FAMILY PLANING
BY DR. OUMA

Objective

- To gain knowledge and understanding on various F/P concepts in kenya and globally
- To be able to offer safe and quality F/P services to clients taking into consideration the clients rights

Specific objectives

- Define F/P, birth control and other population based concepts eg. Demography, fertility, crude birth rate, etc
- Describe history of FP in Kenya
- Describe the benefits of FP to individual, family, community and nation
- Describe the anatomy and physiology of both male and female reproductive systems and menstrual cycle
- Describe the various FP methods practiced in Kenya and globally
- Explain the eligibility criteria for the various FP Methods and their timing
- Explain the FP clients counseling process (GATHER)
- State the clients' reproductive health rights

Definition of terms

- FP is the ability of a woman/couple to decide when to have a child/children, how many and at what interval.
- Birth control is a government's desire to limit the number of children a couple should have depending on the population growth rate of that particular country. It is common in countries with high population growth rates. Each country has its own limits eg. 2, 3, 4 etc.

Definition of terms cont.

- Population is the total number of people in a defined geographical area e.g a village, town, district or a country.
- Demography is the study of populations and their characteristics such as composition by gender, age, ethnicity, race and territorial distribution. It also includes the changes occurring within the population e.g birth rate, mortality, migrations and social mobility (change in status)

Definition of terms cont.

- *Development* is a positive change in the society such as: better housing, better education, transportation, improvement in infrastructure such as roads schools and health facilities.
- *Total Fertility Rate.*

Is the average number of births per woman during her reproductive age (12-49years). It reduced from 8.1 births per woman In 1978 to 4.6 in 2008.

- *Crude birth rates.*

This is the number of births per 1000 population per year.

- *Crude death rate.*

This is the number of deaths per 1000 population per year

- *Infant mortality rate.*

This is the number of infants who die before completing their first year of life per 1000 live births

- *Maternal mortality rate*.

The number of women who die from pregnancy and child birth related causes per 100,000 live births per year.

- *Contraceptive prevalence rate*.

The percentage number of reproductive age women using contraceptives. Currently it is 46%

Population trends in kenya

- The population trends have been changing over the years characterized by changes in size and other demographic indicators as follows:
- 1962- 8.6 million
- 1969= 11million
- 1979= 16.1milion
- 1989=25 million
- 1999= 28 million
- 2009= 40 million

Fertility

- The total fertility rate had been on increase since independence from 6.8 in 1962 to 8.1 in 1978 but has since declined to 4.6 in 2008.
- The reasons for high fertility include:-
- Better nutrition
- Better hygiene
- Better health services
- Early marriages
- Lack of family planning awareness
- Cultural practices encouraging many children
- Sex preferences.

This has led to higher population growth rate and better life expectancy

Effects of a big population

- Constraints on individual and national resources hence limiting development
- Poor delivery of essential services
- Food insecurity
- Environmental degradation
- Social vices such as crime and prostitution
- Overcrowding especially in urban areas
- Poor housing
- Out-break of diseases

History of FP in Kenya

- Practice of FP started long before the modern methods were introduced.
- Each community had its own traditional methods of family planning. Mention a few…
- **Examples of traditional methods of FP:-**
- Practice of polygamy
- Abstinence before marriage
- Delaying of intercourse until the child attained a certain age
- Use of certain herbs which reduce libido or kill spermatozoa
- Female circumcision to reduce libido
- Prolonged breastfeeding

Modern family planning

- Urbanization and civilization have brought about a lot of changes in society which necessitated modern methods of FP
- It took collaborative efforts of multiple stakeholders such as government, private practitioners and international bodies
- In 1950s private practitioners started family planning clinics
- In 1956 Family planning association of Kenya was started spear headed by Dr. Mwathi and other volunteers
- In 1962 FPA was incorporated as a member of the international planned parenthood federation

Government participation

- Initially FP services were offered by FPA with very minimal government support
- In 1965 the government through parliament accepted to play a more active role in the provision of FP services so as to control the rapid population growth.
- This was spearheaded by population council and in 1967 population council of kenya was formed consisting of govt. ministries under direction of ministry of economic planning with government financial support.
- In 1st May1968 Kenya government declared family panning services free of charge and were integrated with other health services in hospitals.
- Several service delivery points and mobile units were established and enrolled nurse midwives trained to offer the services

History of modern FP in Kenya

- Registered nurse midwives were trained in family planning so that they can train family field health workers
- The training was extended to include clinical officers
- These initiatives were supported by international agencies who were working in collaboration with the family planning association of Kenya. Examples of such agencies included:

-International planned parenthood federation

-Pathfinder international

-World bank

-Danish government

-German government and

-Swedish international development agency

Benefits of family planning

- **Woman**

1. Protected from unwanted pregnancies
2. High risky pregnancies are prevented
3. Prevented from diseases such as STIs, cancers and anemia

- **Children**

1. Reduced infant & child morbidity and mortality
2. Prolonged periods of breast feeding
3. Better health care due to reduced costs

Benefits of FP cont.

- **Men**

1. Helps them provide better care to their families as more resources are available
2. Have less stress hence better life

- **Families/couples**

1. Improved family well being
2. Better care in terms of food, clothing, housing, health care and education

Benefits of FP cont.

- **Community**

1. Living standards are improved
2. Availability of better infrastructure and services
3. Less incidence of social vices such as prostitution and crime

- **Nation**

1. Improved economy in terms of GDP
2. Better social services such as health and education

Factors promoting/hindering FP practice

- Ignorance among individuals and communities
- Cultural practices
- Religious beliefs
- High cost of living
- Provider bias/conflict of interest
- Provider values, beliefs and attitudes
- Shortage of facilities and service providers
- Shortage of FP methods

Essentials of FP Service Provision

- Increasing Demand for FP Services
- Increasing Availability and Utilization of Services
- Counseling
- Dual Protection
- Provision of Contraceptives
- Follow-up and Referral System
- Record Keeping
- Supervision
- Logistics
- Cost Considerations for Clients
- Integration of FP with HIV and other RH services

PRICIPLES OF COUNSELLING IN FP.

- Use a rights based approach to treat the client well. Consider the **7** rights of the client:-

1. **Right to information**-offer adequate information
2. **Right to access of services**– don't deny service
3. **Informed choice**- allow client to choose
4. **Safety of service**- infection prevention
5. **Privacy and confidentiality**
6. **Dignity, comfort and expression of opinion**
7. **Continuity of care**

Providers staff needs

- Supportive supervision and management
- Information, training and development
- Supplies, equipment and infrustructure

Principles cont.

- **Interact with the client**

1. Be a good listener, respond to client's concerns
2. Be ready to help
3. Encourage the client to talk and ask questions
4. Ask and answer client's questions

Principles cont.

- **Provide information**

1. Tailor information to clients needs
2. Be non judgmental
3. Bridge the gap between the providers knowledge and client's understanding
4. Avoid too much information (information overload)

Principles cont.

- **Provide the method the client wants**
- Help the client make an informed choice
- Consider the medical eligibility criteria
- Help the client understand and remember
- Demonstrate all the available methods using teaching aids such as samples, posters, charts etc.

Counseling cont.

- The counseling should help the client to understand the following in relation to available methods:-

1. Effectiveness- ability to prevent pregnancy
2. Advantages and disadvantages of each method
3. Side effect and complications
4. How to use the method
5. STI prevention- dual protection
6. When to return

The 6 steps GATHER

- G - greet the client
- A- ask what you can offer to the client
- T- tell the client about available methods
- H- help her make an informed choice
- E- explain how to use the modern method
- R- return visit. Agree with the client

- **ADMINISTRATION PROCESS.**

FP Administration process

- **History taking**

Personal history, health history and previous fp use

- **Physical examination**

General Examination, breast and pelvic examination. Do a pap smear or via vili

- Provide information on all available methods

- This helps the clients to make informed choices

Informed choice

- **Informed means:-**

- Clients have **clear, accurate** and **specific** information that they need to make their own reproductive health choices including a family planning method.
- Clients have their own needs because they have thought over their situation

- **Choice means:-**

- Clients have a wide range of family planning methods to choose from.

-Clients make their own decisions

Physical examination

- **General**- weight and other vital signs e.g BP, Pallor, jaundice.
- **Breast**- Check for any skin lesions, pain, swellings/lumps and any abnormal discharge
- **Abdomen**- Check for any masses in both the abdominal and pelvic organs e.g. liver, intestines, spleen, bladder and uterus

- **Pelvic**- Check for signs of infection, position and status of the cervix
- Do a via vili, pap smear or both depending on the resources status of the facility.

Pelvic examination

- This is very important for family planning clients as it offers them an opportunity to know the **health status** of their **genital organs** as one way of preventing genital cancers.
- It also helps the service provider to **rule out** any **infections** which may require treatment.
- It helps to locate the positions of the uterus such as anteverted, retroverted and mid positions which determine client's eligibility to certain methods such as IUCD.

PELVIC EXAM

- Has three steps:-

1. Inspection for any abnormalities in the external genitalia
2. Speculum examination to view the cervix and do a VIA VILI and or PAP SMEAR
3. Bimanual examination to get the size, consistency and position of the uterus

- **SPECIFIC METHODS OF FAMILY PLANNING.**

The specific methods

- Barrier methods e.g. male and female condoms, diaphragm, cervical caps, spermicides
- Hormonal contraceptives- oral pills and injectables
- Intra-uterine contraceptive devices (IUCD)
- Implants e.g. implanon, norplant and jadelle
- Permanent surgical methods
- Natural methods e.g Lactational amenorrhea methods (LAM) and fertility awareness based methods

A. BARRIER METHODS

1. **Male condom**.

The most commonly used method in this category.

- ***Advantages***

1. Has high success rate if used properly
2. Offers dual protection
3. Does not interfere with the client's hormonal system

4. Has minimal complications
5. Only used when necessary
6. Easily available at a low cost

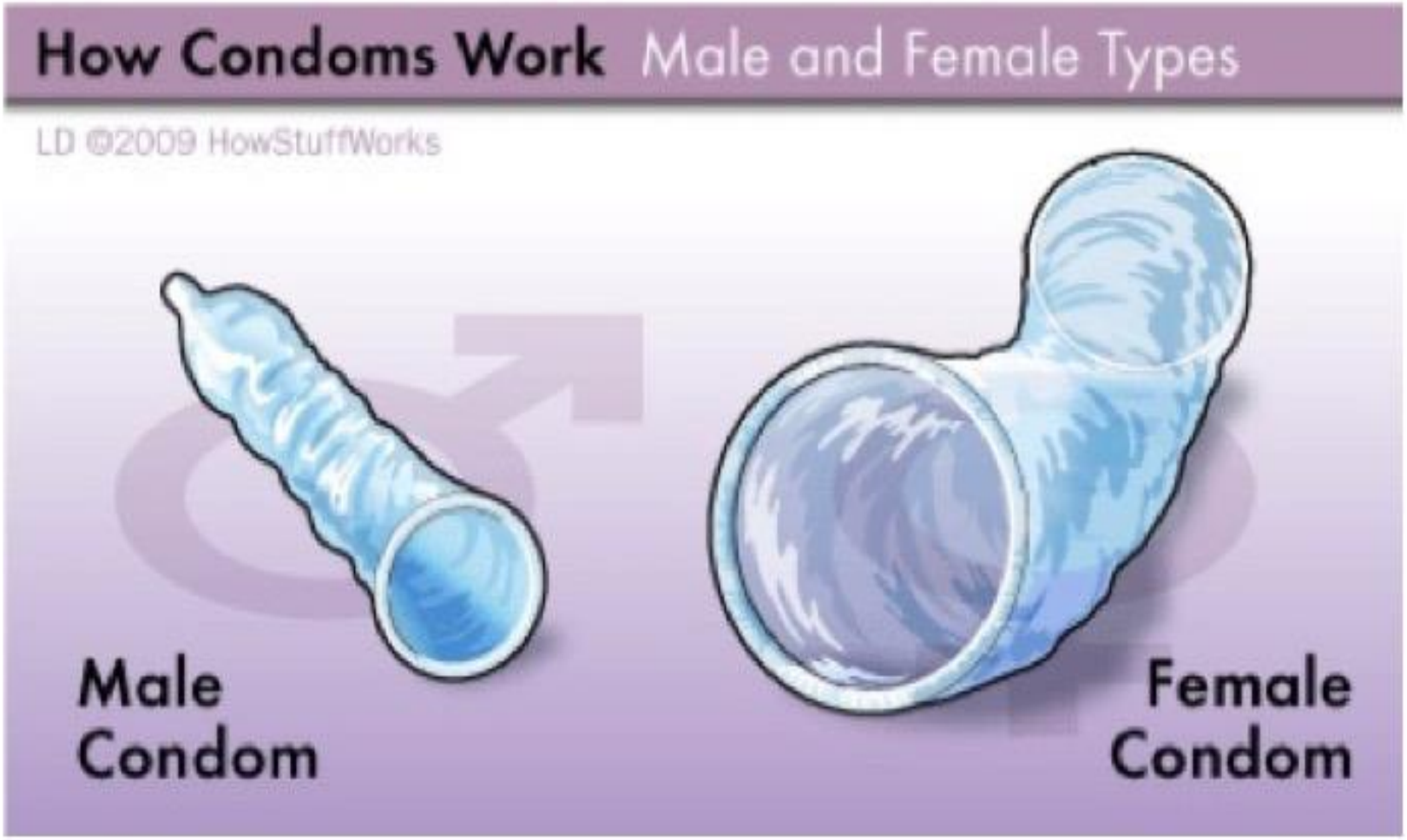
Disadvantages of male condoms

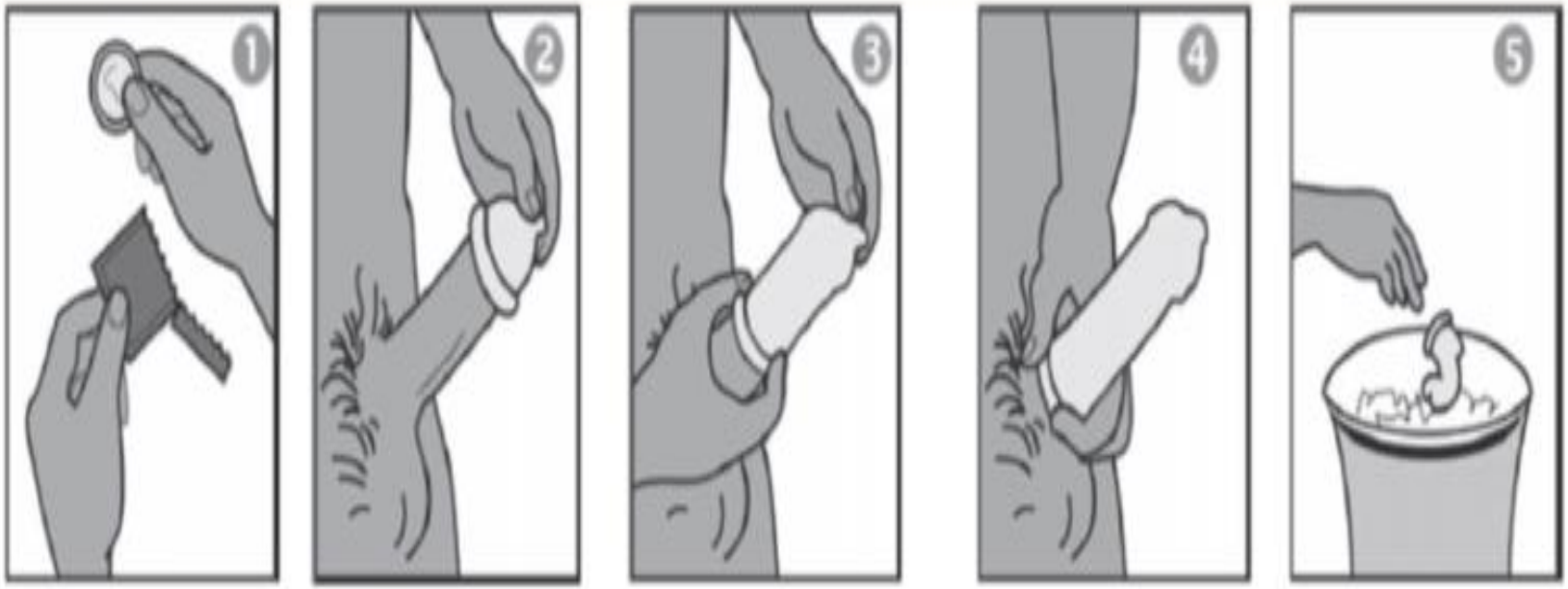
- If not properly used, it has a high failure rate
- Some clients may be allergic to latex
- It Needs understanding and cooperation of both partners

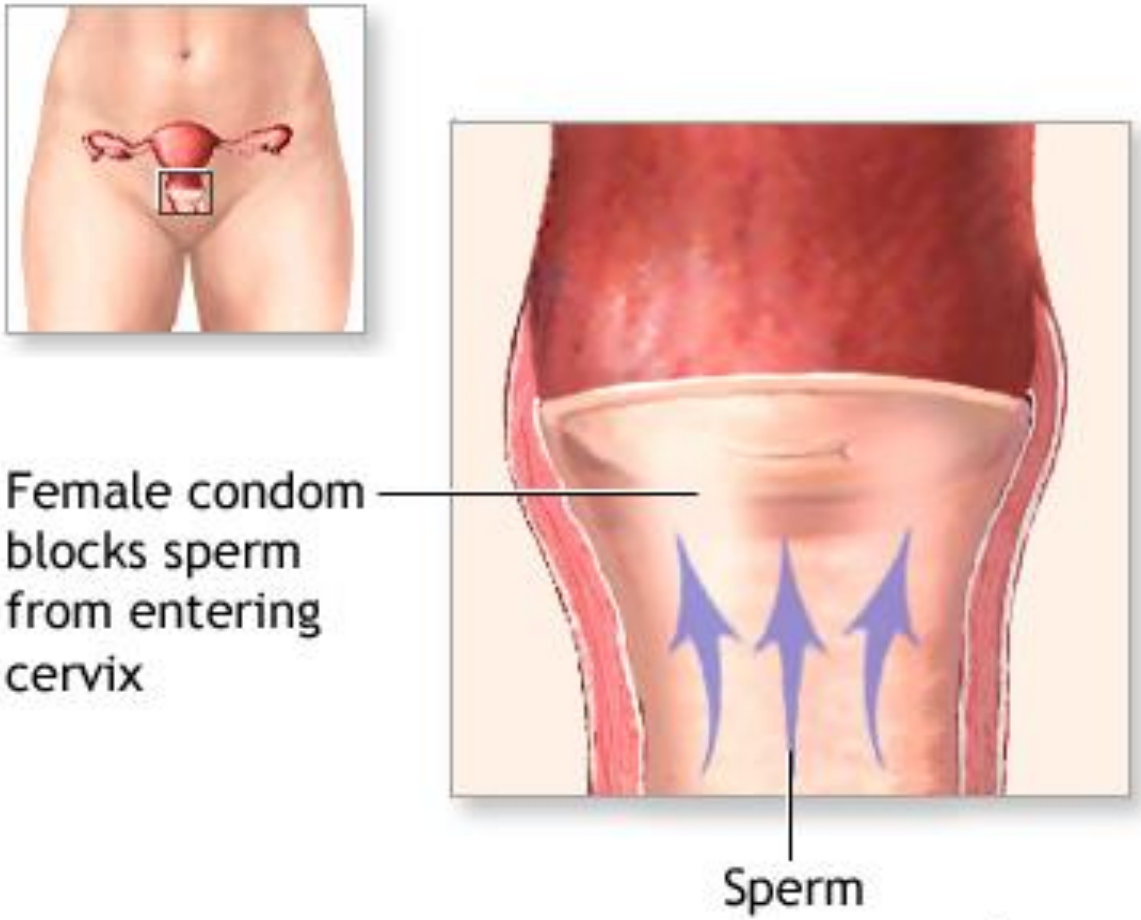
- Cannot be used secretly where one partner is unwilling
- Disposal of used condoms may pose a public health hazard

2.Female condom

- This works the same way as the male condom but it is worn by the female partner.
- It is inserted into the vagina and has two rings whereby one fits in the cervix while the other one at the vulval opening
- For best results it is worn earlier at least ½ an hour or more before sexual intercourse.
- It should not be used together with the male condom at the same time


How Condoms Work Male and Female Types
LD ©2009 HowStuffWorks
Male Condom
Female Condom

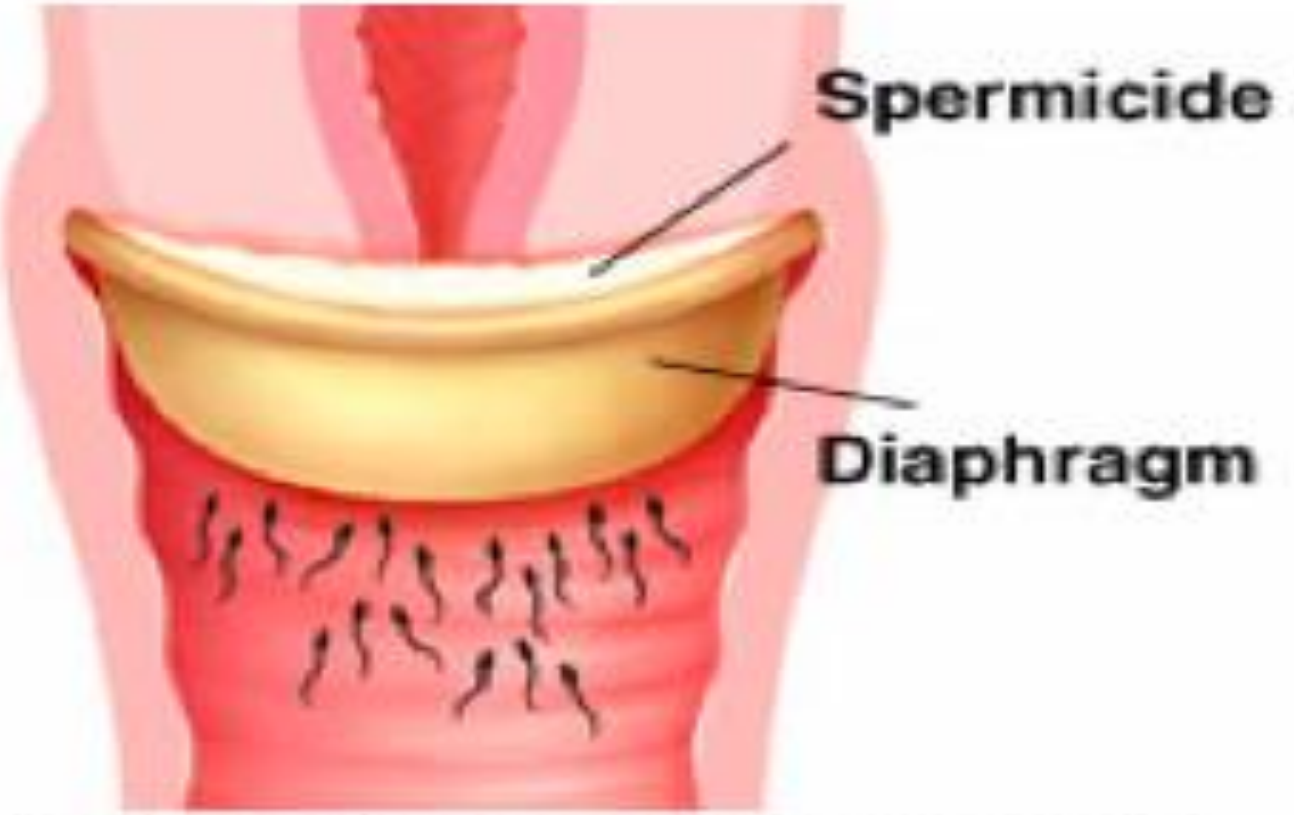

1
2
3
4
5
Use **a new condom** for each sex act
Before any contact, place condom on tip of erect penis **with rolled side out**
Unroll condom all the way to base of penis
After ejaculation, hold rim of condom in place, and withdraw penis while it is still hard
Use only once Throw away used condom safely


Female condom blocks sperm from entering cervix
Sperm
A.D.A.M.

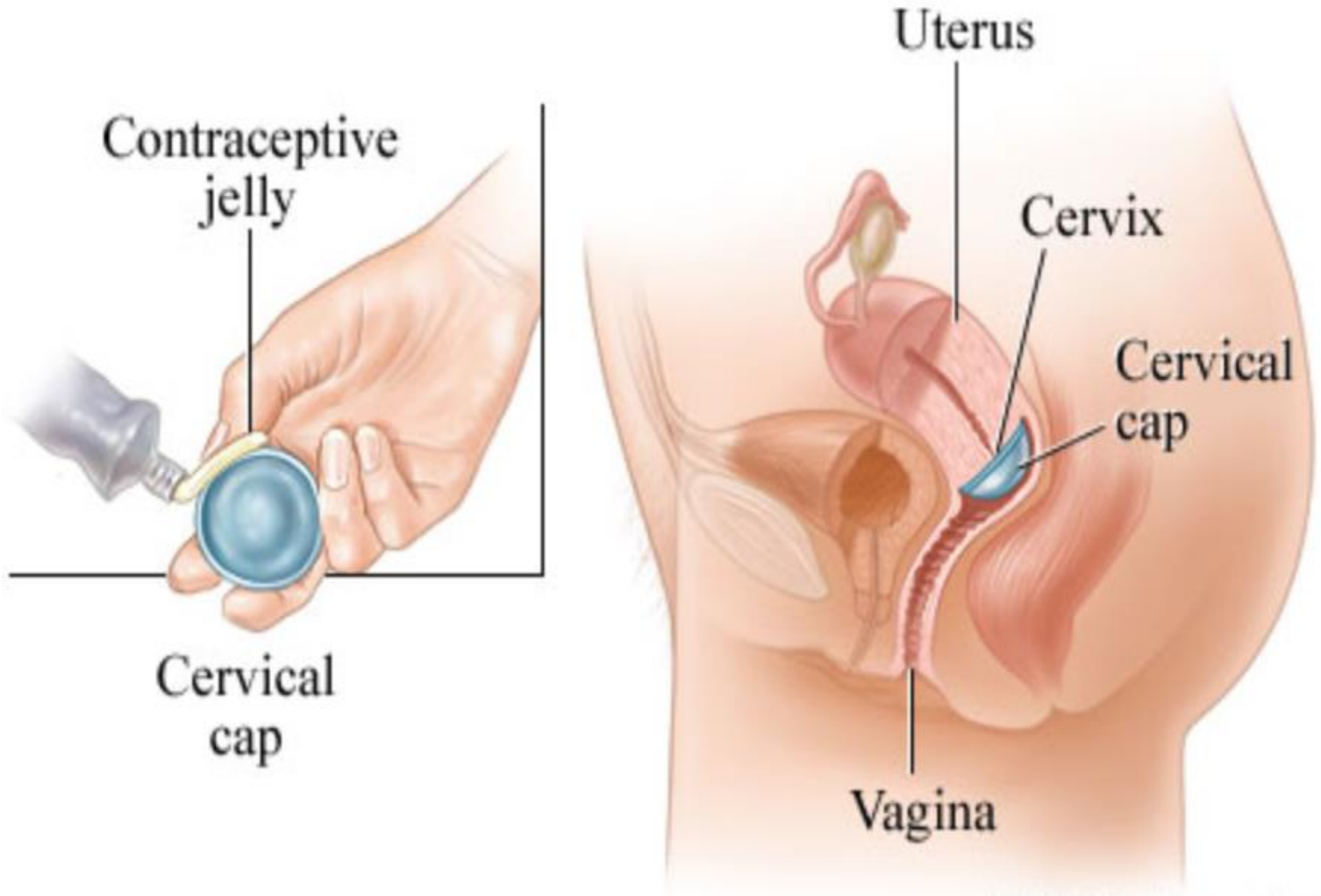
Other barrier methods

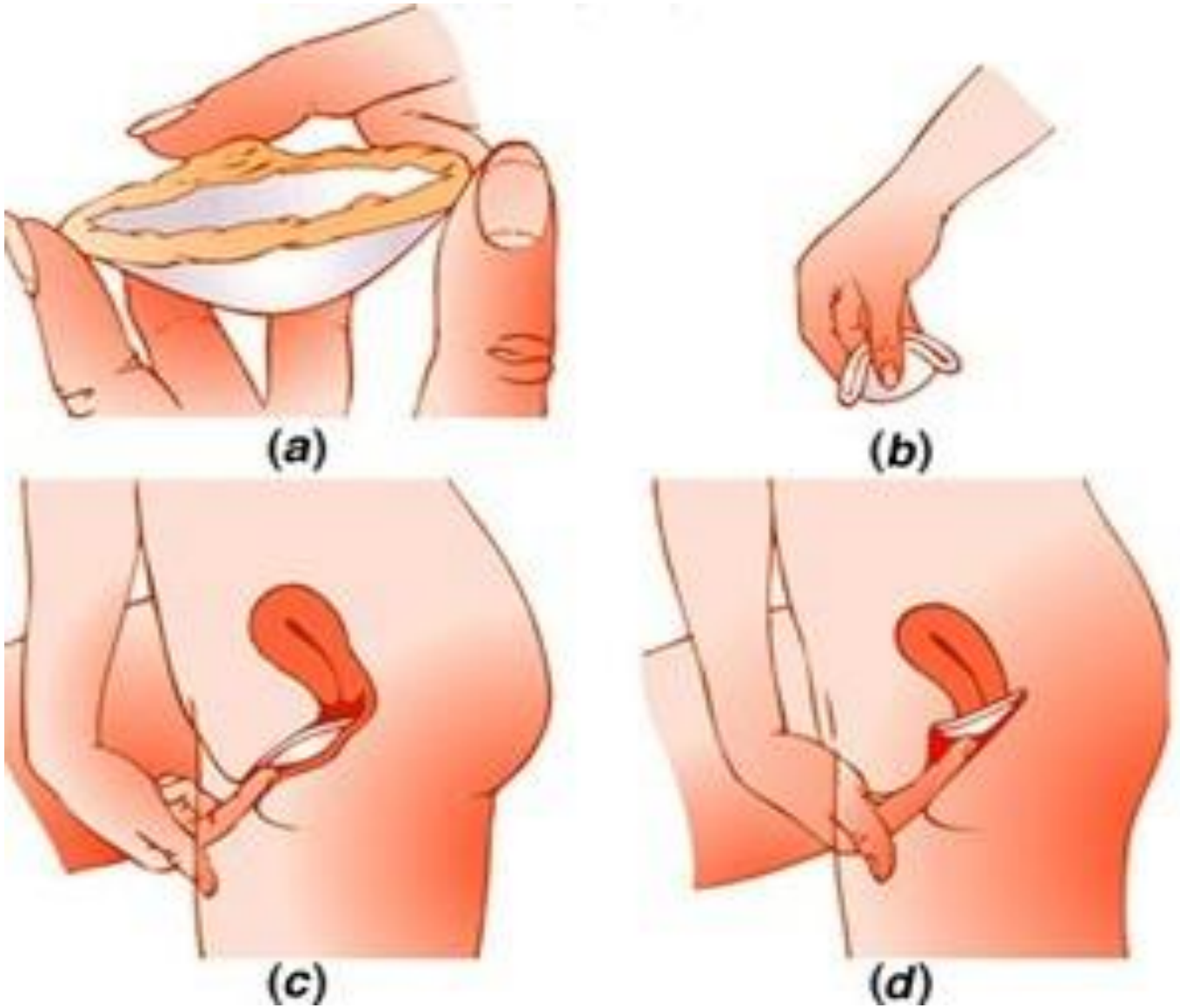
- Diaphragm
- Cervical caps
- Spermicides

These are not commonly used locally due to issues of availability and information about them.



Various birth control methods, such as the diaphragm and spermicide, prevent sperm and egg from meeting.


Contraceptive jelly
Cervical cap
Uterus
Cervix
Cervical cap
Vagina


(a)
(b)
(c)
(d)

B. HORMONAL CONTRACEPTIVES

- These contain artificial/synthetic hormones that mimic the natural estrogen and progesterone hormones produced by the ovary.
- They interfere with the normal functioning of the natural estrogen and progesterone hence preventing ovulation.

- They include:-

❖The combined oral contraceptive (COC)

❖Progesterone only pill (mini pill)

❖Injectable progesterone based contraceptives

❖Long life progesterone based implants

1. THE COMBINED ORAL CONTRACEPTIVE PILL (COC)

- Contain both estrogen and progesterone in low doses.
- Come in packs containing 21 active pills and 7 iron pills (reminder)
- Taken orally 1pill daily
- These suppress ovulation.
- They also thicken the cervical mucus making it difficult for sperms to pass through.

Contraceptive benefits of COC

- COCs are highly effective and are effective immediately when started
- 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 of COCs.

Other benefits of COC Pills

- To alleviate menstrual disorders, including dysmenorrhea (painful periods), irregular cycles, and premenstrual mood syndrome.
- They are prescribed to treat acne or hirsutism, as well.
- Help to prevent anemia especially to clients who have been having heavy menstruation

Non contraceptive benefits of COCs

- Reduction of menstrual flow (lighter, shorter periods)
- Decrease in dysmenorrhea (painful periods)
- Reduction of symptoms of endometriosis
- Improvement and prevention of anemia
- Protection against ovarian and endometrial cancer
- Treatment for acne and hirsutism

Limitations and Side Effects of COCs

1. COCs must be taken daily to be effective, preferably at the same time each day.
2. Effectiveness of COCs might be decreased when taken concurrently with other drugs (e.g., certain anti- tuberculosis, anti-epileptic, and antiretroviral drugs).

3. Clients should refer to MEC for possible interactions.

4. Effectiveness could be lowered in cases of gastroenteritis, severe vomiting, and diarrhea.

5. COCs offer no protection against STIs, including hepatitis B and HIV. Therefore, at-risk individuals should use condoms to ensure protection against STIs.

MINOR SIDE EFFECTS OF COCs

- Nausea (more common in the first 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 first three months)
- Mild headaches
- Breast tenderness
- Slight weight gain
- Mood change

MAJOR COMPLICATIONS OF COCS

– The following major side effects or complications are rare, but possible:

- Myocardial infarction
- Stroke
- Venous thrombosis or embolism, or both

Eligibility for Using COCs

- COCs are safe and appropriate for many women.
- Other women might take COCs with additional monitoring or care and some women should not take COCs at all, or only in very limited circumstances.

Women Who Can Use COCs without Restrictions (Includes MEC Category 1)

- This method is recommended and acceptable with no restrictions for sexually active women of reproductive age (from menarche to menopause) in all of the following specific circumstances:

MEC1 No restrictions or conditions

- Women of any parity, including those who have never given birth (the nulliparous)
- Women who want highly effective protection against pregnancy and who feel they can follow a daily routine of pill taking
- Post-abortion women (should begin within five days of abortion for immediate effectiveness)

- Women with severe dysmenorrhea
- Women with a history of ectopic pregnancy
- Women who suffer from headaches (can initiate pill use [category 1]; but if headaches continue, eligibility changes to category 2)

MEC 1 CONT.

- Women on antibiotics that do not affect effectiveness of COCs
- Women with AIDS, those receiving ARVs that do not interfere with effectiveness of COCs
- Women with Malaria and Non-pelvic TB

MEC 1 Cont.

- Thyroid disease
- Iron-deficiency anaemia
- Benign breast disease
- Endometrial or ovarian cancer

- Abnormal vaginal bleeding patterns: irregular, heavy, or prolonged bleeding

Women Who Can Use This Method with Extra Care (Includes MEC Category 2)

- Women who suffer from obesity, i.e., weight equal or greater than 30kg/ m2 Body Mass Index (BMI)

-Use the method, but counsel about small risk and symptoms of thrombosis. Advise follow-up.

-Initiate method and refer for evaluation as soon as possible. Re-supply as needed.

Women Who Should Not Use COCs (MEC Categories 3 and 4)

- This section outlines circumstances that would absolutely prohibit a woman from using COCs (category 4), as well as circumstances that generally prohibit a woman from using COCs, but would allow it if these three criteria are met:

-No other method is available or acceptable,

-clinical judgment is possible, and careful follow-up can be assured.

- Non-breastfeeding mothers before three weeks postpartum
- Women with a history of hypertension (where blood pressure [BP] cannot be measured), or moderate hypertension (BP is between 140/90 to 159/99)
- Women who smoke (less than 15 cigarettes a day) and are 35 years of age or older

- Women on ARV therapy who are receiving ritonavir or ritonavir-boosted protease inhibitors
- Women on certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, oxcarbazepine, or Lamotrigine)
- Women on TB therapy who are on Rifampicin or Rifabutin

MEC category 4

- Breastfeeding mothers before six weeks postpartum
- Women with current or history of ischemic heart disease
- Complicated valvular heart disease or stroke
- Women who smoke (more than 15 cigarettes a day) and are 35 years of age or older
- Women with a history of or current breast cancer

MEC category 4 cont.

- Women who have had major surgery with prolonged immobilization
- Women with severe cirrhosis

Common Types of COCs

- The Pill comes in packets of 21 or 28 tablets.
- In the 28-pill packet, only the first 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 estrogen and progestin. Examples include Microgynon, Nordette, Marvelon, and Yasmin.

Types of COCs cont.

Biphasic:

The active pills in the packet contain two different dose combinations of estrogen 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 estrogen and progestin. Out of a cycle of 21 active pills, six might contain one combination, five pills contain another combination, while 10 pills contain other combinations of the same two hormones. Examples include Logynon and Trinordial.

Danger signs which fp clients should report immediately to H/worker

- Abdominal pains
- Chest pain or shortness of breath
- Headaches
- Eye problems
- Severe calf muscle pain

N/B Bleeding changes are common, but not harmful. Irregular bleeding typically occurs during the first few months, followed by lighter and more regular bleeding.

Management of Common Side Effects of COCs

- Nausea and dizziness- assess for pregnancy, advice client to take pills with meals or at bed time, reassure the client
- Spotting- assess for pregnancy, assess for other illnesses, reassure, encourage client to take pills at the same time daily. If bleeding gets worse, change method
- Amenorrhea- assess for pregnancy, reassure the client

When to start coc

- 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.
- If a woman misses one or more hormonal pills, the primary advice is to take the missed pill as soon as possible and keep taking pills as usual, one each day. She may take two pills at the same time or on the same day.

What to Do in the Case of Missed Pill(s)

- If a woman misses one or more hormonal pills, the primary advice is to take the missed pill as soon as possible and keep taking pills as usual, one each day. She may take two pills at the same time or on the same day.
- If she misses more than two pills, she will need to take them immediately she remembers and use a back up method

PROGESTIN-ONLY PILLS (POPS)

- As the name suggests, the Progestin-only pills (POPs) contain only one hormone—progestin; they do not contain any estrogen. Therefore they do not cause many of the side effects associated with COC use.
- Progestins do not suppress production of breast milk, which makes POPs an ideal contraceptive method for breastfeeding women
- POPs prevent pregnancy by thickening the cervical mucus, which prevents the passage of sperm, and suppressing ovulation in about 50 percent of cycles.

Types of POPs

- The brands commonly available in the public sector and the local market include Microlut, Micronor, Microval, Ovrette, Norgeston, and Noriday.
- In public health facilities the commonly used pill is microlut

Advantages of POPs

- They are effective.
- They are safe (POPs have no known health risks).
- Women return to fertility immediately upon discontinuation.
- A pelvic exam is not required to initiate use.
- They can be given to a woman at any time to start later. If pregnancy cannot be ruled out, a provider can give her pills to take later, when her monthly bleeding begins.

- Taking POPs does not affect milk production or breastfeeding. It is safe for breastfeeding women and their babies.
- POPs add to the contraceptive effect of breastfeeding. Together, they provide effective pregnancy protection. Typically, pills lengthen the time during which breastfeeding women have no monthly bleeding.
- Taking POPs does not increase blood clotting

Limitations and Side Effects of POPs

- They provide a slightly lower level of contraceptive protection than COCs.
- They require strict daily pill-taking, preferably at the same time each day.
- They do not protect against STIs, including hepatitis B and HIV/ AIDS. Therefore, at-risk individuals should use a barrier method to ensure protection against STIs and HIV/AIDS.
- They may lower effectiveness when certain drugs are taken concurrently (e.g certain anti-tuberculosis, anti-retroviral and anti-epileptic drugs).

- Irregular spotting or bleeding, frequent or infrequent bleeding,
- Use of POPs could be associated with some side effects, which include:

-prolonged bleeding, amenorrhea (less common). Bleeding changes are common, but not harmful.

-Headaches, dizziness, nausea.

-Mood changes.

-Breast tenderness (although less common than with COCs).

Eligibility for Using POPs

- ***Women Who Can Use This Method without Restrictions (Includes MEC Category 1)***
- This method is acceptable for the following sexually active women of reproductive age:

-Women of any parity, including women who have never given birth (nulliparous women)

-Women immediately postpartum, if they are not breastfeeding

-Breastfeeding mothers from four weeks postpartum

- Women of any age who are cigarette smokers
- Women who cannot use COCs as a result of oestrogen-related contraindications
- Post-abortion clients (no additional protection needed if method is initiated within five days after abortion)
- Women with any of the following conditions:
  - Hypertension
  - Sickle cell disease
  - Benign breast disease
- – Viral hepatitis, acute or chronic but mild

- Obese women and girls (individuals whose BMI is greater than 30 kg/m2)
- Women with a family history (first-degree relatives) of DVT or PE, and those who have had minor or major surgery without prolonged immobilization

INJECTABLE CONTRACEPTIVES

- 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 (Progestin only 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

Progesterone only injectables

- 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
- 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

Dosage of injectable contraceptives

- Depot-medroxyprogesterone acetate (DMPA): Depo-ProveraR, Megestron 150mg is given every three months (13 weeks), but can be given upto 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, lower-dose formulation of DMPA that is injected sub-cutaneously. It contains 104 mg of DMPA instead of the 150 mg in the IM formulation. Like the IM formulation, DMPA-SC is given at

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.

Emergency Hormonal Contraceptive Pills (ECPs)

- The use of certain contraceptive methods (very high dozes) 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.
- Ecps should not be used as regular methods since they are less effective

Ecps cont.

- ECPs 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. They 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.

Types of ECPs and Dosage

- *Combined Oral Contraceptives (Yuzpe Method)*
- 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 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 taken as soon as possible after unprotected intercourse within 120 hours. Repeat the same dose in 12 hours.

Ecp progestin only pills

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.

Contraceptive Implants

- Contraceptive implants are small rods that are inserted under the skin of a woman's upper arm to release progestin slowly and prevent pregnancy.
- Contraceptive implants, which are also called sub-dermal implants, do not contain oestrogen; hence are free from the side effects associated with that hormone.
- The latest implant to be registered in Kenya is the two-rod Sino-implant-II (Zarin).

Mode of action

- 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

Device	Design	Hormone	Duration of effectiveness
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 Benefits of Using Contraceptive Implants

- *Contraceptive Benefits*
- As a method of contraception, contraceptive implants are highly effective and safe, and they have significant benefits:
- Contraception is immediate if inserted within the first seven days of menstrual cycle, or within the first five days for Implanon.
- There is no delay in return to fertility.
- They offer continuous, long-term protection

Non-contraceptive Health Benefits

- Other benefits are as follows:
- Implants do not affect breastfeeding.
- They reduce menstrual flow.
- They help prevent ectopic pregnancy (but do not eliminate the risk altogether).
- They protect against iron-deffieciency anaemia.
- They help protect from symptomatic PID.

Eligibility for Using Contraceptive Implants

- Contraceptive implants are safe and appropriate for the majority of women. Some women might use contraceptive implants with additional monitoring/care; and a few women should not use contraceptive implants at all, or only in very limited circumstances.
- *Use Contraceptive Implants without Restrictions (includes ME Category 1)*
- women of reproductive age, from menarche to menopause, with or without children, including the following: Breastfeeding mothers after four weeks postpartum, or immediate postpartum if not breastfeeding

INTRAUTERINE CONTRACEPTIVE DEVICES (IUCDS)

- The IUCD is a flexible device that is inserted into the uterine cavity by a trained service provider through the vagina. Has strings which assist when checking and removing
- It is a safe and highly effective, long-acting contraceptive method.
- There are two broad categories of intrauterine contraceptive devices (IUCDs): the copper-based and the hormone-releasing devices.
- Lippes loop (no longer available) Unmedicated plastic

Coper-based IUCD

- Copper-based devices release copper and work mainly by preventing fertilization
- copper IUCDs reduce the number of viable sperm that reach the fallopian tubes
- prevention of implantation
- In Kenya, the most widely used copper-bearing IUCD is Copper T380A
- It provides protection from pregnancy for as long as 12 years

Hormone-Releasing IUCDs

- The hormone releasing IUCDs are less widely available in Kenya.
- They are made of plastic and work by releasing a progestin, levonorgestrel, during a period of five years.
- They work by suppressing ovulation through 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.

IUCD cont.

- Also, there is a generic version of Mirena that is available in the Kenya market, and it goes by the name of Lingus.
- IUCDs do not prevent pregnancy by causing an abortion.
- IUCDs are very safe; they do not cause PID in low-risk couples
- 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, the strings short, to about 3cm long from the cervical's external os, or coil the strings around the fornix (postpartum insertion).

Advantages and Benefits of IUCDs

- **Contraceptive Benefits**
- IUCDs offer the following contraceptive benefits:
- High effectiveness and safety
- Immediate effectiveness
- Long-acting protection
- Immediate return of fertility upon removal of device

Other Benefits of IUCDs

- 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.

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.
- -–●

When to insert IUCD cont.

- 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 first 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.

Timing of Insertion of IUCD cont.

- If there is suspicion of infection, or there is significant injury to the genital tract, insertion should be delayed until after appropriate treatment (see interval insertion).
- **Interval**: Insert IUCD within the first 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.

MEC for IUCD

- IUCDs can comfortably be inserted to majority of women including those contra-indicated to hormonal methods apart from the hormone releasing IUCDs.
- For MEC category 2,3 and 4 see table in word document

NOTE:

- Postpartum IUCD is contraindicated in situations that increase the risk of infections.
- These situations include:
- • Prolonged rupture of membranes
- • Prolonged labour
- • Puerperal genital infection
- • Puerperal sepsis

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 confirm 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

- 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 first 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.
- Uterine Perforation could occur, but this is rare.

Obtaining This Method

- IUCDs should be provided within facilities that follow appropriate infection prevention practices:
- Level 5 and above (prov. hospitals and others)
- Level 4 (district hospitals)
- Level 3 (health centres, nursing or maternity homes)
- Level 2 (dispensaries, private clinics)
  - Level 1 (outreach by trained clinicians)

Authorized service providers

– IUCDs can be obtained from service providers with appropriate training:

- Medical doctors
- Nurses or midwives
- Clinical officers

Management of common side effects

Type of problem	management
Abnormal bleeding such as spotting, irregular or heavy bleeding	Counsel and reasure the client that the problem is common in the first 3-4 months but will end with time
	If more serious give some NSAIDS eg ibuprofen. She may be advised to see a gynaecologist or choose another method
Pregnancy with the IUCD in situ	Counsel on the possibility of a miscarriage and need to remove it or leave it but have a closer follow up, and to report any signs of excessive bleeding.
A woman experiences abdominal cramps, pain, and severe dysmenorrhoea.	All women should be counselled on potential changes in menstrual cycle before the IUCD is inserted. Examination should rule out partial

VOLUNTARY SURGICAL CONTRACEPTION

- Voluntary Surgical Contraception (VSC) includes female and male sterilisation procedures 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.
- No medical contra-indications to most clients

Caution in voluntary surgial contraception

- 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.
- **Sterilisation does not protect against STIs**, including hepatitis B and HIV/AIDS. If the client is at risk of contracting one of these, the correct use of condoms is recommended following sterilisation.

Female Voluntary Surgical Contraception

- 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
- This is 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 use this method
- 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

Female Voluntary Surgical Contraception

- TL can be performed on a conscious client using local anaesthesia,
- 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.
-

BTL cont.

- 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, or interval)
- Laparoscopic tubal ligation (interval)
- In conjunction with a caesarean section or other abdominal surgery
-

Advantages of TL

- TL is a highly effective, immediate, and safe form of contraception that offers the following benefits:
- After an uncomplicated abortion.
- 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.
- 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

- 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 procedure
- 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).

Limitations of TL cont.

- Only a trained provider can perform the procedure.
- TL does not protect against STIs, including HIV/AIDS and hepatitis B.
-

Women Who Can Use TL

- 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 want a permanent method.

- 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 superficial venous thrombosis.
- Women with headaches, with or without aura.
-

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

Male Voluntary Surgical Contraception (Vasectomy)

- Vasectomy 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.
- vasectomies are not often performed in Kenya. The option is a good solution when a woman has medical conditions that hinder use of all female methods.
-

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 Benefits of Vasectomy**
- Contraceptive benefits 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 of vasectomy

- A vasectomy has some limitations and risks:
- The procedure is virtually irreversible (i.e., success of reversal surgery cannot be guaranteed).
- There are minimal risks and side effects of local anaesthesia.
- The risks associated with surgical procedures.
- A vasectomy does not protect against STIs, including HIV/ AIDS.
- Only a trained provider can offer a vasectomy.
- There is a delay in effectiveness after the procedure has been performed.

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

NATURAL METHODS OF FAMILY PLANNING

- These are methods which do not require the client to use any artificial drug or devise to prevent pregnancy.

- The client is advised to observe natural body changes which determine her fertility and abstain from sexual intercourse when she feels unsafe. They include:

1. Lactational amenorrhea method
2. Fertility awareness methods such as:

- Cervical Mucus
- Ovulation,
- BBT(basal body temperature).

Natural methods cont.

- Withdrawal method (coitus interuptus)

LACTATIONAL AMENORRHOEA METHOD

- The Lactational Amenorrhoea Method (LAM), is a temporary method of natural FP based on the lack of ovulation that results from exclusive breastfeeding.
- LAM works primarily by preventing ovulation—but for this to occur, exclusive breastfeeding is mandatory. Therefore, effectiveness depends on the user .
- As commonly used, the pregnancy rate is about two per 100 women in the first six months. With perfect use, the pregnancy rate is less than one per 100 women

Advantages and Benefits of LAM

- LAM provides effective protection against pregnancy as long as all three LAM criteria are met. Its other contraceptive benefits include the following:
- LAM does not interfere with sexual activity.
- It has no known health risks.
  - Return to fertility is immediate.
  - LAM offers other benefits, as well:
- Optimal breastfeeding provides health benefits for both the mother and the baby.

Benefits of LAM cont.

Breastfeeding provides passive immunity for the child.

- Counselling for LAM encourages women to start a follow-on method at the appropriate time.
- LAM is affordable FP—it has no direct costs.
- Women living with HIV/AIDS can use LAM.

Limitations of LAM

- This method is effective only as long as all three LAM criteria are met. However, there are a number of reasons that discourage a woman from breastfeeding:
- Breastfeeding can transmit HIV from a mother to her baby.
- A woman might not breastfeed because she is taking certain drugs (e.g., mood altering drugs, reserpine, ergotamine, antimetabolites, cyclosporine, cortisone, bromocryptine, radioactive drugs, lithium, or certain anticoagulants).
-

Limitations cont.

- ergotamine, antimetabolites, cyclosporine, cortisone, bromocryptine, radioactive drugs, lithium, or certain anticoagulants).
- Exclusive breastfeeding might be inconvenient or difficult for some women, especially working mothers.
- LAM does not protect a woman against STIs, including hepatitis B, HIV, and AIDS.

Women Who Can Use LAM without Restrictions

- Women whose babies are less than six-months old, who are exclusively breastfeeding, and are amenorrhoeic can use this method as contraception.
- Women should be counselled in advance about future FP options so as to initiate another method as soon as any of the following occurs:
- Supplementary feeding begins, or baby starts to skip regular meals (sleeps through the night).
- Menstruation begins.
- The baby is about to turn six-months old.

Women Who Should Not Rely on LAM

- The woman is not exclusively breastfeeding.
- The woman's menses has resumed.
- The baby is more than six months of age.
- Couples need highly effective protection against pregnancy (e.g., the woman has conditions that make pregnancy dangerous—see **Appendix 2**).

Calendar-Based Methods

- In the calendar-based methods, the couple keeps track of the days in the menstrual cycle to identify the start and end of the fertile time.

1.Standard Days Method (SDM)

- This is based on the fact that there is a fertile window during the woman's menstrual cycle when she can become pregnant.
- Typically, this window occurs several days before ovulation and a few hours after.
- To prevent pregnancy, couples avoid unprotected sex or abstain between days 8-19 of the menstrual cycle.

SDM cont.

- Most women who get their periods about once a month fall within this range. The SDM efficacy is similar to most other user-dependent methods.
- The SDM is appropriate for women who can avoid unprotected sex on fertile days and usually have cycles between 26-32 days long (approximately 80 percent of cycles are in this range).

SDM cont.

- The SDM makes use of Cycle Beads, a color-coded string of beads used with the SDM that represent the days of a woman's fertility cycle.
- Cycle Beads help the woman track her cycle days, know on which days she is fertile, and monitor her cycle length.
- The woman and her partner must avoid unprotected intercourse or abstain on the 12 fertile days identified by the white colour beads.

SDM cont.

- Cycle Beads serve as a visual tool to help women use the SDM correctly.
- On the day she starts her period, the woman moves the ring to the red bead to begin a new cycle and marks that day on her calendar.
- To keep track of her cycle days and know whether she is on a fertile day, the woman moves a rubber ring one bead every day.
- To monitor her cycle length, the woman knows that if her period starts before she moves the ring to the darker brown bead, her cycle is shorter than 26 days.

Sdm cont.

- If she doesn’t start her period by the day after she moves the ring to the last brown bead, her cycle is longer than 32 days.
- If she has a cycle shorter than 26 days or longer than 32 days more than once in a year, the SDM will not be effective for her.

Symptoms-Based Methods

- Symptoms-based methods depend on observation of signs of fertility, such as the
- Presence or absence of cervical mucus,
- Changes in the amounts and characteristics of the cervical mucus,
- Changes in body temperature,
- A combination of the latter two, or
- Use of specific ovulation detection kits.

Cervical Mucus, or Billings Ovulation Method

- In this method, the days of infertility, possible fertility, and maximum fertility of the menstrual cycle are defined by observation of changes in the cervical mucus.
- The woman identifies the fertile time by observing the characteristics of the cervical mucus.
- To use this method correctly, the woman should:
- Avoid sex on days of monthly bleeding.

Billings ovulation method cont.

In cases when ovulation occurs early in the cycle, bleeding could make it hard to observe cervical mucus signs (this can happen to women with short cycles and heavy menses).

- Avoid sex as soon as she notices any secretions. The fertile phase of the menstrual cycle begins with the appearance of a mucus secretion, which changes as the days go by, becoming more stretchy and slippery.
- Recognise evidence of ovulation (peak day), when the mucus is very clear, stretchy (Spinnberkeit's sign), and slippery.

Billings ovulation method cont.

Continue to avoid sex for three more days after peak day, even if secretions completely disappear before three days have expired.

- The couple can resume sex on the fourth day after the peak day and until her next monthly bleeding. The client should be taught to apply the method rules appropriately.
- A major advantage of this method is that it can be used by women wanting to achieve a pregnancy by identifying her fertile days.

Basal body temperature method

- the woman is instructed to take her body temperature either orally, rectally, or vaginally at the same time each morning before getting out of bed and before eating anything.
- The routine for taking the temperature must be the same for the entire cycle.
- The temperature readings are recorded on a special graph paper, which makes it easy to identify small changes in temperature readings.
- The woman's temperature rises by 0.20C - 0.50 C, around the time of ovulation (about midway through the menstrual cycle for many women).

BBT method cont.

- The couple avoids sex from the first day of monthly bleeding until three days after the woman's temperature has risen above her regular temperature.
- The couple should be taught to apply method rules appropriately.

Sympto-thermal Method (Cervical Mucus + BBT)

- In this method, the pre-ovulatory and post-ovulatory infertile phases of the menstrual cycle are identified by a combination of the above two techniques (the cervical mucus and BBT shift), as well as other signs and symptoms around ovulation.
- The signs and symptoms used in the sympto-thermal method include:
- Thermal shift (BBT)
- Cervical mucus changes (BILLINGS)
-

Sympto-thermal+billings method cont.

Cervical changes (consistency, position, openness, or closure)

- Other appropriate signs and symptoms, such as sharp lower abdominal pain (mittelschmerz), breast tenderness, increased libido, or intermenstrual bleeding
- Couples are taught to apply the combined rules of the above methods to identify the fertile time.

New Approaches

- To enhance the efficacy of fertility awareness methods and make the methods easier for couples to use, several new technologies for identifying fertility signs have been developed to provide a more precise way to detect ovulation:
- Advanced thermometers for detection of BBT shift
- Hand-held electronic devices that record multiple signs to predict ovulation
- Ovulation-detection kits that measure levels of luteinizing hormone (LH) in urine
- CycleBeads that help women keep track of their cycle days when using the SDM

Advantages of FAMs Methods

- When used correctly and consistently, FAMs can be reasonably effective and have several other contraceptive benefits:
- They do not require contraceptive commodities and supplies.
- There are no side effects or health risks.
- Some couples like the active involvement of the male partner.
  - These methods offer other benefits, as well:
- They result in an improved knowledge of the reproductive system and possible closer relationship between couples (strengthen male involvement).

Advantages of FAM cont.

They can be used by both literate and illiterate women.

- They allow adherence to religious and cultural norms.
- HIV-positive women can use them.
- Women who want to become pregnant can use them to identify fertile days.
- They can be used where other methods are contra-indicated.

Limitations of These Methods

- These are user-dependent methods, so their effectiveness relies greatly on correct and consistent use.
- Some FAM methods require daily record keeping and monitoring of menstrual cycles.
- Ovulation, Basal-body Temperature, and Sympto-thermal methods require individualized training before use of the methods and more intensive counseling.
- These methods require varying periods of sexual abstinence during fertile phase.
- Both partners must actively cooperate.

Limitations of FAM cont.

These methods offer no protection against STIs, including HIV/ AIDS and HBV.

- Breastfeeding women and current or recent users of injectable contraceptives need to wait until their menstrual cycles resume their regular pattern before they can use the SDM.
- The SDM requires more extensive counselling following recent childbirth, in recent menarche, during perimenopause, and following recent discontinuation of injectable contraceptive methods.

Women Who Can Use FAMs

- All women of reproductive age with established menstrual cycles, including women with disabilities and migrant populations, can use FAM methods if they can learn to identify their fertile days.
- These methods are good FP options for couples that cannot use modern methods on religious, cultural, or medical grounds; and

Women Who Should Not Use This Method

- This method would not be appropriate for the following:
- Women who dislike touching their genitals
- Women whose partners will not cooperate
- Couples who want highly effective protection against pregnancy (e.g., the woman has conditions that can be made worse by pregnancy

Obtaining These Methods

- Health professionals and lay persons who have received training in FAMs and NFP methods can counsel women on these methods.
- Women and couples can obtain assistance at any appropriate site with a qualified service provider.

Withdrawal (Coitus Interruptus) Method

- Coitus interruptus (CI) is one of the traditional methods of birth control. A couple that is using this method may have intercourse in any way acceptable to them until ejaculation is about to occur.
- Before ejaculation, the male withdraws his penis from the vagina and external genitalia of the female in order to prevent sperm from entering the female's reproductive tract, thereby preventing contact between the spermatozoa and the ovum.

Coitus interruptus cont.

- This method might be appropriate for couples who need a temporary method while they await the start of another method, or for those who have entered into a sexual act without any other method and need contraception immediately.
- The method has one strong disadvantage: It demands consistent self-control on the part of the male partner, which could be difficult at times.
- In addition, it is possible for pre-ejaculatory fluid containing sperm to flow out during the excitement phase, before the penis is withdrawn.

Coitus interruptus cont.

- The failure rate of the withdrawal method ranges from 4-10 pregnancies per 100 women per year when it is used consistently, to 14-23 pregnancies per 100 woman per year among actual users (i.e., when it is not used consistently).

Advantages of CI

- Coitus interruptus can be an effective method if it is used correctly, and it is always available for use as a primary or back-up method. This method offers several other benefits:
- CI does not affect breastfeeding.
- CI involves no economic cost.
- CI involves no use of devices or chemicals.
- CI has no health risks associated directly with it.

Limitations of CI

- The withdrawal method has two major limitations:

(1) It does not protect from STIs, including HIV/AIDS and

(2) Effectiveness depends on the willingness and ability of the male partner to use withdrawal with every act of intercourse.

- **NOTE:**
- Couples who have intercourse infrequently should not rely on the withdrawal method because it requires a lot of practice.

Limitations of CI cont.

- Service providers should counsel couples who want to rely on the withdrawal method to use another method while the man is learning to withdraw on time.
- Lack of ejaculatory control (or premature ejaculation) is a contraindication to the use of the withdrawal method of birth control.