Contraception

Client assessment

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O+G history - age, number of children, age of youngest child, history of pregnancies, LMP and cycle, desire for more children, desired timing for birth of next child, breastfeeding status, current sexual partner(s), breast lumps/problems, cervical screening, current/past contraception and ideas for the future - *include partner's view if possible*
STI symptoms & risk - vaginal discharge/itching, ulcers, swellings; previous treatment for STI; >1 sexual partner in the last 3m; sexual partner treated for STI in last 3m; sexual partner has (or thought to have) other sexual partners; client/partner in high risk profession (commercial sex worker, long distance truck-driver)
Medical History – any current medical problems, medication, history of chronic illness or significant disease (check for: headaches, DVT, hypertension, diabetes, breast cancer, liver disease), HIV status, smoking status, personal/family history of breast cancer/screening

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Examination: BP, weight, BMI, cervical screening as necessary.
Further examination as indicated by history

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Pregnancy status – how to be reasonably sure a client is not pregnant:

- She has had a baby <6m ago, is exclusively breastfeeding and has not started menses
- She has had a baby in the last 21d
- Has abstained from sex since the start of her LMP
- Is within 5d of the start of a normal period
- Is within 5d post-miscarriage or post-abortion
- Has had a negative pregnancy test and has not had unprotected sex in the last 3 weeks
- Has been consistently and correctly using a reliable methods of contraception

If in any doubt, wait for period or perform a pregnancy test (not accurate if period not late)

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Discuss possible options of contraception based on client and partner's wishes, availability and Medical Eligibility Criteria (MEC) – see following pages

- Longer-acting methods are recommended
- Remember that condoms is the only method which also protects against STIs – advise dual protection if at risk

Medical eligibility criteria		
(dark green)	**Category 1**	No restrictions for use
(light green)	**Category 2**	Can generally use; some follow-up may be needed
(orange)	**Category 3**	Usually not recommended; **discuss with consultant if no alternative method appropriate**
(red)	**Category 4**	Do not use the method – unacceptable health risk

References

Kenya National Family Planning Guidelines, 6th Edition https://tciurbanhealth.org/wp-content/uploads/2019/04/Kenya-National-Family-Planning-Guidelines-6th-Edition-for-Print.pdf
2016 WHO medical eligibility criteria for contraceptive use: Quick reference chart. USAID/FHI360 October 2016

METHODS OF CONTRACEPTION

(also **BARRIER** = condoms)

		LONG ACTING						SHORT ACTING		NATURAL	
	Type of contraception	**IMPLANTS**	**Cu-IUD** (copper coil)	**Lng-IUS** (hormone-releasing intrauterine system)	**INJECTABLE** (DMPA = depo provera or sayana press; NET-EN)	**VOLUNTARY SURGICAL CONTRACEPTION**		**COC** (combined oral contraceptive)	**POP** (progestogen only pill "minipill")	**Fertility awareness methods**	**Lactation**
						Vasectomy	**Bilateral tubal ligation (BTL)**				
COUNSELLING	**Effectiveness**	99.9% effective 3-5 years duration	99% effective 3-12 years duration depending on brand	99% effective 3-5 years duration depending on brand	99% effective if used correctly and consistently	99.8% effective	>99% effective	99.7% if taken correctly	99.5% effective if taken correctly during exclusive breast-feeding; less effective if not breast-feeding	Variable, pregnancy rates range from 1-14%	User dependent – with perfect use 99% effective
	How it works	Prevents ovulation (usually) Makes cervical mucus too thick for sperm to penetrate	Copper is released which prevents fertilization (by preventing sperm reaching the fallopian tubes)	Progestin is released which prevents fertilization by interfering with sperms motility, thins endometrium, thickens mucus and may also prevent ovulation	Prevents ovulation	Surgical procedure, performed under local anaesthetic, to cut and tie the vas deferens to prevent spermatozoa from mixing with seminal fluid.	Minor operation that involves cutting and tying the fallopian tubes to prevent the sperm from fertilizing the egg and reaching the uterine cavity Carried out at: -minilap -laparoscopically -at C/S or other surgery	Prevents ovulation and thickens cervical mucus	Thickens cervical mucus and can suppress ovulation (but usually not well)	Several approaches – either singly or in combination (which increases effectiveness) Calendar-based methods e.g. CycleBeads Symptom-based methods Withdrawal method	Temporary post-partum method based on the natural effect of breastfeeding in preventing ovulation, due to prolactin release.
	Advantages	Highly effective and safe Provides long-term protection so no frequent clinic visits required Does not contain oestrogen and so does not have cardiac and blood-clotting side effects Does not require daily action Can be used during breastfeeding Can be useful for those with endometriosis, menorrhagia and iron-deficiency anaemia (as often reduces menstrual flow) Protects against endometrial cancer, fibroids and PID Usually immediately reversible (can be some delay)	Highly effective and safe Immediate protection after insertion Long acting protection Does not require client action for efficacy Can be used ater delivery Immediate return to fertility on removal Does not interfere with breast-feeding	As for IUCD but added benefit of minimising menstrual bleeding and reduing pain in dysmenorrhoea and endometriosis	Highly effective and safe Does not contain oestrogen and so does not have cardiac and blood-clotting side effects Does not require daily action Can be used during breastfeeding Can be useful for those with endometriosis, protecs against endometrial cancer and fibroids	Highly effective and safe Permanent Does not affect sex drive No long-term health risks Cheap, easy to perform Fewer side effects and safer than many of the methods available to women The man takes responsibility ofr contracption	Highly effective and safe Permanent Once done, the woman does not have to do anything Does not interfere with sexual desire Cost effective after the initial procedure No significant long-term side effects No hormones Decreased risk of ovarian cancer and possible decreased risk of PID No effect on periods, sexual desire or weight	Lighter, shorter, less painful periods Helps protect from ovarian and endometrial cancers Used in treatment of acne, PCOS Return to fertility immediate on stopping	Safe during breast-feeding, can start from 6w post-partum. Suitable for women with risk factors for heart attack, stroke, blood clots. Return to fertility immediate on stopping.	No side effects or health risks No contraceptive commodities or supplies needed Return to fertility immediate Free Can be used when other methods are contra-indicated	All 3 of the criteria must be met for this method to be effective: 1) Menstrual periods have not resumed 2) The baby is exclusively breastfed 3) The baby is less than 6 months old Return to fertility immediately on stopping breastfeeding Passive immunity for child, no health risks, free, does not interfere with sexual activity
	Disadvantages	Bleeding changes are common but not harmful Some ARVs (EFV) reduce the effectivement of implants (See MEC chart) Insertion and removal requires a minor surgical procedure and can be uncomfortable	Needs to be inserted and removed by a trained health care professional Perforation of the uterus may occur, but is rare Infection is possible during insertion but is very rare if precautions are taken		Delayed return to fertility on stopping (can be several months)	Virtually irreversible Only trained and skilled HCW can perform the surgery Delay in effectiveness after the procedure so need for back-up method for 3 months No protection against STIs and HIV	Does not prevent against STIs and HIV Generally irreversible Need equipped facilities and trained If pregnancy does occur, risk of ectopic Complication rate 0.4-2%	Have to take every day at the same time (within 12h)	Have to take every day strictly at the same time (within 3h)	Clients require extensive eduation and instruction Does not prevent against STIs User-dependent Need cooperation of both partners Require variable periods of abstinence during fertile phase Not easy if irregular cycle	If any of the 3 criteria is no longer met, it is not effective and another FP method must be used Does not protect against STIs Fertility can resume before menses start

	Side effects	Changes in menstrual bleeding –amenorrhoea, spotting, intermenstrual bleeding or prolonged bleeding headache, dizziness, nausea, mood changes, weight changes, mild abdominal pain, breast tenderness	Menstual bleeding and cramping may increase, especially during the first few months after insertion	As per other progestin only contraceptives	Changes in menstrual bleeding – irreg, heavy, light spotting (common in first 6-8m of use), amenorrhoea common; weight changes, headache, dizziness, mood swings, abdo bloating, acne, breast tenderness	Minimal risks and side effects of local anaesthetic and surgery (bleeding, pain and swelling, failure) DISPELLING MYTHS! Not castration, does not interfere with a sexual desire or ability	Very small risk of the surgery itself – bleeding, infection, anaesthesia, bladder/bowel injury Scarring, post-op pain	***Minor*** - Nausea, spotting, headaches, breast tenderness, weight changes, mood changes – these symptoms usually settle after the first few months (see below for details of how to manage) ***Major*** *(rare but possible)* **–** DVT/PE, MI, Stroke	Bleedings changes common - irregular spotting or bleeding, prolonged bleeding Headaches, dizziness, nausea, breast tenderness Mood changes (see below how to manage common side effects)		
	How to use	Implants lasts 3-5 years depending on type			Injection every 1-3 months depending on the type	After vasectomy, the couple must use a backup methods for at least 3 months	In cases of **heavy or painful periods** the active pills can be taken continuously for 3 packs before stopping for a withdrawal bleed (see heavy menstrual bleeding guideline)	Take one pill everyday at the same time, will bleed during the pill-free week (or when taking taking inactive pills) ***Missed pills*** - take any missed pills as soon as possible (see below for further details)	Take one pill every day at exactly the same time (+/- 2h), as soon as finish one pack start the next pack ***Missed/late pills*** - take any missed pills as soon as possible (see below for further details		
PRESCRIBING INFORMATION	**Contraindications**	See MEC chart	See MEC chart	See MEC chart	See MEC chart	No absolute contraindications BUT special care must be taken to ensure that every client who chooses this method does so voluntarily and is fully informed about the permanence of this method and the availability of alternative, long-actiing, highly effective methods. Caution if: nulliparous women, youth, men who have not fathered a child, depression, mental challenges Informed consent must be obtained. Spousal consent is not mandatory, but counselling should be provided for both partners and consent be obtained from both if possible/appropriate Some medical conditions (e.g. valvular heart disease, coagulation disorder) may mean that the procedure should be undertaken in a setting with an experienced surgeon and anaesthetist Provide alternative contrapcetion if there is to be a delay		See MEC chart	As per Implant on MEC chart	Should not be used by women who dislike touching their genitals; whose partners will not cooperate; who need a highly effective form of contraception	
	How to start	Insert within first 7d of menstrual bleeding – provides protection by 24h Can also be inserted at any time, if certain she is not pregnant – but if after day 7 of cycle, not protected for 7d Postpartum and breastfeeding – can insert immediately (but usually less bleeding if >6w); if menses resumed as per above Post-partum and not breast-feeding – insert immediately or within first 21d; if >21d ruel out pregnancy before insertion Post-abortion or miscarriage – can be inserted immediately	Insert IUCD within first 12d of cycle, or at any other time if reasonably sure she is not pregnant Post-partum – can be inserted immediately (as long as not at increased risk of infection – prolonged ROM, prolonged labout, endometritis or puerperal sepsis) Post miscarriage – insert immediately or within 12d if no complications and no suspicion of infection		Give initial injection within the first 7d of cycle if reasonably sure she is not pregnant; if started after day 7 of cycle she will need extra protection for 7d Post-partum – as above if menses; if lactational amenorrhoea start any time after negative pregnancy test; if not breast-feeding can start within 21d, if >21d rule out pregnancy, not protected for 7d			Can start at any time if reasonably sure she is not pregnant - If started within 5d of cycle – effective immediately - If started at other times of cycle, not protected for 7d Post-partum (non-breastfeeding) – can start >21d, not protected for 7d Post-miscarriage or abortion can start immediately Woman can be given the COC to start once her period comes if pregnancy cannot be ruled out	Start on first day of period then protected; if start later, then not protected for 48h Post-partum and breast-feeding can start immediately after birth (MEC 2) or after 4 weeks (MEC 1) Non breast-feeding – if started after 3w, not protected for 48h Post- miscarriage or abortion can start immediately -		
	Follow up	Advise re bruising and discomfort after insertion, keep area dry for 5d, return to clinic if rod comes out or if soreness, pain, heat, pus or redness at insertion site Give card with information about type of implant inserted, date of insertion, month and year when the implant will need to be removed On removal, ensure plan for subsequent contraception	Arrange a visit 3-6 weeks after insertion. Check that IUCD is felt on bimanial examination. If not, then ultrasound. Explain to return if -symptoms of PID (fever, chills, LAP, dyspareunia, unusual vaginal discharge) -missed periods -expelled IUCD		Administer regularly – 2 monthly for NET-EN; 3 monthly for Depo		Complication rate 0.4-2%	-Review after 3 packs – check if tolerating well and BP ok ***-Safety-net advice:*** advise to return immediately if *Chest pain/SOB* *Headaches* *Eye Problems* *Severe calf pain* -Currently in Kenya, only 3 packets of pills can be provided at a time (although recommendations suggest women can be reviewed annually after first follow-up)			It is reasonably certain a woman is not pregnancy is she meets all 3 LAM criteria. She can start a new method with no need for a pregnancy test

Kijabe OPD Guidelines

2016 WHO Medical Eligibility Criteria for Contraceptive Use: Quick Reference Chart for Category 3 and 4

to initiate or continue use of combined oral contraceptives (COCs), depot-medroxyprogesterone acetate (DMPA), progestin-only implants, copper intrauterine device (Cu-IUD), levonorgestrel intrauterine system (LNG-IUS)

CONDITION	Sub-condition	COC	DMPA	Implants	Cu-IUD	LNG-IUS
Pregnancy		NA	NA	NA		
Breastfeeding	Less than 6 weeks postpartum				See i.	See i.
	≥ 6 weeks to < 6 months postpartum					
	≥ 6 months postpartum					
Postpartum not breastfeeding VTE = venous thromboembolism	< 21days				See i.	See i.
	< 21days with other risk factors for VTE*					
	≥ 21 to 42 days with other risk factors for VTE*					
Postpartum timing of insertion	≥ 48 hours to less than 4 weeks	See i.	See i.	See i.		
	Puerperal sepsis					
Postabortion (immediate post-septic)						
Smoking	Age ≥ 35 years, < 15 cigarettes/day					
	Age ≥ 35 years, ≥ 15 cigarettes/day					
Multiple risk factors for cardiovascular disease						
Hypertension BP = blood pressure	History of (where BP cannot be evaluated)					
	BP is controlled and can be evaluated					
	Elevated BP (systolic 140-159 or diastolic 90-99)					
	Elevated BP (systolic ≥ 160 or diastolic ≥ 100)					
	Vascular disease					
Deep venous thrombosis (DVT) and pulmonary embolism (PE)	History of DVT/PE					
	Acute DVT/PE					
	DVT/PE, established on anticoagulant therapy					
	Major surgery with prolonged immobilization					
Known thrombogenic mutations						
Ischemic heart disease (current or history of)				I / C		I / C
Stroke (history of)				I / C		
Complicated valvular heart disease						
Systemic lupus erythematosus	Positive or unknown antiphospholipid antibodies					
	Severe thrombocytopenia		I / C		I / C	

Adapted from: *Medical Eligibility Criteria for Contraceptive Use, 5th Edition*. Geneva: World Health Organization, 2015. Available: http://www.who.int/reproductivehealth/publications/family_planning/en/index.html

CONDITION	Sub-condition	COC	DMPA	Implants	Cu-IUD	LNG-IUS
Headaches	Migraine without aura (age < 35 years)	I / C				
	Migraine without aura (age ≥ 35 years)	I / C				
	Migraines with aura (at any age)		I / C	I / C		I / C
Unexplained vaginal bleeding (prior to evaluation)					I / C	I / C
Gestational trophoblastic disease	Regressing or undetectable β-hCG levels					
	Persistently elevated β-hCG levels or malignant disease					
Cancers	Cervical (awaiting treatment)				I / C	I / C
	Endometrial				I / C	I / C
	Ovarian				I / C	I / C
Breast disease	Current cancer					
	Past w/ no evidence of current disease for 5 yrs					
Uterine distortion (due to fibroids or anatomical abnormalities)						
STIs/PID	Current purulent cervicitis, chlamydia, gonorrhea				I / C	I / C
	Current pelvic inflammatory disease (PID)				I / C	I / C
	Very high individual risk of exposure to STIs				I / C	I / C
Pelvic tuberculosis					I / C	I / C
Diabetes	Nephropathy/retinopathy/neuropathy					
	Diabetes for > 20 years					
Symptomatic gall bladder disease (current or medically treated)						
Cholestasis (history of related to oral contraceptives)						
Hepatitis (acute or flare)		I / C				
Cirrhosis (severe)						
Liver tumors (hepatocellular adenoma and malignant hepatoma)						
AIDS	No antiretroviral (ARV) therapy	See ii.	See ii.	See ii.	I / C	I / C
	Not improved on ARV therapy				I / C	I / C
Drug interactions	Rifampicin or rifabutin					
	Anticonvulsant therapy **					

This chart shows a complete list of all conditions classified by WHO as Category 3 and 4. Characteristics, conditions, and/or timing that are Category 1 or 2 for all methods are not included in this chart (e.g., menarche to < 18 years, being nulliparous, obesity, high risk of HIV or HIV-infected, < 48 hours and more than 4 weeks postpartum).

I/C Initiation/Continuation: A woman may fall into either one category or another, depending on whether she is initiating or continuing to use a method. Where I/C is not marked, the category is the same for initiation and continuation.
NA Not applicable. Women who are pregnant do not require contraception. If these methods are accidentally started, no harm will come
i The condition, characteristic and/or timing is not applicable for determining elgibility for the method
ii Women who use method other than IUDs can use them regardless of HIV/Aids-reltaed illness or use of ART
***** Other risk factors for VTE include previous VTE, thrombophilia, immobility, transfusion at delivery, BMI>30, postpartum haemorrhagem immediately post-CS, pre-eclampsia and smoking
****** Anticonvulsants include phenytoin, carbamazepine, barbituates, primidone, topiramate, levetiracetam, oxycarbazepine and lamotrigine. Lamotrigine is category 1 for implant

Extra Information from national guidelines

https://tciurbanhealth.org/wp-content/uploads/2019/04/Kenya-National-Family-Planning-Guidelines-6th-Edition-for-Print.pdf

Refer to these guidelines for information on missed COCs, switching methods and side effects of other methods

Table 5.3 **Side effects and Management for COCs**

Side effect	Management
Nausea and dizziness	Assess for pregnancy. Reassure client that this is a common side effect in COC users and may diminish in a few months. Advise client to take pills with meals or at bedtime
Amenorrhoea	Assess for pregnancy. If client is not pregnant, explain that this is one of the possible side effects of COC use.
Spotting	Assess for pregnancy, ensure cervical screening is up-to-date Reassure client that irregular spotting is a harmless and common side effect in COC users, especially during the first three months. Assess for other illnesses if appropriate Encourage client to take pills at the same time each day. If spotting persists and is unacceptable for client, prescribe 800 mg ibuprofen three times a day for five days (or other NSAID, except aspirin). If this does not offer relief, help client to choose another FP method.

Table 5.16 **When client misses appointment for injection**

Timing	Suggested action
Comes earlier for her next injection	The repeat injection for both DMPA (IM or SC) and NET- EN can be given up to 2 weeks early.
Comes up to 4 weeks • late for DMPA and 2 weeks late for NET-EN	The repeat injection for DMPA (IM or SC) can be given up to 4 weeks late, and for NET-EN, up to 2 weeks late without requiring additional contraceptive protection.
Comes more than four • weeks for DMPA and more than two weeks for NET-EN	If client is more than 4 weeks late for a DMPA repeat injection, she can have the injection, if it is reasonably certain she is not pregnant (**Note:** DMPA users may develop amenorrhea without pregnancy so pregnancy test or pelvic exam might be needed to rule out pregnancy). If she is more than 2 weeks late for a NET-EN repeat injection, she can have the injection if it is reasonably certain she is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days after injection

Table 5.14 **Side effects of POIs and their management**

Side effect	Management
Irregular spotting or light • bleeding between monthly periods	Spotting or light bleeding is common during use of injectable contraceptives, particularly during the first 6-8 months of use. It is not harmful. Reassure the client If the bleeding is persistent assess for gynecological problems and treat accordingly - If there is no gynecological problem treat with NSAID e.g. Ibuprofen - If the treatment is not effective and she finds the bleeding unacceptable, discontinue injectable and help her choose another method.
Heavy or prolonged • bleeding (lasting more than eight days or twice • as long as her usual menstrual period)	Assess for underlying gynecological problems and manage accordingly. If there are no underlying gynecological problems give any of the following: - Give NSAIDs (Ibuprofen 400-800 mg tds for 7- 14 days) - COCs (one active pill daily up to 1-3 cycles) If client presents when it is 8 weeks or more from the last dose, give another dose of injectable contraceptive and set a new return date based on the current injection. This schedule could speed up the development of amenorrhea, which would stop the bleeding. If bleeding persists and becomes a threat to her life, discontinue injectable and help her choose another method.
Amenorrhea	By the end of the first year on injectables, amenorrhea develops in the majority of clients. Normally amenorrhea does not require any medical treatment. Counselling and reassurance are sufficient. If in doubt, assess for pregnancy, and manage accordingly. If client is bothered by lack of menses despite reassurance, discontinue injectable, and help her choose another method.
Headache or dizziness •	Assess for other causes including raised blood pressure. - Reassure client if symptoms are mild. - If severe, discontinue injectable and refer for evaluation. Help client choose another method.
Breast fullness or tenderness	Assess for pregnancy: If pregnant, discontinue injectable; if not pregnant, reassure and give analgesics If physical examination shows signs of infection, treat with antibiotics and analgesics If she has breast lump or other suspicious lesions, refer for appropriate source for diagnosis.

Table 5.21 **Side effects of implants and their management**

Side Effect	Management
Irregular spotting or • light bleeding	Reassure client that light bleeding/spotting is common in women using this method especially in the first year. It is not serious and usually does not require treatment. If the bleeding is persistent assess for gynecological problems and treat accordingly If there is no gynecological problem treat with non-steroidal anti-inflammatory drugs (NSAIDs) e.g. Ibuprofen or give a cycle of Combined Oral Contraceptives (COCs) If the treatment is not effective and she finds the bleeding unacceptable, remove the implants and help her choose another method.
Heavy or prolonged bleeding (>8 days or twice as much as her usual menstrual period)	Assess for underlying gynecological problems and manage accordingly. Iftherearenounderlyinggynecologicalproblemsgive NSAIDs, COCs or haemostatics - NSAIDs regimes; Ibuprofen: 800 mg three times a day for five days or Mefenamic acid: 500 mg twice a day for five days - COCs regimes; Low-dose COCs: 30 µg ethinylestradiol 150 µg Levonorgestrel a day for 21 days or COCs: 50 µg ethinylestradiol 250 µg Levonorgestrel a day for 21 days - Heamostatics; Transnexamic acid 500mg three times a day for five days or Ethamsylate 500mg three times a day for five days If bleeding persists and becomes a threat to her life, remove the implants and help her choose another method.
Amenorrhea	Reassure her that this is a common occurrence while using implants, and it is not harmful. Amenorrhea does not require any medical treatment. Counselling is sufficient. Ifsuspicious,assess for pregnancy: if she is pregnant, remove the implants; if she is not pregnant, reassure her and continue method.
Headache	Assess for other causes including raised blood pressure. Reassure client if symptoms are mild. If she has migraine headaches without aura, she can continue to use implants if she wishes. If she has migraine headache with aura (MECcategory 3), remove the implants and help her choose a method without hormones.
Breast fullness or tenderness	Assess for pregnancy: if pregnant, remove implant and manage as below (suspected pregnancy); if not pregnant, reassure and give analgesics. If physical examination shows signs of sepsis, treat with antibiotics and analgesics If she has breast lump or other suspicious lesions, refer to appropriate source for diagnosis.
Implant expulsion	Insert a new set in the other arm or in the reverse direction in the same arm, or help the client to select an alternative method.
Suspected •. pregnancy	Assess for pregnancy, including ectopic pregnancy Remove the implants or refer for removal There are no known risks to a fetus conceived while a woman has implants in place

Table 6.6 **Side Effects and Problems Associated with IUCD and Their Management**

Side effect	Management
Abnormal bleeding patterns (spotting, intermenstrual bleeding, prolonged or heavy bleeding)	Reassure her that this problem usually decreases over time. If she requires treatment give a short course of Non-Steroidal Anti Inflammatory drugs e.g. Ibuprofen If persistent spotting or heavy or prolonged bleeding, exclude gynecological problem. - If a gynecological problem is identified, treat the condition or refer for care. - If no gynecological problems are found, and she finds the bleeding unacceptable, especially if there are clinical signs of anemia, remove the IUCD and help her choose another method.
Abdominal cramping and pain	Inform client that some abdominal cramping may occur in the first 24-48 hours If cramping continues give analgesics If pain and cramping is severe evaluate for underlying conditions including signs of partial IUCD expulsion, PID or ectopic pregnancy and treat accordingly. If pain and cramping persists and no cause is found, remove IUCD, counsel client to select another method.
Partner complains about pricking during coitus	This may happen when the threads are cut too short or the IUCD is partially expelled Examine and insert another IUCD
Partial or complete expulsion	Conduct appropriate assessment including pelvic examination to rule out other conditions e.g. infection or pregnancy If complete expulsion is confirmed (seen by woman, confirmed by X-ray or ultra sound) insert IUCD if pregnancy is ruled out or give any other FP method of choice If partial expulsion is confirmed, remove IUCD and insert another IUCD if desired and appropriate or counsel client for any other FP method of choice If IUCD is embedded in cervical canal and cannot be easily removed by standard technique refer appropriately
Woman develops PID	Treat with appropriate antibiotics. There is no need for removal of IUCD if she wishes to continue its use - If symptoms do not improve after a few days of antibiotics, IUD removal may be considered and antibiotic treatment continued. - In all cases woman should be closely monitored until PID is fully resolved
Pregnancy with IUCD	Exclude ectopic pregnancy (ultrasound scan where available; otherwise careful clinical monitoring). If woman wants IUCD to be removed and the IUCD strings are visible or can be retrieved safely from the cervical canal (in the first 3 months): remove IUCD by pulling on the strings gently; explain that she should return promptly if she experiences heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever. If the IUCD strings are not visible, determine if IUCD is still in the uterus by ultrasound. - If the IUCD is not located, this may suggest that an expulsion of the IUCD has occurred. - If the IUCD is located inside the uterus, she can continue with the pregnancy and seek care promptly if she experiences heavy bleeding, cramping, pain, abnormal vaginal discharge, fever.