FAMILY PLANNING

**Learning objectives**

After completion of This lessons the student is expected to be able to:

1. define family planning

2. understand the important rationale of family planning

3. give health education on family planning

4. counsel clients before providing family planning methods

5. give clients instructions on how to use the FP method safely and effectively

6. perform appropriate client assessment before providing family planning

methods

7. discuss advantages and disadvantages of family planning methods

8. list the different types of family planning methods.

9. list most common contraindications and complications of different types of

family planning methods.

**Introduction**

Family planning is the ability of an individual or couple to decide when to have

children how many children they desire in a family and how to space their

children. It is a means of promoting the health of women and families. Family

planning is part of a strategy to reduce the high maternal, infant and child

mortality and morbidity. Family planning is also a critical component of

reproductive health programmes.

The rationale for family planning includes:

• Allowing women and men the freedom to control the number, spacing and

the time at which they have children, family planning helps women and

their families preserve their health and fertility and also contributes to

improving the overall quality of their lives. Family planning also contributes to improving children’s health and

ensuring that they have access to adequate food, clothing, housing, and

educational opportunities.

• It allows families, especially women, the time to adequately participate in

development activities.

**4. Health Education/Communication**

Like other health services, a variety of methods, both formal and informal are

used in health education to offer family planning programs. Some are personal,

that is, involving a health worker in direct contact with an individual or a group.

Others are impersonal, in which the communication does not involve such

contact, for example the use of posters, leaflets, and the mass media

(newspapers, radio, television, and internet). Each method has its advantages

and limitations.

**Personal Methods**

• Have the advantage that the content can be specifically tailored to match

the needs of the individuals present.

Raise the opportunity for discussion where obscure points can be clarified,

objections raised and doubts expressed.

Through such interactive exchange, the health worker can learn more about local

beliefs and habits. It provides the opportunity for reviewing alternative

approaches to the solution of specific problems and there by the community and

the individuals can determine how best to put the new lessons that they have

learnt in to practice in their own circumstances.

During talks with family planning clients (individuals, communities etc,) health

workers must strive to be effective communicators. They must learn to explain

technical information in simple language that is easily understood. They must

know the skill of capturing and retaining the attention of their audiences.

**Impersonal Methods**

However, with the personal approach, each health worker can reach relatively

few people. Impersonal methods, especially the use of the mass media have the

advantage of reaching large numbers of people who may not have direct contact

with health workers.

The message can be repeated over and over again, serving as reminder and

reinforcement. In some communities, materials read in the newspapers or heard

on the radio carry more authority than information that is obtained from local

sources.

Without the opportunity for questions and discussions, however, such messages

may be misunderstood; constant repetition may dull their impact; and individuals

may have difficulty in relating the messages to their own circumstances. By pretesting

health education materials on a small scale before they are widely

distributed one may overcome some of these limitations. Following the findings

from the pretest, one can modify the material and there by make the message

clearer.

**Combined Approach**

It is sometimes possible to combine the advantages of both methods. For

example, wall charts, radio and television programs and similar impersonal

methods could be used as the focus for small group discussions. Alternatively,

after a subject has been discussed, gifted members of the community could be

encouraged to produce wall charts and other teaching materials for others in the

community.

**Innovative approaches**

Some health workers have experimented with approaches to health education

including music and drama as means of projecting health messages. Film star,

sporting heroes, charismatic leaders

**Counseling**

Counseling is a two way process in which clients are helped to arrive at informed

choice of reproductive options and knows how to use them safely, effectively and

continuously.

Good counseling focuses on the individual client’s needs and situation. Good

counselors are willing to listen and respond to the client’s questions and

concerns.

A good counselor:

understands and respects the client’s rights

• earns the clients trust

• understands the benefits and limitations of all contraceptive methods

• understands the cultural and emotional factors that affect a woman’s (or a

couple’s) decision to use a particular contraceptive method

• encourages the client to ask questions uses a non judgmental approach which shows the client respect and

Kindness

• presents information in an unbiased, client-sensitive manner

• actively listen to the client’s concerns

• understands the effect of non verbal communication. In serving clients, it is important to remember that they have:

• the right to decide whether or not to practice family planning,

• the freedom to choose which method to use,

• the right to privacy and confidentiality, and

• the right to refuse any type of examination.

Even though, many contraceptive methods are highly effective, method failure

can occur. In the case of method failure, the client should be counseled about

the available options and referred for appropriate services.

In discussing contraceptive options with clients, service providers should briefly

review all available methods, even if a client knows which method s/he wants.

Service providers should be aware of a number of factors about each client that

may be important, depending on the method in question. These include:

• the reproductive goals of the woman or couple (spacing or timing births)

• personal factors including the time, travel costs, pain or discomfort likely to

be experienced

• accessibility and availability of other products that are necessary to use

the method

• the need for protection against GTIs and other STDs (e.g., HBV,

HIV/AIDS).

Counseling can be divided into three phases:

• initial counseling at reception (all methods are described and the client is

helped to choose the method most appropriate for her/him)

method-specific counseling prior to and immediately following service

provision (the client is given instructions on how to use the method and

common side effects are discussed)

• follow-up counseling (during the return visit, use of the method,

satisfaction and any problems that may have occurred are discussed).

Ideal counseling processes follow the GATHER approach:

G - greet the clients in an open and respectful manner

A - ask clients about themselves and their needs

T - tell clients about the contraceptives choices

h- help client chose appropriate method

E - explain fully how to use the chosen method

R - return visits and if needed referral arranged.

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**2.6. Client assessment**

Client assessment is a method whereby clients are assessed to determine

whether or not a certain method of family planning is suitable for them.

**Objectives**

The primary objectives of assessing clients prior to providing family planning

services are:

• to ascertain that the client is not pregnant

• to assess any conditions which prohibit the use of a particular method,

and

• to identify any special problems that require further assessment, treatment

or regular follow up.

For most clients, this can be accomplished by asking a few key questions.

Unless specific problems are identified, the safe provision of most contraceptive

methods, except IUCDs and voluntary sterilization, does not require performing a

physical or pelvic examination.

Where resources are limited, requiring medical evaluation and/or laboratory

testing e.g., blood sugar and hemoglobin before providing modern contraceptive

methods is not justifiable. To enable clients to obtain the contraceptive method of

their choice, only those procedures that are essential and mandatory for all

clients in all settings should be required.

With the exception of condoms (and diaphragms to a lesser degree), no

contraceptive method provides protection against genital tract infections (GTIs)

or other STDs (e.g., HBV, HIV/AIDS). All clients should be made aware of the

risks of GTI and STD transmission.

**How to tell a client is not pregnant**

You can be reasonably sure a client is not pregnant if she has no signs or

symptoms of pregnancy (e.g., breast tenderness or nausea) and:

• did have intercourse since her last menses

• is within the first 7 days after the start of her menses (days 1-7)

• is within 4 weeks postpartum (for non breastfeeding women)

• is fully breastfeeding, less than 6 months postpartum and has had no

menstrual bleeding

• is within the first 7 days post abortion, or

• has been correctly and consistently using a reliable contraceptive method.

When a woman is more than 6 months postpartum you can still be reasonably

sure she is not pregnant if she has:

• kept her breastfeeding frequency high (about 6-10 times/day and at least

once during the night , no more than 6 hours should pass between any two

feeds).

• still had no menstrual bleeding ( amenorrheic ), and

• no clinical signs or symptoms of pregnancy(See satellite modules for public

health officers and nurses). Pelvic examination is seldom necessary, except to rule out pregnancy of more

than 6 weeks, measured from the last menstrual period (LMP).

Pregnancy testing is unnecessary except in cases where:

• it is difficult to confirm pregnancy (i.e., 6 weeks or less from the LMP); or

• the results of the pelvic examination are equivocal (e.g., the client is

overweight, making sizing the uterus difficult). In these situations, a urine pregnancy test may be helpful, if readily available and

affordable. If pregnancy testing is not available, counsel the client to use a

temporary contraceptive method or abstain from intercourse until her menses

occur or pregnancy is confirmed.

**Family planning methods**

**2.7.1. Traditional family planning**

Before the advent of modern contraceptives and up until the present time

traditional methods are used worldwide. The efficacy of these methods can not

be guaranteed unless certain other procedures are followed. There are three

types of traditional family planning methods:

• Lactational amenorhea method (LAM)

• Abstinence

• Coitus interruptus.

**2.7.1.2. Lactational amenorhea method (LAM)**

Lactational amenorrhea is the use of breast-feeding as a contraceptive method. It

is based on the physiologic effect of suckling to suppress ovulation. To use

breast-feeding effectively as a contraceptive for 6 months after delivery requires

that the mother feed the baby nothing but breast milk (exclusive breast feeding).

**Advantages**

**Contraceptive**

• Highly effective (1-2 pregnancies per 100 women during first 6months of

use)

• Effective immediately

• Does not interfere with intercourse

• No systemic side effects

• No medical supervision necessary

• No supplies required

• No cost involved

**Non contraceptive**

For the Child

• Passive immunization (transfer of protective antibodies)

• Best source of nutrition

• Decreased exposure to contaminants in water, other milk or formulas, or

on utensils

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**Disadvantages**

• User-dependent (requires following instructions regarding breastfeeding

practices)

• May be difficult to practice due to social circumstances

• Highly effective only until menses return or up to 6 months

• Does not protect against STDs (e.g., HBV, HIV/AIDS)

**Who can use LAM**?

• Women who are fully (or nearly fully) breast feeding, whose babies are

less than 6 months old and whose menses have not returned.

**Who should not use LAM?**

• Women whose menses have returned

• Women who are not fully breast feeding

• Women whose babies are more than 6 months old

**Client Instructions**

• For LAM to be effective breast feed the baby on demand about 6-10

times/day and at least once during the night .No more than 6 hours should

pass between any two feeds .

• Keep supply of lubricated condoms or other form of contraceptive at home

• If any of the following occurs consult your health care provider to start

other contraceptive methods

**-** If menses returns

**-** If you no longer breast-feed fully or

**-** if your baby is 6 months old.

• If you or your partner are at risk of STDs including AIDS use condoms.

**b. Abstinence**

Abstinence is a very effective and acceptable method of birth control. Its major

problem is that it is only effective if followed without exception. Also for many couples, going without sex is not an acceptable decision. While abstinence could

be encouraged, the provider must deal non-judgmentally with a client who wishes

to or already engages in premarital sex. It is important that the patient knows the

dangers of unprotected sex which include HIV/AIDS, unwanted pregnancy,

unsafe abortion, pelvic infection and cultural isolation.

**Coitus Interruptus**

Coitus interruptus is the withdrawal of the penis just before ejaculation occurs so

that sperm does not go into the vagina. It is not a reliable method because there

is often pre-ejaculation leakage of sperm which can often lead to pregnancy.

Therefore, this is not a method that can be recommended.

**2.7.2. Natural family planning methods (NFP)**

Natural family planning methods (NFP) or fertility awareness methods (FAM) are

methods which use the body’s natural physiological changes and symptoms to

identify the fertile and infertile phases of the menstrual cycle. The effective use of these methods depends on the client’s ability to use

calendars, write on charts, and read thermometers. Therefore these methods

may not be truly available to a population with low resources and a low rate of

literacy. However, it is important that health professionals be prepared to offer

these methods.

There are 4 main types:

• The rhythm or calendar method

• The basal body temperature (BBT)

• The cervical mucus method (Billings ovulation ) and

• The sympto-thermal method (combination of BBT and Billings Method)

**Advantages**

**Contraceptive**

• Can be used to avoid or achieve pregnancy

• No method-related health risks

• No systemic side effects

• Inexpensive

**Noncontraceptive**

• Promotes male involvement in family planning

• Improves knowledge of reproductive system

• Possible closer relationship for couple

**Disadvantages**

• Moderately effective as a contraceptive (9-20 pregnancies per 100 women

during the first year of use)

• Not recommended for women with irregular cycles

• Effectiveness depends on willingness to follow instructions

• Considerable training required to use the most effective types of NFP

correctly

• Requires trained provider (non-medical)

• Requires abstinence during fertile phase

• Requires daily record keeping

• Vaginal infections make cervical mucus difficult to interpret

• Basal thermometer needed for some methods

Does not protect against STDs (e.g., HBV, HIV/AIDS)

**a. The Calendar Method**

**Basis**

A woman must keep a monthly record of the days she menstruates. From this,

with the help of a qualified natural family planning counselor she can estimate

when she is most likely to get pregnant if she has sex.

**Method**

To calculate the fertile period:

• Monitor the length of at least 6 menstrual cycles while abstaining or using

another contraceptive methods.

• Then calculate the fertile days period by the following method

• From the number of days in the longest cycle, subtract 11. This identifies

the last fertile day of the cycle.

• From the number of days in the shortest cycle, subtract 18. This identifies

the first fertile day of the cycle.

Example: Longest cycle: 30 days minus 11 = 19

Shortest cycle: 26 days minus 18 = 8

• the fertile period is calculated to be days 8 through 19 of your cycle

• Abstain from sexual intercourse during the fertile days.

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N.B- Day 1 is the first day of menstrual flow.

**b. The Basal Body Temperature (BBT) Method**

**Basis**

The hormone progesterone which the ovaries secrete after ovulation induces a

slight rise in body temperature which is maintained until menstruation .The fertile

phase of the menstrual cycle can be determined by taking accurate

measurements of the basal body temperature to determine this shift.

**Method**

• Take body temperature at about the same time each morning (before rising)

and record the temperature on the chart provided by the NFP instructor.

• Use the temperature recorded on the chart for the first 10 days of the

menstrual cycle to identify the highest of the “normal, low” temperatures (i.e.

daily temperatures charted in the typical pattern without any unusual

conditions). Disregard any temperatures that are abnormally high due to fever

or other disruptions.

• Draw a line 0.05-0.10C above the highest of these 10 temperatures. This line

is the cover line or temperature line.

• The infertile phase or safe period begins on the evening of the third

consecutive day that the temperature stays above the cover line (thermal shift

rule). Notes:

• If any of the temperatures fall on or below the cover line during the 3 day

count, this may be a sign that ovulation has not yet taken place. To avoid

pregnancy, wait until 3 consecutive temperatures are recorded above the

cover line before resuming intercourse.

• After the infertile phase begins, it is not necessary to keep taking your

temperature. You may stop until the next menstrual cycle begins and continue

to have intercourse until the first day of the next menstrual period.

Insert chart

**c. Cervical Mucus (Billings) Method**

The cervical mucus method is based on detecting the changes in cervical mucus

secretions and in the sensations in the vagina. Before ovulation, the cervical

mucus becomes slippery and stretchy. The mucus changes are greatest around

the time of ovulation. After ovulation, cervical mucus becomes thick or may

disappear completely. A couple using this method to avoid pregnancy will abstain

from intercourse when the mucus indicates that the woman is fertile. They also

abstain during menstrual bleeding. These couples should avoid intercourse on

alternating days before the appearance of cervical mucus so that the presence of

semen in the vagina does not change the natural appearance of the mucus. The

woman checks her vaginal discharge every day for consistency. When it is very

elastic and thin it indicates that she is about to ovulate. From this she can know

when to abstain from sex. The reliability of the mucus method has been

demonstrated by a recent WHO one year trial of the method in five countries.

Findings indicate a method effectiveness of 97% or better.

**Mechanism of action**

• Same as other natural family planning methods mentioned in core module

• A simple accurate record is the key to success

• A series of codes is used to complete the record. These codes should be

both appropriate to local culture and widely available to NFP users. In

some areas, colored stamps or inks are used ;in others, it is more

convenient to develop symbols that are written by hand; while in still

others ,both methods are combined resulting in hand written symbols that

are recorded with colored pens. Examples are given below:

**Definitions**

**Dry days:** After menstrual bleeding ends, most women have one to a few days in

which no mucus is observed and the vaginal area feels dry. These are called dry

days.

**Fertile days:** When any type of mucus is observed before ovulation, she is

considered to be fertile. Whenever mucus is seen, even if the mucus is of a

sticky, pasty type, the wet fertile mucus may be present in the cervix and fertile

days have started.

**Peak day**: The last day of slippery and wet mucus is called the peak day; it

indicates that ovulation is near or has just taken place. **Client instructions**

• As mucus may change during the day, observe it several times throughout

the day. Every night before you go to bed, determine your level of fertility

and mark the chart with appropriate symbol

• Abstain from sexual intercourse for at least 1 cycle so that you will know

the mucus days

• Avoid intercourse during your menstrual period. These days are not safe,

in short cycles ovulation can occur during your period.

• During the dry days after your period, it is safe to have intercourse every

other night (alternate dry day rule). This will keep you from confusing

semen with cervical mucus.

• As soon as any mucus or sensation of wetness appears, avoid intercourse

or sexual contact. Mucus days, especially fertile mucus days, are not safe

(Early mucus rules).

**Client instructions**

• As mucus may change during the day, observe it several times throughout

the day. Every night before you go to bed, determine your level of fertility

and mark the chart with appropriate symbol

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• Avoid intercourse during your menstrual period. These days are not safe,

in short cycles ovulation can occur during your period.

• During the dry days after your period, it is safe to have intercourse every

other night (alternate dry day rule). This will keep you from confusing

semen with cervical mucus.

• As soon as any mucus or sensation of wetness appears, avoid intercourse

or sexual contact. Mucus days, especially fertile mucus days, are not safe

(Early mucus rules). Mark the last day of clear, slippery, stretchy mucus with an X. This is the

peak day. It is the most fertile time.

• After the peak day, avoid intercourse for the next 3 days and nights.

These days are not safe (peak days rule).

• Beginning on the morning of the fourth dry day, it is safe to have

intercourse until your menstrual period begins again.

**d. Sympto-thermal**

**Method**

This is a combination of checking a woman’s temperature everyday and checking

her vaginal discharge. This is probably the most accurate of any of the natural

family planning methods.

They can be taken in the

form of oral pills, injectables, implants, skin patches, or hormonereleasing

intrauterine systems.

**HORMONAL CONTRACEPTIVE**

**METHODS**

Hormonal contraceptives are among the most widely used FP

methods worldwide. In Kenya, nearly 75 percent of all women using

modern contraceptives choose hormonal methods, with 32 percent

and 61 percent choosing the Pill and injectable contraceptives, They can be taken in the

form of oral pills, injectables, implants, skin patches, or hormonereleasing

intrauterine systems.

respectively.34 Hormonal contraceptives are highly effective (if

used correctly), safe, and convenient.

The following hormonal methods are commonly available in

Kenya:

• Combined oral contraceptives (COCs)

• Progestin-only contraceptive pills (POPs)

• Progestin-only injectable contraceptives (DMPA, NET-EN)

• Progestin-only contraceptive implants (Jadelle, Implanon,

Zarin)

• Hormone-releasing intrauterine systems (LNG20-IUS)

• Dedicated products for emergency contraceptionThese methods are less commonly available in Kenya:

• Combined injectable contraceptives (see Injectable

Contraceptives below).

• Combined contraceptive (skin) patch (Evra), which releases

a daily dose of ethinylestradiol 20μg and a progestogen

(norelgestromin 150μg) transdermally when applied to the buttocks, torso, abdomen, or upper arm. This patch prevents

pregnancy by inhibiting ovulation. Its contraceptive effect

compares well to COCs with similar hormone formulations in

terms of safety and effectiveness. Combined vaginal contraceptive ring (NuvaRing), which

releases a daily dose of ethinylestradiol 15 μg and a progestogen

(etonogestrel 120 μg) when the ring is placed high up in the

vagina. The contraceptive ring prevents pregnancy by inhibiting

ovulation. Its contraceptive effectiveness compares well to

COCs with similar hormone formulations in terms of safety and

effectiveness.

Combined Oral Contraceptive Pills

Combined oral contraceptives are pills that contain synthetic

oestrogen and progesterone (progestins), which are similar to the

natural hormones produced in a woman’s body. These are the

contraceptives commonly referred to as *The Pill*. COCs must be

taken daily to prevent pregnancy. Apart from contraception, COCs

also have other signifi cant health benefi ts. In some cases, they are

used purely for these benefi ts, even where contraception is not

required. For example, COCs are frequently prescribed to alleviate

menstrual disorders, including dysmenorrhoea (painful periods),

irregular cycles, and premenstrual mood syndrome. They are

prescribed to treat acne or hirsutism, as well. of the oestrogen hormone in COCs

has decreased to lower and safer levels, which has decreased the occurrence of side effects. High-dose COCs are now defi ned as

those containing 50 micrograms or more of oestrogen, and lowdose

pills contain 30-35 micrograms of oestrogen. The ultra lowdose

COCs contain 20 micrograms ethinyl oestradiol. Low-dose

pills are the most commonly available COCs in Kenya.

COCs are highly effective in preventing pregnancy

by suppressing ovulation and thickening the cervical mucus, which

prevents the sperm from penetrating the cervix. Note: None of the hormonal methods are effective once pregnancy

is established. COCs do NOT disrupt an existing pregnancy.

**Types of COCs**

The Pill comes in packets of 21 or 28 tablets. In the 28-pill packet,

only the fi rst 21 pills are active pills (i.e., they contain hormones).

The remaining seven pills are not active and usually contain iron.

The low-dose pill comes in three types:

• Monophasic: Each active pill contains the same amount of

oestrogen and progestin. Examples include Microgynon, Lo-

Femenal, Nordette, Marvelon, and Yasmin.

• Biphasic: The active pills in the packet contain two different

dose combinations of oestrogen and progestin. For example,

in a cycle of 21 active pills, 10 may contain one combination,

while 11 contain another. Examples include Biphasil, Ovanon,

and Normovlar.

• Triphasic. The active pills contain three different dose

combinations of oestrogen and progestin. Out of a cycle of

21 active pills, six might contain one combination, fi ve pills

contain another combination, while 10 pills contain other combinations of the same two hormones. Examples include

Logynon and Trinordial .

**NOTE:**

Although Biphasic and Triphasic contraceptive pills are

available in Kenya, they are not in common use. These

guidelines address Monophasic pills only. The service

provider should verify the type of COC that the client is

taking and give her appropriate instructions.

**Advantages of COCs**

*Contraceptive Benefi ts*

As a method of contraception, COCs have many benefi ts:

• COCs are highly effective and are effective immediately when

started within the fi rst fi ve days of the menstrual cycle (see

“Limitations and Side Effects” below).

• COCs are safe for the majority of women.

• COCs are easy to use.

• COCs can be provided by trained non-clinical service

providers.

• A pelvic exam is not required to initiate use if COCs.

*Non-contraceptive Health Benefi ts*

COCs offer several non-contraceptive benefi ts, too:

• Reduction of menstrual flow (lighter, shorter periods)

• Decrease in dysmenorrhoea (painful periods) Reduction of symptoms of endometriosis

• Improvement and prevention of anaemia

• Protection against ovarian and endometrial cancer

• Possible protection from symptomatic pelvic infl ammatory

disease

• Treatment for acne and hirsutism Reduction of symptoms of endometriosis

• Improvement and prevention of anaemia

• Protection against ovarian and endometrial cancer

• Possible protection from symptomatic pelvic infl ammatory

disease

• Treatment for acne and hirsutism

**Limitations and Side Effects of COCs**

COCs must be taken daily to be effective, preferably at the same

time each day. Effectiveness of COCs might be decreased when

certain drugs are taken concurrently (e.g., certain anti- tuberculosis,

anti-epileptic, and antiretroviral drugs). Clients should refer to MEC

for possible interactions. Also, effectiveness could be lowered in

the presence of gastroenteritis, severe vomiting, and diarrhoea.

COCs offer no protection against STls, including hepatitis B and

HIV. Therefore, at-risk individuals should use condoms to ensure

protection against STIs. Use of COCs could be associated with minor and major side effects.

Minor side effects include the following:

• Nausea (more common in the fi rst three months)

• Spotting or bleeding in between menstrual periods, especially

if a woman forgets to take her pills or takes them late (more

common in the fi rst three months)

• Mild headaches

• Breast tenderness

• Slight weight gain

• Mood change

Amenorrhoea (some women see amenorrhoea as an

advantage)

The following major side effects or complications are rare, but

possible:

• Myocardial infarction

• Stroke

• Venous thrombosis or embolism, or both

**Contra-indications**

• Pregnancy (known or suspected)

• Breast-feeding and fewer than 6-8 weeks postpartum

• Unexplained vaginal bleeding (until evaluated)

• Active liver disease (viral hepatitis)

• Age 35 and smoker

• History of heart disease, stroke or high blood pressure (>180/110)

• History of blood clotting problems or diabetes > 20 years

• Breast cancer

• Migraines and focal neurological symptoms.

• Taking drugs like rifampin ,phenytoin and barbiturates

**Client Instructions**

• Take 1 pill each day, preferably at the same time of day.

• Take the first pill on the first to the seventh day (first day is preferred) after the

beginning of your menstrual period.

• Some pill packs have 28 pills. Others have 21 pills. When the 28-day pack is

empty, you should immediately start taking pills from a new pack. When the

21-day pack is empty, wait 1 week (7 days) and then begin taking pills from a

new pack.

• If you vomit within 30 minutes of taking a pill, take another pill or use a

backup method if you have sex during the next 7 days. If you forget to take a pill, take it as soon as you remember, even if it means

taking 2 pills in 1 day.

• If you forget to take 2 or more pills, you should take 2 pills every day until you

are back on schedule. Use a backup method (e.g., condoms) or else do not

have sex for 7 days. If you miss 2 or more menstrual periods, you should come to the clinic to

check to see if you are pregnant.

Service providers should ensure that clients are aware of known

complications that can be associated with COC use, pointing out

that although these complications are rare, clients should return

immediately if they experience any of the following symptoms

(ACHES):

Abdominal pains

• Chest pain or shortness of breath

• Headaches

• Eye problems

• Severe calf muscle pain

**Management of common side effects of COCs**

Nausea and dizziness

Assess for pregnancy.

Reassure client that this is a common side

effect in COC users and may diminish in

a few months.

Advise client to take pills with meals or

at bedtime.

Spotting

Assess for pregnancy.

Reassure client that irregular spotting is a

harmless and common side effect in COC

users, especially during the fi rst three

months.

Assess for other illnesses if appropriate

Encourage client to take pills at the same

time each day.

If spotting persists and is unacceptable for

client, prescribe 800 mg ibuprofen three

times a day for fi ve days (or other NSAID,

except aspirin). If this does not offer relief,

help client to choose another FP method.

Amenorrhoea

Assess for pregnancy. If client is not

pregnant, explain that this is one of the

possible side effects of COC use.

**When to Start**

A woman can start using COCs at any time if it is reasonably certain

she is not pregnant.

- If she begins using COCs within five days after the start of her

monthly bleeding, she will not need a back-up contraceptive

method. If she begins using COCs more than five days after the start

of her monthly bleeding, during the first seven days when she

takes COCs she should also use a backup method.

**Progestin Only Pills (POPs)**

As the name indicates the pill only contains progestin, no estrogen. These pills

may be used during the breast-feeding period, as they do not reduce milk flow.

The low hormone content makes correct intake important. The tablets must be

taken at the same time each day without interruption or contraceptive safety will

be reduced. As there is no estrogen in the pills there is an increased chance of

spotting when used by menstruating women.

**Types of POPs**

The brands commonly available in the public sector and the local

market include Microlut, Micronor, Microval, Ovrette, Norgeston,

and Noriday.

**Mechanism of action**

• Thickens cervical mucus, preventing sperm penetration

• Suppresses ovulation

• Makes the endometrium less favorable for implantation

• Reduces sperm transport in upper genital tract (fallopian tubes)

**Advantages**

**Contraceptive benefits**

• Effective when taken at the same time every day (0.5-10 pregnancies per 100

women during the first year of use)

• Immediately effective (<24 hours)

• Pelvic examination not required prior to use

• Does not interfere with intercourse

• Does not affect breast-feeding

• Immediate return of fertility when stopped

• Convenient and easy-to-use

• Can be provided by trained nonmedical staff

• No estrogenic side effect

**Non contraceptive**

• May decrease menstrual cramps

• May decrease menstrual bleeding and may improve iron deficiency anemia

• Protects against endometrial cancer

• Decreases benign breast disease

• Protects against some causes of PID

**Disadvantages**

• Cause changes in menstrual bleeding pattern (irregular bleeding/spotting

initially) in most women

• Some weight gain or loss may occur

• User-dependent (require continues motivation and daily use)

• Must be taken at the same time every day

• Forgetfulness increases failure

• Resupply must be available

• Effectiveness may be lowered when certain drugs like rifampin ,phenytoin and

barbiturates are also taken

• Do not protect against GTIs or other STDs (e.g., HBV, HIV/AIDS)

**Contra-indications**

• Pregnancy (known or suspected)

• Known or suspected cancer of the reproductive tract and breast

• Undiagnosed genital tract bleeding

• Taking drugs like rifampin ,phenytoin, and barbiturates

**Management of common side effects**

**spotting**

Reassure client that this is common with POP use.

Determine if client had vomiting or diarrhoea

recently or is taking any drugs that might interact

with POPs. If bleeding starts after several months of

normal or no monthly bleeding, or there are other

reasons to suspect pregnancy (e.g., client has missed

pills), assess for pregnancy or other underlying

conditions. Manage condition or refer client to

appropriate level.

Heavy or prolong bleeding

Reassure client that some POP users experience this

type of bleeding, but it is generally not harmful.

For modest relief prescribe 800 mg ibuprofen three

times a day for fi ve days (or other NSAID except

aspirin).

If no relief, suggest other type of POPs if available or

help to choose another method.

Amenorrhoea

If client is breastfeeding, reassure her that it is

normal not to have monthly bleedings while

breastfeeding.

If client is not breastfeeding, reassure her that some

woman stop having monthly bleeding while taking

POPs.

If there are reasons to suspect pregnancy (e.g., the

woman has missed pills), assess for pregnancy. If

client is pregnant, advise her to stop using POPs and

refer for antenatal care (ANC). If she is not pregnant,

reassure her to continue POPs.

Headaches or dizziness

Determine cause. If no cause is found, counsel

client and recommend common painkillers. If

headaches worsen while using POPs (e.g., she

develops migraines with aura), help client select

alternative method. Refer if need be.

Abnormal or suspicious vaginal bleeding

Evaluate client by history and pelvic examination

(refer as necessary), including VIA/ VILI and Pap

Smear. Treat or refer for treatment as necessary.

Mood change or nervousness

Counsel client. If condition worsens, help client

select alternative methods

Severe pain in lower abdomen

Rule out ectopic pregnancy directly or through

immediate referral.

Emergency Hormonal Contraceptive Pills (ECPs)

**Description**

Emergency contraception (EC) refers to the use of certain

contraceptive methods by women to prevent pregnancy after

unprotected sexual intercourse. Hormonal ECPs must be taken

within 120 hours of intercourse, however, the sooner they are

taken, the more effective they are. ECPs provide a second chance

for preventing pregnancy after unprotected sex, either accidental

or coerced sex, or rape.

It should be emphasised that EC should not be used on a regular

basis (from month to month) because it is less effective than other

methods.

Depending on the regimen used and number of hours passed since

unprotected intercourse, ECPs seem to prevent between 75-95

percent of pregnancies that would otherwise have occurred. The

average chance of pregnancy resulting from one act of unprotected

intercourse in the second or third week of the menstrual cycle is

estimated at 8 percent; after emergency oral contraception, it is 1-2

percent.

ECPs work in various ways to prevent pregnancy, largely depending

on the time in a woman’s cycle when she has sexual intercourse.

ECPs do not cause abortion because they work before implantation.

Thus ECPs prevent pregnancy by:

• Preventing or delaying ovulation

• Inhibiting or slowing down transportation of the egg and sperm

through the fallopian tubes, which prevents fertilization and

implantation

ECPs do not work once a woman is pregnant—women and girls

who are already pregnant should not take ECPs.

The success of EC depends on the awareness and knowledge of its

availability and effi cacy prior to an unprotected, unplanned act.

The method is only effective if potential users are aware of the

method by prior information and counselling.

**Types of ECPs and Dosage**

*Combined Oral Contraceptives (Yuzpe Method)*

These contain the hormones oestrogen and progestin, and they

prevent about 75 percent of expected pregnancies. Two standard

dosage options are available: 50 mcg oestrogen pills (e.g., Eugynon): Two tablets to be taken

as soon as possible after unprotected intercourse, but within

120 hours. Repeat the same dose in 12 hours. A total of four

pills are required.

• 30 mcg oestrogen pills (e.g., Microgynon): Four tablets to be

taken as soon as possible after unprotected intercourse, but

within 120 hours. Repeat the same dose in 12 hours. A total of

eight pills are required.

*Progestin-only Oral Contraceptives*

These dedicated ECPs contain the same progestin hormone

(levonorgestrel) as some other progestin-only pills, although in

higher doses. They are more effective than the combined pills,

preventing up to 95 percent of expected pregnancies. Examples of

brands of dedicated ECPs that are available in Kenya are Postinor

2, Pregnon, Smart lady, ECee2, and Truston2.

The standard dosage is as follows:

• One 750 mcg levonorgestrel pill to be taken as soon as possible

after unprotected intercourse, but within 120 hours. Repeat the

same dose in 12 hours. A total of two pills are required; or

• Two 750 mcg levonorgestrel pills to be taken as a single dose

as soon as possible after unprotected intercourse, but within

120 hours. This regimen is to be preferred because it easier to

comply with the one-dose regimen compared to the two-dose

regimen Regular progestin-only pill (POP) may be used: 20 tablets taken

within 120 hours after unprotected intercourse. Repeat the

same dose in 12 hours. A total of 40 pills are required.

**Advantages and Benefi ts of ECPs**

EC provides emergency protection (prevents pregnancy) for

about 75-95 percent of those at risk. EC can reduce unwanted

pregnancies that might lead to child neglect, abandonment, and

unsafe abortions (the latter are a major cause of maternal death

in Kenya). EC is an important element in post-rape care and in

the PMTCT of HIV, and it is an essential component of quality FP

service provision. EC offers the following benefi ts:

• It is safe, effective, and easy to use.

• No medical examination or pregnancy tests are necessary or

required. It is safe, effective, and easy to use.

• No medical examination or pregnancy tests are necessary or

required.

• It can be used at any time during the menstrual cycle.

**Limitations and Side Effects of ECPs**

ECPs have the following limitations:

• ECPs are only effective if used within 120 hours of unprotected

intercourse.

• They are not to be used as a regular method.

• ECPs do not protect against STls, HIV, or AIDS.

• They can cause nausea (more common for the COC regimen).

**Eligibility for Using EC**

ECPs are safe and appropriate for all women. Some women might

take ECPs with additional monitoring or care (see Table 2.9).

*Women Who Can Use ECPs*

Any woman can use ECPs, however emergency oral contraception

should not be used in place of regular FP methods. It should be

emphasised that ECPs contain a much higher dose of hormones

compared to the regular hormonal contraceptive methods.

Therefore, it should be used only in emergency situations such as

the following: Sex took place without contraception, and the woman wants to

avoid pregnancy.

• A woman has run out of oral contraceptives, has missed two

or more POPs, or is more than four weeks late for her DMPA

injection, and has had unprotected intercourse.

• A woman has had coerced sexual intercourse, such as rape. A condom has broken.

• An IUCD has come out of place.

Injectable Contraceptives

**Description**

Injectable contraceptives contain one or two contraceptive

hormones and provide protection from pregnancy for one, two, or

three months (depending on the type) following an injection. About

61 percent of all women in Kenya who use modern contraceptive

methods choose injectable contraceptives. The most widely

used injectable methods contain only a progestin (Progestinonly

Injectable Contraceptives or POIC). Less common methods

are those that contain both progestin and oestrogen (Combined

Injectable Contraceptives or CIC).

**Progestin-Only Injectable Contraceptives (POICs)**

The most widely available injectable contraceptives are

the three-month-interval (13 weeks) Depo Provera (Depotmedroxyprogesterone

acetate-DMPA) and the two-month-interval

Noristerat (Norethisterone enanthate-NET-EN). Both of these

injectables are given by an intramuscular (IM) injection. DMPA has

also been formulated for sub-cutaneous injection at three-month

intervals (DMPA-SC). Because they all contain only progestin, they do not have oestrogen-associated side effects. In addition,

because progestins do not suppress production of breast milk, these

injectables can be used by breastfeeding women after four weeks

postpartum (see Appendix 1 for effectiveness). Progestin-only

injectables prevent pregnancy mainly by suppressing ovulation,

but also by thickening cervical mucus and thereby preventing

sperm from passing through it, and by thinning the endometrium,

which could theoretically prevent implantation.

The dosages for the different injectables are provided below:

• Depot-medroxyprogesterone acetate (DMPA): Depo-ProveraR,

Megestron 150mg is given every three months (13 weeks), but

it can be given as much as two weeks (14 days) earlier or four

weeks (28 days) later.

• Norethisterone enanthate (NET-EN): NoristeratR 200mg is given

every two months, but it can be given as much as two weeks

(14 days) earlier or two weeks (14 days) later.

Depo-subQ provera 104 (also called DMPA-SC) is a new, lowerdose

formulation of DMPA that is injected sub-cutaneously

instead of intramuscularly. It contains 104 mg of DMPA instead

of the 150 mg in the IM formulation. Like the IM formulation,

DMPA-SC is given at three-month intervals.

**Combined Injectable Contraceptives (CICs)**

The CICs consist of a natural oestrogen plus a progestogen. They

prevent pregnancy mainly through the inhibition of ovulation.

**Types of CICs**

Two CIC formulations, both given at four-week intervals, are

on the market: Cyclofem/ Cyclo-Provera, which contains Medroxyprogesterone acetate 25mg plus estradiol cypionate

5mg; and Mesigyna/Norigynon, which contains Norethisterone

enanthate 50mg plus estradiol valerate 5mg. In both preparations, the natural oestrogens might be less potent

compared to the synthetic oestrogens of COCs. In addition, the

intramuscular administration of CICs eliminates the fi rst-pass effect

of the hormones on the liver. As a result, the type and magnitude

of oestrogen-related side effects associated with CICs might differ

from those experienced by COC users. For many conditions, the

WHO MEC has assigned categories for CICs somewhere between

those for COCs and POPs.

The dosages for these injectables are provided below:

• Cyclofem/Cyclo-Provera, containing Medroxyprogesterone

acetate 25mg plus estradiol cypionate 5mg, is given once every

30 days, but it could be given as much as three days earlier or

later.

• Mesigyna/Norigynon, containing Norethisterone enanthate

50mg plus estradiol valerate 5mg, is given once every 30 days,

but it could be given as much as three days earlier or later

**Advantages of Injectable Contraceptives**

*Contraceptive Benefi ts*

As a method of contraception, injectables have many benefi ts:

• They are highly effective and safe.

• A pelvic exam is not required to initiate use.

• They contain no oestrogen, so they do not have the cardiac and

blood-clotting effects, which are associated with oestrogencontaining

pills and injectables.

• These are long-acting methods:35 each injection provides

protection for two or three months, depending on the type.

• Confi dentiality

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• Confi dentiality

*Non-contraceptive Health Benefi ts*

Other, non-contraceptive benefi ts include the following:

• Amenorrhea, which might be benefi cial for women with (or at

risk of) iron-defi ciency anaemia

• Decrease in sickle cell crises

• Reduction of symptoms of endometriosis

• Protection against endometrial cancer

• Protection against uterine fi broids

• Possible protection from symptomatic pelvic infl ammatory

disease

• Possible prevention of ectopic pregnancy

**Limitations and Side Effects of Injectable Contraceptives**

The limitations associated with Injectable contraceptives include

the following:

• Return of fertility may be delayed for about four months or

longer after discontinuation.

• They offer no protection against STIs, including hepatitis B

and HIV; individuals at risk for these should use condoms in

addition to injectable contraceptives.

This method is provider-based, so a woman must go to a health

care facility regularly.

• Use of injectables could be associated with the following side

effects:

– Menstrual changes, such as:

- irregular bleeding

- heavy and prolonged bleeding

- light spotting or bleeding

- amenorrhea, especially after one year of use

Weight gain

– Headache

– Dizziness

– Mood swings

– Abdominal bloating

* Lower libido

**Management of side effects of injectable contraceptives**

Heavy or prolonged

bleeding (lasting more than

eight days or twice as long

as her usual menstrual

period)

**Management**

Explain that heavy or prolonged bleeding

is common in women using injectables,

particularly during the fi rst 6-8 months of use.

If heavy or prolonged bleeding persists,

evaluate as above.

If a gynaecologic problem is identifi ed, treat or

refer client for care.

If the bleeding becomes a threat to the health

of the woman, or is not acceptable to her,

discontinue the injectable. Help her choose

another method. To prevent anaemia, provide haematinics

and advice on diet. In the interim, short-term

treatment with either ethinylestradiol (or COCs)

or nonsteroidal anti-infl ammatory drugs other

than aspirin, might be helpful.

If no cause of the bleeding is obvious and it is

less than 8 weeks from the last dose (injection),

one or more of the following approaches may

be tried:

• NSAIDs such as Ibuprofen and Mefenamic acid

(Ibuprofen 400-800 mg tds for 7-14 days)

• COC, one active pill daily up to 1-3 cycles (or

50mcg pill where bleeding is continuing), or

ethinyl oestradiol 30-50 mcg daily for 7-21

days Injection Estradiol cypronate 5mg IM or

combined injectable contraceptive

However, these approaches may be short-term

or no relief at all.

If client presents when it is 8 weeks or more

from the last dose, give another dose of

injectable contraceptive and set a new return

date based on the current injection. This

schedule could speed up the development of

amenorrhea, which would stop the bleeding.

Amenorrhoea

Headache or dizziness

**Management**

By the end of the fi rst year on injectables,

amenorrhea develops in the majority of

clients. Normally amenorrhoea does not

require any medical treatment. Counselling

and reassurance are suffi cient. If in doubt,

assess for pregnancy, and manage as above.

If client is bothered by lack of menses despite

reassurance, discontinue injectable, and help

her choose another method.

Headache or dizziness

If mild, treat with analgesics and reassure.

Check blood pressure. If it is normal and

headaches persist, discontinue injectable and

refer for evaluation.

Help client choose another method.

**When to Start**

A woman can start injectables at any time if it is reasonably certain

she is not pregnant.

• If she starts using an injectable within seven days after the start

of her monthly bleeding, she will not need a back-up method.

• If she starts using an injectable more than seven days after her

monthly bleeding, she should use a backup method for the fi rst

seven days after injection

Contraceptive Implants

**Description**

Contraceptive implants are small rods that are inserted under the

skin of a woman’s upper arm to release the hormone progestin

slowly and prevent pregnancy. Contraceptive implants, which

are also called sub-dermal implants, do not contain oestrogen;

therefore, they are free from the side effects associated with that

hormone. The latest implant to be registered in Kenya is the tworod

Sino-implant-II (Zarin).

Contraceptive implants prevent pregnancy primarily by making

cervical mucus too thick for sperm to pass through it, and they also

suppress ovulation in many cycles.

**Types of Contraceptive Implants**

Jadelle 2 rods Levonorgestrel

75 mg/rod 5 years

Implanon 1 rod Etonogestrel

68 mg/rod 3 years

Sino-implant

[ZARIN] 2 Rods Levonorgestrel 4 years

75 mg/rod (possibly 5)

**Advantages and Benefi ts of Using Contraceptive Implants**

*Contraceptive Benefi ts*

As a method of contraception, contraceptive implants are highly

effective and safe, and they have signifi cant benefi ts:

• Contraception is immediate if inserted within the fi rst seven days

of menstrual cycle, or within the fi rst fi ve days for Implanon.

• There is no delay in return to fertility.

• They offer continuous, long-term protection

*Non-contraceptive Health Benefi ts*

Other benefi ts are as follows:

• Implants do not affect breastfeeding.

• They reduce menstrual fl ow.

• They help prevent ectopic pregnancy (but do not eliminate the

risk altogether).

• They protect against iron-defi ciency anaemia.

• They help protect from symptomatic PID.

**Limitations and Side Effects of Contraceptive Implants**

This contraceptive method has the following limitations:

• Contraceptive implants must be inserted and removed by

trained providers. This requires a minor surgical procedure

with appropriate infection prevention practices.

• Common side effects of using implants include menstrual

changes, such as irregular light spotting or bleeding, prolonged

bleeding, infrequent bleeding, and amenorrhea.

• Non-menstrual side effects include headache, dizziness,

nausea, breast tenderness, mood changes, weight change, and

mild abdominal pain.

• Contraceptive implants do not protect against STIs, including

hepatitis B and HIV. Individuals at risk should use condoms in

addition to the implants.

*Women Who Can Use Contraceptive Implants without Restrictions*

Breastfeeding mothers after four weeks postpartum, or

immediate postpartum if not breastfeeding Women who prefer not to use or have contraindications to

contraceptives that contain oestrogen or have developed

oestrogen-related complications while taking COCs

• Women with STIs and PID

• Women with HIV and AIDS, unless they are on ARV therapy

• Women with adequately controlled or moderate hypertension

(BP is less than 160/100) and those with history of hypertension

during pregnancy

• Women who have had major and minor surgery without

prolonged immobilisation, or varicose veins

• Women who take broad-spectrum antibiotics, anitfungals or

Antiparasitics Women with any of the following conditions:

– Valvular heart disease

– Sickle cell disease

– Non-migrainous headache or depressive disorders

– Endometriosis, severe dysmenorrhoea, benign ovarian

tumours, fi broids

– Benign breast tumours, endometrial and ovarian cancer

– Goitre

– Viral hepatitis (acute/fl are, carrier, or chronic) or mild

(compensated) cirrhosis

*Women Who Should Not Use Contraceptive Implant*

Women who have severe cirrhosis

or liver tumours (hepatocellular

adenoma or hepatoma) 3

Women who have unexplained

vaginal bleeding suspicious for

serious underlying condition

(before evaluation) 3

Women who have breast cancer or

women with a history of breast cancer 4

Women who currently have DVT

Women whose migraine with aura

became worse while using implants

**Timing for Implant Insertion**

The woman is having

her menstrual cycles.

suggestions

Insert implant within 7 days after the start of her

menstrual bleeding (within the fi rst 5 days for

Implanon). No additional contraceptive protection

is needed.

Insert implant any other time if it is reasonably

certain that she is not pregnant (see checklist).

If it has been more than 7 days since menstrual

bleeding started (within the fi rst 5 days for

Implanon), she will need additional contraceptive

protection for the next 7 days (e.g., condoms, FAM,

or Coitus Interruptus.

The woman is

amenorrhoeic.

suggestions

Insert implant any time if it is reasonably certain

that she is not pregnant. She will need additional

contraceptive protection for the next 7 days.

The woman is

breastfeeding.

Between 4 weeks and 6 months postpartum and

she is amenorrhoeic, insert implant any time. If she

is fully or nearly fully breastfeeding, no additional

contraceptive protection is needed (see LAM).

If she is more than 4 weeks postpartum and her

menstrual cycles have returned, she can have the

implant inserted as advised for other women having

menstrual cycles.

The woman is

switching from

another hormonal

method.

The implant can be inserted immediately if she

has been using her hormonal method consistently

and correctly, or if it is reasonably certain she is

not pregnant. There is no need to wait for her next

menstrual period.

If her previous method was an injectable, she

should have the implant inserted when the repeat

injection would have been given. There is no need

for additional contraceptive protection.

The woman is

switching from an

IUCD (including

hormonal).

The implant can be inserted within 7 days after the

start of menstrual bleeding (5 days for Implanon).

No additional contraceptive protection is needed.

The IUCD can be removed at that time.

The implant can also be inserted at any other time,

if it reasonably certain she is not pregnant.

If she has been sexually active in this menstrual

cycle, and it has been more than 7 days since the

menstrual bleeding started (5 days for Implanon),

it is recommended that the IUCD should remain

in position to be removed at the time of her next

menstrual period. If she has *not* been sexually active in this menstrual

cycle and it has been more than 7 days since

menstrual bleeding started (5 days for Implanon),

she will need protection for the next 7 days, if

the IUCD is removed at that time. Otherwise she

should retain it for removal at the time of her next

menstrual period.

If she is amenorrhoeic or has irregular bleeding,

she can have the implant inserted as advised for

other amenorrhoeic women

**Instructions to Women**

*After Insertion*

Counsel women to expect some soreness or bruising (or both),

after anesthetic wears off. This is common and does not require

treatment. She should be counselled and given these instructions:

• Keep insertion area dry for four to fi ve days.

• Remove the gauze bandage after one or two days, but leave the

adhesive plaster in place for an additional fi ve days.

• Return to the clinic if the rods come out or if soreness develops

after the removal of the adhesive plaster.

• Return to the clinic if she experiences pain, heat, pus, or redness

at the insertion site, or if she sees a rod come out.

The service provider should emphasise that implants must be

removed by the due date, and he should give her in writing the

type of implant she has, the date of insertion, and the month and

year when the implant will need to be removed.

The service provider should ensure that the woman knows where

to go in case of problems with the implants.

*Instructions for Clients Following Removal of Implants*

After a client has had her implant removed, she should be counselled

and instructed as follows:

• Keep removal area dry for four to fi ve days.

• Remove the gauze bandage after one or two days, but leave the

adhesive plaster in place for an additional fi ve days.

• Return to the clinic if swelling and pain develops after the

removal of the adhesive plaster.

**Management of side effects of contraceptive implants**

Amenorrhoea

Reassure her that this is a common occurrence

while using implants, and it is not harmful.

Amenorrhoea does not require any medical

treatment. Counselling is suffi cient.

If suspicious, assess for pregnancy as per Checklist.

If she is pregnant, remove the implants. If she is not

pregnant, reassure her and continue method.

Irregular spotting or

light bleeding

Spotting or light bleeding is common during

implant use, particularly in the fi rst year; clients

should be counselled and reassured that this

problem usually decreases over time.

If a woman has persistent spotting or bleeding, or

bleeding after a period of amenorrhoea, exclude

gynaecologic problems when clinically warranted.

If a gynaecologic problem is identifi ed, treat the

condition or refer client for care.

If STI or PID is diagnosed, she can continue using

implants while receiving treatment (syndromic

approach) and be counselled on condom use.

Irregular spotting or

light bleeding

If no gynaecologic problems are found and she

desires treatment, non-hormonal (NSAIDs other

than aspirin) and hormonal (COCs or Ethinyl

Estradiol) options are available (see below).

If she does not desire treatment or the treatment

is not effective, and she fi nds the bleeding

unacceptable, the implants should be removed.

Help her choose another method.

Heavy or prolonged

bleeding (more than

eight days or twice

as much as her usual

menstrual period)

Reassure client that some women using implants

experience heavy or prolonged bleeding. It is

generally not harmful.

Exclude gynaecologic problems when it is

clinically warranted. Treat the condition or refer

client for care.

If no underlying condition exists and she desires

treatment, non-hormonal (NSAIDs other than

aspirin) and hormonal (COCs or ethinyl estradiol)

options are available.

If she does not desire treatment or treatment is not

effective, and the bleeding becomes a threat to

her health or is unacceptable to her, the implants

should be removed. Help her choose another

method.

Recurrent and

persistent headaches

especially with

blurred vision

Assess for other causes. Reassure client if symptoms

are mild. If severe, remove implants and refer client

for treatment.

Assist client to select another method.

Implant expulsion

In the case of two-rods (Jadelle) or one rod

(Implanon) implants, a new set should be

inserted.36 Insert a new set in the other arm or in

the reverse direction in the same arm, or help the

client to select an alternative method.

**Treatment for Light or Heavy Bleeding**

If a woman experiences light or heavy bleeding while using

contraceptive implants, there are a number of possible treatments:

• Treatment with NSAIDs

– Ibuprofen: 800 mg three times a day for fi ve days

– Mefenamic acid: 500 mg twice a day for fi ve days

• Hormonal management

– Low-dose COCs: 30 μg ethinylestradiol 150 μg levonorgestrel

a day for 21 days

– COCs: 50 μg ethinylestradiol 250 μg levonorgestrel a day for

21 days

– Ethinylestradiol: 50 μg a day for 20 daysHeamostatics: Transnexamic acid 500mg three times a day for

fi ve days or Sylate 500mg three times a day for fi ve days

**INTRAUTERINE CONTRACEPTIVE**

**DEVICES (IUCDS)**

Description

The IUCD is a fl exible device that is inserted into the uterine cavity

by a trained service provider. It is a safe and highly effective, longacting

contraceptive method.

Types of IUCDs

There are two broad categories of intrauterine contraceptive devices

(IUCDs): the copper-based and the hormone-releasing devices.

**Copper-Based Devices**

Copper-based devices release copper and work mainly by

preventing fertilization. Several studies have shown that copper

IUCDs reduce the number of viable sperm that reach the fallopian

tubes, where fertilization normally takes place. In studies in which

the uterine cavity and fallopian tubes were fl ushed after exposure

to semen, no fertilised eggs were found in IUCD users. This is an

indication that prevention of fertilization is so effective in women

using copper IUCDs that other possible mechanisms, such as

prevention of implantation, are not signifi cant. In Kenya, the most

widely used copper-bearing IUCD is Copper T380A, which is made

of plastic with copper sleeves on the arms and copper wire wound

around the stem. It provides protection from pregnancy for as long

as 12 years. Other relatively less utilised copper devices and their

duration of effectiveness are shown in the table below.

**Hormone-Releasing IUCDs**

The hormone releasing IUCDs are less widely available in

Kenya. They are devices made of plastic and work by releasing a

progestin, levonorgestrel, during a period of fi ve years. They work

by suppressing ovulation in some (but not all) cycles, thickening

cervical mucus, and making the endometrium thin. They are also

referred to as Intra-Uterine Systems (IUS). Mirena, the LNG-20 IUS,

is the most widely used hormone-releasing intrauterine system

in use in Kenya. Also, there is a generic version of Mirena that is

available in the Kenya market, and it goes by the name of Lingus.

TYPES OF IUCD AND IT IS CONTRACEPTIVE DURATION

Copper based devices:

Copper T 380A As long as 12 years

TCu380S 8 years

Copper T2OO 8 years

Gynefi x 8 years

NOVA T 5 years

Multiload- MLCu-375 5 years

Multiload- MLCu-250 3 years

Copper T 220 3 years

Hormone-releasing IUCDs:

Mirena (LNG-20IUS), 5 years

Lingus37 - (LNG-IUS) 5 years

Myths and Misconceptions about the IUCD

IUCDs do not prevent pregnancy by causing an abortion. The

devices might cause a miscarriage if accidentally inserted in

a pregnant woman, or in the highly unlikely event of a woman

getting pregnant with an IUCD in place. However, because the

IUCD is highly effective in preventing fertilization, risk of abortion

is almost non-existent if pregnancy is ruled out in all clients prior

to insertion.

IUCDs are very safe; they do not cause PID in low-risk couples.

Risk of infection is very low when the IUCD is inserted using the

“no-touch” technique in women who have no cervical infection.

But if the client already has gonorrhoea or chlamydia at the time

of insertion, or if the service provider inserts the IUCD without

maintaining sterility, there is a small risk of pelvic infection in the

fi rst four weeks after insertion. Prophylactic antibiotics are generally

not recommended for Cu-IUCD insertion unless the risk for cervical,

gonococcal, and chlamydial infections is high and facilities for STI

screening are inadequate. In these cases, such prophylaxis might

be considered. In any case, clients in these circumstances should

be counselled to watch for symptoms of PID, especially during the

fi rst month of insertion, and to return immediately if symptoms

develop. Almost all brands of IUCDs have one or two strings, or threads,

tied to the lower end. The strings hang through the opening of the

cervix into the vagina. After insertion, it is advisable to cut the

strings short, to about 3cm long from the cervical’s external os, or

coil the strings around the fornix (postpartum insertion).

Advantages and Benefi ts of IUCDs

**Contraceptive Benefi ts**

IUCDs offer the following contraceptive benefi ts:

• High effectiveness and safety

• Immediate effectiveness

• Long-acting protection

• Immediate return of fertility upon removal of device

**Other Benefi ts**

IUCDs offer other advantages and health benefi ts, as well:

• IUCDs do not interfere with intercourse.

• Women who are breastfeeding can use IUCDs.

• IUCDs help prevent ectopic pregnancies.

• Women can use IUCDs immediately after delivery (to use

LNG-IUS, breastfeeding women should wait till four weeks

postpartum).

• IUCDs, including the Cu-IUCDS, might help protect from

endometrial cancer.

• LNG-IUS do not increase bleeding as Cu-IUCDS do; they may

reduce menstrual bleeding or cause amenorrhoea.

**Women Who Can Use an IUCD without Restrictions**

**Conditions that apply**

**to both Copper IUCD**

**and LNG-IUS**

Women 20 years of

age or older

Parous women of any

parity

Women who want

long-term, highly

effective protection

against pregnancy

Breastfeeding or nonbreastfeeding

if at least

four weeks postpartum

**Conditions that apply**

**to Cu-IUCD only**

Blood pressure of

160/100 or higher

History or acute DVT/

PE, including those on

anticoagulant therapy

Major surgery

with prolonged

immobilization

THOSE without severe

Thrombocytopenia

**Conditions that apply**

**to LNG-IUS only**

menstrual bleeding

(regular or irregular

patterns): initiation

only (see continuation

under category 2)

Endometriosis or

severe dysmenorrhoea.

(LNG-20 IUS may have

a benefi cial effect on

endometriosis and

dismenorrhoea)

Heavy or prolonged

When Can an IUCD Be Inserted?

The IUCD insertion is categorised as postpartum, postarbotal, and

interval.

• Postpartum insertion (does not apply to LNG-IUS if the woman

intends to or is breastfeeding. Breastfeeding women can have

LNG-IUD inserted at four weeks):

-– Trans-caesarean (i.e., following a caesarean delivery): The

IUCD can be inserted before the uterus is sutured.

-– Post-placental: The IUCD can be inserted within 10 minutes

after expulsion of the placenta following a vaginal delivery.

-– Immediate postpartum: The IUCD can be inserted after the

post-placental window, but within 48 hours of delivery. If

IUCD is not inserted within 48 hours, wait until four weeks

after delivery. Postabortion where there are no complications. Following fi rst

or second trimester abortion, insert the IUCD immediately or

within 12 days. Insertion of the IUCD should be undertaken

only after genital tract infection has been ruled out. If there

is suspicion of infection, or there is signifi cant injury to the

genital tract, insertion should be delayed until after appropriate

treatment (see interval insertion).

• Interval: Insert IUCD within the fi rst 12 days after the start of

menstrual bleeding or any other time of woman’s menstrual

cycle if provider is reasonably sure she is not pregnant.

**Post-insertion Follow-Up**

Arrange a follow-up visit three to six weeks after insertion. If IUCD

strings cannot be felt on bimanual examination, refer client for

ultrasound scan or X-Ray to confi rm whether the device is still in

situ. Advise the woman to use a back-up contraceptive method in

the meanwhile.

Limitations, Problems, and Side Effects with the Use

of IUCDs

IUCDs have the following restrictions, limitations, or side effects:

• An IUCD requires a trained provider to insert and remove the

device.

• Appropriate infection-prevention practices must be observed

during insertion and removal.

• Cu-IUCDs might increase menstrual bleeding and cause

cramping, more commonly during the fi rst few months of use

(LNG-IUs do not increase menstrual bleeding). IUCDs do not protect against STIs or HIV/AIDS.

• An IUCD could be expelled or translocated.

• Perforation of the uterus could occur, but this is rare.

**Management of common problems associated with IUCD use**

PROBLEM

A woman using an IUCD

experiences abnormal bleeding

patterns, such as spotting or light

bleeding between menstrual periods

and heavier or prolonged menstrual

bleeding.

MANAGEMENT

Bleeding problems are common

during the fi rst 3-6 months of

Cu-IUCD use. Clients should be

counselled and reassured that this

problem usually decreases over time.

If she requires treatment, a short

course of NSAIDs, e.g., ibuprofen

800mg, 3 times a day for 5 days; or

Indomethacin 25 mg, twice a day

for 5 days; or Tranexamic acid (a

haemostatic agent) may be given

during the days of bleeding. Do

not use aspirin as it may increase

bleeding.

In women with persistent spotting

and those with heavy or prolonged

bleeding, exclude gynaecologic

problems when clinically warranted.

If a gynaecologic problem is

identifi ed, treat the condition or refer

for care.

If no gynaecologic problems are

found, and she fi nds the bleeding

unacceptable, especially if there are

clinical signs of anaemia, remove the

IUCD and help her choose another

method or refer

**Problem or side effect**

A woman using an IUCD is found to

be pregnant.

**Management**

Exclude ectopic pregnancy with an

ultrasound scan where available

— otherwise, with careful clinical

monitoring.

Explain that she is at risk of second

trimester miscarriage (which might

be a septic miscarriage), and preterm

delivery if the IUCD is left in

place. Advise her that it is best to

remove the IUCD because removal

of the device reduces these risks,

although the procedure itself entails

a small risk of miscarriage. If the IUCD cannot be removed

or the woman refuses to have it

removed, but she wishes to continue

the pregnancy, advise her to seek

care promptly if she has heavy

bleeding, cramping, pain, abnormal

vaginal discharge, or fever. Ensure

careful clinical monitoring (directly

or through referral).

If she does not wish to continue the

pregnancy, counsel her accordingly.

If the woman wants her IUCD to be

removed and the IUCD strings are

visible or can be retrieved safely

from the cervical canal, remove

the IUCD by pulling gently on the

strings.

Explain that she should return

promptly if she has heavy bleeding,

cramping, pain, abnormal vaginal

discharge, or fever. If the woman wants her IUCD to

be removed, but the IUCD strings

are not visible and cannot be safely

retrieved: (1) where ultrasound is

available, determine if the IUCD is

still in the uterus. If the IUCD is not

located, this may suggest that an

expulsion of the IUCD has occurred;

(2) if ultrasound is not available

or if the IUCD is determined by

ultrasound to be inside the uterus,

make clear to her the risks and

advise her to seek care promptly if

she has heavy bleeding, cramping,

pain, abnormal vaginal discharge, or

fever.

PROBLEM

A woman experiences abdominal

cramps, pain, and severe

dysmenorrhoea.

MANAGEMENT

All women should be counselled on

potential changes in menstrual cycle

before the IUCD is inserted.

Examination should rule out partial

expulsion of the IUCD, ectopic

pregnancy, or PID (see below).

Treat dysmenorrhoea with

analgesics. If persistent, rule out

pelvic pathology (refer and manage

as appropriate-referral protocol).

Side effect

A woman using an IUCD is

diagnosed with PID.

Management

Treat the PID using appropriate

antibiotics. There is no need to

remove the IUCD if she wishes to

continue its use.

If symptoms do not improve after a

few (2-3) days of antibiotics, removal

of the IUCD might be considered

and antibiotic treatment continued or

reviewed.

If she does not want to keep the

IUCD, remove it *after* antibiotic

treatment has been started, and have

the woman complete a full course of

antibiotics.

After the IUCD is removed, help

the client to choose another

contraceptive method.

In all cases, the woman should be

closely monitored until the PID is

fully resolved.

**VOLUNTARY SURGICAL**

**CONTRACEPTION**

Introduction

Voluntary Surgical Contraception (VSC) includes female and male

sterilisation procedures41 that are intended to provide permanent

contraception. As such, special care must be taken to assure that

every client who chooses this method does so voluntarily and

is fully informed about the permanence of this method and the

availability of alternative, long-acting, highly effective methods.

Caution must be taken when the following individuals choose

permanent methods: nulliparous women; youth; men who have

not fathered a child; and persons with mental health problems,

including depressive disorders.

The following categories are used for recommending VSC

**Accept (Category A)**: There is no medical reason to deny

sterilisation to a person with this condition.

• **Caution (Category C)**: The procedure is normally conducted in

a routine setting, but with extra preparation and precautions.

• **Delay (Category D)**: The procedure is delayed until the

condition is evaluated and corrected if need be. Alternative

temporary methods of contraception should be provided.

**Special (Category S)**: The procedure should be undertaken in

a setting with an experienced surgeon and staff, equipment

needed to provide general anaesthesia, and other back-up

medical support. For these conditions, the provider must be able

to decide on the most appropriate procedure and anaesthesia

regimen.

Alternative temporary methods of contraception should be provided if referral is required or there is otherwise

any delay.

**NOTE:**

• No incentives are to be given to clients to accept any

form of contraception or to providers to recruit clients

and perform the surgical procedure.

• The client is free to change her mind anytime prior to

the procedure.

• Multiple caesarean sections and grand multiparity are

not absolute indications for female sterilisation. Multiple caesarean sections and grand multiparity are

not absolute indications for female sterilisation.

• Informed consent must be obtained and the client must

sign a standard consent form for the procedure. Spousal

consent is not mandatory, but counselling should be

provided to both partners and consent obtained from

both, if possible, and where appropriate

Female Voluntary Surgical Contraception

**Description**

Female voluntary surgical contraception, also referred to as female

sterilisation or tubal ligation (TL), is a minor surgical operation that

involves cutting and tying the fallopian tubes in order to prevent

the sperm from fertilising the ovum that was released from the

ovary, and reaching the uterine cavity. In Kenya, nearly 14 percent

of users of modern methods of contraception rely on female sterilisation.42 It is a highly effective method of contraception, with

a pregnancy rate of less than one percent of women in the fi rst year

after surgery. TL can be performed on a conscious client using local

anaesthesia, and it is generally a safe procedure when performed

by a trained provider. Few women experience side effects or

complications. Overall rates of complications are in the range of

0.4 to 2.0 percent. TL is a permanent FP method (reversal cannot be assured). Hence,

a client needs thorough and careful counselling before she decides

to have this procedure. A consent form must be signed by the client

in all cases before the procedure is undertaken. In the case of a

mentally challenged client, the surgeon may, after consultation

with a professional colleague, obtain the written consent of the

parent or guardian

**Types of TL**

There are several ways to perform a TL:

• Minilaparotomy (postpartum, postabortion,43 or interval)

• Laparoscopic tubal ligation (interval)

• In conjunction with a caesarean section or other abdominal

Surgery

**Advantages of TL**

*Contraceptive Benefi ts*

TL is a highly effective, immediate, and safe form of contraception

that offers the following benefi ts:

TL does not change sexual function and does not interfere with

Intercourse

• TL is permanent.

• TL has few known side effects

• TL does not affect breastfeeding. *Other Benefi ts*

Women who have TLs have a decreased risk of getting ovarian

cancer and have a possible decreased risk of PID.

**Limitations and Side Effects of TL**

The limitations and side effects of TL are listed below:

• TL is generally irreversible—the success of reversal surgery

cannot be guaranteed.

• Side effects include:

– Minimal risks and side effects of anaesthesia

– Risks associated with surgical procedures

– Some pain for several days after the procedur In rare cases when pregnancy occurs, it is more likely to be

ectopic (although overall, female sterilisation greatly reduces

the risk for ectopic pregnancy compared to women who use no

contraception).

• TL is not provided at all SDPs.

• Only a trained provider can perform the procedure.

• TL does not protect against STIs, including HIV/AIDS and

hepatitis B.e

**Women Who Can Use TL**

TL is considered appropriate and safe for the following:

Women of reproductive age.

• Women who are certain that they have achieved the desired

family size.

• Clients in whom pregnancy would pose a serious health risk.

• Women who understand and voluntarily consent to the

procedure. In certain situations the procedure may be

performed on a mentally-challenged person after consultation

with a professional colleague, and with the written consent of

a responsible parent or guardian. Women who are less than seven or more than 42 days

postpartum.

• Women who have had uncomplicated abortions.

• Women of any reproductive age who are smokers.

• Women with a history of DVT or PE, a family history of DVT or

PE, or who have had major or minor surgery without prolonged

immobilization. Women with superfi cial venous thrombosis.

• Women with headaches, with or without aura.

• Women with irregular, heavy, or prolonged bleeding patterns

or women with severe dysmenorrhoea.

• Women with benign ovarian tumours, benign gestational

trophoblast disease, cervical ectropion, or cervical intraepitelian

neoplasia. Women with an undiagnosed breast lump, benign breast

disease, or a history of breast cancer.

• Women with previous history of PID and STIs who have had a

subsequent pregnancy.

• Women at high risk of HIV or who are already HIV-positive (use

of condoms is strongly recommended following sterilisation).

• Women with non-pelvic tuberculosis.

• Women with gall-bladder disease (asymptomatic or symptomatic

and treated by either cholecystectomy or by medications).

• Women who are viral hepatitis carriers. Women with chronic viral hepatitis, benign focal nodular

hyperplasia and mild (compensated) cirrhosis.

**Women Who Should Not Use TL**

Providers should not perform TL on certain women:

• Women who are uncertain of their desire for future fertility

• Women who cannot withstand surgery

• Women or girls who do not give voluntary informed consent

**Management of common side effects**

**Side effects**

Pain at incision site

**Suggested action**

Determine presence of infection and treat; if

no infection, reassure and provide analgesics.

**Side effects**

Wound infection, fever

**Suggested action**

If skin is infected, clean, dress, and treat with

antibiotics; if abscess is present, incise and

drain; treat with antibiotics for 7-10 days.

**Side effects**

Haematoma

**Suggested action**

Apply warm, moist packs on site, observe for a

few days; if increasing, evacuate

side effect

More serious injuries

e.g., bladder or bowel injury

suggestion

Give appropriate management or refer for further management

**Ectopic Pregnancy after Female Sterilization**

Pregnancy following TL is rare, but when it does occur, it is more

likely to be an ectopic than uterine pregnancy. Ectopic pregnancy

is life threatening and requires immediate treatment. Health

service providers must be prepared to ensure early diagnosis and

management or referral of cases without undue delays. Following

the procedure, advise the client to seek help without delay if she

ever suspects a pregnancy.

Male Voluntary Surgical Contraception (Vasectomy)

**Description**

Vasectomy, or male sterilization, is the surgical process of cutting

and tying the vas deferens in order to prevent spermatozoa from

mixing with semen. Consequently, when ejaculation occurs, the

semen will not have any sperms. The operation is performed under

a local anaesthetic, and it is one of the most effective methods of

contraception—it has a reported failure rate of about 0.1 percent.

Still, vasectomies are not often performed in Kenya.

**Correcting Myths and Misconceptions about the Vasectomy**

Vasectomy is *not* synonymous with castration, and it does not affect

a man’s sexual ability or desire.

A vasectomy does *not* become effective immediately. The client

should be instructed to use condoms or another FP method for

three months after the operation to be completely safe.

Reversal surgery *cannot* be assured. Thorough and careful

counselling is needed before making a decision in order to avoid

future regret. The procedure must be considered permanent.

**Types of Vasectomy**

There are scalpel and non-scalpel vasectomy techniques.

**Advantages and Benefi ts of Vasectomy**

Contraceptive benefi ts of vasectomies include the following:

• The procedure is highly effective and safe.

• There is no change in sexual function—the procedure does not

interfere with sexual intercourse.

• It is permanent.

**Limitations and Risks**

**Allergic Reaction -**Rarely, some men may experience itching and hives, as the result of an allergic reaction to the local anesthetic.

**Antibodies -**After a vasectomy, sperm produced in the testicles are absorbed by the body. This process may cause the immune system to produce antibodies to the sperm. These "anti-sperm antibodies" are mostly harmless, but they can affect the success of a later vasectomy reversal.

**Bruising -**Bruising may occur on the skin of the scrotum or the penis. This is a normal side effect of a vasectomy, and the bruises should be gone after about two weeks.

**Chronic Scrotal Pain -** Fifteen to 19 percent of men who have had a vasectomy experience pain that lasts more than three months and interferes with daily activities. This type of pain, however, can also have causes unrelated to the vasectomy—such as inflammation of the epididymis, trauma, or twisting of the testicle (torsion

**Epididymitis -** One of the more common post-vasectomy complications, occurring in up to 6 percent of vasectomies, epididymitis is caused by inflammation and swelling of the epididymal tube. Heat and anti-inflammatory medications (alone or combined with antibiotics) can usually clear it up within a week.

**Hematoma -** Pooling of blood within the tissue occurs in up to 29 percent of all vasectomy patients. It usually starts within the first week after the procedure, and can cause pain or swelling. While it is rarely serious, you should report any bleeding to your doctor.

**Infection -** Infections occur in about 3.5 percent of vasectomy patients. These are usually minor and respond favorably to antibiotic treatment, antimicrobial creams, and hot baths. More serious infections are rare.

**Postoperative Pain -**Short-term pain after a vasectomy is normal and usually resolves within a day or two, although a slight ache can remain for a while longer. Surgeons usually recommend acetaminophen (e.g. Tylenol) with or without codeine for the first 48 hours, since aspirin and ibuprofen (such as Advil or Motrin) can cause bleeding.

**Sexual Difficulties -**A vasectomy should not affect your sex drive, or your ability to have erections or ejaculate. If you experience sexual difficulties after a vasectomy, contact your doctor. They may be a sign of either emotional or physical issues, including heart disease.

**Sperm Granulomas -**These small, usually painless lumps occur when sperm leak out of the vas and cause an inflammatory reaction. The resulting cluster of immune cells does not pose a danger and usually resolves over time. Granulomas do cause pain in a small number of men, typically about two to three weeks after the vasectomy.

**Men Who Can Use Vasectomy**

Vasectomies are recommended and safe for men of reproductive age

who have achieved their desired family size and who understand

and voluntarily give informed consent for the procedure. This

includes men who are infected with or at risk of HIV or who have

sickle cell disease.

**Men Who Should Not Have Vasectomies**

Vasectomies are not the appropriate choice for every man. Men

who should not have vasectomies include the following:

• Clients who are uncertain of their desire for future fertility

• Clients who cannot withstand surgery

• Clients who do not or cannot give voluntary informed consent

**Management of side effects of vasectomy**

**Side effects**

Pain

Management

Check for blood clots in the scrotum.

Small, uninfected blood clots require rest and

pain-relief medication.

Side effect

Pain lasting for months

Management

Suggest elevating scrotum with snug underwear

( or an athletic supporter.

Suggest soaking in warm water.

Recommend painkillers, such as Ibuprofen

200-400 mg three times a day.

If pain continues or cannot be tolerated, surgery or

injection of the anaesthetic into the spermatic cord

may be considered.

Side effect

Bleeding

Management

Control bleeding

Side effect

Blood clots Small,

Management

Small, uninfected blood clots require rest and

or haematoma pain-relief medication.

Large blood clots or hematoma might need to be

surgically drained.

Infected blood clots require antibiotics and,

possibly, hospitalization.

Side effect

Infection

Management

Treat with antibiotics for 7-10 days, may require

Hospitalisation

Side effect

Abscess

Management

Incise and drain the abscess following

infection-prevention procedures.

Ensure proper wound care.

Treat with antibiotics for 7-10 days.

Occasionally, hospitalisation might be required for

more aggressive treatment (IV antibiotics).

**BARRIER METHODS OF**

**CONTRACEPTION**

Introduction

Barrier methods prevent the sperm from gaining access to the upper

reproductive tract and making contact with the egg. These methods

include male and female condoms, spermicides, diaphragms, and

cervical caps. Whereas condoms, diaphragms, and cervical caps

are mechanical barriers, spermicides are chemicals that interfere

with the movement of the sperm and its ability to fertilise the egg.

Currently in Kenya, the use of diaphragms, cervical caps, and

spermicides is negligible.

In addition, scientifi c evidence has shown

that repeated and high-dose use of the spermicide nonoxynol-9

might cause vaginal and cervical irritation or abrasions, which

could increase the risk of infection with HIV. As a result, the main

focus in this edition of the *FP Guidelines* is on male and female condom

The effectiveness of barrier methods is largely dependent on the

way in which they are used. For example, condoms are only

moderately effective in typical use (15 percent pregnancy rate),

but much more effective when used consistently and correctly (2

percent pregnancy rate; Male and female condoms help prevent both pregnancy and most

STIs (including HIV), because when used correctly, the condoms keep sperm and any disease organisms in semen out of the vagina;

also, they prevent any disease organisms in the vagina from

entering the penis. Another advantage of barrier methods is that,

with the exception of the male condom, all the barrier methods

are controlled by women, and almost every woman can use them.

Barrier methods can be used without restriction

Male Condom

The male condom is a thin, latex rubber sheath or covering, made

to fi t a man’s erect penis. Some are coated with a lubricant or

spermicide. Condoms come in different sizes, colours, and textures.

As stated above, condoms help prevent both pregnancy and some

STIs, including HIV/AIDS. Condom types in the market include

plain, fl avoured, coloured, and spermicide-added condoms.

**Advantages of Condoms**

Condoms are effective contraception if used properly, and they

offer the following benefi ts as a contraceptive:

• Condoms offer contraception only when needed.

• Condoms are easy to obtain and can be used without seeing a

health care provider.

Other benefi ts of using condoms include the following:

• With consistent and proper use, they are highly effective

protection against STIs, including HIV/AIDS.

• Condoms reduce the risk of cervical cancer.

• Condoms prevent premature ejaculation. Almost every man is eligible to use a condom.

• Condoms are easy to use with a little practice.

• There is no health risk associated with this method.

• Condoms do not interfere with the act of intercourse, as do the

foaming tablets.

**Limitations of Condoms**

Some limitations of condoms are the following:

• A new condom must be worn for each act of sexual

intercourse.

• Condoms have a higher failure rate if used inconsistently or

incorrectly.

• Condoms might reduce sensitivity.

• Condoms might cause itching for a few people who are allergic

to latex.

Condoms are user-dependent.

• Condoms cannot be used with oil-based lubricants.

• Condoms are affected by heat, light, and humidity.

**NOTE:**

Male condoms should not be used with petroleum

products and oils, which lead to rapid degeneration and

could reduce their effectiveness in preventing pregnancy

and protection against STI, including HIV/AIDS.

**Men Who Should Use Male Condoms**

Condoms are a good contraceptive choice for men and couples in

a variety of circumstances:

• Men who wish to participate actively in FP

• Couples who need a back-up method (e.g., for missed pills)

• Couples who have sex infrequently and who do not need

continual protection

• Couples who need temporary methods while awaiting another

Method Couples who want protection from STI/HIV

– Those who are not using another method, or

– Those who are using another method for pregnancy

prevention, and are at a risk of acquiring an STI or HIV/AIDS

(dual method use) Postpartum clients or post-abortion clients before initiating

more appropriate methods, or any client who needs more time

to make a decision about a contraceptive method

• Couples living with HIV/IADS—whether discordant or

Concordant

**Men Who Should Not Use Male Condoms**

Men or couples who want a more effective protection against

pregnancy (e.g., when the woman has a condition that makes

pregnancy dangerous, and therefore need to consider a more

reliable method) should not use male condoms (see Appendix 2).

If the woman is at risk of STI, her partner should use a condom in

addition to the more reliable and effective contraceptive method.

**Side effects Management**

Allergy or irritation In case of a latex allergy,

management

advise couple to use

(very rare) another method. Rule out infection.

If the lubricant is a cause of irritation, suggest

using water as a lubricant.

Note: Clients at risk of STI and HIV/AIDS should

be counselled to continue to use condoms

despite discomfort as long as they are at risk.

If irritation is unacceptable to the client, assist in

choosing another method, including the female

condom, which is made of polyurethane. Rule

out infection

side effect

In case of spillage or

Breakage

Management

Offer ECP and counsel on HIV and STIs.

**Advantages and Benefi ts**

*Contraceptive Benefi ts*

Female condoms provide the following contraceptive benefi ts:

• They are effective if used consistently and correctly. The

effectiveness of the female condom is slightly less than the

male condom. The failure rate is about 5 percent in perfect use,

and 21 percent in typical use.

• They offer contraception only when needed.

• Condoms can be used without seeing a health care provider.

*Other Benefi ts*

Other benefi ts to using condoms include the following:

• With consistent and proper use, condoms are highly effective

protection against STIs, including HIV/AIDS.

• They protect against PID.

• The woman can control this method.

• Almost every woman is eligible to use this method.

• It can be inserted eight hours before an anticipated sexual act.

• There is no need to see a health care provider before use.

• Condoms are easy to use with a little practice.

No health risk is associated with the method.

• Unlike latex rubber, there is no known allergy to polyurethane,

the material from which female condoms are made.

**Limitations of Female Condoms**

Female condoms have the following limitations:

• Condom must be inserted before sexual intercourse (although

they can be inserted in advance—as much as eight hours).

• Female condoms are expensive.

• A condom can be used only once—it cannot be reused.

**Women Who Can Use the Female Condom**

All women of reproductive age of any parity, including nulliparous

women, can use a female condom. The female condom is

appropriate in many circumstances:

Women who need to rule out possible pregnancy before

proceeding with another method.

• Women who need a back-up method.

• Women who need temporary methods of contraception.

• Post-abortion clients before initiating other methods.

• Women who need dual protection if they are using another

method for pregnancy prevention, but are at a risk of acquiring

an STI or HIV/AIDS (e.g., a woman who has more than

one partner, or a woman whose partner has more than one

partner).

**Women Who Should Not Use a Condom**

A woman who has one or more conditions that make pregnancy

dangerous and needs a more effective method of protection against

pregnancy may want to consider other, less client-dependant,

methods of contraception

**Disposal of Used Female Condoms**

The female condom should be carefully removed and appropriately

disposed of:

• At the end of intercourse, the woman should hold the outside

rim of the female condom, twist it to seal in the fl uids, and

carefully pull out the device without spilling semen.

• The used condom can be thrown into a pit latrine, burned, or

buried. It should be kept away from children.

• Condoms must not be reused.