How to use WHO's family planning guidelines and tools

Mary Eluned Gaffield
Promoting Family Planning Team
Department of Reproductive Health and Research

Training Course in Sexual and Reproductive Health Research
Geneva 2014
Learning objectives

- To understand the purpose of WHO's family guidelines and tools.

- To be able to identify and apply medical eligibility criteria and practice recommendations for family planning service delivery.

- To know how to use family planning tools for service provision.
The need for evidence-based guidance

- To base family planning practices on the best available published evidence
- To address misconceptions regarding who can safely use contraception
- To reduce medical barriers
- To improve access and quality of care in family planning
WHO guidelines and tools

Medical Eligibility Criteria

Selected Practice Recommendations

The Medical Eligibility Criteria Wheel

Reproductive Choices and Family Planning for People with HIV

CIRE

Decision-Making Tool

Global Handbook

4th edition just published!

Guide to family planning for health care providers and their clients
Guidance developed through consensus

Expert Working Group meetings:

- Country experts
- Representatives of:
  - UNFPA
  - World Bank
  - IPPF
  - USAID
  - CDC
  - NICHD
  - Engender Health
  - FHI
  - JHU/CCP
  - JHPIEGO
  - Intra-Health
  - Georgetown University Medical Center
  - Management Sciences for Health
Medical eligibility criteria for contraceptive use (MEC)

Purpose: Who can safely use contraceptive methods?

- Fourth edition offers ≈ 1800 recommendations for 19 methods
- Available in English, French, Spanish, Arabic, Chinese, Turkish, Romanian, Portuguese, Laotian, Vietnamese, Mongolian
Classification of recommendations

Divided into four categories:

– **1** = a condition for which there is no restriction for the use of the contraceptive method,

– **2** = a condition where the advantages of using the method generally outweigh the theoretical or proven risks,

– **3** = a condition where the theoretical or proven risks usually outweigh the advantages of using the method,

– **4** = a condition which represents an unacceptable health risk if the contraceptive method is used.
Four categories can be simplified where resources for clinical judgement are limited:

- Woman *is* medically eligible to use the method (categories 1 & 2)
- Woman *is not* medically eligible to use the method (categories 3 & 4)

Initiation and continuation

- Where warranted, recommendations will differ if a woman is starting a method (I = initiation) or continuing a method (C = continuation)
  - Example: women with current PID are a category '4' for initiating a copper IUD, but a category '2' for if they are continuing to use an IUD.
- Unless noted, recommendations are the same for initiation and continuation of a method
Classification of recommendations - female and male surgical sterilization

Divided into four categories:

- **Accept 'A'** = There is no medical reason to deny sterilization to a person with this condition,
- **Caution 'C'** = The procedure is normally conducted in a routine setting, but with extra preparation and precautions,
- **Delay 'D'** = The procedure is delayed until the condition is evaluated and or corrected. Alternative temporary methods of contraception should be provided,
- **Special 'S'** = The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anaesthesia, and other back-up medical support. The capacity to decide the most appropriate procedure and anaesthesia regimen is needed. Alternative temporary methods of contraception should be provided, if referral is required or there is otherwise any delay.
<table>
<thead>
<tr>
<th>CONDITION</th>
<th>COC</th>
<th>CIC</th>
<th>P/R</th>
<th>POP</th>
<th>DMPA NET-EN</th>
<th>LNG/ETG Implants</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>BREAST DISEASE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Undiagnosed mass</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>b) Benign breast disease</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>c) Family history of cancer</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>d) Breast cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) current</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>(ii) past and no evidence of current disease for 5 years</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>ENDOMETRICAL CANCER</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>C</td>
</tr>
<tr>
<td>OVARIAN CANCER</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>C</td>
</tr>
<tr>
<td>UTERINE FIBROIDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Without distortion of the uterine cavity</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>b) With distortion of the uterine cavity</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>COC</th>
<th>CIC</th>
<th>P/R</th>
<th>POP</th>
<th>DMPA NET-EN</th>
<th>LNG/ETG Implants</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMOKING</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Age &lt; 35</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>b) Age ≥ 35</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) &lt;15 cigarettes/day</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>(ii) &gt;15 cigarettes/day</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Medical Eligibility Criteria for Contraceptive Use. WHO, Geneva, 2009)
Case study: which methods are safe?

- A 24 year old woman with a family history of breast cancer?
  - COC?
  - IUD?
  - Injectable?
  - Implants?

- A 38 year old woman who smokes less than 1/2 pack of cigarettes per day?
  - COC?
  - IUD?
  - Implants?
  - Injectable?
MEC Wheel

- Offers accessible MEC guidance for most commonly encountered medical conditions.

- Conditions that are either '1' or '2' on back of wheel.

- Locate condition of interest, then turn wheel to identify eligibility category.

- Available in many languages: English, French, Spanish, Chinese, Arabic, Mongolian, Azeri, Latvian, Lithuanian, Russian, Sri Lankan, Myanmar, Armenian, Nepali, Indonesian, Turkish, Burmese, Ukrainian, Khmer.
Electronic wheel demonstration

- Electronic wheel allows you to consult common conditions easily

Now, please click this link to open the electronic wheel:
http://www.who.int/reproductivehealth/publications/family_planning/wheel_v4_2010_EN.swf

Note: The electronic wheel was attached in this presentation with audio.
Selected practice recommendations for contraceptive use

Purpose: How to safely deliver contraceptive methods?

- First published in 2000, revised through expert meetings held in 2004 and 2008
- Second edition offers 33 practice recommendations
- Available in English, French, Spanish, Arabic, Chinese, Romanian, Portuguese, Russian, Vietnamese, Sri Lankan
Practice questions

Examples:

- when to start
- when to re-administer
- how to manage problems
  - missed pills
  - bleeding (progestogen-only methods and IUDs)
  - prophylactic antibiotics and IUD insertion
- what examinations and tests are required before starting a method
1. **When can a woman start combined oral contraceptives (COCs)?**

   Note: The woman may be provided with COCs in advance with appropriate instructions on pill initiation, provided she is medically eligible.

   **Having menstrual cycles**
   - She can start COCs within 5 days after the start of her menstrual bleeding. No additional contraceptive protection is needed.
   - She also can start COCs at any other time, if it is reasonably certain that she is not pregnant. If it has been more than 5 days since menstrual bleeding started, she will need to abstain from sex or use additional contraceptive protection for the next 7 days.

   **Amenorrhoeic**
   - She can start COCs at any time, if it is reasonably certain that she is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.

   **Postpartum (breastfeeding)**
   - If she is more than 6 months postpartum and amenorrhoeic, she can start COCs as advised for other amenorrhoeic women.
   - If she is more than 6 months postpartum and her menstrual cycles have returned, she can start COCs as advised for other women having menstrual cycles.

   *Additional guidance from the Medical eligibility criteria for contraceptive use. Third edition, 2004. Women less than 6 weeks postpartum who are primarily breastfeeding should not use COCs. For women who are more than 6 weeks but less than 6 months postpartum and are primarily breastfeeding, use of COCs is not usually recommended unless other more appropriate methods are not available or not acceptable.*

   **Postpartum (non-breastfeeding)**
   - If her menstrual cycles have not returned and she is 21 or more days postpartum, she can start COCs immediately, if it is reasonably certain that she is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.
# Routine exams or tests

<table>
<thead>
<tr>
<th>Exam or screening</th>
<th>Hormonal methods</th>
<th>IUD</th>
<th>Condoms / Spermicide</th>
<th>Female sterilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast exam</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Pelvic exam</td>
<td>C</td>
<td>A</td>
<td>C</td>
<td>A</td>
</tr>
<tr>
<td>Cervical cancer</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Routine lab tests</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>C</td>
<td>B</td>
<td>C</td>
<td>B</td>
</tr>
<tr>
<td>STI risk assessment</td>
<td>C</td>
<td>A</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>STI screening</td>
<td>C</td>
<td>B</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>**</td>
<td>C</td>
<td>C</td>
<td>A</td>
</tr>
</tbody>
</table>

**Class A:** essential and mandatory in all circumstances  
**Class B:** contributes substantially to safe and effective use  
**Class C:** does not contribute substantially to safe and effective use
Decision-making tool for family planning clients and providers

- A tool for providers and their clients. Contains evidence-based technical information
- Contains evidence-based technical information and a counseling process
- To be used with clients in the clinic
- Uses simple language
- Illustrations for clients
Improved counseling has the potential to:

**Increase:**
- Client satisfaction
- Provider satisfaction
- Correct use of methods
- Continuation of use

**Reduce:**
- Dropout from services
- Unnecessary health risks
- Method failure
- Unwanted pregnancy
Process for helping different types of clients

Welcome
Choosing a Method
Dual Protection
Special Needs
Returning Client
Appendices

Methods

DECISION-MAKING TOOL
for Family Planning Clients and Providers

A WHO FAMILY PLANNING CORNERSTONE

Department of Reproductive Health and Research
World Health Organization, Geneva

A Johns Hopkins Bloomberg School of Public Health Center for Communication Programs
A structured counselling process

Welcome client

Find out reason for visit

Go to correct tab

Tab

Tab

Tab

Tab

Method Tabs

Overview & information for choice

Medical eligibility criteria

Possible side-effects

How to use

When to start

What to remember

Note: Some method sections do not have all these pages.

Introduction for the Provider
Main points on a CLIENT PAGE

Decision-making question: client needs to respond and participate before going to next page

**Possible side-effects**

Many users will have side-effects. They are not usually signs of illness.

- But many women do not have any
- Often go away after a few months

**Most common:**

- Nausea (upset stomach)
- Spotting or bleeding between periods
- Mild headaches
- Tender breasts
- Slight weight gain or loss

*Do you want to try using this method and see how you like it?*
Main points on a PROVIDER PAGE

Possible side-effects

Many users will have side-effects. They are not usually signs of illness.
• But many women do not have any
• Often go away after a few months

Most common:
• Nausea (upset stomach)
• Spotting or bleeding between periods
• Mild headaches
• Tender breasts
• Slight weight gain or loss

Discuss:
• "It can take time for the body to adjust."
• Different people have different reactions to methods.
• About half of all users never have any side-effects.
• Side-effects often go away or lessen within 3 months.

"If these side-effects happened to you, what would you think or feel about it?"
"What would it mean to you?"
"What would you do?"
Discuss any rumours or concerns.
See Appendix 10 on myths.
"Please come back any time you want help or have questions."
"It is okay to switch methods any time."
For dealing with side-effects, see Returning Client tab.

Tell client: skipping pills may make bleeding side-effects worse and risks pregnancy.

Next move:
Does client understand side-effects? Is she ready to choose method?
If she has decided to use method, go to next page.
If not, discuss further or consider other methods.

Decision-making reminder

Provider’s information: questions, phrases, actions, reference information.

"Suggested words you might use."

Page numbering for each section.
Counseling Icons

- Ask if client has questions
- Offer support
- Check understanding
- Listen carefully
Choosing a method

Choosing Method (for new clients)

Ask client: Do you have a method in mind?

If method in mind:
Check if method suits needs and situation. Check dual protection needs.

If no method in mind:
Discuss needs and situation and review method options. Check dual protection needs.

Discuss options for dual protection.

Go to Method Tabs to confirm initial choice
Choosing a method:

Do you have a method in mind?

If you do, let’s talk about how well it suits your needs
- What have you heard about it?
- What do you like about it?

If not, we can find a method right for you

1. Focus on what she knows about the method
2. Check understanding of the method
3. Can also discuss other options

Important for choosing a method:
Do you need protection from pregnancy AND sexually transmitted infections?
Best practices in FP counseling:

1. Focus on needs and situation

You can find a method right for you

No method in mind? We can discuss:
- Your experiences with family planning
- What you have heard about family planning methods
- Your plans for having children
- Protection from sexually transmitted infections (STIs) or HIV/AIDS
- Your partner’s or family’s attitudes
- Other needs and concerns

2. Compare methods in light of needs and situation

Comparing methods

- Most effective and nothing to remember:
  - Fewer side-effects, permanent: Female sterilization, Vasectomy

- Very effective but must be carefully used:
  - Fewer side-effects: LAM
  - More side-effects: IUD, Implants

- Effective but must be carefully used:
  - Fewer side-effects: Male and female condom, Vaginal methods
  - More side-effects: Pills, Injectables

IMPORTANT! Only condoms protect against both pregnancy and STIs/HIV/AIDS
Dual Protection = Protection from pregnancy and STIs/HIV
Dual Protection

Do you have a method in mind?

If you do, let's talk about how it suits you
- What do you like about it?
- What have you heard about it?

If not, we can find a method that is right for you

Important for choosing a method:
Do you need protection from sexually transmitted infections (STIs) or HIV/AIDS?

Comparing methods

Copper IUD
- Small device that fits inside the womb
- Very effective
- Keeps working up to 10 years, depending on type
- We can remove it for you whenever you want
- Very safe
- Might increase menstrual bleeding or cramps
- No protection against STIs or HIV/AIDS

Do you want to know more about the IUD, or talk about a different method?
Clients with special needs

These pages help clients who may need special counselling or advice.

- Younger client...........................................go to next page (page SN2)
- Older client.................................................go to page SN3
- Pregnant/postpartum client......................go to page SN4
- Post-abortion client.................................go to page SN5
- Client living with HIV/AIDS.....................go to page SN6
- Client who wants to become pregnant.........go to page SN7

Next Move:

Go to correct page in this section.
Returning Clients

What method are you using?

- IUD .................. next page
- The Pill .................. page RC 4
- The Mini-Pill .................. page RC 6
- Long-Acting Injectable .................. page RC 8
- Monthly Injectable .................. page RC 10
- Implants .................. page RC 12
- Vasectomy or Female Sterilization .................. page RC 14
- Condoms (male or female) .................. page RC 15
- Vaginal Methods .................. page RC 17
- LAM .................. page RC 19
- Fertility Awareness-Based Methods .................. page RC 21

Next Move:

Go to the correct page to help returning client.
Returning Clients

Long-acting injectable return visit

How can I help?
- Are you happy using the injectable? Need next injection?
- Late for injection?
- Any questions or problems?

Let's check:
- For any new health conditions
- Need condoms too?

Next Move:
Continuing? Give injection. Remind client of date to return for next injection.
Help with problems? Go to next page.
Switching? Discuss other methods. Go to Choosing Methods tab.

Returning Client: long-acting injectable

Find the right page in the section (no tabs)
Returning client

Ask what method client is using:
*Go to method page*

No problems with method

Check for new health conditions. Check about need for STI protection.

Provide method

Problems using method?

Help manage side-effects

Switch method
Managing problems

Help using implants

Any questions or problems? We can help.

- Bleeding changes?
- Infection in the insertion site?
- Headaches?
- Others?

Happy to continue with implants, or want to switch methods?
Method Sections

Overview & information for choice

Medical eligibility criteria

Possible side effects

How to use

When to start

What to remember
For other less common conditions, need to check on providers page.

Medical eligibility criteria in the method section.
Appendices: extra counseling tools

13 appendices with additional tools and information for providers

Ruling out pregnancy:

1. Menstrual period started in the past 7 days?
2. Gave birth in the past 4 weeks?
3. Breastfeeding AND gave birth less than 6 months ago AND periods not returned?
4. Had miscarriage or abortion in the past 7 days?
5. No sex since your last period?
6. Been using another method correctly?

If ANY of these are true, you can start the method now.

The female reproductive system:

- Ovaries
- Fallopian tubes
- The womb lining (endometrium)
- The womb (uterus)
- Cervix
- Vagina
- Clitoris
Comparing effectiveness of methods

<table>
<thead>
<tr>
<th>Method</th>
<th>Frequency</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implants</td>
<td>One-time</td>
<td>Nothing to do or remember</td>
</tr>
<tr>
<td>Vasectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female Sterilization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injections</td>
<td>Need 3</td>
<td>Repeat injections every 1 to 3 months</td>
</tr>
<tr>
<td>Pill</td>
<td></td>
<td>Must take a pill each day</td>
</tr>
<tr>
<td>Male Condoms</td>
<td></td>
<td>Must follow LAM instructions</td>
</tr>
<tr>
<td>Diaphragm</td>
<td></td>
<td>Must use ever time you have sex</td>
</tr>
<tr>
<td>Female Condoms</td>
<td></td>
<td>Must use every time you have sex</td>
</tr>
</tbody>
</table>

8: Facts about STIs and HIV/AIDS

What is a sexually transmitted infection (STI)?

- An STI is a disease that can be spread from person to person by sexual contact.
- Some STIs can be transmitted by any sexual act that involves contact between the penis, vagina, anus, or mouth. For best protection, a couple should use condoms or avoid any sexual activity that involves skin-to-skin contact.
- STIs can cause symptoms, some causing no symptoms. Common symptoms include pain, itching, or burning when urinating, or bleeding from the penis, vulva, or rectum.
- Some common STIs can be treated and cured with antibiotics. These include gonorrhea, chlamydia, syphilis, and Hepatitis B. However, people should not use sexual activity until they are cured.
- Some cannot be cured, including hepatitis B, genital herpes, human papillomavirus (HPV), and HIV.

What is HIV and AIDS?

- HIV (Human Immunodeficiency Virus) is a virus that spreads in the blood, body fluids, and in semen and vaginal fluid of infected people. HIV can be transmitted:
  - by sexual contact (oral, anal, or vaginal; through body fluids)
  - by sharing needles or syringes

- AIDS (Acquired Immunodeficiency Syndrome) is characterized by certain signs and symptoms of disease. The immune system becomes weak, the body is unable to fight disease, and a person may die.

Testing, counselling, and treatment for HIV/AIDS:

- A person living with HIV is not contagious and their health is not affected. Many people with HIV do not know that they are carrying the virus.
- To prevent infections, use condoms or other methods of barrier protection, avoid sexual contact, and use injectable drugs responsibly.
- The only way to kill the virus in blood is to use bleach. Blood tests can detect HIV 6 weeks after the person has been exposed to the virus. Follow-up testing is needed before starting treatment.
- You may wish to begin treatment as soon as possible.
- A person living with HIV should consider treatment after consultation with healthcare providers and counselors.

Anyone at risk for STIs, including HIV, should use CONDOMS!
Reproductive Choices and Family Planning for People with HIV

- Two-day training and job aid – an adaptation of the Decision-Making Tool for Family Planning Clients and Providers
- Developed as part of Integrated Management of Adolescent and Adult Illness (IMAI) series
- Field tested in Uganda and Lesotho
- Developed in collaboration with the INFO Project at Johns Hopkins Bloomberg School of Public Health
- First edition published in 2006 and available on WHO website
Road map of this counseling tool

- **For all clients**
  - **Welcome and discussion topics:** You can have a healthy sexual life
  - **Assessment:** Questions for you
  - **Safer sex and living with HIV**

- **Not in a sexual relationship**
  - **Wants to prevent pregnancy**
    - You can use almost any method
    - Possible protection strategies:
      - Dual protection
    - Know the facts about condoms:
      - Dual protection
    - Comparing methods
    - Making a choice and a plan

- **Thinking about pregnancy**
  - What you need to know
  - Risk of infecting the baby
  - What to consider
  - Having a baby

- **Help using your method**
  - Male condom
  - Female condom
  - The Pill
  - Long-acting injectable
  - Emergency contraception
  - Lactational amenorrhoea method
  - Fertility awareness-based methods
  - Referral methods

- **Appendixes**
  - Appendix 1: Postpartum clients
  - Appendix 2: Tips for talking with your partner
  - Appendix 3: Making reasonably sure a woman is not pregnant
  - Appendix 4: Effectiveness chart
Safer sex and living with HIV

- Can still enjoy sexual intimacy
- There are ways to lower risk
- Some sexual activities are safer than others
Do you know your partner's HIV status?

Questions about sexual relationships:
- Does client know the HIV status of sex partner(s)?
- Does partner(s) know client’s HIV status?

If a partner's status is unknown:
- Discuss reasons that client's partner(s) should be tested for HIV.
  - Even if you are HIV positive, your partner may not be infected.
  - When both partners know their status, they can then know how best to protect themselves.
- When status is unknown, assume your partner is negative and needs protection from infection. Important to use condoms.

If a partner is HIV negative:
- Explain that it is common for a person who is HIV positive to have a partner who is HIV negative.
- HIV is not transmitted at every exposure, but HIV-negative partners are at a high risk of infection.
- Important to always use condoms or avoid penetrative sex.

If both you and your partner are HIV positive:
- If mutually faithful, the couple may choose not to use condoms and may choose another method for pregnancy protection.
- If not mutually faithful or faithfulness is uncertain, condoms should be used or penetrative sex avoided to prevent STIs.

Preparing to disclose HIV status
- Who to tell?
- When to tell?
- How to tell? Make a plan.
- What will you say? Practice with client.
- What will you say or do if…?
- If there is a risk of violence, discuss whether or not to disclose, or how to disclose with counsellor or friend present.

Next step: Discuss safer sex and living with HIV (go to next page).

How to use this page:
- Discuss HIV status of client and partner(s) so they can know how to best protect themselves.
- If client has not disclosed HIV status to partner, discuss benefits and risks of disclosure.
- Help client develop strategy for disclosure, if client is ready.
- Strongly encourage and help with partner testing and counselling.
Family Planning: A Global Handbook for Providers

- Reference guide for family planning providers & summarizes WHO family planning guidance
- Launched in October 2007, updated in 2011
- Over 100,000 copies distributed
- Published by the INFO Project at the Johns Hopkins Bloomberg School of Public Health. Endorsed by nearly 50 organizations
Contents: Method chapters

- Combined oral contraceptives (COCs)
  - Patch
  - Vaginal Ring
- Combined injectable contraceptives (CICs)
- Emergency contraceptive pills
- Progestogen-only pills
- Progestogen-only injectables
- Implants
- Copper-bearing IUD
  - LNG-IUD
- Vasectomy
- Female sterilization
- Lactational amenorrhea method
- Fertility awareness-based methods
  - Withdrawal
- Condom
- Female condom
- Spermicides/diaphragm
Chapter Headings

- Key points
- Helping the Client Decide about Combined Oral Contraceptives (COCs)
- Side effects, health benefits, and risks
  - COCs and cancer
- Who can and cannot use combined oral contraceptives
  - Medical eligibility criteria
- Providing combined oral contraceptives
- Following up users of combined oral contraceptives
- Questions and Answers
Progestin-Only Injectables

Key Points for Providers and Clients

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

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

- Injection can be as much as 2 weeks early or late. Client should come back even if later.

- Gradual weight gain is common.

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

What Are Progestin-Only Injectables?

- The injectable contraceptives depot medroxyprogesterone acetate (DMPA) and norethisterone enanthate (NET-EN) each contain a progestin like the natural hormone progesterone in a woman’s body. (In contrast, monthly injectables contain both estrogen and progestin. See Monthly Injectables, p. 81.)

- Do not contain estrogen, and so can be used throughout breastfeeding and by women who cannot use methods with estrogen.

- DMPA, the most widely used progestin-only injectable, is also known as “the shot,” “the jab,” “the injection,” Depo, Depo-Provera, Megestron, and Pratex.

- NET-EN is also known as norethindrone enanthate, Noristerat, and Syngestral. (See Comparing Injectables, p. 359, for differences between DMPA and NET-EN.)
How Effective?

Effectiveness depends on getting injections regularly; Risk of pregnancy is greatest when a woman misses an injection.

- As commonly used, about 3 pregnancies per 100 women using progestin-only injectables over the first year. This means that 97 of every 100 women using injectables will not become pregnant.
- When women have injections on time, less than 1 pregnancy per 100 women using progestin-only injectables over the first year (3 per 1,000 women).

Return of fertility after injections are stopped: An average of about 4 months longer for DMPA and 1 month longer for NET-EN than with most other methods (see Question 7, p. 79).

Protection against sexually transmitted infections (STIs): None

Side Effects, Health Benefits, and Health Risks

Side Effects (see Managing Any Problems, p. 75)

Some users report the following:

- Changes in bleeding patterns including, with DMPA:
  - First 3 months:
    - Irregular bleeding
    - Prolonged bleeding
  - At one year:
    - No monthly bleeding
    - Infrequent bleeding
    - Irregular bleeding
- NET-EN affects bleeding patterns less than DMPA. NET-EN users have fewer days of bleeding in the first 6 months and are less likely to have no monthly bleeding after one year than DMPA users.
- Weight gain (see Question 4, p. 78)
- Headaches
- Dizziness
- Abdominal bloating and discomfort
- Mood changes
- Less sex drive

Other possible physical changes:
- Loss of bone density (see Question 10, p. 80)

Why Some Women Say They Like Progestin-Only Injectables

- Do not require daily action
- Do not interfere with sex
- Are private: No one else can tell that a woman is using contraception
- Cause no monthly bleeding (for many women)
- May help women to gain weight
**Known Health Benefits**

**DMPA**
- Helps protect against:
  - Risks of pregnancy
  - Cancer of the lining of the uterus (endometrial cancer)
  - Uterine fibroids
  - May help protect against:
    - Symptomatic pelvic inflammatory disease
    - Iron-deficiency anemia
- Reduces:
  - Sickle cell crises among women with sickle cell anemia
  - Symptoms of endometriosis (pelvic pain, irregular bleeding)

**NET-EN**
- Helps protect against:
  - Iron-deficiency anemia

NET-EN may offer many of the same health benefits as DMPA, but this list of benefits includes only those for which there is available research evidence.

**Correcting Misunderstandings** (see also Questions and Answers, p. 78)

- Progestin-only injectables:
  - Can stop monthly bleeding, but this is not harmful. It is similar to not having monthly bleeding during pregnancy. Blood is not building up inside the woman.
  - Do not disrupt an existing pregnancy.
  - Do not make women infertile.

---

**New Formulation of DMPA**

A formulation of DMPA has been developed specifically for injection into the tissue just under the skin (subcutaneously). This new formulation must be delivered by subcutaneous injection. It will not be completely effective if injected in other ways. (Likewise, DMPA for injection into the muscle must not be injected subcutaneously.)

The hormonal dose of the new subcutaneous formulation (DMPA-SC) is 30% less than for DMPA formulated for injection into the muscle—104 mg instead of 150 mg. Thus, it may cause fewer side effects, such as weight gain. Contraceptive effectiveness is similar. Like users of intramuscular DMPA, users of DMPA-SC have an injection every 3 months.

DMPA-SC will be available in prefilled syringes, including the single-use Uniject system. These prefilled syringes will have special short needles meant for subcutaneous injection. With these syringes, women could inject DMPA themselves. DMPA-SC was approved by the United States Food and Drug Administration in December 2004 under the name “depo-subQ provera 104.” It has since also been approved in the United Kingdom.
New Problems That May Require Switching Methods

May or may not be due to the method.

Migraine headaches (see Identifying Migraine Headaches and Auras, p. 360)
- If she has migraine headaches without aura, she can continue to use the method if she wishes.
- If she has migraine aura, do not give the injection. Help her choose a method without hormones.

Unexplained vaginal bleeding (that suggests a medical condition not related to the method)
- Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate.
- If no cause of bleeding can be found, consider stopping progestin-only injectables to make diagnosis easier. Provide another method of her choice to use until the condition is evaluated and treated (not implants or a copper-bearing or hormonal IUD).
- If bleeding is caused by sexually transmitted infection or pelvic inflammatory disease, she can continue using progestin-only injectables during treatment.

Certain serious health conditions (suspected blocked or narrowed arteries, liver disease, severe high blood pressure, blood clots in deep veins of legs or lungs, stroke, breast cancer, or damage to arteries, vision, kidneys, or nervous system caused by diabetes). See Signs and Symptoms of Serious Health Conditions, p. 320.
- Do not give next injection.
- Give her a backup method to use until the condition is evaluated.
- Refer for diagnosis and care if not already under care.

Suspected pregnancy
- Assess for pregnancy.
- Stop injections if pregnancy is confirmed.
- There are no known risks to a fetus conceived while a woman is using injectables (see Question 11, p. 80).

Questions and Answers About Progestin-Only Injectables

1. Can women who could get sexually transmitted infections (STIs) use progestin-only injectables?
   Yes. Women at risk for STIs can use progestin-only injectables. The few studies available have found that women using DMPA were more likely to acquire chlamydia than women not using hormonal contraception. The reason for this difference is not known. There are few studies available on use of NET-EN and STIs. Like anyone else at risk for STIs, a user of progestin-only injectables who may be at risk for STIs should be advised to use condoms correctly every time she has sex. Consistent and correct condom use will reduce her risk of becoming infected if she is exposed to an STI.

2. If a woman does not have monthly bleeding while using progestin-only injectables, does this mean that she is pregnant?
   Probably not, especially if she is breastfeeding. Eventually most women using progestin-only injectables will not have monthly bleeding. If she has been getting her injections on time, she is probably not pregnant and can keep using injectables. If she is still worried after being reassured, she can be offered a pregnancy test, if available, or referred for one. If not having monthly bleeding bothers her, switching to another method may help.

3. Can a woman who is breastfeeding safely use progestin-only injectables?
   Yes. This is a good choice for a breastfeeding mother who wants a hormonal method. Progestin-only injectables are safe for both the mother and the baby starting as early as 6 weeks after childbirth. They do not affect milk production.

4. How much weight do women gain when they use progestin-only injectables?
   Women gain an average of 1–2 kg per year when using DMPA. Some of the weight increase may be the usual weight gain as people age. Some women, particularly overweight adolescents, have gained much more than 1–2 kg per year. At the same time, some users of progestin-only injectables lose weight or have no significant change in weight. Asian women in particular do not tend to gain weight when using DMPA.

5. Do DMPA and NET-EN cause abortion?
   No. Research on progestin-only injectables finds that they do not disrupt an existing pregnancy. They should not be used to try to cause an abortion. They will not do so.
For more information

- Contact: reproductivehealth@who.int