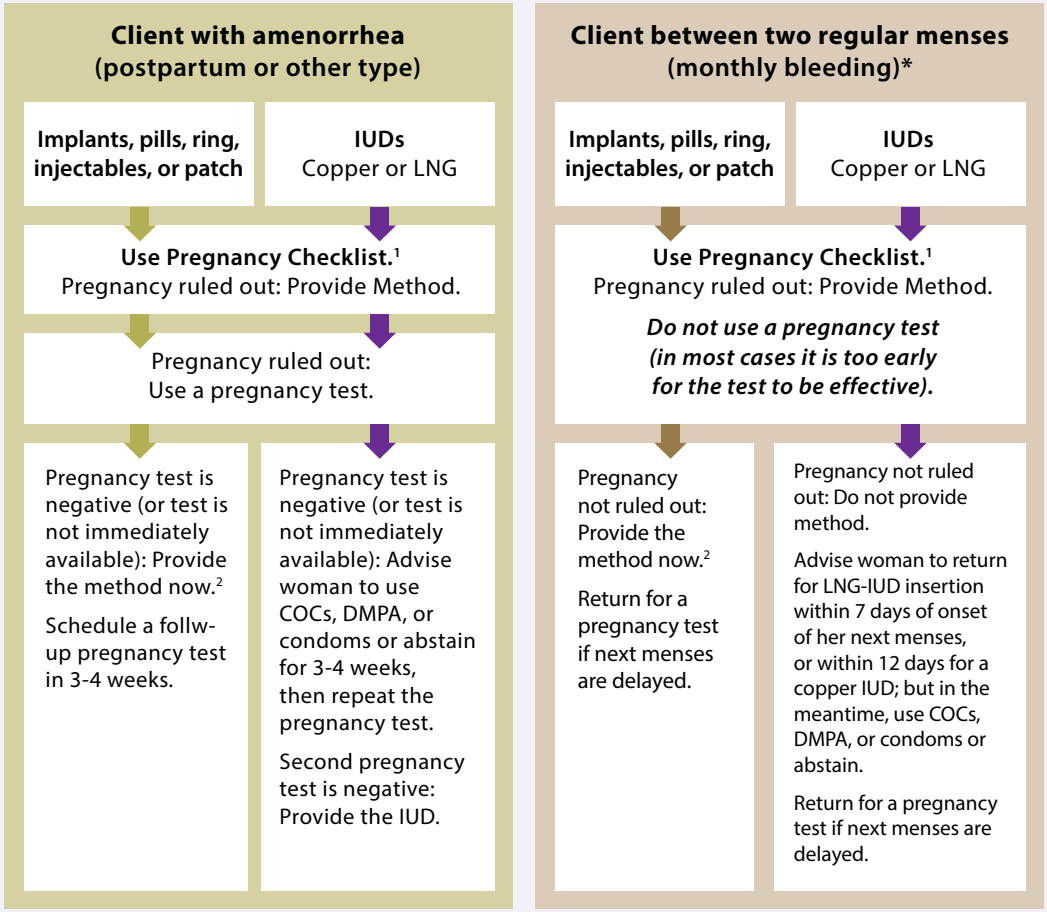
The job aids (Figure 4) on page 48 entitled, "How and When to Use the Pregnancy Checklist and Pregnancy Tests," offers guidance based on the client's chosen method and on whether she has been having menstrual bleeding each month or not having monthly bleedings due to recent childbirth or other reasons. These job aids also address the situation for a woman who has been having monthly bleedings but now has missed her expected monthly bleeding.

Important points to note:

- Unless the client has missed her monthly bleeding, ruling out pregnancy starts with the Pregnancy Checklist. This checklist can provide reasonable certainty that a woman is not pregnant.
- Pregnancy tests are not likely to work before the first day of missed monthly bleeding. Using a test earlier is pointless and wasteful.
- The only contraceptive method known to pose a health risk if started during pregnancy is the IUD (either copper or hormonal). If the Pregnancy Checklist cannot rule out pregnancy, a provider should use another tool to rule out pregnancy before inserting an IUD.
- All hormonal methods except the LNG-IUD can be provided without delay even when uncertainty about pregnancy exists. Follow-up is required in some cases (see job aid in the next page).
- Delaying the start of the method is the worst choice among the 3 tools for assessing pregnancy. She may become pregnant before her next monthly bleeding. The other tools should be used first whenever possible.
- Both the Pregnancy Checklist and a pregnancy test are highly accurate for ruling out pregnancy when used appropriately. When the checklist can be used, there is no reason to prefer a test

Figure 4. How and When to Use the Pregnancy Checklist and Pregnancy Tests

Match your client's menstrual status and chosen contraceptive method with one of the options below and follow the instructions.



[1] See next page for **Pregnancy Checklist**.
[2] For implants, counsel about the need to remove the implant if pregnancy is confirmed and she wishes to continue the pregnancy.

In cases where pregnancy cannot be ruled out, offer emergency contraception if the woman had unprotected sex within the last 5 days.

Counsel all women to come back anytime they have a reason to suspect pregnancy (for example, she misses a period).

*** If the client presents with a late/missed menses, use a pregnancy test to rule out pregnancy.** If using a highly sensitive pregnancy test (for example, 25 mIU/ml) and it is negative, provide her desired method.

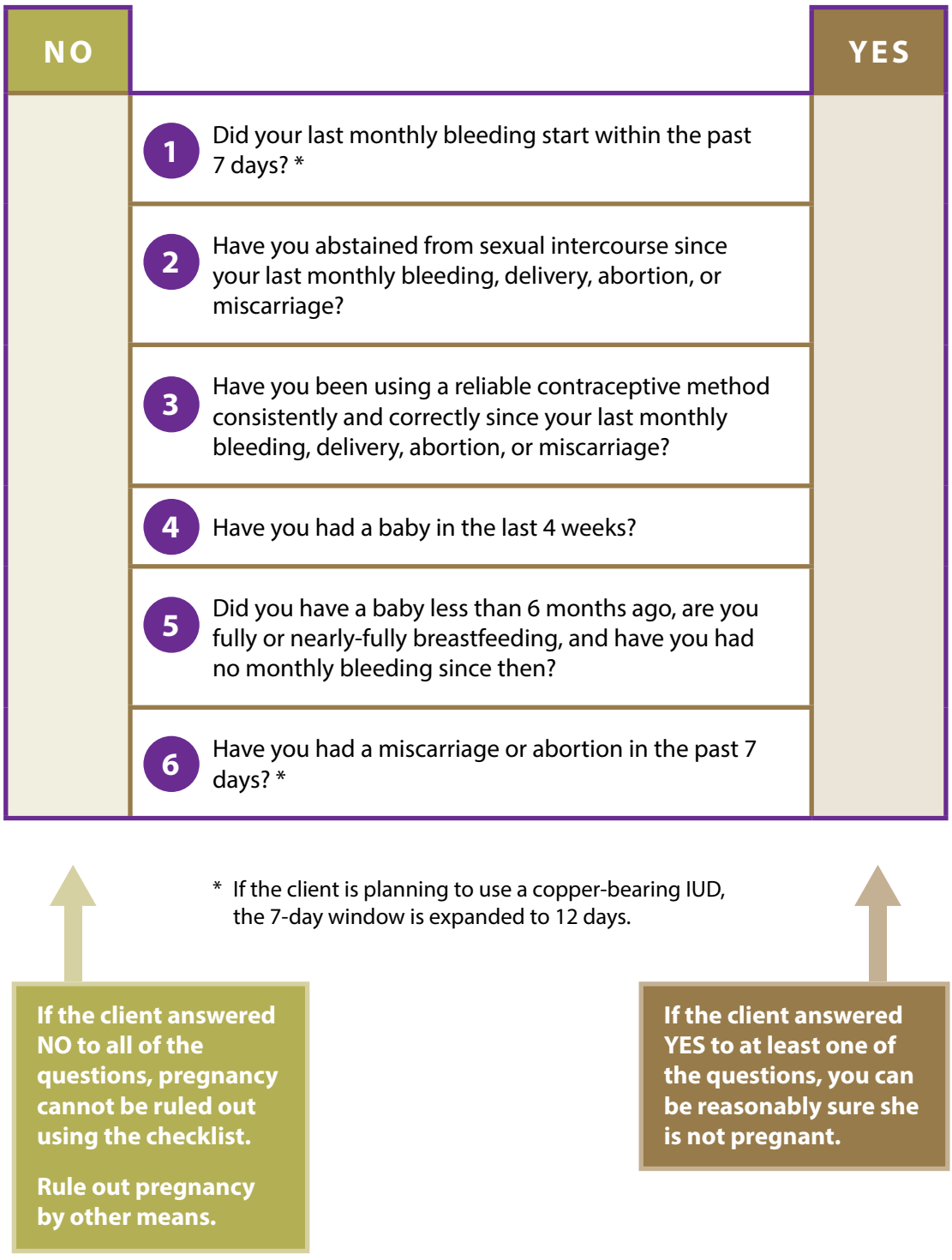
If using a test with lower sensitivity (for example, 50 mIU/ml) and it is negative during the time of her missed period, wait until at least 10 days after expected date of menses and repeat the test.
Advise the woman to use condoms or abstain in the meantime. If the test is still negative, provide her desired method.

If test sensitivity is not specified, assume lower sensiyivity.

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

Figure 5. Pregnancy Checklist

Ask the client questions 1-6. As soon as the client answers "yes" to any questions, stop and follow the instructions below.



Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

II. Contraceptive Technology

A. COMBINED HORMONAL CONTRACEPTIVES

INTRODUCTION

Combined hormonal contraceptives (CHCs) are hormonal drugs, particularly both estrogen and progestogen, similar to those naturally found in a woman's body circulation. These drugs are regularly administered in different contraceptive methods to prevent pregnancy.
These contraceptive drugs may be administered orally, trans-dermally, trans-vaginally, or intramuscularly at different life stages and reproductive cycles.

In this section under CHC, oral and intramuscular methods shall be discussed, however, the patch and vaginal ring will be presented for information only as these methods are not available in the country at present.

Only oral and intramuscular methods are presently available in the country.

MECHANISM OF ACTION

CHCs suppress ovulation or the release of an egg from the ovary.

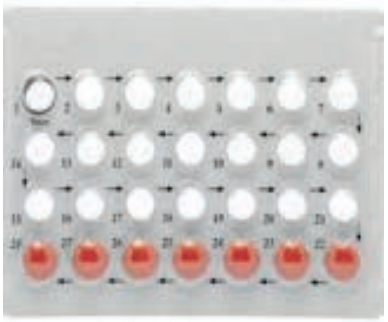
Estrogen in CHCs creates a negative feedback mechanism that makes the brain think that the body has enough hormones that the ovaries no longer need to produce an egg. This phenomenon prevents follicular development, which is necessary for ovulation.

Other progesterone component in the CHC prevents follicular maturation making the cervical mucus thick and prevents the entry of sperm into the uterus. Pregnancy cannot occur without the fertilization of the released egg.

Combined Oral Contraceptives

INTRODUCTION

Combined oral contraceptives (COCs) are also known as "the Pill", low-dose combined pills, oral contraceptive pills, and oral contraceptives. They work primarily by preventing the release of eggs from the ovaries (ovulation). It is generally accepted that the health risks from taking oral contraceptives are lower than those from pregnancy and birth, and "the health benefits of any method of contraception are far greater than any risks from the method".



Source: Britannica.com

Types of COCs

There are four types of COCs according to the amount of hormones they contain. Multiphasic vary on the ratio between the two hormones during the 21 day-cycle.

a.) **Monophasic** — even levels of estrogen and progestin for 21 days, followed by 7 days of placebo
b.) **Biphasic** — one level of strength from days 7-10 and then a second strength for 11-14 days, followed by 7 days of placebo
c.) **Triphasic** — varying levels of estrogen and progestin through 21 days. It has three phases and the brand of formulation determines the length of each phase.
d.) **Quadriphasic** — four different combinations of estradiol valerate and dienogest

The recommendation is to start with monophasic pills. There are literatures which state that the triphasic is the better preparation as it prevents acne and has no effect on blood pressure nor weight gain, but it is not advisable for those at risk of developing diabetes.[4]

There are a number of different formulations or brands, but the average pack is designed to be taken over a 28-day period or cycle. Users take a daily pill that contains hormones (estrogen and progestogen) for the first 21 days of the cycle. The last 7 days of the cycle are hormone-free days. Some packets only contain 21 pills and users are then advised to take no pills for the following week. Other packets contain 7 additional placebo pills or biologically inactive pills. Some newer formulations have 24 days of active hormone pills, followed by 4 days of placebo.

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Who can use

The COCs are safe and suitable for nearly all women who accept to use this as an oral hormonal contraceptive method. Nearly all women can use the COCs safely and effectively, including women who:

- Have or have not had children
- Are married or are not married
- Are of any age, including adolescents and women over 40 years old
- Are in postpartum period and breastfeeding
- Have just had an abortion, miscarriage, or ectopic pregnancy
- Smoke cigarette, if under 35 years old
- Have anemia now or had in the past
- Have varicose veins
- Are living with HIV, whether or not on antiretroviral therapy

Avoid Unnecessary Procedures

Women can begin using COCs:

- Without a pelvic examination
- Without any blood tests or other routine laboratory tests

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4 23 studies comparing monophasic with triphasic showed insufficient evidence that the effectiveness of triphasic preparation differs from the monophasic preparation.

- Without cervical cancer screening
- Without a breast examination
- Without a pregnancy test. A woman can begin using COCs at any time, even when she is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant (see Pregnancy Checklist, p. 50).

Medical Eligibility Criteria for COC

Ask the client the questions below about known medical conditions. Examinations and tests are not necessary. If she answers "no" to all of the questions, then she can start COCs if she wants. If she answers "yes" to a question, follow the instructions. In some cases, she can still start COCs. These questions also apply for the combined patch and the combined vaginal ring.

1. Are you breastfeeding a baby less than 6 months old?

❑ NO ❑ YES

— If fully or nearly fully breastfeeding: Give her COCs and tell her to start taking them 6 months after giving birth or when breast milk is no longer the baby's main food—whichever comes first.

— If partially breastfeeding: She can start COCs as soon as 6 weeks after childbirth.

2. Have you had a baby in the last 3 weeks and you are not breastfeeding?

❑ NO ❑ YES

— Give her COCs now and tell her to start taking them 3 weeks after childbirth. (If there is an additional risk that she might develop a blood clot in a deep vein (deep vein thrombosis or VTE), then she should not start COCs at 3 weeks after childbirth but start at 6 weeks instead. These additional risk factors include previous VTE, thrombophilia, caesarean delivery, blood transfusion at delivery, postpartum hemorrhage, pre-eclampsia, obesity (>_30 kg/m2), smoking, and being bedridden for a prolonged time.

3. Do you smoke cigarettes?

❑ NO ❑ YES

— If she is 35 years of age or older and smokes, do not provide COCs. Urge her to stop smoking and help her choose another method, but not patch or ring.

4. Do you have high blood pressure?

❑ NO ❑ YES

— If you cannot check blood pressure and she reports a history of high blood pressure or is currently being treated for high blood pressure, do not provide COCs. Refer her for a blood pressure check if possible or help her choose a method without estrogen.

— Check her blood pressure if possible:

- If her blood pressure is below 140/90 mm Hg, provide COCs. No need to retest before starting COCs.
- If blood pressure is 160/100 mm Hg or higher, do not provide COCs. Help her choose a method without estrogen, but not a progestin-only injectable.

- If blood pressure is 140–159/90–99 mm Hg, one measurement is not enough to diagnose high blood pressure. Give her a backup method* to use until she can return for another blood pressure measurement or help her choose another method.
- If her next blood pressure measurement is below 140/90 mm Hg, she can start COCs.
- However, if her next blood pressure measurement is 140/90 mm Hg or higher, do not provide COCs. Help her choose a method without estrogen, but not a progestin-only injectable if systolic blood pressure is 160 or higher or diastolic pressure is 100 or higher.

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

5. Have you had diabetes for more than 20 years or damage to your arteries, vision, kidneys, or nervous system caused by diabetes?

❑ NO ❑ YES — Do not provide COCs. Help her choose a method without estrogen but not progestin-only injectables.

6. Do you have gallbladder disease now or take medication for gallbladder disease?

❑ NO ❑ YES — Do not provide COCs. Help her choose another method but not the combined patch or combined vaginal ring.

7. Have you ever had a stroke, blood clot in your leg or lungs, heart attack, or other serious heart problems?

❑ NO ❑ YES — If she reports heart attack, heart disease due to blocked or narrowed arteries, or stroke, do not provide COCs. Help her choose a method without estrogen but not progestin-only injectables. If she reports a current blood clot in the deep veins of the legs (not superficial clots) or lungs, help her choose a method without hormones.

8. Do you have or have you ever had breast cancer?

❑ NO ❑ YES — Do not provide COCs. Help her choose a method without hormones.

9. Do you sometimes see a bright area of lost vision in the eye before a very bad headache (migraine aura)? Do you get throbbing, severe head pain, often on one side of the head, that can last from a few hours to several days and can cause nausea or vomiting (migraine headaches)? Such headaches are often made worse by light, noise, or moving about.

❑ NO ❑ YES — If she has migraine aura at any age, do not provide COCs. If she has migraine headaches without aura and is age 35 or older, do not provide COCs. Help these women choose a method without estrogen. If she is under 35 and has migraine headaches without aura, she can use COCs (see Identifying Migraine Headaches and Auras, Appendix G).

10. Are you taking medications for seizures? Are you taking rifampicin or rifabutin for tuberculosis or other illness?

❑ NO ❑ YES — If she is taking barbiturates, carbamazepine, lamotrigine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, or rifabutin, do not provide COCs. They can make COCs less effective. Help her choose another method but not progestin-only pills, patch, or combined ring. If she is taking lamotrigine, help her choose a method without estrogen.

11. Are you planning major surgery that will keep you from walking for one week or more?

❑ NO ❑ YES — If so, she can start COCs 2 weeks after she can move about again. Until she can start COCs, she should use a backup method.

12. Do you have several conditions that could increase your chances of heart disease (coronary artery disease) or stroke, such as older age, smoking, high blood pressure, or diabetes?

❑ NO ❑ YES — Do not provide COCs. Help her choose a method without estrogen but not progestin-only injectables.

Also, women should not use COCs if they report having thrombogenic mutations or lupus with positive (or unknown) antiphospholipid antibodies. **For complete classifications, see Medical Eligibility Criteria for Contraceptive Use (Appendix B).**

Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable, when relevant to the client.

Who should not use

Women who:

- have breast cancer
- have history of deep venous thrombosis or pulmonary embolism
- have active liver disease
- with familial hyperlipidemia
- with previous arterial thrombosis
- are pregnant
- are more than 35 years old and smoking
- are taking Rifampicin

MECHANISM OF ACTION

- Prevents ovulation by preventing the release of eggs from the ovaries
- Thickens cervical mucus preventing entry of sperms

EFFECTIVENESS

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

There is less than 1 pregnancy per 100 women using COCs and 3 per 1,000 women get pregnant over the first year when there is perfect use. If the pills are taken at exact time COCs are 99.7% effective in preventing pregnancy when used properly. Typical use is 91%.

Factors Affecting Effectiveness

- If started within five days of the beginning of the menstrual cycle (within five days of the first day of menstruation), COCs provide effective contraception from the very first pill
- If started at any other time in the menstrual cycle, COCs provide effective contraception only after 7 consecutive days of active pill use, so a backup method of contraception (such as condoms) must be used until active pills have been taken for 7 consecutive days.
- COCs should be taken at approximately the same time every day. The effectiveness of the COC appears to be similar whether the active pills are taken continuously for prolonged periods of time or if they are taken for 21 active days and 7 days as placebo.
- Other factors that may contribute to a decrease in effectiveness in typical use may include,
    - — missing more than one active pill in a packet,
    - — delay in starting the next packet of active pills (i.e., extending the pill-free, inactive or placebo pill period beyond 7 days),
    - — intestinal malabsorption of active pills due to vomiting or diarrhea,
    - — drug interactions with active pills that decrease contraceptive estrogen or progesterone levels.

ADVANTAGES AND DISADVANTAGES

Advantages of COCs

- Protects against the risk of pregnancy
- Improve conditions such as dysmenorrhea, premenstrual syndrome, and acne
- Reduce symptoms of endometriosis and polycystic ovary syndrome
- Decrease the risk of anemia.
- Reduce lifetime risk of ovarian and endometrial cancer
- Protect against pelvic inflammatory disease, menstrual cramps and menstrual bleeding problems

Disadvantage of COCs

- Associated with increased risk of deep vein thrombosis or pulmonary embolism (very rare)
- Stroke and heart attack (extremely rare)

RETURN TO FERTILITY

Reported rate of pregnancy is 83.1% within the first 12 months of contraceptive discontinuation.

SIDE EFFECTS, ADVERSE REACTION AND THEIR MANAGEMENT

The most common side effect is vaginal bleeding between periods (spotting) or missed/ irregular periods, especially during the first few months of use. The most common changes in bleeding patterns are:

- lighter bleeding and fewer days of bleeding
- irregular bleeding
- infrequent bleeding
- no monthly bleeding
- prolonged bleeding
- Other side effects: Nausea, vomiting, headache, bloating, breast tenderness, swelling of the ankles/feet (fluid retention), or weight change may occur

Complications

COCs increase the risk of venous thromboembolism (including deep vein thrombosis (DVT) and pulmonary embolism.

While lower doses of estrogen in COC pills may have a lower risk of stroke and myocardial infarction compared to higher estrogen dose pills (50 μg/day), users of low estrogen dose COC pills still have an increased risk compared to non-users.

These risks are greatest in women with additional risk factors, such as smoking (which increases risk substantially) and long-continued use of the pill, especially in women over 35 years of age. The estrogen in the pill may cause

- deep vein thrombosis (clot in the leg)
- pulmonary embolus (clot in the lung)
- stroke
- heart attack

The risk of getting a blood clot is very small. The FP provider should check if the client has certain risk factors before prescribing the pill.

Managing side effects

- Adverse effects of COCs usually diminish with continued use of the same brand of COC. Health providers have only to reassure clients that these symptoms will likely resolve within 3 to 5 months and that they are not signs of illness. Not all users experience side effects though.
- Providers should not prescribe any other COC for weight gain, headache, breast tenderness, breakthrough bleeding, mood disturbances, acne or nausea There are no significant differences among formulations.
- Clients can take pills with food or at bedtime to avoid nausea. If symptoms persist after three months, the user should consult the provider for diagnostic tests to determine if there are other conditions which would require more tests, treatment or change in contraceptives.

- Patient education and assessment through medical eligibility criteria before use of contraceptives are important steps to implement.
- Users must be reminded that they should return to the clinic in a timely manner to get their contraceptive resupply and for questions or possible adverse experience with the method.
- Counseling on bleeding changes and importance to keep using the method without concern.
- Side effects like headaches, breast tenderness or weight change are not signs of illness.
- Pills should be taken daily at the same time each day.
- The client should return if side effects bother her or if she has other concerns, as well as to be prompt in getting her pills usually every 3-6 months.

DISPELLING MYTHS AND MISCONCEPTION

1. Some women who seek family planning believe that using COC will cause birth defects in babies.

   Fact: Good evidence shows that COCs will not cause birth defects and will not harm the fetus if a woman becomes pregnant while taking COCs or accidentally starts to take the COCs when already pregnant.

2. Some women believe that COCs cause cancers such as breast cancer, uterine cancer and ovarian cancer.

   Fact: The use of COC is proven to decrease the risk of ovarian and endometrial cancer. It is difficult to know the effect of COC on breast and cervical cancer. The possibly increased risks recorded in some studies are not large enough to outweigh benefits or to change current practice. Use of COCs helps protect women from two cancers: ovarian and endometrial cancers. The protection continues for 15 more years after stopping use. Breast cancer is slightly more common among women who have used COCs in the past ten years. Scientists cannot determine whether COCs actually caused the slight increase in breast cancers or it is possible that the cancers were already there prior to the use of COCs but were found sooner in COC users. Both COC users and women not using COC can have breast cancer.

   Cervical cancer is caused by certain types of HPV. HPV is a common STI that usually clears on its own without treatment but sometimes persists. Use of COC for 5 years or more appears to speed up the development of persistent HPV infection into cervical cancer. The number of cervical cancers associated with COC is very small. If cervical screening is available, FP providers can advise COC users to be screened every three years to detect precancerous changes in the cervix.

3. Some clients believe that COCs reduce sexual pleasure or interest in sex that they cause frigidity in women.

   Fact: No evidence that COCs affect a woman's sex drive. Some women reported either an increase or decrease in sex drive and performance. It is difficult to say whether such changes are a result of COCs or other life event/s.

4. Some clients believe that COCs encourage infidelity, promiscuity, or prostitution in women.

Fact: No evidence that COCs affect sexual behavior.

5. COCs will cause a long delay in conceiving or prevent women from being able to have children in the future.

   Fact: COC does not cause infertility regardless of how long the pill has been used. Some of the non-contraceptive benefits include preserving fertility by offering protection against pelvic inflammatory disease, endometriosis and ectopic pregnancy

NON-CONTRACEPTIVE BENEFITS

Protect against:

- Endometrial cancer
- Cancer of the ovary
- Pelvic inflammatory disease
- Ovarian cysts
- Iron deficiency anemia
- Reduce menstrual cramps and menstrual bleeding problems

HOW TO PROVIDE THE METHOD

The pill user can normally start taking the pill at any point in the menstrual cycle. There is special guidance if she has just had a baby, abortion, or miscarriage. The guidance may also be different if she has a short menstrual cycle. She may need to use additional contraception during her first day on the pill — this depends on when in her menstrual cycle she starts taking it.

- COCs are best taken within the first five days of the menstrual period because pregnancy is not possible at this time.
- Women who start COCs after the fifth day of the onset of their menstruation should practice abstinence or use a backup contraceptive for the next seven days.
- Women who have not recently given birth can start taking COCs any time as long they are certain that they are not pregnant.

Postpartum/post-abortion women

- Breastfeeding women may begin COCs at six months postpartum or when they are no longer breastfeeding. COCs contain estrogen, which may decrease breast milk production.
- Postpartum women who are not breastfeeding may begin taking COCs three weeks after delivery.
- Following a miscarriage, women may begin taking oral contraceptives immediately. No backup contraception is needed if the method is started within the first five days following an abortion.

Shifters from other methods

- If switching from a hormonal method, she can immediately start COCs provided she has been taking her previous method consistently and correctly, or she is reasonably certain she is not pregnant.
- If switching from an IUD and if during the first 7 days of menses, start the pills, remove the IUD, no backup method necessary. However, if after 7 days of start of

menses and she has had sex, start the pills but keep the IUD in place until her next menses.

- The same principle is applied to those about to undergo female sterilization.

Extended or Continuous Cycle Use of COCs

— Users can opt to continue taking the hormonal pills for 12 weeks without a break, followed by one week of non-hormonal pills (or no pills). This is extended use.

— Other women may take hormonal pills without any breaks at all. This is continuous use. Monophasic pills are recommended for such use.

Women can manage to take COCs in different ways but should be properly advised on how to do so. Many women value controlling when they have monthly bleeding, if any, and tailoring pill use as they wish.

Benefits of Extended and Continuous Use of COCs

- Women have vaginal bleeding only 4 times a year or not at all.
- Reduces how often some women suffer headaches, premenstrual syndrome, mood changes, and heavy or painful bleeding during the week without hormonal pills.

Disadvantages of Extended and Continuous Use

- Irregular bleeding may last as long as the first 6 months of use – especially among women who have never before used COCs.
- More supplies needed – 15 to 17 packs every year instead of 13.

Continuous use instructions are:

- A woman should take one hormonal pill every day for as long as she wishes to use COCs. However, if bothersome irregular bleeding occurs, she can stop taking pills for 3 or 4 days and then start taking hormonal pills continuously again.

There are clinical indications for extended or continuous cycle use of COCs that have been used for many years to treat endometriosis, dysmenorrhea, and menstruation-associated symptoms. This is currently the latest packaging/modification of COCs. Any brand of COC can be used in an extended or continuous manner by simply discarding the placebo pills; this is most commonly done with monophasic pills in which all of the pills in a package contain the same fixed dosing of synthetic estrogen and a progestin in each active pill. Personal preference is the most common reason why extended cycle or continuous use COCs are prescribed to adolescents. Extended or continuous use of COCs or other combined hormonal contraceptives carries the same risk of side effects and medical risks as traditional COC use.

SUPPORT FOR CONTINUING USER

Helping the Continuing Users

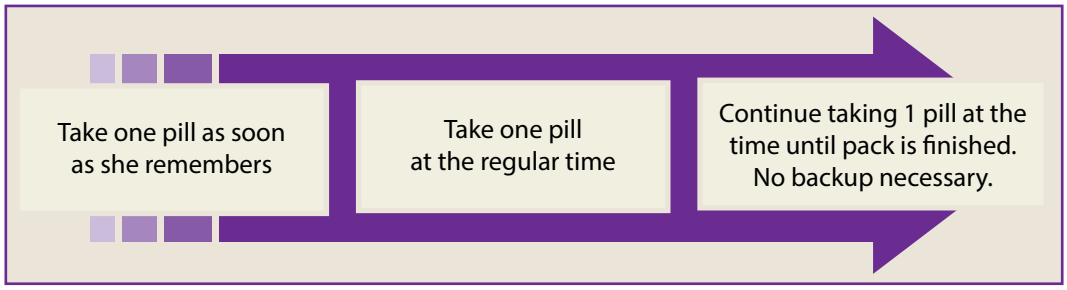
1. Ask how the client is doing with the method and whether she is satisfied. Ask if she has any questions or anything to discuss.
2. Ask especially if she is concerned about bleeding changes. Give her any information or help that she needs.

3. Ask if she often has problems remembering to take a pill every day. If so, discuss ways to remember, making up missed pills, and ECPs, or choosing another method. Adolescents may need extra support.
4. Give her more pill packs—a full year's supply (13 packs), if possible. Plan her next resupply visit before she will need more pills.
5. Every year or so, check blood pressure if possible (see Medical Eligibility Criteria).
6. Ask a long-term client if she has had any new health problems since her last visit. Address problems as appropriate. For new health problems that may require switching methods.
7. Ask a long-term client about major life changes that may affect her needs—particularly plans for having children and STI/HIV risk. Follow up as needed.

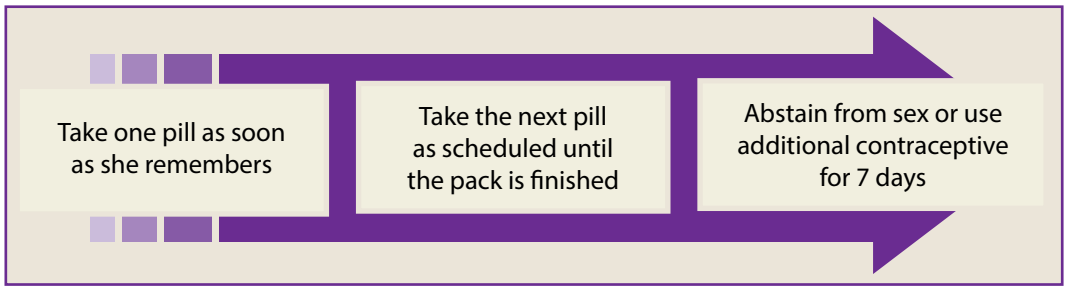
Managing Missed Pills

Figure 6. Procedure to follow when a woman misses her pills

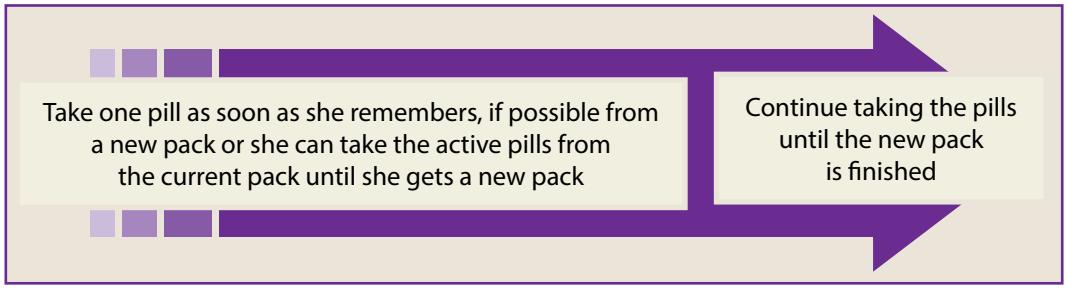
A. If a woman misses 1-2 active COC pills or starts a pack 1 day late



B. If a woman misses 3 or more COC active pills or starts a pack 2-3 days late



C. If a woman misses 3 or more contraceptive pills on the third week



Source: Family Planning Clinical Standards Handbook, 2014

Table 8. Recommended actions after late or missed combined oral contraceptives

If one hormonal pill is late: (<24 hours since a pill should have been taken)	If one hormonal pill is missed: (<24 to <48 hours since a pill should have been taken)	If two or more consecutive hormonal pills have been missed: (≥48 hours since a pill should have been taken)
Take the late or missed pill as soon as possible Continue taking the remaining pills at the usual time (even if it means taking two pills on the same day). No additional contraceptive protection is needed. Emergency contraception is not usually needed but can be considered (with the exception of UPA) if hormonal pills were missed earlier in the cycle or in the last week of the previous cycle.		Take the late or missed pill as soon as possible. (Any other missed pills should be discarded.) Continue taking the remaining pills at the usual time (even if it means taking two pills on the same day). Use backup contraception (e.g., condoms) or avoid sexual intercourse until hormonal pills have been taken for 7 consecutive days. If pills were missed in the last week of hormonal pills (e.g., days 15-21 for 28-day pill packs): Omit the hormone-free interval by finishing the hormonal pills in the current pack and starting a new pack the next day. If unable to start a new pack immediately use backup contraception (e.g., condoms) or avoid sexual intercourse until hormonal pills from a new pack have been taken for 7 consecutive days. Emergency contraception should be considered (with the exception of UPA) if hormonal pills were missed during the first week and unprotected sexual intercourse occurred in the previous 5 days. Emergency contraception may also be considered (with the exception of UPA) at other times as appropriate.

Abbreviation: UPA=ulipristal acetate

Source: CDC, USA

Missing a pill or starting a pack late may not protect a woman from pregnancy. This depends on when and how many pills were missed.

Vomiting and diarrhea: if vomiting within 3 hours, take another pill at once. The next pill should be taken at the right time. If vomiting continues, use another form of contraception until she is able to take the pills for 7 days without vomiting.

Severe diarrhea (6-8 watery poos in 24 hours): continue using the pill as usual but use additional contraceptive like condoms while with diarrhea and for two more days after recovering.

Key Points for Providers and Clients using Combined Oral Contraceptives

Take one pill at the same time each day. For greatest effectiveness a woman must take pills daily and start each new pack of pills on time.

Take any missed pill as soon as possible. Missing pills risks pregnancy and may make some side effects worse.

Bleeding changes are common but not harmful. Typically, there is irregular bleeding for the first few months and then lighter and more regular bleeding. Side effects like headaches, breast tenderness or weight change are also not signs of illness.

Can be given to a woman at any time to start now or later.

The client should return if side effects bother her or if she has other concerns, as well as to be prompt in getting her resupply of pills, usually every 3-6 months.

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

Combined Injectable Contraceptives (Monthly Injectables)

INTRODUCTION

Combined injectable contraceptives (CICs) are monthly injectable preparations that contain a short-acting natural estrogen and a long-acting progestogen given intramuscularly and slowly released in 28-30 days. Below are some of the preparations:

- 25 mg depot medroxyprogesterone acetate and 5 mg estradiol cypionate (Cyclofem)
- 50 mg norethindrone enanthate and 5 mg estradiol valerate (Mesigyna)
- The only preparation available in the country contains noristherone enanthate 50 mg and estradiol valerate 5mg (eg. Norifam).

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Who can use CICs

This method is useful for women who want a highly effective contraceptive method but have problems adhering to other CHC regimens.

This method can be used by women of any age including adolescents and women over 40 years old. It is also suitable for women who want the convenience of an injectable contraceptive without the bleeding irregularities associated with progesterone-only injections.

Applicability of laboratory tests and other ancillary procedures in providing CIC

Women can begin using monthly injectables:

- Without a pelvic examination
- Without any blood tests or other routine laboratory tests
- Without cervical cancer screening

- Without a breast examination
- Without a pregnancy test. A woman can begin using monthly injectables even when she is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant.

Medical Eligibility Criteria for CIC

Ask the client the questions below about known medical conditions. Examinations and tests are not necessary. If she answers "no" to all of the questions, then she can start monthly injectables if she wants. If she answers "yes" to a question, follow the instructions. In some cases, she can still start monthly injectables.

1. Are you breastfeeding a baby less than 6 months old?

❑ NO ❑ YES

— If fully or nearly fully breastfeeding: She can start 6 months after giving birth or when breast milk is no longer the baby's main food—whichever comes first.

— If partially breastfeeding: She can start monthly injectables as soon as 6 weeks after giving birth.

2. Have you had a baby in the last 3 weeks and you are not breastfeeding?

❑ NO ❑ YES

— She can start monthly injectables as soon as 3 weeks after childbirth. (If there is an additional risk that she might develop a blood clot in a deep vein [deep vein thrombosis, or VTE], then she should not start monthly injectables at 3 weeks after childbirth but can start at 6 weeks instead. These additional risk factors include previous VTE, thrombophilia, caesarean delivery, blood transfusion at delivery, postpartum hemorrhage, pre-eclampsia, obesity [>_30 kg/m2], smoking, and being bedridden for a prolonged time.

3. Do you smoke 15 or more cigarettes a day?

❑ NO ❑ YES

— If she is 35 years of age or older and smokes more than 15 cigarettes a day, do not provide monthly injectables. Urge her to stop smoking and help her choose another method.

4. Do you have severe liver disease—active hepatitis, severe cirrhosis, or liver tumor?

❑ NO ❑ YES

— If she reports active hepatitis, severe cirrhosis, or liver tumor, do not provide monthly injectables. Help her choose a method without hormones. If she has mild cirrhosis or gallbladder disease, she can use monthly injectables.

5. Do you have high blood pressure?

❑ NO ❑ YES

— If you cannot check blood pressure and she reports a history of high blood pressure, or if she is being treated for high blood pressure, do not provide monthly injectables. Refer her for a blood pressure check if possible or help her choose another method without estrogen.

Check her blood pressure if possible:

- If blood pressure is below 140/90 mm Hg, provide monthly injectables.
- If systolic blood pressure is 140 mm Hg or higher or diastolic blood pressure is 90 or higher, do not provide monthly injectables. Help her choose a method without estrogen but not progestin-only injectables if systolic blood pressure is 160 or higher, or diastolic pressure is 100 or higher.
- One blood pressure reading in the range of 140–159/ 90–99 mm Hg is not enough to diagnose high blood pressure. Provide a backup method* to use until she can return for another blood pressure check or help her choose another method now if she prefers. If blood pressure at next check is below 140/90, she can use monthly injectables.**

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

** For guidance on routine blood pressure testing, see Appendix G

6. Have you had diabetes for more than 20 years or damage to your arteries, vision, kidneys, or nervous system caused by diabetes?

❑ NO ❑ YES — Do not provide monthly injectables. Help her choose a method without estrogen but not progestin-only injectables.

7. Have you ever had a stroke, blood clot in your leg or lungs, heart attack, or other serious heart problems?

❑ NO ❑ YES — If she reports heart attack, heart disease due to blocked or narrowed arteries, or stroke, do not provide monthly injectables. Help her choose a method without estrogen but not progestin-only injectables. If she reports a current blood clot in the deep veins of the leg (not a superficial clot) or in the lungs, help her choose a method without hormones.

8. Do you have or have you ever had breast cancer?

❑ NO ❑ YES — Do not provide monthly injectables. Help her choose a method without hormones.

9. Do you sometimes see a bright area of lost vision in the eye before a very bad headache (migraine aura)? Do you get throbbing, severe head pain, often on one side of the head, that can last from a few hours to several days and can cause nausea or vomiting (migraine headaches)? Such headaches are often made worse by light, noise, or moving about.

❑ NO ❑ YES — If she has migraine aura at any age, do not provide monthly injectables. If she has migraine headaches without aura and is age 35 or older, do not provide monthly injectables. Help these women choose a method without estrogen. If she is under age 35 and has migraine headaches without aura, she can use monthly injectables (see Identifying Migraine Headaches and Auras, Appendix G).

10. Are you planning major surgery that will keep you from walking for one week or more?

❑ NO ❑ YES — If so, she can start monthly injectables 2 weeks after the surgery. Until she can start monthly injectables, she should use a backup method.

11. Do you have several conditions that could increase your chances of heart disease (coronary artery disease) or stroke, such as older age, smoking, high blood pressure, or diabetes?

❑ NO ❑ YES — Do not provide monthly injectables. Help her choose a method without estrogen, but not progestin-only injectables.

12. Are you taking lamotrigine?

❑ NO ❑ YES — Do not provide monthly injectables. Monthly injectables can make lamotrigine less effective. Help her choose a method without estrogen.

Also, women should not use monthly injectables if they report having thrombogenic mutations or lupus with positive (or unknown) antiphospholipid antibodies. For complete classifications, see **Medical Eligibility Criteria for Contraceptive Use, Appendix B.**

Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable, when relevant to the client.

Using Clinical Judgment in Special Cases

Usually, a woman with any of the conditions listed below should not use monthly injectables. In special circumstances, however, when other or more appropriate methods are not available or acceptable to her, a qualified provider who can carefully assess a specific woman's condition and situation may decide that she can use monthly injectables.

The provider needs to consider the severity of her condition and, for most conditions, whether she will have access to follow-up.

- Not breastfeeding and less than 3 weeks since giving birth, without additional risk that she might develop a blood clot in a deep vein (VTE)
- Not breastfeeding and between 3 and 6 weeks postpartum with additional risk that she might develop VTE
- Primarily breastfeeding between 6 weeks and 6 months since giving birth
- Aged 35 or older and smokes more than 15 cigarettes a day

- High blood pressure (systolic blood pressure between 140 and 159 mm Hg or diastolic blood pressure between 90 and 99 mm Hg)
- Controlled high blood pressure, where continuing evaluation is possible
- History of high blood pressure, where blood pressure cannot be taken (including pregnancy-related high blood pressure)
- Severe liver disease, infection, or tumor
- Aged 35 or older and has migraine headaches without aura
- Younger than age 35 and has migraine headaches that have developed or have gotten worse while using monthly injectables
- Had breast cancer more than 5 years ago, and it has not returned
- Diabetes for more than 20 years or damage to arteries, vision, kidneys, or nervous system caused by diabetes
- Multiple risk factors for arterial cardiovascular disease, such as older age, smoking, diabetes, and high blood pressure
- Taking lamotrigine. Monthly injectables may reduce the effectiveness of lamotrigine.

MECHANISM OF ACTION

- Prevents ovulation
- Thickens cervical mucus
- Thins the lining of the uterus

EFFECTIVITY

Prevents ovulation in 99% of cases as long as applied correctly and regularly; 97% as commonly used.

ADVANTAGES AND DISADVANTAGES

Advantages of CICs

- Immediate effectiveness
- Pelvic examination not required prior to use
- Does not interfere with intercourse
- Few side effects
- Can be provided by a trained nurse or midwife
- Contributes to decreased menstrual flow (lighter, shorter periods)
- Reduces menstrual cramps
- May improve anemia as menses are reduced
- Reduces the risk of ectopic pregnancy
- Protects against some causes of pelvic inflammatory disease (PID)

Disadvantages of CICs

- Do not protect against STI
- Cause changes in menstrual pattern
- Effectiveness lowered by Rifampicin and most anticonvulsants
- Can cause cardiovascular disease but such cases are rare
- Need to get injections every 30 days

RETURN TO FERTILITY

After stopping CIC, there may be a delay in regaining fertility return within a few months after the last injection. On average, women become pregnant about 5 months after their last injection.

SIDE-EFFECTS AND ADVERSE REACTION

- Nausea
- Dizziness
- Mild breast tenderness
- Headaches
- Weight gain
    - — These are due to the estrogen component but disappear within two or three injections.
    - — Changes in bleeding patterns:
        - o Lighter and fewer days of bleeding
        - o Irregular bleeding
        - o Infrequent bleeding
        - o Prolonged bleeding
        - o No monthly bleeding

These side effects become less or disappear within the first few months after starting the injections. Counseling is important for users to understand that these are not signs of illness especially the bleeding changes. She can come to the clinic if she is bothered by side effects or have any problems or questions on her health status.

DISPELLING MYTHS AND MISCONCEPTIONS

- Can stop monthly bleeding, but this is not harmful. It is similar to not having monthly bleeding during pregnancy; but blood is not building up inside the woman.
- Do not make women infertile.
- Do not cause early menopause.
- Do not cause birth defects or multiple births.
- Do not cause itching.
- Do not change women's sexual behavior.
- Do not cause abortion nor birth defects of neonates .

Commonly asked questions about Monthly Injectables

1. **How are monthly injectables different from progestin-only injectables?**

   The major difference between monthly injectables and the progestin-only injectables DMPA or NET-EN is that monthly injectables contain estrogen as well as progestins, making them a combined method. Also, monthly injectables contain less progestin.

   These differences result in more regular bleeding and fewer bleeding disturbances than with progestin-only injectables. Monthly injectables require a monthly injection, whereas NET-EN is injected every 2 months and DMPA, every 3 months.

2. **Do monthly injectables function like combined oral contraceptives?**

   Largely, yes. Monthly injectables are similar to COCs. There are few long-term studies done on monthly injectables, but researchers assume that most of the findings about COCs also apply to monthly injectables. Monthly injectables, however, do not pass through the liver first because they are not taken by mouth like COCs. Short-term studies have shown that monthly injectables have less effect than COCs on blood pressure, blood clotting, the breakdown of fatty substances (lipid metabolism), and liver function. Long-term studies of the health risks and benefits of monthly injectables are underway.

3. **Do monthly injectables cause birth defects? Will the fetus be harmed if a woman accidentally uses monthly injectables while she is pregnant?**

   No. Good evidence from studies on other hormonal methods shows that hormonal contraception will not cause birth defects and will not otherwise harm the fetus if a woman becomes pregnant while using monthly injectables or accidentally starts injectables when she is already pregnant.

4. **Do monthly injectables cause abortion?**

   No. Research on combined contraceptives finds that they do not disrupt an existing pregnancy. They should not be used to try to cause an abortion.

5. **Should the dates for a woman's repeat injections be based on when monthly bleeding starts?**

   No. Some providers think that the next injection should be given only when the next monthly bleeding begins. Bleeding episodes should not guide the injection schedule. A woman should receive the injection every 4 weeks. The timing of injections should not be based on her monthly bleeding.

6. **Can monthly injectables be used to bring on monthly bleeding?**

   No. A woman may experience some vaginal bleeding (a "withdrawal bleed") as a result of an injection, but there is no evidence that giving a woman who has irregular bleeding a single injection of a monthly injectable will cause her monthly bleeding to begin properly about one month later. Also, giving a pregnant woman an injection will not cause an abortion.

7. **Can women who smoke use monthly injectables safely?**

   Women younger than age 35 who smoke any number of cigarettes and women 35 and older who smoke fewer than 15 cigarettes a day can safely use monthly injectables. In contrast, women 35 and older who smoke any number of cigarettes should not use combined oral contraceptives. Women aged 35 and older who smoke more than 15 cigarettes a day should choose a method without estrogen, such as progestin-only injectables, if available. All women who smoke should be urged to stop smoking.

8. **Do monthly injectables lower women's mood or sex drive?**

   Generally, no. Some women using monthly injectables report these complaints. The great majority of injectable users do not report any such changes, however, and some report that both mood and sex drive improve. It is difficult to tell whether such changes are due to monthly injectables or to other reasons. There is no evidence that monthly injectables affect women's sexual behavior.

9. **Can women with varicose veins use monthly injectables?**

   Yes. Monthly injectables are safe for women with varicose veins. Varicose veins are enlarged blood vessels close to the surface of the skin. They are not dangerous. They are not blood clots, nor are they deep veins in the legs where a blood clot can be dangerous (deep vein thrombosis). A woman who has or has had deep vein thrombosis should not use monthly injectables.

10. **Do monthly injectables make a woman infertile?**

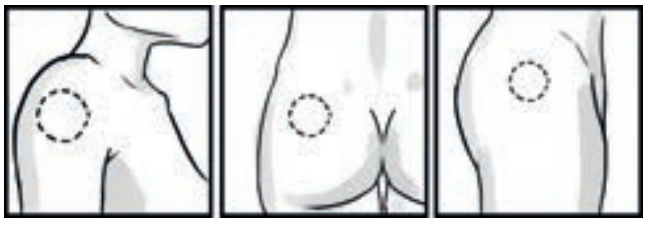
    No. There may be a delay in regaining fertility after stopping monthly injectables, but in time the woman will be able to become pregnant as before, although fertility decreases as women get older. The bleeding pattern a woman had before she used monthly injectables generally returns a few months after the last injection.

11. **How long does it take to become pregnant after stopping monthly injectables?**

    Women who stop using monthly injectables wait about one month longer on average to become pregnant than women who have used other methods. This means they become pregnant on average 5 months after their last injection. These are averages. A woman should not be worried if she has not become pregnant even as much as 12 months after stopping use. After stopping monthly injectables, a woman may ovulate before her monthly bleeding returns—and thus can become pregnant. If she wants to continue avoiding pregnancy, she should start another method before monthly bleeding returns.

HOW TO PROVIDE THE METHOD

A woman using CICs must be injected with one vial of the drug monthly. The drug may be injected into the muscles of the upper arm, thigh, or buttocks. Infection prevention principles must be observed in giving the injection and disposing of the needles and syringes.



IMPORTANT: A woman can start injectables any time she wants if it is reasonably certain she is not pregnant. To be reasonably certain she is not pregnant, use the Pregnancy Checklist on page 50.

WOMAN'S SITUATION	WHEN TO START
Having menstrual cycles or switching from a nonhormonal method	• If she is starting within 7 days after the start of her monthly bleeding, no need for a backup method. • If it is more than 7 days after the start of her monthly bleeding, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method* for the first 7 days after the injection. • If she is switching from an IUD, she can start injectables immediately
Switching from a hormonal method	• Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. • If she is switching from another injectable, she can have the new injectable when the repeat injection would have been given. No need for a backup method
Fully or nearly fully breastfeeding (Less than 6 months after giving birth)	• Delay her first injection until 6 months after giving birth or when breast milk is no longer the baby's main food—whichever comes first.
Fully or nearly fully breastfeeding (More than 6 months after giving birth)	• If her monthly bleeding has not returned, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection. • If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles
Partially breastfeeding (Less than 6 weeks after giving birth)	• Delay her first injection until at least 6 weeks after giving birth.
More than 6 weeks after giving birth	• If her monthly bleeding has not returned, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection. • If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles.
Not breastfeeding (Less than 4 weeks after giving birth)	• She can start injectables at any time on days 21–28 after giving birth. No need for a backup method.
Not breastfeeding (More than 4 weeks after giving birth)	• If her monthly bleeding has not returned, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.

	• If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles. Where a visit 6 weeks after childbirth is routinely recommended and other opportunities to obtain contraception are limited, some providers and programs may give the first injection at the 6-week visit, without further evidence that the woman is not pregnant, if her monthly bleeding has not yet returned.
No monthly bleeding (not related to childbirth or breastfeeding	• She can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.
After miscarriage or abortion	• Immediately. If she is starting within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method. • If it is more than 7 days after first- or second- trimester miscarriage or abortion, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.
After taking emergency contraceptive pills (ECPs)	After taking progestin-only or combined ECPs: • She can start or restart injectables on the same day as taking the ECPs.There is no need to wait for her next monthly bleeding to have the injection. • She will need to use a backup method for the first 7 days after the injection. • If she does not start immediately, but returns for injectables, she can start at any time if it is reasonably certain she is not pregnant. After taking ulipristal acetate (UPA) ECPs: • She can start or restart injectables on the 6th day after taking UPA-ECPs. No need to wait for her next monthly bleeding. Monthly injectables and UPA interact. If an injectable is started sooner, and thus both are present in the body, one or both may be less effective. • Make an appointment for her to return for the injection on the 6th day after taking UPA-ECPs, or as soon as possible after that. • She will need to use a backup method from the time she takes UPA-ECPs until 7 days after the injection. • If she does not start on the 6th day but returns later for injectables, she may start at any time if it is reasonably certain she is not pregnant.

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

Giving the Injection

1. Obtain one dose of injectable, needle, and syringe	• 25 mg MPA/estradiol cypionate or 50 mg NET-EN/ estradiol valerate, intramuscular injection needle, and 2 ml or 5 ml syringe. (NET-EN/estradiol valerate is sometimes available in prefilled syringes.) • For each injection use a disposable auto-disable syringe and needle from a new sealed package (within expiration date and not damaged), if available.
2. Wash	• Wash hands with soap and water, if possible. • If injection site is dirty, wash it with soap and water. • No need to wipe site with antiseptic.
If using a prefilled syringe, skip to step 5.	
3. Prepare vial	• MPA/estradiol cypionate: Gently shake the vial. • NET-EN/estradiol valerate: 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.
4. Fill syringe	• Pierce top of vial with sterile needle and fill syringe with proper dose.
5. Inject formula	• Insert sterile needle deep into the hip (ventrogluteal muscle), the upper arm (deltoid muscle), the buttocks (gluteal muscle, upper outer portion), or outer (anterior) thigh, whichever the woman prefers. Inject the contents of the syringe. • Do not massage injection site.
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 reuse disposable syringes and needles. They are meant to be destroyed after a single use. Because of their shape, they are very difficult to disinfect. o Therefore, reuse might transmit diseases such as HIV and hepatitis. • If reusable syringe and needle are used, they must be sterilized again after each use.

SUPPORT FOR CONTINUING USERS

Helping Continuing Users

Repeat Injection Visits

- 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 is concerned about bleeding changes. Give her any information or help that she needs.
- Give her the injection. The injection can be given up to 7 days early or late.
- Plan for her next injection. Agree on a date for her next injection (in 4 weeks). Remind her that she should try to come on time, but she should come back no matter how late she is. She may still be able to have her injection.
- Every year or so, check her blood pressure if possible (refer to Appendix B, WHO Medical Eligibility Criteria).
- Ask a long-term client if she has had any new health problems that may require switching methods. Address problems as appropriate.
- Ask a long-term client about major life changes that may affect her needs—particularly plans for having children and STI/HIV risk. Follow up as needed.

Missed and Late Injections

- Managing Late Injections
  - — If the client is less than 7 days late for a repeat injection, she can receive her next injection. No need for tests, evaluation, or a backup method.
  - — A client who is more than 7 days late can receive her next injection if:
    - o She has not had sex 7 days since after the scheduled date of her injection, or
    - o She has used a backup method or has taken emergency contraceptive pills (ECPs) after any unprotected sex 7 days since after the scheduled date of her injection.
    - o She will need a backup method for the first 7 days after the injection
  - — If the client is more than 7 days late and does not meet these criteria, additional steps can be taken to be reasonably certain she is not pregnant (see Ruling Out Pregnancy, page 50)
  - — Discuss why the client was late and solutions. If coming back on time is often a problem, discuss using a backup method when she is late for her next injection, taking ECPs, or choosing another method.

Managing Side Effects

Problems Reported as Side Effects [May or may not be due to the method]

- Problems with side effects affect women's satisfaction and use of injectables. They deserve the provider's attention. If the client reports side effects, listen to her concerns, give her advice and support, and, if appropriate, treat. Make sure she understands the advice and agrees with it.
- Offer to help the client choose another method—now, if she wishes, or if problems cannot be overcome.

SIDE EFFECT	HOW TO MANAGE
Irregular bleeding (bleeding at unexpected times that bothers the client)	• Reassure her that many women using monthly injectables experience irregular bleeding. It is not harmful and usually becomes less or stops after the first few months of use. • For modest short-term relief, she can try 800 mg ibuprofen 3 times daily after meals for 5 days, or other nonsteroidal anti-inflammatory drug (NSAID), beginning when irregular bleeding starts. NSAIDs provide some relief of irregular bleeding for implants, progestin-only injectables, and IUDs, and they may also help for monthly injectables. • If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.
Heavy or prolonged bleeding (twice as much as usual or longer than 8 days)	• Reassure her that many women using monthly injectables experience heavy or prolonged bleeding. It is generally not harmful and usually becomes less or stops after a few months. • For modest short-term relief, she can try 800 mg ibuprofen 3 times daily after meals for 5 days, or other NSAID, beginning when heavy bleeding starts. NSAIDs provide some relief of heavy bleeding for implants, progestin- only injectables, and IUDs, and they may also help for monthly injectables. • To help prevent anemia, suggest she take iron tablets and tell her it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas). • If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.
No monthly bleeding	• Reassure her that some women using monthly injectables stop having monthly bleeding, and this not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not pregnant or infertile. Blood is not building up inside her. (Some women are happy to be free from monthly bleeding.)
Weight gain	• Review diet and counsel as needed.

Ordinary headaches (non-migrainous)	• Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever • Any headaches that get worse or occur more often during use of injectables should be evaluated
Breast tenderness	• Recommend that she wear a supportive bra (including during strenuous activity and sleep). • Try hot or cold compresses. • Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever. • Consider locally available remedies
Dizziness	• Consider locally available remedies

New problems that may require switching methods [May or may not be due to the method]

SIDE EFFECT	HOW TO MANAGE
Unexplained vaginal bleeding (that suggests a medical condition not related to the method)	• Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate. • She can continue using monthly injectables while her condition is being evaluated • If bleeding is caused by sexually transmitted infection or pelvic inflammatory disease, she can continue using monthly injectables during treatment.
Migraine headaches (see Identifying Migraine Headaches and Auras, Appendix G)	• Regardless of her age, a woman who develops migraine headaches, with or without aura, or whose migraine headaches become worse while using monthly injectables, should stop using injectables. • Help her choose a method without estrogen.
Circumstances that will keep her from walking for one week or more	• If she is having major surgery, or her leg is in a cast, or for other reasons she will be unable to move about for several weeks, she should: • Tell her doctors that she is using monthly injectables. • Stop injections one month before scheduled surgery, if possible, and use a backup method during this period. • Restart monthly injectables 2 weeks after she can move about again.

Certain serious health conditions (suspected heart or liver disease, high blood pressure (systolic pressure of 140 mm Hg or higher or diastolic pressure of 90 mm Hg or higher), blood clots in deep veins of legs or lungs, stroke, breast cancer, or damage to arteries, vision, kidneys, or nervous system caused by diabetes)	• Do not give the next injection. • Give her a backup method to use until the condition is evaluated. • Refer for diagnosis and care if not already under care
Suspected pregnancy	• Assess for pregnancy. • Stop injections if pregnancy is confirmed. • There are no known risks to a fetus conceived while a woman is using injectables
Starting treatment with lamotrigine	• Combined hormonal methods, including monthly injectables, can make lamotrigine less effective. Unless she can use a different medication for seizures than lamotrigine, help her choose a method without estrogen

Key Points for Providers and Clients using Monthly Injectables

- **Bleeding changes are common but not harmful.** Typically, lighter monthly bleeding, fewer days of bleeding, or irregular or infrequent bleeding.
- **Return on time.** Coming back every 4 weeks is important for greatest effectiveness.
- **Injection can be as much as 7 days early or late.** Even if later, she may still be able to have the injection.

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

Combined Transdermal Patch

INTRODUCTION

The Combined Patch is a small, thin square of flexible plastic worn on a part of the body. This continuously releases two hormones namely progestin and estrogen, like the natural hormones progesterone and estrogen in a woman's body and absorbed directly through the skin into the bloodstream. The woman puts on a new patch every week for three weeks, then no patch for the fourth week. During the fourth week, the woman will have monthly bleeding.

The transdermal contraceptive patch is a safe and convenient birth control method that works really well if used correctly and consistently. The patch is worn on certain parts of the body like the upper outer arm, back, abdomen or buttocks, which releases the hormones through the skin of the woman that prevents pregnancy. It works primarily by preventing the release of eggs from the ovaries (ovulation).

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Who can use the Contraceptive Transdermal Patch

The contraceptive patch isn't suitable for everyone.

A woman may not be able to use the patch if:

- she's pregnant or thinks may be pregnant
- breastfeeding a baby less than 6 weeks old
- smokes and aged 35 or over
- aged 35 or over and stopped smoking less than a year ago
- very overweight
- taking certain medicines, such as St. John's Wort, or medicines used to treat epilepsy, tuberculosis (TB), or HIV

Those who have had any of the following conditions will not be able to use the patch:

- a heart problem
- high blood pressure
- some blood conditions that increase the chance of getting a blood clot, such as lupus (systemic lupus erythematosus)
- breast cancer
- migraine with aura (warning signs)
- disease of the liver or gallbladder

A very small number of people using the patch may develop a blood clot in a vein or an artery.

Client should not use the patch if she had a blood clot before. The risk is higher if:

- first year of using the patch
- she smokes
- very overweight
- unable to move (immobile) or use a wheelchair
- has migraines with aura (warning signs)
- a close family member had a heart attack, stroke or blood clot before they were 45 yrs. old

MECHANISM OF ACTION

Like most birth control methods, the patch releases the hormones estrogen and progestin – similar to the hormones that the woman's body make naturally. The patch continuously releases

the two hormones directly through the skin into the bloodstream. This will prevent ovulation and thus prevents pregnancy. The woman puts on a new patch every week for three weeks, then no patch for the fourth week. During this fourth week, the woman will have monthly bleeding. The patch's hormones also act to thicken the mucus on the cervix. This thicker cervical mucus blocks the sperm from fertilizing the egg.

EFFECTIVITY

Effectiveness depends on the user: The risk of pregnancy is greatest when a woman is late to change the patch.

As commonly used, about 7 pregnancies per 100 women using the combined patch occur over the first year, meaning an effectivity rate of 93 of every 100 women using the combined patch will not become pregnant. When no mistakes are made with the use of the patch, less than 1 pregnancy per 100 women using a patch over the first year results to 3 per 1,000 women. Pregnancy rates are slightly higher among women weighing 90 kg or more.

ADVANTAGES AND DISADVANTAGES

Advantages of Transdermal Patch

Patches can be a good option if effective and long-term birth control that women can quit easily if desired. Because the patch provides a daily dose of estrogen and progesterone, the patch may have other possible health benefits such as:

- Lighter periods; less blood and cramping
- More predictable periods; they start promptly about every 28 days (unless the client wears the patch during the fourth week)
- Less anemia due to blood loss
- Less chance of ovarian cysts, certain cancers, and other illnesses

Disadvantages of Transdermal Patch

Patches might not be the best choice if the client:

- Needs protection against STIs like HIV and chlamydia. The male condom is the best contraceptive for that.
- Client is over 35 years old and smokes.
- Weighs more than 198 pounds. The patch may be less reliable for heavier people.
- Client is pregnant or thinks she might be.
- Client is prone to blood clots, had breast or uterine cancer, or takes drugs for epilepsy. Because the patches continually deliver estrogen, they may raise the chances of these problems slightly more than regular birth control pills do.

RETURN TO FERTILITY

There is no observed delay in the return to fertility after patch use is stopped.

SIDE-EFFECTS AND ADVERSE REACTION

Not everyone will have problems with the patch, but some common issues include:

- Headaches
- Tender breasts
- Nausea or throwing up
- Rash or redness where client placed the patch
- Mood changes
- Menstrual cramps
- Irregular/prolonged bleeding
- No monthly bleeding
- Flu symptoms/upper respiratory infection
- Abdominal pain
- Irritation, redness, or inflammation of the vagina (vaginitis)

There's a small chance the patch may bother the skin where this is placed. If there is a history of sensitive skin or other skin problems, the client might want to consider other options. The patch also could cause more serious but rare problems such as blood clots, stroke, and heart attack. These issues are more common if the user smokes or over 35 years old. The client should be advised to consult right away if she has serious pain in her belly or thigh, especially if the following are noticed:

- Chest pain with cough and shortness of breath
- Headache with dizziness, weakness, or numbness
- Blurred vision
- Speech problem

HOW TO USE

The user wears a new patch for 7 days and replaces it on the same day every week for three weeks. Some skip the patch in the fourth week; but others don't. If the user doesn't wear the patch on the fourth week, the user will probably have a period. After the patch-free week, she should never go without wearing a patch for more than seven days to avoid pregnancy risks.

The user can shower, exercise, and swim with the patch on. The client should be advised to avoid tight clothes that might rub against the patch and to check regularly to make sure the patch stays in place.

SUPPORT FOR CONTINUING USERS

Instructions for late replacement or removal, or if the patch comes off

- Apply a new patch as soon as possible.
- Keep the same patch-change day.
- If late by only 1 or 2 days (48 hours or less), there is no need for a backup method.
- If more than 2 days late (more than 48 hours) or no patch worn for 10 days or more in a row, use a backup method for the first 7 days of patch use

- If more than 2 days late and unprotected sex occurred in the past 5 days, consider taking emergency contraceptive pills
- The patch came off and was off for less than 2 days, apply a patch as soon as possible, no need for backup method but keep the same patch change day
- The patch came off and was off for more than 2 days in week 3, skip the patch-free week and apply a new patch immediately after week 3. If a new patch cannot be started immediately, use a backup method and keep using it through the first 7 days of patch use.

Note: This method is not yet available in the country.

Key Points for Providers and Clients using Combined Patch

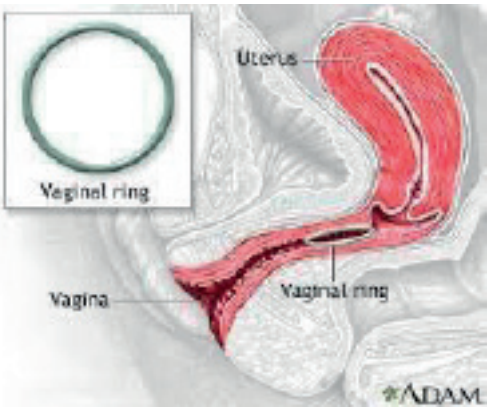
- **A woman wears a small adhesive patch on her body at all times, day and night.** A new patch is put on each week for 3 weeks, and then no patch for the fourth week.
- ***Replace each patch on time for greatest effectiveness.***
- **Bleeding changes are common but not harmful.** Typically, irregular bleeding for the first few months and then lighter and more regular bleeding.

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

Combined Vaginal Ring

INTRODUCTION

The combined vaginal ring (CVR) is a type of contraception that is placed in the vagina for three weeks (all day and all night), where it releases two hormones, estrogen and progesterone, to prevent pregnancy in this three-week period. The fourth week is a rest period or menses may occur. A new ring is inserted after a week. The contraceptive vaginal ring is an effective method of contraception. It is a thin, flexible, see-through ring that is just over 5 cm in diameter. It is a latex-free plastic ring that the user inserts in her vagina every four weeks. This method is not available in the country.



Source: medlineplus.gov

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Who may not use Contraceptive Vaginal Rings?

- Older than 35 years old and smokes
- Sensitive to any component of the vaginal ring

- Taking certain medications for hepatitis
- Are about to be immobilized for prolonged period

Not recommended for women with:

- Diabetes with complications related to her blood vessels
- History of blood clots
- History of breast, uterine cancer, or other liver disease
- History of heart attack or stroke
- Migraines with aura, over age 35 with migraines
- Uncontrolled blood pressure

MECHANISM OF ACTION

The contraceptive vaginal ring contains two hormones: an estrogen called ethinyl estradiol and a progestogen called etonogestrel. They are absorbed through the inside of the vagina. They work in three ways to prevent pregnancy:

1. It prevents ovulation.
2. Thickens the cervical mucus coming from the neck of the womb (cervix). This makes it difficult for sperm to get through to the womb (uterus) to fertilize any egg that might have been released coming from the ovary.
3. They also make the lining of the womb thinner. This makes it less likely that a fertilized egg will be able to attach to the womb.

EFFECTIVITY

The contraceptive vaginal ring is effective. When commonly used, about 7 women get pregnant for every 100 users during the first year. About 1 out of 100 women will get pregnant with perfect use.

The vaginal ring doesn't offer protection from sexually transmitted infections.

ADVANTAGES AND DISADVANTAGES

Advantages of contraceptive vaginal ring

- Comfortable and easy to use
- No need to remember a daily pill
- No required personal fitting
- No need to interrupt sex for contraception
- Can be removed anytime followed by a quick return to fertility
- Safe for women with latex allergy
- Don't appear to cause weight gain
- Less likely to cause irregular bleeding than the COC
- Deliver a smaller level of hormones throughout the body than other types of contraceptives which may reduce the risk of side effects

Disadvantages of contraceptive vaginal ring

- May not feel comfortable inserting or removing it from vagina
- May cause temporary side effects
- Does not protect against STIs
- Need to remember to change and put a new one

RETURN TO FERTILITY

No delay.

SIDE-EFFECTS AND ADVERSE REACTION

- Breakthrough bleeding or spotting
- Vaginal infection or irritation
- Increased vaginal discharge
- Headache
- Nausea/vomiting
- Depression/depressed sex drive

HOW TO USE

- When a woman first uses the ring, she places a new ring into her vagina on the first day of her menstrual period. It is very flexible, and she will be able to squeeze it easily in order to put it in.
- Find a position for inserting the ring that is comfortable. The user can squat, lie down, or raise one leg while standing.
- The position of the ring does not affect how well it works. It helps if it is placed deeply so it does not fall out or the user does not feel it.
- The woman can also insert the ring on day 2-5 of her period and still rely on it straightaway (for example, she can start her new ring on a memorable day such as a Monday).
- If she puts one in for the first time after day 5, she cannot rely on it for contraception, so she needs a secondary protection like a condom for seven days.
- She should leave the ring in place for three weeks. During this time, she should regularly check if it is there.

To insert, squeeze together the opposite sides of the ring between the thumb and index finger; gently push the vaginal ring deep inside the vagina.

- No need to remove the ring during sex.
- The user can remove the ring by hooking it out with her finger when it is time for removal.
- If the vaginal ring falls out, rinse it with cool or warm water, not hot, and reinsert within 2-3 hours.

- Exactly one week later (4th week), put a new ring in on the same day of the week as she put it in the first time. It is only for the first time of use that she should start on the first day of her period.
- The ring should never be left out for more than 48 hours until the fourth week. It can be removed for sex, cleaning or other reasons although removing it is not necessary and not recommended as some women may forget to put it back within 48 hours. If it falls out, she should rinse it in clean water and immediately put it back.

Supporting the User

Instructions for replacement or removal

Left Ring out for 48 hours or less during week 1-3	Put the ring back as soon as possible, no need for backup methods.
Left Ring out for more than 48 hours during weeks 1 or 2	Put the ring back as soon as possible, use a backup method for the next 7 days. If left out for more than 48 hours in the 1st week and unprotected sex occurred in the previous 5 days, consider taking ECP.
Forgot to insert new Ring at be ginning of the cycle	Insert a new ring as soon as possible. If late by only 1-2 days, no need for a backup method but if more than 2 days (more than 48 hours), use a backup method for the first 7 days of ring use.
Kept ring in longer than 3 weeks	If the same ring is used for 28 days, no backup method is needed. Take a ring-free week or start a new ring immediately.

There are new options for using the ring. The Faculty and Sexual Reproductive Health (FSRH) has produced new guidelines on hormonal contraception, including the ring in systematic reviews. Inhibition of ovulation was maintained after leaving the ring in place for 5 weeks which suggested the suppressive effects of CVR lasts a considerable time.

Key Points for Providers and Clients using Combined Vaginal Ring

- **Involves placing a flexible ring in a woman's vagina.** She leaves it there at all times, every day and night for 3 weeks. The ring is removed after 3 weeks and a new ring is inserted seven days later.
- **Start each new ring on time for greatest effectiveness.**
- **Bleeding changes are common but not harmful.** Typically, irregular bleeding for the first few months and then lighter and more regular bleeding.

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

B. PROGESTIN-ONLY METHODS

Progestin-Only Pills

INTRODUCTION

Progestin-Only Pills (POPs) are oral hormonal contraceptives containing only progestins at low doses like the natural hormone progesterone in a woman's body.

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

POPs are also called "minipills" and progestin-only oral contraceptives.

Only two kinds of POPs are available in the Philippines. Both are available in 28-tablet packets.

- 0.5 mg lynestrenol (e.g., Exluton, Daphne)
- 75 µg desogestrel (e.g., Cerazette)

Source: mims.com

Note: Other formulation of POPs such as LNG and Ulipristal are used as emergency contraceptives and will be discussed in the subsequent chapter of this Handbook.

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Who can use the POP

Clients under MEC Category 1 and MEC Category 2 can use the POP.

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

- Are breastfeeding (she can start immediately after childbirth)
- Have or have not had children
- Are married or are not married
- Are of any age, including adolescents and women over 40 years old
- Have just had an abortion, miscarriage, or ectopic pregnancy

- Smoke cigarettes, regardless of woman's age or number of cigarettes smoked
- Have anemia now or had in the past
- Have varicose veins
- Are living with HIV, whether or not on antiretroviral therapy

Medical Eligibility Criteria on POP

Ask the client the questions below about known medical conditions. Examinations and tests are not necessary. If she answers "no" to all the questions, then she can start POPs if she wants. If she answers "yes" to a question, follow the instructions. In some cases, she can still start POPs.

1. Do you have severe cirrhosis of the liver or severe tumor?

❑ NO ❑ YES — If she has severe cirrhosis or severe liver tumor, such as liver cancer, do not provide POPs. Help her choose a method without hormones.

2. Do you have a serious problem now with a blood clot in your leg or lungs?

❑ NO ❑ YES — If she reports a current blood clot in a leg (affecting deep veins, not superficial veins) or in a lung, and she is not on anticoagulant therapy, do not provide POPs. Help her choose a method without hormones.

3. Are you taking medications for seizures? Are you taking rifampicin or rifabutin for tuberculosis or other illness?

❑ NO ❑ YES — If she is taking barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, or rifabutin, do not provide POPs. They can make POPs less effective. Help her choose another method but not combined oral contraceptives.

4. Do you have or have you ever had breast cancer?

❑ NO ❑ YES — Do not provide POPs. Help her choose a method without hormones.

Also, women should not use POPs if they report having thrombogenic mutations or lupus with positive (or unknown) antiphospholipid antibodies. For complete classifications, **see Medical Eligibility Criteria for Contraceptive Use, Annex B.**

Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.

Use by Women with HIV

Women living with HIV or on antiretroviral therapy can safely use POPs.

Providers should urge these women to use condoms along with POPs. Used consistently and correctly, condoms help prevent the transmission of HIV and other STIs.

Who cannot use the POP

Women who have conditions under MEC Category 3 and 4, specifically clients who have/had:

- Acute blood clot in deep veins of legs or lungs
- Breast cancer more than 5 years ago, and it has not returned
- Severe cirrhosis or severe liver tumor
- Systemic lupus erythematosus with positive (or unknown) antiphospholipid antibodies
- Are taking barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, or rifabutin. A backup contraceptive method should also be used because these medications reduce the effectiveness of POPs.

MECHANISM OF ACTION

Work primarily by:

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

EFFECTIVITY

Effectiveness depends on the user.

For women who have monthly bleeding, the risk of pregnancy is greatest if pills are taken late by 3 hours for Lynestrenol or 12 hours for desogestrel or missed completely.

Breastfeeding women: As commonly used, about 1 pregnancy per 100 women using POPs over the first year. This means that 99 of every 100 women will not become pregnant.

When pills are taken every day, less than 1 pregnancy per 100 women using POPs over the first year (3 per 1,000 women).

Less effective for women not breastfeeding: As commonly used, about 7 pregnancies per 100 women using POPs over the first year. This means that 93 of every 100 women will not become pregnant.

There is no delay in fertility after the use of POPs is stopped. The client should choose another more effective method if she desires not to get pregnant.

ADVANTAGES AND DISADVANTAGES

Advantages of using POPs

- Can be used by breastfeeding mothers six weeks after childbirth without affecting the quality and quantity of breast milk
- No estrogen side effects
- Promote compliance in pill-taking, as women take one pill every day with no break, and instructions are easily understandable.

- Can be very effective during breastfeeding
- May help prevent benign breast disease, endometrial and ovarian cancer, and pelvic inflammatory disease.

Disadvantages of using POPs

- May induce changes in menstrual bleeding among women who are not breastfeeding (e.g., irregular periods, spotting or bleeding between periods [common], and amenorrhea possibly for several months [less common]) and prolongs or causes heavy menstrual bleeding in other women
- May cause headaches and breast tenderness (less common)
- Offer no protection against STIs such as HIV/AIDS

RETURN TO FERTILITY

No delay.

SIDE-EFFECTS AND ADVERSE REACTION

Some users report the following:

- Changes in bleeding patterns
- For breastfeeding women, longer delay in the return of monthly bleeding after childbirth (lengthened postpartum amenorrhea)
- Frequent bleeding
- Irregular bleeding
- Infrequent bleeding
- Prolonged bleeding
- No monthly bleeding
- Breastfeeding also affects a woman's bleeding patterns.
- Headaches
- Dizziness
- Mood changes
- Breast tenderness
- Abdominal pain
- Nausea

Other possible physical changes:

- For women not breastfeeding, enlarged ovarian follicles

DISPELLING MYTHS AND MISCONCEPTIONS

- Do not cause a breastfeeding woman's milk to dry up
- Must be taken every day, whether or not a woman has sex that day
- Do not make women infertile
- Do not cause diarrhea in breastfeeding babies
- Reduce the risk of ectopic pregnancy

HOW TO PROVIDE THE METHOD

When to start the POPs

IMPORTANT: A woman can start using POPs any time she wants if it is reasonably certain she is not pregnant. To be reasonably certain she is not pregnant, use the **Pregnancy Checklist** (see page 34). Also, a woman can be given POPs at any time and told when to start taking them.

WOMAN'S SITUATION	WHEN TO START
Fully or nearly fully breastfeeding Less than 6 months after giving birth More than 6 months after giving birth	• If her monthly bleeding has not returned, she can start POPs any time between giving birth and 6 months. No need for a backup method. • If her monthly bleeding has returned, she can start POPs as advised for women having menstrual cycles. • If her monthly bleeding has not returned, she can start POPs any time it is reasonably certain she is not pregnant. She will need a backup method* for the first 2 days of taking pills. (If you cannot be reasonably certain, see How and When to Use the Pregnancy Checklist and Pregnancy Tests on page 33). • If her monthly bleeding has returned, she can start POPs as advised for women having menstrual cycles
Partially breastfeeding If her monthly bleeding has not returned If her monthly bleeding has returned	• She can start POPs any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking pills. (If you cannot be reasonably certain, see How and When to Use the Pregnancy Checklist and Pregnancy Tests on page 34). • She can start POPs as advised for women having menstrual cycles.
Switching from a hormonal method	• She can start POPs at any time. No need for a backup method. • If her monthly bleeding has not returned, she can start POPs any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking pills. • If her monthly bleeding has returned, she can start POPs as advised for women having menstrual cycles
Having menstrual cycles or switching from a nonhormonal method Any time of the month	• If she is starting within 5 days after the start of her monthly bleeding, no need for a backup method. • If it is more than 5 days after the start of her monthly bleeding, she can start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking pills.

If she is switching from an IUD	• She can start POPs immediately (see Copper-Bearing IUD, Switching from an IUD to Another Method, p. 162)
No monthly bleeding (not related to childbirth or breastfeeding)	• She can start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking pills.
After miscarriage or abortion	• Immediately. If she is starting within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method. • If it is more than 7 days after first- or second- trimester miscarriage or abortion, she can start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 2 days of taking pills
After taking emergency contraceptive pills (ECPs) After taking progestin-only or combined ECPs	• She can start or restart POPs immediately after she takes the ECPs. No need to wait for her next monthly bleeding. — A continuing user who needed ECPs due to pill-taking errors can continue where she left off with her current pack. • If she does not start immediately but returns for POPs, she can start at any time if it is reasonably certain she is not pregnant. • All women will need to use a backup method for the first 2 days of taking pills.

Avoid Unnecessary Procedures

Women can begin using POPs:

- Without a pelvic examination
- Without any blood tests or other routine laboratory tests
- Without cervical cancer screening
- Without a breast examination
- Without a pregnancy test. A woman can begin using POPs at any time, even when she is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant.

Explaining how to use the POP

1. How many POPs to give?	• Give as many packs as possible – even as much as a year's supply (13 packs of 28 pills each). This is ideal but dependent on the number of clients and availability of pill supply in health facility

2. Explain pill pack	• Show which kind of pack—28 pills or 35 pills. • Explain that all pills in POP packs are the same color, and all are active pills containing a hormone that prevents pregnancy. • Show how to take the first pill from the pack and then how to follow the directions or arrows on the pack to take the rest of the pills.
3. Give key instruction	• Take one pill each day—until the pack is empty. • Women who are not breastfeeding should take a pill at the same time each day. Taking a pill more than 3 hours late for Lynestrenol pills or 12 hours for desogestrel pills makes it less effective. • Discuss cues for taking a pill every day. Linking pill-taking to a daily activity—such as cleaning her teeth—may help her remember.
4. Explain starting next pack	• When she finishes one pack, she should take the first pill from the next pack on the very next day. • It is very important to start the next pack on time. Starting a pack late risks pregnancy.
5. Provide backup method and explain use	• Sometimes she may need to use a backup method, such as when she misses pills or is late taking a pill. • Backup methods include abstinence, male or female condoms, spermicides, and withdrawal. • Tell her that spermicides and withdrawal are the least effective contraceptive methods. Give her condoms, if possible.
6. Explain that effectiveness decreases when breastfeeding stops	• Without the additional protection of breastfeeding itself, POPs are not as effective as most other hormonal methods. • When she stops breastfeeding, she can continue taking POPs if she is satisfied with the method, or she is welcome to come back for another method.

SUPPORT TO CONTINUING USERS

Giving Advice on Side Effects

IMPORTANT: Thorough counseling about bleeding changes and other side effects is an important part of providing the method. Counseling about bleeding changes may be the most important to help a woman to keep using the method without concern.

Describe the most common side effects

- Breastfeeding women normally do not have monthly bleeding for several months after giving birth. POPs lengthen this period of time.
- Women who are not breastfeeding may have frequent or irregular bleeding for the first several months, followed by regular bleeding or continued irregular bleeding.
- Headaches, dizziness, breast tenderness, and possibly other side effects.

Explain about these side effects

- Side effects are not signs of illness.
- Lack of bleeding does not mean pregnancy.
- Usually become less or stop within the first few months of using POPs.
- Bleeding changes, however, usually persist.
- Common, but some women do not have them.

Explain what to do in case of side effects

- Keep taking POPs. Skipping pills risks pregnancy.
- Try taking pills with food or at bedtime to help avoid nausea.
- The client can come back for help if side effects bother her or if she has other concerns.

Managing Missed Pills

- Remember to emphasize the importance of not forgetting any pill, even for just a few hours.
- Advice the client that if she missed one or more pills, she may have spotting or breakthrough bleeding, and her risk of becoming pregnant increases.
- The client needs to resume taking the pills as soon as possible.
- If the client missed taking a lynestrenol-containing POP by more than three hours or a desogestrel-containing POP by more than 12 hours, she must abstain from sexual intercourse or use a barrier method of contraception during the first 48 hours after restarting the pills.
- If the client is breastfeeding and amenorrheic and missed one or more pills by more than three hours, she must take one pill as soon as possible and continue to take the pills as usual. If more than six months postpartum, use a backup method for the next two days.
- Remind the client to keep track of her periods while taking POP. If she fails to have her menses for more than 45 days, she should see her health care provider for an examination and a pregnancy test.
- If the client experiences spotting or bleeding between periods, she should continue taking the pills on schedule. If bleeding is very heavy or is accompanied by pain, fever, or cramps, she should return to the clinic.
- In most cases, the bleeding is not serious and will stop in a few days. Bleeding is especially likely if she missed a pill. Bleeding is common in the first few months of taking pills.

Role of Partner

The client's partner is welcome to participate in counseling and learn about the method and what support he can give to his partner. A male partner can:

- Support a woman's choice of POPs
- Help her to remember to take a pill at about the same time each day
- Show understanding and support if she has side effects
- Help her to make sure that she has a new pill pack on hand to start on time
- Help to make sure she has ECPs on hand in case she misses pills or starts a new pill pack late
- Use condoms consistently in addition to POPs if he has an STI/HIV or thinks he may be at risk of an STI/HIV

Need for Informed Consent Form

Clients do not need to have a consent form from her partner to be able to take POPs except for adolescents who need parental consent.

When do clients stop using POP and need to see a service provider?

Serious complications are rare with POPs. However, the client must return to the clinic if she has any questions or if any of the following arises (may or may not be caused by POPs):

- Prolonged and/or heavy bleeding (twice as long or more than usual for the client)
- Headaches that start or worsen after starting POPs
- Yellowish discoloration of the skin
- Symptoms of pregnancy (i.e., missed period after several regular cycles), especially if she has signs of ectopic pregnancy, including abdominal pain or tenderness and faintness.

Clients who could NOT comply with the strict schedule and keep on missing the POPs even for 3 hours are counselled about the risk of getting pregnant and have to choose another method and stop taking POP.

Key Points for Providers and Clients using Progestin-Only Pills

- **Take one pill every day.** No breaks between packs.
- **Safe for breastfeeding women and their babies.** Progestin-only pills do not affect milk production.
- **Add to the contraceptive effect of breastfeeding.** Together, they provide effective pregnancy protection.
- **Bleeding changes are common but not harmful.**
- Typically, pills lengthen how long breastfeeding women have no monthly bleeding. For women having monthly bleeding, frequent or irregular bleeding is common.
- **Can be given to a woman at any time to start now or later.**

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

Progestin-Only Injectables

INTRODUCTION

Progestin-Only Injectables (POIs) contain the synthetic hormone progestin and are administered via deep intramuscular (IM) or subcutaneous injection.

Two of these contraceptives are available in the Philippines in the following preparations:

- 1 mL of 150 mg depot medroxyprogesterone acetate (DMPA; Depo-Provera)
- 3 mL of 150 mg DMPA (Depo-Trust)
- 1 mL ampoule of 200 mg norethisterone enanthate (NET-EN; Noristerat)

The above DMPA preparations are given every three months, whereas NET-EN is given every two months.

Another preparation is DMPA-SC (Uniject), which contains only 104 mg of progestin (30% less than that in the regular DMPA). This preparation is given subcutaneously every three months and has similar contraceptive effectiveness but with fewer side effects, such as weight gain.

Note: This is registered in the Philippines and has has high potential for community-based distribution and self-injection by trained clients, specially in hard-to-reach areas.

Are POIs safe to use?

- POIs are very safe. Similar to other progestin-only contraceptives, POIs can be used by women who want a highly effective contraceptive, including those who are breastfeeding or who are not eligible to use estrogen-containing low dose combined oral contraceptives (COCs).
- There is no known harm to the fetus if DMPA is given during pregnancy.
- Extensive studies by the WHO emphasize that DMPA presents no overall risks for cancer, congenital malformations, or infertility.
- Research has revealed the following:
  - Similar to COCs, DMPA exerts a strong protective effect against endometrial cancer.
  - The use of DMPA does not increase the risk of breast cancer.
  - No relationships exist between ovarian cancer and the use of DMPA.
  - DMPA does not increase the risk of liver cancer in areas where hepatitis is endemic.

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Medical Eligibility Criteria for POIs

Ask the client the questions below about known medical conditions. Examinations and tests are not necessary. If she answers "no" to all the questions, then she can start POIs if she wants. If she answers "yes" to a question, follow the instructions. In some cases, she can still start POIs.

1. Are you breastfeeding a baby less than 6 months old?

❑ NO ❑ YES — She can start using progestin-only injectables as soon as 6 weeks after childbirth.

2. Do you have severe cirrhosis of the liver or severe liver tumor?

❑ NO ❑ YES — If she reports severe cirrhosis or severe liver tumor, such as liver cancer, do not provide POIs. Help her choose a method without hormones.

3. Do you have high blood pressure?

❑ NO ❑ YES — Check her blood pressure if possible:

- If she is currently being treated for high blood pressure and it is adequately controlled, or her blood pressure is below 160/100 mm Hg, provide POIs.
- If systolic blood pressure is 160 mm Hg or higher or diastolic blood pressure is100 or higher, do not provide POIs. Help her choose another method, one without estrogen.
- If she reports having high blood pressure in the past, and you cannot check blood pressure, provide POIs.

4. Have you had diabetes for more than 20 years or damage to your arteries, vision, kidneys, or nervous system caused by diabetes?

❑ NO ❑ YES — Do not provide POIs. Help her choose another method, one without estrogen.

5. Have you ever had a stroke, blood clot in your leg or lungs, heart attack, or other serious heart problems?

❑ NO ❑ YES — If she reports heart attack, heart disease due to blocked or narrowed arteries, or stroke, do not provide POIs. Help her choose another method, one without estrogen. If she reports a current blood clot in legs (affecting deep veins, not superficial veins) or in a lung and she is not on anticoagulant therapy, help her choose a method without hormones.

6. Are you having vaginal bleeding that is unusual for you?

❑ NO ❑ YES — If she has unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition, POIs could make diagnosis and monitoring of any treatment more difficult. Help her choose

another method to use while being evaluated and treated (but not implants or a copper-bearing or hormonal IUD). After treatment, re-evaluate for use of POIs.

7. Do you have or have you ever had breast cancer?

❑ NO ❑ YES — Do not provide POIs. Help her choose a method without hormones.

8. Do you have several conditions that could increase your chances of heart disease (coronary artery disease) or stroke, such as high blood pressure and diabetes?

❑ NO ❑ YES — Do not provide POIs. Help her choose another method, one without estrogen.

Also, women should not use progestin-only injectables if they report having lupus with positive (or unknown) antiphospholipid antibodies and not on immunosuppressive treatment or severe thrombocytopenia. For complete classifications, see **Medical Eligibility Criteria for Contraceptive Use, Appendix B.**

Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.

Who cannot use POIs

According to the WHO MEC, clients with the following characteristics and conditions cannot use the method:

Category 3: Do not use the method unless no other appropriate methods are available or acceptable, use with close supervision

- Breastfeeding women, less than six weeks after childbirth
- Multiple risk factors for arterial cardiovascular disease such as old age, smoking, diabetes, and hypertension
- Have high blood pressure (systolic of more than or equal to 160 mm Hg or diastolic of more than or equal to 100 mm Hg)
- Hypertension with vascular disease
- Acute DVT/PE
- Current or history of ischemic heart disease or stroke
- History of breast cancer with no evidence of disease in the last five years
- Unexplained vaginal bleeding prior to evaluation
- Initiation of method in women with systemic lupus erythematosus (with positive antiphospholipid antibodies and severe thrombocytopenia)
- Diabetes with nephropathy, retinopathy, neuropathy, or other vascular diseases
- Severe liver cirrhosis
- Liver tumors such as hepatocellular adenoma or malignant hepatoma

Category 4: Do NOT use the method.

- Diagnosed with breast cancer

MECHANISM OF ACTION

POIs suppress ovulation. After a 150 mg injection of DMPA, ovulation does not occur for at least 14 weeks. Levels of the follicle stimulating hormone (FSH) and luteinizing hormone (LH) are reduced, and an LH surge does not occur with POIs.

Thicken the cervical mucus and impair the entry of sperm into the uterus.

EFFECTIVITY

POIs are 99.7% effective with perfect use and 97.0% effective with typical use, which means about three pregnancies for every 100 women who use the method during the first year. This number is reduced to less than one pregnancy per 100 users with continued use.
The effectiveness of injectables depends on whether the client returns on time for the re-injection. The risk of pregnancy increases when the interval between injections increases or when an injection is missed.

ADVANTAGES AND DISADVANTAGES

Advantages of POIs

- Long acting and reversible
- No need for daily intake
- Does not interfere with sexual intercourse
- Perceived as culturally acceptable by some women
- May be self-administered and may not always be facility/clinic-based
- Involves neither estrogen-related side effects, such as nausea and dizziness, nor serious complications, such as thrombophlebitis or pulmonary embolism
- Does not affect the quantity and quality of breast milk
- Provides beneficial non-contraceptive effects
- Helps prevent iron-deficiency anemia because of scanty menses and the consequent amenorrhea
- Does not affect anti-epileptic drug levels, particularly lamotrigine
- Reduces the risk of ectopic pregnancies
- Prevents endometrial cancer, uterine fibroids, and symptomatic pelvic inflammatory disease
- Reduces sickle cell crises among women with sickle cell anemia
- Reduces symptoms of endometriosis (pelvic pain and irregular bleeding)

Disadvantages of POIs

- Delayed return to fertility by an average of 10 months from the last injection
- Requires an injection every two or three months
- Does not protect against STIs such as HIV/AIDS
- Results in menstrual irregularity during the first few months of use
- Amenorrhea, which causes some women to become anxious about not having menses
- Impossible to discontinue immediately (only until DMPA or NET-EN is cleared from the body)
- Possible bone loss for long-term users, although a study has shown potential reversibility

RETURN TO FERTILITY

Women who stop using DMPA wait about 4 months longer on average to become pregnant than women who have used other methods. This means they become pregnant 10 months on average after their last injection. Women who stop using NET-EN wait about one month longer on average to become pregnant than women who have used other methods, or 6 months after their last injection. These are averages. A woman should not be worried if she has not become pregnant even as much as 12 months after stopping use. The length of time a woman has used injectables makes no difference to how quickly she becomes pregnant once she stops having injections.

After stopping POIs, a woman may ovulate before her monthly bleeding returns—and thus can become pregnant. If she wants to continue avoiding pregnancy, she should start another method before monthly bleeding returns.

SIDE-EFFECTS AND ADVERSE REACTION

The following changes in menstrual bleeding patterns are possible:

- Amenorrhea
- Menstrual irregularity: breakthrough bleeding and spotting, which are common
- On very rare occasions, allergic reactions occur immediately following an injection.

DISPELLING MYTHS AND MISCONCEPTIONS

Progestin-only injectables:

- Can stop monthly bleeding, but this is not harmful and could help prevent anemia. It is similar to not having monthly bleeding during pregnancy.
- Blood is not building up inside the woman. Effectiveness is high regardless of the bleeding pattern.
- Do not disrupt an existing pregnancy.
- Do not make women infertile.

HOW TO PROVIDE THE METHOD

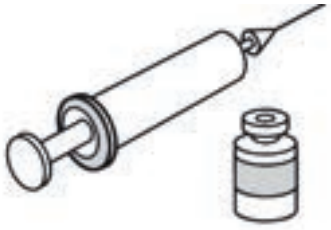
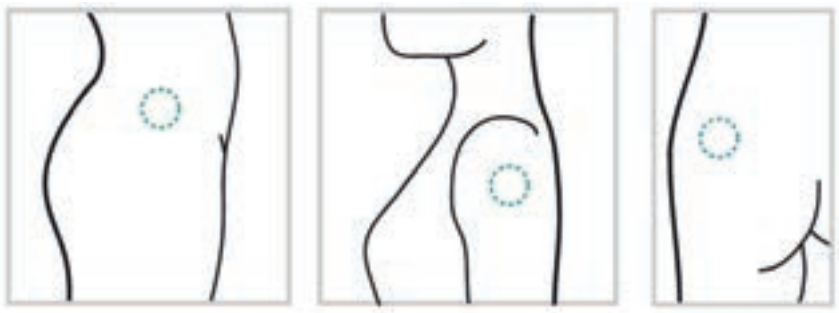
When to Start the POI

IMPORTANT: A woman can start injectables any time she wants if it is reasonably certain she is not pregnant. To be reasonably certain she is not pregnant, use the Pregnancy Checklist on page 50.

WOMAN'S SITUATION	WHEN TO START
Having menstrual cycles or switching from a nonhormonal method	**Any time of the month** • If she is starting within 7 days after the start of her monthly bleeding, no need for a backup method. • If it is more than 7 days after the start of her monthly bleeding, she can start injectables any time if it is reasonably certain she is not pregnant. • She will need a backup method* for the first 7 days after the injection. • If she is switching from an IUD, she can start injectables immediately (see Copper-Bearing IUD, Switching from an IUD to Another Method, p.162).
Switching from a hormonal method	• Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. • If she is switching from another injectable, she can have the new injectable when the repeat injection would have been given. No need for a backup method.
Fully or nearly fully breastfeeding Less than 6 months after giving birth	• If she gave birth less than 6 weeks ago, delay her first injection until at least 6 weeks after giving birth. • If her monthly bleeding has not returned, she can start injectables any time between 6 weeks and 6 months. No need for a backup method. • If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles (see previous page).
More than 6 months after giving birth	• If her monthly bleeding has not returned, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.

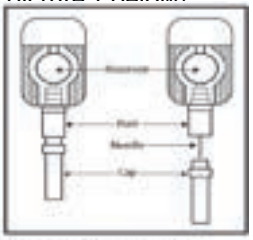
	• If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles (see previous page).
Partially breastfeeding Less than 6 weeks after giving birth	• Delay her first injection until at least 6 weeks after giving birth.
More than 6 weeks after giving birth	• If her monthly bleeding has not returned, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection. • If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles.
Not breastfeeding Less than 4 weeks after giving birth	• She can start injectables at any time. No need for a backup method.
More than 4 weeks after giving birth	• If her monthly bleeding has not returned, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection. • If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles
No monthly bleeding (not related to childbirth or breastfeeding)	• She can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.
After miscarriage or abortion	• Immediately. If she is starting within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method. • If it is more than 7 days after first- or second- trimester miscarriage or abortion, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.

Giving Intramuscular Injection with a Conventional Syringe

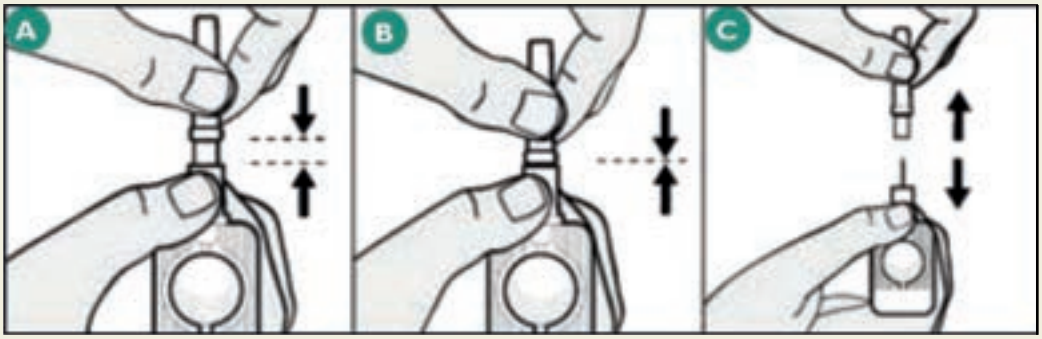
1. Obtain one dose of injectable, needle, and syringe 	• DMPA: 150 mg for injections into the muscle (intramuscular l injection). NET-EN: 200 mg for injections into the muscle. • For each injection, use a prefilled single-use syringe and needle from a new, sealed package (within expiration date and not damaged), if available. • If a single-dose prefilled syringe is not available, use single-dose vials. Check the expiration date. If using an open multidose vial, check that the vial is not leaking. • DMPA: A 2 ml syringe and a gauge 21–23 intramuscular needle. • NET-EN: A 2 or 5 ml syringe and a gauge 19 intramuscular needle. A narrower needle (21–23 gauge) also can be used
2. Wash Hands	• Wash hands with soap and water, if possible. Let your hands dry in the air. • If the injection site is dirty, wash it with soap and water. • No need to wipe the site with antiseptic.
If using a prefilled syringe, skip to step 5.	
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
4. Fill syringe	• Pierce top of the vial with a sterile needle and fill the syringe with proper dose.
5. Inject formula	• Insert sterile needle deep into the hip (ventrogluteal muscle), the upper arm (deltoid muscle), or the buttocks (gluteal muscle, upper outer portion), whichever the woman prefers. Inject the contents of the syringe. • Do not massage the injection site.
	

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 reuse disposable syringes and needles. They are meant to be destroyed after a single use. • Because of their shape, they are very difficult to disinfect. • Therefore, reusing disposable needles and syringes might transmit diseases such as HIV and hepatitis. • If reusable syringes and needles are used, they must be sterilized again after each use.

Giving the Injection with Subcutaneous DMPA in Uniject (Sayana Press)

1. Gather the supplies	Supplies include: • Uniject prefilled injection device at room temperature that has not passed its expiration date • Soap and clean water • Cotton swabs or cotton balls, if available • Safe puncture-proof container for sharps disposal
2. Wash Hands	Wash hands with soap and water, if possible. • Let your hands dry in the air. • If the injection site is dirty, wash it with soap and water. • No need to wipe site with antiseptic.
3. Ask where the client wants the injection	You can give the injection just under the skin: • in the back of the upper arm • in the abdomen (but not at the navel) • on the front of the thigh
4. Open the pouch	• Open the foil pouch and remove the device
5. Mix the solution	• Hold the device by the port (see picture 1 below) • Shake it hard for 30 seconds. • Check that the solution is mixed (granules distributed throughout the solution) and there is no damage or leaking.  Parts of Uniject device

6. Close the gap	• Hold the device by the port. • Take care not to squeeze the reservoir during this step. • Hold the device with the needle pointed upward to avoid spilling the drug. • Push the cap into the port (see part A of picture 2, below). • Continue to push firmly until the gap between the cap and port is closed (see part B of picture 2, below). • Take off the cap (see part C of picture 2, below).



Close the gap and take off the cap.

7. Give the injection  Pinch the skin and inject	• Gently pinch the skin at the injection site (see picture 3). This helps to make sure that the drug is injected into fatty tissue just under the skin and not into muscle. • Hold the port. Gently push the needle straight into the skin with the needle pointing down (never upward) until the port touches the skin. • Squeeze the reservoir slowly. Take 5 to 7 seconds. • Pull out the needle and then release the skin. • Do not clean or massage the site after injecting
8. Discard the used device	• Do not replace the cap. • Place the device in a safety box.
SUPPORTING THE USER	
Give specific instructions	• Tell her not to massage the injection site. • Tell the client the name of the injection. • Agree on a date for her next injection and give her a paper with the date written on it.

Self-Injection with Subcutaneous DMPA Can Be an Option

Women can learn to inject themselves with the DMPA-SC. Some women like self-injection better than injections by health workers. Self-injection may save women time and money. WHO recommends making self-administration of injectable contraception available as an additional approach to deliver injectable contraception to women of reproductive age.

Teaching Clients to Self-Inject

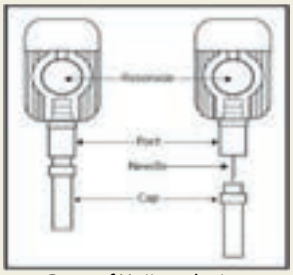
1. Discuss the plan for storage and disposal
   - To safely store the devices for an extended period, the client should place them out of reach of children and animals and maintain them at moderate temperatures, avoiding exposure to direct sunlight or refrigeration.
   - For disposal, it is recommended that the client use a container with a secure lid that cannot be punctured and ensure it is stored away from children, promoting safety and responsible disposal practices.
2. Explain and show the client how to self-inject. See the instructions below.

1. Choose the correct injection site

1. Where to give yourself the injection

   Choose either: the belly or front of the thigh

2. Hold the device and mix the solution



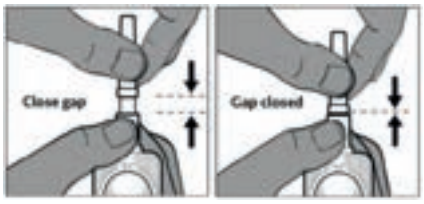
Parts of Uniject device

- After washing hands, open the pouch and take out the injection device.
- Hold the device by the port (not the cap) and shake it hard for about 30 seconds. Make sure the solution is completely mixed.

2. Mix the solution

3. Push the cap and the port together to close the gap

- Point the needle upward.
- Hold the cap with one hand and the port with the other hand.
- Press cap down firmly until the gap is closed.



3. Close the gap

4. Pinch your skin into a "tent"	• Take the cap off the needle. Hold the device by the port. • With the other hand pinch about 4 cm (1 ½ inches) of skin.
5. Put the needle into the skin, and squeeze the reservoir slowly	• Press the needle straight into the skin with the needle pointing downward. • Press the needle in until the port touches the skin completely. • Squeeze the reservoir slowly, for 5-7 seconds.  4. Pinch the skin. 5. Press the needle.
6. Dispose of the needle safely	• Pull the needle out and then let go of the skin. • Put the device in a disposal container that can be closed and cannot be punctured.
7. For your next injection	• Mark a calendar or other reminder for the same day of the month, 3 months from today. • You can give yourself the next injection as early as 2 weeks before that date or as late as 4 weeks after. • If more than 4 weeks late, use another contraceptive method and see a health provider. • Make sure you have another device for the next injection and that it will not expire before then.

3. Ask the client to try it.
4. Ask the woman to inject herself while you are watching.
5. Tell the client where to get more injection devices.

SUPPORT FOR CONTINUING USERS

Repeat Injection Visits

1. Ask how the client is doing with the method and whether she is satisfied. Ask if she has any questions or anything to discuss.

2. Ask especially if she is concerned about bleeding changes. Give her any information or help that she needs.
3. Give her the injection. Injection of DMPA can be given up to 4 weeks late. Injection of NET-EN can be given up to 2 weeks late.
4. Plan for her next injection. Agree on a date for her next injection (in 3 months or 13 weeks for DMPA, 2 months for NET-EN). Remind her that she should try to come on time, but she should come back no matter how late she is.
5. Every year or so, check her blood pressure if possible **(see Medical Eligibility Criteria, Appendix B)**.
6. Ask a long-term client if she has had any new health problems. Address problems as appropriate. New health problems that may require switching methods.
7. Ask a long-term client about major life changes that may affect her needs.

Managing Late Injections

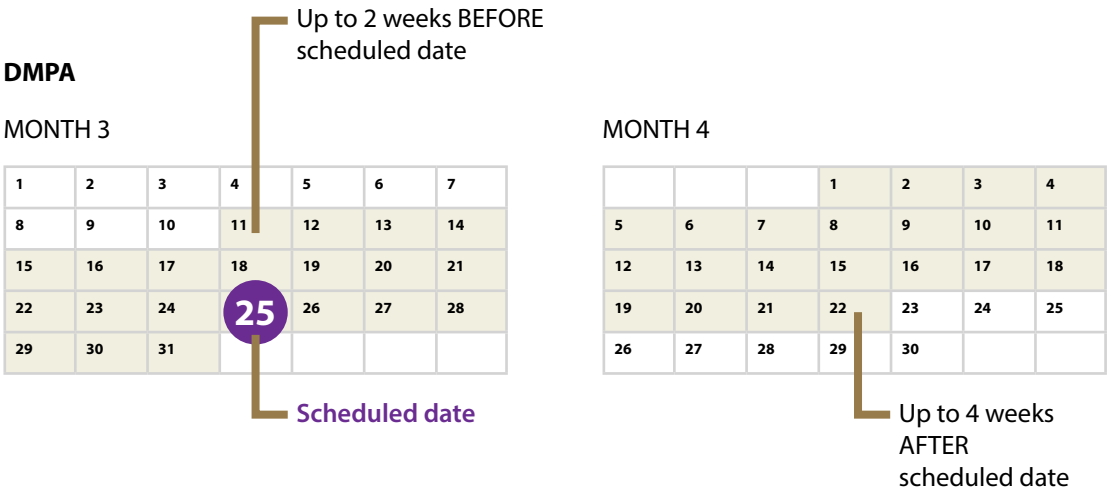
- If the client is less than 4 weeks late for a repeat injection of DMPA or less than 2 weeks late for a repeat injection of NET-EN, she can receive her next injection. No need for tests, evaluation, or a backup method.
- A client who is more than 4 weeks late for DMPA or more than 2 weeks late for NET-EN can receive her next injection if:
  - She has not had sex since 2 weeks after the scheduled date of her injection, or
  - She has used a backup method or has taken emergency contraceptive pills (ECPs) after any unprotected sex since 2 weeks after the scheduled date of her injection, or
  - She is fully or nearly fully breastfeeding and she gave birth less than 6 months ago.
- She will need a backup method for the first 7 days after the injection.
- If the client is more than 4 weeks late for DMPA or more than 2 weeks late for NET-EN and she does not meet these criteria, additional steps can be taken to be reasonably certain she is not pregnant. Follow up as needed.

Support by the Partner

The client's partner is welcome to participate in counseling and learn about the method and what support he can give to his partner. A male partner can:

- Support a woman's choice of a POI
- Show understanding and support if she has side effects
- Help her to remember to get her next injection on time
- Help to make sure she has ECPs on hand in case she is late for an injection by more than 4 weeks for DMPA or more than 2 weeks for NET-EN
- Use condoms consistently in addition to the POI if he has an STI/HIV or thinks he may be at risk of an STI/HIV

When a Woman Can Have Her Next Injection of DMPA or NET-EN



Giving Advice on Side Effects

IMPORTANT: Thorough counseling about bleeding changes and other side effects must come before giving the injection. Counseling about bleeding changes may be the most important help a woman needs to keep using the method without concern

Describe the most common side effects	• For the first several months, irregular bleeding, prolonged bleeding, frequent bleeding. Later, no monthly bleeding. • Weight gain (about 1–2 kg per year), headaches, dizziness, and possibly other side effects.
Explain these side effects	• Side effects are not signs of illness. • Common, but some women do not have them. • The client can come back for help if side effects bother her.

Managing Problems Reported as Side Effects

Note: May or may not be due to the method.

- Problems with side effects affect women's satisfaction and use of injectables. They deserve the provider's attention. If the client reports side effects, listen to her concerns, give her advice and support, and, if appropriate, treat. Make sure she understands the advice and agrees.
- Offer to help the client choose another method, if she wishes, or if problems cannot be overcome.

No monthly bleeding

- Reassure her that most women using POIs stop having monthly bleeding over time, and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not infertile. Blood is not building up inside her. (Some women are happy to be free from monthly bleeding.)
- If not having monthly bleeding bothers her, she may want to switch to monthly injectables, if available.

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

- Reassure her that many women using POIs experience irregular bleeding. It is not harmful and usually becomes less or stops after the first few months of use.
- For modest short-term relief, she can take 500 mg mefenamic acid 2 times daily after meals for 5 days or 40 mg of valdecoxib daily for 5 days, beginning when irregular bleeding starts.
- If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.

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

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

Ordinary headaches (non-migrainous)

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

Mood changes or changes in sex drive

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

Dizziness

- Consider locally available remedies

Weight gain

- Review diet and counsel as needed.

Abdominal bloating and discomfort

- Consider locally available remedies.

New Problems that may Require Switching Methods

Note: May or may not be due to the method.

Migraine headaches (see Identifying Migraine Headaches and Auras, Appendix G)

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

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

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

Certain serious health conditions (suspected blocked or narrowed arteries, serious liver disease, severe high blood pressure, blood clots in deep veins of legs or lungs, stroke, breast cancer, or damage to arteries, vision, kidneys, or nervous system caused by diabetes).

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

Suspected Pregnancy

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

Delivering Contraceptives in the Community

Injectable contraceptives are popular with many women. This method can be more widely available when it is offered in the community as well as in clinics. In 2012, WHO noted that using lay health workers to give injectable contraceptives may increase access to injectables and does not appear to raise safety concerns. WHO suggested that provision of injectables could be added to well-functioning programs that employ lay health workers.

These recommendations are part of a global movement known as task-sharing—empowering more types of health care workers to provide various health services (see Appendix G on Task Sharing). The goal of task-sharing is to serve more people, especially where there are few highly trained health care providers. Lay health workers, auxiliary nurses, and other community-based providers of injectables should be trained and able to give injections safely. Also, they should be able to screen clients for pregnancy and for medical eligibility. They can inform women about the delayed return of fertility and common side effects, including irregular bleeding, no monthly bleeding, and weight gain, and explain the importance of dual protection if a woman is at risk for sexually transmitted infections, including HIV. They also can inform women about the range of methods available, including methods available at the clinic.

All providers of injectables need specific competency-based training and supportive supervision to carry out these tasks. WHO recommends specific monitoring and evaluation of the provision of injectables by lay health workers.

Prefilled syringes aid community-based programs

Prefilled single-dose, single-use injection devices make community and home delivery easier because providers do not have to draw a measured dose into the syringe from a vial. Also, these devices cannot be reused. DMPA is available in a number of prefilled single-dose injection systems. The older formulation for intramuscular injection (DMPAIM) is available in auto-disable syringes.

The newer subcutaneous formulation (DMPA-SC), which is suitable only for injection just under the skin, comes in the Uniject injection system under the brand name Sayana Press and in single-use conventional syringes (see DMPA for Subcutaneous Injection, page 102). The new subcutaneous formulation, particularly in the Uniject system, is likely to make delivery

of DMPA injections in the community and the home easier. In fact, women can learn to inject themselves with this formulation.

Working together, in communities and clinics

For success, clinic-based providers and community-based providers need to work together closely. Programs vary, but these are some ways that clinic-based providers can support community-based providers:

- Managing side effects
- Using clinical judgment concerning medical eligibility in special cases
- Ruling out pregnancy in women who are more than 4 weeks late for an injection of DMPA or 2 weeks late for NET-EN (see Managing Late Injections in the next page)
- Responding to concerns of clients referred by the community-based providers

The clinic also can serve as "home" for the community-based providers, where they go for resupply, for supervision, training, and advice, and to turn in their records.

Key Points for Providers and Clients using Progestin-Only Injectables

Bleeding changes are common but not harmful. Typically, irregular bleeding for the first several months and then no monthly bleeding.

Return for injections regularly. Coming back every 3 months (13 weeks) for DMPA or every 2 months for NET-EN is important for greatest effectiveness.

Injection can be as much as 4 weeks late for DMPA or 2 weeks late for NET-EN. Even if later, she may still be able to have the injection.

Gradual weight gain is common, averaging 1–2 kg per year.

Return of fertility is often delayed. It takes several months longer on average to become pregnant after stopping progestin- only injectables than after stopping other methods.

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

Subdermal Implants

INTRODUCTION

Subdermal implants are small plastic rods, each about the size of a matchstick, that release a progestin like the natural hormone progesterone in a woman's body.

A specifically trained provider performs a minor surgical procedure under local anesthesia to place one or 2 rods under the skin on the inside of a woman's upper arm.

Implants do not contain estrogen, and so they can be used throughout breastfeeding and by women who cannot use methods with estrogen. Up to 3 years of use (for the 1 rod and 4 to 5 years for 2 rods implants. Recent study shows it may be highly effective for 5 years).

Types of Implants

Implanon NXT (Nexplanon): a 1 rod containing Etonogestrel, that replaces Implanon Classic. Implanon NXT this implant is 40 mm long with a 2 mm diameter and contains 68 mg of Etonogestrel. Labeled for 3 years. It also contains barium sulfate that makes it visible on x-ray.

Source: MSD Drug Sheet, 2012

Jadelle: is a 2 rods implant containing 75 mg of levonorgestrel each, is effective for up to five years. This implant is 43 mm long, with each rod consisting of a drug-releasing core, highly effective for 5 years. The trocar used for inserting the rods is made of metal.

Source: Reference Manual, Providing Implants; 2014 Jhpiego Corporation

Levoplant (Sino-Implant (II), 2 rods with 75 mg of levonorgestrel each effective for four years. This implant is 43 mm long, with each rod consisting of a drug-releasing core. The trocar used for inserting the rods is made of plastic.

Source: Levoplant Training Manual, DKT-Woman Care Global 2020

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Who can use Implants

Conditions under MEC 1 and MEC 2

- Safe and Suitable for Nearly All Women
- Nearly all women can use implants safely and effectively, including women who:
  - — Have or have not had children
  - — Are married or are not married
  - — Are of any age, including adolescents and women over 40 years old
  - — Have just had an abortion, miscarriage, or ectopic pregnancy
  - — Smoke cigarettes, regardless of woman's age or number of cigarettes smoked
  - — Are breastfeeding
  - — Have anemia now or in the past
  - — Have varicose veins
  - — Are living with HIV, whether or not on antiretroviral therapy (see Implants for Women with HIV). Use of condom is advisable.
  - — Breastfeeding women, less than 6 weeks after childbirth

Contraindication to its use

Conditions classified as MEC 3 and MEC 4

- Pregnancy
- Acute DVT/PE
- Continued use in women with current or history of ischemic heart disease or stroke
- Systemic lupus erythematosus with positive antiphospholipid antibodies
- Unexplained vaginal bleeding prior to evaluation
- History of breast cancer with no evidence of disease in the last 5 years
- Severe liver cirrhosis
- Liver tumors such as hepatocellular adenoma or malignant hepatoma
- Breast Cancer

MECHANISM OF ACTION

Implants prevents pregnancy by

- Thickening cervical mucus within 24-48 hours (this blocks sperm from reaching an egg)
- Preventing the release of eggs from the ovaries (ovulation)

EFFECTIVENESS

Implants are very effective. It prevents pregnancy in 99.9% of users. For heavier women, the effectiveness of Implanon NXT, Jadelle and Levoplant may decrease near the end of the duration of use stated on the label. These users may want to replace their implants sooner by one year.

ADVANTAGES AND DISADVANTAGES

Advantages of Subdermal Implants

- Reversible, as fertility returns almost immediately after the rods are removed
- Does not require daily intake
- Does not interfere with intercourse
- Effective within 24 hours after insertion
- No estrogen-related side effects, such as nausea and dizziness
- Does not affect the quantity and quality of breast milk
- Has beneficial non-contraceptive effects:
  - Helps prevent iron-deficiency anemia
  - Makes sickle cell crises less frequent and less painful
  - Helps reduce risk of endometrial cancer
  - Reduces risk of ectopic pregnancies

Disadvantages of Subdermal Implants

- Clients cannot start or stop use on their own. Rods must be inserted and
- removed by a specially trained health care provider.
- Minor surgical procedure with local anesthesia is required to insert and to remove rods.
- Discomfort at the insertion site is common up to several days after insertion.
- Rods must be removed after a certain period.
- Initial cost is high.
- In very rare instances when pregnancy occurs, as many as one in every six pregnancies is ectopic.
- No protection is provided against STIs such as HIV/AIDS.
- Implants are more difficult to remove than to insert.

RETURN TO FERTILITY

Immediate return to fertility, no delay after the implants are removed:

Protection against sexually transmitted infections (STIs)

None

SIDE EFFECTS AND ADVERSE REACTIONS

Side Effects

- Changes in bleeding patterns including:
  - First several months to a year:
    - Lighter bleeding and fewer days of bleeding
    - Prolonged bleeding
    - Irregular bleeding
    - Infrequent bleeding
    - No monthly bleeding
  - After about one year:
    - Lighter bleeding and fewer days of bleeding
    - Irregular bleeding
    - Infrequent bleeding
    - No monthly bleeding
    - Users of Implanon and Implanon NXT are more likely to have infrequent bleeding, prolonged bleeding, or no monthly bleeding than irregular bleeding.
    - Headaches
    - Abdominal pain
    - Acne (can improve or worsen)
    - Weight change

- Breast tenderness
- Dizziness
- Mood changes
- Nausea
- Other possible physical changes: Enlarged ovarian follicles

Adverse Reactions/ Complications: uncommon

- Infection at insertion site (most infections occur within the first 2 months after insertion)
- Difficult removal (rare if properly inserted and the provider is skilled at removal)
- Rare: Expulsion of implant (expulsions most often occur within the first 4 months after insertion)
- Extremely rare: There are a few reports of implants found in another place in the body due to improper insertion, for example, in a blood vessel.

DISPELLING MYTHS AND MISCONCEPTIONS

Implants:

- Do not work once they are removed.Their hormones do not remain in a woman's body.
- Do not cause any harm if they stop monthly bleeding. This is similar to not having monthly bleeding during pregnancy. Blood is not building up inside the woman.
- Do not make women infertile.
- Do not increase the risk of ectopic pregnancy

NON- CONTRACEPTIVE HEALTH BENEFIT

- Help protect against:
  - Risks of ectopic pregnancy
  - Symptomatic pelvic inflammatory disease
- May help protect against:
  - Iron-deficiency anemia

HOW TO PROVIDE THE METHOD

WHEN TO START USE OF SUBDERMAL IMPLANT

IMPORTANT: A woman can start using implants any time she wants, if it is reasonably certain she is not pregnant. To be reasonably certain she is not pregnant, use the Pregnancy Checklist on page 50. No tests or examinations are necessary before starting implants, although blood pressure measurement is desirable.

Avoid Unnecessary Procedures

Women can begin using implants:

- Without a pelvic examination
- Without any blood tests or other routine laboratory tests
- Without cervical cancer screening
- Without a breast examination
- Without a pregnancy test. A woman can have implants inserted at any time, even when she is not having monthly bleeding, if it is reasonably certain she is not pregnant (see Pregnancy Checklist on page 49).

WOMAN'S SITUATION	WHEN TO START
Having menstrual cycles or switching from a nonhormonal method	**Any time of the month** • If she is starting within 7 days after the start of her monthly bleeding, no need for a backup method. • If it is more than 7 days after the start of her monthly bleeding, she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method* for the first 7 days after insertion. • If she is switching from an IUD, also see Copper-Bearing IUD, Switching from an IUD to Another Method, p. 162.
Within 10 minutes to 48 hours Postpartum, breastfeeding or not	• Immediately (MEC 2015, Category 2).
Switching from another hormonal method	• Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. • If she is switching from a progestin-only or monthly injectable, she can have implants inserted when the repeat injection would have been given. No need for a backup method.
Fully or nearly fully breastfeeding less than 6 months after giving birth	• If her monthly bleeding has not returned, she can have implants inserted any time between giving birth and 6 months. No need for a backup method (2015 MEC Category 2). • If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles.

More than 6 months after giving birth	• If her monthly bleeding has not returned, she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion (2015 MEC Category 1). • If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles (2015 MEC Category 1).
Partially breastfeeding If her monthly bleeding has not returned	• She can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion (2015 MEC Category 2).
If her monthly bleeding has returned	• She can have implants inserted at any time. No need for a backup method (2015 MEC Category 1).
Not breastfeeding less than 4 weeks after giving birth	• She can have implants inserted at any time. No need for a backup method (2015 MEC Category 1). • If her monthly bleeding has not returned, she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion. • If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles.
No monthly bleeding (not related to childbirth or breastfeeding)	• She can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion (2015 MEC Category 2).
After miscarriage or abortion	• Immediately. If implants are inserted within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method (2015 MEC Category 1). • If it is more than 7 days after first- or second trimester miscarriage or abortion, she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion.
After taking emergency contraceptive pills (ECPs)	**After taking progestin-only or combined ECPs:** • Implants can be inserted on the same day as she takes the ECPs. She will need to use a backup method for the first 7 days. • If she does not start immediately, but returns for an implant, she can start at any time if it is reasonably certain she is not pregnant.

How to use effectively?

Implants are not user dependent and effective use is dependent on proper insertion, timing of insertion and support from providers and the partner or husband.

Use by special population (young or those with comorbidities)

- Implants can be used by adolescents in reproductive age but needs parental consent.
- Post-partum women, breastfeeding or not, may use it immediately as a post-partum method.
- Women with HIV can use it but should be cautioned that those using antiretroviral drugs may reduce its effectiveness and should also use condoms for double protection, specially for pregnant women.

When to stop using?

Clients can stop using the Implants anytime she wants it by having it removed for any reason or at the end of the label of effectiveness – 3 years for Implanon NXT, 4 years for Levoplant and 5 years for Jadelle or anytime she wants, because of side effects, or wants another pregnancy. She however has to be informed that she could get pregnant immediately. If she is not planning to have another pregnancy she has to use another method of her choice.

SCREENING CLIENTS FOR IMPLANT USE

To assess the clients if they can safely use the method they have chosen, a risk assessment is done and the results are recorded in the FP 1 Form. Aside from the STD/STI/HIV risk assessment, the provider can also use the WHO Medical Eligibility Criteria (MEC) for Contraceptive Use. The MEC for Contraceptive Use is one of the tools used in determining whether the clients with existing medical conditions can use a particular contraceptive, in this case Subdermal Implant. Clients with conditions under Category 1 and 2 may use the contraceptive, but those under Category 3 and 4 should not use the contraceptive. The 2015 MEC and 2018 Handbook and SPR reclassified some conditions under Category 3 or 4 as Category 1 or 2 will be marked in this edition such as breastfeeding less than 6 weeks postpartum. These are already discussed under the section who can use and contraindications. If the client do not qualify they are asked to choose another method and the process is repeated.

Note: An electronic MEC Wheel may also be downloaded from the WHO Website.

INSERTION OF IMPLANTS

Inserting implants usually takes a few minutes or longer depending on the skill of the provider. The insertion of Implanon does not require an incision because it is specially made with an applicator similar to a syringe. Aseptic technique must be practiced. The instructions herein are not meant to replace the training required for providers to be able to insert the implants described herein.

Note: The instruction for the single rod Implanon Classic is no longer described herein because it has been replaced by Implanon NXT. The illustrations in the insertion technique of Implanon and NXT and Jadelle are adapted from the Reference Handbook, Providing Implants; 2014 Jhpiego Corporation. The Illustrations for Levoplant Insertion are adapted from the 2020 DKT-Woman Care Training of Trainers.

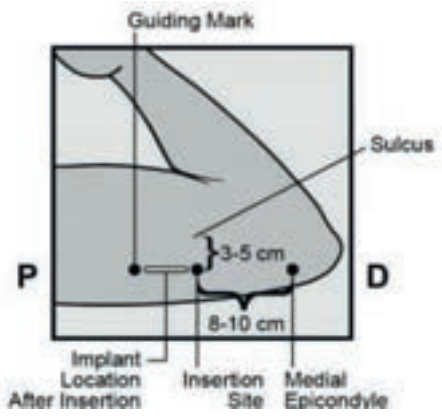
Updates on the Insertion of Implants

Cases of neurovascular injury and migration of the implant from the insertion site within the arm or in rare cases into the pulmonary artery have been reported and may be related to deep or incorrect insertion of the Implanon NXT. To further minimize the risk of neurovascular injury and implant migration, the instructions on insertion and removal of implant had been updated as follows:

Insertion of Single Rod Implant (Implanon NXT)

Step 1

The woman's arm should be flexed at the elbow with her arm underneath her head or as close as possible during insertion and removal.



Step 2

Mark the insertion site (8 cm to 10 cm from the medial epicondyle) and 3-5 cm posterior to the sulcus between the biceps and triceps muscle. Anesthetize the insertion area (by injecting 2 mL of 1% lidocaine) just under the skin along the planned insertion tunnel. Stretch the skin around the insertion site with the thumb and index finger.

Step 3

Insert only the tip of the cannula (needle) at about 30° for the Implanon NXT. The implant should be inserted sub-dermally just under the skin at the inner side of the non-dominant upper arm. The new insertion site is overlying the triceps muscles about 8-10 centimeter from the medial epicondyle of the humerus and 3-5 cm posterior to the sulcus (groove) between the biceps and triceps muscle.

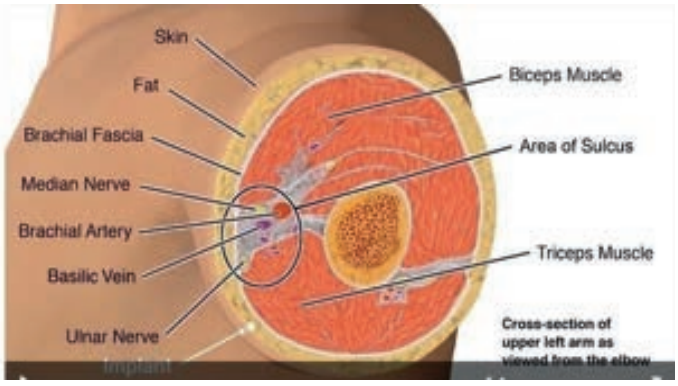
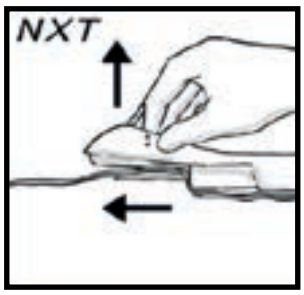


Figure 7. Cross-Section through the Left Upper Arm (middle third)



Step 4

Lower the applicator to a horizontal position. While lifting the skin with the tip of the needle, slide the needle to its full length. Slight resistance is possible, but caution must be exerted in preventing use of excessive force. If the needle is not inserted to its full length, the implant will not be inserted properly.

Step 5

While keeping the applicator in the same position and with the needle inserted to its full length, unlock the purple slider by pushing it slightly down. Move the slider fully back until it stops, leaving the implant now in its final subdermal position and locking the needle inside the body of the applicator. If the slider is not completely moved to the back, the needle will not be fully retracted, and the implant will not be inserted properly. The applicator can now be removed.

Step 6

Always verify the presence of the implant in the woman's arm immediately after insertion by palpation. The presence of the 4 cm rod can be confirmed by palpating both ends of the implant.

Step 7

Apply a small adhesive bandage over the insertion site. Request that the client palpate the implant.

Apply sterile gauze with a pressure bandage to minimize bruising. The client may remove the pressure bandage in 24 hours and the small bandage over the insertion site after three to five days.

INSTRUCTIONS FOR TWO-ROD INSERTION[5]

Location of Implants/Insertion Site

The rods should be inserted beneath the skin on the inner aspect of the upper arm (Figure 8) about 8 cm from the elbow fold. Usually, the arm that the woman uses less should be selected. Use a pen/marker to identify where the implant rods will go and an end point to guide the insertion.

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5 Adapted from "Providing Contraceptive Implants"2015 Trainer's Notebook, Jhpiego and DKT-Woman Care Global, Manual Training of Trainers 2020

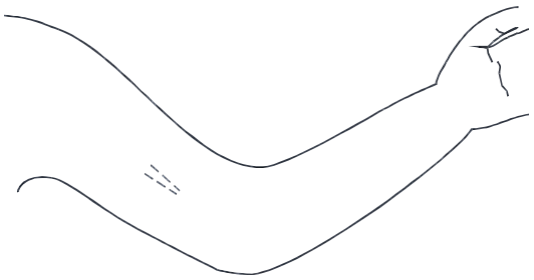


Figure 8. Two Rods Insertion Site

Figure 7-1 shows a cross-section of the upper arm and identifies where the nerve-bundle, major muscles, and vein are. The implant is placed correctly in this figure (3-5 cm posterior to the sulcus, between the biceps and triceps muscle), well away from major blood vessels, muscles, and nerves.

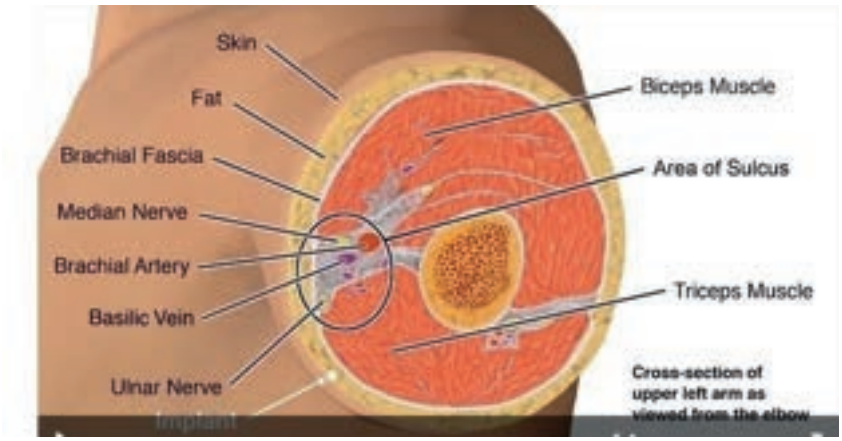


Figure 7-1. Cross-Section through the Left Upper Arm (middle third)

Step-by-Step Instructions for Insertion of Two-Rod Implants

STEP 1. Greet the client, rule out pregnancy, determine that the client wants an implant, is aware of common side effects, accepts them, and has no medical condition that makes implants an inappropriate method per WHO MEC.

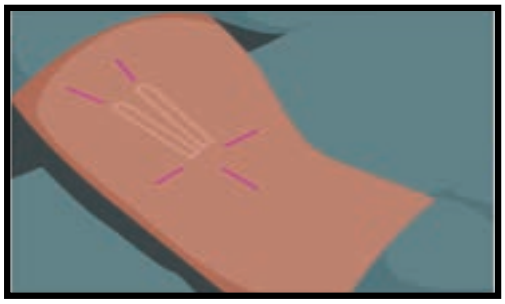
STEP 2: Explain the insertion technique and provide an opportunity to answer questions that the client may have.

STEP 3: Check to be sure the client has washed her entire arm with soap and water and rinsed it thoroughly, being sure to remove all traces of soap (residual soap decreases the effectiveness of some antiseptics). This step is particularly important when client hygiene is poor.

STEP 4: Help position client on the table. Her arm should be well-supported and able to be comfortably bent under the head or as close as possible

STEP 5: Determine the optimal insertion area by measuring 8 cm (3 inches) above the elbow fold. Mark where the incision will be made and the points for the upper end of each rod. If an antiseptic containing alcohol will be used to prep the arm, a pen with permanent ink must be used.

The rods should be inserted beneath the skin on the inner aspect of the upper arm about 8 cm from the elbow fold and 3-5 cm posterior to the sulcus between the biceps and triceps muscle. Usually, the arm that the woman uses less should be selected.



STEP 6: Prepare an instrument tray and open the sterile instrument pack or high-level disinfected container without touching the instruments and other items.

STEP 7: Carefully open the sterile pouch containing the rods by pulling apart the sheets of the pouch and allowing the two rods to fall into a sterile bowl or onto a sterile tray. If a sterile bowl or tray is not available, the rods can be dropped into a high-level disinfected bowl or onto the tray containing the instruments.

Note: Contact with cotton or other cloth makes the rods more reactive (i.e., more apt to cause adhesions or scarring because minute particles of the cotton adhere to the rods).

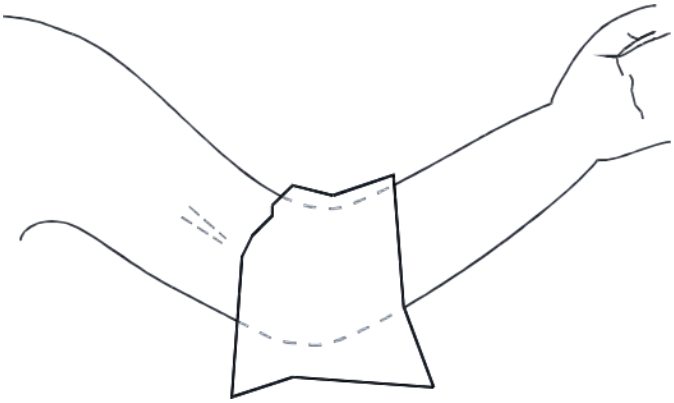
Note: If a rod falls on the floor, it is contaminated. Open a new package and continue with the procedure. Never attempt to sterilize or high-level disinfect contaminated rods.

Pre-Insertion Tasks

STEP 1: Wash hands thoroughly with soap and water and dry them with a clean, dry cloth or air dry. For insertion or removal of two-rod contraceptives, a brief handwashing with plain soap for about 10–15 seconds followed by rinsing in a stream of water is sufficient.

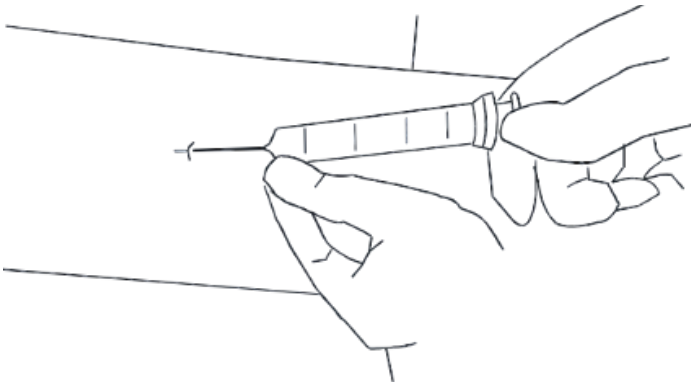
STEP 2: Apply antiseptic solution to the incision area two times. Use the tissue forceps to hold a cotton or gauze swab soaked with antiseptic. Begin by wiping at the insertion site and move outward in a circular motion for 8–10 cm (3–5 inches). If an iodophor (e.g., Betadine) is used, allow to air dry for about 2 minutes before proceeding (Iodophors require up to 2 minutes contact time to release free iodine). Wipe off excess antiseptic only if necessary to see the template marks.

STEP 3: If a sterile surgical drape with a hole in it ("eye sheet") is available, it should be used to cover the arm. The hole should be large enough to expose the area where the rods will be inserted. A second option is to cover the arm just below the insertion area with the sterile side of the sterile glove package or a clean cloth. Alternatively, a decontaminated, washed, and machine- or air-dried drape or cloth can be used.



STEP 4: After verbally checking again to be sure the client is not allergic to the local anesthetic agent or related drugs, fill a syringe with about 2 ml of local anesthetic (1% without epinephrine). This is enough to numb the area while inserting the two rods. Explain to the client that the injection of the anesthetic will be slightly painful but that she shouldn't feel any pain while the two-rod implants are being inserted.

STEP 5: Insert the needle just under the skin at the incision site (point closest to the elbow). Inject a very small amount of anesthetic to raise a small wheal (raised area). Then, without removing the needle, gently advance it under the skin for about 4–5 cm (2 inches) where the two rods will be inserted. This will raise the skin up from the underlying soft tissue. If the needle is less than 2 inches long, push the hub of the needle against the skin so that the tip of the needle reaches between the marks on the skin nearest the shoulder. Pull back on the plunger to be sure the needle is not in a blood vessel. As you withdraw the needle, slowly inject 1 ml of local anesthetic in a track. About 1 ml (cc) is needed for the track.



Place the needle in a safety box to prevent accidental needle sticks.

Note: To prevent local anesthetic toxicity, the total dose should not exceed 10 ml (10 grams/liter) of a 1% local anesthetic without epinephrine.

STEP 6: Put sterile gloves on both hands. A separate pair of gloves must be worn for each client to avoid cross-contamination. Gently massage the area injected to spread the anesthesia around; this will increase its effectiveness.

Note: Do not use powder with gloves. The tiny powder granules may fall into the insertion site and cause scarring (fibrous reaction). If gloves are powdered, wipe powder off gloved fingers with sterile gauze soaked in sterile or boiled water.

STEP 7: Arrange instruments and supplies so that they are easily accessible. Make sure there are two rods and that they are separated. If they are stuck together, separate them with gloved fingers.

Inserting the Two-Rod Implants

Before starting, gently touch the incision site with the tip of the forceps to be sure the anesthetic is working. If the client can feel the forceps, wait 2 more minutes and retest the incision site.

STEP 8: The disposable trocar has 2 ring marks (Figure 9) and a plunger. The first ring mark that is nearest to the trocar tip is used as a marker for how much of the trocar should be left under the skin following the insertion of each rod. The second ring mark that is closest to the hub indicates how far the trocar should be introduced before loading each rod into the trocar.

STEP 9: Use the disposable trocar with the bevel on the tip facing upward, and using gentle pressure, insert directly through the skin to the superficial subdermal layer.

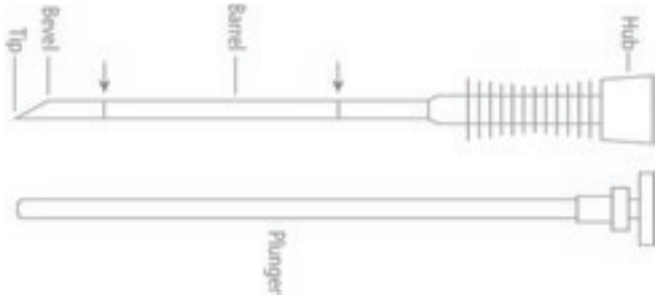
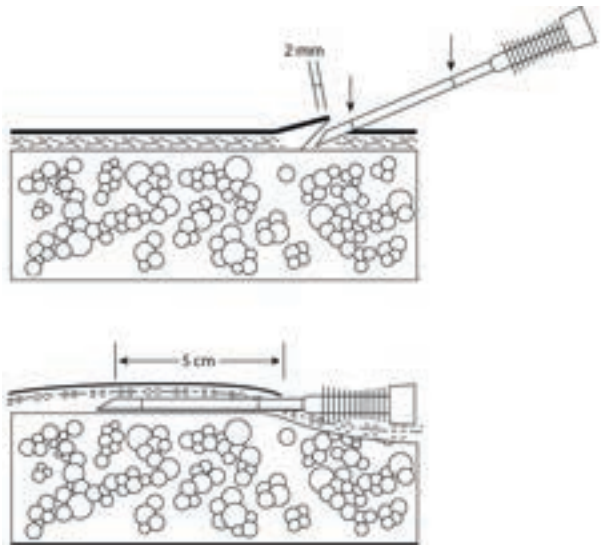


Figure 9. Two-Rod Implant Insertion Trocar

STEP 10: Insert the trocar and plunger through the incision at a shallow angle of about 20–30 degrees from the skin surface with the beveled tip of the trocar facing up. Move the trocar forward, stopping as soon as the tip is completely beneath the dermis (2–3 mm past the end of the bevel). Never force the trocar. If you meet resistance, try another angle.

STEP 11: To keep the rods on a superficial plane, tilt the trocar upward while tenting the skin. Slowly and smoothly advance the trocar and plunger toward one of the marks on the skin. The trocar should be positioned shallow enough so that it can be felt with a finger. It should visibly raise (tent) the skin at all times. The trocar will move easily if it is in a proper, shallow plane.

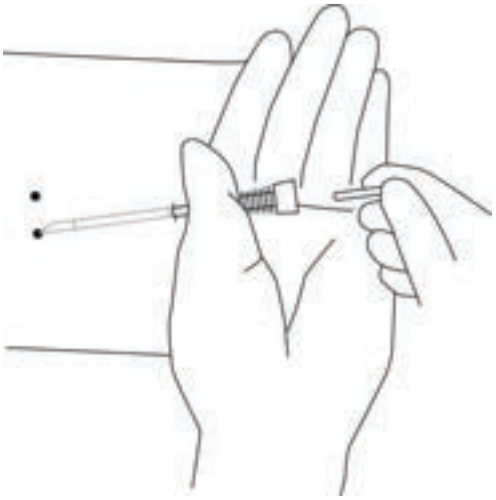


Note: To avoid contaminating the trocar when inserting and pulling back on it, try not to touch it with your gloved fingers, especially the part of the barrel that goes under the skin.
Remember: It is important that the rods be placed subdermally. Deep placement will make removal much more difficult and may injure blood vessel or nerves.

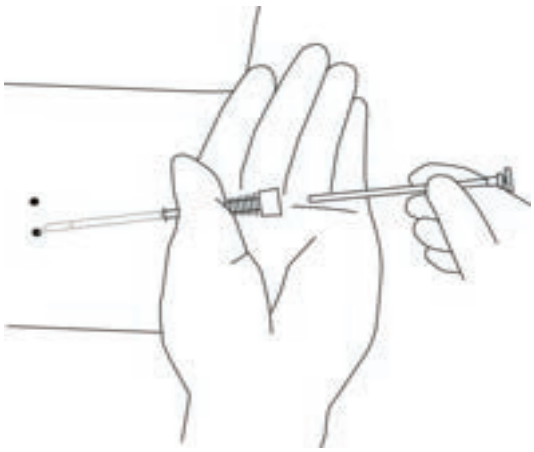
STEP 12: When the trocar has been advanced as far as the mark nearest the hub, remove the plunger from the trocar.

STEP 13: Load the first rod into the trocar. Use either the gloved thumb and forefinger of one hand or a forceps to pick up the rod and insert it in the trocar. Keep the other hand cupped under the trocar in order to catch the rod if it falls.

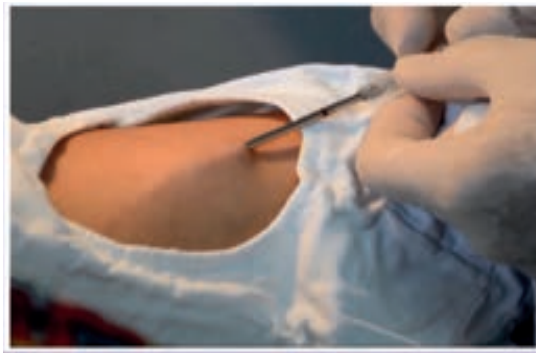
Note: If the rod is picked up by hand, be sure the gloves are free of powder.



Slide the rod into the top of the trocar and reinsert the plunger.

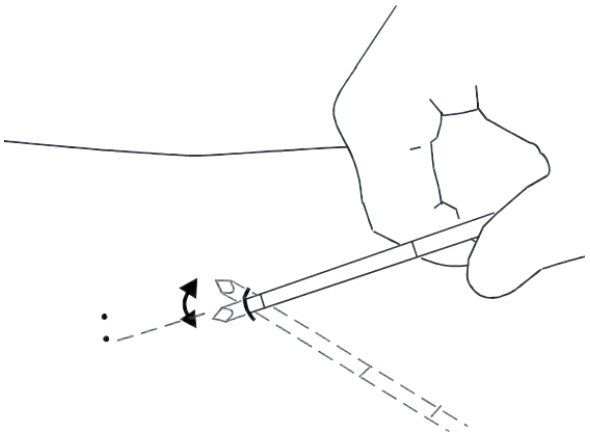


STEP 14: Use the plunger to gently advance the rod toward the tip of the trocar until you feel resistance—but never push down or force the plunger. It is used only to stabilize the rods while you withdraw the trocar. Resistance should be felt when the plunger is inserted about halfway into the trocar. Because the rods are soft, they will bend if pushed too hard with the plunger.

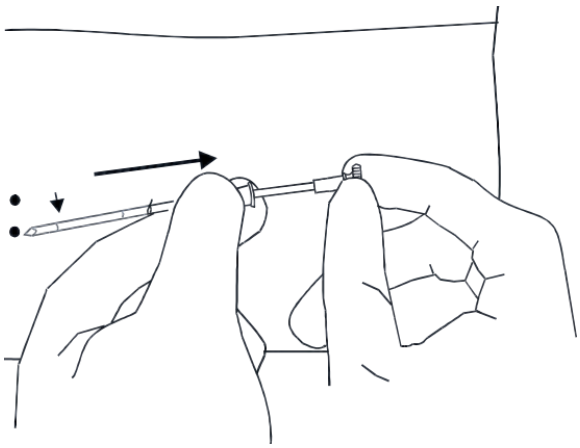


STEP 15: Hold the plunger firmly in place with one hand to stabilize it. NEVER PUSH DOWN ON THE PLUNGER. Check to be sure the trocar is still inserted to the mark nearest the hub.

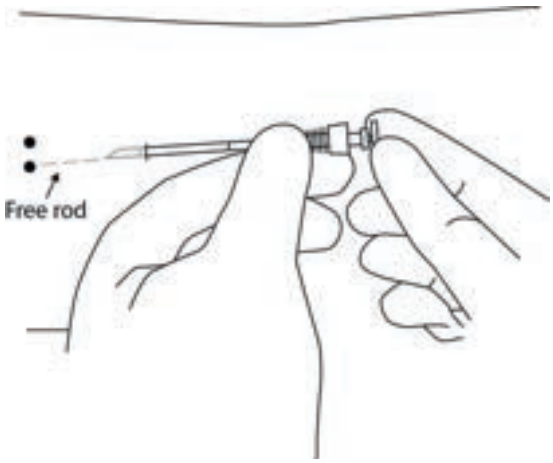
Then, with the thumb and forefinger, withdraw/slide the barrel of the trocar back out of the incision until the first ring mark, which is nearest to the tip, just clears the incision, and the hub touches the handle of the plunger. It is important to keep the plunger steady so as not to push the rod into the tissue.



STEP 16: When the hub of the trocar touches the handle of the plunger, the mark nearest the tip should be visible in the incision and the rod should now be lying beneath the skin, free of the trocar.

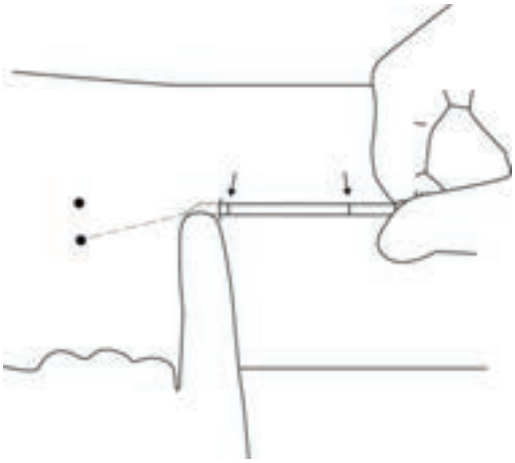


STEP 17: Without completely removing the trocar, move the tip of the trocar laterally away from the end of the first rod to be sure the end is completely free.



Note: To minimize tissue trauma, decrease the chance of infection, and shorten insertion time, do not to remove the trocar from the incision.

Then redirect the trocar about 15°, following the "V" shape marked on the arm. Next, fix the position of the first rod by placing the forefinger of the free hand over the end of the first rod. Then slowly advance the trocar along the side of this finger toward the mark nearest the hub. Doing this will ensure a suitable distance between the rods and will keep the sharp tip of the trocar from cutting the first rod.



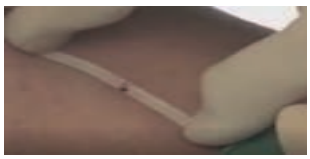
When the mark nearest the hub is reached, load the second rod into the trocar and place it using the same technique.

STEP 18: Palpate the ends of the rods nearest the shoulder to be sure the rods are placed correctly.

STEP 19: In order to minimize the risk of spontaneous expulsion of a rod, palpate the incision area to be sure that the ends of the rods are about 5 mm away from it. The ends of the rods closest to the incision should be no farther apart than the width of a rod, 2–3 mm.

STEP 20: Carefully withdraw the trocar and press down on the incision with a gauzed finger for a minute or so to stop any bleeding. Remove the drape. Clean the area around the insertion site with a small amount of sterile or high-level disinfected water or alcohol ("spirits") applied to a cotton or gauze swab.

Covering the Incision



Bring the edges of the incision together and use surgical tape to close the incision. Apply a Band-Aid or sterile gauze and tape to cover the incision. Sutures are not necessary and may increase scarring.

Check for any bleeding. Cover the insertion area with a dry piece of gauze (pressure dressing) and wrap gauze snugly around the arm to be sure there is no bleeding and to minimize the bruising (subcutaneous bleeding).

Waste Disposal and Decontamination

Before removing gloves, place instruments into a container filled with 0.5% chlorine solution for decontamination. Dispose of the needle and syringe by placing them in a puncture-proof container.

If cloth surgical drape was used (for two-rod insertion), it must be washed and sterilized before reuse. Place the drape in a dry, covered container and remove to the designated washing area.

While still wearing gloves, place all contaminated objects (gauze, cotton, and other waste items) in a properly marked, leak-proof container with a tight-fitting lid or in a plastic bag.

Dispose of gloves and place in a leak-proof container or plastic bag.

Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.

All waste materials should be disposed of by burning or burying.

Client Care

Complete the user card and give it to the client to keep. Also, complete the patient chart label and affix it to the woman's medical record.

Place a note in the client's record indicating the location of the rod(s), type of rod(s), and duration of contraceptive effect (3, 4, or 5 years) and specifying any unusual events that may have occurred during insertion. A simple drawing showing the approximate location of the rods in the client's arm is helpful.

Instruct the client regarding wound care and make a return visit appointment, if needed.

Observe the client for at least 15-20 minutes. Check for bleeding from the incision and ask her how she feels before sending her home. She should be given written, post-insertion care instructions if available and appropriate.

REMOVING IMPLANTS

IMPORTANT: Providers must not refuse or delay when a woman asks to have her implants removed, whatever her reason, whether it is personal or medical. All staff must understand and agree that she must not be pressured or forced to continue using implants. If the implants may be difficult to remove, a provider with the necessary skills should be available. Removals should be provided free of charge if possible.

Explaining the Removal Procedure

A woman needs to know what will happen during removal. The following description can help explain the procedure to her.

Step-by-Step Instructions for Removal of Implant Rod(s)

STEP 1: Before starting the procedure, check to be certain the client is not allergic to antiseptic solutions or local anesthetics.

STEP 2: Check to be sure the client has washed her entire arm with soap and water, and rinsed it thoroughly, being sure to remove all traces of soap. Residual soap decreases the effectiveness of some antiseptics. This step is particularly important when client hygiene is poor.

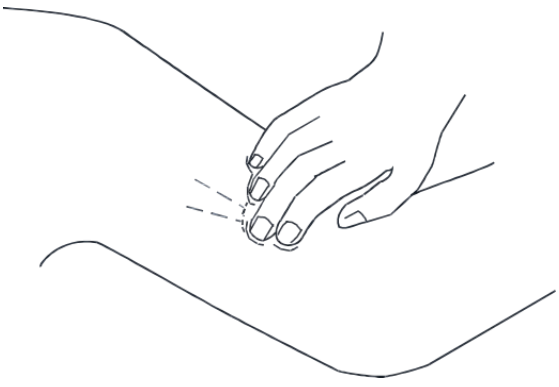
STEP 3: Help position the client on the table. Ask her to lie down on the table so that the arm with the rod/s rests on the table or arm support. Her arm should be well-supported and able to be comfortably extended straight or slightly bent, as the clinician prefers.

STEP 4: Place a clean, dry cloth under her arm.

STEP 5: Wash hands with soap and water and dry with clean towel or use alcohol rub.

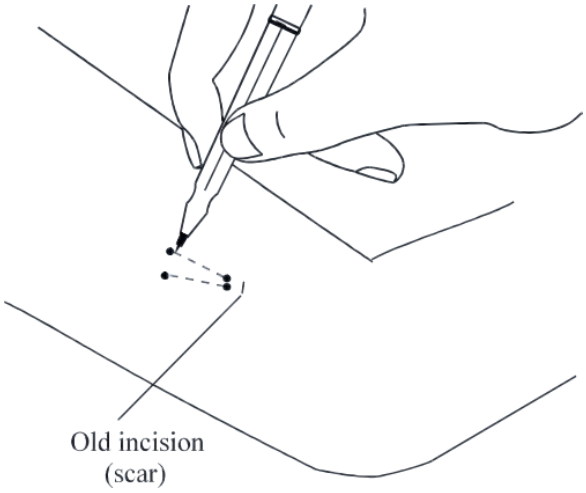
STEP 6: Prepare the instrument tray by carefully opening the Implant Removal Kit. Arrange the instruments. Check that local anesthetic is 1% without epinephrine.

STEP 7: Locate the rod/s by palpation. To gauge where to make the incision, palpate the ends of the rod/s with bare (ungloved) fingers.



Tip: To make locating the rods easier, moisten fingertips with a small amount of soapy water or antiseptic solution. Doing this decreases friction between the client's fingertips and the client's skin and allows the rods to be more easily felt.

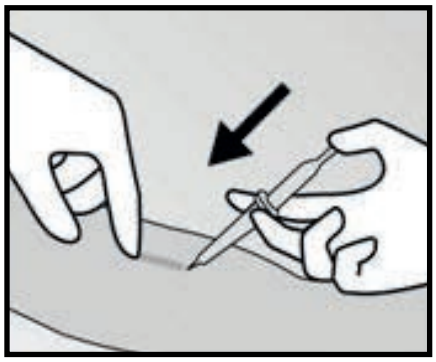
STEP 8: Confirm the position of each rod by making a mark at both ends of the rod/s using a ballpoint or marking pen. If an antiseptic containing alcohol will be used to prep the arm, a pen with permanent ink must be used.



Removing the Implant(s)

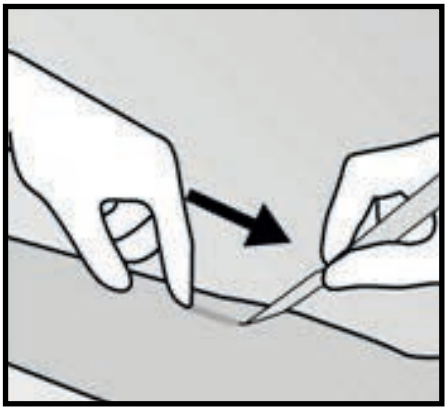
STEP 9: Prepare the removal site with antiseptic by wiping in circular motion two times. Let dry for about 2 minutes. Where the incision will be made, drape with clean or sterile surgical drape such as an "eye sheet" or alternatively place a clean drape over the lower part of the arm.

STEP 10: At the marked incision site, anesthetize the area with up to 1 ml of 1% lidocaine at the marked site where the incision will be made. Be sure to inject the local anesthetic under the implant to keep it close to the skin surface.

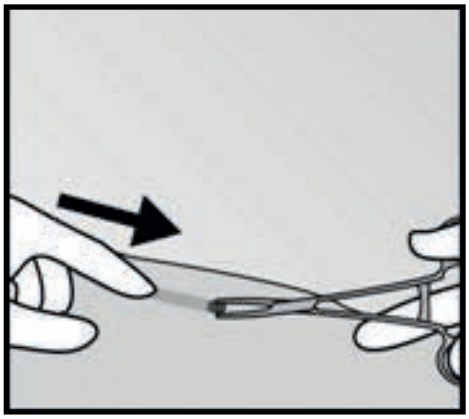


STEP 11: Push down the proximal end of the implant to stabilize it; a bulge may appear indicating the distal end of the implant. Starting at the distal tip of the implant, make a longitudinal incision of 2 mm long toward the elbow and deep enough to expose the rod.

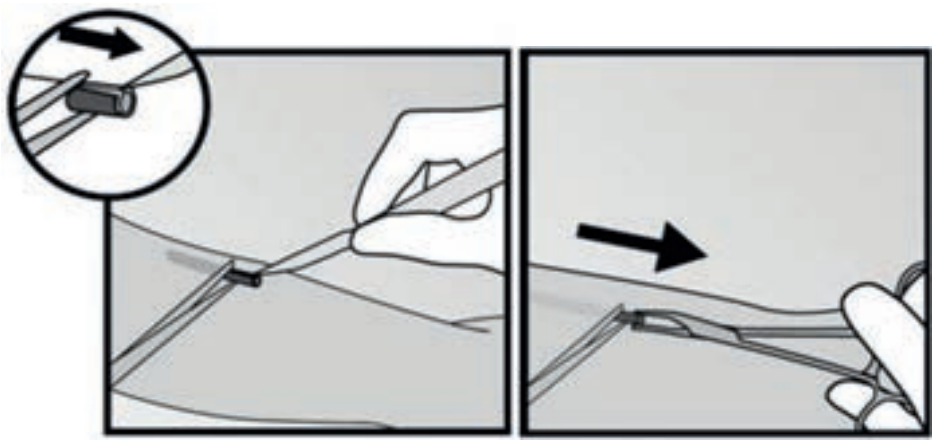
Note: Before making an incision, check that the anesthetic has taken effect by testing with a forceps tip.



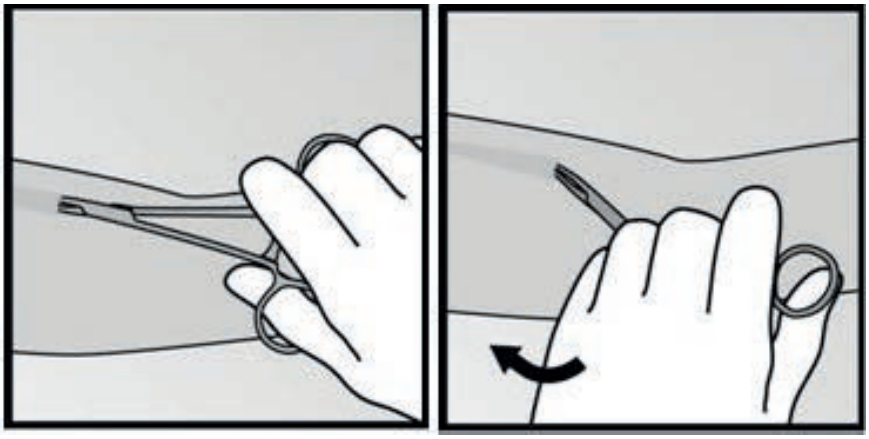
STEP 12: Gently push the implant toward the incision until the tip is visible. Grasp the implant with forceps (preferably curved mosquito forceps) and gently remove the implant.



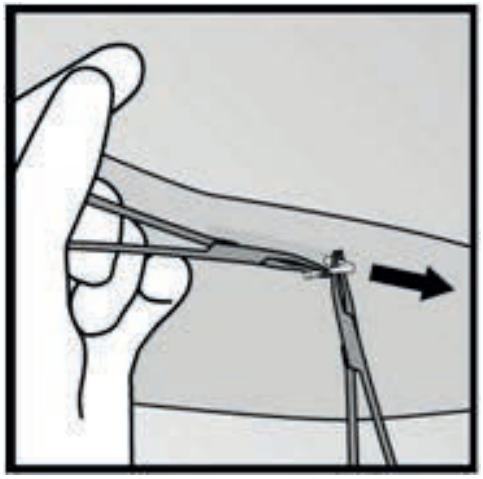
STEP 13: If the implant is encapsulated, use the forceps to gently grasp and stabilize the exposed but encapsulated rod, then make a small incision into the tissue sheath to expose the tip of the rod. With another set of curved mosquito forceps, grasp and gently remove the implant after releasing the first stabilizing forceps.



STEP 14: If the tip of the implant does not become visible in the incision, gently insert a forceps tip into the incision. Flip the forceps over into your other hand.



STEP 15: With a second pair of forceps, carefully dissect the tissue around the implant and grasp the implant. The implant can then be removed.



STEP 16: Confirm that the entire implant, which is 4.0/4.3 cm long, has been removed by measuring its length. If a partial implant (less than 4.0/4.3 cm) is removed, the remaining piece should be removed.

STEP 17: If removing two-rod implants, repeat the procedure for the second rod.

If the client desires to continue contracepting with implants, see section below titled "Follow-On Contraception." If not, continue on with the next section for "Covering the Incision."

Covering the Incision

Press down on the incision with a gauzed finger for a minute or so to stop any bleeding. Remove the drape.

If the client does not want another implant, clean the area around the incision site with a small amount of sterile or high-level disinfected water or alcohol ("spirits") applied to a cotton or gauze swab. Use gauze-covered fingers to hold the edges of the incision together briefly (10–15 seconds). This will help reduce bleeding from the incision.

Bring the edges of the incision together and close with a Band-Aid or surgical tape with sterile gauze or cotton. Sutures are not necessary and may increase scarring.

Check for any bleeding. Cover the insertion area with a dry piece of gauze (pressure dressing) and wrap gauze snugly around the arm to be sure there is no bleeding and to minimize the bruising (subcutaneous bleeding).

Client Care

- Place a note in the client's record indicating the date of removal and specifying any unusual events that may have occurred during removal.
- Instruct the client regarding wound care and make a return visit appointment, if needed.
- Observe the client for at least 15–20 minutes. Check for excessive bleeding from the incision and ask how she feels before sending her home. She should be given written, post-removal care instructions if available and appropriate.

Giving Specific Instructions

Keep arm dry	The user should keep the insertion area dry for 4 days. She can take off the gauze after 2 days and the adhesive bandage and surgical tape when the incision heals, usually after 3 to 5 days.
Expect soreness, bruising	After the anesthetic wears off, her arm may be sore for a few days. She also may have swelling and bruising at the insertion site. This is common and will go away without treatment.
Length of pregnancy protection	Explain that it is important to have implants removed before they start to lose effectiveness. She can have a new set of implants inserted if she wants. Discuss how to remember the date to return for implant removal and possible replacement. Give each woman the following information in writing on a reminder card, like the one shown below, if possible, and explain: • The type of implant she has and in which arm • Date of insertion • Month and year when implants will need to be removed or replaced • Where to go if she has problems or questions about her implants

Waste Disposal and Decontamination

Before removing gloves, place instruments into a container filled with 0.5% chlorine solution for decontamination. Fill syringe (with needle attached) with 0.5% chlorine solution and either place in solution or dispose of needle and syringe by placing in a puncture-proof container. Soak for 10 minutes. After soaking, rinse metal items immediately with clean water to avoid discoloration or corrosion.

- If the scalpel blade will be discarded, remove the scalpel from the chlorine solution. Then take the blade off the scalpel using forceps and place it in a puncture-proof container.
- The surgical drape (if used) must be washed and sterilized before reuse. Place in a dry covered container and remove to the designated washing area.
- While still wearing gloves, place all contaminated objects (gauze, cotton, and other waste items) in a properly marked, leak-proof container with a tight-fitting lid or in a plastic bag.
- Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning inside out.
- If disposing of gloves, place in a leak-proof container or plastic bag.
- If reusing surgical gloves, submerge them in the 0.5% chlorine solution for 10 minutes for decontamination.
- Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.
- All waste material should be disposed of by burning or burying.

SUPPORT TO CONTINUING USER

GIVING ADVICE ON SIDE EFFECTS

IMPORTANT: Thorough counseling about bleeding changes and other side effects must come before inserting implants. Counseling about bleeding changes may be the most important to help a woman to keep using the method without concern.

Describe the most common side effects	• Changes in her bleeding pattern: — Irregular bleeding that lasts more than 8 days at a time over the first year. — Later, regular, infrequent, or no bleeding at all. • Headaches, abdominal pain, breast tenderness
Explain about these side effects	• Side effects are not signs of illness. Lack of bleeding does not mean pregnancy. • Most side effects usually become less or stop within the first year. • Common, but some women do not have them. • Client can come back for help if side effects bother her or if she has other concerns.

MANAGEMENT OF BLEEDING PROBLEMS AND OTHER SIDE EFFECTS

The most frequently reported side effect of contraceptive implants is a change in the menstrual bleeding pattern. Because the changes vary widely, the kind of change a particular client may experience cannot be predicted. If increased frequency of bleeding occurs, the quantity of blood lost is rarely enough to cause anemia, but there have been a few cases that required treatment with iron tablets. Fortunately, these bleeding problems gradually diminish over time, becoming less frequent and bothersome after 9–12 months.

Despite the fact that medical treatment for prolonged or irregular bleeding usually is not necessary, the inconvenience caused by more or less continual bleeding or spotting interferes with the daily and sexual life of women. Any treatment that can quickly and reliably stop the bleeding contributes to comfort and satisfaction of contraceptive implant users. Therefore, service providers should be sensitive to the importance of treating this problem if counseling and reassurance are not sufficient.

Management of Vaginal Bleeding Problems

- Irregular bleeding and prolonged spotting or bleeding (8 days or more) are common and expected in contraceptive implant users—over 65% experienced this during the first year. In addition, moderate menstrual bleeding more than twice as long as a normal menses occurs in 20–30% of implants users during the first 3–6 months. For a woman with prolonged spotting or moderate bleeding, the first approach should be counseling and reassurance. It should be explained that in the absence of other causes (e.g., cervicitis or cervical polyp), this type of bleeding is not harmful, even if prolonged for several weeks. Furthermore, these prolonged bleeding or spotting episodes typically become lighter and shorter in succeeding months.
- If, after reassurance, the woman is still unhappy with the irregular bleeding, but wants to continue using two-rod implants, a short course (1–3 cycles) of COCs may be tried using:
  - A low-dose COC (30–35 μg EE) once daily for 21 days
- If COCs are not appropriate for personal or medical reasons, try:
  - Ibuprofen (or another NSAID) up to 800 mg three times daily for 5 days
- COCs control or stop bleeding by rebuilding the endometrium while ibuprofen, which blocks prostaglandin synthesis, decreases uterine contractions and blood flow to the endometrium. COCs, which also contain a progestin, are preferred over estrogens (either 20–50 μg EE or 1.25 mg conjugated estrogens) because they are more effective.
- Heavy bleeding (twice as long or twice as much as normal) is very uncommon with contraceptive implants but usually can be managed with low-dose COCs (with or without ibuprofen). If the bleeding is not reduced in 3–5 days or is much heavier (1–2 pads or cloths per hour):
  - Determine whether there are other causes for the uterine bleeding.
  - Give 2 low-dose COC pills per day for the remainder of the cycle (at least 3–7 days), followed by 1 cycle (1 pill per day) of COCs.
  - Alternatively (if available), give a 50 μg EE-containing COC or 1.25 mg conjugated estrogen (Premarin) for 14–21 days.
  - Tranexamic acid, 1 g every six hours for five to seven days
  - ***Note:*** Check to be sure vaginal bleeding has decreased within 3 days.

- If COCs or estrogens fail to correct the bleeding problem, the implants may need to be removed for medical reasons (excessive bleeding) or due to the client's wishes.
- Do not perform a dilation and curettage procedure unless another medical condition (e.g., endometrial polyp or incomplete abortion) is suspected. (If uterine evacuation is necessary, handbook vacuum aspiration, not a dilation and curettage procedure, is the preferred method for emptying the uterine cavity).
- For anemia, give nutritional advice on the need to increase iron intake. Use oral iron treatment (one tablet containing at least 100 mg elemental iron, FeSO4, daily for 1–3 months) if hemoglobin ≤ 9 g/dl or hematocrit ≤ 27.

Management of Other Health Problems

Clients may present with health problems that may or may not be method related. The assessment and management of these problems are presented below:

PROBLEM	ASSESSMENT	MANAGEMENT
Acne	Ask how and how often she cleans her face. Ask if she is currently under great stress.	In some women, use of implants can make acne worse. Recommend cleaning face twice a day and avoiding use of heavy facial creams. Counsel as appropriate. If condition is not tolerable, help client choose another (non-hormonal) method.
Breast fullness or tenderness (mastalgia)	Check breasts for: • Lumps or cysts, and • Discharge or galactorrhea (leakage of milk-like fluid), if not breastfeeding. If she is breastfeeding and breast(s) is(are) tender, examine for breast infection.	If physical examination shows lump or discharge suspicious for cancer (e.g., firm, non-tender, or fixed and does not change during menstrual cycle), refer to appropriate source for diagnosis. If no abnormality, reassure. If breast(s) is(are) not infected, recommend a bra that provides additional support. If breast infection, use warm compresses, advise to continue breastfeeding and give antibiotics as appropriate. For any of the above conditions, do not remove rods/capsules unless client requests it after counseling.
Chest pain (especially if it occurs with exercise)	Assess for possible cardiovascular disease (CVD). Also, check: • Blood pressure (BP) • Heart for irregular beats (arrhythmias)	If evidence for CVD, refer for further evaluation. Low-dose progestins do not increase the risk of CVD; therefore, removal of implants is not necessary unless the client requests it.

Depression (mood changes or loss of libido)	Discuss changes in mood or libido.	Depression or loss of libido may be associated with progestins; therefore, if the client thinks her depression has worsened while using implants, help her choose another method.
Excess hair growth (hirsutism) or hair loss	Review history, before and after insertion.	Pre-existing conditions such as excess facial or body hair might be worsened by use of implants. Changes usually are not excessive, may improve over time, and do not require rod/capsule removal unless client requests it after counseling.
Headache (especially with blurred vision)	Ask if there has been a change in pattern or severity of headaches since insertion of implants. Perform physical examination, measure BP. Examine as appropriate: • Eyes (fundoscopic) • Neurologic system	If headaches are mild, treat with analgesics and reassure. Re-evaluate after 1 month if mild headaches persist. If headaches have changed since starting implants (e.g., numbness or tingling accompanied by loss of speech, visual changes, or blurred vision), remove implants and help client choose another (non-hormonal) method.

Role of Partner

The client's partner is welcome to participate in counseling and learn about the method and what support he can give to his partner. A male partner can:

- Support a woman's choice of implants
- Show understanding and support if she has side effects
- Use condoms consistently in addition to the implant if he has an STI/HIV or thinks he may be at risk of an STI/HIV
- Help to remember when the implant is due for removal

Give the client the **Implant Reminder Card** before leaving the clinic which tell the type of implant, the date inserted date of removal or replacement and where to go or call for questions or problem.

Implant Reminder Card

Client's Name: _____

Type of Implant: _____ Arm: L ____ R ____

Date Inserted: _____

Remove or Replace by: Month: _____ Year: _____

If you have any problems or questions, go to:

(NAME AND LOCATION OF FACILITY.)

Key Points for Providers and Clients using Subdermal Implants

Implants are small flexible rods that are placed just under the skin of the upper arm.

Provide long-term pregnancy protection. Very effective for 3 to 5 years, depending on the type of implant. Immediately reversible.

Require specifically trained provider to insert and remove.

A woman cannot start or stop implants on her own.

Little required of the client once implants are in place.

Avoids user errors and problems with resupply.

Bleeding changes are common but not harmful. Typically, prolonged irregular bleeding over the first year, and then becomes lighter.

Implants do not cause cancer. Instead, implants help prevent endometrial cancer.

In case pregnancy occurs, one in every six pregnancies is ectopic.

If not removed beyond the recommended period of use, implants no longer provide protection from pregnancy and are relatively inert.

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

C. EMERGENCY CONTRACEPTION

INTRODUCTION

Emergency contraception (EC) refers to methods of contraception that can be used to prevent pregnancy after unprotected sexual intercourse. These are recommended for use within 5 days but are more effective the sooner they are used after the act of intercourse.

Emergency Contraceptive Pills currently not purchased by the government as prohibited by the RA 10353 or the RPRH Law. However, several brands of combined oral contraceptives containing Levonorgestrel, are being used (off-label) for that purpose.

Key facts

- EC can be used in the following situations: unprotected intercourse, concerns about possible contraceptive failure, incorrect use of contraceptives, and sexual assault if without contraception coverage.
- Methods of emergency contraception are the copper-bearing intrauterine devices (IUDs) and emergency contraceptive pills (ECPs).
- Copper-bearing IUD is the most effective form of emergency contraception available.
- The emergency contraceptive pill regimens recommended by WHO are ulipristal acetate, levonorgestrel, or combined oral contraceptives (COCs) consisting of ethinyl estradiol plus levonorgestrel.

Methods of Emergency Contraception (EC)

The 4 methods of emergency contraception are:

- **COMBINED ORAL CONTRACEPTIVE PILLS** - containing the progestin levonorgestrel combined with an estrogen, usually ethinyl estradiol are not procured/licensed in the country as an emergency contraceptive but are currently used in the Yuzpe method as ECPs.
- **COPPER-BEARING INTRAUTERINE DEVICES** - not recommended post-assault for rape victim
- **ECPS CONTAINING ULIPRISTAL** - not available in the Philippines
- **ECPS CONTAINING LEVONORGESTREL** - not available in the Philippines

Note: The last two ECPs, Ulipristal and Levonorgestrel are not registered nor available in the country

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Who can use Emergency Contraception?

Any woman or girl of reproductive age may need emergency contraception to avoid an unwanted pregnancy. There are no absolute medical contraindications to the use of emergency contraception. There are no age limits for the use of emergency contraception. Eligibility criteria for general use of a copper IUD also apply for the use of copper IUD for emergency purposes. There are no restrictions for the WHO Medical Eligibility Criteria of who can use ECPs.

Some women, however, use ECPs repeatedly for a number of reasons or as their main method of contraception. In such situations, further counselling needs to be given on what other and more regular contraceptive options may be more appropriate and more effective.

Frequent and repeated ECP use may be harmful for women with conditions classified as Medical Eligibility Criteria (MEC) category 2, 3, or 4 for combined hormonal contraception or Progestin-only contraceptives (POC). In such cases counselling is called for the sake of client enlightenment and education particularly on sexual behavior.

Counselling for use of ECPs should include options for using regular contraception and advice on how to use methods correctly in case of perceived method failure. Frequent use of emergency contraception can result in increased side-effects, such as menstrual irregularities, although their repeated use poses no known health risks.

In what situations can Emergency Contraception be used?

Emergency contraception can be used in several situations following sexual intercourse. These include:

- When no contraceptive has been used.
- Sexual assault when the woman was not protected by an effective contraceptive method.
- When there is a concern of possible contraceptive failure, from improper or incorrect use, such as:
  - condom breakage, slippage, or incorrect use
  - 3 or more consecutively missed combined oral contraceptive pills

- more than 3 hours late from the usual time of intake of the progestogen-only pill (minipill), or more than 27 hours after the previous pill
- more than 12 hours late from the usual time of intake of the desogestrel-containing pill (0.75 mg) or more than 36 hours after the previous pill
- more than 2 weeks late for the norethisterone enanthate (NET-EN) progestogen-only injection
- more than 4 weeks late for the depot-medroxyprogesterone acetate (DMPA) progestogen-only injection
- more than 7 days late for the combined injectable contraceptive (CIC)
- dislodgment, breakage, tearing, or early removal of a diaphragm or cervical cap
- failed withdrawal (e.g. ejaculation in the vagina or on external genitalia)
- failure of a spermicide tablet or film to melt before intercourse
- miscalculation of the abstinence period, or failure to abstain or use a barrier method on the fertile days of the cycle when using fertility awareness-based methods; or
- expulsion of an intrauterine contraceptive device (IUD) or hormonal contraceptive implant.

An advance supply of ECPs may be given to a woman to ensure that she will have them available when needed and can take as soon as possible after unprotected intercourse [6].

MECHANISM OF ACTION

ECPs prevent pregnancy by preventing or delaying ovulation, and they do not induce an abortion.

The copper-bearing IUD prevents fertilization by causing a chemical change in sperm and egg before they meet.

EC does not interrupt an established pregnancy nor harm a developing embryo.

EFFECTIVITY

EC can prevent up to over 95% of pregnancies when taken within 5 days after intercourse.

Only 1 in 100 women who had unprotected sex become pregnant for Yuzpe users. LNG is not effective for women with a body mass index of 30 kg/m^2.

When inserted within 120 hours of unprotected intercourse, a copper-bearing IUD is more than 99% effective in preventing pregnancy. This is the most effective form of emergency contraception available. Once inserted, women can continue to use the IUD as an ongoing method of contraception or may choose to change to another contraceptive method.

The World Health Organization (WHO, 1999) pioneered the trials for using a selective progesterone receptor modulator (SPRM) for EC. These trials led to the development of a

6 Source: WHO selected practice recommendations for contraceptive use

second generation SPRM, ulipristal acetate (UPA) at the dose of 30 mg. Ulipristal acetate is now recommended as the first line treatment for EC, due to its higher efficacy and a similar rate of side effects when compared to LNG-EC. Even though there is good evidence that the main mechanism of action is inhibition of ovulation, and a post-fertilization effect has not been shown, some still consider the latter may be also possible, raising the alert on medication and fostering the ethical debate because some religious views consider fertilization the initial event of human life.

Safety

WHO recommends that a copper-bearing IUD, when used as an emergency contraceptive method, be inserted within 5 days of unprotected intercourse. The client can continue to use it as a contraceptive if she likes.

The Yuzpe method can be resorted to since the method is only short term and thought of only once or one time and not advised to be practiced regularly. Any woman can use this method because they are only used in the short term

Known or suspected pregnancy are the precautions and contraindications for the use of LNG and Yuzpe methods. Note that accidental intake of these drugs elicits no known harm to a pregnant woman, the course of her pregnancy, or the fetus. But it does not protect against STIs and HIV.

A copper-bearing IUD is a safe form of EC. It is estimated that there may be less than 2 cases of Pelvic Inflammatory Disease (PID) per 1000 users. The risks of expulsion or perforation are low. This method is particularly appropriate for women who would like to start using a highly effective, long acting, and reversible contraceptive method.

The WHO Medical Eligibility Criteria for contraceptive use states that IUD insertion may further increase the risk of PID among women at increased risk of sexually transmitted infections (STIs), although limited evidence suggests that this risk is low.

SIDE EFFECTS

The known side effects of LNG and Yuzpe methods are because of the relatively high dosage of LNG and the combined estrogen and progesterone:

- Nausea/vomiting
- Tolerable abdominal pain
- Breast pain
- Vaginal bleeding
- Change in menstrual schedule

The known side effects of LNG and Yuzpe method can be addressed as follows:

- Explain to the patient that side effects are not signs of illness.
- Routine use of anti-nausea medications is not recommended. However, if nausea is experienced with the first of the two doses, an anti-nausea medication (e.g., 50 mg meclizine) may be taken one-half to one hour before the second dose.
- If the client vomits within two hours after taking any of the two doses, she should take another dose after taking the anti-nausea medication one-half to one hour before.

If vomiting continues, she can repeat the dose by inserting the previously required number of oral pills high into her vagina. If vomiting occurs more than two hours from taking a dose, she need not repeat the intake.

HOW TO USE

EMERGENCY CONTRACEPTION (YUZPE METHOD) IN THE PHILIPPINES

How is the Yuzpe method used

Within five (5) days after unprotected sex, the Yuzpe method can be administered using any one of the following regimens as soon as possible if available for two (2) doses with a 12-hour interval:

- 0.1 mg ethinyl estradiol + 0.5 mg LNG
- 0.1 mg ethinyl estradiol + 1 mg Norgestrel
- 0.1 mg ethinyl estradiol + 2 mg norethisterone

Available COCs in the country contain different amounts of estrogen and progestins. Thus, the number of pills to be given depends on the preparation of the brand chosen. Not all brands of COCs can be utilized for emergency contraception. However, the acceptable brands for use in the Yuzpe method offer equivalent efficacy. See Table 8 below:

Table 9. Recommended dose of acceptable brands for Yuzpe Method

BRAND	FIRST DOSE (WITHIN 5 DAYS AFTER UNPROTECTED SEX)	2ND DOSE (AFTER 12 HOURS)	LNG PER DOSE	EE PER DOSE
Charlize	4 beige pills	4 beige pills	0.6 mg	0.15 mg
Femenal	2 active pills	2 active pills	0.5 mg	0.10 mg
Femme	4 yellow	4 yellow	0.6 mg	0.125 mg
Lady	4 beige pills	4 beige pills	0.6 mg	0.12 mg
Minipil	5 active pills	5 active pills	0.5 mg	0.10 mg
Nordette	4 active pills	4 active pills	0.6 mg	0.12 mg
Nordiol 21	2 active pills	2 active pills	0.5 mg	0.10 mg
Seif	4 beige pills	4 beige pills	0.6 mg	0.12 mg
Trust	4 beige - yellow pills	4 beige - yellow pills	0.5 mg	0.12 mg

**** The following COCs are NOT recommended for use as Yuzpe method Althea, Cerazette, Daphne, Diane 35, Yazmin and Yaz are not recommended for Yuzpe because they contain a different progesterone.

Commonly asked questions about the LNG and Yuzpe Methods

1. ***Can LNG and Yuzpe be used for abortion?***

   No. These methods only delay or prevent ovulation and slow down sperm transport up the woman's reproductive tract by avoiding fertilization from taking place before the sperm from the unprotected sexual intercourse reaches the end of its life span. Once fertilization has occurred, the hormones from the contraceptives cannot disrupt an ongoing pregnancy.

2. ***Can LNG and Yuzpe increase a woman's chance of ectopic pregnancy?***

   No. So far, no evidence suggests increased risk for ectopic pregnancies in women who become pregnant on the LNG and Yuzpe methods compared with all pregnancies in general.

3. ***Can the LNG and Yuzpe methods cause fetal defects or birth problems to an existing pregnancy?***

   No. The intake of these contraceptives will not cause fetal defects or birth problems compared with all pregnancies in general.

4. ***Should the LNG and Yuzpe methods be used as a regular contraceptive method?***

   No, because all other contraceptive methods are more effective in preventing pregnancies and have less of the unwanted side effects. These methods are only best for preventing pregnancies that might result from having unprotected sex during a believed fertile period. These methods only delay ovulation; therefore, pregnancy may still occur if another unprotected sexual intercourse occurs. Hence, contraceptive selection and use is important. Other contraceptive methods for regular use should be discussed with the client to prevent any future need for the LNG and Yuzpe methods.

5. ***When can the client start using their contraceptive method of choice after the use of LNG and Yuzpe methods?***

   The risk of STIs and HIV and emotional and physical abuse is apparent after sexual assault. These conditions should be addressed aside from offering further FP methods.

   When the client feels comfortable in addressing future FP concerns, she may initiate the use of a regular method after the LNG and Yuzpe methods.

Shifting to regular contraception

Following use of ECPs, women may resume or initiate a regular method of contraception. If a copper IUD is used for emergency contraception, no additional contraceptive protection is needed. Following administration of ECPs with levonorgestrel (LNG) or combined oral contraceptive pills (COCs), women may resume their contraceptive method, or start any contraceptive method immediately, including a copper-bearing IUD.

Following use of ECPs with ulipristal acetate (UPA), women may resume or start any progestogen-containing method (either combined hormonal contraception or progestogen only contraceptives) on the 6th day after taking UPA. They can have an LNG-IUD inserted immediately if it can be determined they are not pregnant. They can also have the copper IUD inserted immediately.

Resumption or Initiation of Regular Contraception after using EC

- After using a copper-bearing IUD (Cu-IUD) for EC - No additional contraceptive protection is needed if she has a Cu-IUD inserted.
- After using LNG-ECPs and combined ECPs
  - — Following administration of LNG-ECPs or combined ECPs, a woman may resume her contraceptive method, or start any contraceptive method immediately, including a Cu-IUD.
  - — If she wishes to start the LNG-IUD, it can be inserted at any time if it can be determined that she is not pregnant. If she does not start immediately but returns for a method, she may start combined hormonal contraceptives (COCs, patch, CVR or injectable contraceptives) or progestogen-only contraceptives (POPs, DMPA or NET-EN injectable contraceptives or implants) at any time if it is reasonably certain that she is not pregnant.
  - — If she does not start immediately but returns for an IUD, she can have it inserted at any time if it is reasonably certain that she is not pregnant.
  - — If she is amenorrheic, she can have an IUD inserted at any time if it can be determined that she is not pregnant.
  - — Need for additional contraception: The woman should be advised to abstain from sexual intercourse or use barrier contraception for 2 days after starting POPs or 7 days after starting combined hormonal contraceptives (COCs, patch, CVR or injectable contraceptives) or other progestogen-only contraceptives (DMPA or NET-EN injectable contraceptives, implants or LNG-IUD) and to have early pregnancy testing at the appropriate time, if warranted (e.g. if no withdrawal bleed occurs within three weeks).

COPPER-BEARING INTRAUTERINE DEVICES AS ECP

WHO recommends that a copper-bearing IUD, when used as an emergency contraceptive method, be inserted within 5 days of unprotected intercourse. This method is particularly appropriate for women who would like to start using a highly effective, long acting, and reversible contraceptive method.

Effectiveness

When inserted within 120 hours of unprotected intercourse, a copper-bearing IUD is more than 99% effective in preventing pregnancy. This is the most effective form of emergency contraception available. Once inserted, women can continue to use the IUD as an ongoing method of contraception or may choose to change to another contraceptive method.

Safety

A copper-bearing IUD is a safe form of EC. It is estimated that there may be less than 2 cases of Pelvic Inflammatory Disease (PID) per 1000 users. The risks of expulsion or perforation are low.

Medical Eligibility Criteria

Eligibility criteria for general use of a copper IUD also apply for the use of a copper IUD for emergency purposes. Women with a condition classified as MEC category 3 or 4 (for example, with current PID, puerperal sepsis, unexplained vaginal bleeding, cervical cancer, or severe thrombocytopenia) for the copper IUD should not use a copper IUD for emergency purposes. In addition, a copper-bearing IUD should not be inserted for EC following a sexual assault as the woman may be at high risk of a sexually transmitted infection such as chlamydia and gonorrhea. A copper-bearing IUD should not be used as emergency contraception when a woman is already pregnant.

The WHO Medical Eligibility Criteria for contraceptive use states that IUD insertion may further increase the risk of PID among women at increased risk of sexually transmitted infections (STIs), although limited evidence suggests that this risk is low. Current algorithms for determining the increased risk of STIs have poor predictive value. The risk of STIs varies by individual behavior and local STI prevalence. Therefore, while many women at increased risk of STIs can generally have an IUD inserted, some women at a very high likelihood of STIs should generally not have an IUD inserted until appropriate testing and treatment occur.

Key Points for Providers and Clients using Emergency Contraceptive Pills

Emergency contraceptive pills (ECPs) help a woman avoid pregnancy after she has sex without contraception.

ECPs help to prevent pregnancy when taken up to 5 days after unprotected sex. The sooner they are taken, the better.

Do not disrupt an existing pregnancy.

Safe for all women — even women who cannot use ongoing hormonal contraceptive methods.

Provide an opportunity for women to start using an ongoing FP method.

Several options can be used as emergency contraceptive pills. Dedicated products, progestin-only pills, and combined oral contraceptives all can act as emergency contraceptives.

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

D. INTRAUTERINE DEVICE

Copper Bearing Intrauterine Device

INTRODUCTION

An Intrauterine Device (IUD) is the most commonly used long-acting reversible contraception method. It is a small plastic device inserted into the uterine cavity by a specifically trained health care provider. It has two stranded monofilament tails tied to the plastic frame that protrudes through the cervical canal into the vagina for detection and removal.

Source: Durbin Global, 2021

Copper bearing IUD (TCu-380A) is a T-shaped plastic device with copper wire wrapped around its stem and copper sleeve around its horizontal arms. The total surface area of copper on IUD is 380 mm2. It contains barium sulfate making it visible through x-rays. It does not contain hormones.

IUD is suitable for clients who want safe, effective, and long-acting reversible method of contraception (LARC).

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Who can or cannot use the Copper-Bearing IUD

Most women can use TCU-380A safely and effectively of any age, including adolescents and women over 40 years old, are breastfeeding, have just had an abortion (not septic), have had PID, have anemia, postpartum less than 48 hours, had past ectopic pregnancy, have HIV clinical disease that is mild or no symptoms, with hypertension or valvular heart disease.

MEC CATEGORIES FOR IUD	
Category 1: Use the method without restrictions	
Women ≥ 20 years old	Diagnosed with benign ovarian tumor, cervical ectropion or cervical intraepithelial neoplasia
Breastfeeding	Deep Vein Thrombosis (DVT) /Pulmonary Embolism
Postpartum less than 48 hours	Known thrombogenic mutations (e.g factor V leiden,; prothrombin mutation; protein S, protein C, and anti thrombin deficiencies)
≥4 weeks postpartum	Superficial Venous Disorders • Varicose Veins • Superficial Venous thrombosis

1st trimester post abortion	Any type of headache
Past ectopic pregnancy	Epilepsy
History of pelvic surgery	Depressive Disorders
Woman who smoke at any age	Any breast disease
Obesity: Body mass index of more than or equal to 30 kg/m^2	Uterine fibroid that do not distort the uterine anatomy
Hypertension of all classifications	History of PID with subsequent pregnancy
Uncomplicated valvular heart disease	Schistosomiasis
Woman diagnosed with systemic lupus erythematosus but with no risk factors	Malaria
Current and history of ischemic heart disease, stroke or hyperlipidemia	Non-pelvic tuberculosis
Any endocrine conditions such as diabetes or thyroid disorders	Current intake of any anticonvulsant or antimicrobial
Any Gall bladder disease, hepatitis, cirrhosis, liver tumors, or history cholestasis	Irregular pattern without heavy bleeding
High risk of HIV	
Category 2: Generally use the method but with more than usual follow-up	
Menarche to <20 years	Among women with anatomical abnormalities not distorting the uterine cavity or interfering with IUD insertion (e.g. cervical laceration or stenosis)
Woman who have not given birth	Initiation of the method in women with past PID and no subsequent pregnancy
Post-abortion in the second trimester	Other STIs (excluding HIV and hepatitis) and vaginitis (including trichomonas vaginalis and bacterial vaginosis)
Complicated valvular heart disease	Asymptomatic or mild HIV clinical disease (WHO stage 1 or 2)

Woman diagnosed with systemic lupus erythematosus and on immunosuppressive treatment	Currently on antiretroviral therapy
Women with heavy or prolonged vaginal bleeding, endometriosis or severe dysmenorrhea	Anemia such as thalassemia, sickle cell disease and iron deficiency anemia
Category 3: Do not use the method unless no other appropriate method is available under close supervision	
≥48 hours to <4 weeks after childbirth	Women with ovarian cancer
Women diagnosed with systemic lupus erythematosus and with severe thrombocytopenia	Severe or advanced HIV clinical disease (WHO stage 3 or 4)
Women with gestational trophoblastic disease or undetectable beta-HCG levels	
Category 4: Do NOT use the method	
During Pregnancy	Current PID
Puerperal Sepsis	Women with gestational trophoblastic disease with persistently elevated beta-HCG
Immediate post- septic abortion	Initiation of method in clients with current purulent cervicitis, chlamydial infection, or gonorrhea
Initiation of method in clients with unexplained vaginal bleeding before evaluation	Initiation of method in clients with pelvic tuberculosis
Initiation of method in client with cervical or endometrial cancer	Current purulent cervicitis or chlamydial infection or gonorrhea
Among women with anatomical abnormalities that distort the uterine cavity (e.g. fibroid)	

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

Medical Eligibility Criteria for Copper-Bearing IUDs

Ask the client the questions below about known medical conditions. If she answers "NO" to all the questions, then she can have an IUD inserted. If she answers "YES" to a question, follow the instructions. In some cases, she can still have an IUD inserted.

1. Did you give birth more than 48 hours ago but less than 4 weeks ago?

❑ NO ❑ YES — Delay inserting an IUD until 4 or more weeks after childbirth.

2. Do you have an infection following childbirth or abortion?

❑ NO ❑ YES — If she currently has infection of the reproductive organs during the first 6 weeks after childbirth (puerperal sepsis) or she just had an abortion-related infection in the uterus (septic abortion), do not insert the IUD. Treat or refer if she is not already receiving care. Help her choose another method or offer a backup method*. After treatment, re-evaluate for IUD use.

3. Do you have vaginal bleeding that is unusual for you?

❑ NO ❑ YES — If she has unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition, use of an IUD could make diagnosis and monitoring of any treatment difficult. Help her choose a method to use while being evaluated and treated (but not a hormonal IUD, progestin-only injectables, or implants). After treatment, re-evaluate for IUD use.

4. Do you have any female conditions or problems (gynecologic or obstetric conditions or problems), such as genital cancer or pelvic tuberculosis? If so, what are these?

❑ NO ❑ YES — Known current cervical, endometrial, or ovarian cancer; gestational trophoblast disease; pelvic tuberculosis: Do not insert an IUD. Treat or refer for care if she is not already receiving care. Help her choose another method. In case of pelvic tuberculosis, re-evaluate for IUD use after treatment.

5. Do you have HIV or AIDS? Do you have any health conditions associated with HIV infection?

❑ NO ❑ YES — If a woman has HIV infection with severe or advanced clinical disease, do not insert an IUD. In contrast, a woman living with HIV who has mild clinical disease or no clinical disease can have an IUD inserted, whether or not she is on antiretroviral therapy.

Assess whether she is at very high individual risk for gonorrhea or chlamydia. Women who have a very high individual likelihood of exposure to gonorrhea or chlamydia should not have an IUD inserted.

Assess whether the client might be pregnant

Ask the client the questions in the pregnancy checklist (see Section on Pregnancy Checklist p. 50). If she answers "YES" to any question, she can have an IUD inserted. For complete classifications, see Medical Eligibility Criteria for Contraceptive Use. Be sure to explain the health benefits, risks, and side effects of the method. When relevant to the client, point out any conditions that would make the method inadvisable.

MECHANISM OF ACTION

Copper ions decrease sperm motility and function, causing local inflammatory reactions in the uterine cavity, thus preventing sperm from reaching the fallopian tube and fertilizing the egg.

EFFECTIVITY

In terms of IUD's perfect use, it is 99.4% effective and with typical use about 99.2% effective. It has very low pregnancy rate about less than 1 pregnancy per 100 women over the first year. TCU-380A is effective for 12 years, according to some studies. However, it is labelled for up to ten years.

ADVANTAGES AND DISADVANTAGES

Advantages of CU-IUD

- Reversible and economical
- Long duration of use up to 12 years
- Highly effective and safe
- Can be safely used by lactating and immediate postpartum women
- Does not interact with client's medications
- No systemic side effects

Disadvantages of CU-IUD

- Requires a well-trained health service provider before performing IUD procedures
- Requires a pelvic exam to insert the IUD
- Does not protect against STI or HIV
- Increase the risk of PID for women with STIs
- Device may be expelled, especially for postpartum insertions

RETURN TO FERTILITY

There is no delay in terms of return to fertility. After removal of the IUD, client's fertility returns immediately. Clients may have another insertion of IUD after removal, or they may start another contraceptive method if they decided not to get pregnant.

SIDE-EFFECTS, HEALTH RISKS AND COMPLICATIONS

Side Effects

Changes in the bleeding pattern is the common side effect of copper bearing IUD. It may occur in the first 3-6 months post-insertion of IUD and the amount or duration of menstrual bleeding may increase up to 50%. Some clients may also experience cramping or discomfort during monthly bleeding. Proper counseling may encourage the client for continued use of IUD.

Health Risks and Complications

IUD may contribute to anemia if the client has low hemoglobin levels with heavier monthly bleeding before IUD insertion. Uterine perforation is a rare complication especially if the health care provider has proper training and experience. Expulsion is the most common cause of IUD failure. There are several factors causing risks of expulsion such as lack of skills and experience of the provider, heavy menstrual flow, and timing of insertion (more than 10 minutes but less than 48 hours after delivery of the placenta). It may also cause pelvic inflammatory disease (PID) if the client has chlamydia or gonorrhea before the IUD is inserted. The risk of genital tract infection among IUD clients is less than 1%. However, if there is lack of proper infection prevention practices, the risk of infection is higher in the first 20 days after insertion.

Warning signs of complications that require immediate follow up visit to health facility

P: period-related problems or pregnancy symptoms

A: abdominal pain or pain during intercourse

I: infections or unusual vaginal discharge

N: not feeling well, fever, chills

S: string problems

Contraindications in using IUD:

- Pregnancy
- Acute PID
- Postpartum endometritis
- Known or suspected uterine or cervical malignancy
- Genital bleeding of unknown origin
- Previously inserted IUD that has not been removed.

Common reason for discontinuation:

- Desire for pregnancy
- Unacceptable vaginal bleeding
- Pain
- Infection

DISPELLING MYTHS AND MISCONCEPTIONS

- IUD does not act as an abortifacient. It prevents fertilization and not the implantation of the fertilized egg.
- IUD does not increase the client's risk of ectopic pregnancy. It prevents pregnancy; thus, it reduces the risk of ectopic pregnancy.
- IUD does not make women infertile. Once the IUD is removed, the woman's fertility returns immediately same as the one who has never used an IUD. Tubal damage resulting to infertility is caused by STIs such as chlamydia.
- IUD does not cause PID. PID is caused by gonorrhea and chlamydia, and not the IUD itself.

- IUD does not need a rest period after its recommended time of removal. It may increase the risk of pregnancy if no contraceptive method is given to the client after the removal of IUD.
- IUD cannot travel from the client's uterus to other parts of her body such as the heart or brain. The IUD stays within the uterus. It is very rare that the IUD perforates the uterus.

NON-CONTRACEPTIVE BENEFITS

Copper-bearing IUD may help protect against the risk of endometrial and cervical cancer.

HOW TO PROVIDE THE METHOD

SCREENING QUESTIONS FOR PELVIC EXAMINATION BEFORE IUD INSERTION

For questions 1-5, if the answer is "yes", refer for diagnosis and treatment as appropriate. Help her choose another contraceptive method and counsel her about condom use if she faces any risk of STIs. Give her condoms, if possible. If an STI or PID is confirmed and she still wants an IUD, it may be inserted as soon as she finishes treatment, if she is not at risk for reinfection before insertion.

1. Is there any type of ulcer on the vulva, vagina, or cervix?

❑ NO ❑ YES — Possible STI

2. Do you have an infection following childbirth or abortion?

❑ NO ❑ YES — Possible PID

3. Are you having vaginal bleeding that is unusual for you?

❑ NO ❑ YES — Possible PID

4. Do you have any female conditions or problems (gynecologic or obstetric conditions or problems), such as genital cancer or pelvic tuberculosis? If so, what problems?

❑ NO ❑ YES — Possible STI or PID

5. Do you have HIV or AIDS? Do you have any health conditions associated with HIV infection?

❑ NO ❑ YES — Possible STI or cervical cancer

6. Assess whether she is at very high individual risk for STIs

❑ NO ❑ YES — If an anatomical abnormality distorts the uterine cavity, proper IUD placement may not be possible. If available, an ultrasound examination can help determine if proper IUD placement is possible. If not, help her choose another method.

Before the Insertion

1. Do pelvic examination to rule out genital infections
2. Take mefenamic acid, paracetamol, or other pain reliever 30 minutes before insertion to reduce cramping and pain.
3. A trained health care provider inserts IUD in a place with the necessary supply and equipment.
4. The health care provider inserts the IUD into the uterus through the vagina and cervix, then cut the strings on the IUD, leaving about 3 cm hanging out of the cervix.
5. The client may feel discomfort or cramping during the procedure. This is normal.

Intrauterine Devices for Women with HIV

- If the women living with HIV have mild or no clinical disease, whether or not they are on antiretroviral therapy, they can safely have an IUD inserted.
- If the women have an advanced or severe HIV infection, IUD insertion is not recommended.
- It is not necessary to remove an IUD if the woman becomes infected with HIV while she has an IUD in place.
- Close monitoring for pelvic inflammatory disease while IUD is in place for an IUD user living with HIV who develops the advanced or severe clinical disease.
- A condom along with the IUD should be used consistently and correctly for women who have HIV or are at risk for HIV since condoms prevent transmission of HIV and other STIs.
- An IUD can be inserted for women who are at risk of HIV but not infected with HIV. It does not increase the risk of HIV infection.

What counseling tips can be provided for those who plan or choose to use an IUD?

The client should undergo FP counseling. All IUD clients must be asked to sign a consent form before the insertion of the procedure. The client should be provided with the following information:

- Characteristics of IUDs
- Client's current and future risk for STIs
- Effectiveness and mechanism of IUD
- Insertion and removal procedures
- Instructions for use and follow-up visit
- Possible side effects and complications
- How to check the strings

Timing of IUD Insertion

Interval Insertion

- Anytime of the month during the menstrual bleeding.
- Any other time within the menstrual cycle, provided that it is reasonably certain that the woman is not pregnant.

- No monthly bleeding (not related to childbirth or breastfeeding)
  - — Anytime if it can be determined that the client is not pregnant.
- Backup method is not necessary if:
- Within 12 days after the start of monthly bleeding
- Anytime of a woman's monthly cycle, provided that it is reasonably certain that the woman is not pregnant.
- Switching from another method
  - — Immediately, if the client is correctly and consistently using the current method or if it is reasonably certain that she is not pregnant. No need to wait for the client's next monthly cycle. Backup method is not necessary.
  - — If the client is switching from an injectable, she can be inserted with the IUD when the next injection would have been given. Backup method is not needed.

Postpartum Insertion

- After childbirth (postpartum) regardless of breastfeeding status
  - — Post-placental: within 10 minutes after delivery of the placenta for immediate postpartum insertion.
  - — Immediate postpartum: within 48 hours after childbirth before discharge.
- If more than 48 hours to less than four weeks, copper IUD insertion is not recommended. Delay it until 4 weeks or more after giving birth.
  - — Intra-cesarean: Immediately after the removal of the placenta prior to closure of the uterus. This is associated with lower expulsion rate.
- Fully or nearly fully breastfeeding: Less than 6 months after giving birth
  - — If monthly bleeding has not returned, IUD can be inserted anytime between 4 weeks and 6 months after giving birth. No backup method is needed.
  - — If monthly bleeding has returned, the same protocol is used for clients who are having menstrual cycle.
- Fully or nearly fully breastfeeding: More than 6 months after giving birth
  - — If monthly bleeding has not returned, IUD can be inserted anytime as long as the client is certainly not pregnant. No backup method is needed.
  - — If monthly bleeding has returned, the same protocol is used for clients who are having menstrual cycle.
- Partially breastfeeding or not breastfeeding
  - — Certainly not pregnant. Backup method is not needed.
  - — If monthly bleeding has returned, the same protocol is used for clients who are having menstrual cycle.

Insertion after miscarriage or abortion

- If within 12 days after first- or second-trimester abortion and no infection present, may immediately be inserted with an IUD. Backup method is not needed.
- If more than 12 days after the first or second trimester abortion, IUD may be inserted anytime if it is reasonably certain that she is not pregnancy.

- May refer or treat the client if infection is present. Once infection is resolved, an IUD may be inserted or help the client to choose another method. After miscarriage or abortion.

SPECIFIC INFECTION PREVENTION TIPS FOR IUD INSERTION OR REMOVAL

Appropriate Setting: Suitable setting for IUD insertion and removal is an examination room in an outpatient clinic or birthing home or minor surgery in a hospital. It should be clean, adequately lit, well ventilated and offers privacy. Nearby handwashing facility should be available.

Appropriate attire for clients and staff: Wearing a cap, mask or gown is not needed for the staff since it is a minor procedure. The clients can wear their own clothing, provided they are clean. However, because of the COVID-19 pandemic, health care providers may use personal protective equipment (PPE) during the procedure or when cleaning of instruments for protection against infectious contamination.

Specific Infection Prevention Measures for the Procedure

- Instruments and supplies should be available and ready for use.
- Make sure that the IUD package is unopened, undamaged, and not beyond the expiry date.
- Wash hands thoroughly with soap and water before doing the procedure. Hands should be dried with a clean, dry cloth or paper towel or air-dried.
- Self-protection such as wearing gloves and physical barrier. Wear high level disinfection or sterile gloves on both hands.
- Follow the "no touch" insertion technique to reduce the risk of contaminating the uterine cavity, which includes not letting the loaded IUD or uterine sound touch any unsterile surfaces. This technique also involves the following:
    - While the IUD is still in the sterile package, load the IUD into the inserter to avoid touching the IUD directly.
    - The cervix should be cleansed with antiseptic solution (povidone iodine or chlorhexidine) two or more times prior to IUD insertion. Do not use alcohol.
    - The uterine sound and the loaded IUD inserter should pass through the cervical canal only once without touching the vaginal wall or speculum blades.
    - It is not recommended to give routine antibiotics for women at low risk of STI.
    - The following protocols should be done after insertion or removal of IUD:
    - Place all instruments in 0.5% chlorine solution.
    - Wipe examination table with chlorine solution for decontamination.
    - Immerse both gloved hands in 0.5% solution and remove by turning it inside out.
    - Dispose gloves in leak-proof container.
    - Wash hands thoroughly with soap and water then dry.
    - Process instruments properly.

Pelvic Examination Prior to IUD Insertion

Prior to IUD insertion, a bimanual pelvic examination and STI screening must be done. In order to check for any signs of PID or anatomical abnormalities, the health care provider must perform a proper pelvic examination.

- The contraindications in doing IUD insertion are active PID, STI, and anatomical abnormalities resulting in a distorted uterus. Treatment of PID must be done first prior to IUD insertion. The health care provider may recommend the use of condoms and/or alternative FP methods while the client is on treatment. If there is any uterine abnormality, other FP methods should be offered.
- The following are signs of possible pelvic abnormalities such as PID, STI, or abnormal uterine cavity. IUD insertion should be deferred if any of these signs are observed.
  - Lower abdominal tenderness when the cervix is moved (possible PID)
  - Tenderness while palpating for the uterus, ovaries, or fallopian tubes (possible PID)
  - Purulent cervical discharge (possible STI or PID)
  - Bleeding of the cervix when touched (possible STI or cervical cancer)
  - Anatomical abnormality of the uterine cavity preventing the proper IUD insertion
  - Difficulty in determining the size and/or position of the uterus that prevents proper IUD insertion
  - Process instruments properly.

Steps in doing the pelvic examination

- Inspection of the external genitalia
- Bimanual or internal examination
- Speculum examination
- Recto-vaginal examination, if needed

Note: If findings from the history and visual inspection are normal or infection is not suspected, the provider may perform the bimanual examination first, then speculum examination. With the speculum still in place, proceed to sound the uterus and IUD insertion. However, if findings from the history and visual inspection are not normal or infection is suspected, perform the speculum examination first, then do bimanual examination. Reinsert the speculum for uterine sounding and IUD insertion only if indicated.

Who should provide IUD insertion and removal

A licensed health service provider (doctors, nurses, and midwives) who have been trained in the provision of basic FP services including Family Planning Competency-Based Training (FPCBT Levels I and II) with certificate of completion should perform IUD insertion and removal.

Participant selection criteria in IUD training:

1. Licensed health service providers with training in FPCBT basic course
2. Hold records of providing FP services in their practice
3. Interested in adding IUD services to their FP practice
4. Owns clinics or are affiliated with clinics suitable for IUD service provision

5. Practicing in areas with expressed need for IUD services and with support from Local Chief executives
6. Have existing ties/connections/collaborations and support from a licensed obstetrician/physician.

INSERTING THE IUD

Clients should undergo FP counseling. All IUD clients must be asked to sign an informed consent before the procedure starts. Do not insert IUD if the uterine depth is <6 cm or >8 cm.

- Talk with the client before the procedure
  - — Explain the procedure of IUD insertion
  - — Show the instruments such as speculum, tenaculum and IUD inserter in the package.
  - — Explain to the client that she will experience discomfort or cramping during the procedure
  - — Ask the client to disclose any feeling of cramping or discomfort any time during the procedure anytime.
- Ibuprofen (200 mg–400 mg), paracetamol (325 mg–1000 mg), or other pain relievers may be given 30 minutes before insertion to help reduce cramping and pain. Do not give aspirin because it slows blood clotting.
  - — It is not recommended to insert an IUD for the following delivery related conditions:
- Rupture of membranes for greater than 18 hours
- Chorioamnionitis
- Unresolved postpartum hemorrhage
- Genital trauma
  - — If the client is deferred due to delivery-related conditions, the FP provider should counsel the client to practice LAM or use another FP method until her next follow-up visit.
- Talk with the client during the procedure
  - — Guide the client through the procedure in a step-by-step manner and reassure her.
  - — Alert the client before a step that may cause pain or might startle her.
  - — Ask regularly if the client feels any pain.
- Talk with the client after the procedure
  - — Ask the client how she feels
  - — Tell her that the procedure is done and the IUD is in place, and she can lie down for a while and then slowly sit up before getting dressed.
  - — Advise her regarding follow-up.

Proper technique and instruments for Interval IUD insertion

1. The health care provider must use proper infection prevention procedures
2. Prepare necessary items before insertion:
   a. Drape to cover the client's pelvic area

b. Clean cloth to place between the client and the examination table
c. Sterile gloves
d. Sterile bivalve speculum
e. Droplight
f. Sterile uterine tenaculum 12 inches
g. Sterile uterine sound 12 inches
h. IUD in unopened, undamaged, sterile package that is not beyond the expiration date
i. Sterile sharp mayo scissors
j. Sterile sponge forceps 12 inches
k. Sterile bowl containing gauze or cotton balls with an antiseptic solution
l. Dry gauze or cotton ball

3. Client may take mefenamic acid, paracetamol, or other pain reliever 30 minutes before insertion to reduce cramping and pain.
4. Only a trained health care provider may perform the IUD procedure with the necessary supplies and equipment.
5. Do pelvic examination to rule out genital infections and to determine the position and size of the uterus and assess the patient's eligibility for UID insertion. Bimanual examination must be done first, then a speculum is inserted into the vagina to inspect the cervix.
6. The provider disinfects the cervix and vagina with antiseptic.
7. The provider may insert the tenaculum through the speculum and grasp the anterior lip of the cervix at 10 and 2 o'clock position to hold the cervix and uterus steady.
8. The provider measures uterine depth using a uterine sound (6-8 cm).
9. The provider loads the IUD into the inserter while both are still in the unopened sterile package (using the "no touch technique"). She should adjust the depth gauge of the inserter.
10. The provider carefully and slowly inserts the IUD into the uterus through vagina and cervix, then cuts the strings on the IUD, leaving about 3 cm hanging out of the cervix.
11. After the insertion the client may rest on the examination table until she feels ready to get dressed.
12. Do not provide routine antibiotics to the client.

NOTE: Do not cut strings while placing IUD postpartum, postplacental or intracesarean. Strings will typically descend during involution and curl in posterior vaginal fornix (75-80% of strings desecend by 12 weeks postpartum).

Proper technique and instruments for Postpartum IUD insertion

1. The health care provider must use proper infection prevention procedures and follow the same technique as with interval insertion with some modification and more emphasis on infection control as the client has just delivered.
2. Prepare necessary items before insertion:
   a. Drape to cover the client's pelvic area
   b. Clean cloth to place between the client and the examination table
   c. Gloves
   d. Droplight
   e. Ring forceps
   f. Placental forceps 33 cm

g. Preloaded postpartum Cu 380 IUD if available
h. IUD in unopened, undamaged, sterile package that is not beyond the expiration date
i. Bowl containing gauze or cotton balls with antiseptic solution
j. Dry gauze or cotton ball

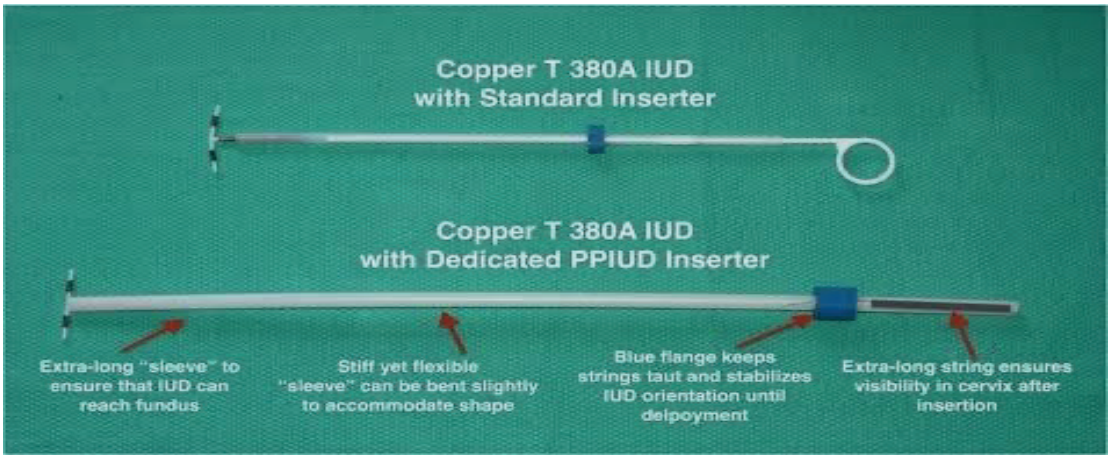
3. Only a trained health care provider performs the IUD procedure with the necessary supplies and equipment
4. The provider cleans the cervix and vagina with antiseptic.
5. The provider may insert the ring forceps through the speculum and grasp the anterior lip of the cervix.
6. Perform immediate postpartum insertion if possible. Insert the placental forceps with IUD through the cervix into the uterine cavity.
7. Elevate uterus with base of hand on abdomen, push lower segment of uterus up towards the client's head. This straightens the sharp vagino-uterine angle that is present after delivery.
8. Place IUD carefully at the fundus. Keep forceps closed until fundus is reached. Release the IUD at the fundus when resistance is felt. Sweep forceps to the side, keeping them slightly open to avoid catching strings during withdrawal. Ensure that IUD or strings are not visible at the cervix or vagina after insertion.
9. Repair any lacerations as necessary.

NOTE: Do not cut strings while placing IUD postpartum, post-placental or intra-cesarean. Strings will typically descend during involution and curl in posterior vaginal fornix (75-80% of strings descend by 12 weeks postpartum)

New Postpartum Intrauterine Contraceptive Device (Postpartum TCu 380A)

The new PPIUD inserter is specially designed to be inserted postpartum with special extra-long loading device for more convenient IUD insertion. The dedicated PPIUD inserter comes preloaded in the insertion sleeve that reduces the need for forceps. It has a longer insertion sleeve compared to the standard IUD inserter for easy access to the uterine fundus, and it also has a longer string that is visible after postpartum insertion.

Characteristic of the New Postpartum IUD inserter



Source: Singh, et. al., 2016

Proper technique and instruments for IUD insertion using Postpartum IUD Inserter

Same preparation as postpartum IUD insertion but using a new postpartum device. In the early years, the Dr. Jose Fabella Memorial Hospital in Manila had experimented with immediate postpartum IUD insertion using the then available Lippe's Loop. Longer inserters were designed locally for proper placement of the IUD in the uterus which was easier than using forceps and improving retention rate.

Currently the new postpartum intrauterine (Copper 380A) device inserter has been introduced with the same concept, but it is not yet available in country. The preparation and overall technique are the same as the postpartum insertion of Copper T but with the modification of using the modern long Cu T inserter. Again, it is important to use appropriate and proper infection prevention procedures.

These are some of the innovations in using the PP Copper T.

- Open the PPIUD inserter package. Make sure that the arms of the IUD is perpendicular to the blue flange and a black line
- Insert the IUD through the cervix and into the lower uterine cavity and remove the ring forceps
- Move the hand toward the fundus and gently depress or stabilize the uterus
- Gently move the PPIUD inserter upwards toward the fundus following the curve of the uterine cavity.
- Confirm that the IUD has reached the fundus
- Move the flange upwards to release the threads. Make sure that the threads are completely free before removing the inserter sleeve
- Maintain the position of the uterus by pressing on it as you remove the inserter
- Cut the strings right at the cervical os.

POST-INSERTION SUPPORT / COUNSELLING

Post-insertion Instructions

1. Ensure that the client is informed of the following:
    a. Type of IUD inserted and date of insertion.
    b. When to have the device removed or replaced.
    c. Expected side effects, such as cramping, heavier menstrual flow, or bleeding between menses. Inform her where to go if she has problems or questions about her IUD.
2. Ways to check IUD:
    a. Wash hands.
    b. Sit in a squatting position.
    c. Ask the client to insert one or two fingers inside the vagina as far as she can until she feels the string.
    d. Ask the client to determine if the strings have changed in length which may denote expulsion.
    e. Tell the clients not to pull the strings to avoid IUD displacement.

3. Proper time to check the IUD strings:
    a. After each menses when the probability of expulsion is high
    b. After noticing any of the following possible symptoms of serious problems:
        — Missed menstrual period, other signs of pregnancy, or an expelled IUD
        — IUD string that seems to be missing or IUD that seems to have been partially or completely expelled. This symptom is determined by the client feeling something hard (plastic device) in her vagina or cervix.

SUPPORT FOR CONTINUING USERS

Follow-up Visit

- A follow-up visit after her first menstrual period or 3-6 weeks after IUD insertion is recommended.

Reasons for Follow-up Visits:

- Routine yearly checkup
- Anytime the client has questions, concerns, or adverse effects/complications such as fever, chills, unusual vaginal discharge (infections); severe bleeding and abdominal cramping in the first month after insertion; and irregular bleeding and /or pain in any cycle (dislocation or perforation)

A routine pelvic examination is not required during follow-up visit. Conduct a pelvic examination if client has signs and symptoms of STI or PID and partial and complete removal of the IUD.

What are the indications for IUD Removal?

- The health care provider should not delay or refuse the removal of IUD when the client requests for its removal because the client is uncomfortable with the side effects or develops medical conditions. The client should not be forced to continue using the IUD but must offer her alternative FP methods.

Reasons for IUD Removal

1. Presence of side effects especially pain and bleeding, which are intolerable to the client
2. Medical reasons
    a. Pregnancy, if threads are visible
    b. Acute PID (endometritis or salpingitis) if necessary and after antibiotics have been started for at least 24 hours
    c. Perforation of the uterus or cervix or IUD translocation
    d. Partial expulsion
    e. Abnormal, heavy bleeding that puts the client's health at risk

When should the IUD be removed

Except for the reasons above, IUD should be removed:

- At the end of 12th year of use when the effective life span of the IUD has been reached.
- At menopause
- Anytime during the menstrual cycle

What happens when IUD is removed?

The copper bearing IUD is a long-acting reversible contraception. When IUD is removed the client may become pregnant as rapidly as a non-IUD user. There is no relation that exists between the duration of IUD use and the return of fertility.

Switching from an IUD to Another Method

SWITCHING TO	WHEN TO START
A hormonal method: combined oral contraceptives (COCs). Progestin-only pills (POPs), progestin-only injectables, monthly injectables, combined patch, combined vaginal ring, or implants	Start the hormonal method immediately and remove the IUD, if starting during the first 7 days of monthly bleeding (first 5 days for COCs and POPs). No backup method is needed. If starting after the first 7 days of monthly period (after the first 5 days for COCs and POPs) and she has had sex since her last monthly bleeding, start the hormonal method immediately. The IUD should be left in place until her next monthly period. If starting after the first 7 days of monthly period (after the first 5 days for COCs and POPs) and she has not had sex since her last monthly bleeding, the IUD can be left in place and be removed during her next monthly period or the IUD can be removed and she can use backup method for the next 7 days (2 days for POPs)
Male or female condoms, spermicides, diaphragms, cervical caps, or withdrawal	The next time she has sex after the IUD is removed.
Fertility awareness methods	In the same cycle that the IUD is removed.
Female sterilization	If during the first 7 days of monthly bleeding, remove the IUD and proceed to do female sterilization procedure. No backup method is needed. If after the first 7 days of monthly bleeding, perform the sterilization procedure. IUD can be left in place until her follow up visit or next monthly period. If follow up visit is not possible, remove the IUD at the time of sterilization. Backup method is not needed.
Vasectomy	Anytime. The client can keep the IUD for 3 months after her partners vasectomy to prevent pregnancy and to ensure that vasectomy is fully effective.
* Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Inform the client that withdrawal and spermicides are the least effective contraceptive method. Give condoms, if possible, to the client.	

What are the Potential Complications and Management Procedures of IUDs?

Prolonged or heavy bleeding

Characterize the bleeding:

- Prolonged bleeding – more than 8 days
- Heavy bleeding – twice as much as usual menses
- Bleeding of more than 3 months.
  - — Examine for possible complications such as infections, uterine abnormalities, and hormonal dysfunctions that is not related with the use of IUD
  - — Check for anemia. Recommend Iron supplementation if present.
  - — For modest short-term management
- Non-steroidal anti-inflammatory drugs, such as ibuprofen (400 mg) or indomethacin (25 mg), should be taken twice daily after meals for five days, beginning when irregular bleeding starts, to achieve modest short-term relief.
- Tranexamic acid (500 mg) should be taken thrice daily for three days and then 1000 mg once daily for two days, beginning when heavy bleeding starts.
- Iron tablets may be taken.

Cramping and pain

In the first 3-6 months of IUD use, cramping is common symptom especially during monthly period. It decreases overtime.

Suggest Mefenamic Acid (500mg), Ibuprofen (200-400mg), Paracetamol (325 mg – 1000mg), or other pain relievers.

If cramping is severe and continues beyond the first 2 days after insertion, evaluate for possible perforation or partial expulsion. If more than 3 months, examine the client. If no problem is noted, give the client pain reliever if she wishes to continue using the IUD.

Possible Anemia

Provide iron tablets if possible. Advise the client to eat food containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).

Missing strings

- If the strings are not visible during examination and IUD is not found inside the uterus, the IUD have gone up into the uterus or the IUD has been expelled unnoticed. Refer the client for an ultrasound (or X-ray if pregnancy can be ruled out) to locate the IUD. Give the client a backup method to use. Discuss reinsertion or may advise another contraceptive method to use.
- Determine the client's risk of pregnancy and asked her the following information:
  - — The last time she felt the string
  - — Her last menstrual period
  - — If she has any signs and symptoms of pregnancy

  - If she used a backup method after the IUD come out
  - For modest short-term management
- Non-steroidal anti-inflammatory drugs, such as ibuprofen (400 mg) or indomethacin (25 mg), should be taken twice daily after meals for five days, beginning when irregular bleeding starts, to achieve modest short-term relief.
  - Refer the client to physician if pregnancy is suspected.
  - Confirm expulsion if pregnancy has been ruled out. Give the client a backup method and advise follow-up on her next menstrual period.

Pregnancy with IUD

Rule out ectopic pregnancy if the client is pregnant. Refer the client to specialist immediately.

If IUD strings are visible:

- Explain that an IUD in the uterus must be removed during pregnancy to avoid risk of preterm delivery, miscarriage, or infection. The provider may remove IUD if less 12 weeks age of gestation. It is not recommended to remove IUD more than 12 weeks age of gestation since gestational sac occupies the whole cavity during this time that would endanger pregnancy.
- If the client agrees on the removal, gently remove the IUD if has proper training or refer for removal.
- If the client chooses to keep the IUD, a nurse or doctor should monitor her closely.
- If IUD strings are visible:
- Refer for an ultrasound to the determine the location of the device.
- If IUD had not been expelled or not accessible, do not remove the IUD. Refer the client to a specialist and consider her as a case of high-risk pregnancy to closely monitor signs of possible complications.
- Advise the client about the risk and inform her to seek immediate care for fever, pain, abnormal vaginal discharge, and heavy bleeding.

Pelvic Inflammatory Disease

The common signs and symptoms of PID are fever or chills, abnormal vaginal discharge, pelvic pain, and cervical motion tenderness, tender pelvic mass, pain during sex or urination, and bleeding after sex or between monthly bleeding. However, infection can also be silent.

- Refer the client to a specialist for management and treatment of PID. Immediate removal of IUD is not necessary.
- Advise the client that treatment should begin immediately to avoid serious complications and the device may not be removed immediately during treatment unless symptoms do not improve within 72 hours. If the client decided to remove the IUD during treatment, the IUD can be removed 2 to 3 days after antibiotic treatment has begun.
- Counsel the client about condom use for protection against future STIs and encourage her partner to receive treatment soon.

Uterine Perforation

If perforation is suspected at the time of insertion or sounding of the uterus, stop the procedure immediately.

Signs of perforation: loss of resistance to upward pressure of inserter or uterine sound, sharp pain during insertion, signs of hemorrhage that requires emergency surgical procedures.

If puncturing is suspected at the time of IUD insertion, perform the following:

- Stop the procedure and refer the client to a surgeon or gynecologist, if necessary.
- Perforation can be confirmed by x-ray or ultrasound.
- In the first hour, keep the client at bed rest and check her vital signs every 5-10 minutes.
- If the client remains stable after one hour, check for signs of intraabdominal bleeding such as low hemoglobin or rebound on abdominal examinations. If she has no signs or symptoms, she may be discharge but she should avoid sex for 2 weeks and provide alternative contraception. Follow up with the client after 1 week.
- If she has rapid pulse and falling blood pressure, or increasing pain around the uterus, refer the client to high level of care.

Partial Expulsion

- Remove the IUD if it partially comes out. Ask the client whether she wants another IUD or another contraceptive method.
- If the client wants another IUD, she can have one inserted at any time if it is reasonably certain she is not pregnant.

Complete Expulsion

- If the client reports that the IUD came out, ask the client whether she wants another IUD or another contraceptive method.
- If the client wants another IUD, she can have one inserted at any time if it is reasonably certain she is not pregnant.
- If complete expulsion is suspected (strings cannot be found on pelvic exam) and the client does not know whether the IUD came out, refer for ultrasound (or X-ray if pregnancy can be ruled out) to assess the location of the IUD. Backup method is needed at this time.

Partner can feel IUD strings during sex

Discuss that this phenomenon sometime occurs when strings are cut too short.

If the client's partner finds the string bothersome, discuss the available options:

- Strings can be cut even shorter, so they are not coming out of the cervical canal. The client's partner will not feel the strings, but she will no longer be able to check her IUD strings.
- If the client wants to check, the IUD can be removed, and a new one can be inserted. To avoid discomfort, the strings should be cut, leaving about 3 cm hanging out of the cervix.

Suspected ectopic pregnancy

Signs and symptoms of ectopic pregnancy:

- Unusual abdominal pain or tenderness
- Abnormal vaginal bleeding or no monthly bleeding
- Lightheadedness or dizziness
- Fainting

Refer the client at once for immediate diagnosis and care if ectopic pregnancy or other serious health condition is suspected.

How can a partner help?

The client's partner can participate during counseling and learn about different contraceptive method and what support he can give to his partner. A male partner can support the client's choice of the IUD, show understanding and support if she has side effects, use condoms consistently and correctly in addition to IUD if he has STI/HIV or thinks he may be at risk of STI/HIV and remind the client about the date of IUD removal.

Key Points for Providers and Clients using Copper Bearing Intra-Uterine Device

Long-term pregnancy protection. Shown to be very effective for up to 12 years, immediately reversible.

Inserted into the uterus by a specifically trained provider.

Little required of the client once the IUD is in place.

Bleeding changes are common. Typically, longer and heavier bleeding and more cramps or pain during monthly bleeding, especially in the first 3 to 6 months.

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

Levonorgestrel Intrauterine Device

INTRODUCTION

Levonorgestrel intrauterine device (LNG-IUD), also known as the levonorgestrel-releasing intrauterine system (LNG-IUS) or hormonal IUD, is a T-shaped polyethylene plastic device about 32 mm long with a steroid reservoir containing 52 mg of levonorgestrel. About 20 ug of levonorgestrel is being released into the uterine cavity every 24 hours. It is immediately reversible.

Source: Durbin Global, 2021

Brand names: Mirena and Kyleena (5 years), Skyla, Liletta, and Jaydess (3 years)

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Who can use LNG-IUD

A client who wants a safe and effective long-acting reversible method of contraception (LARC) is suitable to use LNG-IUD.

MEC CATEGORIES FOR IUD	
Category 1: Use the method without restrictions	
Women ≥20 years old	Epilepsy
Postpartum less than 48 hours, non-breastfeeding	Depressive Disorder
Parous	Irregular pattern without heavy vaginal bleeding
≥4 weeks postpartum	Heavy or prolonged vaginal bleeding (includes regular and irregular pattern)
1st trimester post abortion	Superficial Venous Disorders • Varicose Veins • Superficial Venous thrombosis
Past ectopic pregnancy	Endometriosis
History of pelvic surgery	Cervical ectropion
Woman who smoke at any age	Benign breast disease
Obesity: Body mass index of more than or equal to 30 kg/m2	Family history of breast cancer

Multiple risk factors for arterial cardiovascular disease (such as older age, smoking, diabetes, hypertension and known dyslipidemina)	Uterine fibroids without distortion of the uterine cavity
Hypertension adequately controlled	History of PID with subsequent pregnancy
Elevated blood pressure levels (systolic 140-159 or diastolic 90-99 mmHg)	High risk of HIV
Family history of DVT/PE	Schistosomiasis
Major surgery without prolonged immobilization	Non-pelvic tuberculosis
Minor surgery without immobilization	Malaria
Superficial venous disorder a. Varicose veins b. Superficial venous thrombosis	History of gestational diabetes
Non-migrainous headaches (mild or severe)	Thyroid disorders
Viral hepatitis	Cirrhosis: mild
Anemia	Anticonvulsant therapy
Antimicrobial therapy	
Category 2: Generally use the method but with more than usual follow-up	
Menarche to <20 years	Known thrombogenic mutations
Postpartum <48 hours, non-breastfeeding	Vascular disease
Woman who has not given birth	Current and history of ischaemic heart disease
Post-abortion in the second trimester	Stroke
History of hypertension, where blood pressure cannot be evaluated (including hypertension in pregnancy)	Known dyslipidemia without other known cardiovascular risk factors
History of DVT/PE	Severe thrombocytopeina
DVT/PE established on anticoagulant therapy	Migraine with or without aura
DVT/PE established on anticoagulant therapy	Migraine with or without aura
Major surgery with prolonged immobilization	Cervical intraepithelial neoplasia (CIN)

Undiagnosed breast mass	Past PID without subsequent pregnancy
Vaginitis (including trichomonas vaginalis and bacterial vaginosis	Asymptomatic or Mild HIV clinical disease (WHO stage 1 or 2)
Diabetes: noninsulin or insulin dependent	Gallbladder disease
Antiretroviral therapy	
Category 3: Do not use the method unless no other appropriate method is available under close supervision	
≥48 hours to <4weeks after childbirth	Decreasing undetectable B-HCG levels in gestational trophoblastic disease
Acute DVT/PE	Breast cancer: past and no evidence of current disease for 5 years
SLE: positive (or unknown) antiphospholipid antibodies	Ovarian Cancer
Severe or advanced HIV clinical disease (WHO stage 3 or 4)	Severe Cirrhosis
Hepatocellular adenoma	Malignant liver tumour (hepatoma)
Category 4: Do NOT use the method	
Pregnancy	Initiation of method in client with cervical or endometrial cancer
Puerperal Sepsis	Women with gestational trophoblastic disease with persistently elevated beta-HCG
Initiation of method in clients with unexplained vaginal bleeding before evaluation	Among women with anatomical abnormalities that distort the uterine cavity (e.g. fibroid)
Current breast cancer	Initiation of method in clients with current purulent cervicitis, chlamydial infection or gonorrhea
Current PID	

Medical Eligibility Criteria for LNG-IUD

Ask the client the questions below about known medical conditions. If she answers "no" to all the questions, then she can have an IUD inserted if she wants. If she answers "yes" to a question, follow the instructions. In some cases, she can still have an IUD inserted.

1. Did you give birth more than 48 hours ago but less than 4 weeks ago?

❑ NO ❑ YES — Delay inserting an IUD until 4 or more weeks after childbirth.

2. Do you have an infection following childbirth or abortion?

❑ NO ❑ YES — If she currently has an infection of the reproductive organs during the first 6 weeks after childbirth (puerperal sepsis) or she just had an abortion-related infection in the uterus (septic abortion), do not insert the IUD. Treat or refer if she is not already receiving care. Help her choose another method or offer a backup method*. After treatment, re-evaluate for IUD use.

3. Do you now have a blood clot in the deep veins of your leg or lungs?

❑ NO ❑ YES — If she currently has an infection of the reproductive organs during the first 6 weeks after childbirth (puerperal sepsis) or she just had an abortion-related infection in the uterus (septic abortion), do not insert the LNG-IUD. Treat or refer is she is not already receiving care. Help her choose another method or offer a backup method. After treatment, re-evaluate for LNG-IUD use.

4. Do you have severe cirrhosis or severe liver tumor?

❑ NO ❑ YES — If she reports severe cirrhosis or severe liver tumor such as liver cancer, do not provide the LNG-IUD. Help her choose a method without hormones.

5. Do you have or have you ever had breast cancer?

❑ NO ❑ YES — Do not insert the LNG-IUD. Help her choose a method without hormones.

6. Do you have vaginal bleeding that is unusual for you?

❑ NO ❑ YES — If she has unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition, use of an IUD could make diagnosis and monitoring of any treatment more difficult. Help her choose a method to use while being evaluated and treated (but not a hormonal IUD, progestin-only injectable, or implant). After treatment, re-evaluate for IUD used.

7. Do you have any female conditions or problems (gynecologic or obstetric conditions or problems), such as genital cancer or pelvic tuberculosis? If so, what problems?

❑ NO ❑ YES — Known current cervical, endometrial, or ovarian cancer; gestational trophoblast disease; pelvic tuberculosis: Do not insert an IUD. Treat or refer for care if she is not already receiving care. Help her choose another method. In case of pelvic tuberculosis, re-evaluate for IUD use after treatment.

8. Do you have HIV or AIDS? Do you have any health conditions associated with HIV infection?

❑ NO ❑ YES — If a woman has HIV infection with severe or advanced clinical disease, do not insert an IUD. In contrast, a woman living with HIV who has mild clinical disease or no clinical disease can have an IUD inserted, whether or not she is on antiretroviral therapy.

9. Assess whether she is at very high individual risk for STIs.

❑ NO ❑ YES — Women who have a very high individual likelihood of STI infection should not have an IUD inserted unless gonorrhea and chlamydia are ruled out by lab tests.

Rule out pregnancy.

Ask the client the questions in the Pregnancy Checklist (see page 33). If she answers "yes" to any of these questions, you can be reasonably certain that she is not pregnant, and she can have an IUD inserted. If the Pregnancy Checklist cannot rule out pregnancy, use another tool before inserting an IUD.

Also, women should not use the LNG-IUD if they report having systemic lupus erythematosus with positive (or unknown) antiphospholipid antibodies but are not receiving immunosuppressive treatment.

Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable, when relevant to the client.

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

MECHANISM OF ACTION

Levonorgestrel increases the thickness of the cervical mucus, which makes it difficult for the sperm to pass through the uterus to meet the egg. It also causes suppression of endometrial proliferation and decidualization of the stroma, which is not suitable for the sperm to survive. Thus, preventing the sperm from fertilizing an egg.

EFFECTIVITY

LNG-IUD is one of the most effective long-acting contraceptive methods. In terms of IUDs perfect use and typical use, it is 99.9% effective. It has very low pregnancy rate about less than 1 pregnancy per 100 women over the first year. This means that 998 of every 1000 women will not become pregnant when using LNG-IUD. Mirena and Kyleena are effective for up to 5 years of use. Liletta, Skyla, and Jaydess are effective for up to 3 years of use.

RETURN TO FERTILITY

After removal of LNG-IUD, the client's fertility returns immediately. Clients may have another insertion of LNG-IUD after removal or they may start another contraceptive method if they decide not to get pregnant.

SIDE-EFFECTS, HEALTH RISKS, AND COMPLICATIONS

Side Effects

Changes in bleeding pattern is the common side effect of LNG-IUD, including lighter bleeding, infrequent bleeding, irregular bleeding, no monthly bleeding, and prolonged bleeding. Some clients may experience acne, headache, breast tenderness or pain, nausea, weight gain, dizziness and mood changes. Proper counseling may encourage the client for continued use of IUD.

Health Risks and Complications

LNG-IUD may also cause pelvic inflammatory disease (PID) if the client has chlamydia or gonorrhea before the IUD is inserted. The risk of genital tract infection among IUD clients is less than 1%. However, if there is a lack of proper infection prevention practices, the risk of infection is higher in the first 20 days after insertion. Uterine perforation is a rare complication especially if the health care provider has proper training and experience.

Warning signs of complications that require immediate follow-up visit to health facility

P: period-related problems or pregnancy symptoms

A: abdominal pain or pain during intercourse

I: infections or unusual vaginal discharge

N: not feeling well, fever, chills

S: string problems

Contraindications in using LNG- IUD:

- Pregnancy
- Acute PID
- Postpartum endometritis
- Known or suspected uterine or cervical malignancy
- Current breast cancer

Common reasons for discontinuation:

- Desire for pregnancy
- Amenorrhea
- Pain
- Infection

DISPELLING MYTHS AND MISCONCEPTIONS

- Can be used by women of any reproductive age, including adolescents
- Can be used by nulliparous and multiparous women
- Do not increase the risk of STIs including HIV
- Do not make women infertile
- Do not cause any birth defects
- Do not cause cancer
- Do not move to the heart or to the brain
- Do not cause discomfort for the woman and her partner during sex

NON-CONTRACEPTIVE BENEFITS

LNG-IUD may help protect against the risk of pregnancy, iron deficiency anemia, endometrial and cervical cancer. It also reduces menstrual cramps, heavy monthly bleeding, symptoms of endometriosis (pelvic pain, irregular bleeding) and risk of ectopic pregnancy.

HOW TO PROVIDE THE METHOD

Self-Assessment Tool for "Very High Individual Risk" of Gonorrhea or Chlamydia

1. Explain that having an IUD inserted is not recommended for women who are at very high individual risk for certain STIs (gonorrhea or chlamydia).
2. Tell the client that you are going to list some possibly risky situations that, if they have occurred recently, would place her at very high individual risk for these STI (gonorrhea and chlamydia).
3. List of situations that puts the client at very high risk for gonorrhea or chlamydia
   - A sexual partner has recently had STI symptoms (pus coming from his penis, pain or burning sensation during urination or an open sore in the genital area)
   - She or her sexual partner was diagnosed with STI recently
   - She has had more than one sexual partner recently
   - She has a sexual partner who has had other partners recently
   - She thinks that her partner, who works away from home for long periods of time, has other sexual partners
4. Ask the client whether after considering the risky situation she thinks the IUD is an appropriate choice for her, or whether she would like to consider other contraceptive method

   If the client does not think the IUD is an appropriate choice for her or would like to consider other contraceptive methods:
   - Counsel the client on other contraceptive methods that maybe more appropriate.
   - Urge the use of condom, alone or with other method to protect against STI;
   - STI patients should be advised to consult an STI expert/clinic, and when treated may use condom again (UHC, HCPN, and PHC principles).
   - Consider the need for further evaluation/treatment (if recurrent STI is suspected)
   - Provide the alternative method now, if appropriate (and a backup method if needed)

SCREENING QUESTIONS FOR PELVIC EXAMINATION BEFORE IUD INSERTION

For questions 1-5, if the answer is "yes", refer for diagnosis and treatment as appropriate. Help her choose another contraceptive method and counsel her about condom use if she faces any risk of STIs. Give her condoms, if possible. If an STI or PID is confirmed and she still wants an IUD, it may be inserted as soon as she finishes treatment if she is not at risk for reinfection before insertion.

1. Is there any type of ulcer on the vulva, vagina, or cervix?

❑ NO ❑ YES — Possible STI

2. Does the client feel pain in her lower abdomen when you move the cervix? ❑ NO ❑ YES	— Possible PID
3. Is there tenderness in the uterus, ovaries, or fallopian tubes (adnexal tenderness)? ❑ NO ❑ YES	— Possible PID
4. Is there a purulent cervical discharge? ❑ NO ❑ YES	— Possible STI or PID
5. Does the cervix bleed easily when touched? ❑ NO ❑ YES	— Possible STI or cervical cancer
6. Is there an anatomical abnormality of the uterine cavity that will prevent correct IUD placement? ❑ NO ❑ YES	— If an anatomical abnormality distorts the uterine cavity, proper IUD placement may not be possible. If available, an ultrasound examination can help determine if proper IUD placement is possible. If not, help her choose another method.

LNG-IUD for Women with HIV

- If the women living with HIV have mild or no clinical disease, whether or not they are on antiretroviral therapy, they can safely have LNG-IUD inserted.
- If the women have an advanced or severe HIV infection, LNG-IUD insertion is not recommended.
- It is not necessary to remove an LNG-IUD if the woman becomes infected with HIV while she has an LNG-IUD in place.
- A close monitoring for pelvic inflammatory disease while LNG-IUD is in place for an IUD user living with HIV who develops the advanced or severe clinical disease.
- A condom along with the LNG-IUD should be used consistently and correctly for women who have HIV or are at risk for HIV since condoms prevent transmission of HIV and other STIs.
- LNG-IUD can be inserted for women who are at risk of HIV but not infected with HIV. It does not increase the risk of HIV infection.

What counseling tips can be provided for those who plan or choose to use an IUD?

- Characteristics of IUDs
- Client's current and future risk for STIs
- Effectiveness and mechanism of IUD
- Insertion and removal procedures
- Instructions for use and follow-up visit
- Possible side effects and complications
- How to check the strings

Timing of IUD Insertion

A client can start the LNG-IUD anytime if it is reasonably certain that she is not pregnant. **Use the Pregnancy Checklist on page 49.**

Having menstrual cycle or switching from a nonhormonal method

- Anytime of the month during the menstrual bleeding.
  - — No need for backup method if the client is starting within 7 days after the start of her monthly period.
  - — The client can have the LNG-IUD inserted anytime if it is reasonably certain she is not pregnant when it is more than 7 days after the start of her monthly period. A backup method is needed for the first 7 days after insertion.

Switching from a hormonal method.

- Immediately if the client has been using the method consistently and correctly or it is reasonably, she is not pregnant. No need to wait for her next monthly period.
- No need for backup method if the client is starting within 7 days after the start of her monthly period.
- The client may need a backup method for 7 days if it is more than 7 days after the start of her monthly period that the LNG-IUD is inserted.
- If the client is switching from injectable, she can have the LNG-IUD inserted when the repeat injection would have been given. No backup method is needed.

Soon after childbirth

- Anytime within 48 hours after giving birth
- Delay until 4 weeks if it is beyond 48 hours after giving birth.

Fully or nearly fully breastfeeding (less than 6 months after giving birth)

- The client can have the LNG-IUD inserted anytime between 4 weeks and 6 months if the LNG-IUD is not inserted within the first 48 hours and her monthly period has not returned.
- The client can have the LNG-IUD inserted as advised for women having menstrual cycles if her monthly bleeding has returned.

Fully or nearly fully breastfeeding (more than 6 months after giving birth)

- The client can have the LNG-IUD inserted anytime if it is reasonably certain she is not pregnant if her monthly bleeding has not returned. A backup method is needed for the first 7 days after insertion.
- The client can have the LNG-IUD inserted as advised for women having menstrual cycle if her monthly bleeding has returned.

Partially breastfeeding or not breastfeeding (less than 4 weeks after giving birth)

- Delay the insertion until at least 4 weeks after giving birth if the LNG-IUD is not inserted within the first 48 hours.

Partially breastfeeding or not breastfeeding (more than 4 weeks after giving birth)

- The client can have the LNG-IUD inserted anytime if it can be determined that she is not pregnant when her monthly bleeding has not returned. A backup method is needed for the first 7 days after insertion.
- The client can have the LNG-IUD inserted as advised for women having menstrual cycles if her monthly bleeding has returned.

No monthly bleeding (not related to childbirth or breastfeeding)

- Anytime if it can be determined that the client is not pregnant. A backup method is needed for the first 7 days after insertion.

After miscarriage or abortion

- Immediately, if the LNG-IUD is inserted within 7 days after first or second trimester abortion and if no infection is present. No backup method is needed.
- The client can have the LNG-IUD inserted anytime if it is reasonably certain she is not pregnant when it is more than 7 days after the first or second trimester abortion and no infection is present.
- Treat or refer and help the client to choose another contraceptive method if infection is present. If the client chooses the LNG-IUD, it can be inserted after infection has completely treated.
- If not specifically trained for LNG-IUD insertion after second trimester abortion, delay insertion until at least 4 weeks after abortion.

After taking progestin-only, combined, or ulipristal acetate (UPA) emergency contraceptive pills (ECPs)

- The client can have the LNG-IUD inserted when it can be determined that she is not pregnant, for example, after the start of her next monthly period. Give her a backup method or oral contraceptive pills to use until she can have IUD inserted.
- The client should not have the LNG-IUD inserted in the first 6 days after taking UPA-ECPs. These drugs interact. If the LNG-IUD is inserted sooner, one or both may be less effective since both LNG and UPA are present in the body.

SPECIFIC INFECTION PREVENTION TIPS FOR IUD INSERTION OR REMOVAL

Appropriate Setting: Suitable setting for IUD insertion and removal is an examination room in an outpatient clinic or birthing home or minor surgery in a hospital. It should be clean, adequately lit, well ventilated and offers privacy. A nearby handwashing facility should be available.

Appropriate attire for clients and staff: Wearing a cap, mask or gown is not needed for the staff since it is a minor procedure. However, because of COVID-19 pandemic, health care providers may use personal protective equipment (PPE) such as protective goggles, facemask and aprons during the procedure or when cleaning of instruments for protection against infectious agent contamination.

Specific Infection Prevention Measures for the Procedure

- Instruments and supplies should be available and ready for use.
- Make sure that the IUD package is unopened, undamaged and not beyond the expiry date.
- Wash hands thoroughly with soap and water or use alcohol-based hand rub before doing the procedure. Hands should be dried with clean dry cloth or paper towel or air-dried.
- Self-protection such as wearing gloves and physical barrier. Wear high-level disinfection or sterile gloves on both hands.
- Follow the "no touch" insertion technique to reduce the risk of contaminating the uterine cavity, which includes not letting the loaded IUD or uterine sound touch any unsterile surfaces. This technique also involves the following:
    - While the IUD is still in the sterile package, load the IUD into the inserter to avoid touching the IUD directly.
    - The cervix should be cleansed with antiseptic solution (povidone iodine or chlorhexidine) two or more times prior to IUD insertion. Do not use alcohol.
    - The uterine sound and the loaded IUD inserter should pass through the cervical canal only once without touching the vaginal wall or speculum blades.
    - It is not recommended to give routine antibiotics for women at low risk of STI.
    - The following protocols should be done after insertion or removal of IUD:
    - Place all instruments in 0.5% chlorine solution.
    - Wipe examination table with chlorine solution for decontamination.
    - Immerse both gloved hands in 0.5% solution and remove by turning it inside out.
    - Dispose gloves in leak-proof container.
    - Wash hands thoroughly with soap and water then dry.
    - Process instruments properly.

Pelvic Examination Prior to LNG-IUD Insertion

Prior to IUD insertion, a bimanual pelvic examination and STI screening must be done. In order to check for any signs of PID or anatomical abnormalities, the health care provider must perform a proper and thorough pelvic examination.

- The contraindications in doing IUD insertion are active PID, STI and anatomical abnormalities resulting in a distorted uterus. Treatment of PID must be done first prior to IUD insertion. The health care provider may recommend the use of condoms and/or alternative FP methods while the client is on treatment. If there is any uterine abnormality, other FP methods should be offered.
- The following are signs of possible pelvic abnormalities such as PID, STI, or abnormal uterine cavity. IUD insertion should be deferred if any of these signs are observed.
    - Lower abdominal tenderness when the cervix is moved (possible PID)

- — Tenderness while palpating for the uterus, ovaries, or fallopian tubes (possible PID)
- — Purulent cervical discharge (possible STI or PID)
- — Bleeding of the cervix when touched (possible STI or cervical cancer)
- — Anatomical abnormality of the uterine cavity preventing the proper IUD insertion
- — Difficulty in determining the size and/or position of the uterus that prevents proper IUD insertion

Steps in doing the pelvic examination

- Inspection of the external genitalia
- Bimanual or internal examination
- Speculum examination
- Recto-vaginal examination, if needed

Note: If findings from the history and visual inspection are normal or infection is not suspected, the provider may perform the bimanual examination first, then speculum examination. With the speculum still in place, proceed to sounding the uterus and IUD insertion. However, if findings from the history and visual inspection are not normal or infection is suspected, perform the speculum examination first then do bimanual examination. Reinsert the speculum for uterine sounding and IUD insertion only if indicated.

Who should provide an IUD insertion and removal?

A licensed health service provider (doctor, nurse, and midwife) who have been trained in the provision of basic family planning services including Family Planning Competency-Based Training (FPCBT Levels I and II) with certificate of completion.

Participant selection criteria in IUD training:

1. Licensed health service providers with training in FPCBT course levels 1 and 2
2. Hold records of providing FP services in their practice
3. Interested in adding IUD services to their FP practice
4. Owns clinics or are affiliated with clinics suitable for IUD service provision
5. Practice in areas where there is a need for IUD services and with support from Local Chief executives
6. Have existing ties/connections/collaborations and support from a licensed obstetrician/physician.

INSERTING THE IUD

Clients should undergo FP counseling. All IUD clients must be asked to sign an informed consent before the procedure starts. Do not insert IUD if the uterine depth is <6 cm or >8 cm

- Talk with the client before the procedure
  - — Explain the procedure of IUD insertion
  - — Show the instruments such as speculum, tenaculum and IUD and inserter in the package.

  - — Explain to the client that she will experience discomfort or cramping during the procedure.
  - — Ask the client to disclose any feeling of cramping or discomfort during the procedure anytime.
- Ibuprofen (200 mg–400 mg), Paracetamol (325 mg–1000 mg), or other pain relievers may be given 30 minutes before insertion to help reduce cramping and pain. Do not give aspirin because it slows blood clotting.
  - — It is not recommended to insert an IUD for the following delivery related conditions:
- Rupture of membranes for greater than 18 hours
- Chorioamnionitis
- Unresolved postpartum hemorrhage
- Genital trauma
- Talk with the client during the procedure
  - — Guide the client through the procedure in a step-by-step manner and reassure her.
  - — Alert the client before a step that may cause pain or might startle her.
  - — Ask regularly if the client feels any pain.
- Talk with the client after the procedure
  - — Ask the client how she feels
  - — Tell her that the procedure was done and the IUD is in place, and she can lie down for a while and then slowly sit up before getting dressed.
  - — Advise her regarding follow-up.

Proper Technique and instruments for LNG-IUD insertion

1. The health care provider must use proper infection prevention procedures
2. Prepare necessary items before insertion:
   a. Drape to cover the clients pelvic area
   b. Clean cloth to place between the client and the examination table
   c. Gloves
   d. Bivalve speculum
   e. Droplight
   f. Uterine tenaculum 12 inches
   g. Uterine sound 12 inches
   h. IUD in unopened, undamaged, sterile package that is not beyond the expiration date
   i. Sharp mayo scissors
   j. Sponge forceps 12 inches
   k. Bowl containing gauze or cotton balls with antiseptic solution
   l. Dry gauze or cotton ball
3. Do pelvic examination to rule out genital infections and to determine the position of the uterus and assess the eligibility. Bimanual examination must done first then a speculum is inserted into the vagina to inspect the cervix.
4. Take mefenamic acid, paracetamol, or other pain reliever 30 minutes before insertion to reduce cramping and pain.

5. Only a trained health care provider can perform IUD procedure with the necessary supply and equipment.
6. The provider cleans the cervix and vagina with antiseptic.
7. The provider may insert the tenaculum through the speculum and grasp the cervix at 10 and 2 o'clock position to hold the cervix and uterus steady.
8. The provider slowly and gently passes the uterine sound through the cervix, releases the LNG-IUD inside the uterine cavity, and removes the inserter.
9. The provider inserts the IUD into the uterus through vagina and cervix, then cut the strings on the IUD, leaving about 3 cm hanging out of the cervix.
10. After the insertion the client may rest on the examination table until she feels ready to get dressed.

Giving specific instructions after IUD insertion:

1. Ways to check IUD:
   a. Wash hands.
   b. Sit in a squatting position.
   c. Ask the client to insert one or two fingers inside the vagina as far as she can until she feels the string.
   d. Ask the client to determine if the strings have changed in length which may denote expulsion
   e. Tell the clients not to pull the strings to avoid IUD displacement
2. Proper time to check the IUD strings
   a. After each menses when the probability of expulsion is high
   b. After noticing any of the following possible symptoms of serious problems:
      - Missed menstrual period, other signs of pregnancy, or an expelled IUD
      - IUD string that seems to be missing or IUD that seems to have been partially or completely expelled. This symptom is determined by the client feeling something hard (plastic device) in her vagina or cervix
3. Counseling tips
   a. Advise for a gynecological examination before LNG-IUD insertion, 6 weeks after insertion, then yearly.
   b. The LNG-IUD is effective for 5 years (Mirena) and must be removed by a physician after this time. It can also be removed earlier if required or if the client has no desire to use it.
   c. Advised the client for follow up once she missed her period of 6 weeks to ensure that the IUD has not been expelled and that she is not pregnant.

SUPPORT FOR CONTINUING USERS

Follow-up Visit

- A follow-up visit after her first menstrual period or 3-6 weeks after IUD insertion is recommended.

Reasons for Follow-up Visits:

- Routine yearly checkup
- Anytime the client has questions, concerns, or adverse effects/complications such as fever, chills, unusual vaginal discharge (infections); severe bleeding and abdominal cramping in the first month after insertion; and irregular bleeding and /or pain in any cycle (dislocation or perforation)

A routine pelvic examination is not required during follow-up visit. Conduct a pelvic examination if client has signs and symptoms of STI or PID and partial and complete removal of the IUD.

What are the indications for IUD Removal?

The health care provider should not delay or refuse the removal of IUD when the client requests for its removal because she is uncomfortable with the side effects or develops medical conditions. The client should not be force to continue using the IUD but must offer her alternative FP methods.

Reasons for IUD Removal

1. Presence of side effects especially pain and bleeding, which are intolerable to the client
2. Medical reasons
    - Pregnancy, if threads are visible
    - Acute PID (endometritis or salpingitis) if necessary and after antibiotics have been started for at least 24 hours
    - Perforation of the uterus or cervix or IUD translocation
    - Partial expulsion
    - Abnormal, heavy bleeding that puts the client's health at risk

When should the IUD be removed?

- For the Mirena and Kyleena LNG-IUDs, 5 years after insertion. For Liletta, Skyla, and Jaydess LNG-IUDs, 3 years after insertion
- At menopause
- Anytime during the menstrual cycle

What happens when IUD is removed?

The LNG- IUD is a long-acting reversible contraception. When IUD is removed the client may become pregnant as rapidly as a non-IUD user. No relation exists between the duration of IUD use and the return of fertility.

Switching from an IUD to Another Method

SWITCHING TO	WHEN TO START
A hormonal method: combined oral contraceptives (COCs). Progestin-only pills (POPs), progestin-only injectables, monthly injectables, combined patch, combined vaginal ring, or implants	Start the hormonal method immediately and remove the IUD, if starting during the first 7 days of monthly bleeding (first 5 days for COCs and POPs). No backup method is needed. If starting after the first 7 days of monthly period (after the first 5 days for COCs and POPs) and she has had sex since her last monthly bleeding, start the hormonal method immediately. The IUD should be left in place until her next monthly period. If starting after the first 7 days of monthly period (after the first 5 days for COCs and POPs) and she has not had sex since her last monthly bleeding, the IUD can be left in place and be removed during her next monthly period or the IUD can be removed, and she can use backup method for the next 7 days (2 days for POPs)
Male or female condoms, spermicides, diaphragms, cervical caps, or withdrawal	The next time she has sex after the IUD is removed
Fertility awareness methods	In the same cycle that the IUD is removed
Female sterilization	If during the first 7 days of monthly bleeding, remove the IUD and proceed to do female sterilization procedure. No backup method is needed. If after the first 7 days of monthly bleeding, perform the sterilization procedure. IUD can be left in place until her follow up visit or next monthly period. If follow up visit is not possible, remove the IUD at the time of sterilization. Backup method is not needed.
Vasectomy	Anytime. The client can keep the IUD until a test of her partner's semen shows that vasectomy is working, or for 3 months, when the vasectomy is fully effective to prevent pregnancy.

* Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Inform the client that withdrawal and spermicides are the least effective contraceptive method. Give condoms, if possible to the client.

POTENTIAL COMPLICATIONS AND MANAGEMENT PROCEDURES OF LNG-IUDs

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

- Give the client reassurance that some women may experience irregular bleeding in using LNG-IUD. It usually decreases overtime and stops after the first several months of use.
- If after several months of no bleeding, an irregular bleeding starts. Consider underlying conditions not related to method use.

No monthly bleeding

- Reassure the client that many women experience no monthly bleeding when using LNG-IUD and this is not harmful.
- If monthly period stops very soon after LNG-IUD insertion, assess for pregnancy or other underlying condition.

Heavier or prolonged bleeding

- Reassure the client that some women may experience heavier or prolonged bleeding. It decreases after the first several months of use.
- Give Iron tablets and counsel her that it is important to eat foods containing iron.
- Consider other conditions unrelated to method use when heavier or prolonged bleeding continues or starts after several months of no bleeding.

Cramping and pain

In the first day or 2 after IUD insertion, the client may experience some cramping and pain.

Suggest Mefenamic Acid (500mg), Ibuprofen (200-400mg), Paracetamol (325 mg-1000mg), or other pain reliever.

If cramping is severe and continues beyond the first 2 days after insertion, evaluate for possible perforation or partial expulsion. If more than 3 months, examine the client. If no problem is noted, give the client pain reliever if she wishes to continue using the IUD.

Acne

- The client may consider switching to COC and stop using the LNG-IUD because of acne. Some women experience improvement with their acne after using COC. She may also consider other local remedies.

Ordinary headache

- Suggest aspirin (325 mg -650 mg), Ibuprofen (200-400mg), paracetamol (325mg -1000 mg) or other pain reliever
- Any headache that gets severe or occur frequently during LNG-IUD use should be evaluated.

Breast tenderness

- Advise the client to wear a supportive bra
- May try hot or cold compress
- Suggest aspirin (325 mg -650 mg), Ibuprofen (200-400mg), paracetamol (325mg -1000 mg) or other pain reliever
- Consider locally available remedies.

Weight change

- Advise for lifestyle change, review diet and counsel as needed.

Mood changes

- If the client has serious mood changes, she should be referred for care.

Partner can feel IUD strings during sex

Discuss that this phenomenon sometimes occurs when strings are cut too short.

If the client's partner finds the string bothersome, discuss the available options:

- Strings can be cut even shorter, so they are not coming out of the cervical canal. The client's partner will not feel the strings, but she will no longer be able to check her IUD strings.
- If the client wants to check, the IUD can be removed, and a new one can be inserted. To avoid discomfort, the strings should be cut, leaving about 3 cm hanging out of the cervix.

Pelvic Inflammatory Disease

The common signs and symptoms of PID are fever or chills, abnormal vaginal discharge, pelvic pain, and cervical motion tenderness, tender pelvic mass, pain during sex or urination, and bleeding after sex or between monthly bleeding. However, infection can also be silent.

- Refer the client to a specialist for management and treatment of PID. Immediate removal of IUD is not necessary.
- Advise the client that treatment should begin immediately to avoid serious complications and the device may not be removed immediately during treatment unless symptoms do not improve within 72 hours. If the client decided to remove the IUD during treatment, the IUD can be removed 2 to 3 days after antibiotic treatment has begun
- Counsel the client about condom use for protection against future STIs and encourage her partner to receive treatment soon.

Suspected Ovarian Cyst

- The client may continue using the LNG-IUD during evaluation and treatment
- No need to treat enlarged ovarian cysts unless they grow abnormally large, twist, or burst. Advise the client for follow up after 6 weeks for re-evaluation.

Suspected ectopic pregnancy

Signs and symptoms of ectopic pregnancy:

- Unusual abdominal pain or tenderness
- Abnormal vaginal bleeding or no monthly bleeding
- Lightheadedness or dizziness
- Fainting

Refer the client at once for immediate diagnosis and care if ectopic pregnancy or other serious health condition is suspected.

Uterine Perforation

If perforation is suspected at the time of insertion or sounding of the uterus, stop the procedure immediately.

Signs of perforation: loss of resistance to upward pressure of inserter or uterine sound, sharp pain during insertion, signs of hemorrhage that requires emergency surgical procedures.

If puncturing is suspected at the time of IUD insertion, perform the following:

- Stop the procedure and refer the client to a surgeon or gynecologist, if necessary.
- Perforation can be confirmed by x-ray or ultrasound.
- In the first hour, keep the client at bed rest and check her vital signs every 5-10 minutes.
- If the client remains stable after one hour, check for signs of intraabdominal bleeding such as low hemoglobin or rebound on abdominal examinations. If she has no signs or symptoms, she may be discharge but she should avoid sex for 2 weeks and provide alternative contraception. Follow up with the client after 1 week.
- If she has rapid pulse and falling blood pressure, or increasing pain around the uterus, refer the client to high level of care.

Partial Expulsion

- Remove the IUD if it partially comes out. Ask the client whether she wants another IUD or another contraceptive method.
- If the client wants another IUD, she can have one inserted at any time if it is reasonably certain she is not pregnant.

Complete Expulsion

- If the client reports that the IUD came out. Ask the client whether she wants another IUD or another contraceptive method.
- If the client wants another IUD, she can have one inserted at any time if it is reasonably certain she is not pregnant.
- If complete expulsion is suspected (strings cannot be found on pelvic exam) and the client does not know whether the IUD came out, refer for ultrasound (or X-ray if pregnancy can be ruled out) to assess the location of the IUD. Backup method is needed at this time.

Missing strings

- If the strings is not visible during examination and IUD is not found inside the uterus, the IUD have gone up into the uterus or the IUD has been expelled unnoticed. Refer the client for an ultrasound (or X-ray, if pregnancy can be ruled out) to locate the IUD. Give the client backup method to use. Discuss reinsertion or may advise another contraceptive method to use.
- Determine the client's risk of pregnancy and asked her the following information:
  - The last time she felt the string
  - Her last menstrual period.
  - If she has any signs and symptoms of pregnancy
  - If she used a backup method after the IUD come out.

- Refer the client to physician if pregnancy is suspected.
- Confirm expulsion if pregnancy has been ruled out. Give the client a backup method and advise follow-up on her next menstrual period.

Pregnancy with IUD

Rule out ectopic pregnancy if the client is pregnant. Refer the client to specialist immediately.

If IUD strings are visible:

- Explain that an IUD in the uterus must be removed during pregnancy to avoid risk of preterm delivery, miscarriage, or infection. May remove IUD if less 12 weeks age of gestation. It is not recommended to remove IUD more than 12 weeks age of gestation since gestational sac occupies the whole cavity during this time that would endanger pregnancy.
- If the client agrees to removal, gently remove the IUD if has proper training or refer for removal.
- If the client chooses to keep the IUD, a nurse or doctor should monitor her closely.
- If IUD strings are not visible:
- Refer for an ultrasound to the determine the location of the device.
- If IUD had not been expelled or not accessible, do not remove the IUD. Refer the client to a specialist and consider her as a case of high-risk pregnancy to closely monitor signs of possible complications.
- Advise the client about the risk and inform her to seek immediate care for fever, pain, abnormal vaginal discharge, and heavy bleeding.

Unexplained vaginal bleeding

- Refer or re-evaluate by history or pelvic examination. Diagnose and manage as appropriate.
- The client may continue using the IUD while her condition is being evaluated.
- If bleeding is caused by STI or PID, she may continue using the IUD while on treatment.

Heart disease due to blocked or narrowed arteries

- The client may safely start the LNG-IUD. If the conditions develops while she is using the LNG-IUD:
  - Remove the IUD or refer for removal
  - Help her choose a contraceptive method without hormones
  - Refer for diagnosis and management if not already under care.

Certain serious health conditions (blood clots in deep veins of legs or lungs, breast cancer, gestational trophoblast disease, or pelvic tuberculosis)

- Refer for removal or remove the IUD
- Give the client backup method to use until the condition is evaluated
- Refer for diagnosis and management if not already under care.

How can a partner help

The client's partner can participate during counseling and learn about different contraceptive method and what support he can give to his partner. A male partner can support the client's choice of the LNG-IUD, show understanding and support if she has side effects, use condoms consistently and correctly in addition to IUD if he has STI/HIV or thinks he may be at risk of STI/HIV and remind the client about the date of IUD removal.

KEY LEARNING POINTS FOR PROVIDERS AND CLIENTS USING

Copper bearing IUD

Copper bearing IUD is a long acting, reversible contraception which is very effective up to 12 years.

Only a trained health care provider can do copper-bearing IUD insertion and removal.

Bleeding changes is the most common side effect of copper bearing IUD method.

LNG-IUD

Long-term pregnancy protection. Very effective for 5 years, immediately reversible.

Inserted into the uterus by a specifically trained provider.

Little required of the client once the LNG-IUD is in place.

Bleeding changes are common but not harmful. Typically, lighter, and fewer days of bleeding, or infrequent or irregular bleeding.

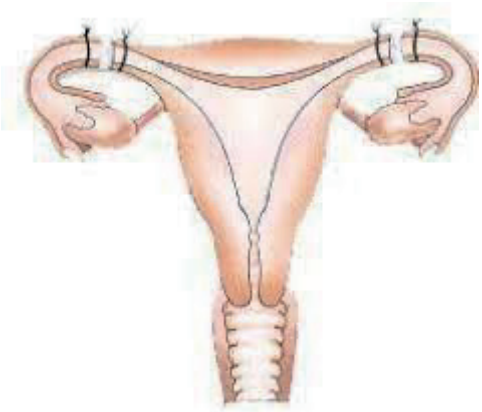
Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

E. STERILIZATION

Female Sterilization

INTRODUCTION

Female Sterilization refers to a relatively simple, permanent operative procedure to prevent pregnancy by blocking the fallopian tubes of women who no longer desire to have children. The two most common surgical approaches often used in the Philippines are minilaparotomy and laparoscopy.



(doh.gov.ph)

1. Minilaparotomy that involves making a small incision in the infra-umbilical area of the abdomen for postpartum minilap and suprapubic for interval minilap. This is to gain access intraperitoneally to the fallopian tubes brought near to the incision to be cut or blocked.
2. Laparoscopy that involves inserting a long, thin scope with lenses to the abdomen through a small incision. This laparoscope enables the doctor to reach and block or cut the fallopian tubes intraperitoneally.

The surgical procedure done is also called tubal sterilization, tubal ligation, voluntary surgical contraception, tubectomy, bi-tubal ligation, tying the tubes, minilap, and "the operation".

Facts about Female Sterilization

1. Female sterilization is more than 99% effective at preventing pregnancy.
2. Because it's a permanent method the couple do not have to think about protecting yourself against pregnancy every time you have sex, so it does not interrupt with sexual intercourse.
3. It does not affect the hormone levels and will still have periods.
4. You'll need to use contraception up until the surgery and until the next period or for 3 months after the operation (depending on the type of sterilization).
5. As with any surgery, there's a small risk of complications, such as internal bleeding, infection or damage to affected if any organs.
6. There's a small risk that the operation will not work. Blocked tubes can rejoin immediately or years later.

7. If the operation fails, this may increase the risk of a fertilized egg implanting outside the womb (ectopic pregnancy).
8. Although it is said to be reversible, the surgical reversal procedure is difficult to perform.
9. Sterilization does not protect against sexually transmitted infections (STIs).
10. Tubal occlusion is a fairly minor surgical operation and many women return home on the same day of the surgery.

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Medical Eligibility Criteria for Female Sterilization

All women can have female sterilization. No medical conditions prevent a woman from undergoing female sterilization. This checklist asks the client about known medical conditions that may limit when, where, or how the female sterilization procedure should be performed. Ask the client the questions below. If she answers "no" to all of the questions, then the female sterilization procedure can be performed in a routine setting without delay. If she answers "yes" to a question, follow the instructions, which recommend caution, delay, or special arrangements.

In the checklist below:

- Caution means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition.
- Delay means postponing female sterilization. These conditions must be treated and resolved before female sterilization can be performed. Help the client choose another method to use until the procedure can be performed.
- Special means special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anesthesia, and other backup medical support. For these conditions, the capacity to decide on the most appropriate procedure and anesthesia regimen also is needed. Help the client choose another method to use until the procedure can be performed.

1. Do you have or have you ever had any female conditions or problems, such as infection or cancer? If so, what problems?

❑ NO ❑ YES

— If she has any of the following, use caution:

- Previous abdominal or pelvic surgery
- Past pelvic inflammatory disease since last pregnancy
- Uterine fibroids
- Breast cancer

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

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

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

• Unrelated to pregnancy

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

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

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

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

❑ NO ❑ YES

— If she has any of the following, use caution:

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

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

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

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

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

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

❑ NO ❑ YES

— If she has any of the following, use caution:

- Moderate iron-deficiency anemia (hemoglobin 7–10 g/dl)
- Severe lack of nutrition (Is she extremely thin?)
- Sickle cell disease
- Inherited anemia (thalassemia)
- Diaphragmatic hernia
- Epilepsy
- Hypothyroidism

- Mild cirrhosis of the liver, liver tumors, or schistosomiasis with liver fibrosis
- Kidney disease
- Obesity (Is she extremely overweight?)
- Elective abdominal surgery at time sterilization is desired (Note: We may do BTL during elective abdominal surgery, if it so happens that the client requested to have it done during the abdominal surgery).
- Depression
- Young age
- Uncomplicated lupus with negative antiphospholipid antibodies

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

- Gallbladder disease with symptoms
- Active viral hepatitis
- Severe iron-deficiency anemia (hemoglobin less than 7 g/dl)
- Lung disease (bronchitis or pneumonia)
- Systemic infection or significant gastroenteritis
- Abdominal skin infection
- Undergoing abdominal surgery for emergency or infection, or major surgery with prolonged immobilization

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

- Severe cirrhosis of the liver
- Hyperthyroidism
- Coagulation disorders (blood does not clot)
- Chronic lung disease (asthma, bronchitis, emphysema, lung infection)
- Pelvic tuberculosis
- HIV with advanced or severe clinical disease

The Importance of Clinical Assessment

Because female sterilization involves a surgical procedure and the administration of local anesthesia (with or without mild sedation and analgesia), the client must undergo a careful, comprehensive yet focused clinical assessment. This assessment is important in every case, but it is even more important when the procedure is performed in hard-to-reach areas, in an outreach service, or in facilities far from supporting higher- level health services.

The assessment must include review of the Medical Eligibility Criteria (above) and a pelvic/ genital examination.

Avoid Unnecessary Procedures

Women can have female sterilization:

- Without any blood tests or routine laboratory tests
- Without cervical cancer screening
- Without a pregnancy test. A woman can have female sterilization even when she is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant (see Pregnancy Checklist on page 49).

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

MECHANISM OF ACTION

Female sterilization works by preventing eggs travelling down the fallopian tubes from the ovaries to the uterus. This means the eggs are blocked at the ligated segment of the fallopian tube and can't meet the sperm, so fertilization cannot occur. The eggs are still released from the ovaries as normal, but do not meet with the sperm and eventually will be absorbed naturally into the woman's body.

How Female Sterilization is carried out

- Up to the present time there have been several methods that female sterilization has been performed to occlude the fallopian tube. The surgeon will block the fallopian tubes (tubal occlusion) by tying, cutting and removing a small piece of the fallopian tube done through laparotomy. This is in both minilap and laparoscopic BTL.
- When doing postpartum BTL, the incision should be subumbilical while in Interval BTL the incision is suprapubic.

The two more popular ways are described as, first, the surgeon accessing the fallopian tubes by making a small cut either near the belly button (as in laparoscopy) or an incision just above the pubic hairline (as in mini-laparotomy).

In laparoscopy, the surgeon uses a laparoscope which is a long, thin instrument with an attached light and camera (a laparoscope) to clearly see the fallopian tubes inside the abdomen. A **laparoscopy** is usually done because it is a faster procedure, however, a mini-laparotomy is recommended for women who:

- have had recent abdominal or pelvic surgery
- are obese
- have a history of pelvic inflammatory disease, a bacterial infection that can affect the womb and fallopian tubes

The occlusion of the fallopian tubes is by applying clips or rings, or by tying, cutting and removing a small piece of the tube.

If blocking the fallopian tubes has not worked, the tubes may be completely removed. This is called a **salpingectomy**.

EFFECTIVITY

Female sterilization is one of the most effective contraceptive methods but carries a small risk of failure with less than 1 pregnancy per 100 women over the first year after having the sterilization procedure (5 per 1,000). This means that 995 of every 1,000 women relying on female sterilization will not become pregnant.

There is no protection against sexually transmitted infections (STIs) in the procedure.

ADVANTAGES AND DISADVANTAGES

Advantages of Female Sterilization

- Nothing to remember, no supplies needed, and no repeated clinic visits required
- No interference with sex
- Has no hormonal side effects
- No effect on breastmilk.
- Can be performed just after a woman gives birth
- Very effective

Disadvantages of Female Sterilization

- Requires minor surgery
- Considered to be permanent as reversal surgery is difficult
- Does not protect against STIs including HIV/AIDS

RETURN TO FERTILITY

Fertility does not return because sterilization generally cannot be reversed. The procedure is intended to be permanent. Reversal surgery is difficult, expensive, and not available in most areas.

SIDE-EFFECTS, HEALTH RISKS, AND COMPLICATIONS

Sterilization may help protect against risk of pregnancy, ovarian cancer and reduces the risk of ectopic pregnancy There are identified risks associated with sterilization such as bowel/ bladder perforation, infection, bleeding, or regret. Complications of surgery and anesthesia is uncommon and extremely rare.

DISPELLING MYTHS AND MISCONCEPTIONS

- Does not make women weak.
- Does not cause lasting pain in back, uterus, or abdomen.
- Does not remove a woman's uterus or lead to a need to have it removed.
- Does not cause hormonal imbalances.
- Does not cause heavier bleeding or irregular bleeding or otherwise change women's menstrual cycles.
- Does not cause any changes in weight, appetite, or appearance.
- Does not change women's sexual behavior or sex drive.
- Does not cause ectopic pregnancy. Instead, it substantially reduces the risk of ectopic pregnancy

NON CONTRACEPTIVE HEALTH BENEFIT

Recent studies (ACOG, 2019) presented that opportunistic salpingectomy may offer obstetrician–gynecologists and other health care providers the opportunity to decrease the risk of ovarian cancer in their patients who are already undergoing pelvic surgery for benign disease. By performing salpingectomy when patients undergo an operation during which the fallopian tubes could be removed in addition to the primary surgical procedure (e.g., hysterectomy), the risk of ovarian cancer is reduced. Although opportunistic salpingectomy offers the opportunity to significantly decrease the risk of ovarian cancer, it does not eliminate the risk of ovarian cancerentirely.

HOW TO PROVIDE THE METHOD

When to perform the procedure

Having menstrual cycle or switching from another method

- May perform procedure anytime of the month as long as it is reasonably certain she is not pregnant.
- Anytime within 7 days after the start of monthly period. No backup method is needed.
- If the client is switching form oral contraceptives, she may continue taking the pill until she finishes the pack to maintain her regular monthly period.
- If the client is switching from an IUD, she can have the procedure immediately

No monthly bleeding

- Anytime of the month as long as the client is reasonably certain she is not pregnant

After childbirth

- Immediately or within 7 days after giving birth.
- Anytime ≥6 weeks postpartum if it is reasonably certain she is not pregnant.

After miscarriage or abortion

Within 48 hours after uncomplicated abortion

After using emergency contraceptive pills (ECPs)

- May give the client a backup method or oral contraceptives to start the day after taking the ECPs until her procedure. The sterilization procedure can be done within 7 days after the start of the client's next monthly period or anytime as long as it is reasonably certain she is not pregnant.

Performing the Sterilization Procedure

Explaining the Procedure

A woman who has chosen female sterilization needs to know what will happen during the procedure. The following description can help to explain the procedure to her.

The Mini-laparotomy Procedure

1. The provider uses proper infection-prevention procedures at all times.
2. The provider performs a physical examination and a pelvic examination. The pelvic examination is to assess the condition and mobility of the uterus
3. The provider inserts a special instrument (uterine elevator) into the vagina, through the cervix, and into the uterus to raise each of the 2 fallopian tubes so they are closer to the incision. This may cause discomfort.
4. The woman usually receives light sedation and analgesia to relax her. She stays awake. Local anesthetic is injected above the pubic hair line. She will not experience serious pain.
5. The provider makes a small horizontal incision (2–5 centimeters) in the anesthetized area. This usually causes little pain. (For women who have just given birth, the incision is made at the lower edge of the navel.)
6. The provider closes the incision with stitches and covers it with an adhesive bandage.

7. The woman receives instructions on what to do after she leaves the clinic or hospital. She usually can leave in a few hours.

The Laparoscopy Procedure

1. The provider observes proper infection-prevention and control procedures at all times.
2. The provider performs a physical examination and a pelvic examination. The pelvic examination is to assess condition and mobility of the uterus.
3. The woman usually receives light sedation and analgesia to relax her. She remains awake throughout the procedure. Local anesthetic is injected under her navel so she will not experience serious pain.
4. The provider places a special needle into the woman's abdomen and, through the needle, inflates (insufflates) the abdomen with gas. This raises the wall of the abdomen away from the pelvic organs.
5. The provider makes a small incision (about one centimeter) in the anesthetized area and inserts a laparoscope. A laparoscope is a long, thin tube containing lenses. Through the lenses the provider can see inside the body and locates the 2 fallopian tubes.
6. The provider performs fulguration/cauterization to close off the fallopian tubes.
7. The provider then removes the instrument and laparoscope. The gas is let out of the woman's abdomen. The provider closes the incision with stitches and covers it with an adhesive bandage.
8. The woman receives instructions on what to do after she leaves the clinic or hospital . She usually can leave in a few hours.

Local Anesthesia is best for Female Sterilization

Performing the female sterilization through minilaparotomy is done under local anesthesia. This is done with or without mild sedation and analgesia. This is much preferred to general anesthesia to affect a quicker waking up of the client.

Local anesthesia with sedation and analgesia:

- is safer than general, spinal, or epidural anesthesia
- let the woman leave the clinic or hospital sooner
- allows faster recovery
- makes it possible to perform female sterilization in more facilities

Sterilization under local anesthesia, with or without mild sedation and analgesia, can be done when a member of the surgical team has been trained to provide sedation and analgesia and the surgeon has been trained to provide local anesthesia. The surgical team should be trained to manage emergencies, and the facility should have the basic equipment and drugs to manage any emergencies.

Health care providers should explain to a woman ahead of time that being awake during the procedure is safer for her. During the procedure, providers should talk with the woman and help to reassure her if needed.

The most common anesthetic used is lidocaine (lignocaine). Many different sedatives and analgesics may be used. The dosage of drugs must be adjusted to body weight. Oversedation should be avoided because it can reduce the client's ability to stay conscious and could slow or stop her breathing.

In some cases, general anesthesia may be needed. For medical conditions needing special arrangements, which may include general anesthesia.

Ensuring Informed Choice

IMPORTANT: A friendly counselor who listens to a woman's concerns, answers her questions, and gives adequate, clear, and practical information about the procedure—especially its permanence—will help a woman make an informed choice and be a successful and satisfied user, without later regret (see Because Sterilization is Permanent, next page). Involving her partner in counseling can be helpful but is not necessary or required.

THE 7 POINTS OF INFORMED CONSENT

Counseling must cover all 7 points of informed consent. In some programs the client and the counselor also sign an informed consent form. To give informed consent to sterilization, the client must understand the following points:

Temporary contraceptive also are available to the client, including long-acting reversible contraceptives.

Voluntary sterilization is a surgical procedure.

There are certain risks of the procedure as well as benefits. Both risks and benefits must be explained in a way that the client can understand.

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 against the procedure at any time before it takes place (without losing rights to other medical, health, or other services or benefits).

The procedure does not protect against sexually transmitted infections, including HIV.

Explaining Self-Care for Female Sterilization

Before the procedure

- The client should use another contraceptive method prior to the procedure.
- The client must avoid eating anything for 8 hours before surgery but she can drink clear liquids until 2 hours before surgery.
- The client must avoid taking any medication 24 hours before the procedure.
- The client should wear clean, loose-fitting clothing to the health facility if possible
- The client must not wear any nail polish or jewelry
- If possible the client may bring her partner, friend or a relative to assist her.

After the procedure

- The client must rest for 2 days and avoid vigorous work and heavy lifting for a week.
- The client should keep the incision clean and dry for 1-2 days
- The client should avoid rubbing the incision for 1 week
- The client must not have sex for at least 1 week.

SUPPORT FOR THE CONTINUING USER

What to do about the most common problems

- The provider may suggest ibuprofen (200-400 mg), paracetamol (325 -1000 mg) , or other pain reliever if the client has abdominal pain and swelling after the procedure. She should not take any aspirin which slows blood clotting.

Plan the Follow-up visit

- Return of visit within 7 days or at least within 2 weeks is highly recommended.
- The FP provider must check the site of the incision and look for signs of infection, and remove any stitches which can be done in the health facility.

Reasons to Return

The client may come back anytime especially if she has questions or she thinks she might be pregnant. She may also follow-up once she noted any problems such as:

- Bleeding, pain, pus, swelling or redness on incision site that becomes worse
- Fever greater than 38 C
- Experiences fainting, persistent light-headedness, or extreme dizziness in the first 4 weeks

Managing any problems reported as complication

Infection at the incision site

- Clean the infected area with soap and water or antiseptic
- May give oral antibiotics for 7-10 days. If infection worsen even after treatment, the client may visit the health facility.

Abscess

- Clean the area with antiseptic, then incise and drain the abscess.
- Give oral antibiotic for 7-10 days. If infection worsen even after treatment, the client may visit the health facility.

Severe pain in lower abdomen

- Assess if the pain is related to surgery such as bleeding, lack of appetite, lack of bowel transit, lack of urination, or fever. May refer the client to higher level of facility with surgical capability.
- If the surgery is more than months or years ago, suspect for an ectopic pregnancy and refer the client to higher level of facility for further evaluation.

KEY POINTS FOR PROVIDERS AND CLIENTS USING FEMALE STERILIZATION

Permanent. Intended to provide life-long, permanent, and very effective protection against pregnancy. Reversal is usually not possible.

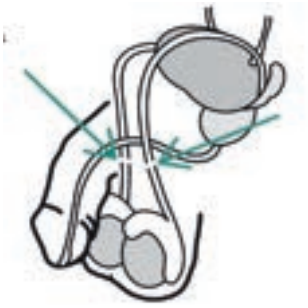
Involves a physical examination and surgery. The procedure is done by a specifically trained provider.

No long-term side effects.

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

Vasectomy

INTRODUCTION



Vasectomy is a permanent method of contraception for men. It entails a minor surgical procedure that is performed by cutting and ligating the vas deferens, the small tube that serves as a passage of the sperm from the testicles to the seminal vesicle and prostate gland where it combines with seminal fluid to form the semen. It provides an option for male partners for an FP method that is safer, simpler, less expensive, and just as effective as female sterilization.

Types

Currently there are two types of vasectomy based on the approach to the Vas Deferens

- No Scalpel Vasectomy (NSV) - uses a specially designed dissecting forceps to make a puncture on the skin of the scrotum to approach the vas. It is the standardized and DOH-approved method for vasectomy It is easier to perform with lesser discomfort and risk of bleeding and infection. Also, there is no perceptible scarring.
- Conventional Vasectomy uses a scalpel to make an incision on the skin of the scrotum to approach the vas.

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Who can have a Vasectomy

With proper counseling and informed consent, any man can have a vasectomy safely, including men who:

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

In some of these situations, especially careful counseling is important to make sure the man will not regret his decision.

Who cannot have a Vasectomy

All men can have vasectomy. No medical conditions prevent a man from using vasectomy. However, there are known medical conditions that may limit when, where, or how the vasectomy procedure should be performed. Ask the client the questions below. If he answers "no" to all of the questions, then the vasectomy procedure can be performed in a routine setting without delay. The following checklist will help the provider determine what to do depending on the response of the client. if the client If he answers "yes" to a question below, follow the instructions, which recommend caution, delay, or special arrangements.

Medical Eligibility Criteria

In the checklist below:

- Caution means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition.
- Delay means postponing vasectomy. These conditions must be treated and resolved before vasectomy can be performed. Give the client another method to use until the procedure can be performed.
- Special means special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anesthesia, and other backup medical support. For these conditions, the capacity to decide on the most appropriate procedure and anesthesia regimen also is needed. Help the client choose another method* to use until the procedure can be performed.

1. Do you have any problems with your genitals, such as infections, swelling, injuries, or lumps on your penis or scrotum? If so, what problems?

❑ NO ❑ YES

— If he has any of the following, use caution:
- Previous scrotal injury
- Swollen scrotum due to swollen veins or membranes in the spermatic cord or testes (large varicocele or hydrocele)
- Undescended testicle—one side only. (Vasectomy is performed only on the normal side. Then, if any sperm are present in a semen sample after 3 months, the other side must be done, too.)

— If he has any of the following, delay vasectomy:
- Active sexually transmitted infection
- Swollen, tender (inflamed) tip of the penis, sperm ducts (epididymis), or testicles
- Scrotal skin infection or a mass in the scrotum

— If he has any of the following, make special arrangements:
- Hernia in the groin. (If able, the provider can perform the vasectomy at the same time as repairing the hernia. If this is not possible, the hernia should be repaired first.)
- Undescended testicles—both sides

2. Do you have any other conditions or infections? If so, what?

❑ NO ❑ YES

— If he has any of the following, use caution:
- Diabetes
- Depression
- Young age
- Lupus with positive (or unknown) antiphospholipid antibodies or on immunosuppressive treatment

— If he has any of the following, delay vasectomy:
- Systemic infection or gastroenteritis
- Filariasis or elephantiasis

— If he has any of the following, make special arrangements:
- HIV with advanced or severe clinical disease (see Vasectomy for Men with HIV, below)
- Blood fails to clot (coagulation disorders)
- Lupus with severe thrombocytopenia

Avoid Unnecessary Procedures

Men can have vasectomy:

- Without any blood tests or routine laboratory tests
- Without a blood pressure check
- Without a hemoglobin test
- Without a cholesterol or liver function check
- Even if the semen cannot be examined by microscope later to see if it still contains sperm

A genital examination should be conducted before performing vasectomy.

MECHANISM OF ACTION

The cutting and tying of the Vas deferens disrupt the flow of the sperm from the testes to the seminal vesicle and prostate glands and they no longer become part of the semen. Although the man continues to have sexual intercourse and climax as before, his semen does not contain sperm so that he cannot father a child, after the vasectomy.

EFFECTIVITY

Vasectomy is very effective at 99.9% for correct use but slightly lower with typical use at 99.8%. *The infertility effect of vasectomy does not happen immediately after the procedure.*

The client or his partner needs to use another effective contraceptive for at least 3 months to ensure that the semen is sperm free, attested by a sperm-free semen examination. A common choice of backup method is the condom.

For this reason, all vasectomy clients should be provided with instructions and practice on the correct use of condoms for use immediately after the vasectomy. Providers often mistakenly assume that all men know how to correctly use condoms, incorrect use is common and is a major cause of condom failure.

ADVANTAGES AND DISADVANTAGES

Advantages of Vasectomy

- Less pain and bruising and quicker recovery.
- Fewer infections and less collection of blood in the tissue (hematoma).
- Total time for the vasectomy has been shorter when skilled providers use the no-scalpel approach.
- Both no-scalpel and conventional incision procedures are quick, safe, and effective.
- Permanent, highly effective
- Less cost than Female sterilization
- Can be done in a doctor's office or in an RHU

Disadvantage of Vasectomy

- It has to be done by a trained physician

RETURN TO FERTILITY

Vasectomy is considered permanent.

SIDE-EFFECTS AND ADVERSE REACTION

Complications

Uncommon to rare:

- Severe scrotal or testicular pain that lasts for months or years

Uncommon to very rare:

- Infection at the incision site or inside the incision (uncommon with conventional incision technique; very rare with no-scalpel technique)

Rare:

- Bleeding under the skin that may cause swelling or bruising (hematoma

Warning Signs of Complications

A client should be advised to get medical attention if he experiences fever, blood or pus oozing from the incision site, or severe pain or swelling.

DISPELLING MYTHS AND MISCONCEPTIONS

- Does not remove the testicles. In vasectomy the tubes carrying sperm from the testicles are blocked. The testicles remain in place.
- Does not decrease sex drive.
- Does not affect sexual function. A man's erection is as hard, it lasts as long, and he ejaculates the same as before.
- Does not cause a man to grow fat or become weak, less masculine, or less productive.
- Does not cause any diseases later in life.
- Does not prevent transmission of sexually transmitted infections, including HIV.

Addressing Common Fears of Vasectomy

The idea of having a vasectomy can raise fears---both real and imagined---about the procedure and what to expect. While apprehension can be common, the best answers are always found in knowing the facts. It is, therefore, recommended that service providers are knowledgeable on the basic facts on vasectomy and skillful in effectively communicating these to potential clients.

HOW TO PROVIDE THE METHOD

When to Perform the Procedure

Any time a man requests it (if there is no medical reason to delay the procedure).

Ensuring Informed Choice

IMPORTANT: A friendly counselor who listens to a man's concerns, answers his questions, and gives adequate, clear and practical information about the procedure—especially its permanence—will help a man make an informed choice and be a successful and satisfied user, without later regrets. Because sterilization is permanent, involving his partner in counseling can be helpful but is not necessary or required.

THE 7 POINTS OF INFORMED CONSENT

Counseling must cover all 7 points of informed consent. In some programs the client and the counselor also sign an informed consent form. To give informed consent to sterilization, the client must understand the following points:

Temporary contraceptives also are available to the client.

Voluntary vasectomy is a surgical procedure.

There are certain risks of the procedure as well as benefits. (Both risks and benefits must be explained in a way that the client can understand.)

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 against the procedure at any time before it takes place (without losing rights to other medical, health, or other services or benefits).

The procedure does not protect against sexually transmitted infections, including HIV.

Benefits of Counseling

- Helps ensure informed, voluntary, and well-considered decisions
- Increases client satisfaction
- Contributes to higher rates of contraceptive continuation
- Increases the likelihood that the client will use the method correctly
- Improves the quality of the family planning program
- Enhances the reputation of the family planning program and its staff

Counseling Potential Vasectomy Clients

There are two reasons why vasectomy counseling is particularly critical:

- Vasectomy is a surgical method
- Vasectomy is intended to be a permanent method

VASECTOMY TECHNIQUE / PROCEDURE

Reaching the Vas: No-Scalpel Vasectomy

No-scalpel vasectomy is the recommended technique for reaching each of the 2 tubes in the scrotum (vas deferens) that carries sperm to the penis. It is becoming the standard around the world.

Differences from conventional procedure using incisions:

- Uses one 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.

Blocking the Vas

For most vasectomies ligation and excision is used. This entails 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.

Applying heat or electricity to the ends of each vas (cauterizing) has an even lower failure rate than ligation and excision. The chances that vasectomy will fail can be reduced further by enclosing a cut end of the vas, after the ends have been tied or cauterized, in the thin layer of tissue that surrounds the vas (fascial interposition).

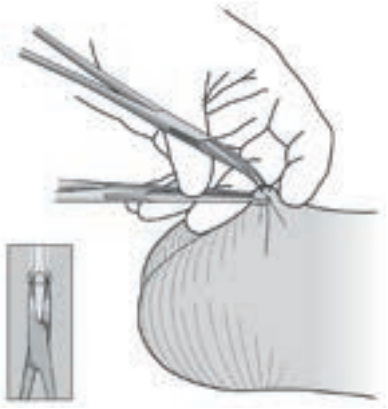
If training and equipment are available, cautery and/or fascial interposition are recommended. Blocking the vas with clips is not recommended because of higher pregnancy rates

Performing the Vasectomy Procedure

Explaining the Procedure

A man who has chosen a vasectomy needs to know what will happen during the procedure. The following description can help to explain the procedure to him. Learning to perform a vasectomy takes training and practice under direct supervision. Therefore, this description is a summary and not detailed instructions.

1. The provider uses proper infection-prevention procedures at all times.
2. The man receives an injection of local anesthetic in his scrotum to prevent pain. He stays awake throughout the procedure.
3. The provider feels the skin of the scrotum to find each vas deferens— the 2 tubes in the scrotum that carry sperm.
4. The provider makes a puncture or incision in the skin of the scrotum
   - Using the no-scalpel vasectomy technique, the provider grasps the tube with specially designed forceps and makes a tiny puncture in the skin at the midline of the scrotum with a special sharp surgical instrument.
   - Using the conventional procedure, the provider makes 1 or 2 small incisions in the skin with a scalpel.



5. The provider lifts out a small loop of each vas from the puncture or incision. Most providers then cut each tube and tie one or both cut ends closed with thread. Some close off the tubes with heat or electricity. They may also enclose one end of the vas in the thin layer of tissue that surrounds the vas
6. The puncture is covered with an adhesive bandage, or the incision may be closed with stitches.
7. The man receives instructions on what to do after he leaves the clinic or hospital The man may feel faint briefly after the procedure. He should stand first with help, and he should rest for 15 to 30 minutes. He usually can leave within an hour.

SUPPORT FOR CONTINUING USERS

- Before the procedure, the man should:
  — Wear clean, loose-fitting clothing to the health facility
- After the procedure, the man should:
  — Rest for 2 days if possible.
  — If possible, put cold compresses on the scrotum for the first 4 hours, which may

decrease pain and bleeding. He will have 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. This will lessen swelling, bleeding, and pain.
  - — Keep the puncture/incision site clean and dry for 2 to 3 days. He can use a towel to wipe his body clean but should not soak in water.
  - — Not have sex for at least 2 to 3 days.
  - — Use condoms or another effective family planning method for 3 months after the procedure. (The previously recommended alternative, to wait for 20 ejaculations, has proved less reliable than waiting 3 months and is no longer recommended.)
- What to do about the most common problems:
  - — Discomfort in the scrotum usually lasts 2 to 3 days. Suggest ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever. He should not take aspirin, which slows blood clotting.
- Plan the follow-up visit:
  - — Ask him to return in 3 months for semen analysis, if available
  - — No man should be denied a vasectomy, however, because follow-up would be difficult or not possible.

How can a partner help?

The client's partner is welcome to participate in counseling and learn about the method and what support she can give to her partner.

A female partner can:

- Understand that vasectomy is permanent
- Discuss as a couple whether they will want more children
- If they will not want more children, support his decision to end his fertility
- Discuss the alternative of female sterilization
- Discuss how they are going to prevent pregnancy during the first 3 months after the procedure, while waiting for vasectomy to become effective: Either use condoms or another method during this time.
- Show understanding and support him through the procedure and recovery
- Use female condoms consistently or encourage him to use male condoms consistently in addition to vasectomy if either partner has an STI/HIV or may be at risk of an STI/HIV.

KEY POINTS FOR PROVIDERS AND CLIENTS USING VASECTOMY

Vasectomy is considered permanent. Intended to provide life-long, permanent, and very effective protection against pregnancy. Reversal is usually not possible.

Involves a safe, simple surgical procedure.

3-month delay in taking effect. The man or couple must use condoms or another contraceptive method for 3 months after the vasectomy.

Does not affect male sexual performance.

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

F. BARRIER METHODS

WHAT ARE BARRIER METHODS?

Barrier methods of birth control mechanically or chemically prevent pregnancy by blocking the sperm from reaching an egg.

Male Condoms

INTRODUCTION

A male condom is a thin sheath of latex rubber placed over an erected penis during sexual contact. It is often times lubricated and some have spermicidal components. When left in place during sexual contact, it prevents the passage of the sperm into the vagina and prevents pregnancy.

A male condom is an effective way to protect a man and his partner from sexually transmitted infections that may be present in the semen.

Condoms are known method with dual protection against the risk of pregnancy and sexually transmitted infections, including HIV. It reduced the risk of HIV infection by 80%-90%. They can reduce the risk of STIs to a very low level if used correctly and consistently. It is the only FP method included in the Philippine FP Program that prevents both pregnancy and sexually transmitted infection.

Source: Mayo Clinic

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Who can use the male condom?

- Couples who inquire about the safe use of condoms and are reliable users.
- Couples who want to use condoms as a backup method due to other FP methods' interruption.
- Couples who are at high risk of STI.
- Couples who want to use condoms as a temporary method until another preferred method is available.
- Couples who have contraindications medically with other methods or those who personally prefer the use of condoms.
- Men who have premature ejaculation as condoms may help delay ejaculation.
- Post vasectomy clients who are awaiting sperm check or semen analysis after three months.

Who cannot use the male condom?

- Some people may have allergy reaction to latex rubber and it is advised that another method be used.

Conditions relating to male and female condoms, spermicides, diaphragms, cervical caps, and the lactational amenorrhea method:

All other conditions listed on the previous pages that do not appear here are a category 1 or NA for male and female condoms, spermicides, diaphragms, and cervical caps, and not listed in the Medical Eligibility Criteria for the lactational amenorrhea method.

= Use the method = Do not use the method — = Condition not listed, does not affect eligibility for method NA = Not applicable **CONDITION**	Male and female condoms	Spermicides	Diaphragms	Cervical caps	Lactational amenorrhea method[#]
REPRODUCTIVE HISTORY					
Parity					
Nulliparous (has not given birth)	1	1	1	1	—
Parous (has given birth)	1	1	2	2	—
< 6 weeks postpartum	1	1	NA[v]	NA[v]	—
CARDIOVASCULAR DISEASE					
Complicated valvular heart disease (pulmonary hypertension, risk of atrial fibrillation, history of subacute bacterial endocarditis)	1	1	2	2	—
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS					
Cervical intraepithelial neoplasia	1	1	1	4	—
Cervical cancer	1	2	1	4	—
Anatomical abnormalities	1	1	NA[w]	NA[x]	—
HIV/AIDS					
High risk of HIV	1	4	4	4	—
Asymptomatic or mild HIV clinical disease (WHO stage 1 or 2)	1	3	3	3	C[y]
Severe or advabced HIV clinical disease (WHO stage 3 or 4)	1	3	3	3	C[y]
OTHERS					
History of toxic shock syndrome	1	1	3	3	—
Unrinary tract infection	1	1	2	2	—
Allergy to latex[z]	3	1	3	3	—

[v] Wait to fit/use until uterine involution is complete.
[w] Diaphragm cannot be used in certain cases of uterine prolapse.
[x] Cap use is not appropriate for a client with severely distorted cervical anatomy.
[y] Caution: Women living with HIV should receive appropriate ARV therapy and exclusively breasfeed for the first 6 months of a baby's life, introduce appropriate complementary foods at 6 months, and continue breastfeeding through 12 months. (See "Maternal and Newborn Health, Preventing Mother-to-Child Transmission of HIV," p. 352.)
[z] Does not apply to plastic condoms, diaphragms, and cervical caps.
[#] For additional conditions relating to the lactational amenorrhea method. see next page.

MECHANISM OF ACTION

Male condoms prevent the entry of the sperm into the vagina. Sperm and other organisms causing STI/HIV do not pass through intact latex rubber or polyurethane condoms. Some condoms have spermicidal coating which intensifies its effectiveness.

EFFECTIVITY

The method's effectiveness depends on the user. Sexually transmitted infections (STI) are more likely when condoms are not used during sexual intercourse. Condoms must be used correctly and consistently to be 98% effective.

Typical use defines as how proper the method works to prevent pregnancy which includes clients that may not use the FP method perfectly and consistently while correctly use may include clients who are following FP method instructions perfectly and consistently.

Factors that influence effectiveness

- Inconsistent use which means condoms are not used in every sexual intercourse.
- Incorrect use of the condom
  - — Unrolling a condom before putting it on
  - — Not "pressing the tip" of the condom
  - — Tearing caused by wearing rings and fingernails
  - — Putting a condom on with the rolled rim toward the penis instead of away from it
  - — Failure to hold on the rim of condom when withdrawing, resulting in spills/leaks
  - — Having intercourse first, then stopping to put condom on
- Condom breakage can occur due to:
  - — Expiration (used after expiration date)
  - — Broken package
  - — Inadequate vaginal lubrication
  - — Defects in the condom
  - — Poor or improper storage with exposure to heat, ultraviolet light, and/or humidity
  - — Weakening of the latex due to application of mineral and vegetable oils as lubricants

Use of miconazole vaginal suppository may cause damage to latex condom

ADVANTAGES AND DISADVANTAGES

Advantages of condom

- Easy to use
- Protects against sexually transmitted infections including HIV
- Inexpensive
- Safe, effective and portable
- Help protect against cervical cancer
- Convenient for short term contraception
- Allows men to share more responsibility for family planning
- Help some men with premature ejaculation or to maintain erection

Disadvantages of condom

- Allergy to latex
- Interrupts the sexual act

- Some men complain of decreased sensitivity
- Slipping off, tearing, spillage of sperm can occur especially among inexperienced users
- Deteriorates quickly when storage conditions are poor

RETURN TO FERTILITY

There is no delay of fertility after stopping the use of male condoms.

SIDE-EFFECTS AND ADVERSE REACTION AND THEIR MANAGEMENT

Extremely rare to get severe allergic reactions among clients with latex allergies. Latex allergy can occur within 24 to 48 hours of use of latex type of condom, and clients with this type of allergy should be advised to use polyurethane condoms or consider other FP methods.

DISPELLING MYTHS AND MISCONCEPTIONS

Clients should be advised of the myths that surround the use of condoms. Some of these contrary beliefs are listed below:

- They do not make men sterile, impotent, or weak.
- They do not decrease men's sex drive.
- They cannot get lost in the woman's body.
- They do not have holes that HIV can pass through.
- They are not laced with HIV.
- They do not cause illness in a woman. Exposure to semen or sperm is unnecessary for a woman's good health.
- They do not cause illness in men and do not make a sperm "back up".
- They are also used by married couples and not only for use outside marriage.
- They do not cause cancer.

NON CONTRACEPTIVE BENEFIT

Protection against human immunodeficiency virus (HIV) and other STIs

HIV transmissions are prevented up to 80% to 95% when condoms are used correctly and consistently during every sexual intercourse.

Condoms can also reduce the risk of STIs if used correctly and consistently.

HOW TO PROVIDE THE METHOD

When to start

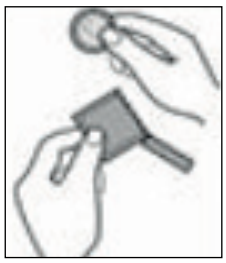
Anytime the client or couple wants protection from pregnancy and STIs

Explaining how to use

Explain the 5 basic steps of using a male condom to get effective results.

1. Use a new condom for each act of sex
    - Examine the pack and look for any perforation or damage to the seal or package.
    - Check the expiration dates and only use before the expiration date.

- If the pack is damaged or has expired discard entirely and use another seal package.
- Open the package carefully; do not use anything to cut or tear open such as teeth, fingernails, or scissors as this may damage the condom.



2. Before any physical contact, place the condom on the tip of the erect penis with the rolled side out
   - Hold the tip of the condom away from the erected penis, press the tip of the condom between the thumb and index finger of one hand, keeping it there whilst the condom is rolled down the penis with the other hand.
   - Pressing the tip prevent any air accumulation that can occur.

3. Unroll the condom all the way to the base of the erect penis.
   - Always put the condom on entirely and securely on the penis before entry into the vagina.
   - Condom should unroll easily. Check the condom if it's on backwards. The condom may be damaged or too old if it does not unroll easily. The client may throw it away and use another condom.

4. Immediately after ejaculation, hold the rim of the condom in place and withdraw the penis while it is still erect.
   - Always hold the condom over the base of the penis while withdrawing the penis out of the vagina. This is to avoid the condom slipping off before completely losing erection.

5. Dispose the used condom safely.
   - Remove the condom by sliding it off the penis carefully and not spilling any semen on or around the vaginal opening.
   - After ejaculation, make a knot with the condom and securely place it in the package and wrap in paper.
   - Dispose of properly.
   - Male condom should never be reused and is not recommended.

Lubricants for Latex Condoms

The client should be advised on the use of lubrication which helps to prevent condom breakage. Non-oil-based lubricants are recommended for latex condoms. Lubricants which are water-based such as spermicides and glycerin, can also be used as well as clean water and saliva. Avoid using oil-based lubricants such as baby oil, coconut oil, petroleum jelly, lotion, cold creams, or massage oil since they can cause condom damage and breakage. For polyurethane condom, any type of lubricant can be used.

SUPPORT FOR CONTINUING USERS

- Always ensure that the client understands the correct use of a condom
  - — Ask the client to explain the basic steps of using the condom by placing it on a penis model or a similar object and removing it.
  - — Inquire from the client if they are satisfied with the method and if they have any further questions.
  - — Ask the client if they are having any difficulty in using the condoms correctly every time during sex and give the client help or advise if necessary.

- Ask clients how many condoms they will need until they can return
  - The FP provider may give the client additional condoms and water based or silicon-based lubricant if available.
- Explain why using a condom with every act of sex is important
  - Explain the importance of using a condom during sexual intercourse.
  - Ensure that the client is aware that one unprotected sexual intercourse can lead to pregnancy, STI or both.
  - If the client has forgotten to use a condom at one time during sex, they should be encouraged to use one the next time during sex and explain the risk again.
- Explain about emergency contraceptive pills (ECPs)
  - Explain the use of ECP in case of errors in condom use to protect from risk of pregnancy.
- Discuss ways to talk about using condoms
  - Discuss skills and techniques about negotiating with the client's partner on condom use.

Role of partner

The client's partner can join the counselling and learn about the method. She can show her support by accepting her man's choice of male condoms. She can discuss with her partner the use of male condoms with full understanding of how to use it. She can remind her partner when to use the condom and help him use it correctly. In case the condom slips, breaks or fails to use it, ECPs should be available on hand.

Condom Storage

- Store condoms in a cool and dry place out of direct sunlight (heat may weaken latex).
- Check the expiration or manufacture date on the box or individual package of condoms.
- Condoms in damaged packages or obvious signs of deterioration (e.g. brittleness, stickiness, or discoloration) should not be used regardless oftheir expiration date
- Latex condoms should not be used beyond their expiration date or more than five years after the manufacturing date.

Managing Any Problems

Mild allergic reaction to condom

- Advise the client to choose another brand of condom. Suggest putting water or lubricant on the condom to lessen the irritation.
- Examine or refer the client for possible vaginal infection or STI.
  - The client may have an allergy to latex if there is no infection and irritation continues to occur.
  - The provider may help the client choose another FP method if not at risk for STI or HIV.
  - If the client is at risk for STIs, suggest using female condoms or plastic male condoms if available. If symptoms become severe, the user should stop using latex condom.

Severe allergic reaction to condom

- The client must stop using latex condoms.

- Refer the client for management since it may lead to life-threatening anaphylactic shock.
- The FP provider may assist the client in choosing other FP method.

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

- If the client notices a break or slip, his partner may use ECPs to help prevent pregnancy in such cases.
- If the client has signs and symptoms of STIs and the condom broke, slipped off, or was not used, assess or refer the client for possible treatment or postexposure prophylaxis against HIV or STIs.
- The health care provider may ask the client reason for breakage or slips:
  - Ask the client to demonstrate how they are opening a condom package and putting the condom on using a model. Correct for any errors.
  - Ask about lubricants that they used if there are any. Too many lubricants may cause the condom to slip off, while too little may cause breakage.
  - Ask when the man withdraws his penis.

Difficulty putting on the condom

- Ask the client to demonstrate how to put the condom on using a model. Correct for any errors.

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

- The client may consider combining condoms with another effective FP method and may use condoms only during fertile period if the couple has no risk of STIs/HIV.
- Discuss another approach on how to talk about condoms with partner and dual protection rationale.

New problems that may require switching methods

- Female partner is using miconazole or econazole (for treatment of vaginal infections)
  - Vaginal miconazole and econazole can damage latex. The female partner may shift to oral treatment, may use female condoms, plastic condoms for male clients, other FP methods or sexual abstinence until completion of treatment

KEY POINTS FOR PROVIDERS AND CLIENTS USING MALE CONDOMS

Male condoms help protect against sexually transmitted infections, including HIV. Condoms are the only contraceptive method that can protect against both pregnancy and sexually transmitted infections.

Require correct use with every act of sex for greatest effectiveness.

Require both male and female partner's cooperation. Talking about condom use before sex can improve the chances one will be used.

May dull the sensation of sex for some men. Discussion between partners sometimes can help overcome this objection.

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

Female Condoms

INTRODUCTION

A female condom is a thin sheath of soft transparent plastic, usually about 7.8 in diameter and 17 cm long. It is made of various materials such as latex, polyurethane, and nitrile. It consists of two flexible rings. One ring has a smaller diameter and is found at the closed end of the condom, which aids in the woman inserting it high within the vagina near the cervix; the other ring is wider and found at the open end of the condom and covers the vulva when properly positioned. Oil-based lubricants do not cause damage to non-latex female condoms.

Source: Mayo Clinic

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Except for allergy to the condom material, no medical conditions prevent the use of this method.

MECHANISM OF ACTION

A female condom works by forming a barrier that helps to keep out sperms from the vagina, hence preventing pregnancy. It also keeps infection from semen, on the penis, or in the vagina from infecting the partner.

EFFECTIVITY

The effectiveness of this method depends on the user. With perfect use, it is about 95%, and typically used, about 79%. The risk of pregnancy or STI is greatest when condoms are not used with every sexual intercourse.

ADVANTAGES AND DISADVANTAGES

Advantages of female condoms

Protection against pregnancy

As commonly used, about 21 per 100 women using female condoms become pregnant over the first year of use. When used correctly with every sexual intercourse, about 5 of 100 women using female condoms become pregnant over the first year of use.

RETURN TO FERTILITY

There is no delay of fertility after stopping the use of female condoms.

SIDE-EFFECTS AND ADVERSE REACTION AND THEIR MANAGEMENT

Side effect may be mild irritation in or around the vagina. To help alleviate this, apply lubricant on the part of condom that comes in contact with the vaginal wall. If symptoms persist, assist and refer the client to a specialist for the treatment of possible vaginal infection or STI. Health benefits of female condoms include protection against pregnancy and STIs, including HIV.

DISPELLING MYTHS AND MISCONCEPTIONS

Female condoms

- Cannot get lost in the woman's body
- Are easy to use but proper use needs to be learned
- Do not have holes that HIV can pass through
- They do not cause illness in a woman because they block the sperm from entering her body
- Are used by married couples and not only for use outside marriage

NON CONTRACEPTIVE BENEFIT

Protection against HIV and other STIs

Condoms can also reduce the risk of STIs, including HIV, when used correctly with every sexual intercourse.

HOW TO PROVIDE THE METHOD

When to start

Anytime the client and her partner want protection from pregnancy and STIs.

Explaining How to Use

Explain the 5 basic steps of using a female condom

1. Use a new female condom for each act of sex.
   - Examine the female condom package for any damage, including the expiry date. Female condoms should not be used after the expiry date. Wash hands with mild soap and clean water before inserting the condom into the vagina.
2. Before any physical contact, insert the condom into the vagina for adequate protection.
   - Insert the condom into the vagina before any physical contact.
   - Insert the condom within 8 hours before sex.
   - Insert the condom before the penis comes in contact with the vagina to achieve the best protection.
   - Assume a comfortable position for insertion, such as squatting, raising one leg, or lying down.
   - Rub the sides of the female condom together to get an even application of the lubricant.
   - Hold the ring at the closed end and squeeze it to become long and narrow.
   - With the other hand, separate the outer lips of the vagina (labia) locate the vaginal canal.
   - Gently push the inner ring into the vagina as far up as it will go.
   - Insert a finger into the condom to help push it into place.
   - Allow approximately 2-3 cm of the condom and the outer ring to cover the outside of the vagina.
3. Ensure that the penis enters the condom and stay inside the condom
   - The man or woman should carefully guide the tip of the penis inside the condom and not between the condom and the vaginal wall.
   - If the penis goes outside the condom, withdraw and try again.
   - If the condom is accidentally removed out of the vagina or pushed into it during sex, put the condom back into 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 the semen.
   - If a couple desires to have sex again, a new condom should be used.
   - Reuse of female condoms is not recommended.
5. Dispose the used condom safely.
   - Wrap the used condom in its package and put it in the rubbish.

Lubricants for Female Condom

The client should be advised that the use of lubrication helps to prevent condom breakage. There are pre-lubricated female condoms, while others have separately packaged lubricants. The clients may also use clean water, saliva or a lubricant made of water, glycol or silicone. For polyurethane and nitrile type of female condoms, oil-based products can be used such as coconut oil or butter, but not with latex female condoms.

SUPPORT FOR CONTINUING USERS

- Always ensure the client understands the correct use of a condom.
  — Ask the client to explain the basic steps of using the female condom by placing it on a model or a similar object and removing it.
- Ask clients how many condoms they will need until they can return.
  — The FP provider may give the client additional condoms and lubricants if available.
- Explain why using a condom with every act of sex is important.
  — Explain the importance of using a condom during sexual intercourse.
  — Ensure the client is aware that one unprotected sexual intercourse can lead to pregnancy, STI or both.
  — If the client has forgotten to use a condom at one time during sex, they should be encouraged to use one the next time during sex and explain the risk again.
- Explain about emergency contraceptive pills (ECPs)
  — Explain the use of ECP in case of errors in condom use to protect from risk of pregnancy.
- Discuss ways to talk about using condoms
  — Discuss skills and techniques about negotiating with the client's partner on condom use.

Role of partner

The client's partner can join the counseling and learn about the method. He can show his support by accepting his partner's chosen method. He can discuss with his partner the use of female condoms with full understanding of how to use it. He can remind his partner when to use the condom and help her use it correctly. If they fail to use the condom or used it incorrectly, ECPs should be available on hand.

Managing Any Problems

Mild allergic reaction to condom

- Advise the client to choose another brand of condom. Suggest putting water or lubricant on the condom to lessen irritation.
- Examine or refer the client for possible vaginal infection or STI.
  - The client may have an allergy to latex if there is no infection and irritation continues to occur.
  - The provider may help the client to choose another FP method if not at risk for STI or HIV.
  - If the client is at risk for STIs, suggest using female condoms or plastic male condoms if available. If symptoms become severe, the user should stop using latex condom.

Difficulty inserting the female condom

- Ask the client to demonstrate how to put the condom on using a model. Correct for any errors.

Inner ring uncomfortable and painful

- The client should reinsert or reposition the condom so the inner ring is tucked back behind the pubic bone and out of the way.

Condom squeaks or make noise during sex

- Advise the client to add more lubricant to the inside of the condom or onto the penis.

Condom slips, is not used, or is used incorrectly

- Take ECPs immediately to prevent pregnancy.
- If the client has signs and symptoms of STIs and the condom slipped off or was not used, assess or refer the client for possible treatment or postexposure prophylaxis against HIV or STIs.
- Ask the client to demonstrate how to put the condom on using a model. Correct for any errors.

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

- The client may consider combining condoms with another effective FP method and may use condoms only during her fertile period if the couple has no risk of STIs/HIV.
- Discuss other approach on how to talk about condoms with partner and dual protection rationale.

Suspected Pregnancy

- Examine for pregnancy.
- The client may use the female condom safely during pregnancy for continued STI protection.

KEY POINTS FOR PROVIDERS AND CLIENTS USING FEMALE CONDOMS

Female condoms help protect against sexually transmitted infections, including HIV. Condoms are the only contraceptive method that can protect against both pregnancy and sexually transmitted infections.

Require correct use with every act of sex for greatest effectiveness.

A woman can initiate female condom use, but the method requires her partner's cooperation.

May require some practice. Inserting and removing the female condom from the vagina becomes easier with experience.

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

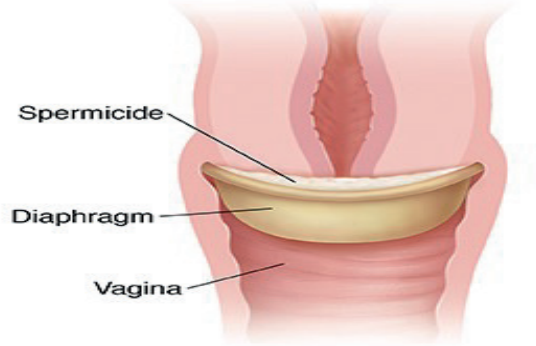
Other Barrier Methods

DIAPHRAGM

INTRODUCTION

A diaphragm is a soft latex cup that covers the cervix and is used as a FP method. The cup is provided with a rim that is firm with a flexible spring that keeps the diaphragm in place. It is normally used with a spermicidal cream, jelly, or foam to improve effectiveness.

Diaphragms comes in different sizes and require fitting by a trained professional.



REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Mostly all women can use the diaphragm safely and effectively. Women with severe allergic reaction to latex cannot use this method but can use a plastic-made diaphragm. Women with HIV infection or have a high risk of HIV infection are not advised to use the diaphragm.

MECHANISM OF ACTION

It works by blocking sperm cells from entering the cervix while the spermicide kills or disables the sperm from meeting the egg.

EFFECTIVITY

The effectiveness of this method depends on the user. The risk of pregnancy is greatest when the diaphragm with spermicide is not used during every sexual intercourse. When typically used, about 17 of 100 women who use the diaphragm with spermicide become pregnant over the first year. This means that 83 of every 100 women using the diaphragm will not become pregnant. When used correctly with every sexual intercourse, about 16 of 100 women who use the diaphragm with spermicide become pregnant over the first year. A diaphragm may provide some protection against certain STIs but should not be relied on as the only protection against STIs.

RETURN TO FERTILITY

There is no delay of fertility after stopping the use of diaphragm.

SIDE-EFFECTS AND ADVERSE REACTION

Women with allergic reactions to a latex rubber-made diaphragm should use a plastic-made diaphragm. The provider can advise the client to use other effective methods. Diaphragms protect against the risk of pregnancy, certain STIs, cervical precancer and cancer. The known health risks include urinary tract infection and bacterial vaginosis or candidiasis. Side effects may include vaginal lesions or irritation in or around the vagina or penis.

HOW TO PROVIDE THE METHOD

Explaining How to Use a Diaphragm

A client can use a diaphragm any time but must wait for six weeks if the client had a full-term delivery or had a second trimester abortion. The provider of this method must observe the following steps:

1. Use proper infection prevention procedures.
2. Instruct the client to assume a lithotomy position for a pelvic examination, and assess for conditions (e.g., uterine prolapse) that may make the diaphragm improper to use.
3. Perform an internal examination to assess the cervix and determine the diaphragm size.
4. Insert a special fitting diaphragm into the client's vagina, and apply it to cover the cervix, making sure that the diaphragm fits properly and does not come out easily.

The following steps must be observed by the user when using a diaphragm:

1. Check the diaphragm for any damage, including the expiration date of the spermicide. Insert the diaphragm less than six hours before having sex.
2. After hand washing with soap and water, squeeze a spoonful of spermicidal cream, jelly, or foam into the cup of the diaphragm and around the rim.
3. Press the rim together to ease the insertion of the device into the vagina. Assume a position that is comfortable for insertion: squatting, raising one leg, sitting, or lying down. While holding the diaphragm with the fingers pressing on the rim, insert the diaphragm into the vagina until the cervix is felt, and then apply it to cover the cervix.
4. Feel the diaphragm and the rim to make sure that it covers the entire cervix, fits properly, and does not come out easily.

5. Keep the diaphragm in place for at least 6 hours after having sex but no longer than 24 hours. For multiple sexual intercourse, make sure that the diaphragm is in the correct position, and insert additional spermicide in front of the cap before each sexual intercourse.
6. To remove the diaphragm, wash hands with soap and water, insert finger to feel for the rim, then gently slide a finger under the rim of the diaphragm to pull it down and out.
7. Wash the diaphragm with mild soap and water and dry it after each use.

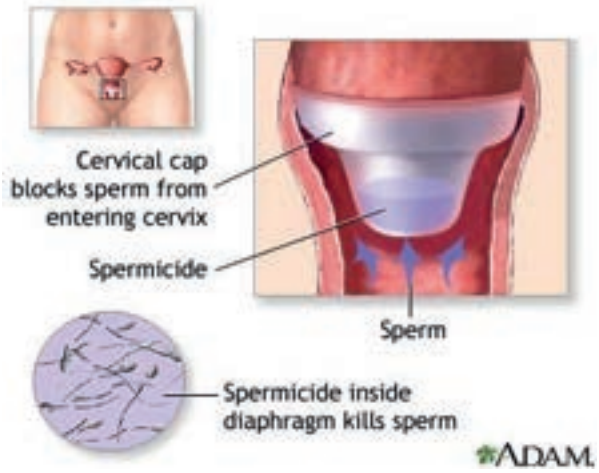
Counseling tips in using Diaphragm

- The diaphragm should be fitted at least six weeks after childbirth or second trimester abortion, when the uterus and cervix have returned to normal size. However, recommend the use of an alternative method until the sixth week.
- Reiterate that the risk of pregnancy is greatest when the diaphragm with spermicide is not used during every sexual intercourse.
- Do not provide a diaphragm for clients who have HIV infections or at high risk for HIV infections. Suggest using condoms instead.

CERVICAL CAP

INTRODUCTION

A cervical cap is one of the least effective methods of FP. It is a cup-shaped device made of soft rubber that fits over the cervix and helped in place at least partially by suction between its firm flexible rim and the surface of the cervix at the upper vaginal wall. A client can use the cervical cap any time but has to wait for six weeks if the client has had a full-term delivery or a second trimester abortion



Source: medlineplus.gov

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Mostly all women can use the cervical cap safely and effectively. However, women who develop lesions on the cervix when in contact with the cervical cap and clients that have been treated for cancer should not use this method. Women with HIV infection or at high risk of HIV infection are not advised to use the cervical cap.

MECHANISM OF ACTION

It works by blocking sperm cells from entering the cervix.

EFFECTIVITY

The effectiveness of this method is dependent on the user. The risk of pregnancy is higher when the method is not used on every sexual intercourse. When typically used, about 32 per 100 women who use the cervical cap with spermicide become pregnant over the first year of use. This statistic indicates that 68 of every 100 women using the cervical cap will not become pregnant.

When used correctly with every sexual intercourse, about 26 per 100 women who use the cervical cap become pregnant over the first year of use. It has no protection against sexually transmitted infections.

RETURN TO FERTILITY

There is no delay of fertility.

SIDE-EFFECTS AND ADVERSE REACTION

Women with allergic reaction to cervical cap should be advised to discontinue use, and the provider should advise her on other effective methods. The cervical cap protects against the risk of pregnancy, but not STIs. Side effects may include vaginal lesions or irritation in or around the vagina. The risk of pregnancy is greatest when the cervical cap with spermicide is not used in every sexual intercourse.

HOW TO PROVIDE THE METHOD

Explaining how to use a Cervical Cap

A client can use the cervical cap any time but have to wait for six weeks if the client has had a full-term delivery or a second trimester abortion. The provider of this method must observe the following steps:

1. Use proper infection prevention procedures.
2. Instruct the client to assume a lithotomy position for a pelvic examination, and assess for conditions (e.g., uterine prolapse) that may make the cervical cap impossible to use.
3. Perform an internal examination to assess the cervix and determine the cervical cap size.
4. Insert a special fitting cervical cap into the client's vagina, and apply it to cover the cervix, making sure that the cervical cap fits properly and does not come out easily.
    - Check the cervical cap for any damage, including the expiration date of the spermicide used. Insert the cervical cap at any time up to 42 hours before having sex. After hand washing with soap and water, fill one third of the cap, including around the rim, with spermicidal cream, jelly, or foam.
    - Press the rim of the cap around the cervix until it is completely covered, and then press gently on the dome of the cap to apply suction and seal the cap.

- Feel the cervical cap and the rim to make sure it covers the entire cervix, fits properly, and does not move out easily.
- For multiple sexual intercourse, make sure that the cap is in the correct position and insert additional spermicide in front of the cervical cap before each sexual intercourse.

Removal of a cervical cap

1. Leave the cervical cap for at least 6 hours after the sexual intercourse but not more than 48 hours from the time it was inserted.
2. Tip the cap rim sideways to break the seal on the cervix, and then gently pull the cap down and out of the vagina.
3. Wash the cervical cap with mild soap and water and dry it after each use.

Important information in using cervical cap

- Ensure that the client understands the correct use by allowing her to repeat how and when to insert and remove the cervical cap.
- Explain that the procedure becomes easier with time, i.e., the more practice she has with inserting and removing the cervical cap, the easier it will get.
- Describe common side effects, such as itching and irritation in or around the vagina or penis and how to go about it.
- Clarify that a cervical cap that becomes thin, damaged, or stiff should not be used and should be replaced. The cervical cap should be replaced every two years.

SPERMICIDES

INTRODUCTION

Spermicides are chemical substances that kill the sperms before they reach the egg. These are available in different forms such as gel, aerosol foam, foam tablet, film tablet, and cream.
Vaginal spermicides are sperm-killing substances, such as nonoxynol-9, benzalkonium chloride, chlorhexidine, menfegol, octoxynol-9, and sodium docusate, which are inserted deep in the vagina, near the cervix, before sex. Spermicide as a contraceptive is not currently used in the Philippines because spermicides are not readily available in drug stores.

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Mostly all women can use spermicides. Persons at high risk for HIV infection and those who have HIV/AIDS cannot use this method.

MECHANISM OF ACTION

Spermicides work by causing the membrane of sperm cells to break, killing them or slowing their movement. This phenomenon keeps the sperm from meeting the egg.

EFFECTIVITY

The effectiveness of the method depends on the user and it is one of the least effective FP methods.

When typically used, about 29 per 100 women who use spermicides become pregnant during the first year. This statistic indicates that 71 of every 100 women using spermicide will not become pregnant.

When used correctly in every sexual intercourse, about 18 per 100 women who use spermicides become pregnant over the first year.

RETURN TO FERTILITY

There is no delay of fertility.

SIDE-EFFECTS AND ADVERSE REACTION

Some users have reported irritation in or around the vagina or penis and vaginal lesions when using spermicides. Care and attention should be given if side effects or problems with spermicide affect their satisfaction with the use of this method. The provider should listen to the client's concerns, give her advice, and treat if necessary. The provider should also help the client to choose another method if she wishes or if problems cannot be rectified.

Spermicides can be used without seeing a health care provider. It can be inserted ahead of time; hence, it does not interrupt sex and the client controls its use. It can protect against the risk of pregnancy.

When using spermicides two or more times a day, it may cause urinary infection. Frequent use of nonoxynol-9 may increase the risk of HIV. Vaginal lesions due to spermicides used will make it easier for the client to become infected with HIV. Clients who have multiple daily acts of sex should use another FP method.

How are the side effects of spermicide use addressed?

Some users report irritation in or around the vagina or penis. The provider should listen to the client's concerns, give her advice, and treat if necessary. The provider may also help the client choose another method if she wishes or if problems cannot be resolved.

HOW TO PROVIDE THE METHOD

Spermicides can be used any time the client wants. The provider of this method must observe the following steps:

1. Explain the process of inserting spermicides into the vagina. Check first the expiration date and avoid using spermicides that are past their expiration date.
    - For foam or cream: shake can of foam; squeeze spermicide from the
    - Can or tube into a plastic applicator. Insert the applicator deep into the vagina, near the cervix, and push the plunger.
    - For tablets, suppositories, jellies: insert the spermicide deep into the vagina, near the cervix, with an applicator or with fingers.

2. Explain when to insert spermicide into the vagina.
    - Foam or cream can be inserted any time less than one hour before sex.
    - Tablets, suppositories, jellies, and film can be inserted between 10 minutes and 1 hour before sex, depending on type.
3. Explain use of spermicide for multiple sexual acts. Instruct the client to insert additional spermicide before each act of vaginal sex. Douching is not recommended after sex because it will wash away the spermicide and increases the risk of STIs. If the client must douche, wait for at least six hours before doing so.

Important information should be provided to the client who chooses to use spermicides

- Ensure that the client understands the correct use by asking her to repeat how and when to insert the spermicide. Assure the client that spermicide use does not cause birth defects if a woman becomes pregnant while using the spermicide.
- Tell the client to avoid too much use of nonoxynol-9 because it may increase the risk of HIV infection or vaginal irritation

KEY POINTS FOR PROVIDERS AND CLIENTS USING BARRIER METHODS

Barrier methods require correct use with every act of sex for greatest effectiveness.

Condom is the only FP method included in the Philippine FP Program that has dual protection which helps to prevent pregnancy and protect against sexually transmitted infections including HIV.

G. LACTATIONAL AMENORRHEA METHOD

INTRODUCTION

Lactational Amenorrhea Method (LAM) is a contraceptive method based on the natural effect of breastfeeding on fertility as a temporary family planning method. "Lactational" means related to breastfeeding. "Amenorrhea" means not having menstrual bleeding.

Source: CDC.gov

3 criteria of LAM to be effective:

- The client exclusively breastfeeds the infant.
  - — Exclusively breastfeeding means no supplement, no food, not even water in addition to breastmilk.
  - — Fully breastfeeding includes both exclusive breastfeeding and almost exclusive breastfeeding (receives vitamins, water, juice in addition to breastmilk).
  - — Nearly fully breastfeeding means that the baby receives some liquid or food in addition to breastmilk but more than three-fourths of all feeds are breastmilk.
- Amenorrhea
  - — The client's monthly bleeding has not returned. There might be a continued spotting in the first week postpartum which is not considered as menstruation if the client is fully lactating.
- Infant is less than 6 months old
  - — The effectiveness of LAM decreases overtime even if the client is fully breastfeeding and her menses have not returned. In about 20% to 50% of clients, ovulation resumes near the end of the 6 months postpartum.

It is not classified as LAM when any of the criteria is not met.

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Who can use the LAM?

Medical eligibility criteria:

All breastfeeding women can safely use LAM, but the following circumstances should make her consider other contraceptive methods:

- Client has HIV infections

- Client is using certain medications (mood altering drugs, reserpine, ergotamine, anit-metabolites, cyclosporine, high doses of corticosteroids, bromocriptine, radioactive drugs, lithium and certain anticoagulants) during breastfeeding
- The newborn has a condition that makes breastfeeding difficult (premature, unable to digest food normally, or having deformities of the mouth, jaw or palate)

LAM for women with HIV

- Women who are living with HIV can use LAM. However, if they are not taking antiretroviral therapy (ART), they will transmit HIV to their infant through breastfeeding. About 14% of their infants will be infected after two years of breastfeeding.
- Women taking ART can use LAM. It reduces the risk of HIV transmission through breastfeeding. Less than 1% of their babies will be infected.
- Exclusively breastfeeding reduces the risk of death from common childhood illnesses and improves the health of the mother and the child.
- The breastfeeding women with HIV should receive appropriate ART interventions, exclusively breastfeed their child for the first six months of life, introduce appropriate complementary foods at six months, and continue breastfeeding for the first 12 months if the national policy supports breastfeeding woman with HIV.
- Using condom correctly and consistently while on LAM should be mandated among women with HIV since it will help to prevent transmission of HIV and STI.
- When one of the LAM criteria is not met, the client should begin to use another FP method in place of LAM.

LAM for postpartum breastfeeding women with COVID-19 infections

- Clients with suspected or confirmed COVID-19 should be encouraged to continue breastfeeding. She may apply appropriate infection prevention and control measures through proper handwashing and wearing of face mask during the time she is breastfeeding her baby. Benefits of breastfeeding outweigh the potential risk of COVID-19 transmission

LAM for women with active pulmonary tuberculosis infection

- If the client has active or untreated tuberculosis, breastfeeding is not advisable. The client may resume breastfeeding if she has been on TB medications for a minimum of two weeks and is verified not infectious.

MECHANISM OF ACTION

Works primarily by preventing the release of egg from the ovaries. Frequent breastfeeding temporarily prevents the release of the natural hormones that cause ovulation. It increases the prolactin level inhibiting the production/secretion of the gonadotrophin-secreting hormone, so women do not ovulate or menstruate. Decrease in breastfeeding precipitates the return of ovulation.

EFFECTIVITY

Typical use defines as how proper the method works to prevent pregnancy which includes clients that may not use the FP method perfectly and consistently while correctly use may include clients who are following FP method instructions perfectly and consistently.

The effectiveness depends on the user. LAM is about 99.5% effective if correctly followed and 98% for typical use.

As typically used, about 2 pregnancies per 100 women using LAM in the first six months after childbirth. This means that 98 of every 100 women relying on LAM will not become pregnant. When used correctly, less than 1 pregnancy per 100 women using LAM in the first 6 months after childbirth.

ADVANTAGES AND DISADVANTAGES

Advantages of LAM

- Help protect against risk of pregnancy
- It enhances breastfeeding practices and enhances the survival of mother and child
- It can be started immediately postpartum
- It is economical and easily available
- It does not require prescription
- No action is required at the time of intercourse
- No commodities or supplies required
- Fosters mother-child bonding
- There are no hormonal side effects or precautions to its use
- It is consistent with religious and cultural practices
- Bridge to other contraceptives since LAM is used for limited time only

Disadvantages of LAM

- No protection against sexually transmitted infections or HIV. Any client using a non-barrier method should also use condom for protection against infections.
- Breastfeeding pattern may be difficult for some women to maintain
- Duration of the method's effectiveness is limited to six-month postpartum period.
- Only useful for breastfeeding women

RETURN TO FERTILITY

It depends on the frequency and intensity of breastfeeding. Fertility will increase when frequency and intensity of breastfeeding decrease.

SIDE-EFFECTS AND ADVERSE REACTION

There are no known side effects or health risks in using LAM.

DISPELLING MYTHS AND MISCONCEPTIONS

The Lactational amenorrhea method:

- Is highly effective when the client meets all 3 LAM criteria
- There is no difference in effectiveness for clients with different weight measurements.
- Can be used by clients with normal nutrition. No special diets are required.
- Can be used for a full 6 months without the need for supplementary foods. Adequate breastfeeding can fully nourish a child for the first 6 months.
- Can be used for 6 months without worry that the women will run out of milk.

NON-CONTRACEPTIVE BENEFITS

- Breastfeeding helps protects against risk of pregnancy for 6 months
- It lessens the chances of postpartum hemorrhage
- It offers protection against breast and ovarian cancer
- It helps the mother to keep her body in good shape.

HOW TO PROVIDE THE METHOD

When to start

Within 6 months after childbirth

- Start breastfeeding immediately after the baby is born. The colostrum (yellow fluid produced by mothers breast in the first few days after childbirth) contains nutrients that are essential to baby's health.
- Anytime as long as she has been fully or nearly breastfeeding and her monthly bleeding has not returned.

When can a woman use LAM

- The client may start LAM at anytime if she meets all criteria required for using the method

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

Explaining how to use

- Breastfeed often
  - — Feeding on demand at least 10-12 times a day in the first few weeks after childbirth
  - — The client should use both breasts to breastfeed the infant on demand with no more than 4 hours interval between any 2 daytime feeds and no more than 6 hours interval between any two nighttime feeds.
- Start other foods at 6 months
  - — At this time, breast milk can no longer fully nourish a growing child and giving other food in addition to breast milk is necessary.
- Plan follow up visit
  - — May plan for the next return visit while the LAM criteria apply, so the client can choose another method.
  - — The health care provider may give condoms or progestin only pills ahead of time, so the client can start to use them if the baby is no longer fully or nearly fully breastfeeding when her monthly bleeding returns and her baby reaches 6 months of age.
  - — The health care provider may also give a complementary family planning method for use if needed if returning to health facility is difficult for the client. Advise to use condoms with LAM if there is a risk for STI or HIV infections.

Questions and Answers about LAM method

1. ***Can LAM be an effective method of family planning?***

   Yes. LAM can be an effective method of family planning if the client has no menses, exclusively breastfeeding and her baby is less than 6 months old.

2. ***When should a mother start giving her baby other foods besides breast milk?***

   At 6 months old, the mother can start giving her baby other food besides breast milk.

3. ***Can women use LAM if they work away from home?***

   Yes. A woman can use LAM while working away from home as long as she meets all 3 criteria for LAM. A woman, who is separated from her infant for less than 4 hours, can use LAM. Women can express their breast milk at least every 4 hours, but pregnancy rate maybe slightly higher for women who are separated from their infants.

4. ***What if a woman learns that she has HIV while she is using LAM? Can she continue breastfeeding and using LAM?***

   If the woman is newly infected with HIV, she has higher risk of transmitting HIV through breastfeeding than the one who is infected earlier because of a higher load of HIV in her body. HIV infected mothers and their infants should receive ARV treatment and continue to do exclusive breastfeeding in the first 6 months of the infant's life, then start complementary feeding and continue breastfeeding for the first 12 months of life. She may consider using another contraceptive method once her menses return and stop exclusive breastfeeding.

SUPPORT FOR CONTINUING USERS

"Come Back Any Time": Reasons to Return

Assure every client that she is welcome to come back any time—for example, if she has problems, questions, or wants another method; she has a major change in health status; or she thinks she might be pregnant. Also, if: she no longer meets one or more of the 3 LAM criteria and so cannot keep relying on LAM.

Helping Continuing Users

Helping Clients Switch to a Continuing Method

1. A woman can switch to another method any time she wants while using LAM. If she still meets all 3 LAM criteria, it is reasonably certain she is not pregnant. She can start a new method with no need for a pregnancy test, examinations, or evaluation
2. To continue preventing pregnancy, a woman *must* switch to another method as soon as any one of the 3 LAM criteria no longer applies.
3. Help the woman choose a new method *before* she needs it. If she will continue to breastfeed, she can choose from several hormonal or nonhormonal methods, depending on how much time has passed since childbirth. After 6 months, if a woman wants to continue breastfeeding, she can consider the progesterone-releasing vaginal ring

Role of partner

The client's partner can join the counseling and learn about the method. The male partner can show his support by accepting his partner's choice of LAM. He should understand about LAM and how it works. He should encourage his partner to frequently breastfeed and not give their baby supplementary food for the first 6 months. He should discuss and plan with his partner what method to use when LAM criteria is not met. ECPs should be available on hand in case the LAM criteria are no longer met.

KEY POINTS FOR PROVIDERS AND CLIENTS USING LACTATIONAL AMENORRHEA METHOD

A family planning method based on breastfeeding. Provides contraception for the mother and best feeding for the baby.

Can be effective for up to 6 months after childbirth, as long as monthly bleeding has not returned and the woman is fully or nearly fully breastfeeding.

Requires breastfeeding often, day and night. Almost all of the baby's feedings should be breast milk.

Provides an opportunity to offer a woman an ongoing method that she can continue to use after 6 months.

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

H. FERTILITY AWARENESS-BASED METHODS

INTRODUCTION

Fertility awareness-based (FAB) methods involve identifying the fertile days of the menstrual cycle, whether by observing fertility signs such as cervical secretion and basal body temperature or by monitoring cycle days. Sometimes called periodic abstinence or natural family planning (NFP), these methods require abstaining from sexual intercourse during the fertile phase to avoid conception.

Source: CDC.gov

The success of these methods depends on factors such as the woman's ability to identify the fertile phase of each menstrual cycle, the competence of the provider, and the couples' motivation and discipline to practice abstinence when required. FAB methods provide an alternative for women who want to use natural methods for medical, religious, or personal reasons.

FAB Methods

1. Calendar-based methods
    - FAB methods include the following calendar-based methods: Calendar Rhythm Method and the Standard Days Method (SDM)
    - These methods keep track of the days of the menstrual cycle to identify the start and end of the fertile period.
    - The Calendar Rhythm Method is also known as the Natural Family Planning Method or NFP. The client should record and track her menstrual cycles to determine her fertile period. It is inexpensive with no side effects but effectiveness is only about 79%. The cycles should be updated every month. It is very popular among the very religious who do not like to use contraceptives.
    - The SDM or standard days method is the only method recommended by the DOH. It identifies a 12-day fertile window (days 8-19) during which women with regular menses (26-32 days) should abstain from sex or use a barrier method. It uses a cycle bead to assist users in tracking their menstrual cycle. Other parameters to observe are basal body temperature or watching for changes to the cervical mucus.
2. Symptoms-based methods
    - These methods depend on observing signs of fertility

- Changes in cervical secretions
  - It determines the beginning and end of the fertile days
  - A client may be fertile when she sees or feels cervical secretions. She may feel vaginal wetness.
- Basal body temperature
  - It determines when ovulation has passed and the fertile days have ended.
  - After the release of an egg during ovulation, the woman's resting body temperature goes up slightly. She is not likely to get pregnant from 3 days after this temperature rise until the start of her next monthly bleeding.

- Example: cervical mucus or Billings Ovulation Method, Two-Day Method, basal body temperature or BBT method, and sympto-hermal method.These methods depend on observing signs of fertility (cervical mucus or Billings Ovulation Method, Two-Day Method, basal body temperature or BBT method, and symptothermal method).

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

Simplified MEC Categories for FAB Method

CATEGORY	ELIGIBILITY CRITERIA
A (Accept)	There is no medical reason to deny the particular FAB method to a woman in this circumstance.
C (Caution)	The method is normally provided in the routine setting, but with extra preparation and precautions. For FAB methods, this usually means that special counselling may be needed to ensure correct use of the method by a woman in this circumstance
D (Delay)	Use of this method should be delayed until the condition is evaluated or corrected. Alternative temporary methods of contraception should be offered.
NA	Not Applicable

Conditions relating to fertility awareness methods:

A = **Accept** C = **Caution** D= **Delay** **Condition**	**Symptoms-based Method**	**Calendar- based Methods**
Age: Post-menarche or perimenopause	C	C
Breastfeeding < 6 weeks postpartum	D	D[aa]
Breastfeeding > 6 weeks postpartum	C[bb]	D[bb]

Post-partum not breastfeeding	D[cc]	D[aa]
Postabortion	C	D[dd]
Irregular vaginal bleeding	D	D
Vaginal discharge	D	A
Taking drugs that affect cycle regularity, hormones, and/or fertility signs	D / C[ee]	D / C[ee]
Disease that elevate body temperature		
Acute	D	A
Chronic	C	A

[aa] Delay until she has 3 months of regular menstrual cycle
[bb] Use caution after monthly bleeding or normal secretions return (usually at least 6 weeks after childbirth)
[cc] Delay until monthly bleeding or normal secretions return (usually < 4 weeks postpartum)
[dd] Delay until she has had one regular menstrual cycle
[ee] Delay until the drug's effect has been determined, then use caution

Medical Eligibility Criteria for FAB Method

Ask the client the questions below. If she answers "NO" to all of the questions, then she can use any fertility awareness-based method. If she answers "YES" to a question below, follow the instructions. No conditions restrict use of these methods, but some conditions can make them difficult to use effectively.

1. Do you have a medical condition that would make pregnancy especially dangerous? (Medical Conditions and Method Choice)

❑ NO ❑ YES — She may want to choose an effective method. If not, stress careful use of fertility awareness-based methods to avoid pregnancy.

2. Do you have irregular menstrual cycles? Vaginal bleeding between periods? Heavy or long monthly bleeding? For younger women: Are your periods just starting? For older women: Have your periods become irregular, or have they stopped?

❑ NO ❑ YES — Predicting her fertile time with only the calendar method may be difficult or impossible. She can use basal body temperature (BBT) and/or cervical mucus, or she may prefer another method.

3. Did you recently give birth or have an abortion? Are you breastfeeding? Do you have any other condition that affects the ovaries or menstrual bleeding, such as stroke, serious liver disease, hyperthyroid, hypothyroid, or cervical cancer?

❑ NO ❑ YES — These conditions do not restrict the use of fertility awareness-based methods. However, these conditions may affect fertility signs, making fertility awareness-based methods difficult to use. Therefore, a woman or couple may prefer a different method. If not, they may need further counseling and follow-up to use the method effectively.

4. Have you had any infections or diseases that may change cervical mucus, basal body temperature, or menstrual bleeding, such as sexually transmitted disease, PID in the last 3 months, or vaginal infection?

❑ NO ❑ YES — These conditions may affect fertility signs, making fertility awareness- based methods difficult to use. However, a woman can use fertility awareness-based methods easily once an infection is treated and reinfection is avoided.

5. Do you take any drugs that affect cervical mucus, such as mood-altering drugs, lithium, tricyclic antidepressants, or antianxiety therapies?

❑ NO ❑ YES — Predicting her fertile time correctly may be difficult or impossible if she uses only the cervical mucus method. She can use BBT and/or the calendar method, or she may prefer another method. Be sure to explain the health benefits, risks, and side effects of the method. When relevant to the client, point out any conditions that would make the method inadvisable.

MECHANISM OF ACTION

FAB methods use one or more indicators to identify the start and end of the fertile period during a menstrual cycle. It involves the determination of the fertile and infertile periods of a woman, observation of the signs and symptoms of fertility and infertility during the menstrual cycle, timing of sexual intercourse to achieve or avoid pregnancy. Its effectiveness depends on the couple's ability to identify fertile and infertile periods and their motivation to practice abstinence when required. Being consistent in observing abstinence during the fertile period helps to prevent pregnancy. Understanding and cooperation of the partner are necessary for the correct use of the method.

EFFECTIVITY

The effectiveness of FAB methods always depends on the user. The risk of pregnancy is greatest when couples have sexual intercourse on fertile days without using a backup method. When typically used, about 15 per 100 women who use periodic abstinence become pregnant over the first year of use. This means 85 out of 100 women relying on periodic abstinence will not become pregnant.

Table 10. Effectiveness of FAB Methods

METHOD	PREGNANCIES PER 100 WOMEN OVER THE FIRST YEAR OF USE	
	Consistent and correct use	As commonly used
CALENDAR-BASED METHODS		
Standard days methods	5	12
SYMPTOMS-BASED METHODS		
Two-Day Method	4	14
Ovulation Method	3	23
Symptothermal Method	<1	2

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

ADVANTAGES AND DISADVANTAGES

Advantages of FAB methods

- Effective when used correctly and consistently
- No physical side effects
- Very little or no cost
- Immediately reversible
- Acceptable for some religious groups that reject or discourage the use of other methods
- No hormonal side effects
- Involves men and encourages responsibility on FP
- Educates couple about women's fertility cycles

Disadvantages of FAB methods

- May inhibit spontaneous sexual behavior
- Difficult to practice (abstinence) on fertile days for some couples
- Will not work without continued discipline and cooperation, and commitment of the couple
- Requires consistent and accurate record-keeping on body changes
- Can become unreliable or difficult to use when menstrual cycle length is short, long, or irregular; when fertility signs and symptoms are affected by illness; or when users are apprehensive or find difficulties in following instructions
- This method does not protect against sexually transmitted infections, including HIV/AIDS

RETURN TO FERTILITY

There is no delay in return of fertility after fertility awareness methods are stopped.

SIDE-EFFECTS AND ADVERSE REACTION

FAB methods help protect against the risk of pregnancy but no protection against sexually transmitted infections. There are no known side effects or health risks in using FAB methods.

DISPELLING MYTHS AND MISCONCEPTIONS

Correcting Misconceptions

- Can be effective if used consistently and correctly
- Do not need literacy or high education
- Do not impair men who abstain from sex
- Do not work when not used correctly and consistently

Fertility Awareness Methods for HIV women

- FAB methods can be safely used by woman who are living with HIV or are on antiretroviral (ARV) therapy
- Advise clients to use condoms along with FAB methods consistently and correctly to prevent transmission of STI/HIV.

Calendar-Based Method

INTRODUCTION

Calendar-based methods are FAB methods that use calendar calculations to determine the fertile and infertile period.

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

All women can use calendar-based methods.

Medical Eligibility Criteria for Calendar-Based Method

All women can use calendar-based methods. Although no medical conditions prevent the use of these methods, some conditions make them difficult to use.

Caution means additional or specialist counseling may be needed to ensure the method is used correctly. This approach can be applied to the following situations:

- Irregularities in menstrual cycles in young women in their first several years after menarche and in older women approaching menopause which make the fertile period difficult to identify.

Delay means that use of a particular fertility awareness-based method has been properly evaluated or corrected. Advise the client of another method to use until the calendar-based method is suitable. This approach applies to the following:

- If a client has recently given birth or is breastfeeding. Delay until she has had at least 3 menstrual cycles and her cycles are regular again. For several months after regular cycles have returned, use with caution.
- Recently had an abortion or miscarriage. Delay until the start of her next monthly period.
- If the client has irregular vaginal bleeding this method should be delayed until cycles have become more regular.

Delay or use with Caution

If the client is taking medication that can make the menstrual cycle irregular such as certain antidepressants, thyroid medications, long-term use of certain antibiotics, or long-term use of any nonsteroidal anti-inflammatory drug.

HOW TO PROVIDE THE CALENDAR-BASED METHOD

When to start providing Calendar-Based Method

With regular menstrual cycle

- Anytime of the month

No monthly bleeding

- Delay calendar-based methods until monthly period returns.

After childbirth (whether or not breastfeeding)

- Delay standard days method until the client has 4 menstrual cycles with an interval of 26-32 days.
- Regular cycle will return earlier for non-breastfeeding woman than breastfeeding woman.

After miscarriage or abortion

- Delay the standard days method until the start of her next monthly cycle.

Switching from a hormonal method

- Delay the standard days method until the start of her next monthly cycle.
- Delay the standard day method when she is switching from injectables until her repeat injection would have been given, and then start at the beginning of her next monthly period.

After taking emergency contraceptive pill

- Delay the standard days method until the start of her next monthly cycle.

Standard Days Method (SDM)

INTRODUCTION

The Standard days method is based on the physiology of menstrual cycle and the functional life span of the ovum and sperm. It can be used by women if their menstrual cycles are 26-32 days. Using this method, she should abstain from sexual intercourse on fertile days (menstrual days 8-19) among women with cycle of 26-32 days. It uses color-coded CycleBeads to mark the fertile and infertile days of woman's menstrual cycle.

REPRODUCTIVE INTENTION: WHO CAN/ CANNOT USE THE METHOD

All women can use this method. The SDM works well for women who usually have menstrual cycles that are 26 to 32 days long. Women with cycles that are not 26 to 32 days long cannot use the method.

EFFECTIVITY

About 5 per 100 women who consistently and correctly use this method and abstain on fertile days become pregnant over the first year of use.

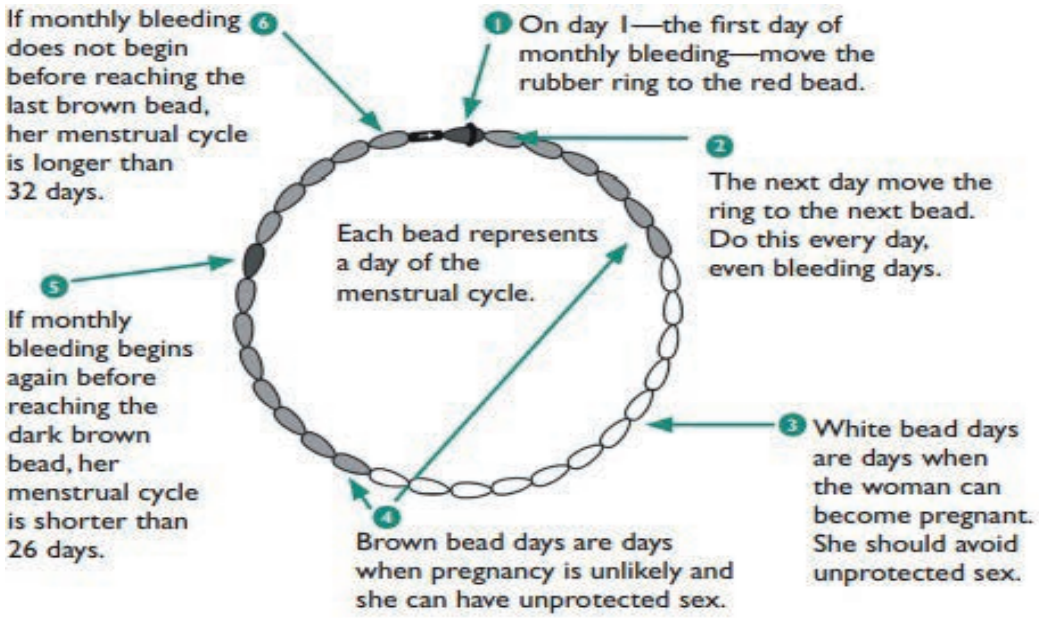
SIDE EFFECTS

The SDM has no known side effects.

HOW TO USE

1. Assess the length of the menstrual cycle if it falls within the range of 26-32 days. If the cycle length is less than 26 days or more than 32 days, the client cannot use the method.
2. If the cycle falls within the range, the provider may give SDM card and cycle beads, which can be used in marking the days of the cycle.
3. Show the client the CycleBeads and instruct her on how to use it.
4. On the first day of the menstrual cycle, the client may put the ring on the red bead and marks with an X the date on the calendar.
5. Move the ring to a bead every morning upon waking up each day. The brown beads signify infertile days and the white beads signify fertile days. If the ring is on white bead (days 8-19 of every cycle), the client may abstains from sexual intercourse.
6. The couple can have unprotected sex from day 1 to day 7 at the beginning of the cycle and from day 20 until her next monthly period begins.
7. If the menstrual bleeding occurs before the dark brown bead, the client cycle is less than 26 days. However if the ring has reached the black bead and the client still has no menstrual bleeding, her cycle is more than 32 days.
8. If either conditions happens twice in a year, the client cannot reliably use the SDM as family planning method.

Figure 10. CycleBeads used for Standard Days Method



Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

Women with special conditions

FP method shifters may also use SDM provided that the following criteria are met:

- Shifting from Pills
  - — Menstrual cycles were within 26-32 days before taking any pill.
- Shifting from Injectables
  - — At least 3 months have passed since the last injection
  - — Menses have returned
  - — Menstrual cycle were within 26-32 days before using injectables
  - — Last menstrual cycles were within 26-32 days
- Recently used IUD
  - — IUD has been removed
  - — Menstrual cycles while using the IUD were within 26-32 days
  - — Last menstrual cycle was within 26-32 days
- Postpartum and/or Breastfeeding
  - — Menstruation has returned
  - — Has had at least four normal menstrual periods
  - — Expects current cycle to be within 26-32 days.

SUPPORT TO USER

Return Visit

Instruct the client to follow-up within seven days of her next menstrual bleeding. Advise the client to bring CylceBeads, client card, and partner if possible.

i-CYLCE BEADS

- It is a smartphone app that allows a woman to use SDM electronically using software application that enables the client to plan or avoid pregnancy easily and effectively
- The application asks for the first day of the period and from that day creates a calendar using the cyclebeads
- The tool determines the client's fertile and infertile period and alerts a woman through an alarm system when to have and when not to have sexual intercourse

The Calendar Rhythm Method

Calendar Rhythm Method is a form of natural family planning that can be done by tracking a woman's menstrual cycle.

- Track the days of the menstrual cycle
  - — The client must record the number of days in each menstrual cycle for at least 6 months. The first day of monthly period is counted as day 1.
- Estimate the fertile time
  - — Shortest recorded cycle minus 18 (start of the fertile period)
  - — Longest recorded cycle minus 11 (end of the fertile period)

- Avoid unprotected sex during fertile time
  - — During fertile time the client avoids vaginal sex or may use condom or diaphragm during fertile days.
- Update calculations monthly
  - — The client updates the calculation each month, always using the 6 previous cycles
  - — Example:
    - o If the shortest of her last 6 cycles was 26 days, 26-18 = 8. She starts avoiding unprotected sex on day 8.
    - o If the longest of her last 6 cycles was 33 days, 33-11= 22. She can have unprotected sex again on day 23.
    - o Thus, she must avoid unprotected sex from day 8 through day 22 of her cycle.

Symptoms-Based Methods

INTRODUCTION

The use of symptom-based methods requires training for the client which involve identifying signs of fertility using the basal body temperature, cervical mucus secretions or cervical changes in which sexual abstinence should be practiced.

REPRODUCTIVE INTENTION: WHO CAN/CANNOT USE?

All women can use symptom-based methods.

Medical Eligibility Criteria

Caution means additional or specialist counseling may be needed to ensure the method is used correctly. This approach can be applied to the following situations:

- Recently had an abortion or miscarriage
- Irregularities in menstrual cycles in young women in their first several years after menarche and in older women approaching menopause, may make the fertile period difficult to identify.
- Chronic condition that increases body temperature (for basal body temperature and symptothermal methods)

Delay means the use of a particular fertility awareness-based method has been properly evaluated or corrected. Advise the client of another method to use until the symptom-based method is suitable. This approach applies to the following:

- If a client has recently given birth or is breastfeeding. Delay until normal secretions have returned, usually at least 6 months postpartum for breastfeeding woman and 4 weeks postpartum for non-breastfeeding woman.
- An acute condition that increases her body temperature.
- If the client has irregular vaginal bleeding this method should be delayed.
- If the client has abnormal vaginal discharge.

Delay or use with Caution

If the client is taking medication that change cervical secretions like antihistamine or raise body temperature such as antibiotics.

HOW TO PROVIDE THE SYMPTOMS-BASED METHOD

When to start providing symptom-based methods

Having regular menstrual cycle

- Anytime of the month

No monthly bleeding

- Delay symptoms-based methods until monthly period returns.

After childbirth (whether or not breastfeeding)

- Once normal secretions have returned, she can begin symptom-based methods.
- Normal secretions will return later in breastfeeding women than non-breastfeeding women.

After miscarriage or abortion

- With special counseling and support, the client can start the method immediately.

Switching from a hormonal method

- The client can start symptom-based methods in the next menstrual cycle after stopping a hormonal method.

After taking emergency contraceptive pill

- Once normal secretions have returned, the client can start symptoms-based method.

Two-Day Method

INTRODUCTION

The Two-Day Method is a natural approach of family planning that relies on cervical secretions as an indicator of fertility. The client checks her cervical mucus at least twice a day and considers herself fertile when she notices any secretions today or yesterday.

EFFECTIVITY

- With correct use about 96% effective while 86% effective with typical use
- About 4 per 100 women who consistently and correctly use the method and abstain on fertile days become pregnant over the first year of use.

SIDE EFFECTS

The Two-Day method has no known side effects.

HOW TO USE

To prevent pregnancy the client is instructed to monitor secretions daily by observing and touching their underwear or sensation of wetness in the genital area every afternoon and / or evening.

The client should avoid sexual intercourse or may use condom if she notices any cervical mucus regardless of the amount color, consistency, or viscosity. If the client did not notice any secretions 2 days in a row, pregnancy is less likely. The couple can have unprotected sex again after the client has had 2 dry days without secretions of any type in a row.

Basal Body Temperature

INTRODUCTION

Is a natural family planning method in which the rise in body temperature during and after ovulation are recorded daily to identify the fertile and infertile period of a woman's cycle. Shortly after ovulation, progesterone becomes a leading factor in the increase of resting body temperature. It is usually estimated by taking temperature immediately after awakening and before physical activity has been undertaken.

EFFECTIVITY

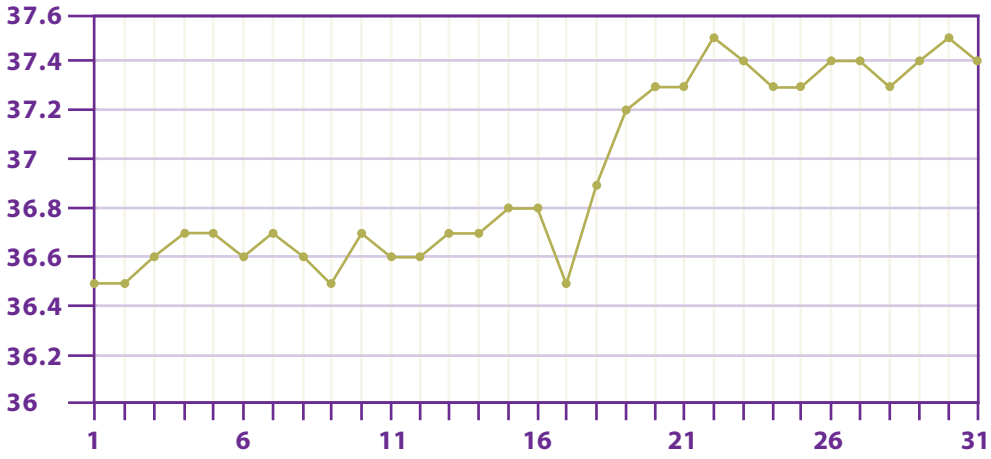
About 1 per 100 client who consistently and correctly use the method and avoid sexual intercourse on fertile days become pregnant on the first year of use.

SIDE EFFECTS

- The basal body temperature has no known side effects

HOW TO USE

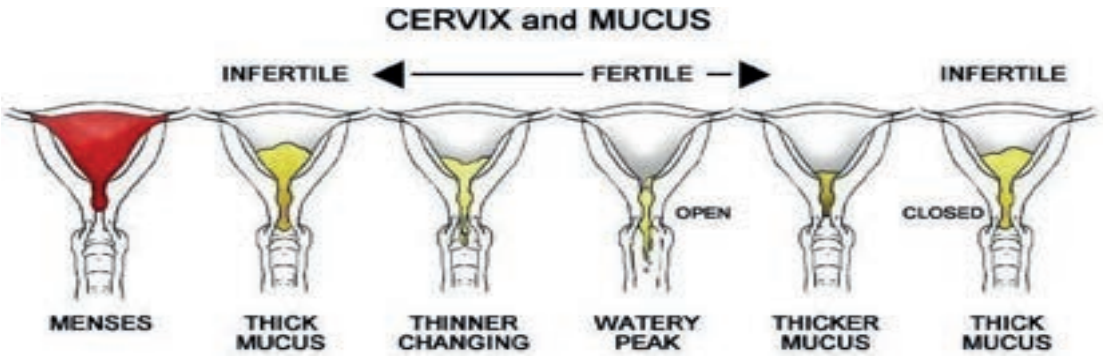
- The client should take the body temperature daily at the same time each morning before she gets out of bed and records her temperature on a graph to compare each day's temperature.
- Identify temperature increase about 0.2 °C to 0.5 °C (0.4 °F to 1.0 °F just after ovulation.
- Avoid sexual intercourse or use condom from the first day of monthly period until 3 days after the temperature has risen above her regular temperature.
- Ovulation has occurred when the temperature has risen above her regular temperature and stay higher for 3 days.
- The couple can have unprotected sex on the 4th day and until her next monthly cycle begins.



Billings Ovulation Method

INTRODUCTION

Billings Ovulation Method is a natural family planning method that is based on symptoms of fertility and infertility. The indication of fertile period is the feeling of wetness and the secretion of slippery, clear mucus while the indication of infertile period is the feeling of dryness and non-stretchy mucus.



EFFECTIVITY

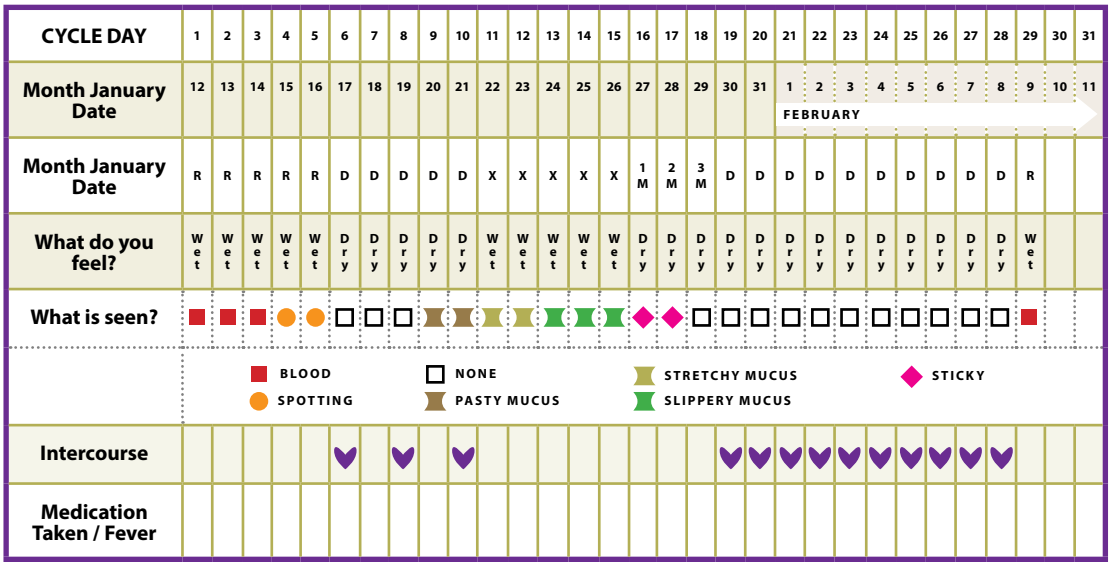
Perfect use has been estimated to be 97% effective while typical use is about 80 % effective. About 3 per 100 women who use the method consistently and correctly and abstain on fertile days become pregnant over the first year of use.

SIDE EFFECTS

- The billings ovulation method has no known side effects.

HOW TO USE

- The client checks her cervical secretions daily on underwear by tissue paper or by finger in or around the vagina. If the client notices any secretions, it means she is fertile and should avoid any sexual intercourse. The secretion has a "peak day" which is the last day that they are clear, slippery, stretchy, and wet. She considers herself fertile for 3 days after the peak days and avoid unprotected sex. On the 4th day after the last day of wetness, all dry days are infertile days. On dry days following menstrual period, the couple can engage in sexual intercourse on alternate nights only to allow semen to disappear and for the cervical mucus to be observed.
- The couple must avoid unprotected sex on the days of heavy monthly bleeding because ovulation might occur early in the cycle, particularly during the last days of monthly period and heavy bleeding could make mucus difficult to observe.
- A couple can have unprotected sex between the end of monthly period and the start of secretions every other day but not for 2 days in a row. Avoiding sex on the second day allows time for semen to disappear and for cervical mucus to be observed.
- A couple can have sex in the evenings after the women has been in an upright position for at least a few hours and has been able to verify the absence of cervical mucus.



Symptothermal Method

INTRODUCTION

It is the natural family planning method that makes use of the client's observation of basal body temperature, cervical mucus/billings ovulation method, and other biological signs to identify her infertile and fertile days. The client may also identify the fertile time by other signs such as breast tenderness and ovulatory pain (lower abdominal pain or cramping around the time of ovulation)

EFFECTIVITY

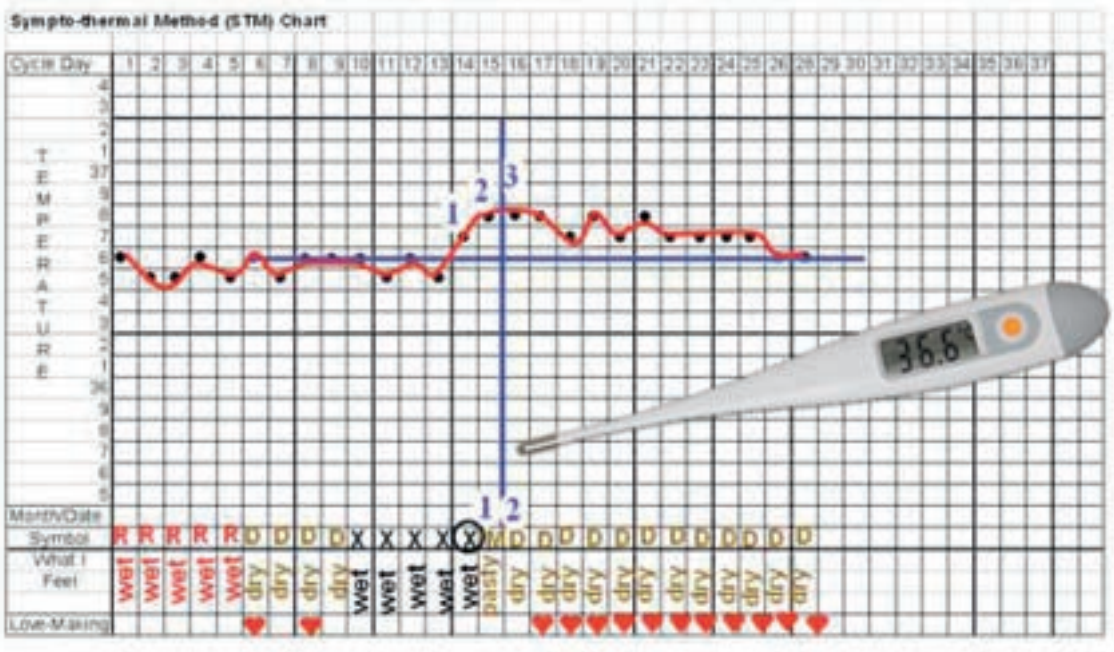
The method is 98% effective as perfectly use. About 2 per 100 women who use the method correctly and consistently and abstain on fertile days become pregnant over the first year of use.

SIDE EFFECTS

- The symptom-thermal method has no known side effects

HOW TO USE

The couple uses the chart by combining BBT and ovulation method instructions to identify the days of fertility and infertility. The couple avoids unprotected sex between the first day of monthly bleeding and either the fourth day after the peak cervical secretions or the third full day after the rise in temperature.



SUPPORT FOR CONTINUING USERS

Follow-up visits:

- Routine return visits are not required. However, the client or the couple can meet with the FP service provider during the first few cycles if they want further assistance.
- Follow-up visit may be done when the client has problems, questions, or wants another method. The FP service provider should encourage the client to come to discuss her experience with the method and answer any questions she may have.
- The FP provider should address any health concerns the client may have and inquire if there is anything unclear.
- The FP provider should also ask the client if she has any difficulty identifying her fertile days.
- Inquire if the client has any trouble avoiding sex or using another method on her fertile days.
- Follow-up visits should also be encouraged to check whether the couple is using the method correctly and to review the observation or records of fertility signs.

KEY POINTS FOR PROVIDERS AND CLIENTS USING FERTILITY-AWARENESS METHODS

Fertility awareness methods require cooperation of both partners. They must be committed to abstaining or using another FP method on fertile days.

The client must be aware of body changes to keep track of fertile and infertile days according to the rules of the specific FAB method being practiced.

To avoid pregnancy, the couple should abstain from sexual intercourse during fertile days.

FAB methods have no side effects or health risks.

Source: Family Planning: A Global Handbook for Providers (WHO, 2022)

III. Ensuring Expanded and Continuous Access to Family Planning Services

A. ENSURING ACCESS TO FAMILY PLANNING INFORMATION AND SERVICES

Identifying women with Unmet modern FP needs

In the Philippine context, Unmet Needs for modern Family Planning (mFP) refers to the proportion of women (women of reproductive age from ages 15-49) who are fertile and sexually active but are not using any modern method of contraception and report not wanting to have any more children (unmet need for limiting) or wanting to delay the birth of the next child (unmet need for spacing). The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior.

How to engage and assist women with modern FP services at the Primary Care Level

The identification of Women with unmet mFP needs in communities and at the household level forms part of the primary care. The identification of these women usually begins with the engagement (i.e. face to face) of community health volunteers who visit them to ask and to inform about modern FP services. Primary care refers to initial contact, accessible, continuous, comprehensive, and coordinated care that is accessible at the time of the client's need, including a range of services for all presenting conditions (UHC IRR, 2019). It also includes the ability to coordinate referrals to other health care providers in the healthcare delivery system when necessary. The provision of information and services on FP is included as part of primary care. Primary Care Providers, trained and certified by the DOH are mainly responsible for serving as gatekeepers and assisting clients in navigating through the network of health care providers. Specifically, primary care providers are composed of the Primary Care Facilities (public and private primary facilities offering primary care services) and the Primary care worker who may be a health professional (i.e. doctor, nurse, midwife) or a community health worker/volunteer, certified by DOH to provide primary care services. Community health volunteers are composed of Barangay Health Workers, Barangay Service Point Officers, BNS, etc. Community health volunteers assist midwives in filling up the Target Client List which is an updated record of all WRA with unmet mFP in a particular barangay/community. Primary care providers, both in the public and private sector, shall act as the navigator, coordinator, and initial and continuing point of contact in the healthcare delivery system. These providers shall ensure accessible, continuous, comprehensive and coordinated care regardless of conditions and concerns.

Expanding reach to clients with demand for FP at different service delivery points

Though there are several ways to expand reach to clients with unmet need for modern FP at different service point levels, there are still activities that provide less interaction between health service providers and clients needing mFP services.

Opportunities for increasing personal contact

Personal contacts with clients, wherein modern FP is discussed, play an important role in encouraging clients who are not using mFP to learn more about FP and seek proper counseling and services. There are several opportunities for expanding such contacts for discussing FP.

These can be at the household/community level or at the facility level.

As for house visits, the recent National Demographic and Health Survey (NDHS) showed that very few health providers who visited women in their homes talked about FP, and these are **missed opportunities** in promoting FP. The NDHS data revealed that on contact communication between non-users of FP and health workers/health service providers reveal that less than 15% of women said that: (1) a field worker discussed FP with them during the fieldworker's visit to the household (indicator of outreach); and (2) a health service provider discussed family planning with them during their visit to a health facility for any reason in the past 12 months (indicator of no-missed opportunities).

NATIONAL DEMOGRAPHIC AND HEALTH SURVEY (NDHS) ROUND	DISCUSSED FAMILY PLANNING WITH WOMEN DURING VISIT OF FIELD WORKER (%)	DISCUSSED FAMILY PLANNING WITH WOMEN WHO VISITED A HEALTH FACILITY IN THE PAST 12 MONTHS (%)	DID NOT DISCUSS FAMILY PLANNING EITHER DURING VISIT OF FIELD WORKER OR VISIT TO HEALTH FACILITY (%)
2003	11.5	13.6	80.3
2008	9.6	12.3	82.5
2013	11.9	14.7	79.5
2017	8.2	14.2	83.3
2022	6.2	10.3	87.4

There are several opportunities for personal contacts with clients to discuss or to inform them of FP. These can be at the community level or at the facility level, and it can be established at the point of service or at the point of referral. Direct contact is also possible during out-patient childcare services where family planning can be discussed with the mother as well. Barangay Health Workers (BHWs) and community volunteers can individually refer women in the community to service providers for further information on FP and appropriate services.

At the health facility level, health providers need to have an innovative or strategic way to reach more clients with unmet need for modern family planning services and deliver the much-needed quality services.

Approaches to integrate Family Planning into other health services

Family Planning services is part of the integrated Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition services offered at the primary health care through a continuum of care approach that enables quality access and guarantees adequate and

appropriate provision of these services in health facilities[7]. The strategy includes integrating FP information and services with the other reproductive/public health services such as antenatal care, postpartum care, HIV/STIs, immunization, well-baby clinic, adolescent health, gender based violence related concerns, consultation for any illness, which are being offered at different levels of service delivery and FP outreach missions.

Point of Opportunity	LEVEL							
	Household/ Community	PRIMARY CARE FACILITY HEALTH SERVICES						Hospital
		ANC	PNC	EPI	NCD	HIV/STIs	Others	
At point of service	Medical/ dental missions; itinerant/ outreach services; Faith-based Organizations	Consultations during 1st to 3rd trimester	Post partum consultations	During routine immunization	Risk screening HPN/DM Club	Routine test during ANC visit HIV Treatment Facilities/ Services among WLHIV Social Hygiene Clinic visits	Women's desk/ WCPUs	OPD Consultation Routine test during ANC visit HIV Treatment HUB/ Services among WLHIV Wards, Delivery Room, OR (LARC/ LAPM)
At point of referral	Community Health Teams, Barangay Health Workers Family Development Sessions (DSWD) Breast-feeding Support Groups Faith-based Organizations **Advocacy groups** Hypertension and Diabetes Clubs	FP-ANC Integration	FP-PNC Integration Breast feeding Support Groups	FP-EPI Integration	Risk screening HPN/DM Club		Women's desk	OPD Consultation Wards Other hospital areas with non-FP service provision

7 AO 2017-0012, Department of Health

In-reach for Family Planning Services

In-reach is a demand generation strategy to reduce missed opportunities in health facilities providing FP services. In-reach activities include health events, provision of communication materials, individual or group information provision, counseling and referral of clients. These activities are being mobilized by trained FP service providers, community health workers, community volunteers and population workers. During In-reach activities, personal contact plays an important role in encouraging clients who are not using modern FP to learn more about FP, and to seek proper counseling and services.

There are conditions that needs to be met for the conduct of in-reach activities in a health facility:

1. Ensure the conduct of regular orientation and referral to maximize opportunities for providing FP information and services are never missed by proactive staff working closely together.
2. Ensure that signage is prominently displayed and visible at the hospital and clients can easily find their way to the FP room or clinic and access FP services.
3. Ensure the availability of IEC materials and events; and FP messages are reinforced in a variety of media throughout the health facility.
4. Ensure the conduct of regular FP Counseling and ensure that health service providers engage in helpful and respectful interactions that enable clients to choose and practice FP methods suitable to their needs

Casual conversations with health care providers in the field suggest that significant efforts in discussing family planning and referring women to health care providers for further information are happening in varying degrees.

B. POLICY SHIFT TOWARDS AN EXPANDED AND INTEGRATED DELIVERY OF FAMILY PLANNING SERVICES BY LGUS

The Responsible Parenthood and Reproductive Health (RPRH) Act of 2012 guarantees the State provision of "information and access, without bias, to all methods of family planning, including effective natural and modern methods which have been proven medically safe, legal, non- abortifacient and effective". Section 6 of the law mandates all accredited public health facilities to provide a full range of modern family planning methods, provided that private health facilities shall also extend FP services to paying patients with the option to grant free care and services to indigents. The country's commitment to the Global Goals for Sustainable Development is expected to catalyze the implementation of this law with its target to ensure universal access to sexual and reproductive healthcare services, including family planning, information and education by 2030.

A multi-player and multi-payer healthcare system prevails in the Philippines. This is challenging for clients to navigate as it involves higher transaction costs. Clients have to deal with different players with overlapping functions and unclear accountabilities – the LGUs, the national government and the private sector. All have different subsystems with their own ways of financing and delivering FP, and individually targeting different types of clients.

Move Towards Universal Health Care (UHC)

The UHC Act designates the DOH to contract P/CWHSs for the provision of population-based health services for free at point of service, and PhilHealth to contract public, private or mixed health care provider networks (HCPNs) for individual-based health services. Its Implementing Rules and Regulations (IRR) defines population-based health services as interventions which "have population groups as recipient", and individual-based health services as those which "can be definitively traced back to one patient, has limited effect at a population level and does not alter the underlying cause of illness". In the case of family planning, FP education and promotion falls under the former while the rest of its services like FP commodity provision, IUD insertion, BTL and vasectomy fall under the latter.

Population-based health services

The P/CWHSs to be contracted by the DOH for this type of services are mandated by the UHC IRR to have the following minimum components: (a) a primary care provider network, (b) accurate, sensitive and timely epidemiologic surveillance systems, (c) proactive, effective and evidence-based health promotion programs or campaigns, and (d) timely, effective and efficient preparedness and response to public health emergencies and disasters, and such other means to ensure delivery of population-based health services. Refer to DOH Administrative Order No. 2020-0018 or *Guidelines on Contracting Province-Wide and City-Wide Health Systems* for details.

Individual-based health services

Under the UHC Act, PhilHealth shall endeavor to contract public, private or mixed health care provider networks (HCPNs) for the delivery of individual-based health services provided that: (a) member access to services is not compromised, (b) such networks agree to service quality, co-payment/co-insurance and data submission standards, (c) during transition, PhilHealth and DOH shall incentivize health care providers that form networks, and (d) the apex or end-referral hospitals determined by the DOH, may be contracted as stand-alone health care providers by PhilHealth (UHC Act, 2019).

HCPNs will be discussed extensively in the section on ensuring client access to FP care under different settings. Details are also provided in DOH Administrative Order No. 2020-0019 or *Guidelines on the Service Delivery Design of Health Care Provider Networks*.

Implications of Supreme Court Ruling on Mandanas-Garcia Petition on FP Service Delivery

The SC Ruling on the Mandanas-Garcia Petition in 2018 clarifies that computation of the "just share" of LGUs covers not only national internal revenue taxes but all collections of national taxes, except those accruing to special-purpose funds and special allotments for the utilization and development of the national wealth. As a result, the National Tax Allocation (formerly Internal Revenue Allocation) will increase by up to 27.6 percent in 2022 (Villaverde, 2021), providing LGUs with additional funds to implement the full devolution of basic services mandated by the Local Government Code (LGC) of 1991.

Executive Order No. 138 entitled *Full Devolution of Certain Functions of the Executive Branch to Local Governments, Creation of a Committee for Devolution, and for Other Purposes* signed in 2021 states that all functions, services, and facilities, which shall be transferred to the LGUs not later than the end of fiscal year 2024, shall include those indicated in the LGC and other

existing laws which subsequently devolved functions of the national government to LGUs. Family Health, Nutrition and Responsible Parenting remains a partially devolved function. Retained refers to areas maintained by the DOH. Partially devolved identifies areas/functions that will be shared between the national government and LGUs, and fully devolved refers to re-devolved functions that are now the entire responsibility of LGUs.

The increased resources to LGUs are expected to strengthen local autonomy, streamline health financing mechanisms and institutionalize P/CWHSs. With this, the DOH focuses on its leader and enabler role, and financier of population-based health services (Villaverde, 2021).

Delivering quality FP care in a Health Care Provider Network (HCPN)

Section 4 of the UHC Act defines an HCPN as a group of primary to tertiary care providers, whether public or private, offering people-centered and comprehensive care in an integrated and coordinated manner, with the primary care provider acting as the navigator and coordinator of health care within the network. Section 18 of this law provides for the formation of HCPNs that ensure integration and effective and efficient delivery of population-based and individual-based health services including those on family planning.

What constitutes an HCPN

DOH Administrative Order No. 2020-0019 or the *Guidelines on the Service Delivery Design of Health Care Provider Networks* recommends the following to constitute an HCPN:

1. Primary Care Provider Network (PCPN), which serves as the patient's initial contact and navigator. A PCPN is a coordinated group of public, private or mixed primary care providers. Primary care facilities for family planning may include the rural health units (RHUs) or health centers (HCs), health stations, stand-alone clinics and birthing homes. Government physicians may be certified by the DOH as primary care providers if they meet the DOH criteria.
2. Tertiary care providers with linkages to an apex hospital and other facilities providing specialized services needed by the catchment population. Hospitals shall provide in-patient services for the HCPN. These may include infirmaries (whenever available), at least one Level 1 secondary hospital providing secondary care, and at least one Level 2 or 3 hospital providing tertiary care. These hospitals, which are expected to handle FP complications, should be linked to an apex hospital to ensure provision of specialty RH services.

The full range of FP services that may not always be available in a single facility will be ensured in an HCPN. The P/CWHS or PhilHealth can partner with other facilities or providers to ensure the provision of a full range of FP services by the network.

Core HCPN standards relevant to FP

An HCPN is recommended to have the following minimum standards to deliver the full range of FP services:

1. Presence of a functional referral system with localized referral protocols, taking into account the local situation

2. A patient record management system that allows for real-time information sharing with members of the network
3. Availability of ambulances and patient transport vehicles as necessary for its catchment population
4. Routine monitoring and evaluation of network member facilities' performance, which may be in terms of agreed target coverage and adherence to FP clinical standards/ CPGs, referral protocols and PhilHealth no co-payment policies
5. Pooled fund management through a Special Health Fund to sustain operations of the network, to include arrangements on PhilHealth claims filing and reimbursement-sharing, among others
6. Unified supply chain inventory management systems for essential medicines, supplies and equipment.

How and where can women access modern FP and RH services in the Health Care Provider Network?

Depending on their identified reproductive health care needs, women can be informed by the health care providers on where they can avail of services or they can be referred to the following levels of care in the service delivery network

The Health Care Provider Network (HCPN) is a network of facilities ranging from Barangay Health Stations (BHS), Rural Health Units (RHUs), district and/or city hospitals, to the provincial and/or DOH-retained hospitals. The DOH and/or the LGU may also engage private health facilities or providers (including, among others, natural family planning providers) to form part of the HCPN. Each facility type shall have defined minimum reproductive health services that it shall provide. The Table 10 below provides the list of FP and other RH services being offered in the HCPN.

Table 11. List of FP and other RH services being offered in the HCPN

REPRODUCTIVE HEALTH CARE SERVICES AT BARANGAY HEALTH STATIONS	
a) Appropriate information (such as importance and benefits, among others) on the following	1. Full range of modern family planning methods, both natural and artificial; 2. Skilled birth attendance; 3. Child nutrition, including breastfeeding; 4. Prenatal and postnatal care; 5. Adolescent health and reproductive/fertility awareness; 6. Male responsibility and reproductive health; 7. Responsible parenthood and values formation; 8. Maternal and newborn care; and 9. Health financing (e.g., PhilHealth maternal and newborn care packages).
b) Interpersonal communication and counseling (IPCC) as applicable;	

c) Dispensing of health products by appropriately trained skilled health professionals for services that include, but are not limited to:	1. Condoms; 2. Natural family planning charts and digital thermometers; 3. Standard days method (SDM) beads; 4. Injectables and oral contraceptive pills; and 5. Immunization and micronutrient supplementation).
d) Resupply of condoms and oral contraceptive pills by volunteers, such as Barangay Health Workers (BHWs), Community Health Teams (CHTs), among others;	
e) Referral to other facilities within the HCPN, as applicable for services not included in the standards set in this provision, such as BTL, NSV, and high-risk pregnancies;	
f) Recognition, recording, reporting and referral of GBV cases;	
Reproductive Health Care Services at Other Primary Care Facilities (i.e. RHUs among others) ***Note: In addition to the reproductive health care services delivered by the BHS, other primary care facilities (such as RHUs, among others) within the HCPN shall provide services that include:***	
a) IPCC on services that include but are not limited to::	1. Infertility and referral to appropriate health care provider; 2. Adolescent counseling; 3. Postpartum depression, post-traumatic stress disorder, and other reproductive mental health concerns
b) Procedures for modern artificial family planning such as IUD insertion and removal, DMPA injection; Implant insertion and removal;	
c) Procedures, materials, and counseling for natural family planning;	
d) Integrated Management of Childhood Illness (IMCI);	
e) Syndromic screening and treatment of RTIs and STIs;	
f) Non-judgmental approach to recognizing, treating and referring post-abortion FP;	
g) Screening examinations such as visual inspection of the cervix using acetic acid wash (VIA), collection of Pap smear specimens, clinical breast exams, digital rectal examinations, among others	
Other primary care facilities shall also endeavor to provide, subject to the needs of the priority populations, the following services	
a) Facility-based delivery;	
b) Prenatal and postnatal care;	

c) Newborn care, including essential newborn care, collection of specimen for newborn screening, and referral to an appropriate facility for newborn hearing screening;

d) Procedures and/or referral for NSV, BTL, insertion of sub-dermal implants, postpartum IUD insertion among others

e) Reproductive mental health services according to guidelines developed by the DOH

f) Other reproductive health care services as mandated by DOH

Note: Private primary health care facilities within the HCPN such as, but not limited to, birthing homes, lying-in clinics, and infirmaries, shall provide basic emergency obstetric and neonatal care, and reproductive health care services in the context of their referral networks. It is also being observed that for primary care facilities owned and operated by a religious group to provide the full range of family planning methods (RPRH IRR);

Reproductive Health Care Services at Hospitals within the Health Care Provider Network

Note: In addition to the services provided by primary care facilities, hospitals within the HCPN shall provide reproductive health services such as, but not limited to, the following:

a) Long-acting and permanent methods of modern family planning such as IUD insertion, Bilateral Tubal Ligation (BTL), and no scalpel vasectomy (NSV), Implant insertion and removal, removal of non-palpable implants, removal of translocated IUD, among others;

b) BEmONC services at Level 1 hospitals, provided that these hospitals shall provide CEmONC services;

c) CEmONC services at Level 2 and Level 3 hospitals;

d) Non-judgmental approach to recognition and management of post-abortion complications.

Note: Hospitals shall also endeavor to provide, subject to the needs of the priority populations, the following services:

a) Diagnostics and management of RTIs and STIs, including HIV;

b) A WCPU to manage cases of gender-based violence;

c) Medical and surgical procedures for definitive management of breast and reproductive tract cancers, other gynecological conditions and disorders, and male reproductive health concerns, including provision of referral in complicated cases;

d) Basic diagnostics for infertility such as, but not limited to, sperm count, ultrasound, with provision for referral to appropriate reproductive endocrinology/infertility treatment centers;

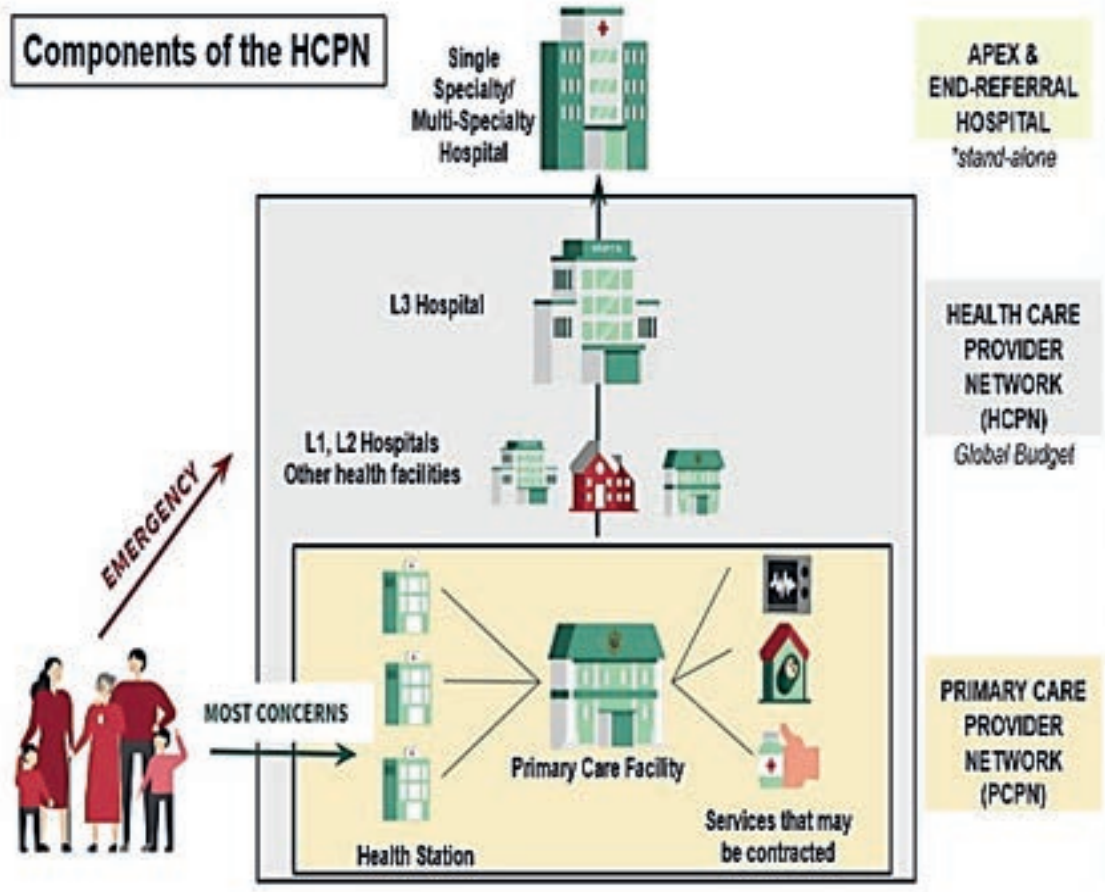
e) Specialist management of reproductive mental health conditions in accordance with DOH guidelines; and

f) Other reproductive health services as mandated by DOH.

How are women being referred by FP practitioners within the Health Care Provider Network?

Depending on their identified reproductive health care needs, women can be informed by the health care providers on where they can avail of services, or they can be referred to the following levels of care in the HCPN.

In instances where the health facility within the HCPN is unable to provide the reproductive health care service required by the client, the facility shall refer the client, within the same consultation hour, to another facility within the HCPN that can deliver the required services. Referring facility shall accomplish a referral letter that indicates the requested reproductive health services and reason for referral. In return, appropriate feedback or a referral note sent back to the referring facility must have been endorsed by the facility who managed the referred client.



Source: DOH, HCPN & Referral Algorithm 2020

How can special population groups such as persons with disabilities be assisted and provided with FP services?

For those WRA with special needs, such as those with disabilities, primary health care facilities should be able to provide the following to obliterate gaps and challenges in terms of access to reproductive health (RH) services.

a) Providing physical access and resolving transportation and proximity issues to clinics, hospitals and places where public health education is provided, contraceptives are sold or distributed or other places where RH services are provided, pursuant to the standards set forth in Implementing Rules and Regulations of Batas Pambansa (BP) No. 344, otherwise known as "An Act to Enhance the Mobility of Disabled Persons by Requiring Certain Buildings, Institutions, Establishments and Public Utilities to install Facilities and Other Devices";

b) Adapting examination tables and other laboratory procedures to the needs and conditions of PWDs;

c) Increasing access to information and communication materials on sexual and reproductive health in braille, large print, simple language, sign language and pictures;

d) Providing continuing education and inclusion of rights of PWDs among health care providers; and

e) Undertaking activities to raise awareness and address misconceptions among the general public on the stigma and their lack of knowledge on the sexual and reproductive health needs and rights of PWDs.

How can Family Planning Services be provided in Geographically Isolated and Disadvantaged Areas (GIDA)?

Outreach for FP services

Family Planning Outreach services has been identified as one of the high impact practices that is being advocated by the Department of Health as a strategy to reduce unmet need for mFP. FP Outreach is a type of service provision conducted to deliver modern FP services in underserved areas. In the Philippines, the RPRH law mandates the National Government and LGUs to provide Mobile Health Care Service (MHCS) appropriate to a locality's terrain in order to deliver health care goods and services, especially to the poor and the needy. The services provided during FP Outreach using MHCS are: Dispensing or distribution of family planning health products; and, Family planning procedures including IUD insertion, BTL using mini laparotomy under local anesthesia, and NSV among others.

Rationale for FP Outreach services

1. FP Outreach services will provide additional opportunities to address limitations to contraceptive options.
2. FP Outreach services may also serve to eliminate barriers to accessing services, mainly where health facilities are located far away or if the community has negative attitudes towards the surrounding health facilities. Outreach services may be more affordable (or offered free) than facility health services hence it helps to improve access of FP services for underserved populations.
3. FP Outreach services serve as opportunities for increasing personal contact between health service providers and the community. Such interactions also foster community dialogue and assist in initiating community action to address all concerns related to FP services.
4. Outreach activities encourages local and LGU leaders to participate and take the responsibility to provide support for FP services; this is because health service providers bring services nearer to their constituents.

Conduct of Mobile Outreach Services for Family Planning

The Responsible Parenthood and Reproductive Health (RPRH) Act of 2012 stipulates that people, especially in geographically isolated or highly populated and depressed areas, shall have access to hospitals and facilities with adequate and qualified personnel, equipment and supplies, and shall not be neglected by providing other means such as home visits or mobile health care clinics as needed.

Under the law, the National Government, through the DOH, is mandated to provide the necessary technical assistance for its effective implementation, i.e. develop standards and protocol and guidelines covering government and private service providers operations to enable them to provide Mobile Health Care Service (MHCS) appropriate to a locality's terrain to deliver quality health care goods and services especially to the underserved communities.

Pursuant to this, DOH Administrative Order 2014-004 entitled *Guidelines for Mobile Outreach Services for Family Planning* was issued to specify the particulars for FP Outreach using MHCS/ Itinerant services aimed at providing modern FP services such as dispensing or distribution of FP health products; and, FP procedures, which may include IUD insertion, BTL using mini laparotomy under local anesthesia, NSV and subdermal Implants among others in underserved areas. Ultimately, this Order hopes to contribute to the scaling up of the delivery of modern FP services to reduce unmet need, especially among the poor.

Furthermore, the Supreme Court (SC) Ruling on the Mandanas-Garcia Petition (2019) concerning the full implementation of the Local Government Code, LGUs are also expected to support the implementation of FP outreach activities which includes the provision of modern Family Planning services and commodities.

GENERAL GUIDELINES

1. The conduct of FP Outreach/ Itinerant services shall be preceded by preliminary activities that justifies the need for FP Outreach, namely: demand generation; counseling and initial screening of clients to be served; organization of outreach team; and identification of host facilities. A lot of the preparation should now be the responsibility of the LGUs.
2. The FP Outreach/Itinerant services that are supposed to provide BTL MLLA, NSV, IUD, and subdermal implant services shall be conducted as an alternative approach for trained and competent team of FP providers in the primary level host facilities (e.g., DOH retained hospitals/ medical centers, provincial hospitals) to perform selected FP services in the primary level host facilities where any or all of the following conditions concur:
    a) high unmet need for FP;
    b) with demand for LAPM/LARC FP methods;
    c) where trained service providers are either inadequate or not available; and,
    d) where investing in fix service sites is not feasible..
3. As part of competency building among the cadre of FP providers, FP Outreach shall be venues where physicians trained on BTL MLLA and other health professionals trained on IUD insertion and subdermal implantation could gain proficiency. This can be done on the condition that a trainer shall always be present to fully supervise the conduct of services that are being rendered by said doctor or health professional and that the said trainer is the lead physician for BTL MLLA services of the Mobile FP Outreach Team.

4. New FP methods shall be introduced during FP Outreach only after the conduct of health promotion activities by community volunteers, with the following components: (1) Informing households and families on the new FP method; (2) Counseling of clients regarding the most appropriate method; (3) Training of providers on the provision of the new FP method; and, (4) Identification of referral facilities for management of complications and adverse reactions.

What are the important Components of Implementing Outreach FP Services through Itinerant Teams?

STAFFING

An FP Outreach using MHCS or not shall be implemented by Mobile FP Outreach Teams composed of at least the following: (1) Physician trained on the provision of BTL MLLA, NSV, IUD, and subdermal implant services; (2) FP-trained nurse; (3) FP trained midwife; (4) circulating staff, and a (5) ancillary staff. It is required that each team be trained on the management of emergencies, which includes using all types of emergency equipment and drugs.

A Mobile FP Outreach Team can be composed of personnel from higher-level public and private health facilities. Each surgeon of the Mobile FP Outreach Team shall provide BTL MLLA and/or NSV services to a maximum of 30 clients per day to ensure the quality of services being provided. Additional teams can be formed to cover additional clients, following the recommended ratio (i.e. l team: 30 clients). The number of clients to be served shall determine the appropriate number of teams and the number of teams to be mobilized shall depend upon available resources care of DOH, LGUs, NGOs and development partners.

The Mobile FP Outreach Team physician shall manage complications during and/or right after an FP Outreach procedure. Patients shall be referred to the emergency backup facility in case the physician is unable to do so and transportation in times of emergency shall be borne by the Host Facility. Appropriate services that should be provided to them.

SPACE AND FACILITY REQUIREMENT

An FP Outreach, using MHCS or not, shall be conducted in a Host Facility which is a hospital or an out-patient clinic like RHUs and CHOs with the following:

1. Bed space for its authorized bed capacity in accordance with DOH Guidelines in the Planning and Design of Hospitals;
2. An operating room with standard equipment and provision for sterilization of equipment and supplies; and,
3. A post-operative recovery room;
4. In case such type of facility is unavailable, a Host Facility can be any facility that complies with the following minimum requirements:
    a) For BTL MLLA – a space simulating a restricted operating room measuring 3m x 3m in size, including provisions for a semi-restricted area such as examination area, preoperative waiting area, recovery area, toilet facilities and changing facilities for clients and staff; and,
    b) For NSV- an enclosed clinic that is well-ventilated and with fly-proof area.
5. Mobile FP Outreach Teams shall each be equipped with the following:

a) at least 5 mini laparotomy sets;
b) at least 3 NSV sets during each scheduled FP Outreach;
c) OR table and OR light;
d) mini sterilizer or boiler; and,
e) drugs and supplies for at least 30 clients

6. FP Outreach shall result from an agreement among the concerned DOH RO, Mobile FP Outreach Team, and Host Facility, written as a MOA which stipulates at least the roles and functions of parties, number of clients to be served, number of teams needed to cover clients, logistical arrangements, PhilHealth revenue sharing, and limitations to the cooperation among parties.
7. An emergency backup facility, i.e. a health facility with supplies, equipment, and trained and experienced staff necessary to handle any complications, shall be informed about the conduct of FP outreach services. Such facility shall be prepared to receive clients from the FP Outreach sites.

IMPLEMENTATION ARRANGEMENTS

A. The steps in setting up and implementing FP Outreach are as follows:

1. Determine demand for FP Services. Demand for FP services shall come from the following sources: (1) data gathered by community health volunteers and community level providers in a locality; (2) estimated unmet need for FP of the poor, which could be derived from the National Household Targeting System for Poverty Reduction (NHTS-PR); and (3) other sources of information that is used by DOH ROs and P/CHOs as guide for program planning and determining resource requirements.
2. Organize Mobile FP Outreach Team/s. The number of teams shall follow the specifications given that each team shall comply with the staff composition prescribed.
3. Identify the host facility. The P/CHO shall identify the health facility of out-patient clinic which shall serve as venue for the FP Outreach.
4. Forge agreements among necessary parties. The concerned DOH RO and/or P/CHO shall coordinate and negotiate with public or private higher-level facilities and Host Facility, regarding the mobilization of Mobile FP Outreach teams.
5. Verify list of potential clients. Information on the number, names and residence of potential clients with unmet need for modem FP shall be obtained from the following sources: (1) Target Client List (TCL); (2) Community Health Team (CHT) or volunteer reports on health use plans/referrals for FP; (3) Municipal/City Link database; (4) reports coming from POPCOM Barangay Service Point Officers; and, (5) faith-based organizations and similar sources.
6. Initial counseling and screening of clients. Rural Health Midwives (RHMs)/Public Health Nurses (PHNs) or other providers assisting the Rural Health Unit (RHU) shall conduct initial FP counseling and screening of FP clients referred to them to determine the appropriateness of long-acting permanent method (LAPM) or long-acting reversible contraception (LARC) to the patient. Ensure Informed Choice Among Clients.
7. The PHO, in coordination with C/MHOs shall endeavor to invite clients to the upcoming FP Outreach as well as inform families and households about available services, assess risks and identify unmet need, and direct CHTs or volunteers to

refer clients to midwives for counseling and screening for eligibility to receive BTL MLLA, NSV, IUD and subdermal implant services.

8. Secure transportation and meals for clients. The LGU of the concerned P/C/MHO shall provide the means for transportation to and from the host facility as well as meals for the Mobile FP Outreach Team, host facility staff, and participating staff/ volunteers of P/C/MHO and RHUs. Accommodation shall also be provided on a need basis.

Flow During FP Outreach activities

1. Registration of clients who will avail of FP outreach services on a "first come first served" basis. Clients should fill out individual patient records. Health promotion materials can be shown or shared while clients wait for services to be given.
2. Counseling and final assessment of client eligibility for LAPM/LARC shall be conducted at the host facility prior to any procedure. Counseling provides an opportunity for clients to learn about all methods of family planning so that they are better able to make informed choices of appropriate methods to use.
3. Pre-procedure assessment shall be conducted on clients by a physician trained on FP particularly BTL-MLLA, NSV, IUD and/or subdermal implant using the WHO Medical Eligibility Criteria (MEC) (please Medical Eligibility Criteria in Annex B).
4. For clients assessed eligible for LAPM/LARC
    - Providers shall ask eligible clients who decide to proceed with the chosen procedure for their signed consent form or ask them to sign one in case they do not have one yet. The form should show the signatures of the client and the spouse (in case of married clients) or of the parent/guardian (in case of minors). Providers shall thoroughly discuss its content and purpose with the client.
    - Those who decide to back out shall be referred to FP-trained health staff and provided with a method of their choice. If the patient has to be referred to another facility, the host facility shall coordinate with the referral facility prior to transferring the client.
5. For clients assessed not yet eligible for LAPM/LARC (i.e. falling in MEC category C, D or S)
    - The provider shall offer alternative temporary methods of contraception to clients until such time that they are finally able to avail of the LAPM/LARC method.
6. If the client decides to proceed with the chosen procedure, the surgical assistant shall prepare clients for the surgical procedure. In cases wherein clients decide to avail of another procedure, the clients shall be referred to FP-trained health staff and be counseled and provided with other FP methods.
7. FP trained physician shall provide BTL MLLA, NSV and subdermal implant services to clients that should be compliant with proper surgical and infection prevention techniques (please refer to Annex C - Standard Infection Prevention Procedures in the Delivery of FP Outreach Services of DOH AO No. 2014-0042).
8. Post-operative care, such as the following, shall be provided especially to BTL clients: (1) ushering to a recovery room after the procedure; (2) monitoring of vital signs for the next 10, 20 and 30 minutes after procedure; (3) provision of 5 days supply of pain reliever (e.g. mefenamic acid 500 mg 3 times a day), and antibiotic (e.g. amoxicillin 500 mg 3 times a day for breastfeeding woman). For

non-breastfeeding woman, Doxycycline 100mg followed by another 100mg after 12 hours, then 100 mg daily for 7 days.

9. Before discharging clients, the Host Facility shall provide both verbal and written post-operative instructions, which should specify the date of the follow-up visit, the names of the health provider, health facility, and the Mobile FP Outreach Team Leader or Coordinator. For BTL clients, removal of sutures shall be referred to a hospital/facility or the RHU covering the residence of the client.
10. The procedures for recording, reporting and monitoring are as follows:
    - All FP clients shall have their FP Form 1 completely filled out prior to any FP procedure such as BTL, NSV, IUD or subdermal implant
    - The hospital statistical report form for FP shall be submitted quarterly or after every outreach visit to their respective provincial health office. For outreach activities outside the hospital, the complete record of the FP client shall be incorporated in the TCL which shall be submitted on a quarterly basis to their respective PHOs.
    - The host facility shall keep a record containing the date of the conduct of any FP procedure such as BTL, NSV, IUD or subdermal implants, complete name of client, age, address, contact number (for follow-up visits), number of children, procedure performed, name of VSC trained doctor and operative assistant who conducted the procedure, signed by both client and VSC provider/s. It shall also keep a surgical record containing the date of VSC procedure, the operative techniques, complete name of client, age, complete name of VSC trained doctor and operative assistant who conducted the procedure, signed by both client and VSC provider/s.
11. To assess the quality of services provided during the outreach, the DOH RO and PHO shall conduct exit interviews with clients, local health workers and LGU officials (client fills up forms). The feedback report is presented to the outreach team and partners to identify areas that need further improvement in the next FP outreach. It will also be used as a basis in assessing the need of the area for LAPM. Outreach services may not be sustained in communities when there are only very few clients. The report may be used to assess the capacities of outreach providers (please refer to Annex D - Sample FP outreach feedback form for clients of DOH AO No. 2014-0042).

B. Financing Scheme

1. The concerned DOH Centers for Health Development shall provide and manage funds for the conduct of FP Outreach Services to augment resources of the concerned PHO. It shall support the operation of the Mobile FP Outreach Team, such as commodities and supplies, including funds and other resources for managing complications and adverse reactions.
2. The DOH -CHD can also contract private providers for the purpose of augmenting the capacities, commodities, supplies and equipment of government providers of LAPM services.
3. Members of Mobile FP Outreach Teams and the Host Facility shall be accredited by the Philippine Health Insurance Corporation (PhilHealth) to be reimbursed for services rendered (i.e. PhilHealth case rate packages for BTL, NSV and IUD insertion). For such a situation, the Mobile FP Outreach Team and the Host Facility shall agree on their preferred sharing scheme.

4. LGUs shall provide logistical support to the conduct of outreach services, which shall include though not limited to the provision of the following: Room and board for the outreach team, emergency services including funds for hospitalization of clients with complications, transport service for the outreach team and potential FP clients especially those living in remote areas, food for FP providers and clients, additional supplies and commodities, support staff including CHTs/local health workers, paraphernalia to promote FP outreach in the area. It shall also support the conduct of health promotion activities in communities and the orientation of health providers on the follow-up care, management of adverse reactions and complications and referral to higher-level facilities when needed.
5. The DOH-CHD may use its Local Health Systems Development (LHSD) fund to augment resources of government and private providers of Mobile FP Outreach providers. It may provide drugs, commodities and supplies to support outreach services. It may outsource private providers to augment the capacities, commodities, supplies and equipment of government providers of LAPM services.
6. The Gender and Development (GAD) fund and health budget of the LGU may be tapped to support logistics for Mobile FP Outreach
7. NGOs, private providers and other partners may use their resources to provide logistical support for the conduct of Mobile FP Outreach.

How can FP and RH services be sustained in times of disasters and during the pandemic?

The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) is a life-saving set of priority activities and tools to be implemented in every humanitarian emergency situations with the goal of reducing maternal mortalities, morbidities and disabilities through specific interventions on coordination, prevention of gender-based violence, prevention of sexually transmitted infections-human immunodeficiency virus/ acquired immunodeficiency syndrome (STI, HIV and AIDS), maternal and neonatal care, and planning for comprehensive reproductive health care following the SPHERE standard.

The goal of the MISP for SRH is to prevent SRH-related morbidity and mortality while protecting the right of the affected community to life with dignity. MISP-SRH objectives are to: 1) identify an organization to lead the implementation of the MISP for SRH, 2). prevent sexual violence and respond to the needs of survivors, 3) prevent the transmission of and reduce morbidity and mortality due to human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs), 4) prevent excess maternal and newborn morbidity and mortality, 5) prevent unintended pregnancies, and 6) plan for comprehensive SRH services integrated into primary health care as soon as possible.

The DOH Administrative Order 2016-0005, "National Policy on the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in Health Emergencies and Disasters" specifically sets the guideline for Maternal and Newborn Health Care in Crisis Situation as mandated under the RPRH Law.

The Law further mandates LGUs and the DOH to ensure that a minimum initial service package for reproductive health which shall include maternal and neonatal health care kits and services as defined by the DOH, temporary facilities such as evacuation centers and refugee camps shall be equipped to respond to the special needs of the following situations: normal and complicated deliveries, pregnancy complications, spread of HIV and STIs, and gender-based violence.

Table 12. The MISP Services during disasters

Safe Motherhood	Family Planning	STIs/HIV/AIDS	Gender-based Violence
Make available skilled health personnel to provide Emergency Obstetric and Newborn Care (EMONC) services. Prenatal care and postpartum services should be made available as situation allows Establish 24/7 referral system. Provide clean delivery kits to pregnant women on their third trimester of pregnancy and to skilled birth attendants. Raise awareness of community on the availability of services.	Provide contraceptives to existing or current users Provide appropriate information on family planning.	Provide access to free condoms Strictly adhere to universal precautions (i.e. rational and safe blood transfusion) Provide Antiretrovirals (ARV) for those undergoing treatment Provide syndromic treatment of STIs	Provide clinical and psychological care for gender violence survivors through the establishment of Women and Child Protection Units in public secondary and teritary hospitals Coordinate with DSWD on mechanisms to prevent and respond to sexual violence in emergencies such as the GBV subcluster Coordinate for proper referral to existing local protection mechanisms such as Local Committee on Anti-Trafficking -VAWC

Key points to remember on MISP

- The six objectives of the MISP for SRH include: ensure identification of an organization to lead the implementation of the MISP for SRH, prevent sexual violence and respond to the needs of survivors, prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs, prevent excess maternal and newborn morbidity and mortality, prevent unintended pregnancies, and plan for comprehensive SRH integrated into primary health care as soon as possible.
- The MISP for SRH is essential to reducing death, illness, and disability while protecting the right to life with dignity.
- Every effort should be made to ensure crisis-affected populations, including women, adolescents, and men, are involved in the program planning and implementation of MISP for SRH services from the onset of an emergency. At minimum, affected communities must be informed of the benefits of seeking services—such as clinical care for survivors of sexual violence, contraception, and EmONC—and how and where to access these services.

- The MISP for SRH Checklist can be used to monitor SRH service provision and coordination in humanitarian emergencies.
- Organizations responding to a crisis should include funding for MISP for SRH activities in proposals to donors

Family Planning during the Pandemic

In response to the effect of the COVID-19 global pandemic in the health system, the DOH Health has issued Department Memorandum 2020-0222 or *Guidelines on the Continuous Provision of Family Planning Services during Enhanced Community Quarantine following the COVID-19 Pandemic* to guide FP providers. This can be applied during any future pandemics or epidemics.

Salient Points in the Guidelines

Compliance to Safety Protocols

1. Strict compliance by FP service providers in all health facilities and those mobilized in communities on the following: (a) Increase physical and mental resilience; (b) Reduce transmission; (c) Reduce contact; and (d) Reduce duration of infection.
2. Strict social distancing and infection prevention measures shall be observed at all times and so warrants that client visits to the health facility will be scheduled to avoid congregation.

Client -Provider Interaction

3. Ensuring that all transactions with clients adhere to the principles of informed choice and voluntarism (ICV) as stated in Administrative Order 2011-0005
4. Clients below 18 years old shall be provided with FP counseling. However, for adolescents needing specific FP services, parental consent shall be secured.

Demand Generation Activities

5. Demand generation activities such as FP education and inter-personal counseling and communication shall continue subject to the mandated social distancing and infection control measures. It is noted however that group demand generation activities such as bench conferences, Usapan, mothers' classes, among others shall be prohibited during ECQ.

Continuous Provision of FP services

6. FP services shall continually be provided along with other essential health services such as but not limited to: maternal care, immunization services, women and child protection services, among others (e.g. birth plans of all pregnant women shall continue to include FP counseling and choices of postpartum FP methods).

7. FP services shall continually be provided along with other essential health services such as but not limited to: maternal care, immunization services, women and child protection services, among others (e.g. birth plans of all pregnant women shall continue to include FP counseling and choices of postpartum FP methods).
8. Availability of commodities shall be ensured by FP service providers and Managers/Coordinators at the provincial and regional levels. If commodities are inadequate, they shall report through the FP Logistics Hotline of the region as indicated in the DM. Information in the FP Hotline shall be reported to the FP Coordinators of the CHDs who shall facilitate the re-distribution of FP supplies in the catchment area.
9. To ensure uninterrupted provision of FP services, a strong referral mechanism and coordination between public and private providers across all levels of care shall be established.
10. In cases where removal of Progestin Subdermal Implant (PSI) or Intrauterine Device (IUD) is not possible, the FP service providers shall:
    a. Advise the client that there are no medical problems caused by delaying the removal of PSI or IUD, remind to not self-remove the contraceptive, and advise to have the PSI or IUD removed by a trained FP service provider once the community quarantine is lifted;
    b. Advise that the client may or may not experience side effects from the PSI since the hormone has been used up for the past three years and that the client should continue to monitor any side effects and changes in the insertion site while the PSI is still inserted subdermally and report any changes and adverse events to the health service providers;
    c. Advise the client to use backup methods to prevent unplanned pregnancy.

Monitoring & Reporting

11. Monitoring of FP inventory status at the facility level through the Pharmaceutical Management Information System (PMIS) shall continue. Pharmacists shall be allowed to re-distribute FP commodities from one facility to another if there are overstocks and stockouts of commodities.
12. Reporting of FP services through the Field Health Service Information System (FHSIS) shall continue amid the COVID-19 pandemic. The Target Client List (TCL) shall be updated regularly. Prior deadlines for submission of reports shall remain in effect.

Specific Guidelines to FP Providers in the Primary Care Facilities

13. Primary care facilities such as birthing clinics, rural health units, urban health centers, barangay health stations, free-standing FP clinics, among others, shall review the TCL for FP to identify current users who are due for resupply of commodities.

14. Primary care facilities such as birthing clinics, rural health units, urban health centers, barangay health stations, free-standing FP clinics, among others, shall review the TCL for FP to identify current users who are due for resupply of commodities.
15. Contact number of the clients shall be indicated in the TCL to enable FP service providers to monitor and ensure continued use. Likewise, FP service providers shall inform all clients of the contact number of the primary care facility to report side effects or any concerns.
16. Clients who are due for resupply shall be informed through text message, phone call, or through the Barangay Health Emergency Response Team (BHERTs)or Barangay Health Workers (BHWs) to visit the primary care facility to get their supply and bring with them the FP client card.
17. Clients who are using oral contraceptive pills such as Combined Oral Contraceptive (COC), Progestin-Only Pill (POP), or male condom shall be provided with 3 months' worth of supplies. Instructions on proper storage and handling of the commodity shall be advised (Annex C of the DM)
18. If client visit to the primary care facility is not feasible, BHERTs/BHW shall be allowed to deliver the re-supply to the clients.
19. If permanent methods (e.g. Bilateral Tubal Ligation (BTL), Non-scalpel Vasectomy (NSV)) are currently unavailable due to COVID-19 restrictions, clients shall be advised to use backup methods until such time that the said services are available.

Specific Guidelines to FP Providers in the Hospitals

20. All hospitals shall continue to provide FP services including long-acting reversible (PSI and postpartum and interval IUD) and permanent methods (BTL and NSV) for postpartum clients following their own hospital protocol.
21. All hospitals and other facilities shall set-up a referral arrangement to RHUs or any lower-level health facilities for the continued FP use of clients as they return to their community.
22. All hospitals are advised to set up hotlines or telemedicine services to enable clients to access medical advice without the need to physically visit the facility.

Sustaining the provision of quality FP services

Family Planning Program Management

Ensuring access and use of FP services depend largely on the capacity of the health facility and its staff to provide the appropriate services in response to the specific conditions and expressed needs of the targeted clients. Local government units thus play a pivotal role in program management and local FP implementation.

The effective management of FP services is central to meeting this demand on a sustained basis. The provision of quality FP services requires the following:

- Presence of competent staff with technical skills to provide culturally appropriate and gender-sensitive counseling techniques and to offer a broad range of FP methods
- Provision of accurate, evidence-based information to ensure informed choice
- Efficient health infrastructure
- Appropriate state-of-the-art functioning equipment
- Accessibility of services that are readily available, affordable, and acceptable to clients
- Continuous and adequate supply of contraceptives and other materials
- Provision of follow-up care
- Establishment of a sustainable management support system

Such provision also requires the organization of management support systems ranging from planning, organization, implementation, monitoring, and evaluation to ensure the efficient and effective delivery of FP services.

Family Planning Services

The FP services provided by a healthcare facility are summarized below:

- FP promotion
- FP counseling and assessment of clients
- FP method provision
- Protective measures for infection prevention and control
- Management of complications and appropriate referral (e.g., reproductive tract infections [RTIs]/sexually transmitted infections [STIs])
- Client follow-up
- Certain health facilities also provide laboratory diagnostic services to FP clients, as needed. These areas had been extensively discussed in the previous Chapters

Quality Management System for Family Planning Service Delivery
The following are important requirements that should be fulfilled when managing FP services in facilities.

A. Appropriate health service infrastructure in an enabling environment

B, Adequate, committed, and competent staff

C. Availability of standard equipment, health products, and other logistics

A. Appropriate Health Service Infrastructure in an Enabling Environment

Health facilities should have adequate and efficient infrastructure and a physical set-up (e.g., FP room/clinic) conducive to the provision of quality FP services. Such infrastructure ensures confidentiality and privacy during the interview, counseling, and physical examination. It should be clean and safe and offers a welcoming atmosphere. A waiting area should also be provided.

To ensure that quality services are maintained, the following measures should be undertaken:

- Strategically and prominently display the menu of FP services offered and the clinic schedule outside the health facility for client information.
- Always maintain cleanliness inside and outside the health facility.
- Ensure that the facility has good lighting and ventilation.
- Ensure the availability of running water at all times.
- Designate a waiting area with adequate seats to ensure client comfort and make IEC materials available while clients are waiting to be served.
- Ensure that the health facility has the following:
- A dedicated area for counseling and an examination room that provide visual and auditory privacy to clients as well as a setting wherein
- Clients can be comfortably examined, and clinic staff can work with ease and convenience
- Containers with decontamination solution for used gloves and instruments
- An area for washing and sterilizing gloves and instruments
- Clean and functioning toilet facilities
- Orderly and updated client records kept in confidentiality
- Storage rooms for contraceptives and other FP supplies that are safe, secured, and maintained in good order condition

B. Adequate, Committed, and Competent Staff

FP services must be provided by competent service providers, which primarily include physicians, nurses, and midwives who have completed appropriate FP training courses.

Physicians, nurses, and midwives generally provide appropriate FP information, education, counseling, and FP methods. Physicians also provide supplementary services to manage medical problems beyond the work scope of work of nurses and midwives.

Other healthcare workers (medical technologists, rural sanitary inspectors, nutritionists, dentists, and trained community health volunteers) may also be trained in FP and may function as FP educators/communicators when they perform their work in the clinic.

CHTs (community health teams) and other trained community health volunteers help generate demand for FP, particularly for women of reproductive age (WRA) with unmet needs. CHTs conduct the profiling and risk assessment of each household member and prepare health use plans together with the heads of the families. The community health volunteers serve as the link or referring arm of household members with health needs to service providers for them to gain access to healthcare.

C. Availability of Standard Equipment, Health Products, and Other Logistics

1. A health facility must have sufficient logistics management to deliver quality FP services effectively. These logistics include the following:
    - A continuous supply of FP commodities to meet the requirements of current and potential FP users.

- Medicine and other medical supplies for dispensing methods like injectables, IUD, implant provisions and voluntary surgical contraception (bilateral tubal ligation [BTL] and no-scalpel vasectomy [NSV]).
- Management of complications, and other health-related conditions
- Standard diagnostic equipment/instruments/supplies to perform physical examinations or laboratory tests, as needed
- Supplies and materials for cleaning and maintaining infection prevention and control
- Required forms for recording client information and services, consent forms, referral forms, and supplies
- IEC materials

2. Quality management also entails those mechanisms be set to ensure that FP service delivery will be well supported. These mechanisms include the following:
    - Ensuring the availability and accessibility of effective and efficient FP services through standard procedures
    - Maintaining appropriate health facility infrastructure and conducive environment
    - Ensuring that systems are in place to install and support competent and proficient service providers through supportive supervision.
    - Training and deployment of community-based health volunteers should also be given support
    - Maintaining an efficient logistics management system that includes the following processes:
        a. Forecasting of health products
        b. Procurement and financing
        c. Allocation and distribution
        d. Warehousing
        e. Establishing management support systems
        f. Information management (e.g., reporting and recording)
        g. Monitoring and evaluation
        h. Service delivery network
        i. Referral system
        j. Public-private partnerships
        k. Quality assurance
        l. Infection prevention and control
        m. Client safety and client responsiveness

Staff Development

Two mechanisms are recommended to develop the capability of staff and improve their competencies in FP service delivery. These mechanisms include attendance in training, post-training evaluation two to six months after training, and regular supervision/ coaching/ mentoring and monitoring of staff.

Training refers to the process of developing staff competencies so that they can effectively perform their expected functions and tasks.

All providers of FP services must undergo the appropriate training. Given the fast turnover of staff in health facilities, a staff development plan must be established and updated yearly. Such a plan must be accompanied by strong advocacy for budgetary support from local officials and mobilization of funds from other sources.

Furthermore, the training approaches and methodologies may be enhanced as appropriate given the new norms brought about by the pandemic situation.

Guidelines for Staff Development

Training of Staff

1. Conduct/update an inventory of the training status of health staff.
2. Conduct training needs analysis (TNA) among staff.
3. Discuss TNA results with staff.
4. Identify gaps in competencies and identify appropriate training courses.
5. Prepare the staff development plan specifying the following:
    a. Name of staff to be trained
    b. Specific training course to attend
    c. Projected schedule for training
    d. Potential sources of funds for training
6. Coordinate with the provincial/city or regional health office for training opportunities for health staff on specific training courses.
7. Mobilize resources to support staff training.
8. Send staff to training and reassign other staff to take on the trainee's tasks.
9. Conduct post-training evaluation two to six months after training for every trainee prior to the issuance of the appropriate certificate.
10. Monitor the application of knowledge and skills learned during the training program.
11. Maintain training certificates and training records.

Supportive Supervision

Supportive supervision refers to organizing and overseeing the work of subordinates responsible for performing certain assigned functions and tasks. This practice is a personal interface between the supervisor and supervisee that must be undertaken regularly to effectively operate the program and sustain staff morale and commitment.

The process is focused on mentoring, constructive feedback, and joint resolution of problems while considering subordinates as clients. Supervision aims to (a) determine the actual performance of staff in all aspects of their work and (b) renew the enthusiasm of the staff for the work they are doing.

The overall guiding principle of supervision involves guidance, support, and assistance by coaching and mentoring the staff in carrying out their assigned tasks well.

Supervision of Staff

1. Organize the work of clinic staff and volunteer workers responsible for implementing/ delivering FP services and general clinic operations, including the following:
    a. Infection control and good housekeeping
    b. Equipment and supplies maintenance and availability of adequate FP commodities
    c. Provision of service to FP/RH clients
    d. Proper recording and reporting
    e. Demand generation
2. Designate the supervisor of an individual or group of staff who will perform specific tasks and reflect these designations in the organizational chart.
3. Prepare the supervisory plan by performing the following:
    a. Identifying staff members who need supervision
    b. Prioritizing the specific program area where supervision is necessary
    c. Scheduling the supervision visit/session
4. Implement the supervision plan.
5. Document the results of the supervision.
6. Give feedback to the supervisee.
7. Develop an action plan with the supervisee to address identified gaps.

Efficient Logistics Management System

Logistics management for FP refers to the process of ensuring that the health facility has sufficient FP commodities and supplies to meet the needs of FP clients and has the necessary equipment or instruments for use in delivering quality FP services.

Under the Universal Health Care Law and with the Supreme Court Ruling of the Mandanas-Garcia Petition (2019), the full responsibility of implementing health programs (which includes the provision of family planning services) are under the Local Government Units. Thus, it is expected that during the transition phase (2022-2024), LGUs are enabled and capacitated to ensure that there will be no disruption in the delivery of family planning commodities and supplies in the primary health care facilities. These can be achieved thru the following:

- Develop a contraceptive distribution guideline to map and identify the catchment areas;
- Conduct campaigns to inform the catchment areas of the LGUs regarding the contraceptive distribution guideline;
- Provide resources for delivering contraceptives to the catchment areas;
- Undertake measures to guarantee local availability of contraceptives. These measures include any of the following:
- Allocate budget to procure contraceptives for free distribution.
- Make available contraceptives for sale at cost recovery basis or at margins above cost.

- Allow consigned commodities from social marketing sources or commercial sources to be made available to clients in LGU outlets.
- Continue with the quarterly distribution and inventory of contraceptive stocks.

Public health facilities shall therefore be enabled have the capacity to establish the needed logistics and management system encompassing the following concerns:

A. Forecasting of health products

Forecasting is the process of determining the commodity requirements (supplies and other services) of all clients (i.e., current users and potential clients with unmet needs).

B. Procurement and financing

Procurement is the process of acquiring commodities and other supplies from credible suppliers at affordable prices and ensuring procurement requirements to safeguard the quality of commodities.

Financing is the process by which the health facility decides on how the FP commodities required by clients will be sourced.

C. Allocation and distribution

This process involves determining how much and where the various commodities and services will be placed to make them available to different target clients. It is crucial that service delivery points who are recipients of family planning commodities from the central level should submit inventory and consumption reports on time to ensure proper allocation of commodities.

D. Logistics Management Information System

This process involves the regular inventory and monitoring of FP stock status at the different service delivery points.

E. Warehousing

Warehousing refers to the process of ensuring that FP commodities are properly kept and maintained in good condition to avoid wastage and to maintain their quality.

Information Management

This system involves collecting, processing, and analyzing of program-related information essential for policy making , planning, and designing interventions appropriate to the needs of target clients. The aim of management information systems (MIS) is to generate a timely, accurate, and complete set of information as a ready reference for health facility managers and staff when they make decisions to improve the delivery of FP services.

Facility-based recording and reporting system: The use of the Field Health Services Information System (FHSIS) as the official management information system of the DOH.

Clinic management requires a sound recording and reporting system. FP workers must be familiar with records and reports and know how to accomplish these documentations accurately. Any health facility can adapt and use the records and reports discussed in this section based on their particular need and interest.

Recording Tools: Facility-based documents

FP SERVICE RECORD OR FP FORM 1

FP Form 1 is the basic record form used in the FP program and corresponds to the individual treatment record form used in other programs. This form contains essential information about the client that enables the health worker to provide quality FP service. This form is filled out by the service provider and is updated every time the client returns for a follow-up visit

TARGET CLIENT LIST (TCL) FOR FP

The TCL is another essential record accomplished in a manner similar to that for FP Form 1.

This form is helpful because:

a) it contains data that help the health worker plan and implement patient care and service delivery;
b) facilitates the monitoring and supervision of service delivery activities to a group of patients/clients identified as eligible/targets to use FP;
c) facilitates the preparation of reports; and
d) provides clinic-level information that can be accessed for future studies.

SUMMARY TABLES (STs)

STs are forms with 12-month columns retained at the facility (BHS) where the midwife records all monthly data. The midwife records a summary of all data from TCL or registries. The ST is the source of data for reports included in the MW Monthly Consolidation Table (MCT). The PHN records data from all barangays. MCT is the source of documents of the PHN for the Quarterly Form. The MCT serves as the output table of the RHU because it contains a list of indicators per barangay.

OTHER RECORDS

These forms are kept in the health facility and include NFP charts, referral slips, supplies ledger cards, and requisition and issue vouchers (RIV), which are important for monitoring the availability of FP supplies in the health facility

Reporting Tools

MONTHLY FORM PROGRAM REPORT

(M1-Brgy) for FP, maternal care, etc. The FP Program indicators found in the TCL and ST are also recorded in M1. The midwife should copy the data from the ST to the Monthly Form, which is submitted monthly to the PHN, which in turn consolidates and prepares the quarterly report.

QUARTERLY FORM PROGRAM REPORT (Q1-RHU)

This form is the municipality/city health report that contains the three-month total of indicators categorized on FP. Only one Quarterly Form should be submitted per municipality/city. If the municipality/city has two or more RHUs/MHCs, the consolidation should be performed by or under the direction of the MHO/CHO who sits as Vice Chairman of the Local Health Board. The Quarterly Form is submitted to the Provincial Health Office for consolidation.

Work and Financial Planning

This system refers to the formulation of a definitive direction and plan of action to address demand for FP services among the population groups. The system involves the identification of approaches and interventions appropriate for the particular situation of the identified beneficiaries. Family planning services in the country are provided by both the government and private sector, with the latter mainly targeting paying clients. Public-private collaboration in family planning helps fill the gap in the public provision of FP care. One way to sustain the provision of quality FP services by LGUs and P/CWHs is through its inclusion in local plans, policies and budgets. Planning must observe the following principles:

- Objectives and activities aligned with the vision/goal of the LGU/ organization and the overall thrust and strategies of the National Family Planning Program
- Use of evidence-based information generated through program reviews, records analysis, or updated census information, as well as the participation of all health staff and other stakeholders (i.e., private sector)
- Appropriate budgeting and financing of program requirements

Local Investment Plan for Health

The local investment plan for health (LIPH) is a three-year plan of LGU or P/CWHS that identifies their goals, targets, strategies, investment requirements, and the needed resource counterparts on health. Sec. 22 of the UHC Act mandates the national government to provide commensurate financial and non-financial matching grants including capital outlay and human resource for health and health commodities to improve the functionality of P/CWHSs, provided that such grants are consistent with the approved LIPHs (City/Province-wide Investment Plans for Health). The health investment plan should consolidate support for health reforms and, more importantly, it should reflect complementation of public and private sector investments in health.

In terms of FP, LIPHs commonly identify the DOH as the source of FP commodities that will be distributed to government health facilities including those owned by LGUs. The DOH also provides FP training and funds the construction, upgrading, equipping, and operations of DOH-retained hospitals and other government health facilities tasked to provide essential health services, including FP. Meanwhile, LGUs fund the health personnel and operations of local health facilities. Some LGUs also procure their own FP commodities and supplies. The private sector and development partners likewise provide support through technical assistance (e.g. conduct of FP training for providers, support to FP logistics management) and capital outlay for health facilities.

The LIPH is translated into an Annual Operational Plan (AOP), which specifies the health-related programs, projects, and activities (PPAs) to be implemented for the year, including their targets, implementation timeframe, investment requirements, fund sources and monitoring plan.

The AOP should be aligned to the LGU's Annual Investment Plan (AIP) to ensure budget allocation for its PPAs. The Provincial/City Health Board and the CHD Regional Director enter into a contractual arrangement (through Terms of Partnership) to implement it.

Funding FP during COVID-19 pandemic: Integration in LGU Disaster Rehabilitation and Recovery Plan

With COVID-19 response and management as the clear priority of the government, it is important for LGUs and P/CWHSs to include FP in their Disaster Rehabilitation and Recovery Plan. Health professionals and allied medical groups can provide expert advice on the identification, design and implementation of FP programs to address the needs of communities during the crisis. Collaboration with the private sector, CSOs, professional organizations, development partners and the affected communities themselves is needed for a more holistic disaster response and synergistic recovery efforts on FP.

The DILG and the World Bank developed the LGU Guide for Rehabilitation and Recovery from COVID-19, which identifies the: (a) rehabilitation and recovery program planning process, (b) implementation mechanism, and (c) options for fund sources to ensure continuation of priority health and social services during the pandemic. LGUs and C/PWHSs should ensure that the PPAs they prioritized in their Rehabilitation and Recovery Plan are included in their Comprehensive Development Plan (CDP).

IV. Financing FP Services through PhilHealth Reimbursements

The National Health Insurance Program (NHIP) was established to provide health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of the Philippines. PhilHealth a tax-exempt Government Corporation attached to the Department of Health for policy coordination and guidance is the agency tasked to administer the NHIP.

Immediate Eligibility

Sections 6.1 and 9.1 of the IRR of the Universal Health Care Act provide that "every Filipino shall be granted immediate eligibility". In accordance to this provision, PhilHealth Circular 2019-0010 entitled *Granting on Immediate Eligibility Among Members* was issued to operationalize the provision of the law. As such, this policy and procedure ensure immediate eligibility for all in accessing PhilHealth benefits.

Accreditation

Health care institutions and professionals who met the minimum requirements for accreditation are eligible to participate in the NHIP. By granting the privilege of participation in the NHIP ensures that health care services they render have the desired and expected quality.

Institutional health care providers licensed/certified by the DOH are granted automatic accreditation provided requirements for accreditation are met by the institution. Table 12 and Table 13 provide information on the accreditation requirements of PhilHealth to be complied by the health care providers prior to participation in the NHIP.

Table 13. Accreditation Requirements for Health Facilities for Family Planning PhilHelth Benefits

General Requirements	Additional Requirements for Accreditation		
1. Provider Data Record[8] 2. Performance Commitment[9]	Facility	Initial	Renewal
	Hospital	Valid DOH License	• Valid DOH License • Audited Financial Statement

8 PhilHealth Provider Data Record for Health Care Institution
9 PhilHealth Performance Commitment for Health Care Institution

3. Accreditation Fee[10] 4. Proof of PhilHealth Accreditation of Health Care Professional 5. Updated payment for premium contributions of health facility staff 6. Only for initial accreditation of facilities: a. E-copies (JPEG format) of recent photos of the facility b. Location map c. Statement of Intent — for applications within the last quarter of the year (if applicable)	Ambulatory Surgical Clinics (for FP) Infirmaries/ Dispensaries/ Primary Care Facilities Birthing Homes Free-Standing FP Clinic	Valid DOH License	• Valid DOH License • Audited Financial Statement
	Primary Care Health Facility or Clinic/Rural Health unit or Health Center	See item 6 in the general requirements	General Requirements

Table 14. Accreditation Requirements for Health Care Professionals for FP PhilHealth Benefits

GENERAL REQUIREMENTS	ADDITIONAL REQUIREMENTS	
1. Properly accomplished Provider Data Record[11] 2. Signed Performance Commitment[12] 3. Photocopy of valid (updated) PRC license 4. 1 x 1 ID picture – 2 pcs 5. Updated payment for premium contributions	**Physicians** 1. Specialty Board Certificate (if applicable) 2. Certificate of Good Standing (CGS) from PMA or its Local component society 3. Certificate of Completed residency Training (if applicable) 4. Proof of trainings in the following: i. Non-scalpel Vasectomy ii. Subdermal Contraceptive Implant Insertion and Removal	**Midwives and Nurses** IUD Insertion 1. Certificate on Family Planning Competency Based Training (FPCBT) Level 2 or Comprehensive Family Planning Course; or 2. Post-Partum Training Course (if PPIUD only) Subdermal Contraceptive Implant Package 1. Certificate of Training on Subdermal Implant Insertion and Removal

10 Free-Standing Facility – Php1,500; For facilities providing other benefit packages - see table on accreditation fees in page 33 of MOP on accreditation
11 Provider Data Record for Health Care Professional
12 Performance Commitment for Health Care Professional

PhilHealth Benefits

Table 15. PhilHealth Family Planning Benefits

Benefit Package and Amount of Benefit	Services included	Conditions and RVS / Package Code	Where available
Voluntary Surgical Contraception Procedures **P4,000.00** **HCI Fee: P3,000** **PF: P1,000**	Healthcare facility fee component to cover all applicable health facility charges inclusive of any of the following: • Room and Board • Drugs and medicines used during surgery or confinement • X-ray, laboratory and other ancillary procedures • Supplies used during surgery or confinement • Use of special rooms e.g., operating room, recovery room Physician fee component to cover any of the following: • Family planning counseling and client assessment • Intra-operative services including provision of anesthesia, postoperative consultation within 90 days from day of surgery including dressing changes, local incision care, removal of sutures, management of complications that do not require hospitalization	Vasectomy including non-scalpel vasectomy*— Package Code: 55250 Ligation or transection of fallopian tube (s), abdominal or vaginal* approach — RVS 58600	Accredited hospitals, ambulatory surgical clinics (ASCs) and Primary care facilities and Free-Standing Family Planning (FP) Clinics (For Non-scalpel vasectomy only)

IUD Package **P2,000** **HCI: P1,200** **PF: P800**	Counseling, Professional fee, IUD device, and use of the facility and all other related services patients may require	Interval or Postpartum (PPUID)*– Package Code: 58300 Note: PPIUD may be claimed as second case rate	Birthing homes/Lying-in clinics/maternity clinics; Infirmary/dispensaries; Free-Standing Family Planning (FP) Clinics
Subdermal contraceptive implant **P3,000** **HCI: P1,800** **PF: P1,200**	Professional services: consultation and counseling prior to the procedure, performance of the procedure, follow-up and counseling after the procedure Health Facility: Use of the facility, Medicine and supplies including the contraceptive implant	Insertion of implantable subdermal Package Code: FP 001 Note: The package may only be availed of once every 730 days.	Accredited hospitals, ambulatory surgical clinics (ASCs). Infirmary/dispensary, and primary care facilities and Free-Standing Family Planning Clinics

Note:
1. *May be claimed as second case rate
2. The No Balance Billing Policy is applicable to all FP methods mentioned above provided that:
   a. Members or dependents belong to the indirect contributors and Domestic Workers or Kasambahay categories
   b. Services were availed of in PhilHealth accredited public and private HCI (except for private infirmary or dispensaries)

Benefit Availment

For eligibility checking, claims submission, and processing, FP clinics shall have the following capabilities, facilities and equipment:

1. Access to Health Care Institution (HCI) Portal and submit claims electronically;
2. Knowledgeable st.1ff authorized to access and send information;
3. Computer;
4. Document scanner;
5. Internet connection; and
6. Bank account for Auto Credit Payment Scheme (ACPS).

Documents for filing of claims

The Health Care Institution (HCI), where the procedure was done, must submit the following documents within 60 days after the procedure or after discharge (in case of inpatient admission):

1. PhilHealth Benefit Eligibility Form (PBEF) which indicates "YES," meaning the patient is eligible to avail of the benefits.
   a. Statement of Account or its equivalent
   b. Properly accomplished Claim Form 2

2. In case the PBEF indicates "NO," meaning the patient (member or dependent) is not eligible to avail of the benefits, the following documents must be submitted:
    a. Documents as enumerated in the PBEF; or photocopy of 4Ps, CCT, MCCT
    b. Properly accomplished Claim Form 2
3. In cases when the health care institution does not have a Health Care Institution Portal which generates the PBEF, then the following documents must be submitted:
    a. Properly accomplished Claim Form 1
    b. PhilHealth ID or MDR with validity period or
    c. A duly accomplished PMRF with attached photocopy of the Pantawid Pamilyang Pilipino Program (4Ps), CCT, MCCT ID
    d. Properly accomplished Claim Form 2

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APPENDICES

APPENDIX A. Current Thrusts of the National Family Planning Program (The High Impact Practices)

Based on the 2017-2022 National Objectives for Health (NOH), the adjusted modern Contraceptive Prevalence Rate (mCPR) target for all women of reproductive age (WRA) by 2022 is 30 per cent (Table 1). To reach this, an approximate of 8.7 million WRA should be reached and served by 2022; while 1.9 million of which are new acceptors of modern FP.

Table 1. Estimated total number of WRA 2017-2022

YEAR	ESTIMATED TOTAL NO. OF WRA (PSA ESTIMATES)	NOH ANNUAL MCPR TARGET	ESTIMATED NO. OF WRA TO REACH MCPR TARGET IN NOH	TARGET NEW ACCEPTORS FROM THE BASELINE
2017	26,888,828	25%	6,695,318	0
2018	27,276,379	26%	7,091,859	396,540
2019	27,649,577	27%	7,465,386	770,068
2020	28,009,459	28%	7,842,649	1,147,330
2021	28,354,078	29%	8,222,683	1,527,364
2022	28,684,460	30%	8,605,338	1,910,020

Source: DOH, 2019

In 2020, there were around 8.1 million women who are currently using a modern Family Planning (mFP) method. This translates to an mCPR of 26.3 per cent among all WRA (Fig. 1). Compared from the previous year, there is a notable increase in current users by six per cent (6%) or approximately 460,000 WRA. Likewise, new acceptors of mFP increased by 43 per cent. While a significant number of dropouts was also reported at 28 per cent, which may have been due to the effects of the COVID-19 pandemic.

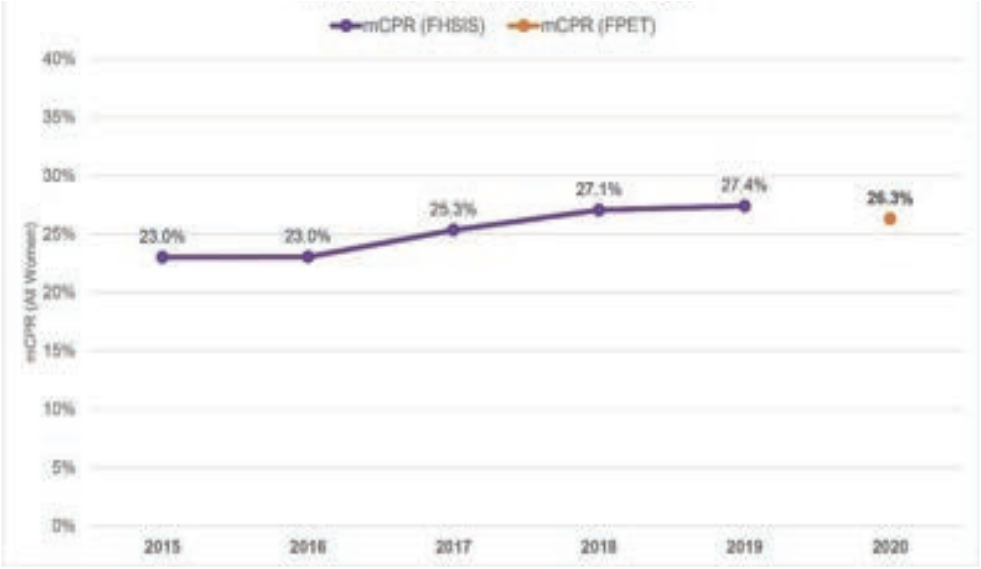

Figure 1. Trend in mCPR targets (all WRA) from 2015 to 2020 (Note: 2020 mCPR was generated using the FPET tool, while mCPR from years 2015-2019 was generated through the DOH FHSIS. Also note that FPET covers both public and private sector mFP users).

Based on the 7th RPRH Report of 2020, the Commission on Population (POPCOM) determined 59.47 per cent mCPR for married women based on their computations using Field Health Service, Information System (FHSIS) and Philippines Statistics Authority (PSA) population projection.

In the same report, a significant decrease in the number of individuals reached by demand generation activities in 2020 was noted when compared to 2019 accomplishment (Fig. 2). Restrictions in mobility brought by lockdowns and social distancing protocols challenged in the implementation of demand generation activities.

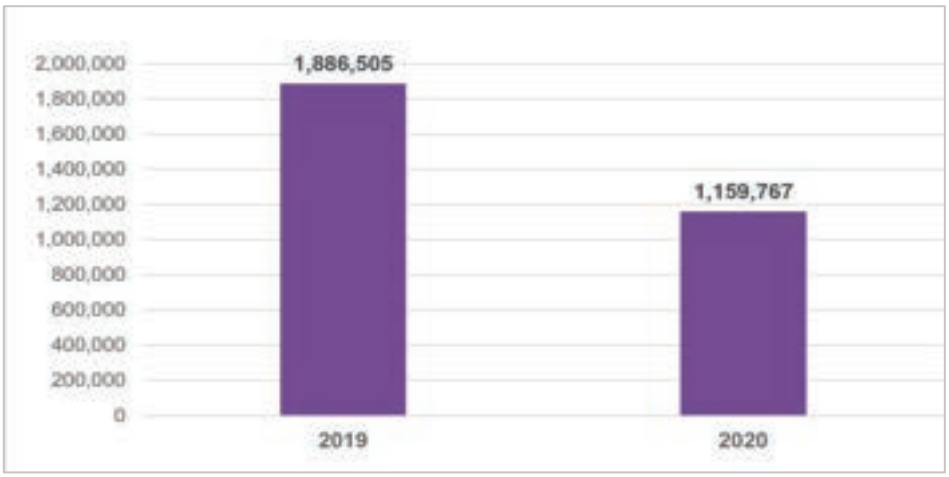

Figure 2. Individuals with sexual and reproductive health needs reached during demand generation activities, 2019 and 2020
(Source: POPCOM, 2019 and 2020)

The FP High Impact Practices

FP Goals is a model used by the DOH to estimate growth in the country's mCPR through introduction or scaling up of various high impact practices (HIPs) in FP (Family Planning, 2020). This Avenir Health model was designed to work over a specific timeframe (2018 to 2022) with an established baseline in FP programming (e.g. NDHS, administrative reports), and planned scale-ups or expansions of HIPs. Note that the tool can actually project several years of targeted goals to achieve the reduction in unmet mFP needs.

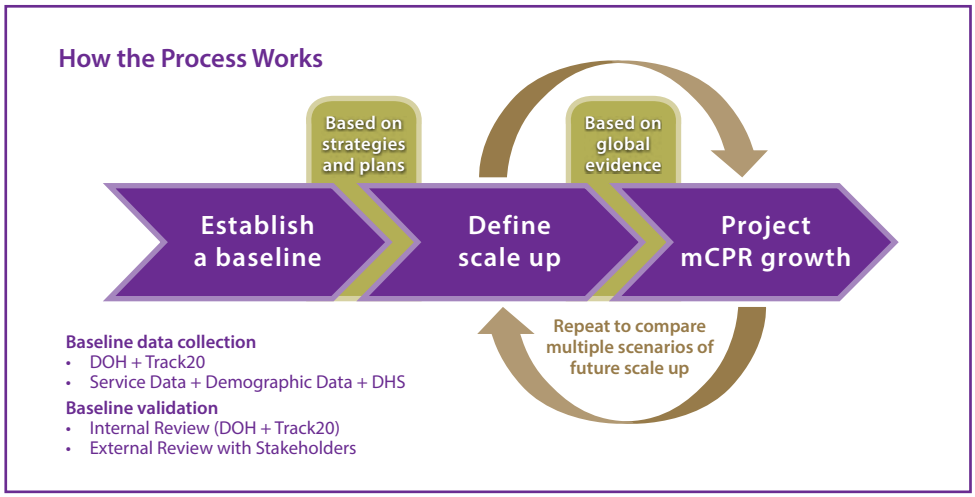

Figure 3. Process of mCPR Growth
(Source: DOH, 2020)

The model works in projecting mCPR using the HIP on Postpartum Family Planning (PPFP). First, it establishes the baseline coverage of the HIPs and it determines the percentage change in coverage of the HIP in the end line. By identifying these, the model estimates the growth in mCPR.

Table 2. Scenarios and HIP strategies in increasing growth of mCPR

SCENARIO NO. 1	SCENARIO NO. 2	SCENARIO NO. 3
Current CIP Strategies (PPFP and FP Outreach)	**CIP+ Method Availability**	**CIP + Method Availability + Youth**
PPFP (Community + Facility)	PPFP (Community + Facility)	PPFP (Community + Facility)
Mobile Outreach	Mobile Outreach	Mobile Outreach
Social Marketing (SBCC)	Social Marketing (SBCC)	Social Marketing (SBCC)
	+ Stock Out Reduction	Stock Out Reduction
	+ Increased Availability of LARCs in Public Sector	Increased Availability of LARCs in Public Sector
		+ Youth-Focused Intervention

Source: DOH, 2020

The National FP Program identified three (3) scenarios in order to determine and estimate HIPs with the highest growth of mCPR model (Table 2). This is in view of achieving the targeted mCPR by 2022. Applying the HIPs of scenario no. 2 at the national level, Table 3 estimates the mCPR growth from the baseline to the end line objectives by 2022.

Table 3. Scenario no. 2 current CIP and method availability

STRATEGIES	BASELINE 2018	SCALE-UP 2022
1. POSTPARTUM FP		
a. Community-based interventions (Pregnant women reached/tracked)	36%	↑ 50%
b. Facility-based interventions (Facilities offering quality PPFP)	54%	↑ 70%
c. Integration of PPFP with Immunization	3%	↑ 10%
2. MOBILE FP OUTREACH MISSIONS		
a. No. of Outreach/Itinerant Teams	173	↑ 359
b. Average No. of FP clients served per Team	640	↑ 1270
3. SOCIAL MARKETING (or Demand Generation)		
a. Comprehensive community engagement (RPFP Classes by DSWD and POPCOM)	5%	↑ 10%
b. Interpersonal and Communication interventions (Counseling services)	20%	↑ 28%
4. FP STOCKOUT REDUCTION (Average)	Reduce stockout incidence by ↓ 70% per method	
a. Condoms (male)	14%	7%
b. Injectables	17%	9%
c. Implant	72%	22%
d. IUD	16%	8%
e. Pills	26%	13%
5. PUBLIC SECTOR INTERVENTIONS		
a. Facilities offering pills	96%	↑ 98%
b. Facilities offering injectables	95%	↑ 98%
c. Facilities offering IUDs	63%	↑ 80%
d. Facilities offering Implants	49%	↑ 70%

Source: DOH, 2020

APPENDIX B. Summary Tables and Checklists: WHO Medical Eligibility Criteria for Contraceptive Use

SUMMARY TABLES FOR WHO MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE METHOD				
CONDITION	**COMBINED ORAL CONTRACEPTIVES**	**COMBINED INJECTABLE CONTRACEPTIVES**	**PROGESTIN-ONLY OCS**	**PROGESTIN-ONLY INJECTABLES**
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY				
PREGNANCY	NA	NA	NA	NA
AGE	Menarche to < 40 years = 1		Menarche to < 18 years = 1	Menarche to < 18 years = 2
	> 40 years = 2		18 – 45 years = 1	18 - 45 years = 1
			> 45 years = 1	> 45 years = 2
PARITY a) Nulliparous	1	1	1	1
b) Parous	1	1	1	1
BREASTFEEDING (BF) a) < 6 weeks post- partum	4	4	3	3
b) 6 weeks to < 6 months (primarily breastfeeding)	3	3	1	1
c) > 6 months post-partum	2	2	1	1
POSTPARTUM (non-breastfeeding women)				
a) < 21 days				
(i) without other risk factors for VTE	3	3	1	1
(ii) with other risk factors for VTE	3/4	3/4		
b) > 21 days			1	1
(i) without other risk factors for VTE	2	2		
(ii) with other risk factors for VTE	2/3	2/3		
c) > 42 days	1	1		

<table>
<tr><th>PROGESTIN-ONLY IMPLANTS</th><th>COPPER IUDS (TCU- 380A IUD)</th><th>PROGESTIN-BEARING IUD (LNG-IUD)</th><th>VASECTOMY</th><th>BILATERAL TUBAL LIGATION (BTL)</th></tr>
<tr><td>NA</td><td>4</td><td>4</td><td>NA</td><td>Delay</td></tr>
<tr><td>Menarche to < 18 years = 1</td><td colspan="2">Menarche to < 20 years = 2</td><td rowspan="3">Young age = Caution</td><td rowspan="3">Young age = Caution</td></tr>
<tr><td>18 - 45 years = 1</td><td colspan="2" rowspan="2">> 20 years = 1</td></tr>
<tr><td>> 45 years = 1</td></tr>
<tr><td>1</td><td>2</td><td>2</td><td></td><td>Accept</td></tr>
<tr><td>1</td><td>1</td><td>1</td><td></td><td>Accept</td></tr>
<tr><td>3</td><td></td><td></td><td></td><td rowspan="3">Accept</td></tr>
<tr><td>1</td><td></td><td></td><td></td></tr>
<tr><td>1</td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td rowspan="8">a) < 7 days = Accept
7 to < 42 days = Delay
> 42 days = Accept

b) Pre-eclampsia / eclampsia:
(i) Mild pre-eclampsia = Accept
(ii) Severe pre-eclampsia / eclampsia = Delay

c) Prolonged rupture of membrane: 24 hours of more = Delay

d) Puerperal sepsis, intrapartum hemorrhage = Delay</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">1</td><td></td><td></td><td></td></tr>
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</table>

CONDITION	COMBINED ORAL CONTRACEPTIVES	COMBINED INJECTABLE CONTRACEPTIVES	PROGESTIN-ONLY OCS	PROGESTIN-ONLY INJECTABLES
POSTPARTUM (breastfeeding or non-breastfeeding women, including post-caesarean section)				
a) < 48 hours including insertion immediately after delivery of placenta				
b) > 48 hours to < 4 weeks				
c) > 4 weeks				
d) Puerperal sepsis				
POSTABORTION				
a) First trimester	1	1	1	1
b) Second trimester	1	1	1	1
c) Immediate post- septic abortion	1	1	1	1
PAST ECTOPIC PREGNANCY	1	1	2	1
HISTORY OF PELVIC SURGERY including caesarean section) (see also postpartum section)	1		1	1
SMOKING				
a) Age<35	2	2	1	1
b) Age > 35				
(i) < 15 cigarettes/ day	3	2	1	1
(ii) > 15 cigarettes/ day	4	3	1	1
OBESITY				
a) > 30 kg/m2 body mass index (BMI)	2	2	1	1

PROGESTIN-ONLY IMPLANTS	COPPER IUDS (TCU- 380A IUD)	PROGESTIN-BEARING IUD (LNG-IUD)	VASECTOMY	BILATERAL TUBAL LIGATION (BTL)
				e) Severe antepartum or postpartum hemorrhage = **Delay** f) Severe trauma to the genital tract: cervical or vaginal tear at time of delivery = **Delay** g) Uterine rupture or perforation = **Special**
	1	1 = not BF 3 = BF		
	3	3		
	1	1		
	4	4		
				a) Uncomplicated = **Accept** b) Post-abortal sepsis or fever = **Delay** c) Severe post-abortal hemorrhage = **Delay** d) Severe trauma to the genital tract: cervical or vaginal tear at time of abortion = **Delay** e) Uterine perforation = **Special** f) Acute hematometra = **Delay**
1	1	1		
1	2	2		
1	4	4		
1	1	1		**Accept**
1	1	1		
1	1	1		**Accept**
1	1	1		**Accept**
1	1	1		**Accept**
				Caution
1	1	1		

CONDITION	COMBINED ORAL CONTRACEPTIVES	COMBINED INJECTABLE CONTRACEPTIVES	PROGESTIN-ONLY OCS	PROGESTIN-ONLY INJECTABLES
b) Menarche to <18 years old and > 30 kg/m2 BMI	2	2	1	DMPA = 2 NET-EN = 1
BLOOD PRESSURE MEASUREMENT UNAVAILABLE	NA	NA	NA	NA
CARDIOVASCULAR DISEASE				
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIO-VASCULAR DISEASE (such as older age, smoking, diabetes, and hypertension)	3/4	3/4	2	3
HYPERTENSION				
a) History of hypertension where blood pressure CANNOT be evaluated (including hypertension during pregnancy)	3	3	2	2
b) Adequately controlled hyperten- sion, where blood pressure CAN be evaluated	3	3	1	2
c) Elevated blood pressure levels (properly taken measurements)				
(i) systolic 140-159 mm Hg or diastolic 90-99 mm Hg	3	3	1	2
(ii) systolic >160 mm Hg or diastolic >100 mm Hg	4	4	2	3
d) Vascular disease	4	4	2	3
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is measurable and normal)	2	2	1	1
DEEP VENOUS THROMBOSIS (DVT) / PULMONARY EMBOLISM (PE)				
a) History of DVT/ PE	4	4	2	2
b) Acute DVT/PE	4	4	3	3

PROGESTIN-ONLY IMPLANTS	COPPER IUDS (TCU- 380A IUD)	PROGESTIN-BEARING IUD (LNG-IUD)	VASECTOMY	BILATERAL TUBAL LIGATION (BTL)
1	1	1		
NA	NA	NA		
2	1	2		**Special**
2	1	2		
1	1	1		**Caution**
1	1	1		**Caution**
2	1	2		**Special**
2	1	2		**Special**
1	1	1	1	**Accept**
2	1	1		**Accept**
3	1	3		**Delay**

CONDITION	COMBINED ORAL CONTRACEPTIVES	COMBINED INJECTABLE CONTRACEPTIVES	PROGESTIN-ONLY OCS	PROGESTIN-ONLY INJECTABLES
c) DVT/PE and established on anticoagulant therapy	4	4	2	2
d) Family history (first degree relatives)	2	2	1	1
e) Major surgery				
(i) with prolonged immobilization	4	4	2	2
(ii) without prolonged immobilization	2	2	1	1
f) Minor surgery without immobilization	1	1	1	1
KNOWN THROMBO-GENIC MUTATIONS (e.g. Factor V Leiden; Prothrombin mutation; Protein S, Protein C and Antithrombin deficiencies)	4	4	2	2
SUPERFICIAL VENOUS THROMBOSIS				
a) Varicose veins	1	1	1	1
b) Superficial thrombophlebitis	2	2	1	1
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE	4	4	I C 2 3	3
STROKE (history of cerebro-vascular accident)	4	4	I C 2 3	3
KNOWN HYPERLIPIDEMIAS (screening is NOT necessary for safe use of contraceptive methods)	2/3	2/3	2	2
VALVULAR HEART DISEASE				
a) Uncomplicated	2	2	1	1

Legend:
I - Initiation
C - Continuation

PROGESTIN-ONLY IMPLANTS	COPPER IUDS (TCU- 380A IUD)	PROGESTIN-BEARING IUD (LNG-IUD)	VASECTOMY	BILATERAL TUBAL LIGATION (BTL)
2	1	2		**Special**
1	1	1		**Accept**
2	1	2		**Delay**
1	1	1		**Accept**
1	1	1		**Accept**
2	1	2		**Accept**
1	1	1		**Accept**
1	1	1		**Accept**
I C 2 3	1	I C 2 3		**Delay**
I C 2 3	1	2		**Caution**
2	1	1		**Accept**
1	2	2		**Caution**

CONDITION	COMBINED ORAL CONTRACEPTIVES		COMBINED INJECTABLE CONTRACEPTIVES		PROGESTIN-ONLY OCS		PROGESTIN-ONLY INJECTABLES	
b) Complicated (pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis)	4		4		1		1	
RHEUMATIC DISEASES								
SYSTEMIC LUPUS ERYTHEMATOSUS							I	C
a) Positive (or unknown) antiphospholipid antibodies	4		4		3		3	3
b) severe thrombocytopenia	2		2		2		3	2
c) Immunosuppressive treatment	2		2		2		2	2
d) None of the above	2		2		2		2	2
NEUROLOGIC CONDITIONS								
HEADACHES	I	C	I	C	I	C	I	C
a) Non-migrainous (mild or severe)	1	2	1	2	1	1	1	1
b) Migraine								
(i) without aura Age < 35	2	3	2	3	1	2	2	2
Age>35	3	4	3	4	1	2	2	2
(ii) with aura (at any age)	4	4	4	4	2	3	2	3
EPILEPSY	1		1		1		1	
DEPRESSIVE DISORDERS								
DEPRESSIVE DISORDERS	1		1		1		1	

Legend:
I - Initiation
C - Continuation

PROGESTIN-ONLY IMPLANTS	COPPER IUDS (TCU- 380A IUD)		PROGESTIN-BEARING IUD (LNG-IUD)		VASECTOMY	BILATERAL TUBAL LIGATION (BTL)
1	2		2			**Special**
3	I	C	3			**Special**
	1	1				
2	3		2		2	**Special**
2	2		1		1	**Special**
2	1		1		2	**Caution**
I	C	1	I	C		**Accept**
1	1		1	1		
2	2	1	2	2		**Accept**
2	2	1	2	2		**Accept**
2	3	1	2	3		**Accept**
1		1	1			**Caution**
1		1	1		**Caution**	**Caution**

CONDITION	COMBINED ORAL CONTRACEPTIVES	COMBINED INJECTABLE CONTRACEPTIVES	PROGESTIN-ONLY OCS	PROGESTIN-ONLY INJECTABLES
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS				
VAGINAL BLEEDING PATTERNS				
a) Irregular pattern without heavy bleeding	1	1	2	2
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	1	1	2	2
UNEXPLAINED VAGINAL BLEEDING (suspicious for serious condition) Before evaluation	2	2	2	3
ENDOMETRIOSIS	1	2	1	1
BENIGN OVARIAN TUMORS (including cysts)	1	1	1	1
SEVERE DYSMENORRHEA	1	1	1	1
GESTATIONAL TROPHOBLASTIC DISEASE				
a) Decreasing or undetectable Beta- HCG levels	1	1	1	1
b) Persistently elevated Beta-HCG levels or malignant disease	1	1	1	1
CERVICAL ECTROPION	1	1	1	1
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	2	2	1	2
CERVICAL CANCER (awaiting treatment)	2	2	1	2
BREAST DISEASE				
a) Undiagnosed mass	2	2	2	2
b) Benign breast disease	1	1	1	1

Legend:
I - Initiation
C - Continuation

PROGESTIN-ONLY IMPLANTS	COPPER IUDS (TCU- 380A IUD)		PROGESTIN-BEARING IUD (LNG-IUD)		VASECTOMY	BILATERAL TUBAL LIGATION (BTL)
			i	C		
2	1		1	1		**Accept**
2	2		1	2		**Accept**
3	I	C	I	C		**Delay**
	4	2	4	2		
1	2		1			**Special**
1	1		1			**Accept**
1	2		1			**Accept**
1	3		3			**Accept**
1	4		4			**Delay**
1	1		1			**Accept**
2	1		2			**Accept**
2	I	C	I	C		**Delay**
	4	2	4	2		
2	1		2			**Accept**
1	1		1			**Accept**

CONDITION	COMBINED ORAL CONTRACEPTIVES	COMBINED INJECTABLE CONTRACEPTIVES	PROGESTIN-ONLY OCS	PROGESTIN-ONLY INJECTABLES
c) Family history of cancer	1	1	1	1
d) Current breast cancer	4	4	4	4
e) Breast cancer in the past and no evidence of current disease for 5 years	3	3	3	3
ENDOMETRIAL CANCER	1	1	1	1
OVARIAN CANCER	1	1	1	1
UTERINE FIBROIDS				
a) Without distortion of the uterine cavity	1	1	1	1
b) With distortion of the uterine cavity	1	1	1	1
ANATOMICAL ABNORMALITIES				
a) That distort the uterine cavity				
b) That do not distort the uterine cavity				
PELVIC INFLAMMATORY DISEASE (PID) a) Past PID (assuming no current risk factors of STIs)				
(i) with subsequent pregnancy	1	1	1	1
(ii) without subsequent pregnancy	1	1	1	1
b) PID - current	1	1	1	1

Legend:
I - Initiation
C - Continuation

PROGESTIN-ONLY IMPLANTS	COPPER IUDS (TCU- 380A IUD)		PROGESTIN-BEARING IUD (LNG-IUD)		VASECTOMY	BILATERAL TUBAL LIGATION (BTL)
1	1		1			**Accept**
4	1		4			**Caution**
3	1		3			**Accept**
1	I	C	I	C		**Delay**
	4	2	4	2		
1	I	C	I	C		**Delay**
	3	2	3	2		
1	1		1			**Caution**
1	4		4			**Caution**
	4		4			
	2		2			
	I	C	I	C		
1	1	1	1	1		**Accept**
1	2	2	2	2		**Caution**
1	4	2	4	2		**Delay**

CONDITION	COMBINED ORAL CONTRACEPTIVES	COMBINED INJECTABLE CONTRACEPTIVES	PROGESTIN-ONLY OCS	PROGESTIN-ONLY INJECTABLES
STIs				
a) Current purulent cervicitis or chlamydial infection or gonorrhoea	1	1	1	1
b) Other STIs (excluding HIV and hepatitis)	1	1	1	1
c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	1	1	1	1
d) Increased risk of STIs	1	1	1	1
HIV/AIDS				
HIGH RISK OF HIV	1	1	1	1
HIV-INFECTED	1	1	1	1
AIDS	1	1	1	1
Clinically well on ARV therapy	If on treatment, see DRUG INTERACTIONS section.			
OTHER INFECTIONS				
SCHISTOSOMIASIS				
a) Uncomplicated	1	1	1	1
b) Fibrosis of the liver	1	1	1	1
TUBERCULOSIS				
a) Non-pelvic	1	1	1	1
b) Known pelvic	1	1	1	1
MALARIA	1	1	1	1
ENDOCRINE CONDITIONS				
DIABETES				
a) History of gestational disease	1	1	1	1

Legend:
I - Initiation
C - Continuation

PROGESTIN-ONLY IMPLANTS	COPPER IUDS (TCU- 380A IUD)		PROGESTIN-BEARING IUD (LNG-IUD)		VASECTOMY	BILATERAL TUBAL LIGATION (BTL)
	I	C	I	C		Delay
1	4	2	4	2		
1	2	2	2	2		Accept
1	2	2	2	2		Accept
1	2/3	2	2/3	2		Accept
1	I	C	I	C	Accept	Accept
	2	2	2	2		
1	2	2	2	2	Accept	Accept
1	3	2	3	2	Special	Special
	2	2	2	2		
1	1		1			Accept
1	1		1			Caution
	I	C	I	C		
1	1	1	1	1		Accept
1	4	3	4	3		Special
1	1		1			Accept
1	1		1		Caution	Accept

CONDITION	COMBINED ORAL CONTRACEPTIVES		COMBINED INJECTABLE CONTRACEPTIVES		PROGESTIN-ONLY OCS	PROGESTIN-ONLY INJECTABLES
b) Non-vascular disease						
(i) non-insulin dependent	2		2		2	2
(ii) insulin dependent	2		2		2	2
c) Nephropathy / retinopathy / neuropathy	3/4		3/4		2	3
d) Other vascular disease or of > 20 years' duration	3/4		3/4		2	3
THYROID DISORDERS						
a) Simple goiter	1		1		1	1
b) Hyperthyroid	1		1		1	1
c) Hypothyroid	1		1		1	1
GASTROINTESTINAL CONDITIONS						
GALLBLADDER DISEASE						
a) Symptomatic						
(i) treated by cholecystectomy	2		2		2	2
(ii) medically treated	3		2		2	2
(iii) current	3		2		2	2
b) Asymptomatic	2		2		2	2
HISTORY OF CHOLESTASIS						
a) Pregnancy- related	2		2		1	1
b) Past COC-related	3		2		2	2
VIRAL HEPATITIS	I	C	I	C		
a) Acute or flare	3/4	2	3	1	1	1
b) Carrier	1	1	1	1	1	1
c) Chronic	1	1	1	1	1	1

Legend:
I - Initiation
C - Continuation

PROGESTIN-ONLY IMPLANTS	COPPER IUDS (TCU- 380A IUD)	PROGESTIN-BEARING IUD (LNG-IUD)	VASECTOMY	BILATERAL TUBAL LIGATION (BTL)
2	1	1	**Caution**	**Accept**
2	1	2		**Caution**
2	1	2		**Special**
2	1	2		**Special**
1	1	1		**Accept**
1	1	1		**Special**
1	1	1		**Caution**
2	1	2		**Accept**
2	1	2		**Accept**
2	1	2		**Delay**
2	1	2		**Accept**
1	1	1		**Accept**
2	1	2		**Accept**
1	1	1		**Delay**
1	1	1		**Accept**
1	1	1		**Accept**

CONDITION	COMBINED ORAL CONTRACEPTIVES	COMBINED INJECTABLE CONTRACEPTIVES	PROGESTIN-ONLY OCS	PROGESTIN-ONLY INJECTABLES
CIRRHOSIS				
a) Mild (compensated)	1	1	1	1
b) Severe (decompensated)	4	3	3	3
LIVER TUMORS				
a) Benign (adenoma)			3	3
(i) Focal nodular hyperplasia	2	2	2	2
(ii) Hepatocellular adenoma	4	3	3	3
b) Malignant (hepatoma)	4	3/4	3	3
ANEMIAS				
THALASSEMIA	1	1	1	1
SICKLE CELL DISEASE	2	2	1	1
IRON-DEFICIENCY ANEMIA	1	1	1	1
DRUG INTERACTIONS				
ANTIMICROBIAL THERAPY				
a) Broad spectrum antibiotics	1	1	1	1
b) Antifungals	1	1	1	1
c) Antiparasitics	1	1	1	1
d) Rifampicin or rifabutin therapy	3	2	3	DMPA = 1 NET-EN = 2
ANTICONVULSANT THERAPY				
a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidine, topimarate, oxcarbazepine)	3	2	3	DMPA = 1 NET-EN = 2
b) Lamotrigrine	3	3	1	1

PROGESTIN-ONLY IMPLANTS	COPPER IUDS (TCU- 380A IUD)	PROGESTIN-BEARING IUD (LNG-IUD)	VASECTOMY	BILATERAL TUBAL LIGATION (BTL)
1	1	1		**Accept**
3	1	3		**Special**
3	1	3		
2	1	2		**Accept**
3	1	3		**Caution**
3	1	3		**Caution**
1	2	1		**Caution**
1	2	1	**Accept**	**Caution**
1	2	1		Hemoglobin <7 g/dL = **Delay** Hemoglobin >= 7 to <10 g/dL = **Caution**
1	1	1		
1	1	1		
1	1	1		
2	1	1		
2	1	1		
1	1	1		

CONDITION	COMBINED ORAL CONTRACEPTIVES	COMBINED INJECTABLE CONTRACEPTIVES	PROGESTIN-ONLY OCS	PROGESTIN-ONLY INJECTABLES
ANTIRETROVIRAL THERAPY				
a) Nucleoside reverse transcriptase inhibitors (NRTIs)	1	1	1	DMPA = 1 NET-EN = 1
b) Non- nucleoside reverse transcriptase inhibitors (NNRTIs)	2	2	2	DMPA = 1 NET-EN = 2
c) Ritonavir-boosted protease inhibitors	3	3	3	DMPA = 1 NET-EN = 2
OTHER CONDITIONS RELEVANT ONLY FOR MALE / FEMALE SURGICAL STERILIZATION				
LOCAL INFECTIONS				
a) scrotal skin infection				
b) active STI				
c) balanitis				
d) epididymitis or orchitis				
e) abdominal skin infection				
COAGULATION DISORDERS				
PREVIOUS SCROTAL INJURY				
SYSTEMIC INFECTION OR GASTROENTERITIS				
LARGE VARICOCELE				
LARGE HYDROCELE				
FILARIASIS, ELEPHANTIASIS				
INTRASCROTAL MASS				
CRYPTORCHIDISM				
INGUINAL HERNIA				

Legend:
I - Initiation
C - Continuation

PROGESTIN-ONLY IMPLANTS	COPPER IUDS (TCU- 380A IUD)		PROGESTIN-BEARING IUD (LNG-IUD)		VASECTOMY	BILATERAL TUBAL LIGATION (BTL)
	I	C	I	C		
1	2/3	2	2/3	2		
2	2/3	2	2/3	2		
2	2/3	2	2/3	2		
						Delay
					Delay	
					Delay	
					Delay	
					Delay	
						Delay
					Special	**Special**
					Caution	
					Delay	**Delay**
					Caution	
					Caution	
					Delay	
					Delay	
					Caution	
					Special	

CONDITION	COMBINED ORAL CONTRACEPTIVES	COMBINED INJECTABLE CONTRACEPTIVES	PROGESTIN-ONLY OCS	PROGESTIN-ONLY INJECTABLES
RESPIRATORY DISEASES a) Acute (bronchitis, pneumonia)				
b) Chronic (i) asthma				
(ii) bronchitis				
(iii) emphysema				
(iv) lung infection				
FIXED UTERUS DUE TO PREVIOUS SURGERY OR INFECTION				
ABDOMINAL WALL OR UMBILICAL HERNIA				
DIAPHRAGMATIC HERNIA				
KIDNEY DISEASE				
SEVERE NUTRITIONAL DEFICIENCIES				
PREVIOUS ABDOMINAL OR PELVIC SURGERY				
STERILIZATION CONCURRENT WITH ABDOMINAL SURGERY a) Elective				
b) Emergency (without previous counseling)				
c) Infectious condition				
STERILIZATION CONCURRENT WITH CAESAREAN SECTION				

PROGESTIN-ONLY IMPLANTS	COPPER IUDS (TCU- 380A IUD)	PROGESTIN-BEARING IUD (LNG-IUD)	VASECTOMY	BILATERAL TUBAL LIGATION (BTL)
				Delay
				Special
				Special
				Special
				Special
				Special
				Special
				Caution
				Caution
				Caution
				Caution
				Caution
				Delay
				Delay
				Accept

APPENDIX C. Listing of the FDA Registered Contraceptive (as of November 2021)

REGISTRATION NUMBER	BRAND NAME	GENERIC NAME	MANUFACTURER	COUNTRY OF ORIGIN	ISSUANCE DATE	EXPIRY DATE
DR-XY21633	Mercilon	Desogestrel + Ethinylestradiol	Organon (Ireland) Limited	Ireland	17-Nov-17	16-Nov-22
DR-XY2299	Marvelon 28	Desogestrel + Ethinylestradiol	N.V. Organon	Netherlands	17-Nov-17	16-Nov-22
DR-XY23241	NORDETTE	Levonorgestrel + Ethinylestradiol	Pfizer Ireland Pharmaceutical	Ireland	16-Nov-17	16-Nov-22
DR-XY25428	Meliane	Gestodene + Ethinylestradiol	Delpharm Lille SAS	France	20-Feb-20	03-Jun-23
DR-XY28181	Yasmin	Drospirenone + Ethinylestradiol	Bayer Weimar GmbH Und Co. KG	Germany	17-Nov-17	16-Nov-22
DR-XY34401	Micropil Plus	Norethisterone + Ethinylestradiol; Ferrous Fumarate	Pascual Laboratories, Inc.	Philippines	06-Dec-19	17-Mar-23
DR-XY34970	YAZ	Drospirenone + Ethinylestradiol	Bayer Weimar GmbH Und Co., KG	Germany	20-Jul-18	20-Jul-23
DR-XY37779	FEMME	Levonorgestrel + Ethinylestradiol + Ferrous Fumarate	Nanjing Baijingyu Pharmaceutical Co., Ltd.	China	15-Jun-20	16-Nov-22
DR-XY38297	Protec	Ethinylestradiol + Levonorgestrel + Ferrous Fumarate	HLL Lifecare Ltd	India	16-Nov-17	16-Nov-22
DR-XY40787	Estrelle Plus	Desogestrel + Ethinylestradiol	Steril-Gene Life Sciences (P) Ltd.	India	27-Oct-20	28-Mar-22
DR-XY46395	Daisy-30	Desogestrel + Ethinylestradiol	Mylan Laboratories Ltd.	India	26-Aug-20	09-Jul-25
DR-XY46499	Zinnia P	Levonorgestrel + Ethinylestradiol	Mylan Laboratories Limited	India	03-May-21	17-Jan-26
DR-XY46542	Althea	Cyproterone Acetate + Ethinylestradiol	Pond's Chemical Thailand R.O.P.	Thailand	09-Nov-20	22-Mar-24
DR-XY46840	Diane 35	Cyproterone Acetate + Ethinylestradiol	Bayer Weimar GmbH und Co. KG	Germany	11-Mar-20	11-Mar-25
DR-XY6690	Diane 35	Cyproterone Acetate + Ethinylestradiol	Bayer Weimar GmbH und Co. KG	Germany	19-Feb-20	04-Jun-21
DR-XY8804	Seif	Levonorgestrel + Ethinylestradiol	Schering do Brasil Quimica e Farmaceutica Ltda.	Brazil	17-Dec-20	03-Mar-23

REGISTRATION NUMBER	BRAND NAME	GENERIC NAME	MANUFACTURER	COUNTRY OF ORIGIN	ISSUANCE DATE	EXPIRY DATE
DRP-2063	Charlize	Ethinylestradiol + Levonorgestrel ; Ferrous Fumarate	Pond's Chemical Thailand R.O.P.	Thailand	17-Jun-20	07-May-23
DRP-336	Trust Pill	Ethinylestradiol + Levonorgestrel ; Ferrous Fumarate	Pond's Chemical Thailand R.O.P.	Thailand	17-Nov-17	16-Nov-22
DRP-3738	Minipil	Levonorgestrel + Ethinylestradiol	Laboratorios Leon Farma, S.A.	Spain	17-Nov-17	16-Nov-22
DRP-3750	Lizonya	Drospirenone + Ethinylestradiol	Laboratorios Leon Farma, S.A.	Spain	17-Nov-17	16-Nov-22
DRP-3751	Liza	Drospirenone + Ethinylestradiol	Laboratorios Leon Farma, S.A.	Spain	17-Nov-17	16-Nov-22
DRP-4297	Julianne®	Ethinylestradiol + Levonorgestrel	Famy Care Ltd.	India	17-Nov-17	16-Nov-22
DRP-4439	Cybelle	Cyproterone Acetate + Ethinylestradiol	Laboratorios Leon Farma, S.A.	Spain	17-Nov-17	16-Nov-22
DRP-4625	Lizelle	Drospirenone + Ethinylestradiol	Laboratorios Leon Farma, S.A.	Spain	29-Nov-19	16-Aug-23
DRP-8208	Famila 28F	Levonorgestrel + Ethinyl Estradiol + Ferrous Fumarate	Zafa Pharmaceutical Laboratories (Pvt.) Ltd.	Pakistan	29-May-19	04-Feb-24
DRP-9557	Suncet 35	Cyproterone Acetate + Ethinylestradiol	Sun Pharmaceutical Industries Ltd.	India	08-Mar-21	08-Mar-26
DR-XY27146	Cerazette	Desogestrel	NV Organon	Netherlands	06-Nov-19	20-Nov-23
DR-XY40817	Estrelle	Desogestrel	Steril-Gene Life Sciences (P) Ltd.	India	17-Nov-17	16-Nov-20
DR-XY25174	Mirena	Levonorgestrel	Bayer Oy	Finland	17-Nov-17	05-May-19
DR-XY30778	Angeliq	Drospirenone + Estradiol	Bayer Weimar GmbH und Co. KG	Germany	04-Jan-21	19-May-25
DR-2477	Primolut N	Norethisterone	Bayer Weimar GmbH und Co. KG	Germany	23-Sep-19	08-Jul-24
DR-XY30830	None	Medroxyprogesterone Acetate	Umeda Co., Ltd	Thailand	17-Nov-17	16-Nov-22
DR-XY32846	Provestin	Medroxyprogesterone Acetate	L.B.S. Laboratory Limited Partnership	Thailand	19-Jul-18	15-Jan-22

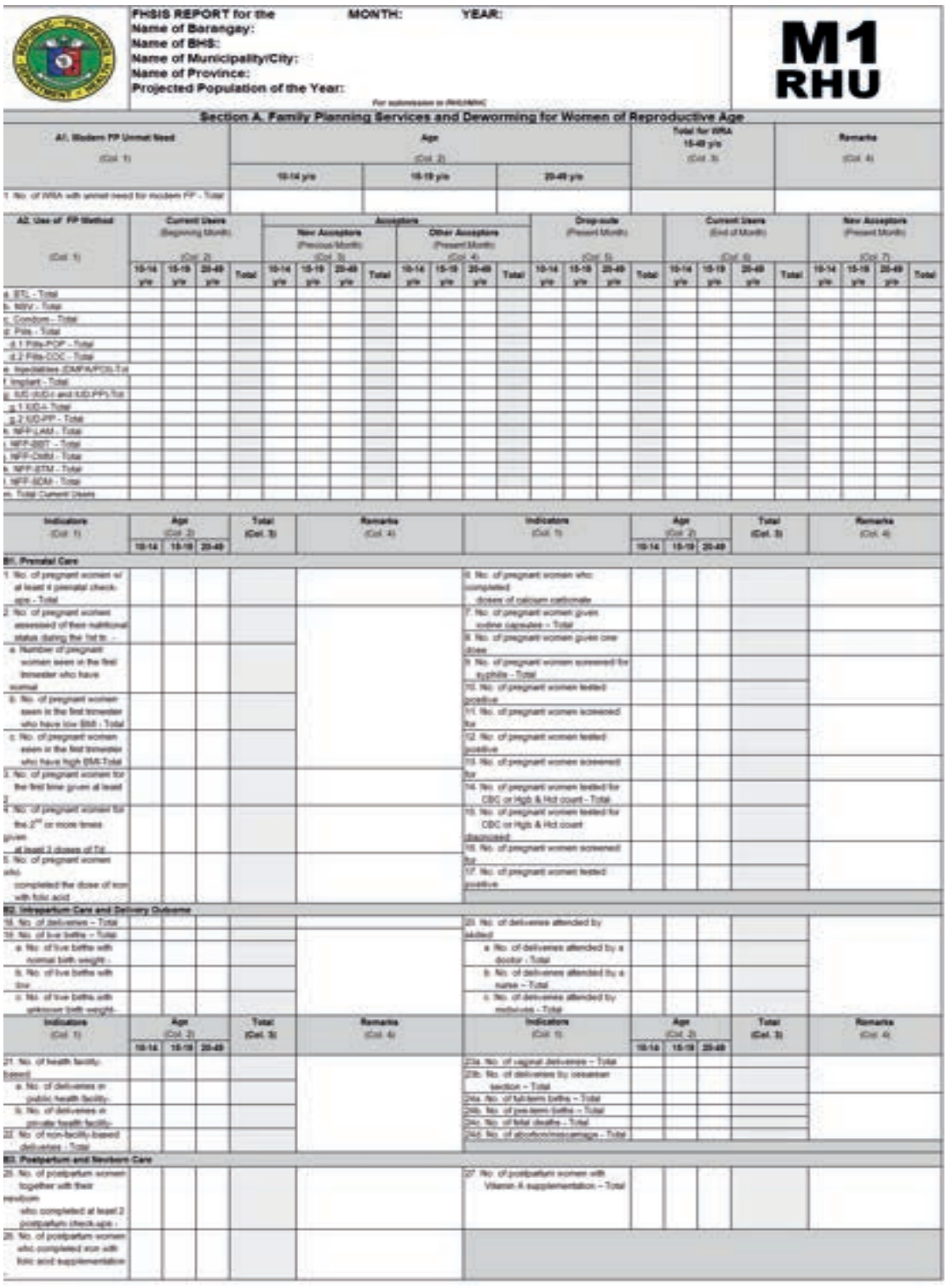
REGISTRATION NUMBER	BRAND NAME	GENERIC NAME	MANUFACTURER	COUNTRY OF ORIGIN	ISSUANCE DATE	EXPIRY DATE
DR-XY34137	Depotrust	Medroxyprogesterone Acetate	Umeda Co., Ltd	Thailand	31-Jul-18	16-Nov-22
DR-XY39023	Depo-gestin	Medroxyprogesterone Acetate	A.N.B. Laboratories Co. Ltd.	Thailand	25-Jul-18	16-Nov-22
DR-XY40409	Depofemme	Medroxyprogesterone Acetate	PT Trisaya Nagamas Farma	Indonesia	17-Nov-17	16-Nov-22
DR-XY42049	Protec	Medroxyprogesterone Acetate	A.N.B. Laboratories Co. Ltd.	Thailand	12-Apr-18	30-May-23
DR-XY46394	Famy-Depo	Medroxyprogesterone Acetate	Mylan Laboratories Ltd.	India	26-Jun-20	09-Jul-25
DR-XY46989	Depo-Provera	Medroxyprogesterone Acetate	Pfizer Manufacturing Belgium NV	Belgium	05-Aug-20	05-Aug-25
DR-XY47081	Sayana Press	Medroxyprogesterone Acetate	Pfizer Manufacturing Belgium NV	Belgium	14-Jan-21	15-Jan-26
DRP-1934	Provera	Medroxyprogesterone Acetate	Pfizer Italia S.R.L.	Italy	23-Jun-20	22-Sep-23
DRP-338	Lyndavel	Medroxyprogesterone Acetate			17-Nov-17	16-Nov-22
DRP-363	Depotrust	Medroxyprogesterone Acetate	Umeda Co., Ltd	Thailand	20-Feb-20	15-Aug-23
DRP-3643	Depo-gestin	Medroxyprogesterone Acetate	A.N.B. Laboratories Co. Ltd.	Thailand	30-Jul-21	16-Nov-22
DRP-4426	Db-10	Medroxyprogesterone Acetate	Unicure Remedies Pvt. Limited	India	05-May-20	23-May-23
DRP-4426-02	Medrofix	Medroxyprogesterone Acetate	Unicure Remedies Pvt. Ltd.	India	18-May-21	23-May-23
DRP-4426-03	Medroxcure	Medroxyprogesterone Acetate	Unicure Remedies Pvt. Ltd.	India	31-Aug-21	23-May-23
DRP-4426-04	Xygyn	Medroxyprogesterone Acetate	Unicure Remedies Pvt. Ltd.	India	26-Aug-21	23-May-23
DRP-4428	Db-5	Medroxyprogesterone Acetate	Unicure Remedies Pvt. Limited	India	10-Mar-20	23-May-23
DR-XY38455	Qlaira	Estradiol valerate + Dienogest	Bayer Weimar GmbH und Co. KG	Germany	17-Nov-17	16-Nov-22
DR-XY42440	Visanne	Dienogest	Bayer Weimar GmbH und Co. KG	Germany	13-Jul-20	23-Aug-23
DR-XY21353	Progynova	Estradiol Valerate	Delpharm Lille SAS	France	23-Jun-20	15-Jul-23
DR-XY23891	Progynova	Estradiol Valerate	Delpharm Lille SAS	France	12-Jan-18	09-Jul-22

REGISTRATION NUMBER	BRAND NAME	GENERIC NAME	MANUFACTURER	COUNTRY OF ORIGIN	ISSUANCE DATE	EXPIRY DATE
DR-XY35422	Norifam	Norethisteron Enanthate + Estradiol Valerate	Zafa Pharmaceutical Laboratories (Private) Limited	Pakistan	15-Jun-20	09-Feb-24
DR-XY42910	Oestrogel	Estradiol (as Hemidydrate)	Besins Manufacturing Belgium S.A.	Belgium	25-Mar-19	07-Nov-23
DR-XY45805	Vagifem	Estradiol (as Hemihydrate)	Novo Nordisk A/S	Denmark	03-Mar-17	03-Mar-22
DR-XY47080	Estrofem	Estradiol (as Hemihydrate)	Novo Nordisk A/S	Denmark	22-Dec-20	22-Dec-25
DR-XY18077	Exluton	Lynestrenol	N.V. Organon	Netherlands	17-Nov-17	16-Nov-22
DRP-2088	Daphne	Lynestrenol	Pond's Chemical Thailand R.O.P.	Thailand	17-Nov-17	16-Nov-22
DR-XY41423	ENDOMETRIN	Progestogen	Q Pharma AB	Sweden	21-Dec-16	21-Dec-21
DR-XY44905	Esmya	Ulipristal (as acetate)	Cenexi	France	27-Nov-15	27-Nov-20
DR-XY41412(For DOH Use Only)	Implanon NXT	Etonogestrel	N.V. Organon	Netherlands	29-Sep-20	29-May-25
DVR-7641	TRUST® COPPER T IUD (TCU 380A)		Pregna International Ltd.	India	06-Feb-20	17-Dec-24
MDR-09294	TRUST PPIUD (POSTPARTUM TCU 380A)		Pregna International Ltd. - Plot NO. 2019, Survey No. 168, Dahbel Co. Op. Industrial Soc. Ltd.. Dabhel Daman (U.T.) 396 210, India	India	21-Apr-21	26-Feb-26
MDR-00420	FEEL MALE LATEX CONDOM ULTRATHIN		Nulatex HCPN. Bhd.	Malaysia	03-Jun-19	09-Mar-23
MDR-00421	FEEL MALE LATEX CONDOM FLAVOURED & COLORED		Nulatex HCPN. Bhd.	Malaysia	03-Jun-19	09-Mar-23
MDR-01160	PLAYSAFE-TIGER MALE LATEX CONDOM		Takaso Rubber Producst HCPN. Bhd.	Malaysia	02-Dec-19	15-Apr-24
MDR-03008	ZOOM CONTOURED NATURAL RUBBER LATEX MALE CONDOM		Subira Pharmaceuticals Pvt. Ltd.	India	25-Aug-16	29-Apr-21

REGISTRATION NUMBER	BRAND NAME	GENERIC NAME	MANUFACTURER	COUNTRY OF ORIGIN	ISSUANCE DATE	EXPIRY DATE
MDR-03009	ZOOM DOTTED NATURAL RUBBER LATEX MALE CONDOM		Subira Pharmaceuticals Pvt. Ltd.	India	22-Aug-16	29-Apr-21
MDR-03010	ZOOM ULTRA THIN NATURAL RUBBER LATEX MALE CONDOM		Subira Pharmaceuticals Pvt. Ltd.	India	25-Aug-16	29-Apr-21
MDR-03012	ZOOM PROLONGER DOTTED NATURAL RUBBER LATEX MALE CONDOM		Subira Pharmaceuticals Pvt. Ltd.	India	16-Oct-16	29-Apr-21
MDR-03158	ZOOM ALOE VERA DOTTED NATURAL RUBBER LATEX MALE CONDOM		Subira Pharmaceuticals Pvt. Ltd.	India	12-Oct-16	28-May-21
MDR-06150	UNIMEX MALE CONDOM CATHETER		Ningbo Greatcare Trading Co., Ltd.	China	11-Dec-18	25-Oct-23
MDR-07829A	ENDURE MALE LATEX CONDOM (NATURAL PLAIN)		Cupid Limited	India	04-Mar-20	25-Mar-25
MDR-07829B	ENDURE MALE LATEX CONDOM (COLORED PLAIN)		Cupid Limited	India	16-Mar-20	25-Mar-25
MDR-07829C	ENDURE MALE LATEX CONDOM LARGE (NATURAL PLAIN)		Cupid Limited	India	01-Apr-20	25-Mar-25
MDR-07829D	ENDURE MALE LATEX CONDOM ULTRA THIN (NATURAL PLAIN)		Cupid Limited	India	01-Apr-20	25-Mar-25
MDR-10458A	ENDURE MALE LATEX CONDOM - COLORED (PINK), RIBBED, NON-FLAVORED		Indus Medicare Limited - Hyderabad, India	India	15-Oct-20	15-Oct-21

REGISTRATION NUMBER	BRAND NAME	GENERIC NAME	MANUFACTURER	COUNTRY OF ORIGIN	ISSUANCE DATE	EXPIRY DATE
MDR-10458B	ENDURE MALE LATEX CONDOM - NATURAL, RIBBED, NON-FLAVORED		Indus Medicare Limited - Hyderabad, India	India	15-Oct-20	15-Oct-21
MDR-10458C	ENDURE MALE LATEX CONDOM - COLORED, DOTTED, FLAVORED/ NON-FLAVORED		Indus Medicare Limited - Hyderabad, India	India	15-Oct-20	15-Oct-21
MDR-10458D	ENDURE MALE LATEX CONDOM - NATURAL, DOTTED, FLAVORED/ NON-FLAVORED		Indus Medicare Limited - Hyderabad, India	India	15-Oct-20	15-Oct-21
MDR-10458E	ENDURE MALE LATEX CONDOM - COLORED, SMOOTH, FLAVORED/ NON-FLAVORED		Indus Medicare Limited - Hyderabad, India	India	15-Oct-20	15-Oct-21
MDR-10458F	ENDURE MALE LATEX CONDOM - NATURAL, SMOOTH, FLAVORED/ NON-FLAVORED		Indus Medicare Limited - Hyderabad, India	India	15-Oct-20	15-Oct-21

APPENDIX D. Samples of Department of Health Family Planning Forms from the RHU Level



FHSIS REPORT for the **MONTH:** **YEAR:**
Name of Barangay:
Name of BHS:
Name of Municipality/City:
Name of Province:
Projected Population of the Year:

M1
RHU

Section A. Family Planning Services and Deworming for Women of Reproductive Age

A1. Modern FP Unmet Need (Col. 1)	Age (Col. 2) 10-14 y/o	15-19 y/o	20-49 y/o	Total for WRA 15-49 y/o (Col. 3)	Remarks (Col. 4)
1. No. of WRA with unmet need for modern FP - Total					

A2. Use of FP Method (Col. 1)	Current Users (Beginning Month) (Col. 2)				Acceptors: New Acceptors (Previous Month) (Col. 3)				Acceptors: Other Acceptors (Present Month) (Col. 4)				Drop-outs (Present Month) (Col. 5)				Current Users (End of Month) (Col. 6)				New Acceptors (Present Month) (Col. 7)			
	10-14 y/o	15-19 y/o	20-49 y/o	Total	10-14 y/o	15-19 y/o	20-49 y/o	Total	10-14 y/o	15-19 y/o	20-49 y/o	Total	10-14 y/o	15-19 y/o	20-49 y/o	Total	10-14 y/o	15-19 y/o	20-49 y/o	Total	10-14 y/o	15-19 y/o	20-49 y/o	Total
a. BTL - Total																								
b. NSV - Total																								
c. Condom - Total																								
d. Pills - Total																								
d.1 Pills-POP - Total																								
d.2 Pills-COC - Total																								
e. Injectables (DMPA/PCS)-Tot																								
f. Implant - Total																								
g. IUD (IUD-I and IUD-PP)-Tot																								
g.1 IUD-I- Total																								
g.2 IUD-PP - Total																								
h. NFP-LAM - Total																								
i. NFP-BBT - Total																								
j. NFP-CMM - Total																								
k. NFP-STM - Total																								
l. NFP-SDM - Total																								
m. Total Current Users																								

Indicators (Col. 1)	Age (Col. 2) 10-14	15-19	20-49	Total (Col. 3)	Remarks (Col. 4)	Indicators (Col. 1)	Age (Col. 2) 10-14	15-19	20-49	Total (Col. 3)	Remarks (Col. 4)
B1. Prenatal Care											
1. No. of pregnant women w/ at least 4 prenatal check-ups - Total						6. No. of pregnant women who completed dose of calcium carbonate					
2. No. of pregnant women assessed of their nutritional status during the 1st tri -						7. No. of pregnant women given iodine capsules – Total					
a. Number of pregnant women seen in the first trimester who have normal						8. No. of pregnant women given one dose					
b. No. of pregnant women seen in the first trimester who have low BMI - Total						9. No. of pregnant women screened for syphilis - Total					
c. No. of pregnant women seen in the first trimester who have high BMI-Total						10. No. of pregnant women tested positive					
3. No. of pregnant women for the first time given at least 2						11. No. of pregnant women screened for					
4. No. of pregnant women for the 2nd or more times given at least 3 doses of Td						12. No. of pregnant women tested positive					
5. No. of pregnant women who completed the dose of iron with folic acid						13. No. of pregnant women screened for					
						14. No. of pregnant women tested for CBC or Hgb & Hct count - Total					
						15. No. of pregnant women tested for CBC or Hgb & Hct count diagnosed					
						16. No. of pregnant women screened for					
						17. No. of pregnant women tested positive					
B2. Intrapartum Care and Delivery Outcome											
18. No. of deliveries – Total						20. No. of deliveries attended by skilled					
19. No. of live births – Total						a. No. of deliveries attended by a doctor - Total					
a. No. of live births with normal birth weight -						b. No. of deliveries attended by a nurse – Total					
b. No. of live births with low						c. No. of deliveries attended by midwives - Total					
c. No. of live births with unknown birth weight											

Indicators (Col. 1)	Age (Col. 2) 10-14	15-19	20-49	Total (Col. 3)	Remarks (Col. 4)	Indicators (Col. 1)	Age (Col. 2) 10-14	15-19	20-49	Total (Col. 3)	Remarks (Col. 4)
21. No. of health facility-based						21a. No. of vaginal deliveries – Total					
a. No. of deliveries in public health facility-						21b. No. of deliveries by cesarean section – Total					
b. No. of deliveries in private health facility-						24a. No. of full-term births – Total					
22. No. of non-facility-based deliveries - Total						24b. No. of pre-term births – Total					
						24c. No. of fetal deaths - Total					
						24d. No. of abortion/miscarriage - Total					
B3. Postpartum and Newborn Care											
25. No. of postpartum women together with their newborn who completed at least 2 postpartum check-ups -						27. No. of postpartum women with Vitamin A supplementation – Total					
26. No. of postpartum women who completed iron with folic acid supplementation											

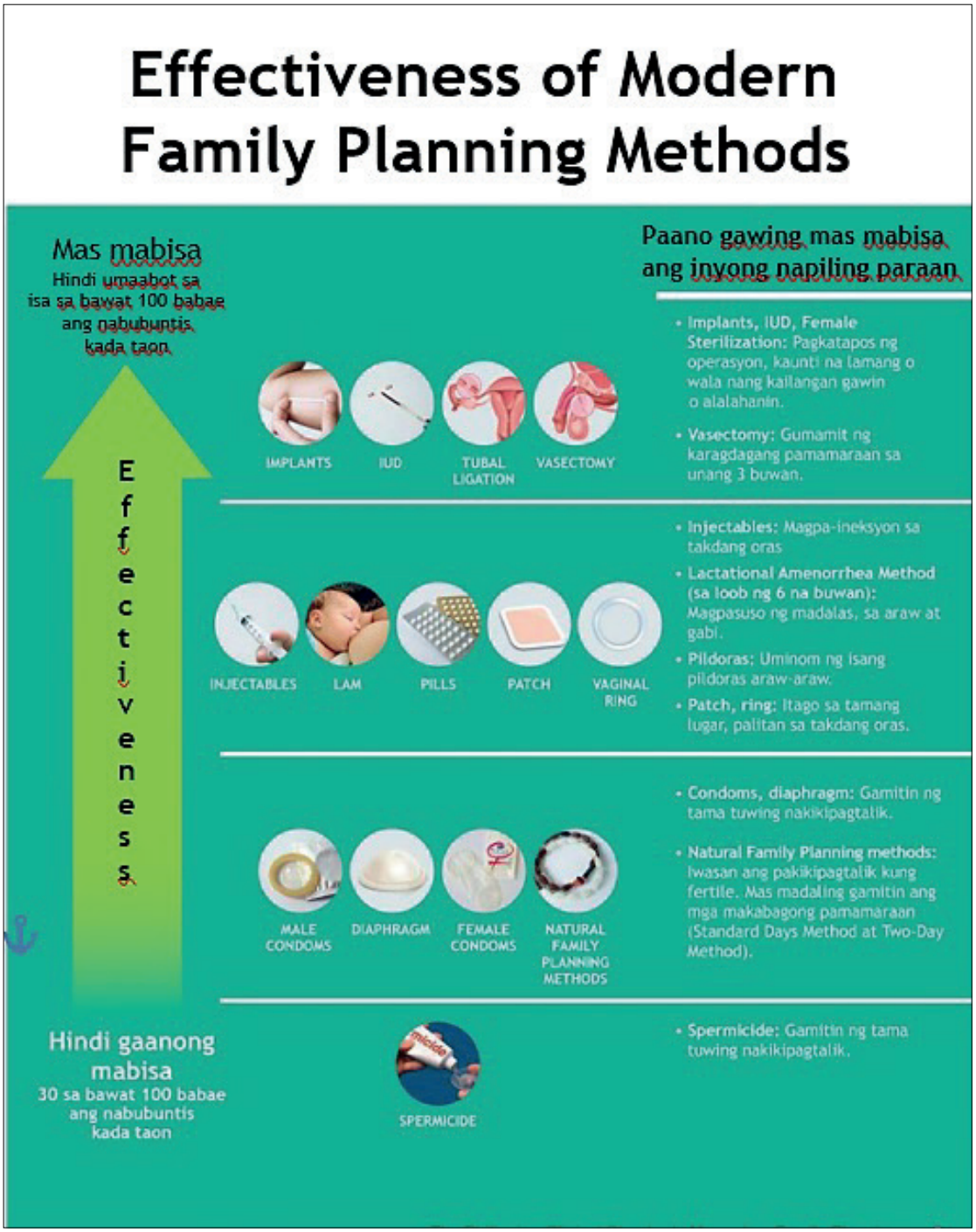
FHSIS REPORT for the MONTH: YEAR:
Name of Health Facility:
Name of Barangay:
Name of Municipality/City:
Name of Province:
Projected Population of the Year:
For submission to the next administrative level

M2

Section A.2.g. Ten Leading Causes of Morbidity in Pregnant Women

No.	Name of Diseases	Number of Cases	Rate per 100,000 population
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

APPENDIX E. FP Method Effectiveness



APPENDIX F. Anatomy and Physiology of Human Reproductive Tracts

Purpose

This chapter provides an overview of the human reproductive system as part of the introduction to family planning (FP) methods. Specifically, this chapter has the following objectives:

1. To show the different parts and functions of the male and female reproductive systems in relation to the different contraceptives
2. To enumerate the different phases of the menstrual cycle
3. To explain how fertility awareness works

Basic knowledge of the anatomy and physiology of human reproduction will help in understanding the mechanism of reproduction and the action of various contraceptive methods, as described below.

- Fertility awareness-based methods prevent pregnancy through abstinence during the woman's fertile period. The fertile period is determined by observed changes in the cervical mucus and/or basal body temperature and by the length of the menstrual cycle.
- Hormonal methods may either prevent ovulation or thicken the cervical mucus or both.
- Barrier methods prevent the meeting of the egg and the sperm by preventing the transport/ascent of the sperm from the vagina into the uterus/fallopian tubes.
- Voluntary surgical contraceptive methods, such as bilateral tubal ligation, also prevent the meeting of the egg and sperm by blocking the passage way of the sperm from the epididymis to the seminal vesicle (as in vasectomy) or of the ova from the ovary to the fallopian tubes.

MALE REPRODUCTIVE SYSTEM

External Genitalia

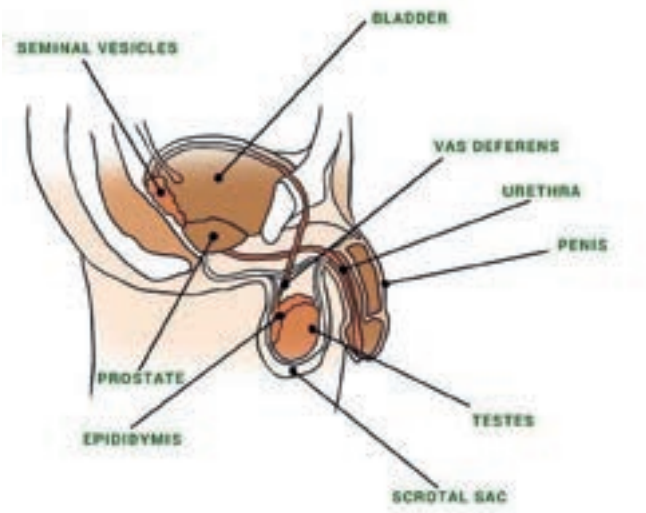
The male external genitalia consist of the following:

1. Penis
   - It is made up of spongy erectile tissues.
   - The penis becomes erect when a man becomes sexually excited; it stiffens and grows in both width and length.
   - An erect penis is approximately 5 inches to 7 inches in length and approximately 1 inch to 1.5 inches in diameter.
   - The penis serves as a passageway of the urine and of the semen during sexual intercourse.
2. Scrotal sac
   - This is a pair of wrinkled skin pouches that contain and protect the testes or testicles.
   - The scrotum controls the temperature of the testicles. The scrotal temperature is approximately 6 °C lower than the body temperature, which is ideal for sperm production.

Internal Genitalia

The male internal genitalia consist of the following:

1. Testicles (testes)
   - The testicles are the organs that produce the sperm cells and the male hormone testosterone.
   - These organs are located in the wrinkled-looking pouch called the scrotum, which hangs behind the penis.
   - An adult male has two testicles about the size of plums or a native guava. The testicles contain hundreds of thousands of chambers where the sperms develop.
2. Epididymis
   - The epididymis is a small tube located at the base of the testes.
   - It is the site where maturing sperms develop before ascending the seminal vesicles through the vas deferens.
3. Vas deferens (sperm duct)
   - The vas deferens passes from the testes to the back of the prostate gland.
   - Each of the two sperm ducts joins with the seminal vesicle on each side before entering the prostate gland as a single duct.
   - The vas deferens acts as a storage place and passageway for the sperm from the testes to the prostate gland.
4. Seminal vesicles
   - The seminal vesicles produce the nourishing and lubricating seminal fluid that contributes part of the semen.
   - This is where the sperm and the semen mix.
5. Prostate gland
   - The prostate gland is situated at the base of the urinary bladder and surrounds part of the urethra.
   - It secretes an alkaline fluid that forms part of the semen.
6. Urethra
   - The urethra is a duct that passes from the lower part of the bladder through the prostate gland and then into and through the penis.
   - It serves as a common pathway for semen or urine.



Physiology

- Sperms are produced daily in the testes of males at the start of puberty. Males remain fertile throughout their lifetimes unless diagnosed with an injury or a disease that affects fertility.
- Sperms are microscopic male reproductive cells that comprise less than 2% of the total ejaculate. They are much smaller than the egg cells. Each has a head and a tail like a tadpole.
- Sperms that are produced pass through the epididymis, vas deferens, and then seminal vesicles where they mix with the seminal fluid.
- Sperms mix with the seminal fluid and enter the prostate gland where additional fluid is added to nourish them.
- Sperms can survive in the vas deferens and seminal vesicle for up to 90days.
- Sperms ejaculated during sexual intercourse swim through the vagina, cervical opening, uterus, and then fallopian tubes.
- Sperms can live for four to six hours in the vagina but can live for three to five days once they reach the uterus and the fallopian tubes. They usually reach the tubes within 1 hour to 1.5 hours after ejaculation.
- Sperms that reach the top of the uterus are divided between the two fallopian tubes. They swim against the strong current set up by the cilia in the fallopian tubes, which draw the egg down toward the uterus.
- Each ejaculate contains 100 to 600 million sperms in approximately a teaspoon of seminal fluid.
- Only approximately 2,000 of the 100 to 600 million sperms reach the tubes, and only one sperm actually penetrates the egg cell. The rest help in dissolving the covering of the egg to enable one sperm to penetrate it. The rest of the sperms die and are absorbed by the body after fertilization.

FEMALE REPRODUCTIVE SYSTEM

External Genitalia

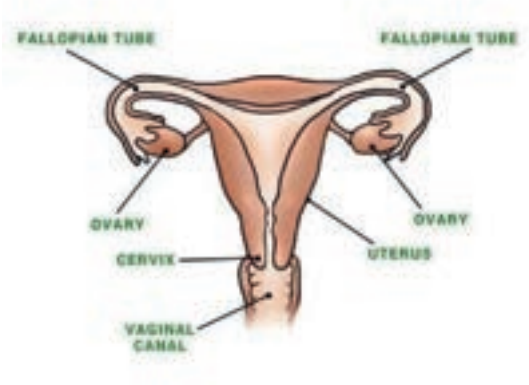
1. Vagina
   - The vagina is the passage that extends from the external structure or vulva to the cervix.
   - This passage receives the penis during sexual intercourse.
   - It allows the flow of menstrual blood from the uterine cavity to the exterior.
   - It is the usual passage through which the baby is born.
2. Labia majora
   - The labia majora are made up of two thick outer folds of skin that protect the inner sensitive parts of the vulva.
3. Labia minora
   - The labia minora consists of two thinner internal folds of tissues that cover the vaginal opening and meet in front over a sexually sensitive structure called the clitoris.
4. Clitoris
   - The clitoris is a small-pea sized organ composed of highly sensitive tissue similar to that of the penis.

5. Urethra
    - The urethra is the tube through which the urine passes from the bladder to the exterior at the urethral opening between the clitoris and the vaginal opening.

Internal Genitalia

The female internal genitalia consist of the following:

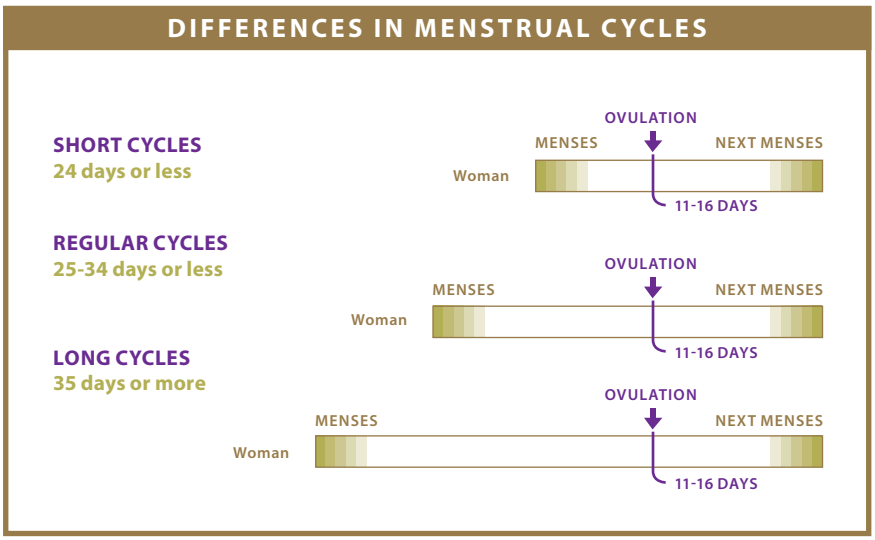
1. Uterus
    - The uterus is a hollow muscular organ that lies between the bladder and the rectum.
    - A lining called the endometrium covers the cavity of the uterus.
    - The uterus receives the fertilized ovum.
    - It expands as the fetus (baby) grows and expels the baby at birth.
2. Cervix
    - The cervix is the lower part of the uterus that opens into the vagina.
    - Glands called the cervical crypts line the cervical canal. These glands produce cervical mucus under the influence of the hormone estrogen. The spermatozoa depend on the cervical mucus for their survival and transport to the female reproductive tract.
3. Fallopian tubes
    - The fallopian tubes are located on each side of the upper part of the uterus.
    - The end of each fallopian tube is dilated and opens close to the ovary.
    - The fallopian tubes transport the ovum released from the ovary to the uterus.
    - They enable the sperm to move from the uterus toward the ovary.
    - Fertilization of the ovum by the sperm occurs at the distal third of the fallopian tubes closest to the ovary.
4. Ovaries
    - The ovaries are the female reproductive organs that produce the ova or eggs.
    - These organs are attached to either side of the uterus.
    - They produce two hormones, estrogen and progesterone, which prepare the lining of the uterus to receive a fertilized ovum.



Menstrual Cycle

- The menstrual cycle begins on the first day of menstrual bleeding and ends on the day before bleeding begins again. Bleeding normally lasts from three to five days.

- The length of a woman's menstrual cycle normally varies by a few days from cycle to cycle.
  - o A menstrual cycle is usually 25 to 34 days long (also known as a regular cycle).
  - o Some women may have short cycles (24 days or less) or long cycles (35 days or more).
- The postovulatory days are usually fixed in all of these cycles (11 to 16 days), whereas the preovulatory days vary in length.



The physiological and anatomical changes during the menstrual cycle are summarized in a matrix in Table 1.

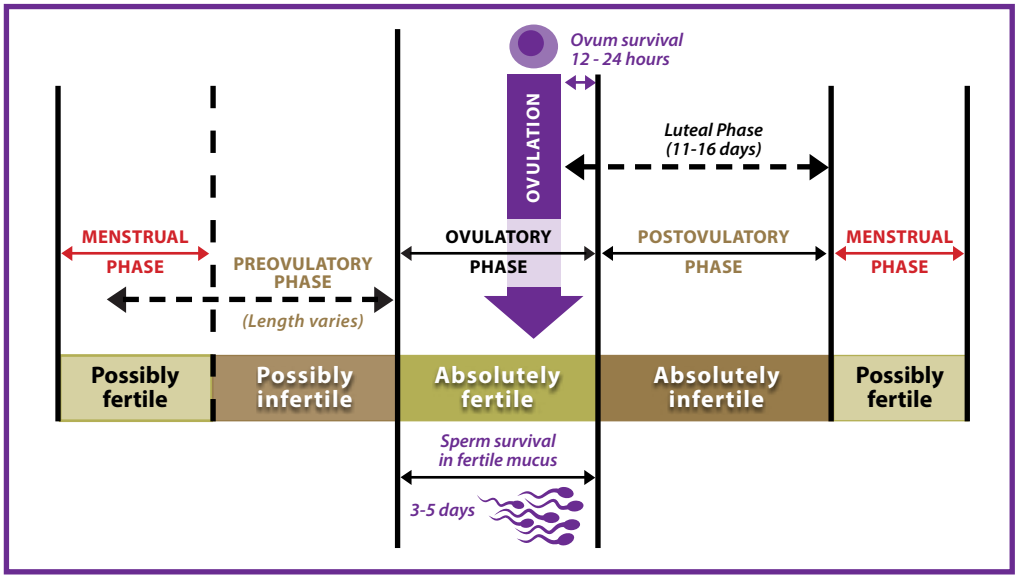
Table 1. Menstrual cycle matrix (based on an average 28-day cycle)

Structures	Menstrual phase	Preovulatory phase	Ovulatory phase	Post-ovulatory phase
Lining of uterus	Sheds during this phase	Begins to thicken	Continues to thicken	Stays in place until menstruation starts
Egg	Begins to grow in the ovaries	Continues to grow	Matures and is finally released	If not fertilized, dissolves and is absorbed
Cervical mucus	None	At the beginning of this phase, thick, sticky, and opaque	Wet, slippery, stretchy, and clear; vaginal sensation is wet	Loses its wet quality and is no longer sticky and stretchy; vaginal sensation is dry

Basal body temperature	Low (~36°C–36.5°C)	Low (~36°C–36.5°C)	Slightly drops by 0.2 °C to 0.5°C	Rises by 0.2°C to 0.5°C and remains high until next menstruation starts
Change in cervix	Open	Firm and closed	Soft and open	Firm and closed
Hormonal change	Both estrogen and progesterone levels drop	Capsule around the egg begins secreting estrogen, and its level rises.	Estrogen slightly drops but remains high; progesterone begins to rise.	Estrogen and progesterone remain high until day 22 when they begin to decrease.

Fertility and Joint Fertility

- Fertility is the ability of a person to bear children. Females and their male partners must be fertile to bear a child.
- Although the female is the one who becomes pregnant, carries the child, and goes through childbirth, fertility involves contributions from both the male and the female, with the former contributing the sperm and the latter contributing the egg.
- During their reproductive years, males are always fertile. Their bodies constantly function every single day and make females pregnant any time. The male's fertility ends either at death or at the diagnosis of an injury or disease that affects fertility.
- By contrast, females undergo changes every few weeks that cause their bodies to be fertile for only a few days at a time and then become infertile during the other days before becoming fertile again. Female fertility ends at menopause.
- Joint or combined fertility involves the united and equal contribution of the male and female in the decision and ability to have a child.

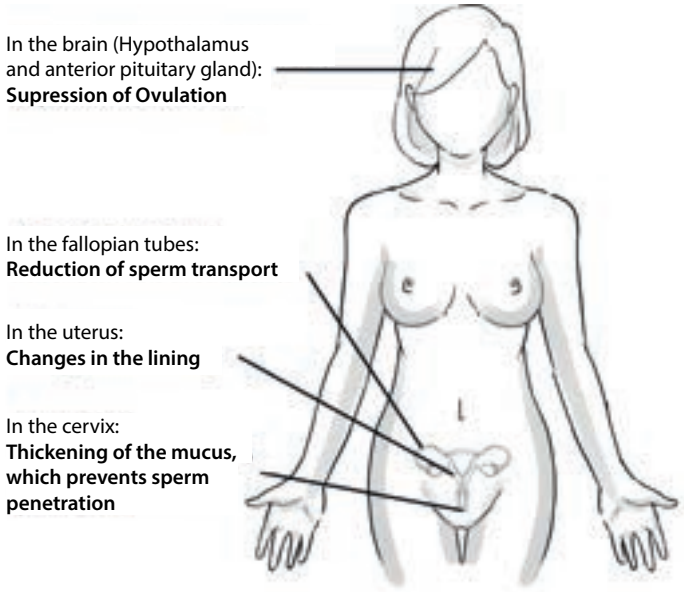


Mechanisms of Action of Different FP Methods

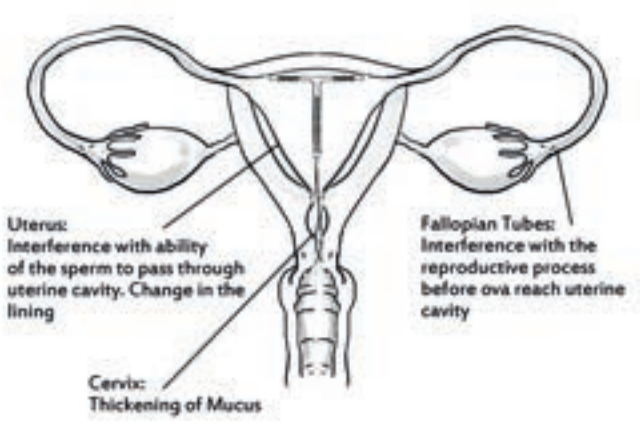
- The brain controls the hormones that regulate the reproductive systems. It also affects sexual activities.
- Hormones are substances produced by special organs or glands in the body; these substances are carried by the bloodstream to targeted parts of the body where certain actions are needed.
- The pituitary gland releases the hormones that control the release of other hormones from other glands in the body and the actions of the reproductive structures in the bodies of both males and females.
- Although most of these actions are involuntary, they can be controlled or modified by the person through various interventions, such as the timing of sexual intercourse, or through the use of contraceptive drugs and devices.

Below are the sites of action of the different FP methods.

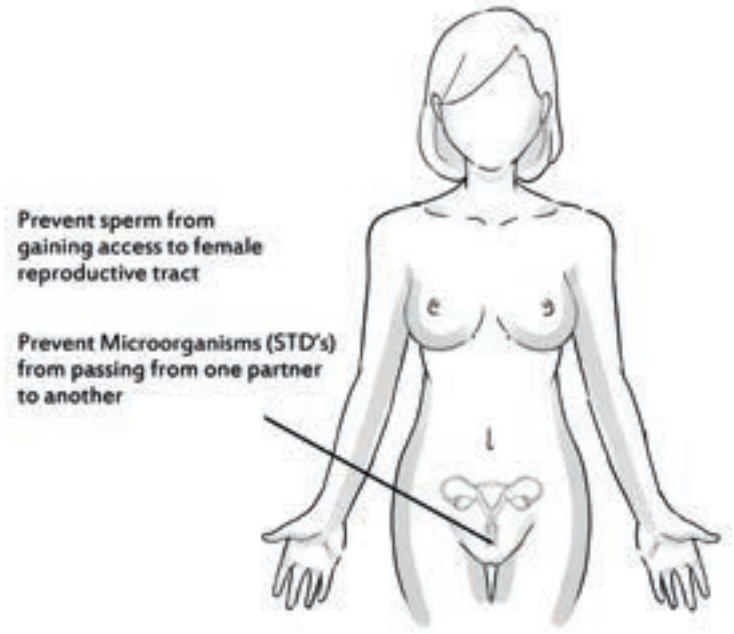
D. Hormonal contraceptives: Combined Oral Contraceptive (COC), Progestin-Only Pill (POP), Progestin-Only Injectable (POI), Combined Injectable Contraceptive (CIC)



E. Intrauterine devices: Copper T380A, IUS



F. Barrier methods: male and female condoms, diaphragm, cervical caps, spermicides



G. Fertility awareness-based methods

- For contraception, sexual intercourse should be avoided during the fertile phase of the menstrual cycle.
- For contraception, sexual intercourse could be near midcycle (usually10 to 15 days) when conception is most likely.

APPENDIX G. Additional Notes / References from WHO, Global Handbook for Family Planning Providers, 2018 edition

Guidance on Routine Blood Pressure Checking

Should women who choose COCs and certain other hormonal contraceptives be routinely tested for high blood pressure?

It is desirable for all women to have blood pressure measurements taken routinely before starting a hormonal method of contraception. However, in some settings blood pressure measurements are unavailable. In many of these settings, pregnancy-related morbidity and mortality risks are high, and these methods are among the few methods that are widely available. In such settings women should not be denied use of these methods simply because their blood pressure cannot be measured.

Women with high blood pressure or very high blood pressure should not use combined hormonal methods—COCs, monthly injectables, patch, or combined ring. Where blood pressure cannot be measured, women with a history of high blood pressure should not use these methods. Women with very high blood pressure should not use progestin-only injectables. Women can use progestin-only pills (POPs), implants, and LNG-IUDs even if they have high or very high blood pressure readings or a history of high or very high blood pressure.

High blood pressure is defined as systolic pressure 140 mm Hg or higher or diastolic pressure 90 mm Hg or higher. Very high blood pressure is defined as systolic pressure 160 mm Hg or higher or diastolic pressure 100 mm Hg or higher.

For more guidance concerning blood pressure, see the Medical Eligibility Criteria checklists in the chapters on COCs, progestin-only injectables, and monthly injectables.

Guidelines in the Prevention of Mother to Child Transmission of HIV Infection

PREVENTING MOTHER TO CHILD TRANSMISSION OF HIV

A woman living with HIV can pass HIV to her child during pregnancy, delivery, or breastfeeding. Treatment can greatly reduce the chances of this.

Lifelong antiretroviral therapy (ART) is recommended for all adults and children from the time their HIV-positive status is known. A woman who started ART before pregnancy or when tested during pregnancy greatly reduces the chances that her baby will be infected in the uterus or during delivery. ART for the mother also greatly reduces the chances of passing HIV to her infant through breast milk.

Also, the newborns of mothers living with HIV should receive 2 anti- retroviral drugs (ARVs) for the first 6 weeks of life. This further reduces the chances of HIV passing from mother to child in the period around birth.

How can family planning providers help prevent mother-to-child transmission of HIV?

- *Help women—and men—avoid HIV infection.* Women and men at high risk of HIV infection can take PrEP, pre-exposure prophylaxis, a daily oral treatment with ARVs.
- *Prevent unintended pregnancies:* Help women who do not want a child to choose a contraceptive method that they can use effectively.
- *Offer HIV counseling and testing:* In all settings offer counseling and testing in family planning facilities to all pregnant women and to the partners of women with HIV. Where HIV is common, offer testing to all women. Testing in family planning facilities can be helpful because a woman's HIV status might affect her choice of a family planning method. If testing in family planning facilities is not possible, refer clients to an HIV testing service or offer self-testing so that they can learn their HIV status.
- *Refer for prevention of HIV transmission:* Refer women with HIV who are pregnant, or who want to become pregnant, to services for prevention of mother-to-child transmission, if available. If a couple wants to have a child, and one partner has HIV while the other does not, they can take steps to reduce the chances of passing HIV while trying for conception.
- *Promote and support appropriate infant feeding:* In each country national authorities decide which of 2 infant feeding practices should be promoted to pregnant women and mothers living with HIV and that all health facilities should support. The 2 practices are either breastfeeding while mothers receive ART or (2) avoiding all breastfeeding (while mothers still receive ART). Countries decide which practice will lead to more children surviving free of HIV, depending on conditions in the country.

Where national authorities have decided to promote and support breastfeeding and ART for mothers with HIV:

- Counsel all women, including women with HIV, that breastfeeding, and especially early and exclusive breastfeeding, is the best way to promote the child's survival
- Mothers living with HIV and their infants should receive appropriate ART, and mothers should exclusively breastfeed their infants for the first 6 months of life, then introduce appropriate complementary foods and continue breastfeeding
- All children need complementary foods from 6 months of age.
- Mothers living with HIV should breastfeed for at least 12 months and may continue breastfeeding for up to 24 months or more (like other women) while being fully supported to keep taking ART
- Breastfeeding should stop only when a nutritionally adequate and safe diet without breast milk can be provided
- When mothers decide to stop breastfeeding, they should stop gradually within one month, and infants should be given safe and adequate replacement feeds to enable normal growth and development. Stopping breastfeeding abruptly is not advised

- Even when ART is not available, breastfeeding (exclusive breastfeeding in the first 6 months of life and continued breastfeeding for the first 12 months of life) may still give infants born to mothers living with HIV a greater chance of survival while avoiding HIV infection than not breastfeeding at all.
- If a woman is temporarily unable to breastfeed—for example, she or the infant is sick, she is weaning, or her supply of ARVs has run out—she may express and heat-treat breast milk to destroy the HIV before feeding it to the infant. Milk should be heated to the boiling point in a small pot and then cooled by letting the milk stand or by placing the pot in a container of cool water. This approach should be used only short-term, not throughout breastfeeding.
- Women with HIV who are breastfeeding need support to maintain their own nutritional status and keep their breasts healthy. Infection of the milk ducts in the breast (mastitis), a pocket of pus under the skin (breast abscess), and cracked nipples increase the risk of HIV transmission. If a problem does occur, prompt and appropriate care is important.

Where national authorities have decided to recommend that mothers living with HIV should avoid all breastfeeding even where ART is provided:

- Mothers living with HIV should receive skilled counseling to ensure that they provide a replacement food that is safe and adequate and is safely prepared, stored, and given to their infant.
  - For infants less than 6 months of age, the recommended alternative to breastfeeding is commercial infant formula, as long as home conditions outlined below are met. Home- modified animal milk is not recommended as a replacement food in the first 6 months of life.
- For infants more than 6 months of age, alternatives to breastfeeding include:
  - Commercial infant formula milk, as long as home conditions outlined on the next page are met
  - Animal milk (boiled for infants under 12 months), as part of a diet providing adequate micronutrients. Children should be fed meals, including milk-only feeds, other foods, and combination of milk feeds and other foods, 4 or 5 times per day.
- All children need complementary foods from 6 months of age
- Mothers living with HIV should consider replacement feeding only if all the following conditions are met:
  - safe water and sanitation are ensured in the household and community; and
  - the mother or caregiver can reliably provide sufficient infant formula to support the infant's normal growth and development; and
  - the mother or caregiver can prepare it cleanly and frequently enough so that it is safe enough and carries a low risk of diarrhea and malnutrition; and

  - — the mother or caregiver can give the replacement feeding exclusively in the first 6 months; and
  - — the family supports this practice; and
  - — the mother or caregiver can obtain comprehensive child health services.
- If infants and young children are known to be living with HIV, mothers should be strongly encouraged to exclusively breastfeed for the first 6 months of life and continue breastfeeding up to 2 years or beyond.

Identifying Migraine Headaches and Auras

Identifying women who suffer from migraine headaches and/or auras is important because migraines, and aura in particular, are linked to higher risk of stroke. Some hormonal contraceptives can increase that risk further.

Migraine Headaches

- Recurring, throbbing, severe head pain, often on one side of the head, that can last from 4 to 72 hours.
- Moving about often makes the migraine headache worse.
- Nausea, vomiting, and sensitivity to light or noise may also occur

For women who want a hormonal method or are using one:

If a woman reports having very bad headaches, ask her these questions to tell the difference between a migraine headache and an ordinary headache. If she answers "yes" to any 2 of these questions, she probably suffers from migraine headaches. Continue to Identifying Migraine Auras, below.

1. Do your headaches make you feel sick to your stomach?
2. When you have a headache, do light and noise bother you a lot more than when you do not have a headache?
3. Do you have headaches that stop you from working or carrying out your usual activities for one day or more?

Migraine Auras

- Nervous system disruptions that affect sight and sometimes touch and speech.
- Almost all auras include a bright area of lost vision in one eye that increases in size and turns into a crescent shape with zigzag edges.
- About 30% of auras also include a feeling of "pins and needles" in one hand that spreads up the arm and to one side of the face. Some auras also include trouble with speaking. Seeing spots or flashing lights, or having blurred vision, which often occurs during migraine headaches, is not aura.

Auras develop slowly over several minutes and go away within an hour, typically before the headache starts. (In contrast, a sudden blackout in one eye, particularly with a feeling of "pins and needles" or weakness in the opposite arm or leg, may indicate a stroke.)

Ask this question to identify the most common migraine aura.

If a woman answers "yes," she probably suffers from migraine auras.

1. Have you ever had a bright light in your eyes lasting 5 to 60 minutes, loss of clear vision usually to one side, and then a headache? (Women with such aura often bring one hand up beside their heads when describing the vision change. In some cases the bright light is not followed by a headache.)

If her headaches are not migraines and she does not have aura, she can start or continue hormonal methods if she is otherwise medically eligible. Any later changes in her headaches should be evaluated, however.

Can a Woman with Migraines and/or Aura Use a Hormonal Method?

In situations where clinical judgment is limited:

YES: can use **NO**: do not use **I**: Initiation **C**: Continuation

	Combined methods†		Progestin-only methods§	
Migraine headaches	**I**	**C**	**I**	**C**
Without Aura				
Age < 35	Yes	No	Yes	No
Age ≥ 35	No	No	Yes	Yes
With aura, at any age	No	No	Yes	No

† Methods with estrogen and progestin: combined oral contraceptives, monthly injectables, combined patch and combined vaginal ring

§ Methods with progestin only: progestin-only pills, progestin-only injectables, and implants

Task-Sharing: WHO Recommendations

Many countries and programs are changing their policies or regulations to allow more types of providers to offer contraceptive methods—a change known as task-sharing. Task-sharing refers to expanding the levels of health care providers who can appropriately deliver health services. Task-sharing helps to:

- address shortages and uneven distribution of providers, particularly in rural and remote areas
- give higher-level clinicians more time to use their specialized skills
- provide more family planning methods at the primary care level, and
- overall, increase access to safe and timely care

To encourage and guide task-sharing, WHO has developed recommendations on which types of health workers can safely and effectively provide specific family planning methods. WHO based these recommendations on evidence that a wide variety of providers can safely and effectively provide contraception. The table on the next page summarizes the WHO recommendations.

Specific competency-based training and continued educational support help all types of health care providers do a better job at providing family planning. They are particularly important when providers take on new tasks. Some tasks and some providers require more training and support than others. Training needs to cover skills in informing and counseling clients about choosing and using specific methods, including their side effects, as well as any specific technical skills such as how to give injections or insert and remove an IUD or an implant. Even specialist doctors need training in specific techniques—for example, no-scalpel vasectomy and laparoscopic tubal sterilization. Checklists and other job aids can help a wide range of providers and managers in various ways, such as screening clients for medical eligibility criteria, making sure all steps in a process are carried out (such as infection prevention), and ensuring good quality of services.

As programs plan for task-sharing and carrying it out, maintaining quality and safety are the top concerns. Successful task-sharing requires that a program pay attention to:

- training and support
- supplying the new providers with the method
- supervision
- referral for managing any complications
- changes to protocols, regulations, and training programs
- salaries or payment that reflect the providers' scope of practice

APPENDIX H. List of Issuances Related to Family Planning

ISSUANCE NUMBER	TITLE (Link Below)	TYPE OF ISSUANCE
AO 2014-0041	Guidelines on the Recognition of Family Planning Training Providers of the DOH https://drive.google.com/file/d/1S2_qbYIr4t6zAI2uTZmN6MFzO5mc65uX/view?usp=sharing	Administrative Order
AO 2014-0042	Guidelines on Implementation of Mobile Outreach Services for Family Planning https://drive.google.com/file/d/1yotOHP-5ftzo_VUozKQh8yzyfebcb1cL/view?usp=sharing	Administrative Order
AO 2014-0043	Guidelines on the Estimation of Unmet Need for Modern Family Planning https://drive.google.com/file/d/1pPqIoE1lU0DAIH2x2wT_KQ1avbTnKpE7/view?usp=sharing	Administrative Order
AO 2015-0002	Creation of a National Implementation Team (NIT) and Regional Implementation Teams (RIT) for Republic Act 10354 (RPRH Law of 2012) https://drive.google.com/file/d/167crHoW7OJWk7aM7hZ9nkSJ_nJ8NpQ1S/view?usp=sharing	Administrative Order
AO 2015-0006	Inclusion of Progestin Subdermal Implant as one of the Modern Methods Recognized by the National Family Planning Program https://drive.google.com/file/d/1J41CKc_2NFH8jjom7NSpTnk-KYZ8brMy/view?usp=sharing	Administrative Order
AO 2015-0027	Guidelines on the Registration and Mapping of Conscientious Objectors and Exempt Health Facilities Pursuant to the Responsible Parenthood and Reproductive Health Act https://drive.google.com/file/d/1DAkB9y6zQB8xgQQuUucjqlCdfVBS6bxB/view?usp=sharing	Administrative Order
AO 2016-0005	National Policy on the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in Health Emergencies and Disasters https://drive.google.com/file/d/1hCQ1cx9OQ-jLTL6Tca06koYxMd3gj5cM/view?usp=sharing	Administrative Order
AO 2017-0002	Guidelines on the Certification of Free Standing Planning Clinics https://drive.google.com/file/d/17-Pl50JuQgGLCaYdvFTLIYLkn_Cw-yFX/view?usp=sharing	Administrative Order
AO 2017-0005	Guidelines in Achieving Desired Family Size through Accelerated and Sustained Reduction in Unmet Need for Modern Family Planning Methods https://drive.google.com/file/d/1F_ysdeWLj47ANucC244fC-jng2N1-imS/view?usp=sharing	Administrative Order
DC 2015-0195	Frequently Asked Questions on the Implementation of the RPRH Act and IRR, in consideration of the Supreme Court Decision https://drive.google.com/file/d/1aA3oLl8PcTvItcChmLRpxOplZDyyQv2a/view?usp=sharing	Department Circular

DC 2015-0300	Clarification of Annex A Section 4 of AO 2015-0006 entitled "Inclusion of Progestin Subdermal Implant as one of the Modern Methods Recognized by the National Family Planning Program" https://drive.google.com/file/d/1ZvGbPbGQHO1gdGfIwElAjamFuUbqDHo8/view?usp=sharing	Department Circular
DC 2016-0068	Clarification of Section IV.E, General Guidelines of AO No. 2014-0041 entitled "Guidelines on the Recognition of Family Planning Training Providers of the DOH" https://drive.google.com/file/d/1ajOFIohugjydT7LUH-bZHPLX54fPfrwm/view?usp=sharing	Department Circular
DC 2016-0305	Clarification on the Bilateral Tubal Ligation (BTL) as One of the Services of Family Planning Program https://drive.google.com/file/d/13gg-H18CQ7p8Wzl1wWp_48agWqInQTfr/view?usp=sharing	Department Circular
DC 2017-0301	Reproductive Health Programs and Services of the DOH Pursuant to the RA 10354 or the RPRH Act of 2012 https://drive.google.com/file/d/15FmT5GW-wm0UUiCucPZ6ywKjwcsGvcaH/view?usp=sharing	Department Circular
DM 2014-0311	Adoption of the Philippine Clinical Standards Handbook on Family Planning, 2014 Edition in the Implementation of Programs, Projects and Other Initiatives Related to Family Planning https://drive.google.com/file/d/1JbDwhEbcBlJ7gfKHjSlP7XOs01bqKUr9/view?usp=sharing	Department Memorandum
DM 2014-0312	Guidelines in Setting up Family Planning Services in Hospitals https://drive.google.com/file/d/1ZNCivC9bm1yA8gt_LixUUIm0bHpnkORs/view?usp=sharing	Department Memorandum
DM 2015-0174	Reiteration of Compliance to the Policy on Informed Choice and Voluntarism in Delivery of Family Planning Services https://drive.google.com/file/d/1UWo5N6i6mxUMYC1o2ee99ex34qSggKdx/view?usp=sharing	Department Memorandum
DM 2015-0186	Access to Family Planning (FP) Commodities by DOH Regional Hospitals and Medical Centers and Provincial Hospitals https://drive.google.com/file/d/1rmQq03Nq4rYiuMrKQbFWiNIBNOOXGpKn/view?usp=sharing	Department Memorandum
DM 2015-0357	Use of the Revised Family Planning Form 1 https://drive.google.com/file/d/1J-H_TZMDeAUdsKOC_ORnv7u5LIiTebA2/view?usp=sharing	Department Memorandum
DM 2016-0405	Guidelines in the Implementation of Purple Ribbon Awards for Responsible Parenthood for Reproductive Health (RPRH) Program for the Medium Term 2016-2022 https://drive.google.com/file/d/1jIaerzJT0YJLxGnEIXzrZGA39hHOiWWw/view?usp=sharing	Department Memorandum
DM 2017-0249	Application Form for Free Standing Family Planning Clinics Applying for DOH Certification https://drive.google.com/file/d/1gUifQmPbncTMdPuZIFEJM4aFQFqGJP0D/view?usp=sharing	Department Memorandum

DM 2019-0303	Implementation of the Joint Memorandum Circular (JMC) No. 2019-01 on "Policy Guidelines for the Intensified Implementation of the National Program on Family Planning (NPFP) Towards Better Health Outcomes, Poverty Reduction and Socio Economic Development" https://drive.google.com/file/d/13gcv6_tpY57zpUu-AynyxH0PmzJ8StKE/view?usp=sharing	Department Memorandum
DM 2020-0194	Quick Assessment on Availability of Family Planning (FP) Services in Health Facilities during COVID-19 Outbreak https://drive.google.com/file/d/1T9gMjaoJ_enUn6gWzWHb0n7SVVlpXdhH/view?usp=sharing	Department Memorandum
DM 2020-0222	Guidelines on the Continuous Provision of Family Planning Services during Enhanced Community Quarantine following the COVID-19 Pandemic https://drive.google.com/file/d/1MQFdO0V9ZruWmv4HW4x8xyx5J2bE0CuX/view?usp=sharing	Department Memorandum
DM 2020-0297	Annual Targets for Modern Contraceptive Prevalence Rate (mCPR) among ALL WOMEN in the National Objectives for Health (NOH) 2017-2022 https://drive.google.com/file/d/1EyJjMbWGfqPWjXRpBBCNc89OxjqULZZE/view?usp=sharing	Department Memorandum
DM 2020-0336	Adoption of the Family Planning Estimation Tool (FPET) to Produce the Annual Estimate of Modern Contraceptive Prevalance Rate (mCPR) for National and Regional Level https://drive.google.com/file/d/1xAtqbGrgynF7A8hGdTevDu9mVmMYJ84Z/view?usp=sharing	Department Memorandum
DO 2017-0345	Guidelines on the Forecasting, Procurement, Allocation, and Distribution of Modern Family Planning Commodities https://drive.google.com/file/d/11tr4hTQcjQ99FHChXHOQ4G7LOyrIAA5r/view?usp=sharing	Department Order
EO 12	Attaining and Sustaining "Zero Unmet Need for Modern Family Planning" through the Strict Implementation of the Responsible Parenthood and Reproductive Health Act, Providing Funds therefor, and for Other Purposes https://drive.google.com/file/d/1Uhr1ZyyoM75q5TaHLFpx_U_3hEJGjH6d/view?usp=sharing	Executive Order
MC 2017-0004	EO No.12 dated January 9, 2017 entitled "Attaining and Sustaining "ZERO Unmet Need for Modern Family Planning" through the Strict Implementation of the Responsible Parenthood and Reproductive Health Act, providing funds thereof, and for other purposes" https://drive.google.com/file/d/19Qp8KogeOhX-zv_Pu6n1BCwwEWmDn0F0/view?usp=sharing	Memorandum Circular
MC 2021-0041	DOH-POPCOM Joint Memorandum Circular No. 2021-0001 entitled "Observance of the Family Planning Month on August 2021 with the Umbrella Theme "Usap Tayo sa Family Planning' https://drive.google.com/file/d/1RbwlB7QoHdZd3hKBp4-ychdBIjusHmzl/view?usp=sharing	Memorandum Circular

UNIVERSAL HEALTH CARE		
ISSUANCE NUMBER	**TITLE** (Link Below)	**TYPE OF ISSUANCE**
Governance and Accountability		
AO 2021-0036	Guidelines on Compliance with Section 35 (b) of republic Act No. 11223 (Universal Health Care Act): All Drug, Medical Device, Biological and Medical Supplies Manufacturers to Submit Reports on Disclosure of Financial Relationships with Health Care Providers and Health Care Professionals https://drive.google.com/file/d/1Bg9IRYr82LKDhp4ttX4UHPlqqCPZvT44/view?usp=sharing	Administrative Order
AO 2021-0011	Implementing Guidelines of Section 35 of the Republic Act No. 11223, otherwise known as the "Universal Health Care Act", on Standards on Receipt, Assessment and Management of Conflict of Interest https://drive.google.com/file/d/1T4Ee2a5tXJSyvZLccFYXkw-R9R4TRBTn/view?usp=sharing	Administrative Order
AO 2021-0008	Guidelines in Public Access to Price Information of All Health Services and Goods in Health Facilities in the Philippines https://drive.google.com/file/d/1wyRjOFk4VRi8HTZzUlfWoBTyjBAzktSu/view?usp=sharing	Administrative Order
AO 2020-0061	Guidelines on the Public Health Ethics Review and Creation of the DOH Public Health Ethics Committee https://drive.google.com/file/d/1GochtVD8X-OBrAxmkCfuvoMiF5s113cG/view?usp=sharing	Administrative Order
AO 2020-0058	Guidelines on the Transformation of the Health Promotion and Communication Service (HPCS) to the Health Promotion Bureau (HPB) https://drive.google.com/file/d/1JkUwh8RBozl8cxEDcx6iMnW1MdsQd9OQ/view?usp=sharing	Administrative Order
AO 2020-0042	Health Promotion Framework Strategy in Province-wide and City-wide Health Systems https://drive.google.com/file/d/1nRrP96g47TAzLdtK3lz7bl6oSlc8pFOD/view?usp=sharing	Administrative Order
AO 2020-0041	The New Implementing Guideline on Health Technology Assessment to Guide Funding Allocation and Coverage Decisions in support of Universal Health Care https://drive.google.com/file/d/1zl6PFsk9vmo0R7Jav0GpjirFgqsoJ1NY/view?usp=sharing	Administrative Order
DC 2021-0132	Interim Guidelines on the Estimation of Burden of Disease in the Philippines https://drive.google.com/file/d/1x8qr5eHqxi1-lrpth1mg6TzsqcTwfhCA/view?usp=sharing	Department Circular
DO 2020-0369	Guidelines on the creation of the Health Technology Assessment Council for the implementation of the Universal Health Care Act https://drive.google.com/file/d/13jQ_A58Mt1sw3UZ3LrHzAavyqK4tlj4L/view?usp=sharing	Department Order

DPO 2019-5496	Creation of the Health Technology Assessment Council-Core and Subcommittees https://drive.google.com/file/d/1jefw2EvYF5GpZajYwqq3bbjd0beSwCVN/view?usp=sharing	Department Personnel Order
DPO 2019-5496a	Amendment to Department Personnel Order No. 2019-5496 dated 10 October 2019 entitled Creation of the Health Technology Assessment Council-Core and Subcommittees https://drive.google.com/file/d/1RfdF88H2E-ZSvGxkSxfcT3b3gnyyoSQk/view?usp=sharing	Department Personnel Order
MC 2021-0036	DOH-PSA Joint Administrative Order No. 2021-0001 entitled "Guidelines on the Public Availability and Accessibility of all Health, Nutrition, and Demographic-related Administrative and Survey Data" https://drive.google.com/file/d/15dNnApUI12MZgL85gMzWIPappeooVUFg/view?usp=sharing	Memorandum Circular
MC 2021-0026	DOH-PHIC Joint Memorandum Circular No. 2021-0001 entitled "Implementing Guidelines of Section 31 of the Republic Act No. 11223, otherwise known as the "Universal Health Care (UHC) Act" on the Processing and Submission of Health and Health-related Data https://drive.google.com/file/d/1P0xFfXUZwPfUUFHV4d_gyTnP90BEjVo1/view?usp=sharing	Memorandum Circular
MC 2021-0020	DOH-PHIC Joint Administrative Order (JAO) No. 2021-0002 entitled "Mandatory Adoption and Use of National Health Data Standards for Interoperability" https://drive.google.com/file/d/1SkqAzhncZjNh8bUDIIRP9i7Ag9RjVdgo/view?usp=sharing	Memorandum Circular
MC 2021-0019	DOH-PHIC Joint Administrative Order (JAO) No. 2021-0001 entitled "Guidelines on the Implementation and Maintenance of an Integrated Health Information System" https://drive.google.com/file/d/1WvB5L6Fv95kfcwdukuBTggXPFoj6YKyC/view?usp=sharing	Memorandum Circular
MC 2021-0010	DOH-DILG Joint Administrative Order No. 2021-0001 entitled "Guidelines for the Operationalization of the Health Impact Assessment (HIA) Review Process for Development Projects" https://drive.google.com/file/d/1ezKAy1V-gQWTFLJ3FnLIlBBXC4PnOJK0/view?usp=sharing\	Memorandum Circular
Human Resources for Health		
AO 2020-0038	Guidelines on the Deployment of Human Resources for Health under the National Health Workforce Support System https://drive.google.com/file/d/1hKg2DqJu6dlTz_KsZ9GP4nQ4myEFiZ8r/view?usp=sharing	Administrative Order
DC 2021-0253	Dissemination of the National Human Resources for Health Master Plan 2020-2040	Department Circular
JAO 2020-01	Guidelines on the Certification of Primary Health Care Workers for Universal Health Care	Joint Admin. Order
MC 2021-0038	DOH-CHED-PRC Joint Administrative Order No. 2021-0001 entitled "Guidelines for the Reorientation of Health Professions Education Curricula and Training Programs to Primary Health Care (PHC)"	Memorandum Circular

MC 2021-0014	DOH-PRC Joint Administrative Order No. 2021-0001 Guidelines on the Establishment, Utilization and Maintenance of the National Health Workforce Registry https://drive.google.com/file/d/1Jzxrl-D8W68x8vbr0vt7OuEM8AjiCeTa/view?usp=sharing	Memorandum Circular
Local Health Systems		
AO 2020-0037	Guidelines on Implementation of the Local Health Systems Maturity Levels (LHS ML) https://drive.google.com/file/d/1mHKUfihcQ070Qg1emwRR0x_QuodwDB2R/view?usp=sharing	Administrative Order
AO 2020-0022	Guidelines on the Development of Local Investment Plans for Health https://drive.google.com/file/d/1t3efh3OKoCNtTdCBleL_bGGDZjYWVgeg/view?usp=sharing	Administrative Order
AO 2020-0021	Guidelines on Integration of the Local Health Systems into Province-wide and City-wide Health Systems (P/CWHS) https://drive.google.com/file/d/14dRlNpqJN9s4KLthH0se81f-UXdEcmdg/view?usp=sharing	Administrative Order
JMC 2021-0001	Guidelines on the Allocation, Utilization, and Monitoring of, and Accountability for, the Special Health Fund https://drive.google.com/file/d/1NeHgagU693GbpehJb_JJ1bKCd5adqGU4/view?usp=sharing	Joint Memorandum Circular
Miscellaneous Provisions		
DO 2020-0406	Revised Implementing Guidelines of Performance Governance System and the use of the Office Performance Commitment and Review as part of its Cascading Framework https://drive.google.com/file/d/1rbxuwubrQsrmse1YBsqD-UUUJGKFsBlH/view?usp=sharing	Department Order
National Health Insurance Program		
PC 2020-0024	Governing Policies on No Co-Payment/No Balance Billing or PhilHealth Benefit Packages https://drive.google.com/file/d/1NgTAEWgpqNC_Q1a6YbhbRMhJqMgrjToE/view?usp=sharing	PhilHealth Circular
Regulations		
AO 2021-0038	Framework for the Philippine Essential Medical Devices List and Price Reference Index https://drive.google.com/file/d/1rjeTZTkgYwDQHBdcWUBr_RCft83d0KyK/view?usp=sharing	Administrative Order
AO 2021-0035	Mandatory Provision of Fairly Price Generics in support of the Universal Health Care https://drive.google.com/file/d/1Gka9D2JzBkrdssYPuaBVxIyesWmfVU2e/view?usp=sharing	Administrative Order

AO 2021-0029	Guidelines on the Prioritization of Processing of Applications for DOH Authorizations of Health Facilities Located in GIDAs in the Philippines https://drive.google.com/file/d/1UfoMD5xneVYMuWpuNCMEwpyO12jzUN9k/view?usp=sharing	Administrative Order
AO 2021-0020	Revised Guidelines on National Practice Guideline Development, Adoption and Dissemination https://drive.google.com/file/d/1TntLyZ23ilZivUWyNmcbbvc2tN9r80mK/view?usp=sharing	Administrative Order
AO 2021-0015	Standards on Basic and Non-Basic Accommodation in Al Hospitals https://drive.google.com/file/d/175vFyrsADX-ATtMzjA4VnI6OKPnn4-o7/view?usp=sharing	Administrative Order
AO 2021-0008	Guidelines in Public Access to Price Information of All Health Services and Goods in Health Facilities in the Philippines https://drive.google.com/file/d/1akT9Xmc_btV-vqQwQ4hV3Q_SfknXjjMv/view?usp=sharing	Administrative Order
AO 2020-0047	Rules and Regulations Governing the Licensure of Primary Care Facilities in the Philippines https://drive.google.com/file/d/14Goy3XeBNpguKJFUdhCfdLQaN9pgw9HI/view?usp=sharing	Administrative Order
AO 2020-0043	Guidelines on Ensuring the Affordability of Essential Medicines in DOH Facilities through the Regulation of Price Mark-ups https://drive.google.com/file/d/1NoHXy7POO0v2vorXBeXCI3CbvqA3epW4/view?usp=sharing	Administrative Order
AO 2020-0039	Guidelines in the Implementation of Maximum Retail Price (MRP) on Drugs and Medicines https://drive.google.com/file/d/1N-QmRdEP5rVOtNSuMEsgSBWJDGyLNe3B/view?usp=sharing	Administrative Order
AO 2020-0023	Guidelines on Identifying Geographically-Isolated and Disadvantaged Areas and Strengthening their Health Systems https://drive.google.com/file/d/1nKmmocKLCzNyiTcN5pvcwphPj_FwJbUI/view?usp=sharing	Administrative Order
MC 2021-0025	DOH-DILG-PHIC Joint Administrative Order No 2021-0001 entitled "Guidelines on the Implementation of Telemedicine in the Delivery of Individual-Based Health Services" https://drive.google.com/file/d/1Ab3PG5snks2rinbJmO2Bx3UhSuUckCcU/view?usp=sharing	Memorandum Circular
MC 2021-0008	DOH-PHIC-DTI Joint Administrative Order No. 2021-0001 entitled "Constitution of the Price Negotiation Board and Implementing Guidelines on Price Negotiation for Innovative, Proprietary, Patented and Single-Sourced Health Commodities" https://drive.google.com/file/d/14y5YbBLotcIu_haX09vvo_Kerjjp6YuJ/view?usp=sharing	Memorandum Circular

Service Delivery		
AO 2020-0040	Guidelines on the Classification of Individual-based and Population-based Primary Care Service Packages https://drive.google.com/file/d/1lt_giZ6B10VszTI3hh2gPT6lNz7aMrSo/view?usp=sharing	Administrative Order
AO 2020-0036	Guidelines on the Institutionalization of Disaster Risk Reduction and Management in Health (DRRM-H) in Province-wide and City-wide Health Systems https://drive.google.com/file/d/1Bi_r0mXDUVaFBVIFnxgbZWUSKVT2ayFM/view?usp=sharing	Administrative Order
AO 2020-0019	Guidelines on the Service Delivery Design of Health Care Provider Networks https://drive.google.com/file/d/1qcKFohKI4Uk7SDXVggIlz25JAdExI2ye/view?usp=sharing	Administrative Order
AO 2020-0018	Guidelines on Contracting Province-Wide and City-Wide Health Systems https://drive.google.com/file/d/134lDQk2_GOVkw8EkJlp_RVX700KFKCwv/view?usp=sharing	Administrative Order
AO 2020-0020	Governing Policies on PhilHealth Costing and Costing Methodology https://drive.google.com/file/d/1D4x0oPTvbWAs-4of12JENKvHz7ll7l4G/view?usp=sharing	PhilHealth Circular
RA 11332	The 2020 Revised Implementing Rules and Regulations of Republic Act No. 11332, or the Mandatory Reporting Notifiable Diseases and Health Events of Public Health Concern Act https://drive.google.com/file/d/1BQ9N2QtydylwvwTTihJASPwTpnsew-dk/view?usp=sharing	Republic Act
UHC-related Policies		
AO 2021-0026	Monitoring and Evaluation Framework for Republic Act 11223, Otherwise known as the Universal Health Care Act https://drive.google.com/file/d/1uA_9EOpNhPxogsyvk59wln5nhogwglU4/view?usp=sharing	Administrative Order
AO 2021-0006	Guidelines in Supporting Universal Health Care and the Local Health System Integration by the International Health Partners https://drive.google.com/file/d/1Mta5mPoV8N3OpHI2bzWwqkkmC7VblGZt/view?usp=sharing	Administrative Order
AO 2021-0002	Revised Guidelines on the Implementation of the Local Government Unit (LGU) Health Scorecard (HSC) https://drive.google.com/file/d/1Rf_V3UAgLY2iKvR3gfTMtCjwF3X35oAQ/view?usp=sharing	Administrative Order
AO 2020-0029	Roles, Functions and Responsibilities of the Department of Health Representatives https://drive.google.com/file/d/1JRa3pUxTx-MUGE81_o43WppikSQo4id4/view?usp=sharing	Administrative Order

AO 2020-0027	Guidelines on the Implementation of the Local Government Unit Health Scorecard https://drive.google.com/file/d/1416jhAw_2gQPL4XXW1pNrLALm31K0_6G/view?usp=sharing	Administrative Order
DM 2020-0275	Dissemination of the Local Government Unit Health Scorecard Handbook of Procedures (LGU HSC MOP) https://drive.google.com/file/d/1ftxPw98G_1RG9g2jt-F1Ekv_9Uabun1m/view?usp=sharing	Department Memorandum
Universal Health Care		
AO 2020-0024	Primary Care Policy Framework and Sectoral Strategies https://drive.google.com/file/d/1_M7bt3xxflH2S5CJRat0GmJua5UuWEX4/view?usp=sharing	Administrative Order
DC 2020-0176	Circulation of the Handbook Standards for Primary Care Facilities https://drive.google.com/file/d/1RqVJqzreWug9_Cw1hZwCurRKKhtMZoBf/view?usp=sharing	Department Circular
JAO 2020-0001	Guidelines on the Registration of Filipinos to a Primary Care Provider https://drive.google.com/file/d/1QqL1Qt7sQxYMvXHqOb9TYs-LJqR4XcZ2/view?usp=sharing	Joint Administrative Order
PC 2020-0022	Implementing Guidelines for the PhilHealth Konsultasyong Sulit at Tama (PhilHealth Konsulta) Package https://drive.google.com/file/d/1LRuLPLSf0xToZIpiON_WqgQOo6-jbuEw/view?usp=sharing	PhilHealth Circular
PC 2020-0021	Accreditation of Health Care Providers for PhilHealth Konsultasyong Sulit at Tama (PhilHealth Konsulta) Package https://drive.google.com/file/d/1xawkcdqlCAQcH1LcS-_i3sLCHIGYcMyy/view?usp=sharing	PhilHealth Circular
PC 2020-0002	Governing Policies of the PhilHealth Konsultasyong Sulit at Tama (PhilHealth Konsulta) Package: Expansion of the Primary Care Benefit to Cover All Filipinos https://drive.google.com/file/d/1aI1hjWATHKJqzt0oacXddwoq69kYorrp/view?usp=sharing	PhilHealth Circular


CYCLE DAY
Month January - Date
Month January Date
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