Training Course in Sexual and Reproductive Health Research
Geneva 2015

How to use WHO's family planning guidelines and tools

Mary Lyn Gaffield, Human Reproduction Team, World Health Organization

Learning objectives

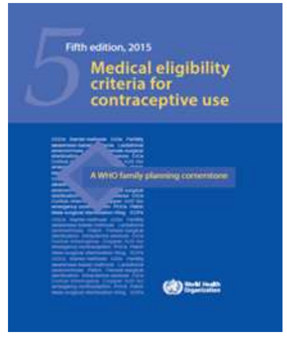
- To understand the purpose of WHO's family guidelines and tools.
- To be able to identify and apply medical eligibility criteria and practice recommendations for family planning service delivery.
- To know how to use family planning tools for service provision.

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

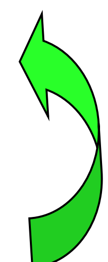
WHO guidelines and tools

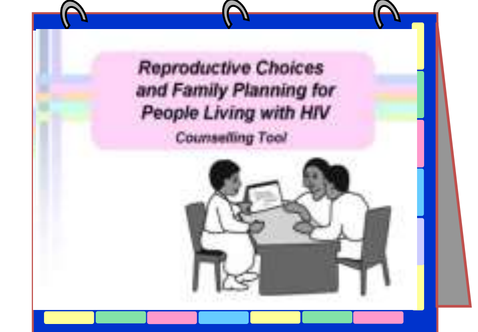
Medical Eligibility Criteria



The 2015 Medical Eligibility Criteria Wheel

5th edition just published!



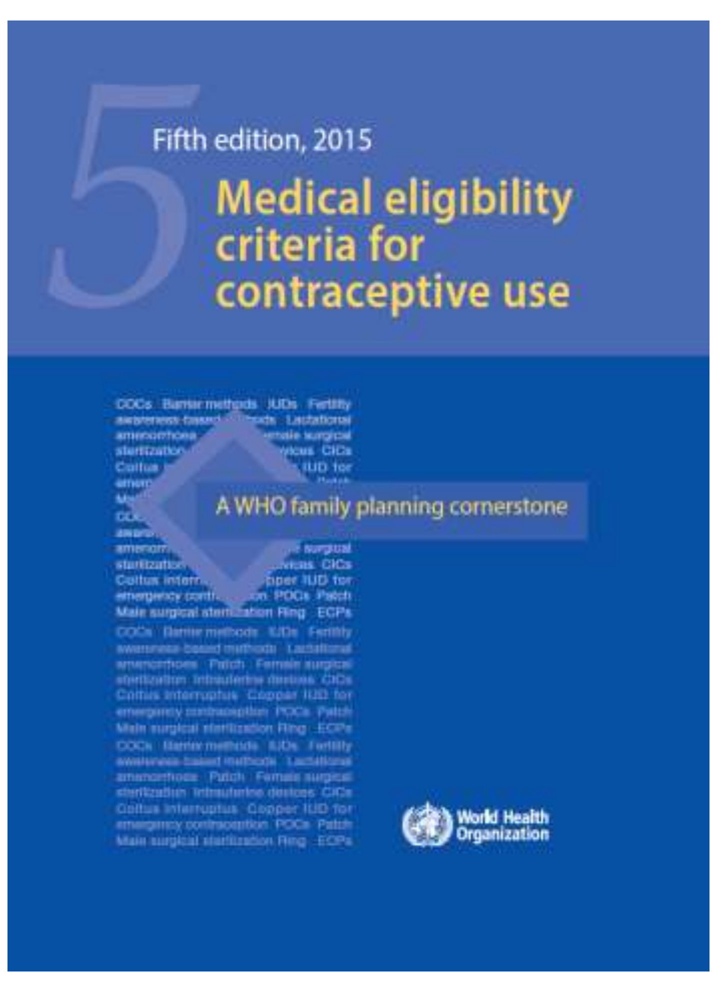


Reproductive Choices and Family Planning for People with HIV

Global Handbook

Guide to family planning for health care providers and their clients

Medical eligibility criteria for contraceptive use (MEC)



Purpose: **Who can safely use contraceptive methods?**

- First published in 1996, revised through expert meetings held in 2000, 2003, 2008 and 2014
- Fifth edition offers ≈ 2000 recommendations for 25 methods
- Available in English; available soon in French, Spanish, and Portuguese. WHO will facilitate other language translations.

MEC 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

Where warranted, recommendations will differ if a woman is starting a method (I = initiation) or continuing a method (C = continuation)

CATEGORY	WITH CLINICAL JUDGEMENT	WITH LIMITED CLINICAL JUDGEMENT
1	Use method in any circumstances	**Yes** (Use the method)
2	Generally use the method	
3	Use of method not usually recommended unless other more appropriate methods are not available or not acceptable	**No** (Do not use the method)
4	Method not to be used	

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 conduced 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.

Clarifications

- Clarification of the classification, in cases where the number itself does not adequately communicate the essence of the recommendation
  - Appears in the right hand column of the MEC document
  - Responsibility of guideline development group

Presentation of recommendations: an example

SUMMARY TABLE							
	COC//P/CVR	CIC	POP	DMPA/NET-EN	LNG/ETG/ IMPLANTS	CU-IUD	LNG-IUD
OBESITY							
a) ≥ 30 kg/m^2 BMI	2	2	1	1	1	1	1
b) Menarche to < 18 years and ≥ 30 kg/m^2 BMI	2	2	1	2[a]	1	1	1

Source: Medical Eligibility Criteria for Contraceptive Use. WHO: Geneva, 2015.

Presentation of recommendations – another example

SUMMARY TABLE							
	COC//P/CVR	CIC	POP	DMPA/NET-EN	LNG/ETG/ IMPLANTS	CU-IUD	LNG-IUD
ENDOCRINE CONDITIONS							
DIABETES							
a) History of gestational disease	1	1	1	1	1	1	1
b) Non-vascular disease							
i) non-insulin-dependent	2	2	2	2	2	1	2
ii) insulin-dependent	2	2	2	2	2	1	2
c) Nephropathy/retinopathy/ neuropathy	3/4[a]	3/4[a]	2	3	2	1	2
d) Other vascular disease or diabetes of > 20 years' duration	3/4[a]	3/4[a]	2	3	2	1	2

Source: Medical Eligibility Criteria for Contraceptive Use. WHO: Geneva, 2015.

Case study: which methods can be used ?

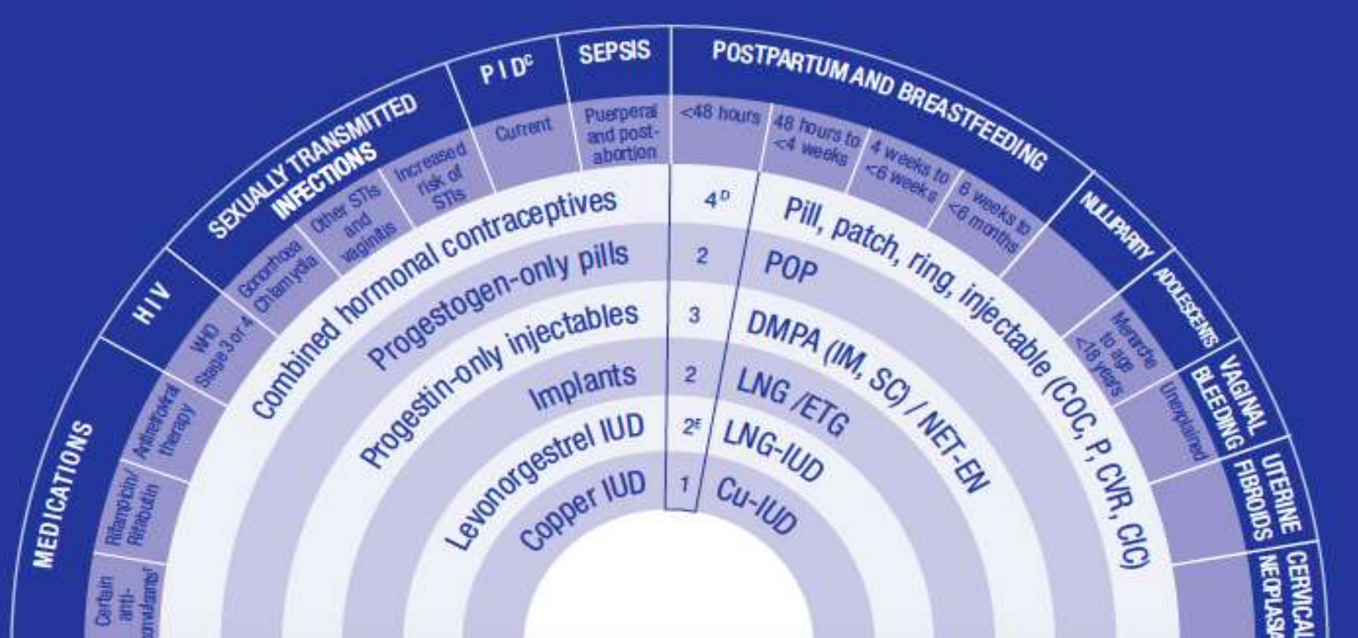
- A 24 year old woman with a body mass index greater than 30 kg/m^2 ?
  - COC ?
  - IUD ?
  - Injectable ?
  - Implants ?

- A 38 year old woman who with diabetes for more than 20 years ?
  - COC ?
  - IUD ?
  - Implants ?
  - Injectable ?

WHO

MEDICAL ELIGIBILITY CRITERIA WHEEL FOR CONTRACEPTIVE USE

2015



MEC Wheel

- Offers accessible MEC guidance for most commonly encountered medical conditions.
- Recommendations available numerous methods
  - Combined methods (pills, the patch, the vaginal ring, combined injectable)
  - Progestogen-only methods (injectable [DMPA IM & subcutanesou, NET-EN], implants, pills)
  - Copper-bearing IUD
  - LNG-releasing IUD
- Conditions that are either '1' or '2‘, appear on back of wheel.
- Additional explanations for certain recommendaitons apear on the back of wheel
- Locate condition of interest, then turn wheel to identify eligibility category.

A	If condition develops while using method, can continue using it during treatment.
B	If very high likelihood of exposure to gonorrhoea or chlamydia =3.
C	If past pelvic inflammatory disease (PID) all methods =1, including IUDs.
D	If <3 wks, not breastfeeding & no other VTE risk factors =3.
E	If not breastfeeding =1.
F	If 3 to <6 wks, not breastfeeding & no other VTE risk factors =2, with other VTE risk factors =3.
G	If ≥6 wks & not breastfeeding =1.
H	If uterine cavity distorted preventing insertion =4.
I	Refers to hepatocellular adenoma (benign) or carcinoma/ hepatoma (malignant).
J	If adenoma CIC =3, if carcinoma/hepatoma CIC =3/4.
K	CIC =3.
L	If established on anticoagulation therapy =2.
M	If condition developed while on this method, consider switching to non-hormonal method.
N	Risk factors: older age, smoking, diabetes, hypertension, obesity & known dyslipidaemias.
O	If cannot measure blood pressure & no known history of hypertension, can use all methods. Either systolic or diastolic blood pressure may be elevated.
P	If age <18 yrs & obese DMPA/NET-EN =2.
Q	For insulin-dependent & non-insulin-dependent. If complicated or >20 yrs duration, COC/P/CVR, CIC =3/4; DMPA, NET-EN =3.
R	If <15 cigarettes/day CIC =2. If ≥15 cigarettes/day COC/P/CVR =4.
S	Aura is focal neurological symptoms, such as flickering lights. If no aura & age <35 COC/P/CVR, CIC =2, POP =1. If no aura & age ≥35 COC/P/CVR, CIC =3, POP =1.
T	Barbituates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate & lamotrigine.
U	If barbituates, carbamazepine, oxcarbazepine, phenytoin, primidone or topiramate CIC =2.
V	If lamotrigine =1.
W	DMPA =1, NET-EN =2.
X	CICs =2.
Y	If antiretroviral therapy with EFV, NVP, ATV/r, LPV/r, DRV/r, RTV: COC/P/CVR, CIC, POP, NET-ET, Implants =2; DMPA =1. For all NRTIs, ETR, RPV, RAL each method =1. See jacket for full names of medications.
Z	If WHO Stage 3 or 4 (severe or advanced HIV clinical disease) IUD =3.

Conditions that are category 1 and 2 for all methods (method can be used)

Reproductive Conditions: Benign breast disease or undiagnosed mass • Benign ovarian tumours, including cysts • Dysmenorrhoea • Endometriosis • History of gestational diabetes • History of high blood pressure during pregnancy • History of pelvic surgery, including caesarean delivery • Irregular, heavy or prolonged menstrual bleeding (explained) • Past ectopic pregnancy • Past pelvic inflammatory disease • Post-abortion (no sepsis) • Postpartum ≥ 6 months

Medical Conditions: Depression • Epilepsy • HIV asymptomatic or mild clinical disease (WHO Stage 1 or 2) • Iron-deficiency anaemia, sickle-cell disease and thalassaemia • Malaria • Mild cirrhosis • Schistosomiasis (bilharzia) • Superficial venous disorders, including varicose veins • Thyroid disorders • Tuberculosis (non-pelvic) • Uncomplicated valvular heart disease • Viral hepatitis (carrier or chronic)

Other: Adolescents • Breast cancer family history • Venous thromboembolism (VTE) family history • High risk for HIV • Surgery without prolonged immobilization • Taking antibiotics (excluding rifampicin/rifabutin)

With few exceptions, all women can safely use emergency contraception, barrier and behavioural methods of contraception, including lactational amenorrhoea method; for the complete list of recommendations, please see the full document.

"Combined" is a combination of ethinyl estradiol & a progestogen.

CIC: combined injectable contraceptive **COC**: combined oral contraceptive pill
Cu-IUD: copper intrauterine device **CVR**: combined contraceptive vaginal ring
DMPA (IM, SC): depot medroxyprogesterone acetate, intramuscular or subcutaneous
ETG: etonogestrel **LNG**: levonorgestrel **LNG-IUD**: levonorgestrel intrauterine device
NET-EN: norethisterone enanthate **P**: combined contraceptive patch
POP: progestogen-only pill

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

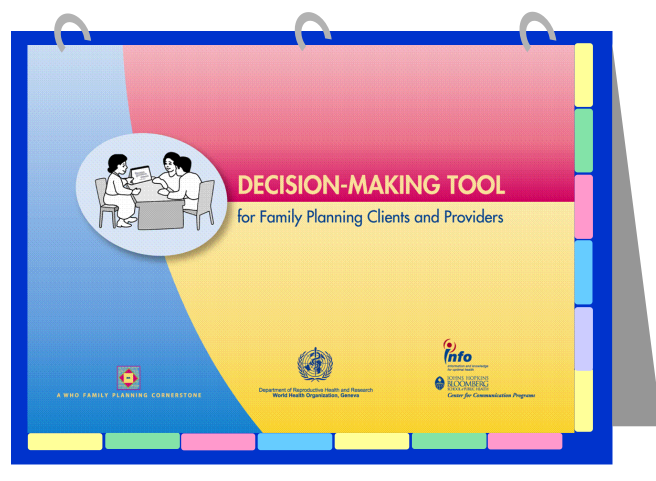
Exam or screening	Hormonal methods	IUD	Condoms / Spermicide	Female sterilization
Breast exam	C	C	C	C
Pelvic exam	C	A	C	A
Cervical cancer	C	C	C	C
Routine lab tests	C	C	C	C
Hemoglobin	C	B	C	B
STI risk assessment	C	A	C	C
STI screening	C	B	C	C
Blood pressure	**	C	C	A

Class A: essential and mandatory in all circumstances

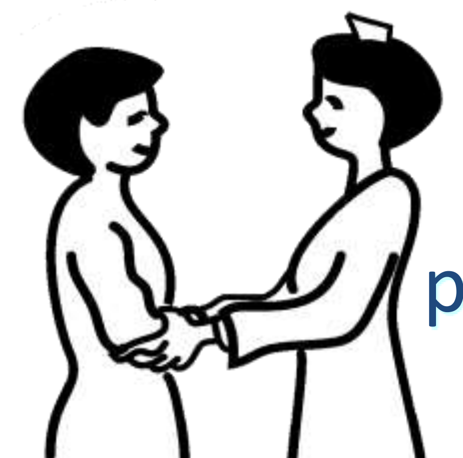
Class B: contributes substantially to safe and effective use

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

DECISION-MAKING TOOL

for Family Planning Clients and Providers

A WHO FAMILY PLANNING CORNERSTONE

Department of Reproductive Health and Research
World Health Organization, Geneva

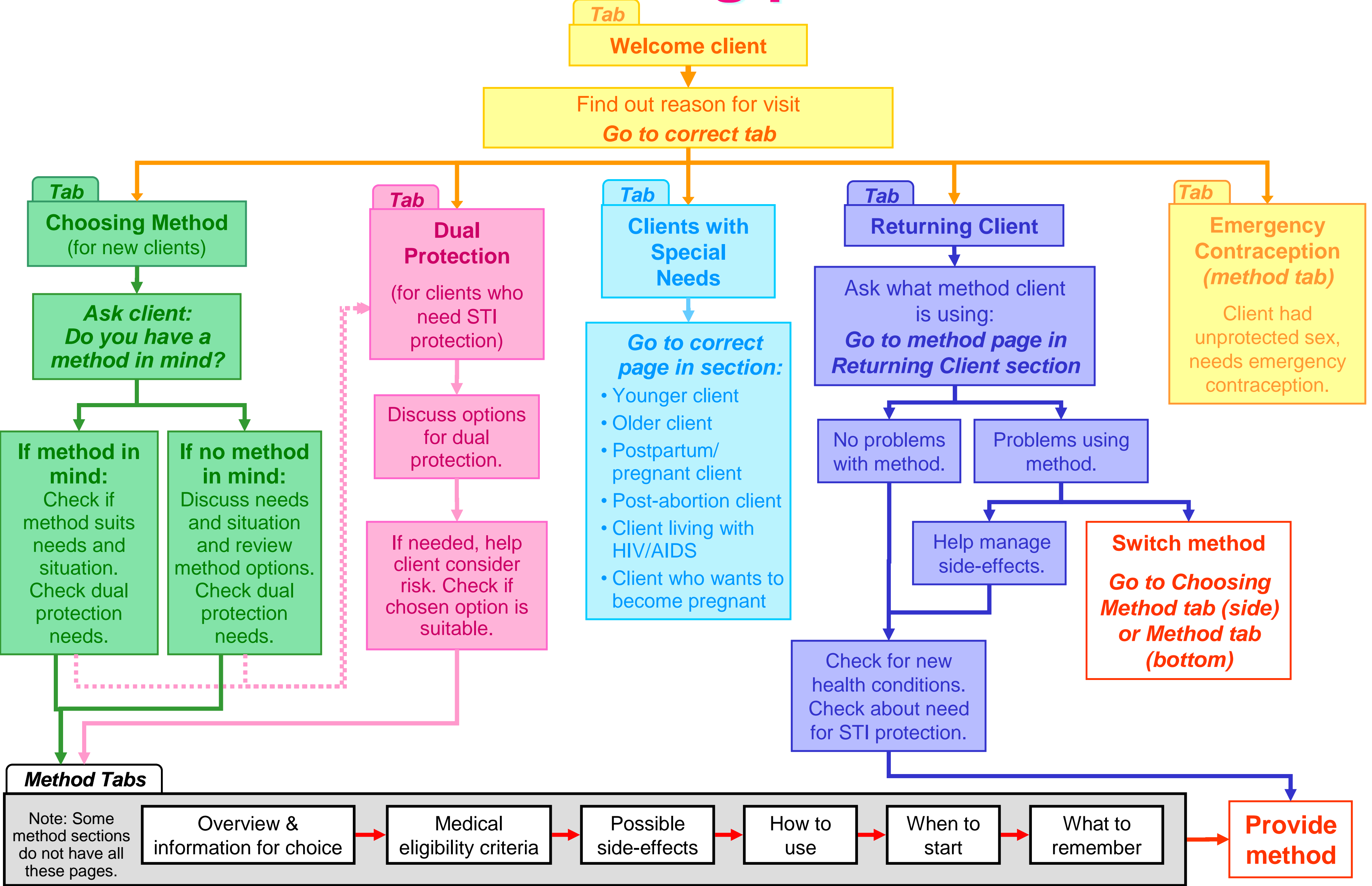
Info
JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH
Center for Communication Programs

- Welcome
- Choosing a Method
- Dual Protection
- Special Needs
- Returning Client
- Appendices

EC	IUD	Pill	Mini Pill	Inject	Mon Inject	Impl	Vase	Steril	Cond	FemC ond	Vag Meth	LAM	FAB

Methods

A structured counselling process



Main points on a CLIENT PAGE

Most important points for client

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

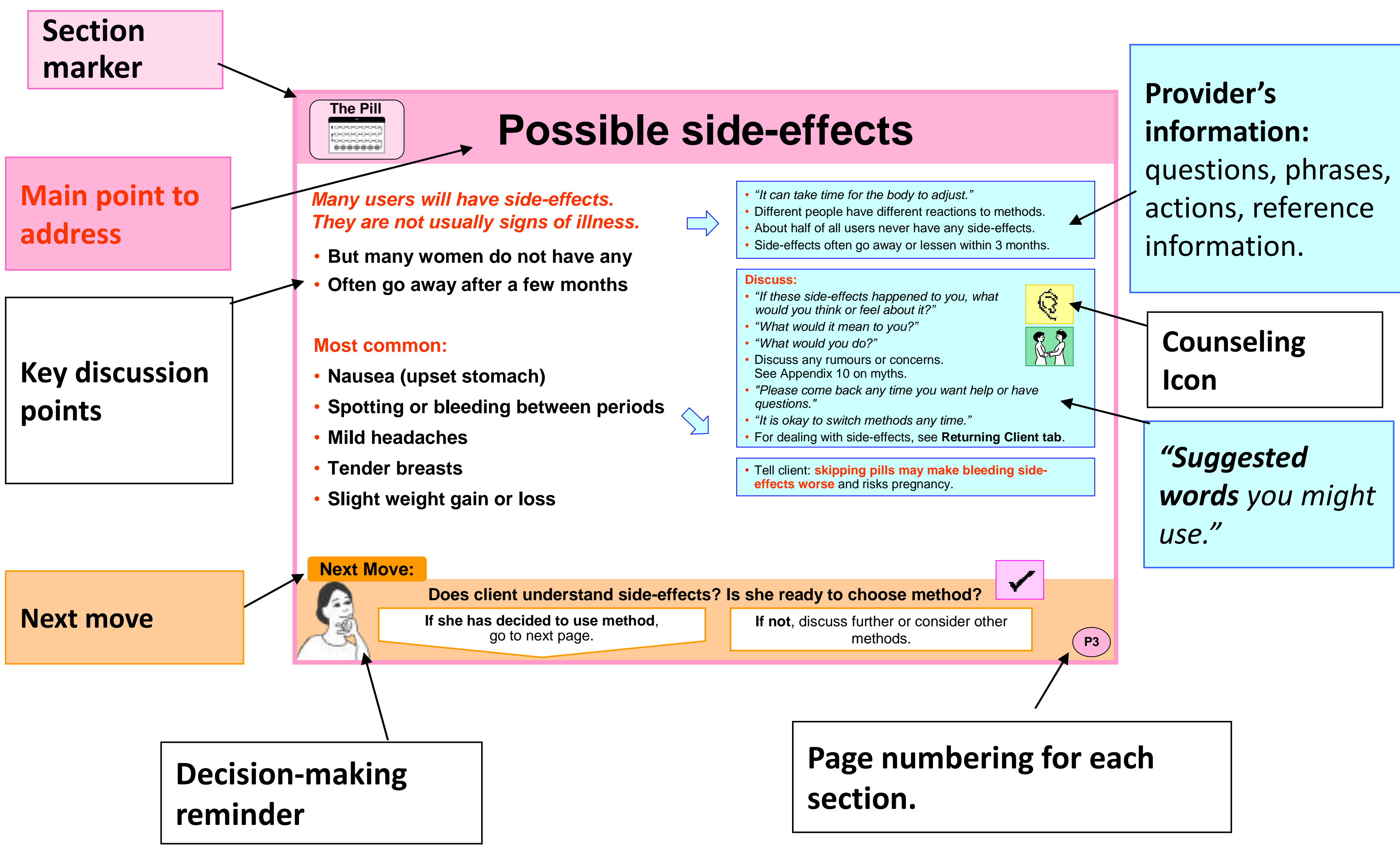
Most common:

- 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?

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

Main points on a PROVIDER PAGE



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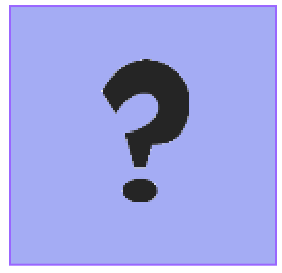
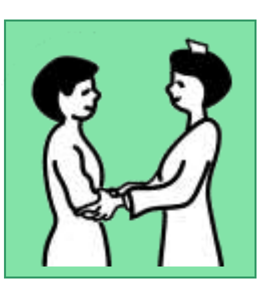
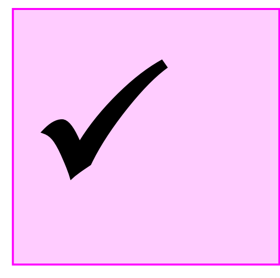
Counseling Icons



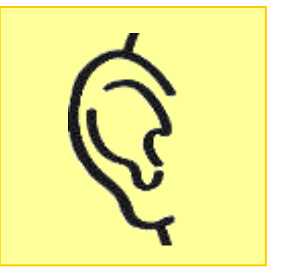
Ask if client has questions



Offer support



Check understanding



Listen carefully

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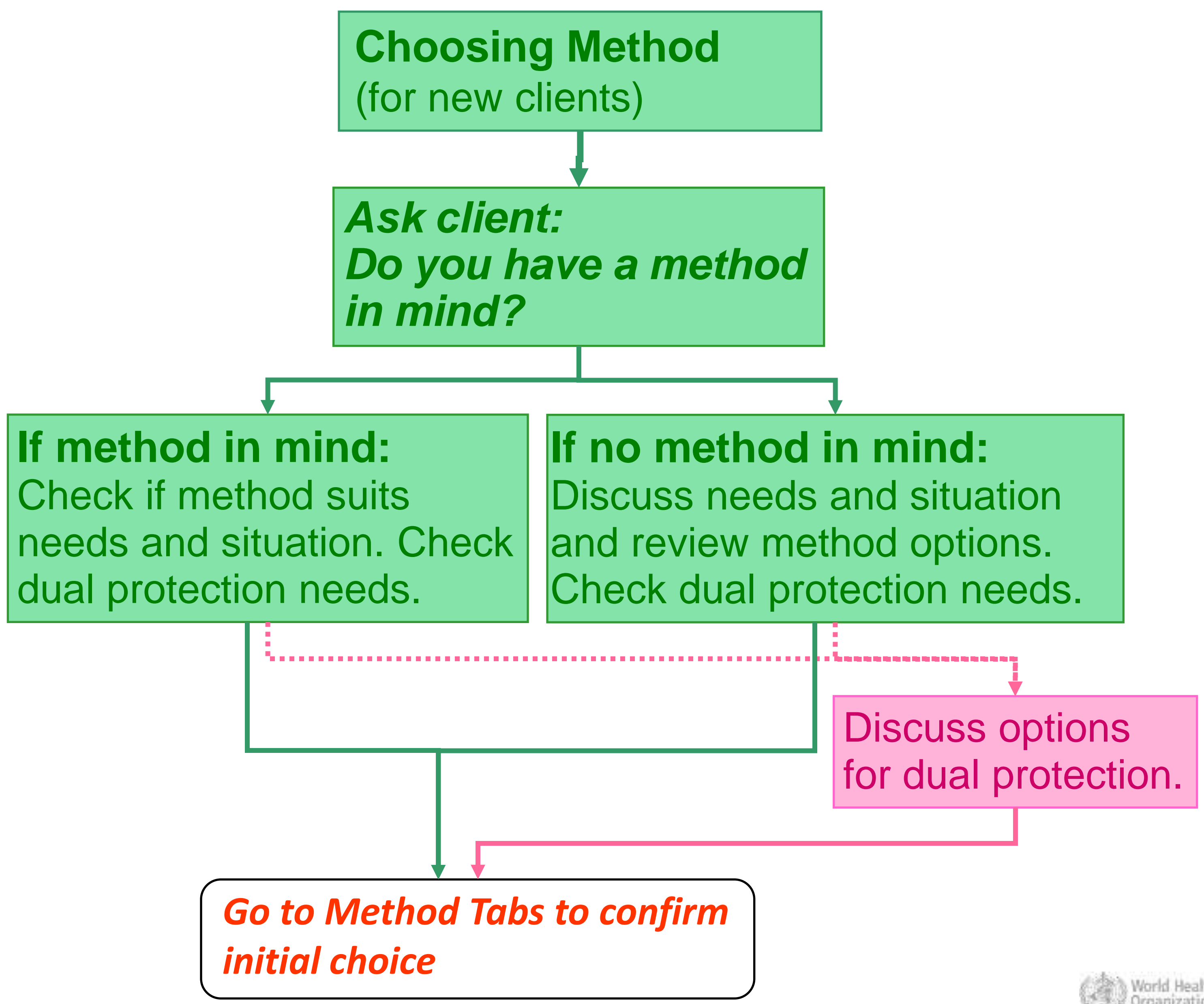
Choosing a method



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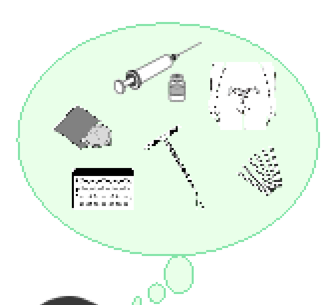
Choosing a method:

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

Important for choosing a method:

*Do you need protection from pregnancy **AND** sexually transmitted infections?*

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

Best practices in FP counseling:

1. Focus on needs and situation

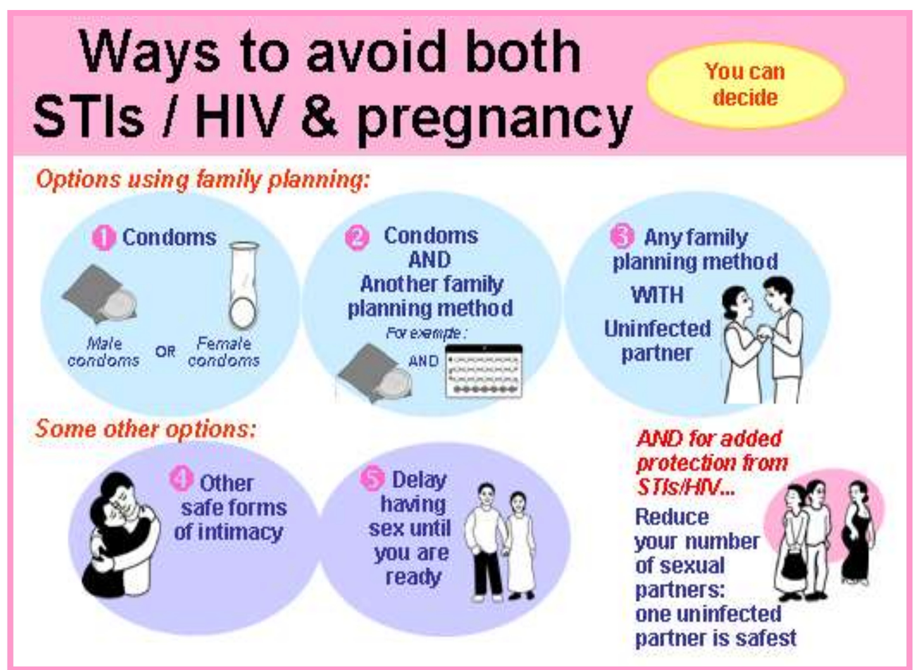
2. Compare methods in light of needs and situation

Comparing methods

Most effective and nothing to remember.	Very effective but must be carefully used.	Effective but must be carefully used.
Fewer side-effects, permanent: Female sterilization, Vasectomy	*Fewer side-effects:* LAM	*Fewer side-effects:* Male and female condom, Vaginal methods, Fertility awareness-based methods
More side-effects: IUD, Implants	*More side-effects:* Pills, Injectables	

IMPORTANT! Only condoms protect against both pregnancy and STIs/HIV/AIDS

Dual Protection



Dual Protection = Protection from pregnancy and STIs/HIV

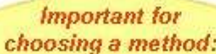
Dual Protection

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?

Part of the decision-making process

Comparing methods

Most effective and nothing to remember.	Very effective but must be carefully used.	Effective but must be carefully used.
Fewer side-effects, permanent: Female sterilization, Vasectomy	*Fewer side-effects:* LAM	*Fewer side-effects:* Male and female condom, Vaginal methods, Fertility awareness-based methods
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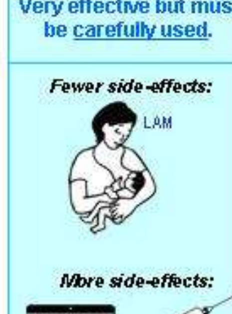
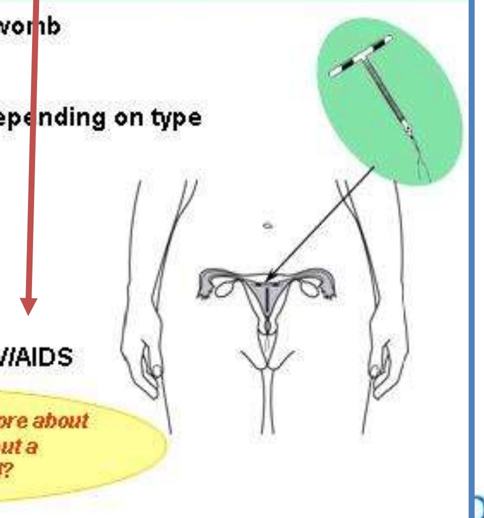


IMPORTANT! Only condoms protect against both pregnancy and STIs/HIV/AIDS

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?

Special Needs

Special needs

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.

SN 1

Returning Clients

Returning Client

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

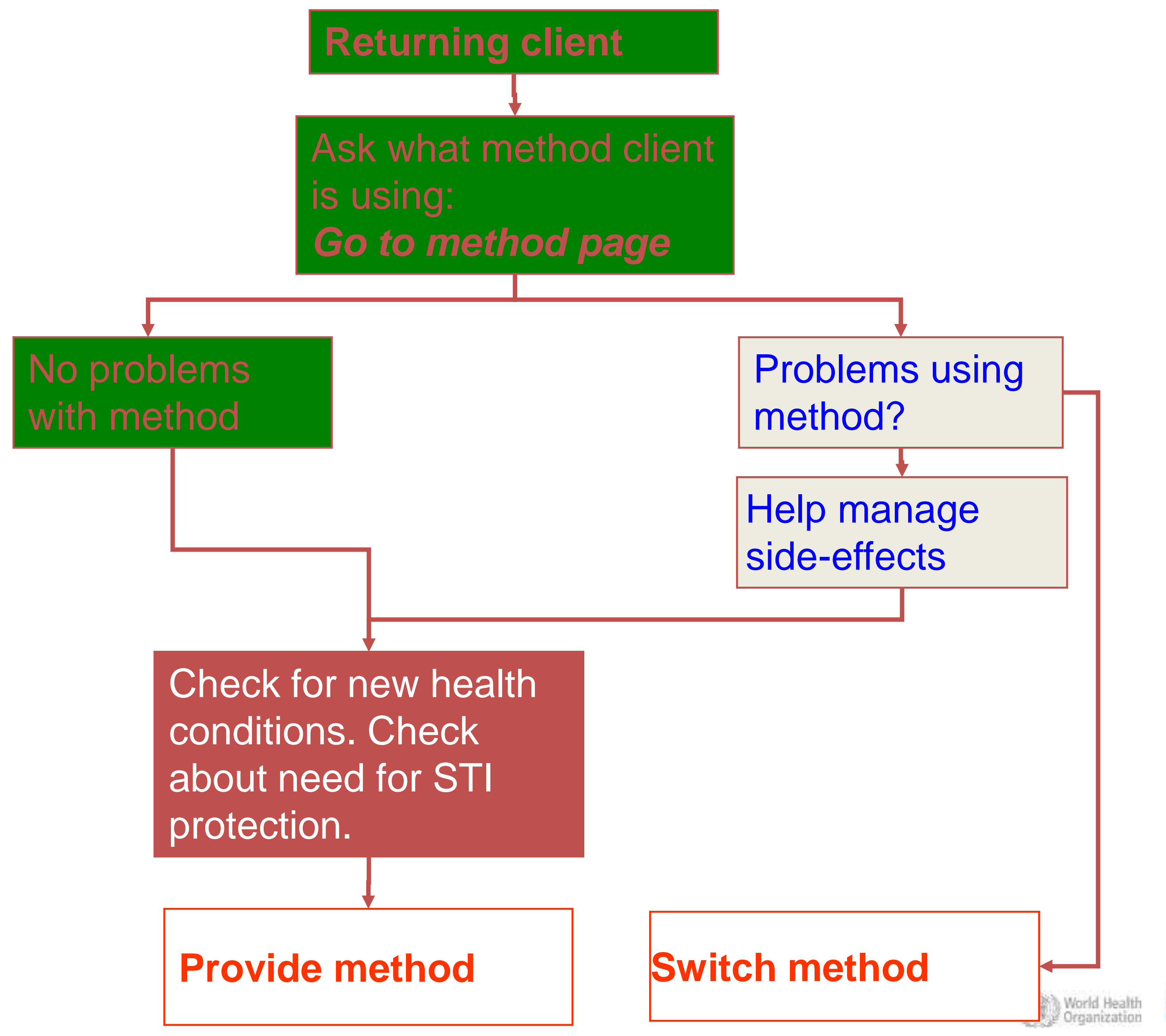
LAM..........................page RC 19

Fertility Awareness-Based Methods............page RC 21

Next Move:

Go to the correct page to help returning client.

TAB: Returning Client


Returning client
Ask what method client is using:
Go to method page
No problems with method
Problems using method?
Help manage side-effects
Check for new health conditions. Check about need for STI protection.
Provide method
Switch method
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Returning Clients

Long-acting Injectable

Long-acting injectable return visit

How can I help?

- **Are you happy using the injectable? Need next injection?**
  - If client is satisfied, check for any new health conditions before giving repeat injection. See below.
  - *Remember to use safe injection procedures!* (see Long-acting Injectable tab page LI5).
- **Late for injection?**
  - Up to 2 weeks late: can have injection without need for extra protection.
  - More than 2 weeks late: she can have next injection if reasonably certain she is not pregnant (for example, she has not had sex since intended injection date). She should use condoms or avoid sex for 7 days after injection. Consider emergency contraception if she had sex after the 2 week "grace period."
  - Discuss how she can remember next time.
- **Any questions or problems?**
  - To help manage side-effects and other problems, go to next page.
  - Wants to switch methods?
    "It's okay to change methods if that's what you decide."
  - Wants to stop family planning? Discuss reasons, consequences, next steps.

Let's check:

- **For any new health conditions**
  - Client should usually stop long-acting injectables and choose another method if:
  - she has developed high blood pressure;
  - she has developed migraines that affect her vision, speech or movement;
  - she reports certain other new health conditions or problems (see list in Long-acting Injectable tab page LI2).
- **Need condoms too?**
  - Check how client is preventing STIs/HIV/AIDS. If not protected, go to Dual Protection tab. Give condoms if needed.

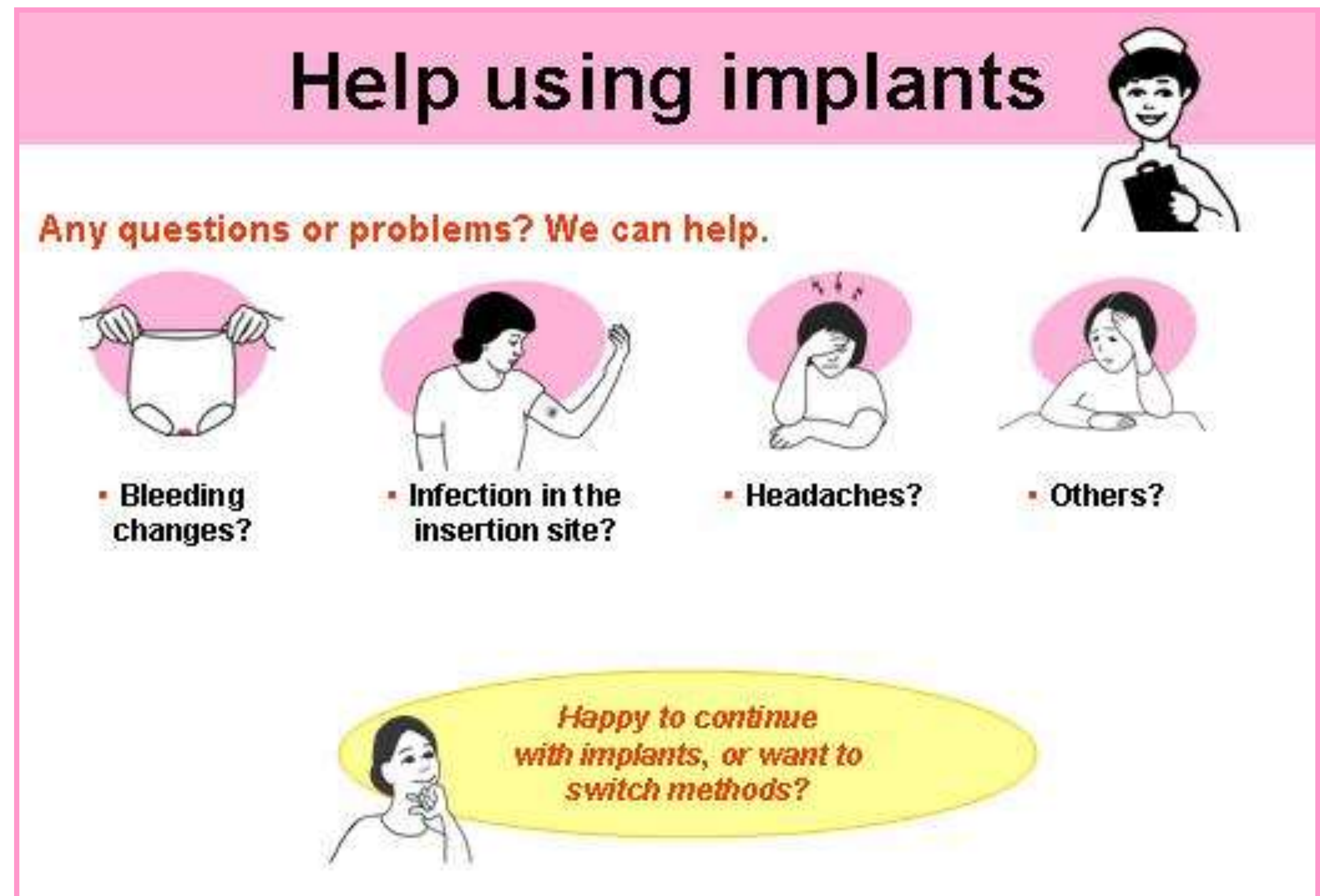
Next Move:

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 Method tab.

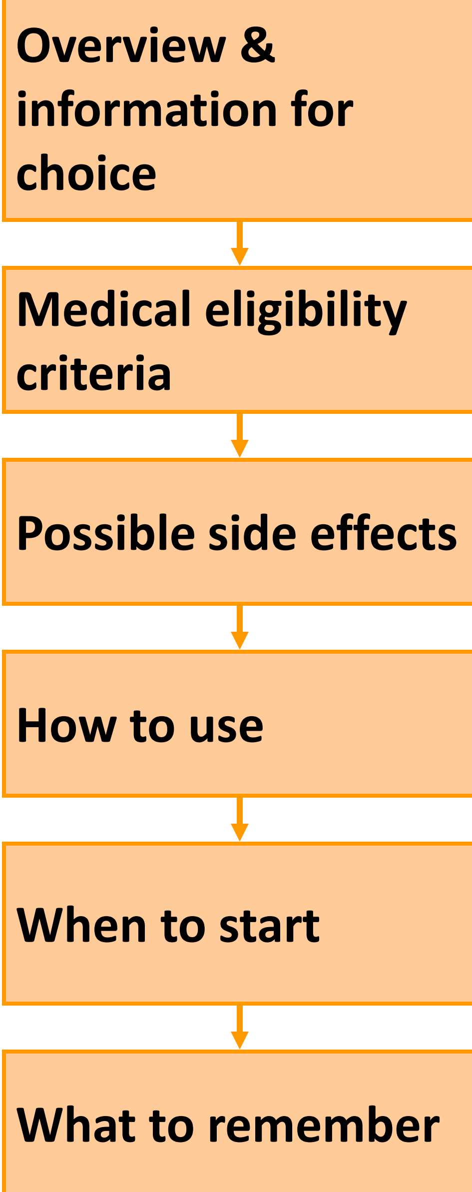
Returning Client: long-acting injectable RC 8

Find the right page in the section (no tabs)

Managing problems

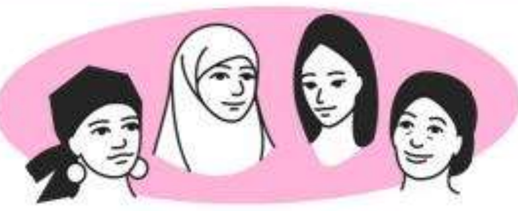


Method Sections



Who can and cannot use the pill

Most women can safely use the pill



But usually cannot use the pill if:

- Smoke cigarettes AND age 35 or older

- High blood pressure

- Gave birth in the last 3 weeks

- Breastfeeding 6 months or less

- May be pregnant
- Some other serious health conditions

Medical eligibility criteria in the method section

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

The Pill

Who can and cannot use the pill

Most women can safely use the pill. But usually cannot use the pill if:

- **Smoke cigarettes AND age 35 or older**
- **High blood pressure**
- **Gave birth in the last 3 weeks**
- **Breastfeeding 6 months or less**
- **May be pregnant**
- **Some other serious health conditions:**

Usually cannot use with any of these serious health conditions (if in doubt, check handbook or refer)

"We can find out if the pill is safe for you. Usually, women with any of these conditions should use another method."

- Check blood pressure (BP) if possible. If systolic BP 140+ or diastolic BP 90+, help her choose another method (but not a monthly injectable). (If systolic BP 160+ or diastolic BP 100+, also should not use long-acting injectable.)
- If BP check not possible, ask about high BP and rely on her answer.

- If in doubt, use pregnancy checklist in Appendix 1 or perform pregnancy test.

- Ever had stroke or problem with heart or blood vessels.
- Migraine headaches*: she should not use the pill if she is over 35 and has migraines, or at any age if her vision, speech or movement is affected by the migraines. Women under 35 who have migraines without these symptoms, and women with ordinary headaches CAN usually use the pill.
- Ever had breast cancer.
- Has 2 or more risk factors for heart disease, such as hypertension, diabetes, smokes, or older age.
- Gallbladder disease.
- Has ever had blood clot in lungs or deep in legs. Women with superficial clots (including varicose veins) CAN use the pill.
- Soon to have surgery? She should not start if she will have surgery making her immobile for more than 1 week.
- Serious liver disease or jaundice (yellow skin or eyes).
- Diabetes for more than 20 years, or severe damage caused by diabetes.
- Takes pills for tuberculosis, fungal infections, or epilepsy (seizures/fits).

*What is a migraine?

Ask: *"Do you often have very painful headaches, perhaps on one side or throbbing, that cause nausea and are made worse by light and noise or moving about?"*

Next Move:

Client able to use the pill: go to next page.

Client unable to use the pill: help her choose another method, but not monthly injectable.

P2

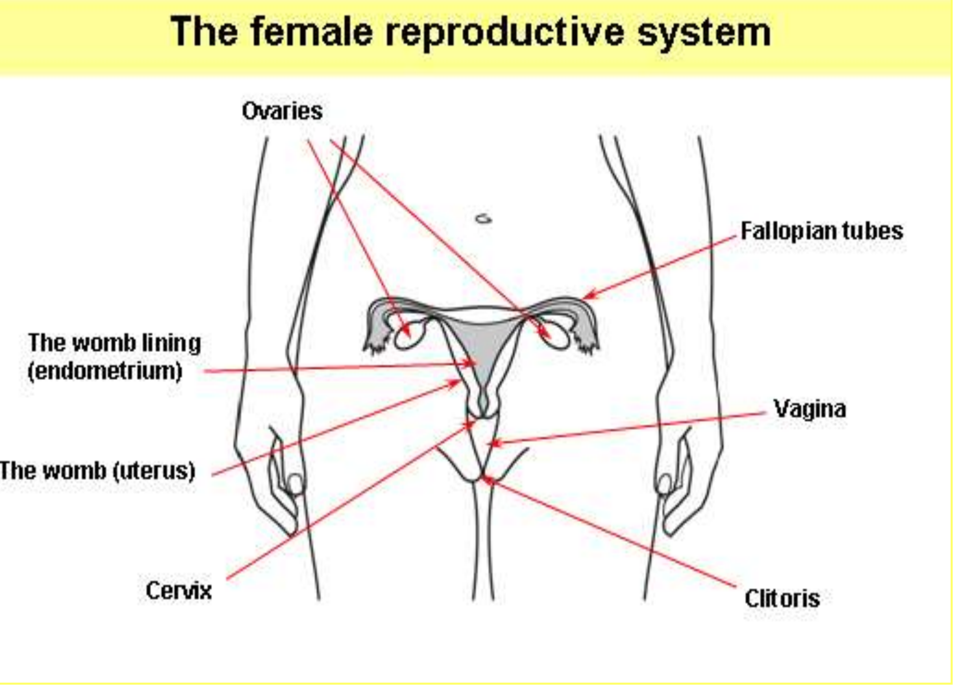
Appendices: extra counseling tools

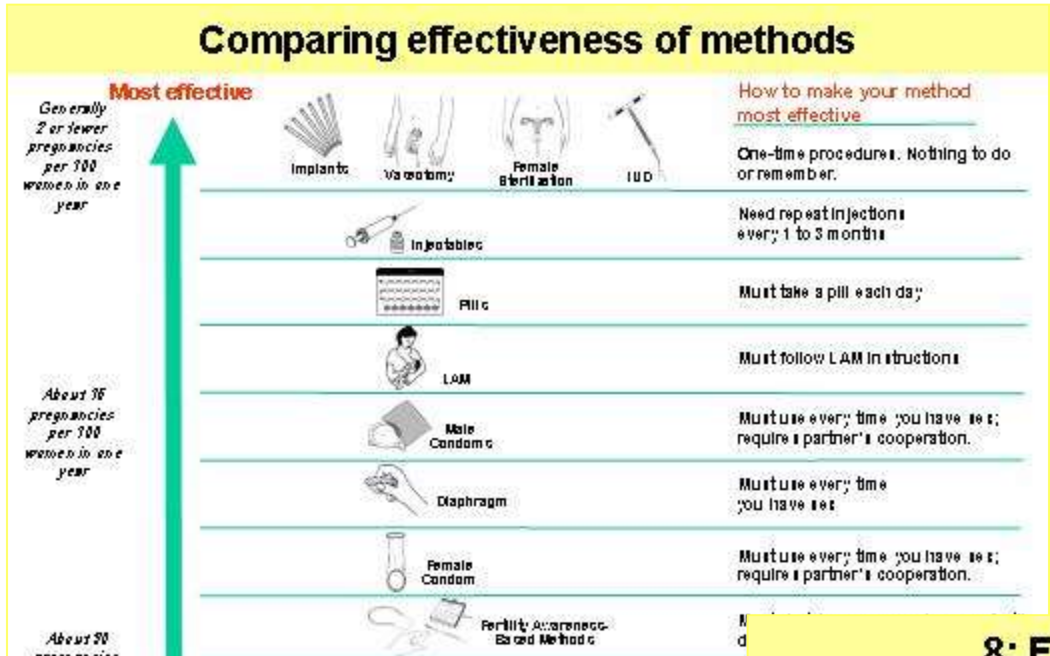
Ruling out pregnancy

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 anothe method correctly?

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

13 appendices with additiona tools and information for providers





8: Facts about STIs and HIV/AIDS

What is a sexually transmitted infection (STI)?

- An STI is an infection 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 and/or mouth. For best protection, a couple should use condoms, or avoid any contact in the genital area (including oral and anal sex).
- STIs may or may not cause symptoms. Some cause pain. Often, however, people (particularly women) may not know that they have an STI until a major problem develops.
- Some common STIs can be treated and cured with antibiotics. These STIs include gonorrhoea, chlamydial infection, chancroid and syphilis. Trichomoniasis, while usually not sexually transmitted, also can be treated.
- Some cannot be cured, including hepatitis B, genital herpes, human papilloma virus (HPV) and HIV (see right).
- If a woman has an STI, she is at greater risk for some reproductive cancers, pelvic inflammatory disease, ectopic pregnancy, miscarriage and HIV infection. Some STIs can cause infertility and death, particularly if not treated.

To see who is at risk for STIs, see Dual Protection tab, page DP2.

What are HIV and AIDS?

- HIV (Human Immunodeficiency Virus) is a virus that is present in the blood, body fluids and in some body secretions of infected people. HIV can be transmitted:
  - by sexual contact (through semen or vaginal fluids during penetrative vaginal and anal sex, and to a much lesser degree during oral sex);
  - through infected blood, in particular through shared or reused syringe needles and equipment (either for medical injections or drug use);
  - from mother to child during pregnancy or childbirth or through breast milk.
- HIV is NOT TRANSMITTED through the air, by insect bites, through saliva or kissing (as long as there are no cuts in the mouth), through touching or hugging, or by sharing food, plates or cups.
- Girls and young women are at particularly high risk of acquiring HIV during unprotected sexual intercourse due to social and biological vulnerability.
- AIDS (Acquired Immune Deficiency Syndrome) is characterized by certain diseases that develop during the final stages of the HIV infection (if left untreated). Illnesses develop because HIV progressively weakens the immune system and reduces the body's ability to fight disease (for example, pneumonia, tuberculosis, malaria, shingles or diarrhoea).
- After a person contracts HIV, signs and symptoms of disease can normally take many years to develop.

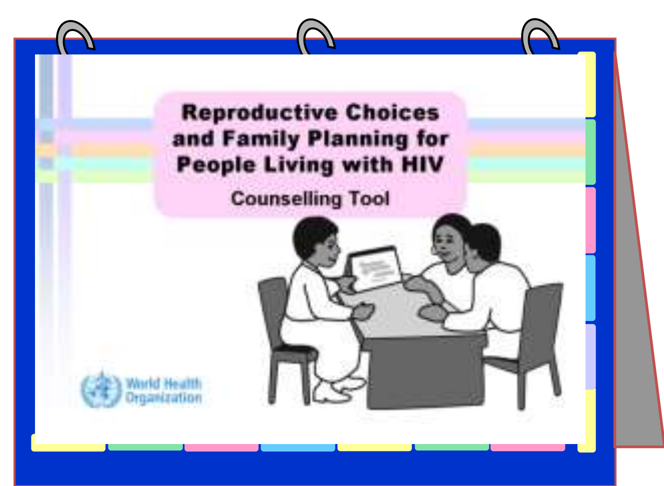
Testing, counselling, and treatment for HIV/AIDS

- A person living with HIV usually looks and feels healthy. Most people with HIV do not know that they are carrying the virus.
- To prevent infections and to promote access to care and treatment, it is important for a person to know his/her HIV status.
- The only way to tell if a person has HIV is a blood test. Blood tests can usually detect HIV 6 weeks after the person has been exposed to the virus. Positive test results need confirmation before diagnosing or counselling the patient.
- Recommend HIV testing for all clients who may be at risk of acquiring HIV. Testing should always be voluntary, based on informed consent, and be combined with counselling. Assure client that all tests are confidential.
- When a client learns that he/she has a positive HIV test result, offer counselling and support, including couple counselling. Encourage sexual partners to tell each other their test results, if this is not risky. Refer as appropriate.
- As of 2005, AIDS has no definite cure and there is no vaccine against HIV. However, in some places, treatment for HIV with antiretroviral drugs may be available. Treatment can significantly enhance quality of life and length of life.
- To prevent mother-to-child transmission of HIV, a wide range of services should be made available for women living with HIV, including family planning services, drugs to avoid transmission to the baby, and proper breastfeeding advice and support.

Anyone at risk for STIs, including HIV, should use CONDOMS!

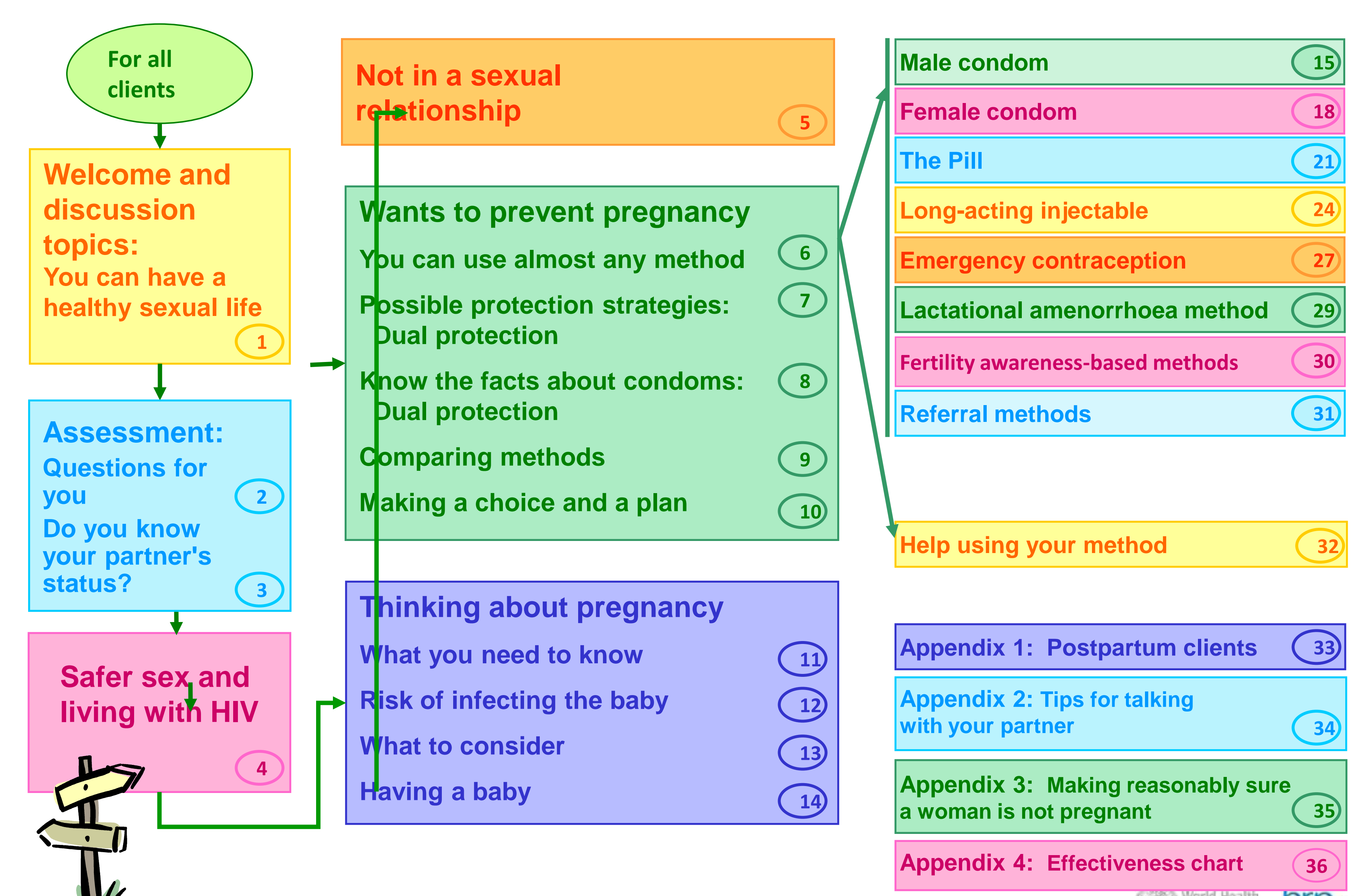
AP 8

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



Safer sex and living with HIV

- Can still enjoy sexual intimacy
- There are ways to lower risk
- Some sexual activities are safer than others

Any questions?

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.

How to use this page:

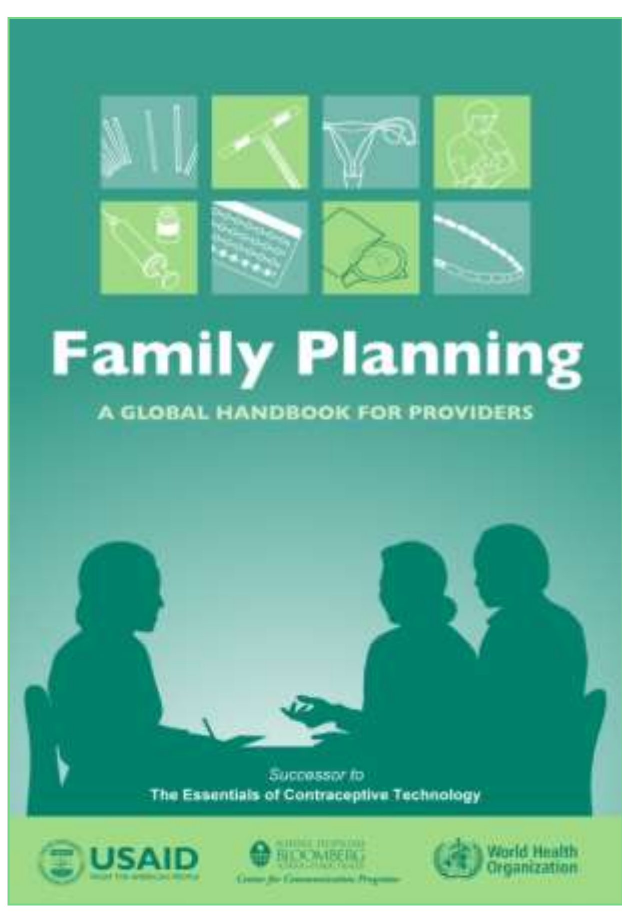
- Discuss HIV status of client and partner(s) so they can know how to best protect themselves.
- If client has not disclosed HIV status to partner, discuss benefits and risks of disclosure.
- Help client develop strategy for disclosure, if client is ready.
- Strongly encourage and help with partner testing and counselling.

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

Preparing to disclose HIV status

- Who to tell?
- When to tell?
- How to tell? Make a plan.
- What you will 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.

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
- Soon to be updated in 2016 (incorporating new WHO guidance on multiple SRH topics)
- 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 Petogen.
- NET-EN is also known as norethindrone enanthate, Noristerat, and Syngestal. (See Comparing Injectables, p. 359, for differences between DMPA and NET-EN.)

- Given by injection into the muscle (intramuscular injection). The hormone is then released slowly into the bloodstream. A different formulation of DMPA can be injected just under the skin (subcutaneous injection). See New Formulation of DMPA, p. 63.
- Work primarily by preventing the release of eggs from the ovaries (ovulation).

How Effective?

More effective

Less 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).

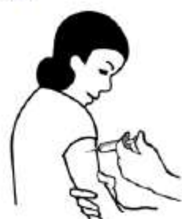
Protection against sexually transmitted infections (STIs): None

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

Known Health Risks

DMPA

None

NET-EN

None

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:

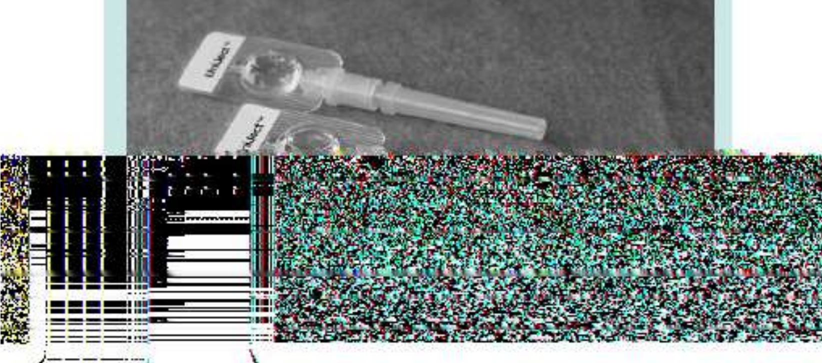
- Can stop monthly bleeding, but this is not harmful. It is similar to not having monthly bleeding during pregnancy. Blood is not building up inside the woman.
- Do not disrupt an existing pregnancy.
- Do not make women infertile.

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. 368)

- 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 further information http://www.who.int/reproductivehealth/en/ Tweet to @HRPresearch