# Family planning

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Introduction to contraception

Consult the most recent National Contraception Clinical Guidelines (especially in women with medical conditions).

Women should decide their own family planning method, in consultation with their health care professional,taking into consideration safety, efficacy, acceptability, and access. Always obtain a complete medical and sexual history and perform an appropriate physical examination in order to ensure that there are no contra-indications to using a particular method. Always exclude pregnancy before commencing contraception.

Contraceptive methods

Hormonal contraception and IUCDs do not prevent sexually transmitted infections (STIs), including HIV. Dual protection i.e. the use of a condom in combination with another contraceptive method is recommended to reduce the risk of STIs, including HIV.

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| Contraceptive method | Advantages  include: | Disadvantages  include: |
| Copper IUCD  (see Section 7.1) | 1. Suitable for most women, including nulliparous women. 2. Provides long-term protection i.e. 5 years. 3. Convenient, does not require frequent follow up. 4. Works immediately on insertion. 5. Non-hormonal therefore no interaction with other medication and no hormonal side effects. 6. Fertility returns on removal of IUCD in women of child-bearing age. | 1. Some discomfort or cramping during and following insertion. 2. IUCD must be inserted or removed by a trained health care professional. 3. Should not be used in women with menorrhagia, active pelvic inflammatory disease (PID), purulent cervicitis, unexplained uterine bleeding, cervical and endometrial cancers or other uterine abnormalities. |
| Levonorgestrel Intrauterine device (LNG-IUD)  (see Section 7.2.2) | 1. Suitable for most women, including nulliparous women. 2. Provides long-term protection (up to 5 years). 3. Convenient, does not require frequent follow up. 4. Works immediately on insertion. 5. Immediate return to fertility on removal. 6. Reduces menstrual cramps, heavy menstrual bleeding, and symptoms of endometriosis. 7. Can be inserted postpartum (within 48 hours after delivery).  |  | | --- | | LoE:IIb[[1]](#endnote-2) | | 1. Bleeding changes are common but not harmful. Typically, lighter and fewer days of bleeding, or infrequent or irregular bleeding. 2. LNG-IUD must be inserted or removed by a trained health care professional. 3. Should not be used in women with active PID.  |  | | --- | | LoE:IIIb[[2]](#endnote-3) | |
| Hormonal subdermal: progestin-only implant (see Section 7.2.1) | 1. Provides long-term protection i.e. 3 years (etonogestrel) or 5 years (levonorgestrel). 2. Convenient, does not require frequent follow up. 3. Can be used in women >35 years who are obese, who smoke, or who have diabetes, hypertension, or a history of venous thromboembolism. 4. Fertility returns on removal of implant in women of child-bearing age. | 1. Frequent bleeding irregularities. 2. Implant must be inserted or removed by a trained health care professional under aseptic conditions to prevent infection. 3. Incorrect insertion and removal technique may result in complications. |
| Hormonal injectable: progestin-only (see Section 7.2.2) | 1. Daily adherence is not required. 2. Long-acting i.e. given every 8 or 12 weeks. 3. Interactions with other medicines do not lower contraceptive effect. 4. Can be used postpartum. 5. Can be used in women >35 years who are obese, who smoke, or who have diabetes, hypertension, or a history of venous thromboembolism. | 1. Delayed return to fertility of up to 9 months, after last injection. 2. Frequent bleeding irregularities (irregular, prolonged and/or heavy bleeding, or amenorrhoea).  |  | | --- | | LoE:IIIb[[3]](#endnote-4) | |
| Hormonal oral:  progestin-only (see Section 7.2.3) | 1. Fertility returns within 3 months of discontinuing the pill. 2. Can be used postpartum. 3. Can be used in women >35 years who are obese, who smoke, or who have diabetes, hypertension, or a history of venous thromboembolism. | 1. Daily adherence is required. 2. Interactions with other medicines can lower contraceptive effect. 3. Lower efficacy compared with COC. 4. Frequent bleeding irregularities. |
| Hormonal oral:  combined oral contraceptive (COC)  (see Sections 7.2.3 and 7.2.4) | 1. Non-contraceptive benefits, e.g.: alleviation of dysmenorrhoea, premenstrual syndrome, and menorrhagia. 2. Fertility returns within 3 months of discontinuing COC. | 1. Daily adherence is required. 2. Interactions with other medicines can lower contraceptive effect. 3. Cannot be used in women with venous thrombo-embolic disease. 4. Cannot be used immediately postpartum. |
| Barrier: male and female condoms (see Section 7.3) | 1. Protects against STIs, including HIV. | 1. Possibility of breakage or slipping off. 2. Possible allergic reaction to latex. 3. Lower efficacy than other contraceptive methods therefore advised as dual contraception. |
| (Refer to the most recent SAHPRA registered package inserts for detailed information). | | |

Effectiveness of family planning methods

Rates of unintended pregnancies per 100 women:

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| Contraceptive method | Failure rate in 1st year (%) | | % of women continuing  use at one year |
| Consistent and  correct use | As typically  used |
| Copper IUCD | 0.6 | 0.8 | 78 |
| LNG-IUD | 0.2 | 0.2 | 80 |
| Progestin-only subdermal implant | 0.05 | 0.05 | 84 |
| Progestin-only injectable | 0.3 | 3 | 56 |
| Progestin-only oral pill (not breastfeeding) | 0.3 | 8 | 67 |
| Progestin-only oral pill (during breast feeding) | 0.5 | 1 | n/a |
| Combined oral contraceptive (COC) pill | 0.3 | 3 | 67 |
| Barrier: female condoms | 5 | 21 | 41 |
| Barrier: male condoms | 2 | 15 | 43 |
| Sterilisation: male – vasectomy | 0.1 | 0.15 | 100 |
| Sterilisation: female - tubal ligation | 0.5 | 0.5 | 100 |
| No method | 85 | 85 | n/a |
| Key: 0-0.9: very effective 10-25: moderately effective  1-9: effective 26-32: less effective | | | |  | | --- | | LoE:IIIb[[4]](#endnote-5) | |

## Intrauterine contraceptive copper device (IUCD)

Z30.0/Z30.1/Z30.5

Dual protection with barrier methods is recommended to reduce the risk of STIs including HIV.

The IUCD is a long-term contraceptive method that is effective, safe and reversible. It has no hormonal effects or drug interactions..It does not require daily adherence or frequent follow up.

**HIV infection is NOT a contra-indication to the use of an IUCD.**

**IUCDs are often the most suitable contraceptive for women on antiretrovirals and other enzyme-inducing medicines, because of the absence of drug interactions.**

* Copper IUCD, e.g.:
* Cu T380A, 380mm² copper device.

Devices with lower copper surface area are not recommended.

The IUCD can be inserted at any time during the menstrual cycle, once pregnancy has been excluded (by clinical history or with a pregnancy test if required). Insertion at menstruation may be easier for the woman and results in less discomfort and spotting.

Copper IUCDs may be inserted immediately postpartum or post miscarriage (within 48 hours) by specially trained health care professionals, provided that no contra-indications are present (chorioamnionitis, ruptured membranes for more than 18 hours, or postpartum haemorrhage).

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| LoE:IIb[[5]](#endnote-6) |

Alternatively, an IUCD may be inserted at least 4 weeks postpartum.

Advise women when to return:

1. Expulsion of IUCD or if strings of the IUCD protrude.
2. Complications (excessive bleeding, excessive pain, fever, or foul-smelling discharge).

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| LoE:IVb[[6]](#endnote-7) |

1. Routine follow-up after 3–6 weeks.

Copper IUCD is not recommended for women with menorrhagia, active pelvic inflammatory disease (PID), purulent cervicitis, unexplained uterine bleeding, cervical and endometrial cancers or other uterine abnormalities.

For mild pain and discomfort after insertion:

* Ibuprofen, oral, 400 mg 8 hourly with or after a meal as needed for up to 3 days.

##### REFERRAL

1. Excessive pain or bleeding after insertion.
2. Signs of infection within 7 days of insertion (e.g. fever, abdominal pain and/or foul-smelling discharge).
3. Abnormal bleeding for > 3 months.

## Contraception, hormonal

**CAUTION**  
Before starting hormonal contraception, advise women about the expected bleeding patterns, both initially and in the longer term.

### Subdermal implant

Z30.0/Z30.4/Z30.8

Dual protection with barrier methods is recommended to reduce the risk of STIs, including HIV.

The subdermal implant is an effective, safe, reversible, and convenient long-term contraceptive method that does not require daily adherence or frequent follow-up.

* Progestin-only subdermal implant contraceptive, e.g.:
* Etonogestrel, subdermal, 68 mg, single-rod implant.

The progestin-only subdermal implant can be inserted at any time during the menstrual cycle, once pregnancy has been excluded. If the implant is inserted within 7 days of the onset of the menstrual cycle the contraceptive effect is achieved on the day of insertion.

The main reason for discontinuation of the implant is irregular bleeding. This requires good counselling before the implant is inserted to inform women that this side effect can occur and can be treated. See Section 7.6: Breakthrough bleeding with contraceptive use.

Progestin-only hormonal contraceptives are contraindicated in certain conditions e.g. unexplained vaginal bleeding, active liver disease. Consult the package insert in this regard.

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| LoE:IIIb[[7]](#endnote-8) |

**CAUTION**  
Medicines that induce the metabolism of progestins could reduce contraceptive efficacy. These medicines include efavirenz, rifampicin, phenytoin, carbamazepine, and phenobarbital.   
Women on these medicines should be advised to use alternate contraceptive methods such as the copper IUCD or DMPA.  
If the client chooses to use the implant, then she should be advised to use dual contraception.

###### Insertion and removal procedures

1. Participation in a training session is strongly recommended to become familiar with the use of the subdermal implants and techniques for insertion and removal.
2. Only health care professionals familiar with these procedures should insert and remove subdermal implants, under aseptic conditions.
3. Insert the implant **subdermally just under the skin of the upper non-dominant arm.**
4. **Important: Refer to the package inserts for detailed information**.

Insertion of etonogestrel 68 mg implant:

1. Insertion should only be performed with the preloaded applicator.
2. Have the woman lie on her back on the examination table with her non-dominant arm flexed at the elbow and externally rotated so that her wrist is parallel to her ear and her hand is positioned next to her head.
3. Identify anatomical surface markings to establish the area of insertion, which is the inner side of the non-dominant upper arm about 8–10 cm above the medial epicondyle of the humerus, avoiding the sulcus (groove) between the biceps and triceps muscle and the large blood vessels and nerves situated in the neurovascular bundle deeper in the subcutaneous tissue.
4. Clean the insertion site with an antiseptic solution.
5. Anaesthetise the insertion area.
6. Mark the insertion site with a marker.
7. Insert the implant subdermally:.
   * Remove the transparent protection cap by sliding it horizontally in the direction of the arrow, away from the needle.
   * Puncture the skin with the tip of the needle slightly angled less than 30° relative to the skin surface.
   * Lower the applicator to a horizontal position. While lifting the skin with the tip of the needle, slide the needle to its full length. You should be able to see the applicator just below the skin. Be seated, looking at the applicator from the side and NOT from above to clearly see the insertion and positioning of the needle just under the skin.
   * While keeping the applicator in the same position and the needle inserted to its full length, unlock the purple slider by pushing it slightly down. Move the slider fully back until it stops.
   * The implant is now in its final subdermal position. Remove the applicator.
8. Always verify the presence of the implant in the woman’s arm immediately after insertion by palpation and allow her to feel the implant as well.
9. Apply sterile gauze with a pressure bandage to minimise bruising. The woman may remove the pressure bandage in 24 hours and the small bandage over the insertion site after 3–5 days.

Insertion of levonorgestrel 2 x 75 mg implants:

1. Clean the woman‘s upper arm with an antiseptic solution.
2. The optimal insertion area is in the medial aspect of the upper arm about 6-8 cm above the fold of the elbow.
3. Use the scalpel to make a small incision (about 2 mm) just through the dermis of the skin. Alternatively, the trocar may be inserted directly through the skin without making an incision.
4. The implants will be inserted subdermally, in the shape of a narrow V, opening towards the armpit.
5. Anesthetise two areas about 4.5 cm long, to mimic the V shape of the implantation site.
6. Mark the insertion site with a marker.
7. Open the implant pouch by pulling apart the ﬁlm of the pouch and let the two implants drop on a sterile cloth. Note: Always use sterile gloves or forceps when handling the implants. If an implant is contaminated, e.g. falls on the ﬂoor leave it for later disposal. Open a new package and continue with the procedure.
8. The implant is provided with a disposable trocar that is sharp enough to penetrate the skin directly. Thus the disposable trocar can be used to puncture the skin and insert the rods, without the need for an incision.
9. The trocar has two marks. One mark is close to the handle and one close to the tip. When inserting the implants, the mark closest to the handle indicates how far the trocar should be introduced under the skin before loading each implant. The mark closest to the tip indicates how much of the trocar should be left under the skin after the insertion of the ﬁrst implant. When inserting the trocar, avoid touching the part of the trocar that will go under the skin.
10. Once the tip of the trocar is beneath the skin it should be directed along the subdermal plane horizontally by pointing it slightly upwards and raising the skin (tenting). Failure to keep the trocar in the subdermal plane may result in deep placement of the implants, causing a more difficult removal. Throughout the insertion procedure, the trocar should be oriented with the bevel up.
11. Advance the trocar beneath the skin about 5.5 cm from the incision to the mark closest to the handle of the trocar. Do not force the trocar, and if you feel any resistance, try another direction.
12. Remove the plunger when the trocar is advanced to the correct mark.
13. Load the first implant into the trocar with either tweezers or fingers.
14. Push the implant gently with the plunger to the tip of the trocar until you feel resistance. Never force the plunger.
15. Hold the plunger steady and pull the trocar back along it until it touches the handle of the plunger. lt is important to keep the plunger steady and not to push the implant into the tissue.
16. Do not completely remove the trocar until both implants have been placed. The trocar is withdrawn only to the mark closest to its tip.
17. When you can see the mark near the tip of the trocar in the incision, the implant has been released and will remain in place beneath the skin. You can check this by palpation.
18. Insert the second implant next to the first one, to form a V shape. Fix the position of the first implant with the left fore-ﬁnger and advance the trocar along the side of the ﬁnger. This will ensure a suitable distance between implants. To prevent expulsions, leave a distance of about 5 mm between the incision and the ends of the implants. You can check their correct position by cautious palpation of the insertion area.
19. After inserting the second implant, press the edges of the incision together, close with a skin closure and dress the wound.
20. Advise the woman to keep the insertion area dry for 3 days.
21. The gauze and the bandage may be removed as soon as the incision has healed, usually after 3–5 days.

For pain after insertion:

* Ibuprofen, oral, 400 mg 8 hourly with or after a meal as needed for up to 5 days.

Removal of progestin-only subdermal implants:

Remove etonogestrel implants at the end of 3 years and levonorgestrel implants at the end of 5 years.

1. Locate the implant/s by palpation. If impalpable refer for ultrasound removal.
2. Clean the removal site with an antiseptic solution.
3. Anaesthetise the removal area.
4. Push down the proximal end of the implant and a bulge may appear to indicate the distal end of the implant.
5. Make a 2-4 mm vertical incision with the scalpel close to the distal end of the implant, towards the elbow.
6. Remove the implant very gently, using a small forceps (preferably curved mosquito forceps). Where an implant is encapsulated, dissect the tissue sheath to remove the implant with the forceps.
7. Confirm that the complete implant has been removed by measuring the length (etonogestrel rod: 40 mm; levonorgestrel rods: 43 mm). Close the incision with a steristrip or plaster and dress.
8. Advise the woman to keep the arm dry for a few days.

##### REFERRAL

1. Heavy or prolonged bleeding, despite treatment with COCs.
2. Infection at insertion site, inadequately responding to initial course of antibiotic treatment. See Section 5.4.3: Cellulitis.
3. Failure to locate an implant (in the arm) by palpation.

### Levonorgestrel intra-uterine DEVICE (LNG-IUD)

Z30.0/Z30.4/Z30.8

Dual protection with barrier methods is recommended to reduce the risk of STIs including HIV.

The LNG-IUD is an effective, safe, reversible, long-term contraceptive method that has minimal hormonal adverse effects and is not prone to drug interactions. It does not require daily adherence or frequent follow up.

* Progestin-only intrauterine device, e.g.:

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| LoE:IIb[[8]](#endnote-9) |

* Levonorgestrel, intrauterine device, 52 mg.

**HIV infection is NOT a contra-indication to the use of an LNG-IUD.**

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| LoE:IIIb[[9]](#endnote-10) |

The LNG-IUD is a T-shaped plastic device that steadily releases a small amount of levonorgestrel every day. It has the added benefit of reducing menstrual cramping and heavy menstrual bleeding. It can be inserted by specially trained health care professionals, at any time during the menstrual cycle, once pregnancy has been excluded (by clinical history or with a pregnancy test if required). Insertion at menstruation may be easier for the womant, and results in less discomfort and spotting. For use by women of any age, regardless of whether they had children before.

LNG-IUD may be inserted immediately postpartum or post miscarriage (within 48 hours) provided that no contra-indications are present (chorioamnionitis, ruptured membranes for more than 18 hours or postpartum haemorrhage). Provider require specific training in postpartum insertion by hand or using a ring forceps.

LNG-IUD may also be inserted at 4 or more weeks postpartum.

Advise women when to return:

1. Expulsion of LNG-IUD or if strings of the LNG-IUD protrude.
2. Complications (excessive bleeding, excessive pain, fever or foul smelling discharge).

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| LoE:IIIb[[10]](#endnote-11) |

1. Routine follow-up after 3–6 weeks.
2. First time migraine or severe headaches during use.

LNG-IUD is not recommended for women with acute venous thromboembolism, severe liver cirrhosis, active pelvic inflammatory disease (PID), purulent cervicitis, unexplained uterine bleeding, cervical- breast- ovarian- or endometrial cancers, or other uterine abnormalities.

For mild pain and discomfort after insertion:

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| LoE:IVb |

* Ibuprofen, oral, 400 mg 8 hourly with or after a meal as needed for up to 3 days.

##### REFERRAL

1. Excessive pain or bleeding after insertion.
2. Signs of infection within 7 days of insertion (e.g. fever, abdominal pain and/or foul-smelling discharge).
3. Abnormal bleeding for > 3 months.
4. First time migraine or severe headaches.

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| LoE:IVb[[11]](#endnote-12) |

### Injectable

Z30.0/Z30.4

Dual protection with barrier methods is recommended to reduce the risk of STIs, including HIV.

* Progestin-only injectable contraceptive, e.g.:

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| LoE:IIIb[[12]](#endnote-13) |

* Medroxyprogesterone (long-acting), IM, 150 mg, 12 weekly.

Progestin-only hormonal contraceptives are contraindicated in certain conditions e.g. unexplained vaginal bleeding. Consult the package insert in this regard.

When to start the injection

1. The injection can be started anytime within the menstrual cycle, provided pregnancy has been excluded. If the first injection is given within 7 days of the onset of the menstrual cycle, the contraceptive effect is achieved on the day of the first injection.
2. If started after day 7,advise the woman to abstain from intercourse or use condoms for the next 7 days.

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| LoE:IVb[[13]](#endnote-14) |

1. Can be used postpartum.

Late injection

1. If it has been <2 weeks since the missed injection, the next injection can be given without loss of protection. Continue with dual contraceptive method, i.e. condom in combination with the injection.
2. If it has been >2 weeks since the missed injection, exclude pregnancy:

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| Pregnancy test positive | Pregnancy test negative or unavailable |
| 1. Refer for ante-natal care (See Section 6.4: Antenatal care).   ***or***   1. TOP, see Section 6.3: Termination of pregnancy (TOP). | 1. Provide emergency contraception, if indicated (see Section: 7.4 Contraception, emergency). 2. Administer the next injection. 3. Advise the woman to abstain from intercourse or use condoms to prevent pregnancy for the next 7 days. |

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| LoE:IVb[[14]](#endnote-15) |

There is uncertainty of the risk of HIV acquisition associated with progestin injectable contraceptives (Refer to the WHO MEC 2017 guidelines[[15]](#endnote-16)). Dual protection is recommended.

##### REFERRAL

Heavy or prolonged bleeding, despite adequate treatment with combined oral contraceptives. See Section 7.6: Breakthrough bleeding with contraceptive use.

### Oral

Z30.0/Z30.4

Dual contraception with barrier methods, are recommended to reduce the risk of STIs, including HIV.

###### Monophasic preparations:

* Progestin only pills, e.g.:

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| LoE:IIIa[[16]](#endnote-17) |

* Levonorgestrel, oral, 30 mcg daily.
* Progestins and estrogen, fixed combinations, e.g.:
* Ethinylestradiol/ levonorgestrel, oral, 30 mcg/150 mcg:
* 21 tablets ethinylestradiol/levonorgestrel, 30 mcg/150 mcg and

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| LoE:IIIa[[17]](#endnote-18) |

* 7 tablets placebo.

###### Triphasic preparations:

* Progestins and estrogen, sequential preparations, e.g.:
* Ethinylestradiol/levonorgestrel, oral:
* 6 tablets ethinylestradiol/levonorgestrel, 30 mcg/50 mcg
* 5 tablets ethinylestradiol/levonorgestrel, 40 mcg/75 mcg and
* 10 tablets ethinylestradiol/levonorgestrel, 30 mcg/125 mcg and

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| LoE:IIIa[[18]](#endnote-19) |

* 7 tablets placebo.

Counselling:

1. Hormonal oral pills must be taken at the same time every day without interruption.
2. Taking the hormonal oral pill with food or at bedtime may alleviate nausea.
3. If the woman is not using dual contraception with barrier methods and vomits within 2 hours, or has severe diarrhoea within 12 hours of taking the hormonal oral pill, repeat the dose as soon as possible. Recommend condom use.
4. Women who have persistent vomiting or severe diarrhoea resulting in two or more missed pills must follow instructions for missed pills - see section 7.2.4. Recommend condom use.

###### Contraindications and guidance to starting the hormonal oral pill

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|  | Progestin only | Combined estrogen/progestin |
| Contra-indications | Progestin only preparations are contraindicated in certain conditions (Consult the package insert in this regard).  Contraindications include:   1. Abnormal uterine bleeding of unknown cause. 2. Myocardial infarction/stroke. 3. Liver disease. 4. Cancer of the breast/ genital tract. 5. Known or suspected pregnancy.  |  | | --- | | LoE:IVb[[19]](#endnote-20) | | Combination preparations contraindicated in certain conditions (Consult the package insert in this regard).  Contraindications include:   1. Women >35 years of age who smoke ≥15 cigarettes a day or have risk factors for cardiovascular disease:    * heart disease    * liver disease    * thromboembolism    * certain cancers |
| When to start the pill | 1. Exclude pregnancy. 2. Start anytime within the menstrual cycle, but it is advisable to start during menses. 3. If the first pill is given between days 1 and 5 of the menstrual cycle the contraceptive effect is achieved immediately. 4. If the pill is started at any other time, it needs to be taken for at least 7 days before it protects against pregnancy. | |

###### Medicine interactions

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| Enzyme-inducing medicines interacting with oral contraceptives | | Recommendation |
| **Therapeutic class** | **Examples** |  |
| Anti-tuberculosis | Rifampicin | Use copper IUCD or alternatively use dual contraception e.g. condoms in combination with COCs. |
| Anti-epileptics | Phenobarbital |
| Phenytoin |
| Carbamazepine |
| Antiretrovirals | Nevirapine |
| Lopinavir/ritonavir |
| Efavirenz |

Non-liver enzyme inducing medicines

Lamotrigine:

1. Lowering of contraceptive effect not expected.
2. Oral contraceptives may reduce lamotrigine concentration by 50%, increasing the risk of seizures. Consider alternative dual contraception method.

Breastfeeding

1. Women who are intending to breastfeed should delay initiation of COCs until cessation of breastfeeding or at 6 months postpartum, whichever occurs earlier.

##### REFERRAL

Abnormal vaginal bleeding for >3 months.

### Missed pills

###### Progestin only pills

Efficacy is rapidly lost if one pill is forgotten or taken >3 hours late. Recommend dual contraception for all scenarios for at least 7 days.

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| LoE:IVb[[20]](#endnote-21) |

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| Scenario | Action |
| One pill forgotten or if pill taken >3 hours late and unprotected sexual intercourse has not occurred in the past 5 days. | Take pill as soon as remembered and continue taking one pill daily at the same hour. |
| One pill forgotten or if taken 3 hours late and unprotected sexual intercourse has occurred in the past 5 days. | Give emergency contraception (see Section 7.4).  Take one pill the next day and continue taking one pill daily at the same hour. |

###### Combination of progestin and estrogen in each pill

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| LoE:IVb[[21]](#endnote-22) |

Missing active pills and extending hormone free interval leads to decreased contraceptive efficacy. Recommend dual contraception for all scenarios for at least 7 days.

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| LoE:IVb[[22]](#endnote-23) |

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| Scenario | Action |
| One active pill forgotten. | Take pill as soon as remembered and take next one at usual time. |
| ≥ Two pills forgotten during the first 7 active pills of the pack and sexual intercourse has occurred in the past 5 days. | Give emergency contraception (see Section 7.4).  Restart active pills 12 hours later. |
| ≥ Two pills forgotten during the middle 7 active pills of the pack. | Take the most recent missed pill immediately (discard the other missed pills).  Continue taking remaining pills as usual.  No emergency contraception required. |
| ≥ Two pills forgotten in the last 7 active pills of the pack and sexual intercourse has occurred in past 5 days. | Continue active pills of current pack.  Omit the inactive pills and immediately start the active pills of the next pack. |

## Contraception, barrier methods

Z30.0/Z30.4/Z30.5

Condoms (male and female) alone are the least effective contraceptive method and should be used in combination with other contraceptive methods (e.g. copper IUCD). Condoms are recommended to reduce the risk of the acquisition of STIs and HIV infection.

Condoms (male and female) or other barrier methods may be an option for contraception where other methods are contraindicated.

## Contraception, emergency

Z30.0/Z30.4

Emergency contraception is indicated to prevent pregnancy after unprotected intercourse in women not using contraception or where contraception is likely to be ineffective:

1. forgotten tablets (See Section 7.2.4: Missed pills)
2. slipped or broken condom
3. injectable contraception given >2 weeks late
4. sexual assault

**Emergency contraception after pregnancy is excluded**

Do a pregnancy test in all women and female adolescents. Children must be tested and given Emergency contraception from Breast Tanner Stage III.

* Copper IUCD, e.g.:
* Cu T380A, inserted as soon as possible after unprotected intercourse and not

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| *LoE:IIIb[[23]](#endnote-24)* |

later than 5 days.

**OR**

* Levonorgestrel 1.5 mg, oral, as a single dose as soon as possible after

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| *LoE:Ia[[24]](#endnote-25)* |

* unprotected intercourse, and not later than 5 days.
* If the client vomits within 2 hours, repeat the dose.

Advise women that their period should be on time; very rarely is it delayed but it should not be more than 7 days late. If this occurs, they should come back for a pregnancy test.

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| **CAUTION**  Emergency contraceptive tablets must be taken as soon as possible, preferably within 72 hours of unprotected intercourse, and not later than 5 days.  Enzyme inducers (including efavirenz and carbamazepine) cause a significant reduction in levonorgestrel concentrations. Women on these medicines should preferably have copper IUCD inserted ***or*** alternatively double the dose of levonorgestrel.  Women > 80 kg or BMI ≥ 30 should also preferably have copper IUCD inserted ***or*** alternatively double the dose of levonorgestrel.   |  | | --- | | LoE:IIIb[[25]](#endnote-26) | |

##### REFERRAL

Women in need of emergency contraception must be referred for HIV counselling and testing and PEP.

## Voluntary sterilisation, male and female

Z30.2

###### Female sterilisation

Also known as tubal occlusion or tubal ligation. This is a permanent, surgical contraceptive method for women who do not intend to have more children.

Women who opt for sterilisation should be adequately counselled and referred.

###### Male sterilisation

Also known as vasectomy. This is a permanent surgical contraceptive method for men who do not intend to have more children.

Men who opt for this method should be adequately counselled and referred.

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| LoE:IIIb[[26]](#endnote-27) |

**CAUTION**  
Sterilisation does not protect against sexually transmitted infections (STIs), including HIV. If there is a risk of STI/HIV, the correct and consistent use of condoms is recommended.

## Breakthrough bleeding with contraceptive use

N92.0/N92.1/N92.4

##### DESCRIPTION

Breakthrough bleeding refers to unscheduled or irregular vaginal bleeding, which often presents as spotting, or prolonged or frequent bleeding in women using hormonal contraception. The pattern and duration of these unscheduled bleedings vary with the contraceptive method used.

##### GENERAL MEASURES

Before starting hormonal contraception, counsel women regarding possible bleeding patterns, both initially and in the longer term.

Clinical assessment:

1. Current method of contraception and duration of use.
2. Drug interactions.
3. Cervical screening history.
4. Risk of sexual transmitted infections (e.g. Chlamydia trachomatis).
5. Menstrual and break though bleeding history prior to current method being initiated.
6. Exclude pregnancy.

|  |  |
| --- | --- |
| Hormonal contraceptives causing breakthrough bleeding | Treatment |
| Progestin-only injectables | * COC containing 30 mcg ethinylestradiol, oral, for 14 days.  |  | | --- | | LoE:IIIb[[27]](#endnote-28) | |
| Progestin subdermal implants | * Ethinylestradiol/levonorgestrel, oral, 30/150 mcg, daily for 20 days. |
| Progestin intrauterine devices | Refer – see Section 7.2.2. |
| Combined oral contraceptive pill   1. Unscheduled bleeding with COC usually settles with time. 2. Changing to another COC in the first 3 months is not recommended. | * Change COC to another COC containing the lowest dose of ethinylestradiol, oral, daily.   If bleeding persists:   * Change COC to a COC containing 35 mcg ethinylestradiol, oral, daily.  |  | | --- | | LoE:IVb | |

##### REFERRAL

1. Pelvic pain.
2. Pelvic mass.
3. Heavy bleeding.
4. Abnormal cervix on speculum examination (e.g. polyps).
5. Bleeding not controlled by treatment above.

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