# CONTRACEPTIVE FLIPCHART

## INFORMATION FOR CLINICIANS

Papua New Guinea



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# How to use this tool

The Information for Clinicians booklet is designed to aid clinicians and clients during counselling on contraception.

For your consultation you will need the following.

## Contraceptive Flipchart: Decision making tool

This flipchart can help clinicians to correctly inform the client to:

- Gain awareness of contraceptive methods available to them
- Understand key considerations for each contraceptive method
- Choose and use a contraceptive method

## World Health Organization (WHO): Medical Eligibility Criteria (MEC) Wheel

## WHO: Family Planning – A global handbook for providers 2022

### Consultation and counselling overview

This section provides a brief overview of information to remember for consultation and counselling, and guidance for priority populations.

### Contraceptive overview

Serves as a one-page overview of each contraceptive method, including use, advantages, disadvantages, and effectiveness.

### Management of problems

A quick reference guide on issues or side effects that may arise with each contraceptive method and actions for the healthcare provider to take to effectively manage the client. In some cases, this may include the discontinuation of the contraceptive method.

# Consultation and counselling overview

## Clinical consultation

A successful clinical consultation includes effective counselling and history taking.

To start the consultation, it is important to:

1. Greet the client with warmth and respect and thank them for coming
2. Explain that the consultation will be confidential (e.g., "What you say will not be told to others")
3. Invite the client to talk and make it clear that you want to listen
4. Take a comprehensive clinical history and encourage the client to speak openly so you can tailor the consultation to their needs (i.e., based on age, contraceptive goals, ability to consent etc.)

Clients choose contraceptive methods based on a number of factors. Some examples include:

- Effectiveness, ease of use, and safety
- How long the client wants protection from pregnancy
- Health benefits and possible side effects and risks

# Key considerations of consultation and counselling: history taking

Key consideration for successful contraceptive counselling are outlined in the table below.

| Key Considerations | Method |
|---|---|
| Communication skills | • Pay full attention—listen, relax, soft body postures, face the client<br>• Use facial expressions that show interest i.e., acceptance (smiling) and concern<br>• Give verbal encouragement (e.g., "I see," "I understand") and positive gestures (e.g., nodding the head)<br>• Avoid checking your watch, phone, or looking away<br>• Use simple language and an appropriate tone of voice |
| Ask questions | • Ask one question at a time; wait for an answer<br>• Ask open-ended questions to encourage the client to express their needs<br>• Avoid leading questions, or closed questions (e.g., "You don't want to get pregnant, do you?")<br>• Avoid judgmental questions or questions starting with "Why" or "Why didn't you?"<br>• Repeat a question in a different way if the client has not understood<br>• If asking a sensitive question, explain why |
| Family planning information | • Provide overview of various family planning methods<br>• Give focused and relevant information on methods of interest, and help the client identify a method<br>• Guide the client through the counselling process |
| Answering questions and addressing concerns effectively | • Explain the benefits of family planning and healthy pregnancy spacing<br>• Advise on how to prevent sexually transmitted infections (STIs)<br>• Advise on how to have a healthy pregnancy (if the client wants to become pregnant)<br>• Inform the client when needs or concerns are beyond the clinician's capability<br>• Give information on returning for follow up (e.g., to ensure the method suitable or if concerns arise) |

# Diverse groups

During every family planning consultation, it is important to put each client's family planning needs in the context of their unique situation.

The following diverse groups have important considerations when choosing family planning or contraceptive options.

Refer to the relevant sections in WHO: Family Planning – A global handbook for providers.

| Group and reference page | Outline |
|---|---|
| **Adolescents/young people** **(p. 329)** | All contraceptives are safe for young people. Young people have a right to sexual and reproductive health services that meet their needs and are non-judgmental and respectful, regardless of age. A key factor in contraception for young people is minimising risk of STI transmission. |
| **Men/sexual partners** **(p. 333)** | Sexual partners are important in providing support for contraceptive use and STI/human immunodeficiency virus (HIV) transmission minimisation. For instance, men can use contraceptive methods such as male condoms and vasectomy.<br>Clinicians can provide services to sexual partners, both as supporters of ongoing contraception, and empower to be vigilant around minimising STI/HIV transmission. |
| **Clients approaching menopause** **(p. 335)** | By itself, age does not restrict contraceptive choice. To prevent pregnancy, clients can use any method if they meet the eligibility criteria. Hormonal methods effect bleeding, and so it may be difficult to know if a woman using them has reached menopause. |
| **Clients with disabilities** **(p. 337)** | People with a disability have the same sexual and reproductive health needs and rights as people without disabilities and need appropriate education to make informed choices. However, often they are not given adequate information about sexual and reproductive health or proper care.<br>People with a disability are more vulnerable to abuse than people without disability. They are at increased risk of being infected with HIV and other STIs, and gender based violence (GBV). |

# Contraceptives for clients with STIs/HIV

People with STIs, including HIV, can use most family planning methods safely and effectively.

## Avoiding STIs

Family planning clinicians can talk to clients about how they can protect themselves from STIs, including HIV, and pregnancy by using a dual protection strategy.

There are 5 types of dual protection strategies:

1. Use a male or female condom correctly with every act of sex (and get regularly tested)
2. Use condoms consistently and correctly, plus another family planning method
3. If both partners know they are not infected, use any family planning method to prevent pregnancy and maintain only one sexual partner
4. Engage in safer sexual intimacy that avoids intercourse or otherwise prevents semen and/or vaginal fluids from coming into contact with each other's genitals
5. Delay or avoid sexual activity (either avoiding sex at any time that it might be risky or abstaining for a longer time)

## Contraception use with STIs/HIV

Adapted from '**Special Family Planning Considerations for Clients with STIs, including HIV**' in WHO: Family Planning – A global handbook for providers **(p. 349)**

| Group and reference page | Has STIs | Has HIV |
|---|---|---|
| Intrauterine device (IUD) | Caution advised* | Safe in ***most*** situations* |
| Tubal ligation | | |
| Vasectomy | | |
| Spermicides | Can safely use spermicides | Caution advised* |
| Combined oral contraceptive pill (COC), monthly injectables | Can safely use combined hormonal methods | |
| Progestin-only pills (POP), injectables and implants | Can safely use progestin only methods | |

*Refer to 'Special Family Planning Considerations for Clients with STIs, including HIV' in WHO: Family Planning – A global handbook for providers **(p. 349)**

# Contraception for postpartum women

Ideally, contraception should start during antenatal care to help with family planning.

A client who is not fully breastfeeding is able to become pregnant as soon as 3 weeks after childbirth. They should not wait until the return of monthly bleeding to start a contraceptive method. Tell them about other methods in case they stop Lactational Amenorrhea Method or want additional protection.

A client who is fully breastfeeding in the first 6 months after childbirth will have protection against pregnancy, if they remain amenorrhoeic. Exclusive breastfeeding for the first 6 months is also best for the baby's health.

## Earliest time to initiate contraception in the postpartum period

| Family Planning Method | Fully Breastfeeding | Partially or Not Breastfeeding |
|---|---|---|
| Hormonal IUD (LNG-IUD) | Immediately | |
| Copper-bearing IUD (CuIUD) | Within 48 hours | |
| COC | 6 months after childbirth | 34 weeks after childbirth if not breastfeeding<br>6 weeks after childbirth if partially breastfeeding |
| POP | Immediately | |
| Progestin-Only Injectables | 6 weeks after childbirth | Immediately if not breastfeeding<br>6 weeks after childbirth if partially breastfeeding |
| Male or Female Condoms | Immediately | |
| Diaphragm | Can be fitted 6 weeks after childbirth | |
| Vasectomy | Immediately (or during partner pregnancy) | |
| Tubal ligation | Within 7 days – otherwise wait 6 weeks | |
| Fertility Awareness Methods (FAM) | Start when normal secretions have returned (for symptoms-based methods) or she has had 3 regular menstrual cycles (for calendar-based methods)<br>This will be later for breastfeeding women than for women who are not breastfeeding | |
| Lactational Amenorrhea Method (LAM) | Immediately | (Not applicable) |

Adapted from 'Earliest Time That a Woman Can Start a Family Planning Method After Childbirth' in WHO: Family Planning – A global handbook for providers **(p. 377)**

# Gender-based violence

Clients who experience violence often seek health services, however many will not mention the violence. Clinicians of sexual and reproductive health care are in a good position to identify people who experience Gender-based violence (GBV) and to attend to their physical health needs as well as provide psychological support.

Violence can include the following.

- Physical violence: acts such as hitting, slapping, kicking, punching, beating, and using a weapon
- Sexual violence: unwanted sexual contact or attention, coercive sex, forced sex (rape) or sex that is not consensual, i.e., taking off a condom halfway through sex without their partner's knowledge
- Psychological violence: insults, intimidation, threats to hurt someone they love, humiliation, isolating a partner from family or friends, restricting access to resources and reproductive coercion
- Reproductive coercion: pressure, manipulation, trickery, threats, and the use of various kinds of abuse to dictate or interfere with a person's reproductive choices (e.g., a woman being prevented from using a method of contraception or having the method controlled by another person)

Violence can lead to a range of health problems including injuries, unwanted pregnancy, STIs including HIV, decreased sexual desire, pain during sex and chronic pelvic pain.

## What can clinicians do?

Help their clients feel comfortable speaking freely about any personal issue, including violence. Assure every person that their visit will be confidential and give them the opportunity to discuss issues that concern them.

1. Raise awareness of GBV
   - Help raise awareness of GBV among clinic and reception staff
   - Make contact and establish referral pathways to local organisations that provide services to those living with domestic violence or have been sexually assaulted
   - Display posters and leaflets that discourage violence and encourage healthy relationships with mutual respect and shared decision making
   - Display information about where to seek help and support groups

## 2. Asking about violence

You should provide a supportive environment in which abuse can be discussed. If you suspect abuse, you may ask direct questions in a caring and non-judgmental manner. Do not ask questions in the presence of the partner, as this may increase the risk of violence.

You might ask:

- "Are you afraid of your husband (or partner)?"
- "Have they or someone at home threatened to hurt you? If so, when?"
- "Have they or someone at home threatened to kill you?"
- "Do they bully or insult you?"
- "Do they try to control you?"
- "Have they forced you into sex when you didn't want it?"

## 3. LIVES

The letters in the word "LIVES" can help you to remember the 5 tasks you can complete to save lives.

| | | |
|---|---|---|
| **L** | **Listen** | Listen closely with empathy, not judgement |
| **I** | **Inquire** | Assess and respond to her needs and concerns – emotional, physical, social, and practical |
| **V** | **Validate** | Show that you believe and understand with supportive statements, tone, and body language |
| **E** | **Enhance safety** | Discuss how to protect them from further harm<br>If not in immediate danger, help make a long-term plan |
| **S** | **Support** | Support by helping them connect to information, services, and social support |

## 4. Document abuse in the client's records

Treat any injuries and discuss with them how they can make the best choices for family planning in her circumstances. Carefully and confidentially document the client's history of abuse along with symptoms or injuries and the cause of the injuries if relevant.

# Common contraceptive problems

Many contraceptives have similar common side effects and standard management can often be employed.

Refer to the relevant sections in WHO: Family Planning – A global handbook for providers (corresponding page number in table) for further details.

| Side effect | Standard management | Implant | Copper IUD (CuIUD) | Hormonal IUD (LNG-IUD) | Combined Oral Contraceptive Pill (COC) | Progestin-only Pill (POP) | Progestin-only Injectable |
|---|---|---|---|---|---|---|---|
| Irregular bleeding/ spotting | Reassurance: it is generally not harmful, irregular bleeding is common. It usually lessens or stops after the first few months of method use.<br><br>For modest, short-term relief, non steroidal anti inflammatory drugs (NSAIDS) can be used (different regime for each contraceptive).<br><br>If irregular bleeding continues or you suspect something may be wrong for other reasons, see 'unexplained vaginal bleeding' in 'reasons for switching methods.' | Per standard management<br><br>Refer to **p. 152** | Per standard management<br><br>Refer to **p. 182** | If irregular bleeding starts after several months of no bleeding, consider underlying conditions unrelated to method use | Could also be due to:<br>• missed pills<br>• taking pills at a different time each day<br>• vomiting or diarrhea<br>• taking anticonvulsants<br>• For additional management:<br><br>Refer to **p. 20** for COC<br><br>Refer to **p. 42** for POP | | Per standard management<br><br>Refer to **p. 90** |

## Common contraceptive problems

| Side effect | Standard management | Implant | Copper IUD (CuIUD) | Hormonal IUD (LNG-IUD) | Combined Oral Contraceptive Pill (COC) | Progestin-only Pill (POP) | Progestin-only Injectable |
|---|---|---|---|---|---|---|---|
| **No monthly bleeding** | If the client has no monthly bleeding soon after contraception commencement, rule out pregnancy.<br>Reassure them that the use of hormonal contraceptives can stop monthly bleeding, and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. No bleeding does not indicate infertility. | The client might have been pregnant during insertion<br>If they are pregnant, remove the contraceptive | | The client might have been pregnant during insertion<br>Rule out pregnancy (refer to back cover of flipchart) | Per standard management<br>Check if client is skipping 7 non-hormonal pills<br>Refer to **p. 21** | Per standard management<br>No monthly bleeding is normal, especially if breastfeeding<br>Refer to **p. 42** | Per standard management<br>Refer to **p.90** |
| **Heavy/ prolonged bleeding** | Reassurance: it is generally not harmful. The use of hormonal contraceptives or IUDs can cause heavy or prolonged bleeding. It usually lessens or stops after the first few months of use.<br>For modest, short-term relief, NSAIDS can be used (different regime for each contraceptive).<br>Provide iron tablets if possible. Instruct the client to eat foods containing iron.<br>If bleeding continues or you suspect something may be wrong for other reasons, refer to '**problems that may require switching methods**' section in the relevant contraceptive chapter, and seek further medical advice. | Per standard management<br>For short-term relief, initially try:<br>• 800 mg ibuprofen 3 times daily after meals for 5 days, beginning when irregular bleeding starts<br>Other NSAIDs:<br>Refer to **p. 152** for Implant<br>Refer to **p. 181** for CuIUD | | Per standard management<br>Refer to **p. 211** | | Per standard management<br>Refer to **p. 43** | Per standard management<br>Refer to **p. 90** |

## Common contraceptive problems

<table>
<tr><th>Side effect</th><th>Standard management</th><th>Implant</th><th>Copper IUD (CuIUD)</th><th>Hormonal IUD (LNG- IUD)</th><th>Combined Oral Contraceptive Pill (COC)</th><th>Progesterone Only Pill (POP)</th><th>Progestin- Only Injectable</th></tr>
<tr><td>Mild/ ordinary headache</td><td>Suggest aspirin (325–650 mg), paracetamol (325-1000mg), ibuprofen (200-400mg), or other pain reliever.<br>Any headaches that get worse or occur more often during use of contraceptive should be evaluated.</td><td>Per standard management</td><td colspan="5">Per standard management<br>Also suggest aspirin (325-650mg)<br>Some women get headaches during hormone free week of COC, consider continuous use, refer to p. 21</td></tr>
<tr><td>Acne</td><td>Consider locally available remedies.<br>If client wants to stop using chosen contraceptive because of acne, they can consider switching to COCs. Often, acne improves with COC use.</td><td>Per standard management</td><td colspan="2">Per standard management</td><td>Usually improves with COCs use, it may worsen for a few women<br>If acne persists longer than a few months, change to different COC formulation, as available</td><td colspan="2">Per standard management</td></tr>
<tr><td>Weight changes</td><td>Review diet and counsel as needed.</td><td>Per standard management</td><td colspan="3">Per standard management</td><td colspan="2">Per standard management</td></tr>
</table>

## Common contraceptive problems

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<tr><th>Side effect</th><th>Standard management</th><th>Implant</th><th>Copper IUD (CuIUD)</th><th>Hormonal IUD (LNG- IUD)</th><th>Combined Oral Contraceptive Pill (COC)</th><th>Progesterone Only Pill (POP)</th><th>Progestin- Only Injectable</th></tr>
<tr><td>Breast tenderness</td><td>Recommend they wear a supportive bra.<br>Suggest aspirin (325-650mg), paracetamol (325-1000mg), ibuprofen (200-400mg), or other pain reliever.<br>Try a hot or cold compress.<br>Consider locally available remedies.</td><td>Per standard management</td><td rowspan="3"></td><td colspan="4">Per standard management<br>Breastfeeding clients on POP, refer to p. 356</td></tr>
<tr><td>Mood changes</td><td>Ask about changes in their life that could affect mood or sex drive and give support as appropriate.<br>Clients who have serious mood changes such as major depression should be referred for care.<br>Consider locally available remedies.</td><td>Per standard management</td><td colspan="4">Per standard management<br>Some women experience nausea with continuous use of pills. Consider hormone free week (COC only) or taking pill before bedtime or with food</td></tr>
<tr><td>Nausea and dizziness</td><td>Consider locally available remedies.<br>Clients on injectables may also experience abdominal bloating.</td><td>Per standard management</td><td>Per standard management</td><td>Per standard management<br>Some women experience nausea with continuous use of pills. Consider hormone free week (COC only) or taking pill before bedtime or with food<br>Some women experience depression in the year after giving birth – this in not related to POPs</td><td>Per standard management</td></tr>
</table>

# Impants

## Contraceptive overview

| Discussion points | |
|---|---|
| **Overview** | • The implant is a small, flexible rod which is inserted under the skin of the inner upper arm<br>• Contains 1 hormone (progestin): works mainly by thickening the cervical mucus and by stopping ovulation<br>• Three types of implants available:<br>- Jadelle – 2x rods, 5 years effectiveness<br>- Implanon – 1x rod, 3 years effectiveness<br>- Levoplant – 2x rods, 4 years effectiveness |
| **Use** | • Inserted and removed by trained clinician in simple surgical procedure<br>• No delay in return to fertility once implant is removed |
| **Advantages** | • > 99% effective<br>• Do not need to remember to take a pill or have regular injections<br>• May experience no vaginal bleeding at all or very light bleeding<br>• May reduce painful periods, premenstrual syndrome (PMS) and acne |
| **Disadvantages** | • The most common side-effect with the implant is a change to the pattern of vaginal bleeding:<br>- bleeding frequency (about one in every five women have no bleeding at all)<br>- irregular light bleeding<br>- prolonged and/or frequent bleeding<br>• It does not protect against STIs and HIV<br>• Some experience skin bruising when it is first put in the arm |

## Management of problems

Further detail can be found in WHO: Family Planning – A global handbook for providers **(p. 151)**

| Problems | Actions to manage problems |
|---|---|
| **Pain after insertion or removal** | • For pain after insertion, check whether the bandage or gauze on their arm is too tight<br>• Put a new bandage on the arm and advise them to avoid pressing on the site/heavy lifting for a few days<br>• Suggest aspirin (325-650mg), ibuprofen (200-400mg), paracetamol (325-1,000mg), or other pain reliever |
| **Infection at the insertion site** | • Do not remove the implant – clean the area with antiseptic, give oral antibiotics for 7-10 days<br>• Ask the client to return after taking all antibiotics if any heat, redness, pain, or discharge draining from the wound<br>• If infection is present when they return, remove the implant, or refer for removal |
| **Abscess** | • Do not remove the implant – clean the area with soap and water or antiseptic, cut open (incise) and drain the abscess<br>• Give oral antibiotics for 7-10 days<br>• Ask the client to return after taking all antibiotics if there is any heat, redness, pain, or discharge draining from the wound<br>• If infection is present when they return, remove the implant, or refer for removal<br>• Expulsion or partial expulsion often follows infection – ask the client to return if they notice an implant coming out |

## Implants

| Problems | Actions to manage problems |
|---|---|
| **Expulsion** | • Rare – usually occurs within a few months of insertion or with an infection<br>• If no infection is present after explanation and counselling, replace the expelled rod or capsule through a new incision near the other rods or capsules, or refer for replacement |
| **Severe abdominal pain** | **Abdominal pain**<br>• May be due to various problems, such as enlarged ovarian follicles or cysts<br>• Clients can continue to use implants during evaluation<br>• There is no need to treat enlarged ovarian follicles or cysts unless they grow abnormally large, twist or burst<br>• Reassure that abdominal pain usually disappears on its own<br>**Ectopic pregnancy**<br>• Be particularly alert for additional signs or symptoms of ectopic pregnancy<br>• Ectopic pregnancy is rare and not caused by implants but can be life-threatening<br>• In the early stages of ectopic pregnancy, symptoms may be absent or mild, but eventually, they become severe<br>• A combination of these signs or symptoms should increase suspicion of ectopic pregnancy:<br>- unusual abdominal pain or tenderness<br>- abnormal vaginal bleeding or no monthly bleeding – especially if this is a change from their usual bleeding pattern<br>- light-headedness or dizziness<br>- fainting<br>- if ectopic pregnancy or other serious health condition is suspected, refer at once for immediate diagnosis and care |

## Implants

| Problems | Actions to manage problems |
|---|---|
| **Problems that may require switching methods** | **Unexplained vaginal bleeding**<br>• Refer or evaluate by history or pelvic examination – diagnose and treat appropriately<br>• The client can continue the implant while their bleeding is being evaluated<br>• If bleeding is caused by STI or pelvic inflammatory disease (PID), they can continue using the implant during treatment<br>• If no cause can be found, consider stopping implants to make diagnosis easier and provide another method of client choice until condition is evaluated and treated<br>**Migraine headache**<br>Refer to **'Job Aid – Identifying Migraine Headaches and Auras'** in WHO: Family Planning – A global handbook for providers **(p. 458)**<br>• If they have migraine headaches with aura the implants should be removed<br>• Help the client to choose a method without hormones, refer for diagnosis and management if not already under GP or specialist care<br>**Serious health conditions (listed below)**<br>If any of the following conditions arise, remove the implant and help them choose another method without hormones. Refer for diagnosis and management if not already under specialist care.<br>• Heart disease: a client who has heart disease due to blocked or narrowed arteries can safely start implants; if, however, the condition develops while using implants, discontinue implants<br>• Liver disease<br>• Stroke<br>• Breast cancer<br>• Blood clots in deep veins of legs or lungs<br>**Suspected pregnancy**<br>• Assess for pregnancy, including ectopic<br>• Remove the implant if pregnant and wanting to carry the pregnancy to term |