POSTPARTUM FAMILY PLANNING

Supplement to
The Philippines Clinical Standards Manual
on Family Planning

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FOREWORD

The Postpartum period represents a critical window of opportunity for women to receive family planning services as many women will access health services during pregnancy and childbirth at which point they can be introduced and linked with family planning methods that can help attain their reproductive intentions.

The **Postpartum Family Planning Supplement to The Philippine Clinical Standards Manual on Family Planning** augments the existing edition to further enhance the quality of family planning (FP) services delivered by clinic-based providers in both public and private sector. Critical focus is devoted to the postpartum period as often times, this represents a missed opportunity to introduce family planning methods that will improve the health of our women and families. It contains updated information on different family planning methods that can be used in the postpartum period including timing of initiation, attributes, risks and benefits. The information presented here is drawn from actual experiences of family planning experts, and backed up by evidence-based medical information and effective FP practices recommended by highly credible international references and organization such as World Health Organization (WHO). This supplement is a timely and relevant publication that can aid in our target to reach our Millennium Development Goals (MDGs) of reducing child mortality rates and improving maternal health. This further contributes to our wider objective of bringing Universal Health Care (UHC) to all Filipinos.

The health service providers will always be central in the overall delivery of quality health care to our people. I strongly urge that FP providers utilize this supplement to complement *The Philippine Clinical Standards Manual on Family Planning* in ensuring quality in the delivery of family planning services to women and families who need them most. And with this, we can achieve and sustain better maternal and newborn health outcomes.

Enrique T. Ona, MD, FPCS, FACS
Secretary of Health

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We hope that as more healthcare providers and facilities across the country integrate the postpartum family planning services into their existing Maternal and Child Health programs, we will be able to provide high quality services to more women who need family planning services and eventually achieve our MDGs 4 & 5 commitments to reduce maternal and child mortality.

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AMTSL	Active Management of the Third Stage of Labor
ARV	Anti-retroviral
CHO	City Health Office
DMPA	Depo-Medroxyprogesterone Acetate
DOH	Department of Health
FP	Family Planning
HIV	Human Immunodeficiency Virus infection
ICV	Informed Choice and Voluntarism
IM	Intra-muscular
IUD	Intrauterine contraceptive Device
LAM	Lactational Amenorrhea Method
LARC	Long-acting Reversible Contraceptive
MCH	Maternal and Child Health
MEC	Medical Eligibility Criteria
PID	Pelvic Inflammatory Disease
PPFP	Postpartum Family Planning
PPIUD	Postpartum Intrauterine Device
PROM	Prolonged Rupture of Membrane
RHU	Rural Health Unit
STI	Sexually Transmitted Infection
VTE	Venous Thromboembolism
WHO	World Health Organization

INTRODUCTION

The provision of Family Planning (FP) services in the postpartum period, when a woman is most receptive, is not routine for most practitioners involved in FP/ MCH care. Majority of postpartum women when asked will say that they do not plan to get pregnant again in the next few years. And yet they do not access from FP services prior to going home from a birthing facility. Postpartum women, constitute a sizeable percentage of the unmet need for modern FP methods in the Philippines. Unfortunately, the time after birth is often a missed opportunity for FP as a life-saving health intervention

The postpartum period refers to the period beginning immediately after the birth of a child and delivery of placenta continuing until about six weeks.

There are multiple studies that show that close pregnancy spacing may lead to adverse maternal, perinatal and infant outcomes. The WHO (2006), in reviewing the evidence, came up with the following recommendations for healthy pregnancy intervals:

- A woman after giving birth should wait for at least 2 years but not more than 5 years before getting pregnant again.
- A woman should wait for at least 6 months after a miscarriage or abortion before getting pregnant again.
- A young woman should wait until after she is at least 18 years of age before getting pregnant.

Spacing pregnancies 2 years or more apart could prevent 30% of maternal mortality and 10% of child mortality (Lancelet 2012; 380: 147-56).

The reasons why postpartum FP is not institutionalized include:

- Limited knowledge on the available choices that can be offered to postpartum women whether they are breastfeeding or not
- Failure to integrate postpartum family planning (PPFP) counseling in the antenatal care, early labor and immediate postpartum period
- Confusion as to when fertility comes back and unpredictability of the timing of the onset of intercourse
- Myths and misconceptions surrounding postpartum FP
- Lack of standardized protocol for postpartum FP service delivery

The key to successful integration of postpartum family planning in MCH is to offer the service while the mother is still in the birthing facility. Referral for FP services at a later time is not heeded. Other measures that help the mother choose an FP method in the postpartum period include:

- Start counseling during the antenatal visits
- Focus on the health and economic benefits of birth spacing or limiting for the woman and her family
- Make sure that there are different methods available for the mother in the birthing facility

This addendum to the Philippine Clinical Standards Manual discusses different contraceptive methods that can be used in the postpartum period including timing of initiation, attributes, and risks and benefits of the available choices. The thrust of the Department of Health (DOH) is to meet the increasing demand for permanent and long acting reversible contraceptive (LARC) methods and therefore more attention is given to postpartum IUD and implants in the discussion. Bilateral tubal ligation and vasectomy are covered in separate guidelines. For a more detailed discussion of the other methods contained in this addendum, the reader is advised to refer to The Philippine Clinical Standards Manual on Family Planning (2006). This material serves as a quick and easy reference for use by public and private service providers attending to deliveries in birthing units of hospitals, lying-ins, RHUs or CHOs.

LACTATIONAL AMENORRHEA METHOD (LAM)

What is the method?

All postpartum women should be encouraged to breastfeed.

Breastfeeding in itself is not a contraceptive method. However, if the following 3 criteria of LAM are met, the method can be used as an effective contraception for up to 6 months after birth.

- exclusively breastfeeding
- amenorrhea
- the baby is less than 6 months old

The requirement to exclusively breastfeed means that no other liquid or solid food is given. Also, the baby is fed on demand and often, that is, at least every 4 hours during the daytime and at least every 6 hours at night.

When menstruation has returned, it is a signal that the woman's fertility has returned and therefore, breastfeeding/ suckling is no longer effective in preventing ovulation.

At 6 months, the WHO recommends that supplemental feeding be initiated which will decrease suckling and as a consequence decrease the effectiveness of LAM.

Women who received LAM counseling and accepted the method are more likely to use a modern method of contraception later on when any of the criteria for LAM is no longer met or even when all 3 criteria are still met. Adding an appropriate method of contraception while the woman is still on LAM will provide continuous protection should she stop breastfeeding, start menstruation, or decide to supplement-feed the baby.

When to start LAM?

Initiate exclusive breastfeeding within one hour after birth.

How effective is LAM?

Perfect use: **99.5%** Typical use: **98%**

What is the continuation rate of the method at 1 year?

There is no 1-year continuation rate of LAM as a contraceptive method because the criteria limits its use to 6 months.

What is the mechanism of action?

Suppression of ovulation brought about by the woman's hormonal response to the baby's suckling.

What are the advantages of using the method?

- benefits both the mother and the newborn
- effective if the 3 criteria of LAM are strictly met
- no side effects
- all postpartum women can use LAM and exceptions are rare
- it can be started immediately right after giving birth
- no expense

What are the disadvantages and side effects of the method?

- can only be used for a relatively short period of time
- can not protect the mother from STIs including HIV

Who cannot use the method?

- those with HIV infection
- postpartum women who are using certain medications: mood-altering drugs, reserpine, ergotamine, antimetabolites, cyclosporine, high doses of corticosteroids, bromocriptine, radioactive drugs, lithium, certain anticoagulants
- when the newborn has a condition (e.g. cleft lip and palate) that makes it difficult to breastfeed

HORMONALS: PROGESTIN-Only method

Progestin-Only Pills

What is the method?

There are 2 preparations of oral progestin-only pill in the Philippines, namely:

- 0.5-mg Lynestrenol, a 28-day pill taken daily without any gaps, at the same time of the day, everyday
- 75-ug Desogestrel, a 28-day pill taken the same way as above

Progestin-only pill can be used both by breastfeeding and non-breastfeeding women. Many studies show that progestins do not have adverse effects on breast milk production and quality of milk produced as well as on infant health, growth and development.

When to start the progestin-only pill?

For breastfeeding women:
start at 6 weeks postpartum

For non-breastfeeding women:
start immediately prior to discharge of the mother from the facility

How effective is the progestin-only pill?

Perfect use: **99.5%** Typical use: **99.0%**

What is the continuation rate of the method at 1 year?

The continuation rate is **68%**.

What is the mechanism of action?

Progestin thickens the cervical mucus, which then serves as a barrier to the entry of sperm in the uterus.

What are the advantages of the method?

- more effective if used concomitantly with breastfeeding
- rapid return to fertility after discontinuation
- no side effects of estrogen

- prevents cancer of the ovary and endometrium as well as fibrocystic conditions of the breast

What are the disadvantages of the method?

- menstrual changes are the norm with users
- daily pill intake at exact time everyday may be susceptible to discontinuation

Who cannot use the method?

- women who are taking certain anti-convulsants and antiretroviral (ARV) therapy
- post partum women who currently have a blood clot in the legs or lungs
- patients who currently have or had a history of breast cancer

Progestin-Only Injectible

What is the method?

The available progestin-only IM injections and their respective dosages are the following:

- 150-mg Depo-Medroxyprogesterone Acetate (DMPA) IM given in the deltoid or gluteal muscle every 3 months
- 200-mg Norethisterone enanthate IM given in the deltoid or gluteal muscle every 2 months

Progestin-only injectable can be used by both breastfeeding and non-breastfeeding women. Many studies show that progestins do not have adverse effects on breast milk production and quality of milk produced as well as on infant health, growth and development.

When to start the progestin-only injectable?

For breastfeeding women:
start at 6 weeks postpartum

For non-breastfeeding women:
start immediately prior to discharge of the mother from the facility

How effective is the progestin-only injectable?

Perfect use: **99.7%** Typical use: **97%**

What is the continuation rate of the method at 1 year?

The continuation rate for DMPA is **56%**.

What is the mechanism of action?

Progestin thickens the cervical mucus, which then serves as a barrier preventing the entry of sperm in the uterus.

What are the advantages of the method?

- no daily pill intake
- no side effects of estrogen
- private
- prevents endometrial cancer, anemia and ectopic pregnancy

What are the disadvantages of the method?

- menstrual changes are the norm with users
- slow return to fertility after discontinuation
- requires regular visit to the clinic every 3 months for DMPA and 2 months for norethisterone enanthate for next dose
- women are not protected against HIV and STIs

Who cannot use the method?

- women who are taking rifampicin, rifabutin, certain anti-convulsants and ARV therapy.
- postpartum women who currently have a blood clot in the legs or lungs
- patients who currently have or had a history of breast cancer

Single Rod Subdermal Implant

What is the method?

Single rod subdermal implant is a long-acting, progestin-only hormonal contraceptive which is effective for 3 years. The white flexible implant contains 68 mg of etonogestrel and releases at a rate of 60-70 micrograms/ day at 5-6 weeks and gradually decreases to 35-45 micrograms/ day at the end of the first year, 30-40 micrograms/day at the end of the second year and finally to 25-30 micrograms at the end of the third year.

The provider who wishes to insert etonogestrel implants should undergo training to ensure that the correct technique is learned and utilized. Most of the unintended pregnancies that result after insertion are due to incorrect insertion technique or insertion on the wrong day of the menstrual cycle. If the provider is not careful, the implant may fall out of the needle before insertion is completed. The insertion site must be palpated after insertion to confirm the presence of a matchstick-sized implant. If the implant is inserted beyond the first 5 days of the menstrual cycle, the provider must make sure that the client is not pregnant. Wrong timing is not an issue in postpartum insertions.

Post-marketing surveillance on single rod subdermal implants since 1998 did not show any deleterious effects on the fetus if the user gets pregnant or even if the implant is inadvertently inserted in a pregnant client. If a user is found to be pregnant, the implant is simply removed and no additional intervention is necessary.

Single rod subdermal implant is the most effective long-acting reversible contraceptive. It is immediately effective because it is rapidly absorbed and reaches an ovulatory-inhibiting level on the first day of insertion and the maximum level is attained within 1-13 days. Fertility returns immediately after removal. Etonogestrel decreases to undetectable level within 1 week after it is removed with fertility returning usually within 3 weeks.

The ovarian function of single rod subdermal implant users is not completely suppressed. The estradiol levels of users is above the level normally seen in the early follicular phase which is above the level necessary to maintain bone mass. There is evidence that bone mass in users is not adversely affected by etonogestrel.

There is evidence that insertion of single rod subdermal implant in the immediate postpartum period does not have any adverse effects on the hemostatic mechanism of the client in the first 12 weeks postpartum when the thrombosis risk is highest. Immediate postpartum insertion likewise does not have any effect on the metabolic functions of the infant and also does not influence the amount and quality of milk produced by the client. Breastfed infants ingest about 0.2% of the daily maternal dose and decreases over time as lactation is continued. Long-term data on breastfed children of single rod subdermal implant users showed no differences in growth, physical and psychomotor development compared with children whose mothers had IUDs.

When to start the method?

- For breastfeeding, partially breastfeeding and non-breastfeeding clients: the etonogestrel implant may be inserted immediately after delivery, before she is discharged from the birthing facility.
- Later than 21 days, a client who is not on LAM is advised to use back up protection for 7 days after insertion. If the client were already sexually active and has not been using LAM, pregnancy should be excluded or the first natural period is awaited prior to insertion.

How effective is the method?

Perfect use: **99.95%**
Typical use: **99.95%**

- The effectiveness of single rod subdermal implants is not user-dependent. There are no daily routines compared with oral contraceptives or quarterly clinic appointments as with DMPA. This is ideal for postpartum women whose attention and time is primarily devoted to taking to care of their infants rather than themselves and therefore do not have to worry about missed FP appointment or missed dosage.

- Drugs that reduce the effectiveness of hormonal contraceptives also decrease the effectiveness of single rod subdermal implants.

Cytochrome P450 Enzyme-inducing drugs that decrease the effectiveness Single Rod Subdermal Implant

- Anticonvulsants: Carbamazepine, hydantoins, barbiturates, oxcarbazepine
- Antituberculosis, antifungal and antiviral: Rifampicin, rifabutin, griseofulvin, ARVs for HIV
- Other liver enzyme inducers: St. John's Wort

What is the continuation rate?

- 84% continuation rate at 1 year
- Single rod subdermal implant has the best continuation rate among the reversible contraceptive methods.

What is the mechanism of action of etonogestrel implant?

Single rod subdermal implant inhibits ovulation. No ovulation occurs in the first 2 years and in the third year it may happen but rarely. In addition, it thickens the cervical mucus and makes it impenetrable to the spermatozoa.

What are the advantages of the method?

- lesser complaint of dysmenorrhea
- highly effective and long acting
- compatible with breastfeeding
- immediate effectivity after insertion and immediate return to fertility after removal
- the procedure is easy to learn for providers

What are the disadvantages and side effects of the method?

- altered menstrual bleeding pattern, which is unpredictable. There may be changes in the frequency, duration and amount of bleeding
- headache
- weight gain
- acne
- breast pain/discomfort
- emotional lability
- abdominal pain
- requires a trained provider to insert

Who cannot use the method?

- pregnant women
- current venous thromboembolism (VTE)
- steroid-dependent tumors such as benign or malignant liver tumors and known or suspected breast cancer

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POSTPARTUM IUD

What is the method?

The Intrauterine Device (IUD) is a T-shaped small plastic device placed inside the uterine cavity. There are 2 types of IUD available in the Philippines -- Copper T-380A, which has coils of copper wire wound around its horizontal and vertical arms and Mirena, which contains and slowly releases levonorgestrel from its vertical arm. Currently, only the TCu-380A is used for postpartum insertion.

The global initiative to increase Postpartum Intrauterine Device (PPIUD) insertion is due to the following reasons:

- The evidence for its safety and effectiveness when inserted during the immediate (10 minutes after placental expulsion) and early postpartum periods (within 48 hours) is supported by strong data in the literature.

- The evidence-based medical eligibility criteria for its specific use has changed and whereas in the past there were 39 WHO Medical Eligibility Criteria (MEC) category 4 conditions, currently there are only 10.

• The success of the PPIUD programs globally, support the feasibility of implementing this approach.

• The IUD is repositioned as an attractive alternative to BTL in low-resource settings because it can be continuously used for 12 years with minimal cost for the user.

The risk of pelvic inflammatory disease with the IUD is very low and this risk is highest only within the first 20 days post insertion. After that, the IUD user's risk approximates that of non-users. Current estimate is at 1.6 cases of Pelvic Inflammatory Disease (PID) per 1,000 women per year. The main causes of pelvic infection in IUD users are lack of provider skill, inconsistent or improper infection prevention measures, and pre-existing infection. However, PID following PPIUD insertion may also be due to newly acquired infection with gonococcus and/or chlamydia trachomatis. In this situation, both the client and her partner should be treated.

Pelvic infection following IUD insertion is treated without removing the device. However, if the client's infection does not improve within 3 days, then removal of the IUD is necessary.

Postpartum women who are HIV-infected but clinically well, especially if they are on ARVs may be offered PPIUD. The IUD does not increase the incidence of pelvic infection, does not facilitate progression to AIDS and does not increase the transmission of the virus to an uninfected partner. In women who are not HIV-infected but whose partner is infected, the use of IUD does not increase the risk of acquiring the virus. It must be emphasized, however, that condom use at all times is recommended to reduce the risk of acquiring and/or transmitting HIV.

Although menstrual bleeding in some women with IUD increases, this rarely results to anemia. Therefore, even in anemic postpartum women, the IUD is a safe option to offer but the anemia should be treated with iron folate.

The expulsion rate for PPIUD is higher compared with interval insertion and generally ranges from 10-15%. This rate can be reduced to 4-5% by using the correct instrument (Kelly placental forceps) and correct technique. The expulsion rate is also related to the timing of PPIUD insertion with the rate lower when the IUD is inserted in the immediate postpartum (within 10 minutes of placental expulsion) and during a cesarean section compared with early postpartum insertion (within 48 hours postpartum).

Uterine perforation during interval insertion although uncommon, occurs. The risk of perforation during PPIUD insertion appears to be less compared with interval IUD. A WHO review in 2009 reported no cases of perforation. Caliskan, et al., in 2003 had one case of uterine perforation. In an unpublished series of 10,000 cases in El Salvador, Bataglia, et al., did not have a single case of uterine perforation.

A Cochrane Database Review (2003) on the safety of PPIUD yielded the following conclusions:

• PPIUD is safe and effective.

- There are very few medical reasons that make the PPIUD an inappropriate option (Please refer to "Who cannot use the method" section below).
- PPIUD has the following unique advantages: clients are highly motivated to use FP method, assurance that she is not pregnant, and convenience.
- Compared with interval insertion, expulsion rate with PPIUD is higher.
- Feasibility of implementation is proven by the success of the PPIUD programs globally.
- Early follow up is recommended to assess for expulsion and other complications.

PPIUD insertion should follow active management of the third stage of labor (AMTSL). AMTSL does not interfere with PPIUD insertion. It is an important component of postpartum management that can potentially save lives because it prevents postpartum hemorrhage. An expert review panel suggests that expulsion and perforation are not increased when AMTSL is done prior to PPIUD insertion. The panel further suggests that the uterine contractions resulting from AMTSL may even hold the IUD in place rather than push it out.

In the Philippines, by age 19 years, 37% of the female population already had sex. Births under 19 constitute about 12% of the total births in the country. And these figures are increasing. Both the young client and the provider rarely select the most effective method for this population, which are the long acting reversible contraceptives (LARCs), namely, IUD and implant. Barriers to IUD and implant use in the young include provider bias, myths and misconceptions surrounding the method, lack of access and trained providers.

LARCs have higher continuation rates, lower unintended pregnancy rates and better satisfaction rates among young users compared with the short acting reversible contraceptives such as the COCs, minipill, patches, and DMPA. LARCs therefore are the method of choice for this population.

When to start?

Immediate postpartum:
within 10 minutes after placental expulsion in a normal vaginal delivery or during cesarean section (intracesarean)

Early postpartum:
within 48 hours postpartum after a normal vaginal delivery. If possible perform the procedure within 24 hours postpartum.

How effective is PPIUD?

Perfect use: **99.4%** Typical use: **99.2%**

What is the continuation rate of the method at 1 year:

The continuation rate is very good at 78% per year.

What is the mechanism of action?

Copper released from the Copper T-380A inhibits sperm and ovum transport. The spermatozoa and the ovum do not meet therefore fertilization does not take place.

What are the advantages of the method?

- highly effective, long-term method which is immediately effective upon insertion
- inexpensive
- does not require daily action
- immediate return to fertility upon removal
- effective for 12 years
- well-tolerated and satisfaction rate is high among users
- few side effects, absent hormonal side effects
- few complications
- protects against ectopic pregnancy
- compatible with breastfeeding

What are the disadvantages and side effects of the method?

- menstrual pattern may change, may be heavier and more painful especially in the first 3 months but improves over time
- higher expulsion rate compared with interval insertion
- a trained provider is required for insertion and removal

Who cannot use the method?

Eligibility Criteria for Postpartum Insertion

MEC Category 4

- postpartum women with chorioamnionitis (not in WHO MEC)
- puerperal sepsis
- postpartum endometritis
- unresolved postpartum hemorrhage (not in WHO MEC)
- following septic abortion

MEC Category 3

- between 48 hours and 4 weeks postpartum
- prolonged rupture of membranes (PROM) greater than 18 hours (not in WHO MEC)

Postpartum Insertion of the IUD- The Process

PPIUD services when fully integrated in the antepartum, intrapartum and postpartum care of a pregnant woman is not a separate procedure but rather become part of the process of achieving healthier lives for the mother, baby and whole family. The integration is implemented in stages and culminates in the insertion of IUD.

The foundation for quality of care in the provision of PPIUD services rests on the adherence of the provider to the following tenets of care:

- respect for the client
- standardized counseling keeping in mind ICV principles
- standardized infection prevention protocol
- global performance standards for the procedure
- systematic and accurate recording and reporting

Stages in the Integration of PPIUD Services in the Care of a Pregnant Woman

A) PPFP Education/Counseling in the Antenatal Period

- Provide basic information about healthy birth spacing or limiting as

part of general health education and discussion of the available options for the woman based on her reproductive intentions.

• Once the woman expresses interest in a particular method, i.e. IUD, more specific information is given on this method. Discuss the various timing for insertion and remind her that immediate (10 minutes after placental expulsion) and intracesarean insertions are associated with fewer problems compared with insertions done later but within 48 hours postpartum.

• Initial screening for medical eligibility for IUD use is done.

• If a decision has been arrived at, this information should be reflected in her record or in her mother and baby book (MCB).

• Although the decision is solely the woman to make, her husband or her family may be engaged in the discussion.

• The woman is reminded of her decision several times in the course of her antenatal care and encouraged to ask questions which should be answered in clear and straightforward manner. She can always change her decision and must not be made to feel that she is imposed upon.

B) Confirmation of the Client's Choice in the Facility (Potential IUD Acceptor)

• Although a decision has been arrived at during the antenatal period, confirmation of the decision has to be made when the woman is admitted in labor. This is necessary so that the staff attending to her can prepare for the procedure. She should also be encouraged to ask questions and further counseling be given, if necessary. Should the client change her mind and not proceed with PPIUD, alternative FP options may be presented. **It is important to note that counselling at this point is only done when the woman is in early labor and not discomfited by painful contractions.**

• For women in early labor who walks in without prior counseling and screening, an abbreviated process of health education on birth spacing or limiting, general PPFP counseling, method-specific counseling on the method she is considering and finally screening for eligibility for the method chosen is undertaken by the provider. If the woman choses PPIUD, proper documentation of the decision is made and preparation for the procedure is done.

• If the woman is scheduled for a cesarean section, confirmation of her choice is made upon admission.

• During this time a careful review of the medical eligibility of the client for her chosen method should be undertaken even if previous screening was already done prior to her admission.

• Timing of PPIUD insertion is again discussed and the association of immediate postpartum and intracesarean insertions with fewer problems compared with later insertions is highlighted. If the procedure is done within 10 minutes after placental expulsion, it becomes part of the delivery process and not treated as a separate procedure as when it takes place within 48 hours when the mother is already in the wards or in her room

recovering and she needs to be brought to a separate procedure room for IUD insertion.

C) Second Confirmation in the Delivery Room (After Delivery)

• A second screening for eligibility prior to final confirmation that the woman really opted for IUD is necessary. There may be conditions related to labor and delivery, the occurrence of which may exclude the postpartum woman from PPIUD. These conditions are not included in the WHO MEC for IUD.

> Chorioamnionitis - characterized by fever of 38ºC and abdominal pain with one of any of the following findings: tender uterus, foul-smelling amniotic fluid or fetal tachycardia greater than 160 beats per minute.

> Prolonged rupture of membranes (PROM) for 18 hours or more prior to delivery - increases woman's risk of infection.

> Unresolved postpartum hemorrhage - addressing this life threatening condition takes precedence over an elective procedure. Aside from difficulty in inserting an IUD in a woman who is actively bleeding, the continuing hemorrhage may dislodge the IUD.

> Extensive vaginal lacerations- repair of extensive vaginal lacerations should be done first before inserting the IUD. If the lacerations are not bleeding they are covered with sterile gauzes or towel when inserting the IUD. In women who already had repair of the lacerations, the provider makes sure that inserting an IUD will not be too uncomfortable and disrupt the repair.

• For postpartum women who did not benefit from antenatal PPFP counseling, an abbreviated process of general health education on birth spacing or limiting, PPFP counseling, method-specific counseling on the method chosen, and medical eligibility screening for that particular method can still be done after she is adequately rested from the delivery. The provider must keep in mind the ICV principles while counseling the postpartum women. If the woman opted and assessed to be medically eligible for PPIUD, she is prepared for the procedure and an IUD inserted within 48 hours postpartum.

D) Post-insertion Care and Counseling

• Post-insertion care and counseling should be integrated in the protocols for postpartum and newborn care. Counseling which is focused on what to expect with the IUD, identification and timely consultation for problems that may arise and importance of follow up to assess for expulsion, complications and satisfaction with the method is done after the patient has sufficiently rested and can pay attention to the discussion.

• The woman should be admonished to immediately return to the facility for heavy vaginal bleeding, severe lower abdominal discomfort, fever, and even a general feeling of not feeling well. She should also be advised to come for any unusual discharge, suspicion

of expulsion, further questions or problems, or wants the IUD removed.

• A reminder card is given to the woman with information on the type of IUD inserted, date of insertion, date of removal, date of follow up visit and who to contact for non-urgent issues. This information should also be reflected on the woman's record.

E) Routine Follow-up Care for PPIUD Clients

• Follow-up of PPIUD clients is important because this is when potential problems are identified and managed, tolerability and satisfaction of the user are evaluated, and other concerns of the client are addressed. This is also the time when key messages on birth spacing and limiting are reinforced and continued breastfeeding encouraged.

• If the IUD is expelled, a new IUD is inserted if the client so wishes. Provider should take note that reinsertion should not be done between 48 hours and 4 weeks postpartum and must make sure that the client is not pregnant. If reinsertion is not desired, alternative FP methods are offered if reasonably certain that the client is not pregnant.

• STI prevention is discussed.

POST MISCARRIAGE FAMILY PLANNING

Spontaneous miscarriage is not an uncommon occurrence and induced abortion is still a significant cause of maternal mortality and morbidity in the Philippines.

The WHO recommends that a woman who had a miscarriage or induced abortion should wait 6 months before getting pregnant again to prevent adverse maternal and perinatal outcomes. Although most women who had a miscarriage or induced abortion would not want to get pregnant too soon, they seldom receive assistance in family planning. And yet these are the clients who need to get started on contraceptives immediately because ovulation may resume as early as 11 days after treatment and therefore are at higher risk for unplanned pregnancy.

Factors that limit access to post miscarriage family planning include:

- Provider bias or lack of knowledge about which method is appropriate for the post miscarriage client.
- No established link between post miscarriage care and family planning.
- Lack of commodities to give to the client prior to discharge from the facility.
- Client's and provider's misconception that fertility would resume only after the next menstruation comes.

Family planning services for a post miscarriage client should be in the context of her personal preferences, constraints and social situation. When a woman freely and voluntarily

chooses the method she would use, there is a greater likelihood that she will be satisfied and will continue to use the method correctly. Some women may plan to get pregnant soon after a miscarriage and they should not be discouraged if there are no medical reasons why they should not.

Counseling and informed choice are key to good FP services. In counseling a post miscarriage client, the information that she needs to know are the following:

- That she can get pregnant as soon as 2 weeks after treatment.
- That there are several methods to choose from which are safe, effective and can be started prior to discharge from the facility.
- If FP services are not offered in the facility, the client should be given information where and how to get these services. And if she was started on FP prior to discharge, she should be informed where to go for follow up and/or refill for additional doses.
- Characteristics of the various methods (mode of action, benefits, side effects, etc.)
- What to expect from the use of the chosen method.
- That other options are available when chosen method is discontinued.

Guidelines for contraceptive use by clinical condition*

No complications after treatment of incomplete miscarriage

Temporary methods

- Oral contraceptives (combined or progesterone-only)
  - can be started immediately prior to discharge
- Injectables (DMPA, NET-EN)
  - can be given prior to discharge
- Implants
  - can be given immediately prior to discharge
- IUD
  - can be inserted immediately prior to discharge
- Barrier methods
  - advise use when sexual activity resumes
- Natural family planning
  - ***NOT RECOMMENDED*** until regular menses return

Voluntary surgical sterilization

- not the time for clients to make a decision about permanent methods

Confirmed or presumptive diagnosis of infection

Temporary methods

- Oral contraceptives (combined or progesterone-only pill)
  - start prior to discharge
- Injectables (DMPA, NET-EN)
  - can be given prior to discharge
- Implants
  - can be given immediately prior to discharge
- IUD
  - ***DO NOT INSERT*** until infection resolves (usually 3 months)
- Barrier methods
  - advise use when sexual activity resumes

- Natural family planning
  - ***NOT RECOMMENDED*** until regular menses returned

Voluntary surgical sterilization

- not done until infection is resolved (usually 3 months)

Injury to the genital tract (e.g., uterine perforation from instrumentation)

Temporary methods

- Oral contraceptives (combined or progesterone-only pill)
  - start prior to discharge
- Injectables (DMPA, NET-EN)
  - can be given prior to discharge
- Implants
  - can be given immediately prior to discharge
- IUD
  - ***DO NOT INSERT*** until injury has healed (3 months)
- Barrier methods
  - advise use when sexual activity resumes
- Natural family planning
  - ***NOT RECOMMENDED*** until regular menses resume

Voluntary surgical sterilization

- may be done after the injury has healed (3 months)

Hemorrhage and severe anemia (Hb <7 gm/dl, Hct <20)

Temporary methods

- Combined oral contraceptive pill
  - start prior to discharge

(decreases menstrual bleeding which helps in improving anemia)

- Progesterone-only pill
  - can be given immediately prior to discharge, start client on iron folate concomitantly
- Injectables (DMPA, NET-EN)
  - can be given immediately prior to discharge, start client on iron folate concomitantly
- Implants
  - can be given immediately prior to discharge, start client on iron folate concomitantly
- Copper IUD
  - can be given immediately prior to discharge, start client on iron folate concomitantly
- Levonorgestrel IUD
  - can be given immediately prior to discharge, start client on iron folate concomitantly
- Barrier methods
  - advise use when sexual activity resumes
- Natural family planning method
  - ***NOT RECOMMENDED*** until regular menses resume

Voluntary surgical sterilization (BTL)

- Delay until the anemia improves

Second-trimester incomplete miscarriage

Temporary methods

- Oral contraceptive pills (combined or progesterone-only pills)
  - start prior to discharge
- Injectables (DMPA, NET-EN)
  - can be given prior to discharge
- Implants
  - can be inserted prior to discharge
- IUD

- ***DELAY*** insertion for 4-6 weeks

• Barrier methods
  - advise use when sexual activity resumes

• Natural family planning
  - ***NOT RECOMMENDED*** until regular menses resume

Voluntary surgical sterilization (BTL)

• delay procedure until 4-6 weeks postpartum

The ovary resumes follicular development as early as 1 week following a first trimester miscarriage which is why it is very important that FP be started prior to discharging the client from a facility.

Post miscarriage care is not complete unless assessment of the client's risk for STI and HIV is done. All women should be advised that only male and female condoms when consistently used will protect against the acquisition of STI and HIV.

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Annex

Recording of Postpartum Family Planning Data

Instructions for completing the FP Service Record or FP Form 1 to include information on Postpartum Family Planning
(adapted from Family Planning Competency-Based Training: Basic Course Handbook)

SIDE A
Fill out or check the required information at the far right of the form:

Client number, date and time client was interviewed

Client name: last name, given name, date of birth, education, and occupation
Spouse name: last name, given name, date of birth, education, and occupation

Complete address of the client: number of the house, street, barangay, municipality, and province

Average monthly income in peso

Choose "yes" or "no" for the couple's plan for more children

Choose "new" or "continuing/current user" for type of acceptor

Number of living children

Previously used method

Reasons for practicing FP: completed the desired family size, economic, and others
Check among the list of FP method, the method accepted
Check if the FP method chosen was during postpartum period or interval

SIDE B
Fill in the required information at the far left of the form on client number and name, date of birth, education, occupation, and address.

On the first column, record the date when the service was delivered to the client.
On the second column, record the method accepted/number of supplies given.
On the third column, record the following:

- Medical observations
- Complaints
- Services rendered, procedures/interventions done (lab, treatment)
- Reasons for stopping or changing the methods
- Laboratory results

On the fourth column, record the name of the provider with the corresponding signature.
On the fifth column, record the next service date or appointment date.

FAMILY PLANNING SERVICE RECORD

SIDE A

CLIENT NO.: _____ **TYPE OF ACCEPTOR:** ☐New to the program ☐Continuing User **PREVIOUSLY USED METHOD:** _____ **DATE/TIME** _____

NAME OF CLIENT: Last Name | Given Name | MI | ___/___/___ Date of Birth | HIGHEST EDUC | OCCUPATION | NO. STREET | BARANGAY | MUNICIPALITY | PROVINCE

NAME OF SPOUSE: Last Name | Given Name | MI | ___/___/___ Date of Birth | HIGHEST EDUC | OCCUPATION

AVERAGE MONTHLY INCOME: _____

NO. OF LIVING CHILDREN: _____ **PLAN MORE CHILDREN:** ☐Yes ☐No **REASON FOR PRACTICING FP:** _____

METHOD ACCEPTED: ☐COC ☐POP ☐Injectable ☐Condom ☐IUD ☐ BTL ☐NSV ☐LAM ☐SDM ☐BBT ☐BOM/CMM/STM ☐Implant **TIMING :** ☐Postpartum ☐Interval

MEDICAL HISTORY

HEENT
- ☐ Epilepsy/Convulsion/Seizure
- ☐ Severe headache/dizziness
- ☐ Visual disturbance/blurring of vision
- ☐ Yellowish conjunctivae
- ☐ Enlarged thyroid

CHEST/HEART
- ☐ Severe chest pain
- ☐ Shortness of breath and easy fatigability
- ☐ Breast/axillary mass
- ☐ Nipple discharge (specify if blood or pus)
- ☐ Systolic of 140 and above
- ☐ Diastolic of 90 and above
- ☐ Family history of CVA (strokes), heart attack, asthma, rheumatic heart diseases

ABDOMEN
- ☐ Mass in the abdomen
- ☐ History of gall bladder disease
- ☐ History of liver disease

GENITAL
- ☐ Mass in the uterus
- ☐ Vaginal discharge
- ☐ Intermenstrual bleeding
- ☐ Postcoital bleeding

EXTREMITIES
- ☐ Severe varicosities
- ☐ Swelling or severe pain in the legs not related to injuries

SKIN
- ☐ Yellowish skin

HISTORY OF ANY OF THE FOLLOWING
- ☐ Smoking
- ☐ Allergies
- ☐ Drug intake (anti-tuberculosis, anti-diabetic, anticonvulsant)
- ☐ STI/HIV/AIDS/PIDS
- ☐ Bleeding tendencies (nose, gums, etc.)
- ☐ Anemia
- ☐ Diabetes

OBSTETRICAL HISTORY
- ☐ Number of pregnancies:
  ___Full term ___Premature
  ___Abortion ___Living Children
- ☐ Date of last delivery ____/____/____
- ☐ Type of last delivery _____
- ☐ Past menstrual period _____
- ☐ Last menstrual period _____
- ☐ Number of days menses
  ___Scanty ___Moderate ___Heavy
  ___Painful ___Regular
- ☐ Hydatidiform mole (within the last 12 months)
- ☐ Ectopic pregnancy

STI RISKS
- ☐ With history of multiple partners
- ☐ For Women:
- ☐ Unusual discharge from vagina
- ☐ Itching or sores in or around vagina
- ☐ Pain or burning sensation
- ☐ Treated for STIs in the past
- ☐ For Men:
- ☐ Pain or burning sensation
- ☐ Open sores anywhere in genital area
- ☐ Pus coming from penis
- ☐ Treated for STIs in the past

PHYSICAL EXAMINATION

Blood pressure: _____ mm/Hg
Weight _____ kg/lbs
Pulse rate _____ /min

CONJUNCTIVA
- ☐ Pale
- ☐ Yellowish

NECK
- ☐ Enlarged thyroid
- ☐ Enlarged lymph nodes

BREAST
- ☐ Mass
- ☐ Nipple discharge
- ☐ Skin-orange peel or dimpling
- ☐ Enlarged axillary lymph nodes

THORAX
- ☐ Abnormal heart sounds/cardiac rate
- ☐ Abnormal breath sounds/respiratory rate

ABDOMEN
- ☐ Enlarged liver
- ☐ Mass
- ☐ Varicosities

EXTREMITIES
- ☐ Edema
- ☐ Varicosities

PELVIC EXAMINATION

PERINEUM
- ☐ Scars
- ☐ Warts
- ☐ Reddish
- ☐ Laceration

VAGINA
- ☐ Congested
- ☐ Bartholin's cyst
- ☐ Warts
- ☐ Skene's gland discharge
- ☐ Rectocele
- ☐ Cystocele

CERVIX
- ☐ Congested
- ☐ Erosion
- ☐ Discharge
- ☐ Polyps/cysts
- ☐ Laceration

CONSISTENCY
- ☐ Firm
- ☐ Soft

UTERUS
Position
- ☐ Mid
- ☐ Anteflexed
- ☐ Retroflexed

Size
- ☐ Normal
- ☐ Small
- ☐ Large
- ☐ Mass

Uterine Depth: ____ cms.
(for intended IUD users)

ADNEXA
- ☐ Mass
- ☐ Tenderness

RISKS FOR VIOLENCE AGAINST WOMEN (VAW)
- ☐ History of domestic violence or VAW
- ☐ Unpleasant relationships with partner
- ☐ Partner does not approve of the visit to FP clinic
- ☐ Partner disagrees to use FP

Referred to: ☐ DSWD ☐ WCPU ☐ NGOs
☐ Others (specify: _____)

ACKNOWLEDGEMENT:
This is to certify that the Physician/Nurse/Midwife of the clinic has fully explained to me the different methods available in family planning and I freely choose the _____ method.

_____ Client Signature

_____ Date

Reminder: Kindly refer to PHYSICIAN for any check (/) marks prior to provision of any method for further evaluation

SIDE B	FAMILY PLANNING SERVICE RECORD				
CLINET NUMBER ______ NAME OF CLIENT: ______ (Last Name, Given Name, MI) ___/___/___ Date of Birth **Education** ______ **Occupation** ______ **Address** ______ (No. Street *Barangay* Municipality Province	**DATE SERVICE GIVEN**	**METHOD TO BE USED/ SUPPLIES GIVEN** (cycles, pieces, etc.)	**REMARKS** • MEDICAL OBSERVATION • COMPLAINTS/ COMPLICATION • SERVICE RENDERED/ PROCEDURES/ INTERVENTIONS DONE (i.e. laboratory examination, treatment, referrals, etc.)	**NAME AND SIGNATURE OF PROVIDER**	**NEXT SERVICE DATE**

Instructions for Completing the Target Client List (TCL)
for Family Planning to include Postpartum Family Planning
(adapted from Family Planning Competency-Based Training: Basic Course Handbook)

The TCL is filled out by health workers when providing services and is updated every time a client comes back for a follow-up visit. It has the following purposes:

1. It helps the health worker plan and carry outpatient care and service delivery
2. It facilitates the monitoring and supervision of service delivery activities
3. It facilitates the preparation of reports,
4. it provides clinic-level data that can be accessed for further studies.

In the Right Upper Corner of the TCL form (front page) - put the name of FP method. This page includes listing of all clients who accepted any modern FP method for the first term or new to the program or currently using a specific FP method e.g. pill, so each specific method will have a separate TCL.

Column 1: DATE (OF REGISTRATION) - Indicate in this column the date month, day, and year a client made the first clinic visit or the date when client re-started his/her availment of the FP service.

Column 2: FAMILY SERIAL NUMBER - Indicate in this column the number that corresponds to the number written on the family folder or envelope or individual treatment record. This column will help you to easily facilitate retrieval of the record.

Column 3: CLIENT'S NAME - Write the client's complete name.
(given name, middle initial, and family name).

Column 4: ADDRESS - Record the client's present permanent place of residence (number of the house, name of the street, barangay, municipality, and province) for monitoring follow-up of clients.

Column 5: AGE - Indicate in this column the age of the female client or wife as of last birthday. In the case of a male client, indicate the age of client's wife.

Column 6: NUMBER OF LIVING CHILDREN - Indicate number of living children.

Column 7: TYPE OF CLIENT AND CODES OF CLIENTS - Write on this column the code of the following client categories.

Column 8: PREVIOUS METHOD - Refers to last method used prior to accepting a new method. Enter in this column the codes as indicated below the front page of Target Client List

Column 9: FOLLOW-UP VISITS - Write the next scheduled date of visit in the appropriate column for the month followed by a slash, e.g. 3-31/. When the client returns for the scheduled visit, write the date at the right of the slash, e.g. 3-31/3-29. A client who is scheduled for a particular month but fails to make the clinic visit will have only one date entered for that particular month.

Column 10: DROPOUT - If a client fails to return for the next service date, he or she is considered a dropout. Enter the date the client became a dropout under column "Date" and indicate the reason under column "Reason." Validate client first prior to dropping out from the record.

Column 11:REMARKS - Indicate in this column the date and reason for every referral made (to other clinics) and referral received (from other clinics), which can be due to medical complications or unavailable family planning services and other significant findings to client care.
Method Dropouts (when is a client considered a dropout from the method):

LACTATIONAL AMENORRHEA METHOD (LAM)

• has her menses any time within six months postpartum (bleeding or spotting within 56 days postpartum is not considered as menses); or

• practices mixed regular feeding and/or regularly introduces solid food, liquid, vitamins within the first six months or not exclusively breastfeeding her baby or; when the child reaches six months old.

NATURAL FAMILY PLANNING (NFP)

a. Basal Body Temperature Method - If the user fails to chart her own fertile and infertile periods, she is considered a dropout.

b. Cervical Mucus or Billings Ovulation Method - If the user fails to chart her own fertile and infertile periods, she is considered a dropout.

c. Sympto-thermal Method - If the user fails to chart her own fertile and infertile periods, she is considered a dropout.

d. Standard Days Method - If the user has no indication of (a) SDM use through beads or (b) knowledge of first day of menstruation or cycle length.
Note: Validate chart monthly if client needs to be dropped.

PILLS - If the client

• fails to return for a re-supply/clinic visit on the scheduled date unless client was validated as getting supplies from other sources other than the clinic;

• gets supplies and/or transfers to another clinic; the client is considered as a current user in the clinic where she transferred, but is a dropout in her former clinic;

• desires to stop the pills for any reason.

INJECTABLE (DMPA) - If the client

• fails to return for more than two weeks from the scheduled date of injection unless client was validated getting supply from other sources other than the clinic;

• gets herself injected with DMPA in another clinic; the client is considered a current user in the clinic where she transferred, but is a dropout in her former clinic;

• stops to receive the injection for any reason.

INTRAUTERINE DEVICE (IUD) - If the client

• does not return to the clinic for checkup for three to six weeks; not later than three months after her first post-insertion menses or has not been followed-up for two years;

• requests for IUD removal;

• has had her IUD expelled.

CONDOM - If the client

• fails to return for a re-supply/clinic visit on scheduled visit unless client was validated getting supplies from other sources other than the clinic;

• gets supplies from another clinic and/or transfers to another clinic; the client is considered a current user in the clinic where she transferred, but is a dropout in her former clinic;

• stops using the method for any other reason.

VOLUNTARY SURGICAL CONTRACEPTION

• ***Tubal ligation -*** If the client is already menopausal (average: 50 years old);

• ***Vasectomy -*** indefinite

NOTE TO SERVICE PROVIDERS: For client using pills, injectables, IUDs, condoms, tubal ligation or vasectomy, validate client first whether she/he is using the method or not before dropping her/him out from the record.

TARGET CLIENT LIST FOR FAMILY PLANNING

METHOD OF CONTRACEPTIVE _____

DATE OF REGISTRATION mm/dd/yy (1)	FAMILY SERIAL NO. (2)	NAME (3)	ADDRESS (4)	AGE (5)	NUMBER OF LIVING CHILDREN (6)	TYPE OF CLIENT* (use codes) (7)	PREVIOUS METHOD** (use codes) (8)

**Type of client*

CU = Current Users
NA = New Acceptors
CM = Changing Method
CC = Changing Clinic

***Previous Method*

CON = Condom
INJ = Depo Medroxyprogesterone Acetate (DMPA)
IUD = Intrauterine Device
PPIUD = Postpartum Intrauterine Device
Pills = Pills
NFP – BBT = Basal Body Temprerature
NFP – CM = Cervical Method
NFP – STM = Sympto-thermal Method
NFP – LAM = Lactational Amenorrhea Method
IMP = Single Rod Subdermal Implant
NFP – SDM = Standard Days Method
MSTR/Vasec = Male Ster/Vasectomy
FSTR/BTL = Female Ster/Bilateral Tubal Ligation
RS = Restart


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