FAMILY PLANNING/REPRODUCTIVE HEALTH TRAINING MANUAL FOR PRIVATE SECTOR PHYSICIANS

USAID FROM THE AMERICAN PEOPLE

Evidence

DAY ONE

Session 1

- **Introduction:**
  - ❖ Goal
  - ❖ Learning Objectives
  - ❖ Schedule
  - ❖ Expectations and ground rules.
  - ❖ Pre-test

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Goal

- **Ensure availability and Improving the quality of FP/RH services delivered by private sector providers for youth in Egypt.**

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Objectives

- **By the end of this training course, each participant will be able to:**
  - Discuss the population problem in Egypt highlighting latest findings of EDHS (2014) and importance of family planning as a human right.
  - Discuss available contraceptives with respect to mode of action, effectiveness, indications, WHO medical eligibility criteria, how to use and side effects,
  - Manage problems associated with contraceptive practice.

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Objectives

- Enable clients to safely and effectively use specific FP methods through proper counseling and service provision.
- Demonstrate the steps of client clinical assessment.
- Demonstrate appropriate CuT380A IUD insertion and removal on pelvic model.
- Follow infection control practices in FP clinics.
- Describe postpartum and post abortion FP methods.

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Objectives (Cont.)

- Demonstrate appropriate implanon insertion and removal on arm model.
- Discuss Emergency contraception pills (ECPs) with clients.
- Identify the role of men in FP and GBV.
- Discuss issues surrounding FGM/C.
- Identify sexually transmitted infections (STIs) in RH practices.

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Session 2

❑ **Topics:**

- ❖ The population situation in Egypt (Population problem, EDHS).
- ❖ Client rights.
- ❖ Benefits of FP, Compliance.

❑ **Objectives:**

By the end of the session the participant will be able to:

- ✓ Discuss the elements of the population problem in Egypt and it's consequences.
- ✓ Discuss FP practice in Egypt using DHS 2014 data.
- ✓ Explore Health benefits of family planning as a human rights.
- ✓ Explain healthy timing and spacing of pregnancies.

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المشكلة السكانية فى مصر

- **تعريف المشكلة السكانية :**
- هي الخلل في التوازن بين موارد الدولة وحاجات السكان أو بمعني آخر بين معدلات التنمية الاقتصادية ومعدلات النمو السكاني. وكلما اتسعت الفجوة بينهما أنخفض مستوي المعيشة وتدني بالنسبة للأسرة والفرد، وبالتالي ينخفض المستوي الاجتماعي أي مزيد من التخلف وعدم القدرة علي الإنتاج نتيجة تدني خصائص السكان فتتفاقم المشكلة.

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المشكلة السكانية فى مصر

❑ الآثار السلبية الناتجة عن المشكلة السكانية :

- أستمرار معدلات النمو السكانى على مستوياتها الحالية سيؤدى إلى تراجع العائد على جهود التنمية و يؤدى إلى أنخفاض فى نصيب الفرد فى الأنفاق على التعليم و الصحة و الإسكان و النقل و المواصلات و نصيبه فى الأرض الزراعية و المياه و الطاقة بأنواعها، كما ستجعل هذه الزيادة الحد من البطالة و الأمية والإكتفاء الغذائى أكثر صعوبة.
- تزايد التحديات البيئية الناتجة عن الزيادة السكانية فيما يتعلق بالمياه و التلوث و النمو العشوائى و ضعف القدرة على التخلص من النفايات مما ينعكس سلبا على صحة المواطنين.

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❑ وتهدف السياسة القومية للسكان فى مصر الى :

- الارتقاء بنوعية المواطن المصرى من خلال خفض معدلات الزياده السكانيه .
- أعادة التوزيع الجغرافي والسكاني لمصر .
- الارتقاء بالخصائص السكانية .
- تقليل التفاوتات الديموجرافية والاجتماعية والاقتصادية بين المجموعات السكانية والمناطق الجغرافية المختلفة.

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Population Situation in Egypt

- Total population was 88 million at the time of EDHS in 2014.
- The latest figure according to CAPMAS is 93.2 million in Jun 2017.
- More than one third of Egypt's population is under the age of 15 years.

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Fertility in Egypt

- Total fertility rate is defined as: the number of children a woman would have by the end of her childbearing (or reproductive) years.
- Total fertility rate has increased from 3 in 2008-EDHS to 3.5 in 2014-EDHS.

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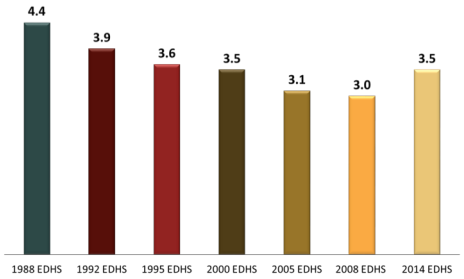
Fertility Trends, 1988-2014

Births per woman for three-year period before the survey



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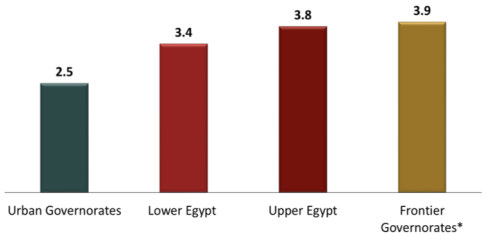
Fertility by Place of Residence

Births per woman for 3-year period before the survey



**Does not include North and South Sinai governorates*

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Fertility by place of residence

- **Fertility by Governorate:**
  - Governorates with the lowest fertility rates:
    - Alexandria – 2.2
    - Cairo – 2.6
  - Governorates with the highest fertility rates:
    - Matrouh – 4.8
    - Fayoum – 4.6
    - Souhag – 4.3
    - Assuit – 4.2

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Median age at First Birth for women

- Although the legal age at marriage for women in Egypt is 18 years,6.4 % of women age 15-17 were ever-married while 6.2% were currently married.
- Teenage Childbearing: 7% of married women between the ages of 15-19 are *already mothers* and 4% are *pregnant* with their first child.

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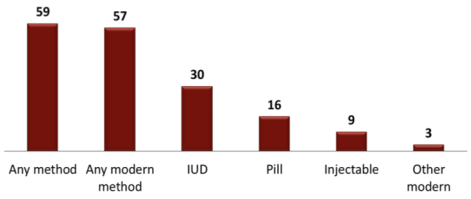
Current Use of Contraception

Percent of currently married women age 15-49



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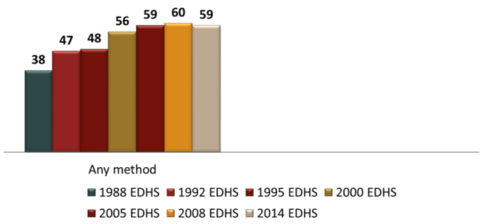
Trends in Use of Family Planning

Percent of currently married women age 15-49



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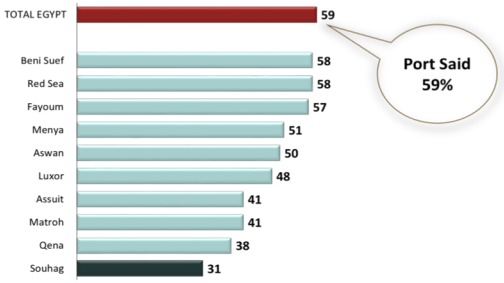
Governorates with Contraceptive Use At/Below the National Average

Percent of currently married women age 15-49 using any method of contraception



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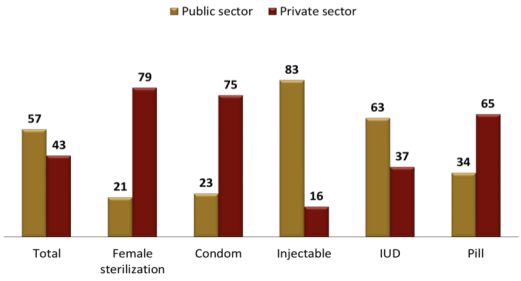
Source of Contraception

Percent distribution of current contraceptive users



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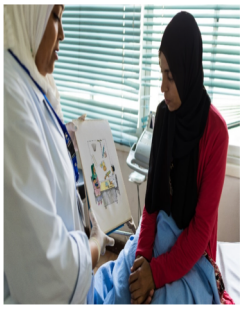
Unmet Need for FP services

- Women are considered as having an unmet need for family planning if they wish to: space their next birth OR to limit childbearing altogether BUT are not using contraception.
- 13% of currently married women have an unmet need for family planning:
  - 5% spacing.
  - 8% limiting.



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Unmet Need(Cont.)

- In other words: 2 million women in Egypt don't get the FP methods they need to space or stop child bearing.
- **Main Reasons given by women for nonuse contraception although they do not want to get pregnant:**
  - Fertility- related reasons (Breastfeeding , not menstruated since last birth).
  - Opposition to use (Respond opposed, husband opposed, religious prohibition).
  - Lack of knowledge.
  - Method- related reasons (Fear of side effects, costs to much, preferred method not available, lack of access/ too far, no method available……)

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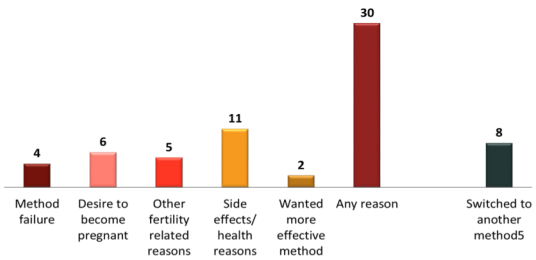
Contraceptive discontinuation rates by reason for Stopping use



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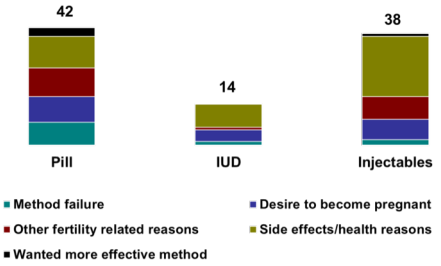
Contraceptive discontinuation rates by method and reason for stopping use

Among women age 15-49



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Family Planning as a Human right in Egypt

- Free Decision and Access to FP is a fundamental human right.
- It was proclaimed by the International Community since the late 1960s.
- That is the right to decide Whether, When and How many times to have children, as well as the means to exercise this human right.

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Informed decision-making /voluntarism (USAID)

- Includes effective access to information to FP choices, to the counselling services and supplies needed.
- Freedom of choice to obtain or decline services.
- No pressures or element of force, fraud, deceit, or misrepresentation affects the decision.

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Clients rights

1. **Information: The right to learn about the** benefits and availability of family planning.
2. **Access: The right to obtain services** regardless of sex, creed, color, marital status or location.
3. **Choice: The right to decide freely whether to** practice family planning and which method to use.
4. **Safety: The right to be able to practice safe** and effective family planning.
5. **Privacy: The right to have a private** environment during counseling or services.

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Clients rights

6. **Confidentiality: The right to be assured that** personal information will remain confidential.
7. **Dignity: The right to be treated with** courtesy, consideration, and attentiveness.
8. **Comfort: The right to feel comfortable when** receiving services.
9. **Continuity: The right to receive** contraceptive services and supplies for as long as needed.
10. **Opinion: The right to express views on the** services offered.

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Healthy Timing and Spacing of Pregnancies

Healthy timing and spacing of pregnancies helps women bear children at healthy times in their lives. Mothers and infants are then more likely to survive and stay healthy when spacing between pregnancy by 3-5 years.

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Healthy Timing and Spacing of Pregnancies

- **There are actions must be taken to strengthen family planning as an essential intervention for child survival:**

1- Educate families on family planning's role in ensuring pregnancies occur at the healthiest times in a woman's life. This helps avoid high-risk pregnancies.

Healthy times for a pregnancy are:

- At least 24 months after a live birth* – this interval is consistent with the WHO/UNICEF recommendation of breastfeeding for 2 years.
- Between ages 20 and 35.
- At least 6 months after a miscarriage.

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Healthy Timing and Spacing of Pregnancies

- **There are actions must be taken to strengthen family planning as an essential intervention for child survival: (cont)**

2. Expand the mix of available contraceptives, including long-acting, reversible methods, to help couples effectively delay, time, space, and limit pregnancies to achieve their fertility intentions.

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Benefits of family planning

- FP helps save the lives of countless women and children, help alleviate poverty ,reduce stress on the environment and economy, ensure families are better able to feed, clothe, and educate their children.

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Benefits of family planning

- Prevents pregnancy related to health risks, Spacing 3 years and more has positive impact on women's health and well being:
  - Prevents death and health problems in young women.
  - Prevents unintended pregnancy in older women with decreased MM (maternal mortality) and morbidity.
  - FP practice decrease maternal mortality (MM) by 30 %.
  - Reduces unsafe abortion and its consequences.

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Benefits of family planning

- Healthy timing and spacing of pregnancies reduces infant and child mortality.
- Decrease infant mortality , infants of mothers who die as a result of giving birth also have a greater risk of death and poor health.
- FP reduces the risk of unintended pregnancy among women living with HIV with subsequent reduction in mother to child transmission few infected babies.
- FP reduces adolescent pregnancy and its subsequent complications.

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Benefits of family planning

- Female and male condoms help in preventing STIs and HIV transmission (dual protection).
- **Non contraceptive benefits of COCs:**
  - **Help in treating or reducing the following conditions：**
    - Acne.
    - Cyclic breast pain.
    - Dysmenorrhea.
    - Decrease ectopic pregnancy.
    - Functional ovarian cysts.

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Benefits of family planning

- Endometriosis.
- Hirsutism associated with PCOS.
- Iron deficiency Anemia.
- Metrorrhagia.
- Mid-cycle or ovulatory pain.
- Reduces the incidence of ovarian and endometrial cancer.
- Premenstrual syndrome.
- Uterine fibroids.

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Session 3

❑ **Topics:**

- Anatomy of female and male reproductive system.
- Physiology of female reproductive system.
- Client clinical assessment.

❑ **Objectives:**

By the end of the session the participant will be able to:

- ✓ Describe the anatomy of female and male reproductive system.
- ✓ Explain the physiology of female reproductive system.
- ✓ Demonstrate the steps of client clinical assessment.

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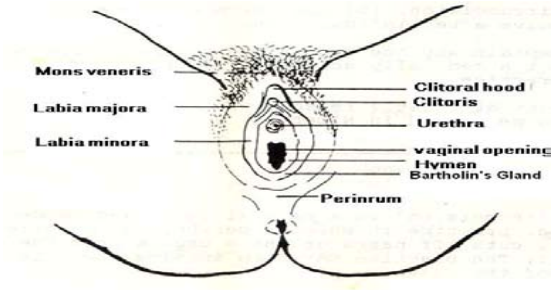
External Female Genitals



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External Female Genitals

- **Mons pubis:** is a pad of fatty tissue over the pubic bone, which becomes covered with hair during puberty, protects the internal sexual and reproductive organs.
- **Labia majora:** Two spongy folds of skin - one on either side of the vaginal opening covering and protecting the genital structures.
- **Labia minora:** Two erectile folds of skin between the labia majora that extend from the clitoris on both sides of the urethral and vaginal openings.
- **Clitoris:** An erectile, hooded organ at the upper joining of the labia that contains a high concentration of nerve endings and is very sensitive to stimulation.

All the above together, along with the opening of the vagina, they are known as the vulva.

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External Female Genitals

- **Urethra:** The external opening of the urinary tract.
- **Vaginal opening:** The external opening of the genital tract.
- **Hymen:** A thin membrane that surrounds the opening to a young woman's vagina.
- **Perineum:** is a network of muscles located between and surrounding the vagina and the anus that support the pelvic cavity and help keep pelvic organs in place.

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External Female Genitals

❑ **Role of the clitoris and Labia:**

- These organs are very rich of nerve endings that make them extremely sensitive organs. Touch stimulation of the nerve endings in the labia and especially the clitoris produces sensations of sexual pleasure and orgasm.

❖ The external genital organs include the mons pubis, labia majora, labia minora, Bartholin glands, and clitoris. The area containing these organs is called the vulva. The external genital organs have these main functions:

- Enabling sperm to enter the body.
- Protecting the internal genital organs from infectious organisms.
- Providing the sexual pleasure.
- Directs the urine in a stream by the labia minora preventing splashing and soiling of the vulva.

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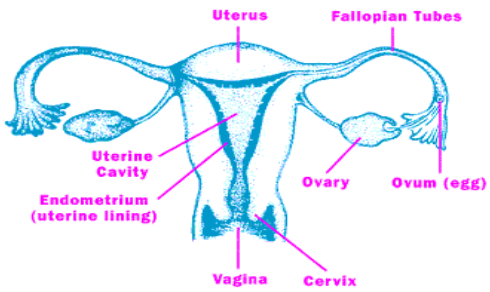
Internal Female Genitals



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Internal Female Genitals

- **Vagina:** is a muscular, highly expandable, tubular cavity leading from the vestibule to the uterus.
- **Bartholin's glands:** two small, round structures. These glands secrete a mucus-like fluid during sexual arousal, providing vaginal lubrication.
- **Cervix:** the lower part of the uterus that protrudes into the vaginal canal, it has an orifice that allows passage for menstrual flow from the uterus and passage of sperm into the uterus.
- **Ovaries:** are two organs located at the end of each fallopian tube, that produce ova (releasing one per month from puberty to menopause).

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Internal Female Genitals

- **Uterus:** is a hollow, thick-walled, pear-shaped, muscular organ located between the bladder and rectum, it is the site of implantation of the fertilized ovum.
- **Endometrium:** lining of the uterus, which gradually thickens and then is shed during monthly bleeding.
- **Fallopian tubes:** are a pair of tubes that extend from the upper uterus, extending out toward the ovaries (but not touching them), through which ova travel from the ovaries toward the uterus and in which fertilization of the ovum takes place.

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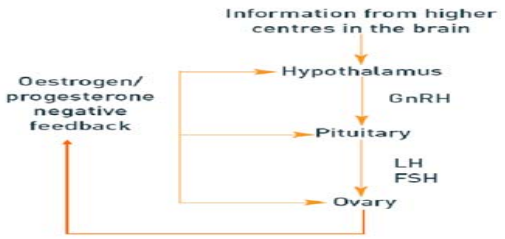
Physiology of female reproductive system

Endocrine regulation of ovarian functions



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Physiology of Reproduction

❑ **Menstruation**

- Menstruation is a woman's monthly bleeding.

- The menstrual blood is partly blood and partly tissue from the inside of the uterus (endometrium shedding).

-Most menstrual periods last from three to five days.

❑ **Menstrual Cycle**

- A cycle starts on the first day of a period (the 1st bleeding day).
- The average menstrual cycle is 28 days long.
- The parts of the body involved in the menstrual cycle include the brain, pituitary gland, uterus and cervix, ovaries, fallopian tubes, and vagina.

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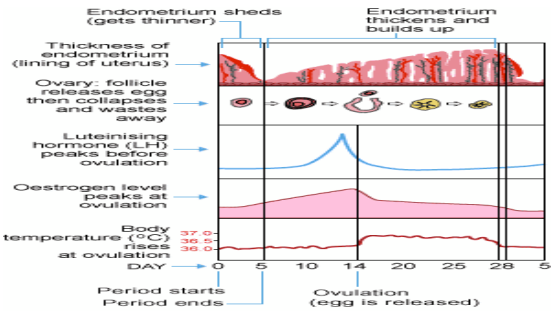
Physiology of female reproductive system



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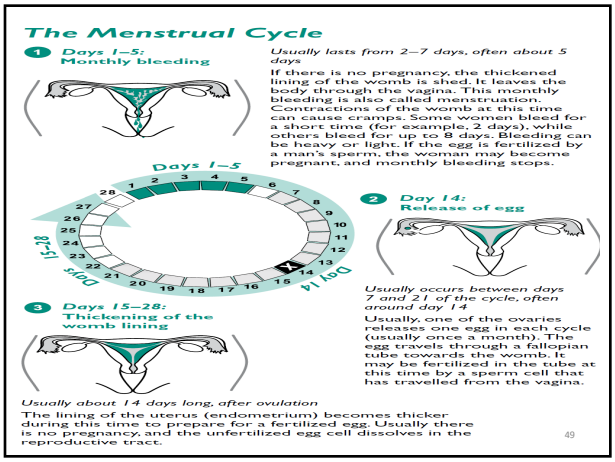

Ovulation

- **Hormones and releasing factors affecting ovulation:**
  - Gonadotropin Releasing Hormone (GnRH).
  - Follicle Stimulating Hormone (FSH).
  - Luteinizing Hormone (LH).
  - Human Chorionic Gonadotropin (HCG).
  - Oxytocin.

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Ovulation

- **Estrogen:** secreted by the ovaries and responsible for the following:
  - Secondary sex characteristics.
  - Uterine lining development.
- **Progesterone:** secreted by the ovaries and responsible for the following:
  - Strongly inhibits GnRH release (stops production of LH and FSH).
  - Uterine lining development (promotes gestation, hence 'progesterone').

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Fertilization

Male role in fertilization is the ejaculation of the semen (containing sufficient number of motile and normal sperms) out of the male body into the vagina during sexual intercourse.

❑ **Conception:**

It occurs if an active sperm fertilizes the ovum.

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Physiology of female reproductive system

❑ **Sexual Desire and the Sexual Response Cycle:**

- Sex starts with desire in response to various stimuli like vision, sound, smell, memory, etc...
- Desire is a purely mental process that originates in the brain (not in external genital organs) and is influenced by personal, cultural, ethical and social factors.
- Sexual desire may or may not progress to the next phases of the sexual response cycle i.e. arousal, plateau, orgasm then resolution phases which are the physical reactions to sexual desire.

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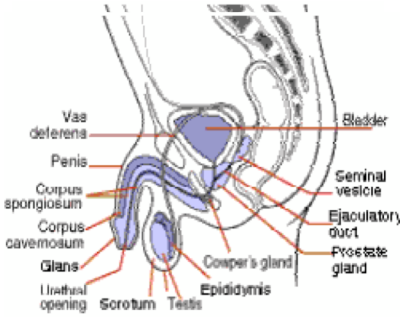
Male Genitals



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Male Genitals

- **Penis:** Cylindrical structure with the capacity to be flaccid or erect Very sensitive to stimulation, Glens penis is the most highly innervated part penetrates the vagina during sex, provides passage for both urine and semen.
- **Scrotum:** A pouch of skin hanging directly under the penis and contains the testes, protects the testes and maintains the temperature necessary for the production of sperms.
- **Testicles:** Paired, oval-shaped organs located in the scrotum, produce sperms and male sex hormone **(testosterone)**, highly innervated and sensitive to touch and pressure.

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Male Genitals

- **Vas deferens:** Paired tubes that carry the mature sperms from the epididymis to the urethra.
- **Seminal vesicles:** A pair of glandular sacs that secrete about 60% of the fluid that makes up the semen in which sperms are transported.
- **Prostate:** Glandular structure that secretes some of the fluid that makes up the semen, the alkaline quality of the fluid neutralizes the acidic environment of the male and female reproductive tracts.

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Client's Clinical Assessment

- **Before examination :**It is so important that physician explain the steps of the examination to the woman so she will be prepared and knows what to expect.
- **After Examination:** it is so important to communicate to the woman your findings and discuss openly her options.

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Client's Clinical Assessment (Cont.)

- **A general medical examination** is recommended to:
  - All new clients and repeated annually.
  - When clients complained having any side effects.
- **A pelvic examination is recommended:**
  - Before inserting IUDs.
  - When clients complain from reproductive tract symptoms.

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Steps for General Examination

- **History Taking:**
  - **Identifying Information**: Basic information e.g. Age …. Etc)
  - **Demographic information**: How big Is your family ?
  - **History of present illness**: complain and symptoms
  - **Medical history:** what is your current health status, medications used.
  - **Family Planning History**: what are methods used before ? For how long? When and why interrupted ? Children spacing?

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Steps for General Examination (Cont.)

- **History Taking:**
  - **Menstrual history:** how consistent is your menstrual cycle? what is pattern of the menses ?
  - **Obstetric history:** History of operations including deliveries?
  - **Gynecological History:** History of visiting a gynecologist, past diagnosis
  - **Reproductive goals:** what are your future goals for your family size and their health status ?

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Steps for General Examination (Cont.)

❑ **Physical Examination :**

- Vital signs.
- Height.
- Weight in Kg.
- Overall general condition.
- Head and neck.
- Heart.
- Chest and Lungs.
- Abdominal examination.
- Extremities.
- **Note:** measuring blood pressure is a must for all new clients and before hormonal methods re-supply every 3 months.

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Steps for General Examination (Cont.)

❑ **Documentation:**

- All findings, information provided, procedures done, and steps followed must be clearly stated in the Personal file within the family file.
- It has to be done immediately during or after meeting client's need.

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Steps for Pelvic Examination

Before starting any examination, ensure the privacy of the client and have an open dialogue with the woman about the procedure and the steps.

❑ **External Genitalia:**

1. Inspect the following structures:
   - Mons pubis, observe pubic hair for lice, or other skin lesions
   - Labia minora and majora for inflammation, ulcerations, nodules, and female genital mutilation/cutting.
2. Inspect the vulva and perineum.
3. Observe for any discharge or prolapse, inflammation, ulceration, nodules, previous episiotomy scars, genital warts, or other presentation.

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Steps for Pelvic Examination (cont.)

❑ **Bimanual Examination:**

During bimanual examination, physician must palpate for the following:

- Vagina for cysts or masses.
- Cervix for consistency (soft or firm), mobility (mobile or immobile), tenderness (tender or non-tender).
- Supra pubic for tenderness or masses.
- Uterus : size, shape, position, consistency, mobility, and tenderness.
- Adnexa: enlargement, masses or tenderness.

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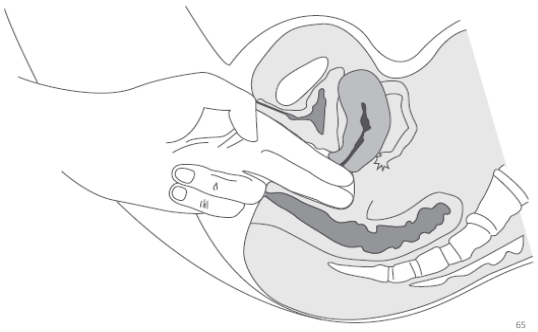
Bimanual Examination:



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Steps for Pelvic Examination (cont.)

❑ **Speculum Examination:**

❖ Inspect the cervix :

Observe position, prolapse, transformation zone, ulceration, discharge, polyps, cysts, nodules, color, plaques, and contact bleeding or bleeding from the vagina.

❖ Abnormal findings include:-

– Purulent discharge, Pelvic Inflammatory Disease (PID), Ectropion, Nabothian cyst –Cervicitis, Herpes, Cervical polyp, Cervical carcinoma, Cervical prolapse

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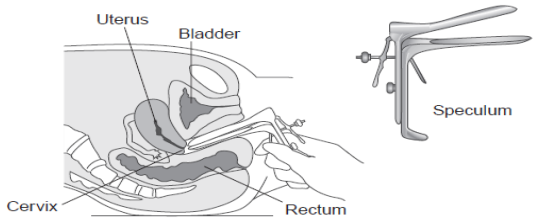
Speculum Examination



67

- At the end of the examination, the doctor should discuss with the woman his findings, consequences, and her future options.

68

Session 4

❑ **Topics:**

- WHO medical eligibility criteria.
- Combined oral contraceptive pills (COCs)

❑ **Objectives:**

By the end of the session participants will be able to:

- ✓ Explain WHO medical eligibility criteria.
- ✓ Discuss Combined oral contraceptive pills (COCs), mode of action, how to use, effectiveness, medical eligibility criteria, side effects, and management of selected problems.

69

WHO Medical Eligibility Criteria for contraceptive use

Known medical conditions that might affect eligibility for the use of a contraceptive method are classified into four categories:

Category	With clinical judgment	With limited clinical judgment
1	Use the method under any circumstances.	Yes (use the method)
2	Generally use the method.	
3	Use of the 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.	

70

WHO Medical Eligibility Criteria for contraceptive use

CATEGORY 1 — A condition for which there is no restriction for the use of the contraceptive method.

CATEGORY 2 — A condition where the advantages of using the method generally outweigh the theoretical or proven risks.

CATEGORY 3 — A condition where the theoretical or proven risks usually outweigh the advantages of using the method.

CATEGORY 4 — A condition which represents an unacceptable health risk if the contraceptive method is used.

71

WHO Medical Eligibility Criteria for contraceptive use

- **A=** COC is (**category 3**) without other risk factors for VTE. And (**category 4**) with other risk factors for VTE.
- **F** = COC is (category **2**) without VTE risk factor and (**category 3**) with VTE risk factor.
- **D** = combined hormonal injectable is (category **3**) with severe liver cirrhosis.
- **0** = CIC is (**category 2**) in case of Gall Bladder Diseases (medically treated, current Or Past-COC related.
- **L** = CIC is (**category 2**) in case of anticonvulsant and Rifampicin
- **I** = Initiation
- **C** = Continuation

72

WHO Medical Eligibility Criteria for contraceptive use

Condition	COC/CIC	POP	DMPA	IMPLANON	CU IUD
Party					
nulliparous					
Breastfeeding					
• <6 weeks postpartum					
• 6 weeks to <6 months					
• >6months postpartum					
Postpartum (non-breastfeeding)					
• <3 weeks	A				
• >3 weeks <6 weeks	F				
Postpartum (breastfeeding or non-breastfeeding women, including post caesarean section)					
• <48 hours					
• 48 hours to <4 weeks					
• >4 weeks					
Puerperal sepsis					

73

WHO Medical Eligibility Criteria for contraceptive use

Post abortion					
• First trimester					
• Second trimester					
• Immediate post septic abortion					
Past ectopic pregnancy					
Hypertension					
• Adequately controlled hypertension					
• Consistently elevated blood pressure level					
➢ Systolic>140 to159 or diastolic>90 to99 mmHg					
➢ Systolic>=160 or diastolic >=100 mmHg					

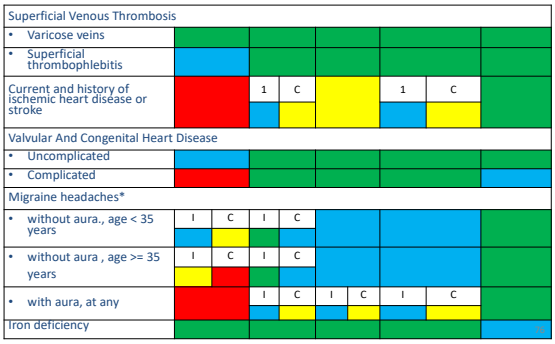
74

WHO Medical Eligibility Criteria for contraceptive use

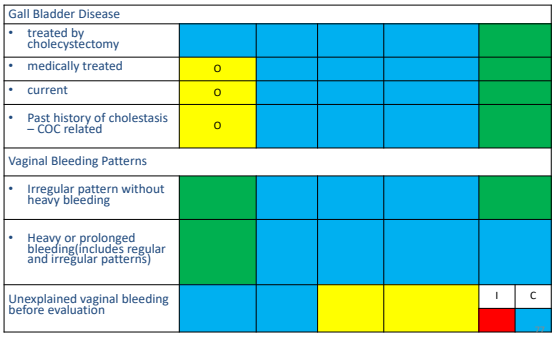
History of high blood pressure during pregnancy (where current blood pressure is normal)					
Certain anti convulsant	L				
Rifampicin or Refabutin	L				
Venous thromboembolism					
• History of VTE					
• Current VTE					
• Current VTE (on anticoagulants)					
• Family history of VTE (first degree relative)					
Major surgery					
• With prolonged immobilization					
• Without prolonged immobilization					
• Minor surgery without immobilization					

75

WHO Medical Eligibility Criteria for contraceptive use



WHO Medical Eligibility Criteria for contraceptive use



WHO Medical Eligibility Criteria for contraceptive use

78

WHO Medical Eligibility Criteria for contraceptive use

STIs						
• Purulent cervicitis, chlamydia or gonorrhea					I	C
• Vaginitis (including trichomonas vaginalis and bacterial vaginosis)						
• Increased risk of STIs						
Tuberculosis						
• Non pelvic						
• Pelvic					I	C
Diabetes						
• Non vascular disease						
• Retinopathy- Nephropathy						
• Diabetes >20 yrs duration						

79

WHO Medical Eligibility Criteria for contraceptive use

Thyroid Disorders						
• Hyperthyroid						
• Hypothyroid						
Viral Hepatitis						
• Acute or flare	I	C				
• Carrier						
Liver Cirrhosis						
• Mild (compensated)						
• Severe (decompensated)	D					

80

Combined oral contraceptives (COCs)

❑ **What are combined oral contraceptives?**

Pills that contain low doses of 2 hormones –a progestin and estrogen like the natural hormones progesterone and estrogen in a woman's body.

❑ **Brands available in the Market :**

- **Microcept** (0.03 mg ethinylestradiol, 0.15 mg levonorgestrel)
- **Triocept**
- **Cilest**
- **Genera**
- **Marvelon**
- **Yasmeen**

81

Combined oral contraceptives (COCs) (Cont.)

- **Mechanism of action:** COCs prevent pregnancy essentially by
  - Preventing ovulation.
  - Partially by increasing the viscosity of the cervical mucus making it difficult to be penetrated by sperms.
- **Effectiveness:**
  - When no pill- taking mistakes are made (with regular use), less than 1 pregnancy per 100 women using COCs over the first year (3 per 1000 women).

82

Combined oral contraceptives (COCs) (Cont.)

- **Advantages :**
  - Safe and highly effective when taken correctly and consistently.
  - Reversible.
  - No action needed at time of intercourse.
  - Reduces menstrual irregularities, anemia , painful menses.
  - Reduces risk of ovarian and uterine cancer.

83

Combined oral contraceptives (COCs) (Cont.)

- **Disadvantages:**
  - Requires daily administration.
  - Not recommended during breastfeeding women as it affects the quantity of breast milk, yet they can be used after 6 months of child birth.

84

Combined oral contraceptives (COCs) (Cont.)

- **Side effects:** Some users report the following :
  - Changes in bleeding patterns including :
    - lighter bleeding and fewer days of bleeding.
    - Irregular bleeding.
    - No monthly bleeding.
  - Headaches, dizziness, nausea, breast tenderness, weight gain, and mood changes.

85

Combined oral contraceptives (COCs) (Cont.)

- **Who can use COCs?**

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

- Have or have not children.
- Are of any age, including married adolescents and women over 40 years old.
- Have just had an abortion or miscarriage.
- Smoke cigarettes if under 35 years old.
- Have anemia now or had in the past.
- Have varicose veins.
- Are infected with HIV, whether or not on antiretroviral therapy, unless that therapy includes Ritonavir.

86

Combined oral contraceptives (COCs) (Cont.)

- **Who can not use COCs? i.e. category 3 - category 4 of WHO medical eligibility criteria)**
  - Are breast feeding baby less than 6 months old.
  - Women have had a baby in the last 3 weeks and are not breastfeeding.
  - There is an additional risk that she might develop a blood clot in a deep vein, then she should not start COCs at 3 weeks after child birth, but better start at 6 weeks instead.
  - These additional risk factors include previous VTE, Thrombophilia, caesarean delivery, blood transfusion at delivery, postpartum hemorrhage, pre-eclampsia, obesity> 30kg/m2, smoking, and being bedridden for a prolonged time.
  - Women who smoke cigarettes, If they are 35 years of age or older.

87

Combined oral contraceptives (COCs) (Cont.)

- **Who can not use COCs?**
  - Women who have cirrhosis of the liver, or liver tumors. Those should choose a method without hormones.
  - Have blood pressure 140/90mmHg or higher.
  - Have had diabetes for more than 20 years and its complications, or with diabetes less than 20 years but with complications.
  - Have gallbladder disease now or are taking medication for gallbladder disease.
  - Have had a stroke, blood clot in their leg or lungs, heart attack, or other serious heart problems.

88

Combined oral contraceptives (COCs) (Cont.)

- **Who can not use COCs?**
  - Have or have had breast cancer, they choose a method without hormones.
  - Have migraine headaches.
  - Are taking medication for seizures, or Rifampicin for tuberculosis or other illness.
  - Are planning major surgery that will keep them from walking for one week or more.
  - Have several conditions that could increase their chances of heart disease (coronary artery disease) or stroke such as older age- smoking – diabetes or high blood pressure ≥ 140/90 mmg.

89

Combined oral contraceptives (COCs) (Cont.)

- **When to start?** A woman can start using COCs any time if it is reasonably certain she is not pregnant (pregnancy checklist annex3).
  - **Any time of the month :**
    - If she is starting within5 days after the start of her monthly bleeding, no need for a backup method.
    - If it is more than 5 days after the start of her monthly bleeding, she can start COCs any time it is reasonably certain she is not pregnant, but she will need a backup method for the first 7 days of taking pills.
  - **Switching from a hormonal method :** immediately if she has been using the method consistently and correctly.

90

Combined oral contraceptives (COCs) (Cont.)

- **When to start?**
  - **Fully or nearly fully breastfeeding:**
    - More than 6 months after giving birth:
    - IF her monthly bleeding has not returned she can start using COCs any time if it is reasonably certain she is not pregnant, but she will need a backup method for the first 7 days of taking pills.
    - IF her monthly bleeding has returned she can start COCs as advised for women having menstrual cycles.

91

Combined oral contraceptives (COCs) (Cont.)

- **Not breastfeeding** :
  - **She start COCs at any time on days 21-28 after giving birth.**
  - More than 4 weeks after giving birth : if her monthly bleeding has not returned she can start COCs any time if it is reasonably certain she is not pregnant, but she will need a backup method for the first 7 days of taking pills.
  - if her monthly bleeding has returned she can start COCs as advised for women having menstrual cycles.

92

Combined oral contraceptives (COCs) (Cont.)

- **After miscarriage or abortion**:
  - Immediately if she is starting within 7 days after first or second trimester miscarriage or abortion no need for a backup method .
  - if it is more than 7 days after first or second trimester miscarriage or abortion she can start COCs any time if it is reasonably certain she is not pregnant, but she will need a backup method for the 7 days of taking pills.

93

Managing missed pills

Scenario	Action taken
Key Message	• Take a missed hormonal pill as soon as possible. • Keep taking pills as usual, one each day. (She may take 2 pills at the same time or on the same day.)
Missed 1 or 2 pills? Started new pack 1 or 2 days late?	• Take a hormonal pill as soon as possible. • Little or no risk of pregnancy.
Missed pills 3 or more days in a row in the first or second week? Started new pack 3 or more days late?	• Take a hormonal pill as soon as possible. • Use a backup method for the next 7 days. • Also, if she had sex in the past 5 days, can consider ECPs (see Emergency Contraceptive Pills).

94

Managing missed pills

Missed 3 or more pills in the third week?	✓ Take a hormonal pill as soon as possible. ✓ Finish all hormonal pills in the pack. ✓ Start a new pack the next day. ✓ Use a backup method for the next 7 days. ✓ Also, if she had sex in the past 5 days, can consider ECPs (see Emergency Contraceptive Pills).
Managing the missed effect of a pills due to :	
Severe vomiting or diarrhea	✓ If she vomits within 2 hours after taking a pill, she should take another pill from her pack as soon as possible, then keep taking pills as usual. ✓ If she has vomiting or diarrhea for more than 2 days, follow instructions for 3 or more missed pills, above.

95

Managing problems Associated with COCs

Problem	Action taken
Irregular bleeding	✓ Reassure client (becomes less or stop after the first few cycles). ✓ Advise taking the pills at the same time every day. ✓ Exclude vomiting ,diarrhea or taking other medications. ✓ Teach her how to take missed pills. ✓ Try 800 mg Ibuprofen or other NSAID at 3 times daily for 5 days. ✓ Try other formula of COCs. ✓ If irregular bleeding continues ,consider other underlying conditions not related to method use.

96

Managing problems Associated with COCs (Cont.)

Problem	Action taken
No monthly bleeding:	✓ Reassure client. ✓ Ask if she has been taking a pill every day. ✓ Did she skip the 7 days break. ✓ Advise on how to take missed pills. ✓ Exclude pregnancy.
Ordinary Headache	✓ Suggest Aspirin, NSAIDs or paracetamol. ✓ Evaluate.
Breast tenderness	✓ Wear supportive bra. ✓ Use Analgesics.
Nausea or dizziness	✓ Take COCs at bedtime or with food .

97

Managing problems Associated with COCs (Cont.)

Problem	Action taken
Mood changes or change in sex desire	✓ Check if there are changes in her life affecting her mood. ✓ Refer for evaluation.
Acne:	✓ Usually improves with COCs. ✓ Give different formula for at least 3 months .
Unexplained Vaginal bleeding:	✓ Refer for evaluation by history and pelvic exam. ✓ Diagnose and treat as appropriate. ✓ Do not stop COCs during evaluation. ✓ Treat PID or STIs if exists without stopping pills.

98

Managing problems Associated with COCs (Cont.)

Problem	Action taken
Migraine headaches	✓ Stop COCs. ✓ Help her choose a method that does not include estrogen.
Conditions in which client will be unable to move for several weeks (major surgery or her leg in a cast).	✓ Tell her doctor that she is using COCs. ✓ Stop COCs during this period and use a backup method . ✓ Start COCs 2 weeks after she can move again.
Suspected pregnancy:	✓ Assess for pregnancy . ✓ Stop taking COCs if pregnancy is confirmed. ✓ No known risks to the fetus.

99

Managing problems Associated with COCs (Cont.)

Problem	Action taken
Certain serious health conditions (heart and liver disease, high blood pressure , DVT, stroke, breast cancer, complicated DM, clots in the lung..):	✓ Stop taking COCs. ✓ Use a backup method (e.g. condom, spermicides). ✓ Refer for diagnosis and care.
Weight gain:	✓ Review diet habit and counsel as needed.

100

Follow-up

- After the first prescription, the client should be seen after three months for pill re-supply.
- Annual examination should be encouraged.
  - ➢ **The client should report immediately to the clinic if she experience:**
  - – Severe chest pain.
  - – Severe headache.
  - – Severe pain in the legs.

101

Session 5

❑ **Topics:**

Hormonal contraceptives (Cont.)

- Progestin only pills.
- Injectable methods.
- Emergency contraception.

❑ **Objectives :**

By the end of the session the participant will be able to:

- ✓ Discuss effectiveness, how to use, side effects and medical eligibility criteria of progestin only pills and injectable methods (combined and progestine only) as well as common problems and its management.
- ✓ Identify common rumors about oral contraceptive pills , injectables and implants and how to respond to it
- ✓ Discuss types and how to use emergency contraception.

102

Progestin – only pills (POP)

- **What are progestin only pills?**
  - Pills that contain very low doses of a **progestin** like the natural hormone progesterone in a woman's body
- **Mechanism of action:**
  - They make the cervical mucus thicker, thus prevent sperms from ascending to meet the ovum.
  - Occasionally they prevent ovulation.
- **Brands available in the Market :**
  - **Microlut**
  - **Exluton**
  - **Levonor**

103

Progestin – only pills (cont.)

- **Effectiveness:**
  - **Breastfeeding women:**
    - As commonly used, about **1** pregnancy per **100** women using POPs over the first year.
    - When pills are taken every day, less than 1 pregnancy per 100 women using POPs over the first year**(3 per 1,000women).**
  - **Non breastfeeding Less effective :**
    - As commonly used, about **3** to **10** pregnancies per 100 women using POPs over the first year.
    - When pills are taken every day at the same time, less than 1 pregnancy per 100 women using POPs over the first year **(9 per 1,000 women).**

104

Progestin – only pills (cont.)

- **Advantages:**
  - Can be used by breastfeeding women , does not affect quality or quantity of milk.
  - Easy to use, one is taken every day continuously.
  - Does not contain estrogen which is contraindicated for some woman.
  - May help prevent uterine and ovarian cancer.

105

Progestin – only pills (cont.)

- **Disadvantages:**
  - Pills must be taken at same time every day.
  - Incorrect pill intake and missing a pill significantly reduces efficacy , particularly among non- breastfeeding women.

106

Progestin – only pills (cont.)

- **Side effects:** Some users report the following :
  - Changes in bleeding patterns especially among breast feeding women:
    - Delay in return of monthly bleeding after childbirth.
    - Frequent or irregular or prolonged bleeding.
    - No monthly bleeding.
  - Headaches.
  - Dizziness, nausea, mood changes.
  - Breast tenderness.
  - Abdominal pain.
  - Other possible physical changes among non breastfeeding women for e.g. enlarged ovarian follicles.

107

Progestin – only pills (cont.)

- **Who can not use Progestin – only pills? (i.e. category 3 - 4 women of WHO of medical eligibility criteria) women who:**
  - Have severe liver cirrhosis, liver infection or liver tumor.
  - Have a blood clot in their legs or lungs.
  - Are taking medication for seizures, or Rifampicin or Rifabutin for tuberculosis or other illness.
  - Have or have ever had breast cancer.

108

Progestin – only pills (cont.)

- **When to start?** A woman can start using POPs any time if it is reasonably certain she is not pregnant (pregnancy checklist Annex3).
  - Among menstruating women : if she is starting within 5 days after the start of her monthly bleeding, no need for a backup method.
  - No monthly bleeding, or more than 5 days after the start of her monthly bleeding she can start POPs any time if it is reasonably certain she is not pregnant, she will need a backup method for the first 2 days of taking pills).

109

Progestin – only pills (cont.)

- **Fully or nearly fully breastfeeding.**
  - She can start after giving birth.
  - If her monthly bleeding has not returned, and fully lactating she can start POPs with no need for a backup method.
  - If her monthly bleeding has returned she can start POPs as advised for women having menstrual cycles.

110

Progestin – only pills (cont.)

- **Non breastfeeding women:**
  - Less than 4 weeks after giving birth: she can start POPs any time no need for a backup method.
  - More than 4 weeks after giving birth: if her monthly bleeding has not returned, she can start POPs any time if it is reasonably certain she is not pregnant she will need a backup method for the first 2 days of taking pills.
  - If her monthly bleeding has returned she can start POPs as advised for menstruating women.

111

Progestin – only pills (cont.)

❖ **Switching from a hormonal method :**

- She can start immediately if she has been using the method consistently and correctly.

❖ **After miscarriage or abortion:**

- She can start immediately if she is starting within 7 days after first or second trimester miscarriage or abortion with no need for a backup method .
- if it is more than 7 days after first or second trimester miscarriage or abortion she can start POPs any time if it is reasonably certain she is not pregnant, but she will need a backup method e.g. condom for 2 days of taking pills.

112

How to use the method

- Take one pill every day at the same time.

(it is recommended **not to be delayed for more than 3 hours).**

- No break between packs.

113

Managing missed pills

Breastfeeding(exclusive) and have no monthly bleeding (LAM)

↓

•Take a missed pill as soon as possible.
•Keep taking pills as usual, one each day.
(She may take 2 pills at the same time or on the same day.)

Breastfeeding and have monthly bleeding regularly

↓

•If yes, she also should use a backup method for the next 2 days.
•Also, if she had sex in the past 5 days, can consider taking Emergency Contraceptive Pills.

The same applied for Severe vomiting Or diarrhea

*If she vomits within 2 hours after taking a pill she should take another pill from her pack as soon as possible and keep taking pills as usual .

114

Managing problems Associated with POPs

Problem	Action taken
No monthly bleeding	✓ Normal during breast feeding . ✓ If not breast feeding , reassure (common in many women and it is not harmful).
Irregular bleeding :	✓ Reassure woman, it is common and may stop after few months. ✓ Emphasis that pills must be taken at the same time every day. ✓ Exclude vomiting ,diarrhea ,anticonvulsants and Rifampicine . ✓ Take missed pills properly including after vomiting and diarrhea. ✓ Try Ibuprofen 800 mg 3 times for 5 days or other NSAIDs. ✓ Try other POPs formula for 3 months . ✓ Consider other underlying conditions not related to method use.

115

Managing problems Associated with POPs (cont.)

Problem	Action taken
Heavy or prolonged bleeding:	✓ Reassure client. ✓ Try NSAIDs. ✓ Provide iron tablets to prevent anemia. ✓ If bleeding continues ,consider other underlying conditions.
Head aches, mood changes and changes in sex drive	✓ Check if there are changes in her life affecting her mood or sexual desire. ✓ Refer to evaluation.

116

Managing problems Associated with POPs (cont.)

Problem	Action taken
Unexplained vaginal bleeding:	✓ Refer for evaluation by history and pelvic exam and treat as appropriate. ✓ Do not stop POPs. ✓ Treat PID or STIs if they exist.
Migraine:	✓ She may continue with POPs if no aura. ✓ If she has migraine aura, stop POPs and give non hormonal method. ✓ **If Serious health conditions** are suspected e.g. blood clots in deep veins of legs or lung, liver disease or breast cancer) . ✓ Stop POPs, give backup method and refer for diagnosis and care.

117

Managing Problems Associated with POPs (cont.)

Problem	Action taken
Severe lower abdominal pain:	✓ May be due to several problems such as enlarged ovarian follicles or cysts . ✓ Continue POPs during evaluation. ✓ Reassure that cysts will disappear and evaluate after 6 months. ✓ Exclude ectopic pregnancy although POPs do not cause ectopic pregnancy. ✓ Refer for immediate diagnosis and care if you suspect ectopic pregnancy or other serious conditions.
Suspected pregnancy :	✓ Assess for pregnancy including ectopic. ✓ Stop POPs. ✓ Assure client that no known risk to fetus .

118

Combined (monthly) Injectables

- **What are monthly injectable?**
  - Monthly injectable contain 2 hormones (progestin and an estrogen) like the natural hormones progesterone and estrogen in a woman's body.
- **Available brands in the market:**
  - **Mesocept ampoule**.

  Contain 50 mg Norethisterone enanthate + 5 mg estradiol valerate

119

Combined (monthly) Injectables (cont.)

- **Mechanism of action, advantages, disadvantages, side effects are similar to those of COCs.**
- **How effective?**
  - Risk of pregnancy is greatest when a woman is late for an injection or misses it.
  - When women have injection regularly on a monthly basis, less than 1 pregnancy per 100 women using injection over the first year (5 per 10.000 women)
  - Return of fertility after injections are stopped, it takes an average of about one month longer than with most other methods.

120

Combined (monthly) Injectables (cont.)

- **When to start?**
  - She can start monthly injectable like COCs:
    - If she is menstruating, she can start within 7 days after the start of her monthly bleeding and no need for a backup method.
    - If it is more than 7 days after the start of her monthly bleeding she can start any time it is reasonably certain she is not pregnant but she will need a backup method for the first 7 days after the injection.

121

Combined (monthly) Injectables (cont.)

- **Planning the next injection:**
  - Every 4 weeks, she should come on time, however she may come 7 days early or late and still get an injection.
- **Management of problems:**
  - Irregular bleeding :

    Reassure her that many women experience irregular bleeding , it is not harmful and usually becomes less or stops after the first few months of use.

122

Progestin only-(3 month) Injectables

- **What are progestin only (3 month) injectables ?**
  - The injectable contraceptive Depot medroxyprogesterone acetate 150 mg (DMPA) contains a progestin like the natural hormone progesterone in a woman's body, it is known as Depo-provera.
  - It is taken every 3 months.
- **Mechanism of action:**
  - The cervical mucus become thick and ascending to meet the ovum.
  - Occasionally it prevents ovulation.

123

Progestin only-(3 month) Injectables (cont.)

- **Effectiveness:**
  - Taking injections regularly every 3 months is important to achieve the greatest effectiveness.
  - User should be instructed to come every 3 months for subsequent injections, however she may come 2 weeks early or 4 weeks late and still get an injection.
  - When women have injections regularly every 3 months, less than 1 pregnancy per 100 women using progestin only injectables over the first year (3per 1000 women).
  - **Note: Return of fertility after injections are stopped: an average about 4-9 months longer for DMPA than with most other methods.**

124

Progestin only-(3 month) Injectables (cont.)

- **Side effects:** Some users report the following:
  - Changes in bleeding patterns:
    - First 3 months: irregular bleeding or prolonged bleeding.
    - At one year: no monthly bleeding or irregular bleeding.
  - Weight gain, headaches, dizziness, abdominal bloating and discomfort, mood changes and reduced sex drive.
  - Other possible physical changes: loss of bone density.

125

Progestin only-(3 month) Injectables (cont.)

- **Known health benefits:**
  - Helps protect against: risks of pregnancy, uterine fibroids, endometrium and ovarian cancer.
  - May help protect against: symptomatic pelvic inflammatory disease and iron deficiency anemia.

126

Progestin only-(3 month) Injectables (cont.)

- **Who can not use Progestin-only (3 month) injectables? i.e. (Women of category3-4 of medical eligibility criteria).**
  - Are breast feeding a baby less than 6 weeks old.
  - Have severe cirrhosis of the liver, a liver function, or liver tumor.
  - Have high blood pressure, 160/100 mmHg or higher.
  - Have had diabetes for more than 20 years, with complications.

127

Progestin only-(3 month) Injectables (cont.)

- Have had a stroke, blood clot in their legs or lungs, heart attack, or other serious heart problems.
- Have vaginal bleeding that is unusual for them.
- Have or have had breast cancer.
- Have several conditions that could increase their chances of heart disease (coronary artery disease) or stroke such as diabetes or high blood pressure.

128

Progestin only-(3 month) Injectables (cont.)

- **When to start?**
  - **Having menstrual cycles:**
    - If she is **starting within 7 days after the start of her monthly bleeding**, no need for a backup method.
    - If it is more than 7 days after the start of her monthly bleeding, she can start injectable any time it is reasonably certain she is not pregnant but she will need a backup method for the first 7 days after the injection.

129

Progestin only-(3 month) Injectables (cont.)

- **Fully or nearly fully breastfeeding:**
  - ❖6 weeks – 6 months after giving birth:
  - If her monthly bleeding has not returned, and she is fully lactating she can start injectable any time between 6 weeks and 6 months with no need for a backup method.
  - If her monthly bleeding has returned she can start injectable as advised for women having menstrual cycles.
  - ❖More than 6 months after giving birth:
  - If her monthly bleeding has not returned, and fully lactating she can start injectable any time if it is reasonably certain she is not pregnant but she will need a backup method for the first 7days after the injection.
  - If her monthly bleeding has returned she can start injectable as advised for women having menstrual cycles.

130

Progestin only-(3 month) Injectables (cont.)

- **Non breastfeeding women:**
  - Less than 4 weeks after giving birth: she start injectable any time no need for a backup method.
  - More than 4 weeks after giving birth: if her monthly bleeding has not returned, she can start injectable any time if it is reasonably certain she is not pregnant but she will need a backup method for the first 7 days after taking the injection.
  - if her monthly bleeding has returned she can start injectable as advised for women menstruating.

131

Progestin only-(3 month) Injectables (cont.)

- **After miscarriage or abortion:**

  She can start within 7 days after first or second trimester miscarriage or abortion with no need for a backup method.

  if it is more than 7 days after first or second trimester miscarriage or abortion she can start injectable if it is reasonably certain she is not pregnant, but she will need a backup method for the first 7 days after taking the injection.
- **Switching from a hormonal method :**

She may start immediately if she has been using the method consistently and correctly.

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Managing problems Associated with (3- month)Injectables

Problem	Action taken
No monthly bleeding :	✓ Reassure client. ✓ Consider switching to monthly injectable.
Irregular bleeding:	✓ Reassure client. ✓ 500 mg Mefenamic acid twice after meals for 5 days or 40 mg Valedecoxib daily for 5 days. ✓ If bleeding continues consider other underlying conditions not related to method use.

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Managing problems Associated with (3- month)Injectables (cont.)

Problem	Action taken
Heavy or prolonged bleeding:	✓ She can try (one at a time) beginning when heavy bleeding starts: ✓ 500 mg of Mefenamic acid twice daily for 5 days. ✓ 40 mg of Valdecoxib daily for 5 days. ✓ 50 ug Ethinyl estradiol daily for 21 days. ✓ Help woman to choose another method. ✓ Iron tablets. ✓ Consider underlying conditions unrelated to method use .

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Managing Late Injections

- If the client is **less than 4 weeks** late for a repeat injection of DMPA, she can receive her next injection. No need for tests, evaluation, or a backup method.
- A client who is **more than 4 weeks** late for DMPA, can receive her next injection if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days.

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Emergency contraception pills

- **What are emergency contraceptive pills?**
  - A method to prevent unwanted pregnancy anytime up to 5 days after unprotected intercourse.
  - It does not protect against sexually transmitted disease.

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Emergency contraception pills

- **Emergency contraception can be provided using one of two methods:**

1. Emergency contraceptive pills (ECPs)
   - Use within 5 days.
   - Pills contain a progestin only, or a progestin and an estrogen , previously called " morning after" pills or postcoital contraceptives.
2. Intra-uterine devices (IUDs)
   - Insert within 5 days and continue use as long term method.

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Emergency contraception pills

- **Mechanism of action?**
  - Work by preventing or delaying ovulation.
- **What pills can be used as emergency contraceptive pills?**
  - A special ECP product with levonorgestrel only, or estrogen and levonorgestrel combined.
- **Brands available in the Market :**

- Contraplan.

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Emergency contraceptive pills-ECPs (cont.)

❑ **When to take them?**

- The sooner ECPs are taken the better they prevent pregnancy.
- Can prevent pregnancy when taken any time up to 5 days after unprotected sex.

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Emergency contraceptive pills-ECPs (cont.)

❑ **How effective?**

- If 100 women each had unprotected sex once during the second or third weeks of menstrual cycle (ovulation period) without using contraception 8 can become pregnant.
- If 100 women used progestin only ECPs, 1 from 8 will become pregnant which mean that 7 will be protected.
- If 100 women used estrogen and progestin (combined) ECPs, 2 from 8 will become pregnant which mean that 6 will be protected.
- It is enough to say that progestin only ECPs are more effective than combined pills as ECPs.

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Emergency contraceptive pills (cont.)

❑ **Side effects:**

- Changes in bleeding patterns:
  Slight irregular bleeding for 1-2 days after taking ECPs, or monthly bleeding that starts earlier or later than expected in the week after taking ECPs.
- Headaches, dizziness, abdominal pain, fatigue, vomiting, breast tenderness and nausea.

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Emergency contraceptive pills (cont.)

- **Dosing information:**
  - Levonorgestrel only: 1.5 mg in a single dose.
  - If she is using a 2-dose regimen, tell her to take the next dose within 12 hours each contain 0.75 mg levonorgestrel
  - Combined (Ethinyl estradiol and Levonorgestrel, low dose or standard dose COC: two doses each dose should contain at least :
    - 100 microgram (0.1 mg) Ethinyl estradiol.
    - 500 microgram (0.5 mg) Levonorgestrel.

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Emergency contraceptive pills (cont.)

- **ECPs appropriate in many situations** for example, after:
  - Voluntary sexual intercourse where no contraceptive is used.
  - Sex was forced (rape) or coerced.
  - Contraceptive mistakes, such as:
    - Condom was used incorrectly, slipped, or broken.
    - Couple incorrectly used a fertility awareness method.
    - Man failed to withdraw , before ejaculation.
    - Failure to take COCs for 3 consecutive days or POPs more than 3hours especially if not lactating
    - IUD has come out of place.
    - Woman is more than 4 weeks late for her repeat injection of DMPA or more than 7 days late for her repeat monthly injection.

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أهم الشائعات المتعلقة بحبوب تنظيم الأسرة

- **حبوب تنظيم الأسرة تسبب العقم:** لا تسبب أقراص تنظيم الأسرة العقم بدليل أن مقدمي الخدمة يركزون على أهمية أن تأخذ السيدات الأقراص في موعدها خشية أن يحدث حمل وقد يلجأ مقدمو الخدمة لتغيير الوسيلة للسيدات اللاتي لا يتذكرن أخذ الأقراص في موعدها.
- **حبوب تنظيم الأسرة تسبب الأورام:** لا تسبب أقراص تنظيم الأسرة أي نوع من أنواع الأورام سواءً الحميدة أو الخبيثة بل العكس هو الصحيح حيث أثبتت الأبحاث العلمية أن أقراص تنظيم الأسرة تقي السيدات من بعض الأورام مثل: الأورام الخبيثة للرحم والمبيضين.
- **حبوب تنظيم الأسرة تتسبب في ولادة أطفال مشوهين:** لم تسجل أي حالة ولادة طفل به عيوب أو تشوهات ناتجة من استعمال الأم لأقراص تنظيم الأسرة بالخطأ بينما هي حامل.

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أهم الشائعات المتعلقة بحقن و كبسولات تنظيم الأسرة (١)

- **حقن تنظيم الأسرة تسبب العقم:** لا تسبب حقن تنظيم الأسرة العقم ولكنها تتسبب في أنقطاع الدورة الشهرية أثناء الأستخدام لدى بعض السيدات وعند التوقف عن الأستخدام تعود الدورة الشهرية منتظمة كما الحال قبل أستعمال الحقن ولكن قد تحتاج المرأة لبعض الوقت حتى تعود دورتها الشهرية للأنتظام (أقل من 9 شهور).

- **حقن تنظيم الأسرة تسبب الأورام:** أول أكتشاف لقدرة حقن الديبوبروفيرا على تنظيم الأسرة حدث بين السيدات اللاتي يعالجن من أورام الرحم الخبيثة بنوع من الحقن يحتوي على نفس الهرمون الموجود في حقن الديبوبروفيرا ولذلك فإن حقن الديبوبروفيرا تقي السيدات من أورام الرحم الخبيثة.

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أهم الشائعات المتعلقة بحقن و كبسولات تنظيم الأسرة(٢)

- **تسبب الوسائل الهرمونية زيادة فى الوزن :** قد تسبب الوسائل الهرمونية بعض التغيرات الطفيفة فى الوزن سواء بالزيادة أو النقصان و قد يكون مقدار الزيادة من 1 إلى 2 كيلو كل سنة و يجب على السيدة مراجعة عاداتها الغذائية أثناء استخدام الحقن.

- **الكبسولة تسيح عند تعرض السيدة لحرارة الفرن:** تغرس الكبسولة تحت الجلد و لذا فإنه من غير الممكن وصول حرارة الفرن إليها.

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