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NATIONAL CONTRACEPTION CLINICAL GUIDELINES

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NATIONAL CONTRACEPTION CLINICAL GUIDELINES 2019

1 FOREWARD

The development of the revised National Contraception Clinical Guidelines (2019) and the associated South African Handbook for Contraceptive Method Provision (2019) builds on two previous policy and guideline documents, the National Contraception and Fertility Planning Policy and Service Delivery Guidelines (2012) and the National Contraception Clinical Guidelines (2012). The National Contraception Clinical Guidelines will form the basis for the implementation of the National Health Insurance and are designed to support women's agency and choice in a rights-based approach.

There are a number of changes and new additions to the 2019 revision. These are based on changes to the World Health Organization Medical Eligibility Criteria (WHO MEC), emerging global evidence as well as recommendations from the Department of Health (DOH), contraception managers and healthcare providers. Significantly, the changes are to WHO MEC category for hormonal injectable from WHO MEC 2 to 1, and changes to guidelines for women who are breastfeeding –to start progestogen-only pills or implants at any time post-partum (changed from WHO MEC category 3 to 2). In addition, these guidelines include updated guidance for new methods of contraception, which may be phased into the South African contraceptive method mix available at public health facilities.

In keeping with the principle of integration and the chronic care model, the HIV section (Chapter 4, National Contraception Clinical Guidelines DOH 2012), a stand-alone chapter in previous guidelines, has been integrated into this document. This guideline revision is guided by national frameworks and policies, as outlined in the National Integrated Sexual and Reproductive Health and Rights Policy and National Contraception Clinical Guidelines (2012).

The provision of contraception is guided by the principles, policy framework, and counselling guidelines outlined in the National Integrated Sexual and Reproductive Health and Rights Policy and in this document, combined with sound clinical judgement and care. The goal of this guideline is to promote, through informed choice and with a rights-based approach, high quality and safer reproductive health services.

DR A PILLAY

ACTING DIRECTOR GENERAL: HEALTH

NOVEMBER 2019

TABLE OF CONTENTS

TABLE OF CONTENTS (CONT)

TABLE OF CONTENTS (CONT)

LIST OF FIGURES AND TABLES

ACRONYMS

ART	Antiretroviral therapy
BMD	Bone mineral density
CHC	Combined hormonal contraception
COC	Combined oral contraceptive
Cu IUD	Copper intrauterine device
DMPA	Depot medroxyprogesterone acetate
DMPA-IM	Depot medroxyprogesterone acetate intramuscular
DMPA-SC	Depot medroxyprogesterone acetate subcutaneous
DOH	Department of Health
DTG	Dolutegravir
DVT/PE	Deep vein thrombosis and pulmonary embolism
EC	Emergency contraception
ECP	Emergency contraceptive pills
ENG	Etonogestrel
FSH	Follicle-stimulating hormone
HIV	Human Immunodeficiency Virus
HRT	Hormonal replacement therapy
IEC	Information, education, and communication
IUD	Intrauterine device
LAM	Lactational amenorrhoea method
LARC	Long-acting reversible contraception
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex
LNG	Levonorgestrel
LNG-IUS	Levonorgestrel releasing intrauterine system
MEC	Medical eligibility criteria
NET-EN	Norethisterone enanthate
NNRTI	Non-nucleoside reverse transcriptase inhibitors
PEP	Post-exposure prophylaxis
PID	Pelvic inflammatory disease
PMTCT	Prevention of mother to child transmission
POCs	Progestogen-only contraceptives
POPs	Progestogen-only pills
PPC	Postpartum contraception
PrEP	Pre-exposure prophylaxis

SRH	Sexual and reproductive health
SRHR	Sexual, reproductive health and rights
STI	Sexually transmitted infection
TB	Tuberculosis
TLD	Tenofovir 300mg / Lamivudine 300mg / Dolutegravir 50mg
TOP	Termination of pregnancy
T&T	Test & treat
VTE	Venous thromboembolism
WHO	World Health Organization

INTRODUCTION

The Department of Health (DOH) has developed a National Integrated Sexual and Reproductive Health and Rights (SRHR) Policy.[1] This policy addresses the many cross-cutting issues relating to SRH service provision, drawing together the principles, rights, and guidance for planning and implementation that underpin the provision of quality, comprehensive, and integrated SRHR services in South Africa. The National Integrated SRHR Policy is supported by several clinical and service delivery guidelines covering related programmatic areas, including the National Contraception Clinical Guidelines.

Other documents include:

- National Contraception Clinical Guidelines (2019)
- National Guideline for Implementation of Choice on Termination of Pregnancy Act (2019)
- National Clinical Guideline for Safe Conception and Infertility (2019)
- Sexually Transmitted Infections Management Guidelines (2015)
- National Guideline on the Management of Post-Exposure Prophylaxis (PEP) in Occupational and Non-Occupational Exposures (2019)
- National Clinical Guideline for Cervical Cancer Control and Management (2019)
- National Clinical Guideline for Breast Cancer Control and Management (2019)
- National Clinical Guidelines on Genetics Services (2018)
- National Guideline for the Prevention of Mother to Child Transmission of Communicable Infections (HIV, Hepatitis, Listeriosis, Malaria, Syphilis and TB) (2019)

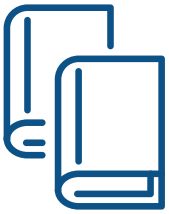
In addition, there are several other documents which are relevant to healthcare providers:

- National Guidelines for Expanding Combination Prevention and Treatment Options: Oral Pre-exposure Prophylaxis (PrEP) and Test and Treat (T&T) (2017)
- National Guideline for the Prevention of Mother to Child Transmission of Communicable Infections (HIV, Hepatitis, Listeriosis, Malaria, Syphilis and TB) (2019)
- Maternal and Neonatal Care Guidelines (2016)
- The Ideal Clinic Manual (2017)
- The Integrated Clinical Services Management (ICSM) [2017]
- National Adolescent and Youth Policy 2017-2021 (2017)
- National Adolescent SRHR Framework Strategy 2014-2019 (2014)

The development of the revised **National Contraception Clinical Guidelines (2019)** and the associated **South African Handbook for Contraceptive Method Provision (2019)** builds on two previous policy and guideline documents, the National Contraception and Fertility Planning Policy and Service Delivery Guidelines (2012) and the National Contraception Clinical Guidelines (2012).

The National Integrated Sexual and Reproductive Health and Rights Policy and National Contraception Clinical Guidelines (2019) and **South African Handbook for Contraceptive Method Provision (2019)** supersede all previous versions.

NOTE: These National Contraception Clinical Guidelines have been developed as a companion document to the South African Handbook for Contraceptive Method Provision.



Readers are urged to use the Clinical Guidelines in conjunction with the Handbook.

The South African Handbook for Contraceptive Method Provision provides information on the following methods:

1 / Intrauterine contraception
- 1.1 Copper intrauterine device (Cu IUD)
- 1.2 Levonorgestrel releasing intrauterine system (LNG-IUS)

2 / Hormonal contraception: Progestogen-only contraception
- 2.1 Subdermal implants
- 2.2 Progestogen-only injectables
- 2.3 DMPA by subcutaneous injection – DMPA-SC
- 2.4 Progestogen-only pills
- 2.5 Drug interactions and progestogen-only contraceptives

3 / Hormonal contraception: Combined hormonal contraceptives (CHCs)
- 3.1 Combined hormonal methods
  - 3.1.1 Combined patch
  - 3.1.2 Combined vaginal ring
  - 3.1.3 Monthly injectables
  - 3.1.4 Drug interactions and combined hormonal contraceptives with regards to anti-retroviral therapy (ART)

4 / Emergency contraception
- 4.1 Emergency contraceptive pills
- 4.2 Emergency Cu IUD insertion

5 / Barrier methods
- 5.1 Male condom
- 5.2 Female condom

6 / Voluntary sterilisation (voluntary surgical contraception)
- 6.1 Female sterilisation
- 6.2 Male sterilisation (vasectomy)

The **Job Aids and Annexures** in the National Clinical Guidelines have been replicated in the Handbook for Contraceptive Method Provision for ease of reference.

WHAT'S NEW?

What is new in the National Contraception Clinical Guidelines 2019?

There are a number of changes and new additions to the 2019 revision of the National Clinical Contraception Guidelines. These are based on changes to the World Health Organization Medical Eligibility Criteria (WHO MEC), emerging global evidence and recommendations from DOH, contraception managers and healthcare providers. These changes include:

NEW AND EXPANDED SECTIONS

- contraceptive counselling
- post-partum contraception
- contraception guidelines for adolescents

NEW RECOMMENDATIONS FROM WHO

- a summary of key changes to the WHO MEC Category
    - changes to the WHO MEC for women at high risk of HIV and the concomitant changes to the WHO MEC categories, as summarised in Section 2.11
    - changes to guidelines for women who are breastfeeding, with updated guidance that women can start progestogen-only pills or implants at any time post-partum (changed from WHO MEC category 3 to 2)
- annexures with WHO MEC have been updated

GUIDELINES FOR NEW METHODS

Guidelines for new methods of contraception, which may be phased into the South African contraceptive methods available at public health facilities, including:

- a lower dose depot medroxyprogesterone acetate injection given subcutaneously [DMPA-SC], which has the potential to be self-injected or given by trained lay workers
- intrauterine device (IUD):
- new smaller LNG-IUS (containing 19.5 mg LNG)
- combined hormonal vaginal ring (Ethinylestradiol/etonogestrel)
- combined hormonal transdermal patch (Ethinylestradiol/norelgestromin)

RECOMMENDATIONS TO STRENGTHEN EXISTING METHODS

- encourage the procurement and use of the 10-year Copper T
- increased access to LNG-IUS (containing 52mgs LNG) at clinic level (e.g. Mirena)

UPDATED AND EXPANDED GUIDELINES FOR CURRENT METHODS

- includes expanded sections on IUD and implant insertions and removals
- management of side effects for Cu IUDs and implants
- revised guidelines on the use of prophylactic antibiotics and IUD insertion (Section 2.7)

HIV AND CONTRACEPTION

In keeping with the principle of integration and the chronic care model, the HIV section (Chapter 4, National Contraception Clinical Guidelines DOH 2012), a stand-alone chapter in previous guidelines, has been integrated into this document. Additionally, these updated guidelines include expanded guidance relating to women at high risk of HIV (Section 2.11) and drug interactions with contraception (Section 2.13). Shifts in HIV treatment in South Africa since 2012 are also reflected, including universal test and treat, emphasis on combination prevention, and the expanded provision of oral PrEP.

IUD AND ANTIBIOTICS

The National Contraception Clinical Guidelines (2012) recommended prophylactic antibiotic use at the time of Cu IUD/LNG IUS insertion. After an expert review process, it is recommended to no longer provide routine prophylactic antibiotic use at the time of IUD/IUS insertion, but to strongly encourage routine follow up at 4 to 6 weeks post-insertion, with a clear invitation to return to clinic anytime sooner if client experiences any symptoms suggestive of pelvic inflammatory disease (PID) and ensure immediate access to services.

ALIGNMENT WITH NATIONAL PRIORITIES AND FRAMEWORKS

This policy revision is guided by national frameworks and policies, as outlined in the National Integrated Sexual and Reproductive Health and Rights Policy and National Contraception Clinical Guidelines (2012).

SCOPE

These guidelines cover modern methods of contraception. In step with contemporary thinking, modern methods of contraception are described as methods which use a product or medical procedure that interferes with reproduction from acts of sexual intercourse.[2] Non-modern methods, also known as traditional or natural methods, are generally less reliable and effective than modern methods. In light of the high rates of unintended pregnancies, unmet need for contraception, and HIV prevalence in South Africa, these methods are not actively promoted in the National Clinical Contraception Guidelines.

1 A FRAMEWORK FOR THE CLINICAL GUIDELINES

This section begins with an overview of the documents used to inform the clinical guidelines and includes:

- a summary of the WHO MEC
- an explanation of the importance and relevance of long-acting reversible contraception (LARC)
- a summary of contraceptive effectiveness and continuation rates

1.1 Global practice/key documents used to develop these guidelines

These clinical guidelines are informed by global, evidence-guided practice, and use the WHO's four cornerstones of family planning, the South Africa National Contraception Clinical Guidelines (2012)[3] and the South Africa National Contraception and Fertility Planning Policy and Service Delivery Guidelines (2012).[4]

The WHO's four cornerstones of family planning

- Medical Eligibility Criteria for Contraceptive Use (5th edition, 2015)[5]
- Family Planning: A Global Handbook for Providers (Revised 2018 Update)[6]
- Selected Practice recommendations for Contraceptive Use (Third Edition 2016)[7]
- Decision-making Tool for Family Planning Clients and Providers

1.2 WHO medical eligibility criteria

The WHO medical eligibility criteria for contraceptive use (WHO MEC)[5] provide guidance for the safe use of contraceptives. Revised every five years, the WHO MEC is the product of a collaborative review of all clinical, epidemiological, and programmatic research on modern contraceptive methods.

The suitability of each method in the presence of specific factors, including medical conditions, are categorised by weighing the health risks against the benefits. The resulting medical eligibility criteria allow contraceptives to be prescribed in line with clients' personal preferences while maintaining an adequate margin of safety. The WHO MEC are classified into four categories, as explained in Table 1 and provide the framework for these clinical guidelines.

Healthcare providers are urged to familiarise themselves and utilise the WHO MEC to determine eligibility for respective methods, summarised by condition, in Annex 1. There are several quick reference tools available, including the WHO MEC wheel[8] and a one-page quick reference tool (Job Aid 11).

Table 1 / WHO MEC classification categories

CATEGORY	CLASSIFICATION	WITH CLINICAL JUDGEMENT	WITH LIMITED CLINICAL JUDGEMENT
CATEGORY 1	A condition for which there is no restriction for the use of the contraceptive method	Use the method in any circumstances	**YES, USE THE METHOD**
CATEGORY 2	A condition for which the advantages of using the method generally outweigh the theoretical or proven risks	Generally, use the method	
CATEGORY 3	Condition for which the theoretical or proven risks usually outweigh the advantages of using the method	Use of method not usually recommended unless more appropriate methods are not available or not acceptable	**NO, DO NOT USE THE METHOD.**
CATEGORY 4	A condition that represents an unacceptable health risk if the contraceptive method is used	Method not to be used	

1.3 Long-acting reversible contraception, contraceptive effectiveness, and continuation rates

Internationally, there has been increasing focus on LARCs, which are among the most effective contraceptive methods and have the greatest potential to reduce unintended pregnancies. These guidelines refer to LARCs in terms of their relative effectiveness and higher continuation rates, as well as whether or not they are reversible.

These include:

- intrauterine contraception:
  - copper IUD (5 and 10 years, depending on the type)
  - levonorgestrel-releasing intrauterine system (LNG-IUS) (5 years)
- subdermal progestogen implants (single-rod for 3 years; two-rods for 4 or 5 years, depending on the type)

Key points about LARCs:

- LARCs are highly effective (see Table 2). They do not rely on regular compliance and correct use in the same way as pills or barrier methods.
- LARCs are reversible compared to effective, permanent methods, such as male and female sterilisation.
- Most LARCS result in immediate return to fertility when stopping.
- LARC methods combine reversibility with highly effective contraception, they are not client-dependent nor do they require repeated visits to the clinic, as required by shorter-term methods such injectables, pills, and barrier methods.
- LARC methods have superior continuation rates compared with short-term methods and, despite high initial costs (in particular with intrauterine systems and implants), are proven to be more cost-effective in the long term in terms of costs of pregnancies averted, continuation rates, plus method, and service delivery costs.[9]
- Evidence has shown that expanding the number of method choices available can lead to improved satisfaction, increased acceptance, and increased prevalence of contraceptive use.[10]

Counselling clients about effectiveness, return to fertility, and whether methods are permanent or reversible form an important part of counselling and method selection. More information is provided in Section 3.1.

NOTE ABOUT INFORMED CHOICE

While there are many advantages to LARCs, informed decision-making and balanced, unbiased counselling is critical. It is also of paramount importance to consider *all* methods of contraception (— barrier, short– and long–acting reversible and permanent methods) in the context of the client's life and needs.

Table 2a shows failure rates for methods over a three-year period. Table 2b provides a comparison of methods in relation to effectiveness and continuation rates, comparative charts are also provided in Job Aid 8.

Table 2a / Method failure rates[11]

MEDIAN CUMULATIVE TYPICAL-USE CONTRACEPTIVE FAILURE RATES BY METHOD ACROSS 43 COUNTRIES, AT 12, 24 AND 36 MONTHS			
Method	**12 months**	**24 months**	**36 months**
Implant	0.6	1.0	1.1
IUD	1.4	1.9	2.1
Injectable	1.7	3.6	5.5
Pill	5.5	10.8	15.1
Male condom	5.4	13.3	16.0
Withdrawal	13.4	27.4	35.7
Periodic abstinence	13.9	25.8	32.4

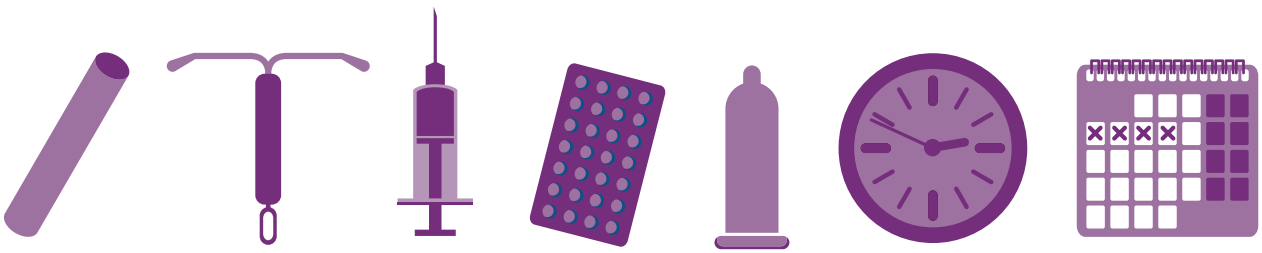


Table 2b / Percentage of women experiencing an unintended pregnancy during the first year of typical use and the first year of perfect use of contraception, and the percentage continuing use at the end of the first year, United States.[7]

Method	Typical use	Perfect use	% of women continuing use at one year
Male sterilization	0.15	0.1	100
Female sterilization	0.5	0.5	100
Implanon©	0.05	0.05	84
Intrauterine contraceptives			
Mirena©	0.2	0.2	80
ParaGard (copper T)©	0.8	0.6	78
Depo-Provera	6	0.2	56
NuvaRing©	9	0.3	67
Evra patch	9	0.3	67
Combined pill and progestin-only pill	9	0.3	67
Diaphragm	12	6	57
Condom			
Male	18	2	43
Female	21	5	41
Sponge			36
Nulliparous women	12	9	
Parous women	24	20	
Withdrawal	22	4	46
Fertility awareness-based methods	24		47
Sympto-thermal method		0.4	
Ovulation Method		3	
TwoDay Method©		4	
Standard Days Method©		5	
Spermicides	28	18	
No method	85	85	

most effective
highest continuation

least effective
lowest continuation

For a more detailed table with footnotes - see Job Aid 8 (Adapted from Trussell, 2011)

2 IMPORTANT CLINICAL ISSUES IN CONTRACEPTION SERVICE PROVISIONS

The provision of contraception is guided by the principles, policy framework, and counselling guidelines outlined in the National Integrated Sexual and Reproductive Health and Rights Policy and in this document, combined with sound clinical judgement and care. In this section, selected clinical issues are highlighted in order to flag key clinical practice considerations underpinning contraceptive service provision.

2.1 Client assessment and screening

History taking

It is important to take a comprehensive personal medical history particularly before clients select hormonal contraception, Cu IUD (copper intrauterine device), or sterilisation (see Job Aid 4 for an example of history taking checklist).

HIV testing

HIV counselling and testing, and discussions relating to risk and prevention, should be provided as a routine part of the consultation. The frequency of an HIV test should be guided by possible exposure to HIV, for both the client and their sexual partners. Clients who test HIV-positive should be initiated onto antiretroviral treatment, as per national Test and Treat guidelines.

Sexually transmitted infection (STI) screening and management

Should be done as an integrated part of contraception service provision, as per national DOH guidelines.

Tuberculosis (TB)

Due to the high incidence of HIV and TB co-infection, the consultation is an opportunity to screen, provide information, treat, or refer, as per national DOH TB guidelines.

Blood pressure

The measurement of blood pressure is essential for sterilisation. It is recommended that blood pressure is measured before and during the use of hormonal contraception. However, where this is not possible, hormonal methods should not be denied, providing there is no history of high blood pressure. Where feasible, provision must be made to check blood pressure on a subsequent visit.

Pelvic examination

This is only essential before fitting an intrauterine contraceptive device/system or before female sterilisation, unless the need for a pelvic examination is indicated in the history taking. This needs to be performed with sensitivity and with a focus on privacy and dignity.

Breast and cervical screening

Where possible, the consultation should serve as an opportunity to educate clients about breast self-examination and the purpose and value of cervical screening. Information should be provided concerning the frequency of cervical screening, as per national guidelines. The actual screening, where appropriate, can be done on the initiation of a contraceptive method or at a mutually agreed appointment.

For HIV-positive women

Provide a cervical screening on HIV diagnosis, and then every three years. If there is an abnormal smear, manage according to national guidelines with annual checks recommended until resolved and thereafter every three years.

For HIV-negative women

Free cervical screenings from the age of thirty at ten-year intervals are recommended.

Screening for pregnancy

Ensuring a client is not pregnant is important when screening for contraception. It is especially recommended before starting hormonal contraceptives and before IUD insertion. There are several tools available for this (see Job Aid 3).

2.2 Follow-up visits

Follow-up visits should be scheduled according to sound medical reasoning. Unnecessary, frequent follow-up visits should be discouraged. Recommendations for the timing of follow-up visits for each method are given in the method-specific sections of the Handbook for Contraceptive Method Provision (2019), which are based on WHO Selected Practice Recommendations for Contraceptive Use 2016. Clients should always be encouraged to return if they have queries or are anxious or need support with the method, particularly with regards to the management of side effects.

2.3 Initiating contraceptive methods in non-menstruating women

Generally, clinical care providers should rule out pregnancy prior to the initiation of most contraceptive methods. Traditionally, menstruation was considered to be a reliable indicator that a woman was not pregnant. However, it is not necessary to restrict the initiation of the contraceptive method to menstruation. A woman can initiate contraception at any time in her menstrual cycle as long as the health care provider is reasonably sure that she is not pregnant.

In most cases, pregnancy can be ruled out by asking a series of questions. Each of these questions describes a situation when pregnancy is highly unlikely (see Job Aid 3 for pregnancy checklist).

If it's not possible to completely rule out pregnancy, a woman should either wait until her next menses to insert an IUD/IUS or initiate hormonal methods of contraception. However, women may start hormonal methods immediately and have a pregnancy test done if they miss their next period. Those who want to initiate oral contraceptive pills can be given a pack to take home with instructions on how to start on the first day of their next menses.[5, 12]

2.4 Management of side effects

The client's tolerance, understanding, and support with regards to side effects contribute significantly to method continuation and satisfaction. Understanding the potential common side effects is an important aspect of informed decision-making when selecting a method. Healthcare providers should not avoid providing information about common side effects for fear of putting clients off a method as research shows that it is helpful and reassuring to know what to expect.

Discontinuation is often due to a lack of tolerance and support with regards to side effects, and both counselling and the management of side effects is important. Key counselling messages about side effects is provided in Section 3. The specific management of side effects is provided under each method in the Handbook for Contraceptive Method Provision (2019).

2.5 Emergency contraception

Emergency contraception (both emergency contraception pills and the Cu IUD) are effective within 120 hours (five days) after unprotected sex, but the sooner it is used, the more effective it is. This is addressed in more detail in the Handbook for Contraceptive Method Provision (2019).

2.6 Re-injection within the grace period for late injections

In clients presenting late, the grace period for repeat injection (without the need to rule out pregnancy), is four weeks for DMPA (both IM and SC) and two weeks for NET-EN.12 This does not mean that injections of DMPA and NET-EN should be routinely scheduled for 16 and 10 weeks – clients should still be encouraged to come for reinjection on time. Reassure clients to come as soon as they can if they have missed an appointment, rather than staying away altogether.

2.7 IUDs and antibiotics

The National Contraception Clinical Guidelines (2012)[3] recommended prophylactic antibiotic use at the time of Cu IUD/LNG IUS insertion. This recommendation has been reviewed and, based on lack of evidence of any significant benefits associated with prophylactic antibiotic cover for IUD insertion and the potential risks of increasing antibiotic drug resistance, the following is now recommended:

- Do not to provide routine prophylactic antibiotic use at the time of IUD/IUS insertion, but strongly encourage follow-up at 4-6 weeks post-insertion, with a clear invitation to return to the clinic anytime sooner if client experiences any symptoms suggestive of PID and ensure immediate access to services.
- In addition, healthcare providers are encouraged to:
    - Promote awareness about the signs and symptoms of STIs across all methods, and not only Cu IUD (e.g. lower abdominal pain, offensive/bad-smelling discharge, fever, pain during intercourse or discomfort/burning urine).
    - Encourage clients to come back at any time if they have concerns, rather than waiting for a scheduled visit.
    - Use the internal examination when screening and preparing for insertion of IUD to detect any symptoms of STIs and treat as per local protocols prior to insertion.
    - Emphasise the importance of preventing infection at the time of insertion using a no-touch technique. Provide guidance about how to do insertion under aseptic conditions, using sterile water or saline or povidone-iodine (betadine) for swabbing cervix prior to the sounding uterus and IUD insertion, as detailed in the **Handbook for Contraceptive Method Provision.**

2.8 Postpartum contraception

Postpartum contraceptive counselling and services are important but are often a missed opportunity. Postpartum contraception should be an integral part of antenatal and postnatal care – after delivery, at the six-week postpartum visit, and at subsequent visits for infant immunisation. This is discussed in Section 5.

2.9 Post-miscarriage and post-TOP contraception

After miscarriage or termination of pregnancy (TOP), all women should be offered personalised counselling and be provided with a contraceptive method of their choice from the full range of available methods. Any method of the client's choice may be initiated immediately following uncomplicated miscarriage or TOP (at any gestational stage), provided that the medical eligibility criteria are met. Early initiation of contraception is advisable because ovulation occurs as early as two weeks post-TOP/miscarriage, so a woman can become pregnant almost immediately afterwards. This is discussed in Section 5.

2.10 Combination prevention

HIV prevention needs to embrace several strategies including a risk discussion, HIV testing, STI management, PrEP (where available), PEP (where appropriate), as well as contraception and condom use (see Job Aid 7).

2.11 Hormonal contraception and HIV risk

- Over the last 20 years, researchers have examined the possible link between contraception and HIV. The WHO has met periodically with experts in the field to review evidence relating to this matter. Due to emerging research, the WHO revised the WHO Medical Eligibility Criteria from WHO MEC 1 to MEC 2 for both DMPA and NET-EN in December 2016.

- The Evidence for Contraceptive Options and HIV Outcomes (ECHO) Study took place between December 2015 and September 2017. This open-label randomised clinical trial was designed to evaluate whether there is a substantial difference in the risk of HIV acquisition among women using three methods of contraception.* The study showed no statistically significant differences in HIV acquisition among women using intramuscular depot medroxyprogesterone acetate (DMPA-IM), copper IUDs, or levonorgestrel (LNG) implants. The study was designed to detect a difference in HIV risk of 50% or more between any two of the three methods investigated in the ECHO trial. It remains possible that smaller differences may exist which may be important in contraceptive and HIV prevention decision-making for individual women at very high HIV risk.

  NOTE: The ECHO results cannot be generalized to other hormonal contraceptives *not included in the study.*

- This new high-quality evidence supersedes the low to low-moderate quality evidence from observational studies that had been previously informed WHO's guidance.†

- In August 2019, the WHO Medical eligibility criteria for contraceptive use were reviewed. The WHO convened the Guideline Development Group to assess the ECHO study results‡ as well as all of the evidence on hormonal contraception and risk of HIV acquisition since the previous review in 2016, together with a systematic review of all published evidence on copper-bearing IUDs and HIV risk.§

* See http://echo-consortium.com/

† WHO revises recommendations on hormonal contraceptive use for women at high HIV risk Press Release 29 August 2019

‡ Evidence for Contraceptive Options and HIV Outcomes (ECHO) Trial Consortium. HIV incidence among women using intramuscular depot medroxyprogesterone acetate, a copper intrauterine device, or a levonorgestrel implant for contraception: a randomised, multicentre, open-label trial. Lancet. 2019;394(10195):303–13. doi: 10.1016/S0140-6736(19)31288-7.

§ World Health Organization. Contraceptive eligibility for women at high risk of HIV. Guidance statement: recommendations on contraceptive methods used by women at high risk of HIV. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO.

Summary of WHO key recommendations**:

Women's risk of HIV does ***not*** restrict their contraceptive choice.
Women at risk of HIV are eligible to use the following, without restriction:

 *All progestogen-only contraceptive methods* **(MEC Category 1)**	This includes progestogen-only pills (POPs), intramuscular and subcutaneous depot medroxyprogesterone acetate (DMPA-IM and DMPA-SC), norethisterone enanthate (NET-EN) injectables, and levonorgestrel (LNG) and etonogestrel (ETG) implants.
 *Copper-bearing intrauterine devices (Cu-IUDs) and LNG IUDs* **(MEC Category 1)**	In considering the use of IUDs, many women at a high risk of HIV are also at risk of other sexually transmitted infections (STIs); for these women, providers should refer to the MEC recommendation on women at an increased risk of STIs, and the Selected Practice Recommendations for Contraceptive Use: Third Edition (section on STI screening before IUD insertion).
 *All combined hormonal contraceptive methods* **(MEC Category 1)**	This includes combined oral contraceptives (COCs), combined injectable contraceptives (CICs), combined contraceptive patches, and combined vaginal rings.

- Efforts to expand contraceptive method options and ensure full and equitable access to family planning services must continue. This needs to include the strengthening of:
    - HIV and STI prevention and management
    - integration of contraceptive and HIV/STI services, combined with other sexual and reproductive health services, as appropriate
    - promotion of and improved access to combination prevention options, including PrEP
    - engagement and involvement of male partners and communities in contraceptive options, and HIV and STI prevention

2.12 Fixed-dose tenofovir / lamivudine / dolutegravir (TLD) and contraception for HIV-positive women

TLD is a fixed-dose combination of tenofovir 300mg/lamivudine 300mg/dolutegravir 50mg (TLD), that provides many benefits as a first-line antiretroviral treatment, including improved tolerability, high effectiveness, lower rates of treatment discontinuation, a higher genetic barrier to resistance, and fewer drug interactions than with other ARV drugs.[13]

WHO recommends TLD as first-line ART for women and adolescent girls using effective contraception, or not of childbearing potential, as well as adolescent girls, breastfeeding women, and pregnant women, from eight weeks after conception.[14] TLD may be potentially teratogenic (causing an increased risk of neural tube defects) if taken at conception and within the first 28 days after conception. While it is not the scope of these guidelines to provide detailed information on ART management, initiating dolutegravir (DTG) in women wanting to conceive now or in the future may carry risks.

** Adapted from: World Health Organization. Implementing Best Practices (IBP) Initiative: WHO updates recommendations for contraceptive eligibility for women at high risk of HIV. 29 August 2019. global@knowledge-gateway.org

The following algorithm provides guidance for first-line TLD and TLE prescription for women (as per the DOH national ART guidelines):

Figure 1 / Guidance for the provision of first line TLD and TLE for women

Adult Women and Adolescent Girls ≥ 35 kg[1] and ≥ 10 years of Age

WOMEN OR ADOLESCENT GIRLS OF CHILDBEARING POTENTIAL?

YES

NO

DETERMINE CURRENT PREGNANCY AND FERTILITY INTENTIONS

Pregnant, up to 6 completed weeks of gestation, or actively wanting to conceive in the near future.[2]	All other WOCP, including: Pregnant, from 7 weeks gestation onwards Not pregnant, and not currently desiring to become pregnant
Provide all necessary information on DTG and EFV-based regimens including the risk of NTDs for this and subsequent pregnancies. Discuss postpartum contraceptive options.[3]	Provide all necessary information on DTG and EFV-based regimens including the risk of NTDs and recommend contraception. Provide her with a choice of contraceptive options as desired.[3]
TEE RECOMMENDED	**TLD RECOMMENDED**

CLIENT MAKES AN INFORMED CHOICE AFTER UNDERSTANDING RISKS AND BENEFITS

TEE[1,4] | **TLD[1, 5, 6]**

1. For adolescent girls who weight less than 35 kg , replace tenofovir with abacavir (ABC)
2. Women wanting to conceive should be started on folate and should be counselled to defer attempts to conceive until they are virally suppressed. See also “Contraception and Safe Conception” on page 9 of the PMTCT guideline.
3. Women should be provided a choice of contraceptive options (which includes condoms, oral contraceptives, implants, injectables, and IUCDs)
4. Women who choose to use TEE around the time of conception can be offered a switch to TLD if their VL is suppressed at 3 months on ART.
5. Documentation that the woman has been counselled and consents to receive DTG must be included in the patient’s chart/file.
6. If a woman’s fertility intentions change and she is concerned about the risk of NTDs, she can be offered a switch from TLD to TEE, provided that she has a suppressed VL in the last 6 months.

2.13 Drug-drug interactions between hormonal contraceptives and certain medications

The following section provides guidance for healthcare providers regarding drug-drug interactions between hormonal contraceptives and certain medications that are commonly used by women of reproductive age in South Africa. Additionally, key practice and counselling points are outlined below.

Why is this an important issue for healthcare providers to know about?

- Certain medications commonly used by women of reproductive age can interact with some hormonal contraceptives in a woman's body, either decreasing or increasing the contraceptive hormone levels.
- These drug-drug interactions (DDIs) are not harmful to a woman's health but may impact the effectiveness of her hormonal contraceptive method, placing users at increased risk of unintended pregnancy. This requires additional counselling.

Common DDIs

- Commonly used medications that have been shown to interact with hormonal contraceptives in a way that decreases contraceptive hormonal levels are typically referred to as enzyme-inducing drugs (EIDs) or strong enzyme-inducing drugs (SEIDs). These are listed in Table 3.

- For more detailed information on hormonal contraceptive drug-drug interactions with specific medications and implications for contraceptive counselling and provision, see Table 4, and refer to Job Aid 9.

Table 3 / Commonly used medications that can reduce blood levels of hormones and may reduce contraceptive effectiveness

Certain HIV antiretroviral medications (ART)	**Non-nucleoside reverse transcriptase inhibitors (NNRTIs)** Efavirenz (EFV) Nevirapine (NVP) **Protease inhibitors (PIs)** Ritonavir-boosted atazanavir (ATV/r) Ritonavir-boosted lopinavir (LPV/r) Ritonavir-boosted darunavir (DRV/r) Ritonavir (RTV)
Certain anticonvulsant medications	Phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine
Certain antimicrobials medications	Rifampicin Rifabutin

Table 4 / Drug Interaction effect on the efficacy

METHOD	DRUG INTERACTION
REDUCTION IN EFFICACY	
Oral contraceptive pills (both combined and progestogen-only)	Adversely affected by drug-drug interactions with enzyme-inducing drugs (EIDs)
Contraceptive vaginal ring	Adversely affected by drug-drug interactions with enzyme-inducing drugs (EIDs
Contraceptive implant	Adversely affected. Evidence shows that efficacy reduced in women taking efavirenz (NNRTI), resulting in unintended pregnancies. While effectiveness is reduced it remains better than most other methods of contraception in typical use.[††]
Oral emergency contraceptive pills	Effectiveness may be reduced by enzyme-inducing drugs. The first choice emergency contraceptive method for clients on enzyme-inducing drugs is the Cu IUD. However, if this is not a suitable option, emergency contraceptive pills should be provided. Progestogen-only ECP (two x 1.5 mg tablets taken as a single dose, or if the dedicated product is not available, use COCs containing 30 µg Ethinylestradiol + 150 µg levonorgestrel (e.g. Nordette/Oralcon). Six tablets followed by six tablets 12 hours later.
Progestogen-only injectable NET-EN	Effectiveness may be reduced by drug-drug interactions although there is limited data available.
NO EFFECT	
Cu IUD	Not affected by drug-drug interactions, remains very highly effective at preventing pregnancy.
Progestogen-only injectable DMPA	Not affected by drug-drug interactions, remains very highly effective at preventing pregnancy.
NO DATA	
Combined contraceptive patch	Drug-drug interactions with the combined contraceptive patch have not been studied but these are expected to be similar to combined hormonal pills.
Hormone-releasing IUD	Drug-drug interactions with the hormone-releasing IUD have not been studied. But these are not expected to significantly affect method effectiveness.

[††] Patel RC et al. Concomitant contraceptive implant and efavirenz use in women living with HIV: Perspectives on current evidence and policy implications for family planning and HIV treatment guidelines Journal of the International AIDS Society 2017, 20:21396 http://www.jiasociety.org/index.php/jias/article/view/21396 | https://doi.org/10.7448/IAS.20.1.21396

BOX 1 / IMPORTANT ADDITIONAL POINTS FOR PROVIDERS TO BE AWARE OF WITH RESPECT TO HIV MEDICATIONS AND CONTRACEPTION:

- All contraceptive methods are medically safe to use with HIV medications (ART).
- Most HIV medications do not interact with hormonal contraceptive methods.
- These interactions do not decrease the effectiveness of the HIV medications.
- These interactions can potentially lead to decreased effectiveness of some hormonal contraceptive methods.
- Providers should always ask which specific HIV medications a woman is taking in her ART regimen in order to appropriately advise her on interactions.
- Efavirenz (NNRTI) has been clearly shown to compromise the effectiveness of several hormonal contraceptives, including the implant, and clients need to be advised of this.
- Dolutegravir (DTG) (integrase inhibitor) is unlikely to interact with hormonal contraception because it does not induce or inhibit the enzymes involved in hormonal contraceptive metabolism. Though not well-studied yet, it is thought that DTG can be effectively used with all hormonal contraceptives. The WHO MEC has not yet provided specific guidance on DTG and hormonal contraception, however other integrase inhibitors are WHO MEC Category 1 and the US CDC MEC classifies all hormonal contraceptives as MEC Category 1 for women using DTG. Based on this, DTG is unlikely to interact with or to decrease the effectiveness of hormonal contraceptives. Hormonal contraception with DTG is currently advised as an effective combination.
- The effectiveness of the Cu IUD and DMPA injectable are not affected by drug-drug interactions with HIV medications and remain very effective at preventing pregnancy for women using HIV medications.

Counselling guidance for drug-drug interactions and contraception

- As part of quality contraceptive care, healthcare providers should always ask clients about their health conditions and medication use at every visit in order to counsel on appropriate contraceptive options.

- Healthcare providers need to be aware of the implications of drug-drug interactions between hormonal contraceptives and commonly used EIDs, such as HIV and TB medications and anticonvulsants. This knowledge allows them to appropriately counsel clients using such medications about potentially reduced effectiveness, alternative contraceptive methods that will be more effective at preventing pregnancy, and the importance of correct and consistent condom use.

- Clients wanting highly effective reversible contraception and using medications known to interact with hormonal contraception, should be

advised that the Cu IUD and DMPA injectable used correctly and consistently are the first choice methods for highly effective pregnancy prevention.

- If after thorough counselling about drug-drug interactions and the reduced contraceptive effectiveness, a woman still wishes to choose to use a contraceptive method that may interact with her medication, she should be given the contraceptive method of her choice. It is important to note that implants remain highly effective despite drug-drug interactions, and in some cases, they may even be the most effective method for a particular woman (if other methods are inappropriate or unacceptable to her or she cannot adhere well to other methods). In such cases, the woman should be encouraged to use condoms correctly and consistently.

A summary of the WHO MEC for the drug to drug interactions is provided in Job Aids 10 and 12.

2.14 Pharmacovigilance

All adverse events related to contraceptive methods should be reported as per agreed national and provincial pharmacovigilance protocol. Report any adverse events related to contraceptive use, including contraceptive failures, drug-drug interactions, and delivery of babies with congenital abnormalities following contraceptive failure. The form must be used as active surveillance (see Job Aid 10).

3 COUNSELLING IN THE CONTEXT OF CONTRACEPTION SERVICE PROVISION

Counselling is an essential component of the client's consultation. The investment in time for a thorough consultation is worth the return it provides in terms of quality client quality. Women who feel they have participated in the choice and management of their contraceptive method will ultimately be satisfied and are more likely to continue with their selected method. Clients who feel engaged and empowered by their contraceptive decision-making will also feel more comfortable returning should they have any concerns. Counselling complements sound clinical care and assists in ensuring that a rights-based, client-focused approach guides contraceptive provision.

Counselling should facilitate informed choice, provide ongoing support, and be a gateway to comprehensive SRHR and HIV health services. Table 5 summarises the important components that frame effective counselling during contraceptive services.

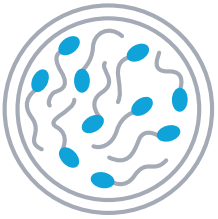
Table 5 / Important components underpinning the contraceptive provision

Quality of care	• Ensure privacy for the consultation. • Ensure providers are equipped with essential clinical and counselling skills. • Provide methods guided by clinical and evidence-based competence. Assist clients to choose a contraceptive method that is appropriate to their personal circumstances and preferences BUT is clinically safe and takes into account drug interactions with ART, TB, and other medications, as well as their fertility desires. • Ensure access by providing information in a manner that clients understand.
Rights-based service provision	• Respect a rights-based approach as articulated in the SRHR Policy, which includes informed choice and decision-making, and the right to choose when to prevent pregnancy, plan for pregnancy or terminate pregnancy. » Informed choice includes the decision to initiate, continue, discontinue, or switch to another method. This is particularly important with regards to the provider- dependant methods requiring insertion or removal. • Be sensitive to the needs and perceptions of HIV-positive clients. Research has shown that HIV-positive women perceive healthcare providers' attitudes to be a barrier when discussing sex, contraception, and the desire to become pregnant. • Acknowledge that the right to plan, prevent, or express sexual desires and sexuality is applicable to all. • Integrate SRHR services into HIV services, including contraceptive services.
Diversity	• Be aware of and accommodate diversity in a non-judgmental manner. • Do not make assumptions: » Not all clients are part of a heterosexual couple. The client may be single or non-heterosexual (e.g. lesbian, gay, bisexual, transgender, intersex, and questioning/queer persons). » Clients may have more than one sexual partner. » Clients may identify as male, female, X (non-binary), or transgender. » Clients may have vaginal or anal sex.

The balance between counselling and information giving	• Establish open, interactive communication. • Explore what has motivated the client to attend the clinic. • Encourage the client to express their needs, ask questions, and express concerns.
Client-centred	• Provide impartial information on the contraceptive methods available without provider bias (i.e. convenience bias or personal opinion). • Provide relevant information on the chosen method, including insertion process (if applicable), usage instructions, re-supply or removal requirements, common side effects and how to deal with them, warning signs of complications, follow-up arrangements, and return to fertility. • Provide information selectively according to the level and detail appropriate to the client. • Ensure that clients understand and have the information they need to adhere to their contraceptive method of choice.
Integration: HIV and SRH	• Seek opportunities for SRHR and HIV integration (see Section 8.1). • Offer HIV testing at each visit. • Discuss the advantages of a client knowing both their HIV status and the HIV status of their partner(s). • Emphasise the importance of: » re-testing after possible exposure to HIV » correct and consistent condom use as dual protection for HIV and STI prevention, plus any other available HIV prevention methods (PrEP, where available, and PEP, where indicated).
Community of care	• Develop an integrated approach to prevention and planning for pregnancy. • Encourage the client to keep appointments, to come back with any concerns, and to return even if scheduled appointment dates are missed. • Provide counselling to clients who wish to discontinue contraception to plan for pregnancy. Provide information related to getting pregnant, such as PMTCT, HIV prevention, risk of transmission and acquisition, the importance of a healthy lifestyle and, where indicated and feasible, screening of common genetic disorders.
Couple counselling and partner involvement	• Where appropriate and desired by the woman, support both partners to be involved in the contraception method decision-making process. Partner involvement has benefits in relation to supporting contraceptive use, the use of dual protection (condom use), and in considering contraception options for males such as vasectomy, where appropriate. • Counsel couples that the decision to plan for pregnancy should ideally involve both partners. • Be sensitive when asking couples if there has been a disclosure of HIV status. Discuss this separately with the client prior to the consultation with the client's partner. • Never make the involvement of a male partner a precondition for access to contraception for women.

3.1 Important counselling themes

The following are important counselling themes, which need to complement clinical services and form part of the method of provision and management, as appropriate:



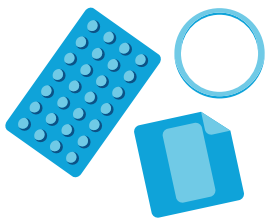
FERTILITY PLANNING COUNSELLING

Preventing or planning for pregnancy?

- Discussion topics should include the client's future fertility plans, specifically their desire to prevent pregnancy or plan to get pregnant. Clients should be encouraged to communicate about their fertility intentions and to understand the importance of planning for healthy pregnancies.
- A client's fertility plans should be discussed at the initial assessment as well as all subsequent consultations. The desire to get pregnant is not always planned, and clients must be encouraged to discuss if their fertility plans have changed.
- Clients must understand how long their chosen contraceptive method is effective so that they can plan follow-up appointments accordingly. This information is provided in the method-specific information.

Healthy timing and spacing for pregnancy

- *Communicate information on healthy timing and spacing of pregnancies.*
  The time intervals recommended by the WHO[6] are below.
- *Spacing after a live birth:*
  The recommended interval before attempting the next pregnancy is at least 24 months in order to reduce the risk of adverse maternal, perinatal, and infant outcomes.
- *Spacing after a spontaneous miscarriage or induced termination of pregnancy:*
  The recommended minimum interval to the next pregnancy should be at least six months in order to reduce the risk of adverse maternal and perinatal outcomes.
- *Delay pregnancy till 18 years:*
  Recommended that women should delay their first pregnancy until at least age 18.[15]



CONTRACEPTION METHOD-SPECIFIC COUNSELLING

Counselling about effectiveness

The effectiveness of a contraceptive method is an important factor to take into account when deciding on a method. It is an integral part of informed decision-making and

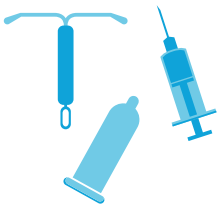
needs to be done in a way that is meaningful and clearly understood by the client. The chart in Job Aid 8 and Table 2 (comparing contraceptive effectiveness) are useful tools for this discussion. Client should understand that correct method use contributes to effectiveness. Provider-dependent, long-acting methods are more effective than client-dependent, shorter-acting methods.

Essential information about methods for informed choice

In counselling about choice, it is not possible or necessary to provide complete information about every method. Clients benefit from key information, as is relevant to them. The aim of counselling for informed decision-making is to assist the client to choose a method appropriate to their needs and tolerance of side effects. Well-informed clients are more likely to be satisfied with their method.

Clients need to understand:

- how the method works (mechanism of action)
- effectiveness
- how to use the method and maximise its effectiveness
- possible side effects
- ensure clients know how to ameliorate symptoms and reassure them about the safety of their chosen method
- return to fertility, including when to return for additional supplies, next dosage, removal, and reinsertion
- rights related to contraception use in terms of choice, continuation, and when to stop



COUNSELLING ABOUT PREVENTION AND RISK REDUCTION

Combination prevention

Integrate counselling about HIV and STI prevention into contraceptive services (see Job Aid 7). The provision of contraception provides an opportunity to engage in discussions about risk and prevention. This includes the risk to HIV and STIs, exposure to gender-based or intimate partner violence and sexual abuse, and sexual exploitation.

Job Aid 7 provides information on how to implement a key risk assessment. It is critical for clients to understand their risk and identify ways to reduce risk in the context of their lives (risk reduction).

Additional key issues include:

- dealing with barriers to reducing risk
- exploring strategies to reduce risk, including dual protection, HIV testing, client awareness of their status as well as that of their partner(s), re-testing if exposed to HIV after testing, adherence to ART if HIV-positive, PrEP (if available), and PEP where appropriate, and contraception. Always emphasise consistent and proper condom use and the use of lubricants where necessary
- discuss STI signs and symptoms and the importance of treating STIs for both the client and their partner. Manage where indicated

COUNSELLING ABOUT SIDE EFFECTS

It is important to be clear and honest about possible side effects of contraceptive methods to ensure clients can make an informed decision about methods and know what to expect. Do not avoid mentioning side effects for fear of putting women off certain methods. It is better for women to know what to expect and be empowered to manage any side effects.

On the other hand, contraception is more than side effects.

Explain how the method works and explore the benefits and advantages of each method to give a balanced perspective. Some points to emphasise to clients include:

- *All methods have advantages and possible drawbacks.*
  We have to weigh risks vs the benefits.

- *Different women tolerate side effects differently.*
  Not all women experience side effects. For some women a side effect may be unacceptable; for others, it is not a problem.

- *Many side effects diminish after time.*
  The woman and her body need to adapt to the method. It is important to let a method settle before switching.

- *Some women are happy to put up with side effects as the advantages outweigh the disadvantages.*

- *Reassure that side effects are not harmful.*
  They may cause discomfort, but they are not dangerous.

- *Some side effects can be managed with medication.*
  Encourage the client to come to the clinic to discuss any problems they may experience.

- *Reassure clients that it is their right to change to another method if they are dissatisfied, but to give the method a fair chance to assess if it is suitable before switching.*

- *While reported side effects must be taken seriously, explore:*
  - whether the reported side effect is indeed related to the method
  - whether there may be other possible causes, either medical or personal

- *Encourage discussion and questions.*

- *Deal with commonly held beliefs and myths.*

Job Aid 1 provides a summary of basic counselling skills.

A commonly used checklist is the **GATHER approach** – this is a useful way to remember the cycle of contraceptive counselling:

GATHER APPROACH

GREET
Greet the client, welcome them and establish report

ASK
Ask the client about the purpose of their visit, their fertility desires (to plan or prevent, now and in the longer term) and contraceptive needs.

TELL
Tell them about their options. Provide information to enable informed choices.

HELP
Help guide informed decision-making by explaining the advantages and disadvantages, including efficacy, convenience, side effects etc. in the context of their lives

EXPLAIN
Explain how the method works and how to use it to maximise its efficacy. Explain dual protection and HIV/STI prevention.

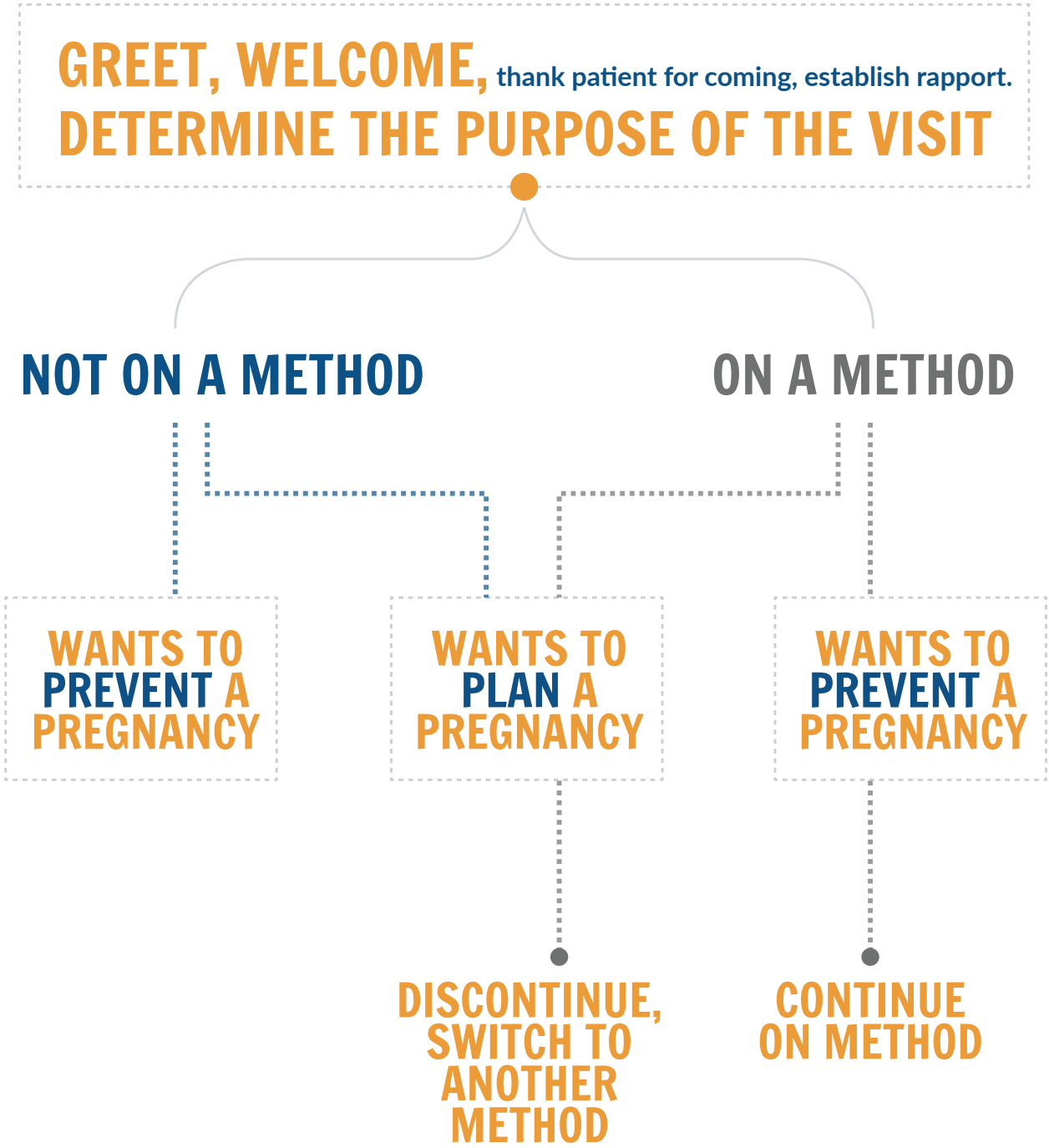
RETURN / REFER / REASSURE
Provide a **return** date and referral details. **Reassure** the importance of **returning** before the scheduled visit if concerned.

4 METHOD PROVISION

4.1 Algorithm for method provision

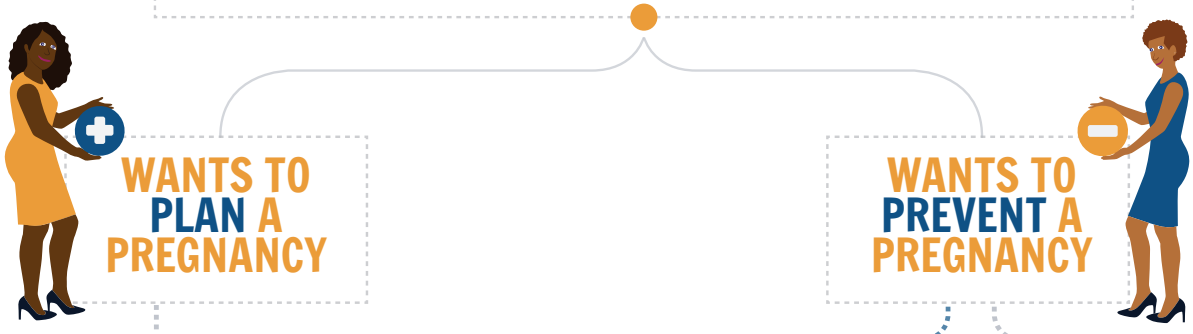
Generally, there are several reasons for clients to seek contraceptive services. This is described in Figure 2 below.

Figure 2 / Contraceptive seeking reasons



A summary of the respective processes and key counselling issues are summarised in Figure 3 below.

Figure 3 / Contraceptive processes and counselling



GREET, WELCOME, thank patient for coming, establish rapport.
DETERMINE THE PURPOSE OF THE VISIT

WANTS TO PLAN A PREGNANCY

WANTS TO PREVENT A PREGNANCY

DISCUSS STOPPING AND RETURNING TO FERTILITY (IF ON METHOD)

- explore previous pregnancies, attempts to get pregnant, etc.
- check for pregnancy HIV status, HIV testing for self and partner
- work up for health pregnancy, PMTCT, STI screening
- safer contraception counselling, as appropriate to couple's HIV status (serodiscordant, seroconcordant, both HIV-negative)
- PrEP

NOT ON A METHOD

REQUESTS CONTRACEPTION

INFORMED DECISION MAKING

- available methods
- effectiveness, benefits, drawbacks, side effects
- check for pregnancy, history taking
- method selection
- method-specific screening

ON A METHOD

CONTINUE ON METHOD

- assess satisfaction on method, re-visit discussion about fertility intentions
- support and management of side effects
- any method-specific assessment, screening and examination checks

DISCONTINUE, SWITCH TO ANOTHER METHOD

- explore reasons for... discontinuation? switching? stopping?
- re-visit discussions about fertility intentions

METHOD SPECIFIC COUNSELLING

- how the method works, efficacy
- how to use the method correctly (client
- controlled) and how the method is administered or inserted (provider dependent), information
- about removal
- stopping the method, return to fertility common side effects and their management,
- when to seek help
- potential drug interactions and the implications thereof what to do if method is used incorrectly
- (for example, missed pill/s or coming late for re-injection) or appointments are missed
- information about emergency contraception and TOP, should the method fail HIV and STIL prevention, dual protection, combination prevention

DECIDES TO SWITCH

DECIDES TO CONTINUE AFTER COUNSELLING

DECIDES TO STOP

- follow up requirements, return date
- encouragement to return
- take away information
- clinic card completion
- any other medication?

4.2 Summary of processes for method provision

There are nine critical discussion points to address when working with a client to determine which contraceptive method is best for them. These are not distinct steps. There will likely be overlap and changes in the sequence as the consultation unfolds with different clients with varied needs and levels of understanding. However, these elements provide a discussion framework for contraceptive method determination.

HISTORY TAKING AND SCREENING

The primary purpose of history taking and screening is to determine if there are any conditions or issues which influence method selection. This is an opportunity to learn relevant details about the client's personal circumstances, contraceptive, obstetric, menstrual, gynaecological, and basic medical history (including any medications that the client is currently taking, as well as any HIV-related issues). All of these may influence contraceptive use. Explain that this information is needed to help choose the best method. (see Job Aids 4, 5, 6, 7).

RISK DISCUSSION

A risk discussion enables the health care provider to address issues related to risk and vulnerability and provides the client with an opportunity to assess their own risk and find ways to minimize it. This discussion provides an entry point to consider combination prevention options and more holistic care, not only related to HIV and SRHR but also to the client's well-being in general. See Job Aid 7 for more details on how to conduct a risk assessment and examples of questions to ask the client.

FUTURE REPRODUCTIVE INTENTIONS

This discussion will include the client's current and future desires to prevent pregnancy or to get pregnant and how to plan for it.

INFORMED DECISION-MAKING

Clients need to know about all available contraceptive methods in order to make an informed choice. The level of detail provided about different methods will depend on the client's interest in particular methods and their existing knowledge. See Job Aid 2 for a guide to informed decision-making.

Ask the client which methods are of specific interest to them.

- Explore previous contraceptive methods used by the client, discuss the client's experience with previous methods, including whether or not they were acceptable, their reasons for stopping or for switching to another method, any side effects, etc.
- Check the client's knowledge and ensure they are aware of all the available options. Check for any questions, doubts, rumours, or misperceptions.
- Briefly describe each available method of contraception that is of interest to the client and any other available methods that may be suitable.

BOX 2 / METHOD SPECIFIC COUNSELLING

- **How the method works**
- **Effectiveness (Job Aid 8) and benefits of the method**
- **Common side effects of the method**
- **Return to fertility**
- **Any special considerations relating to the client's circumstances**
- **Use appropriate educational aids (such as flip charts, models, diagrams) to assist understanding**
- **Inform the client about the availability of emergency contraception in cases of method failure**
- **Explain the importance of dual protection (barrier method plus other contraceptive method)**
- **See Job Aid 2 for a guide to informed decision-making and Job Aid 9 for method effectiveness**

MEDICAL ELIGIBILITY FOR THE METHOD OF CHOICE

- Some methods are not medically safe for some clients. Recommended screening procedures (history taking and examination) for each available method are given within the relevant method-specific sections in the **Handbook for Contraceptive Method Provision (2019)**.
- WHO Medical Eligibility Criteria are summarized in Annex 1.
- See guidelines about comprehensive history taking (Job Aid 4) and examination checklists (Job Aid 7).
- Explain to the client that screening is necessary to ensure the method can be used safely (Job Aids 5 and 6).
- If, as a result of screening, a method is not deemed safe, clearly and sensitively explain the reason(s) to the client. Then help the client choose another method. Abnormal conditions that are identified during client screening (for example abnormal vaginal bleeding, STIs, or suspicious cervical lesions) should be appropriately managed or referred.

NOTE

In resource-limited settings or in settings where there is a high demand for contraception, pre-contraceptive general examination and screening should not be a barrier to contraception initiation. While physical examination and laboratory tests may be part of good preventive medicine, very few contraceptive methods require specific tests or examinations prior to initiation. The method-specific assessment and pre-existing medical conditions that may exclude use of certain methods are detailed in the **Method Specific Guidelines for Health Care Providers** (2019) (See Job Aid 5).

CHECK THAT THE CLIENT IS NOT PREGNANT

- Establish that the client is not already pregnant. To initiate certain contraceptive methods, a history-based checklist that rules out pregnancy (Job Aid 3) may be sufficient. For example, hormonal contraceptives will not abort an established pregnancy.
- Early urine pregnancy testing should be used for those clients for whom the checklist is unsuitable (for example, women who have discontinued progestogen-only injectables and have not yet resumed regular menstruation).

METHOD PROVISION

- Provide the method or procedure for insertion.
- Supply condoms to all clients who are at risk of exposure to HIV and STIs.
- Provide appropriate IEC (information, education, and communication) materials for the client to take away.
- Ensure the client has her health card (client held record).
- Provide any other medication the client requires.

CONCLUDING THE CONSULTATION

Make arrangements for a follow-up visit. These should be scheduled for each contraceptive method as medically indicated. In addition:

- Ensure that appropriate arrangements for follow-up visits are scheduled with each client according to sound medical reasoning. Recommendations for the timing of follow-up visits for each contraceptive method are given under the respective method-specific sections in Handbook for Contraceptive Method Provision (2019).
- Ensure that clients are encouraged to come back at any time if they have any health concerns. Clients who are dissatisfied with a method and wish to change methods should be free to do so and should be given the necessary information and counselling.
- Ensure that health care providers and clients have a mutually agreed upon plan in case the client

cannot make the next appointment. Ensure the client understands the importance of returning for a follow-up visit, even if late.

- Ensure that all relevant findings are briefly recorded on the client's card. These may be of particular clinical use when reviewing the client card at future clinic visits.

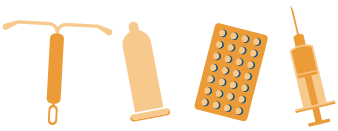
FOLLOW UP VISITS

Key counselling and clinical management points in follow up visits include:

- Welcome the client to provide feedback on their contraceptive method and provide appropriate counselling.
- Ask the client if they have any questions. Find out whether they are happy with the method or have any concerns. Ask if they have had any health problems or if they have started any new medication since their last visit.
- Check method compliance and correct use, as appropriate.
- Remind clients about the availability of emergency contraception as a backup.
- Confirm that the client's fertility plan has not changed and that she still wants to prevent pregnancy. Use this as an opportunity to discuss future pregnancy planning.
- Provide integrated HIV and SRHR screening and discussion.

Conduct physical examinations at follow up visits, as appropriate.

- These may include any examinations and checks as indicated in the method-specific sections of the Handbook for Contraceptive Method Provision (2019).
- These may also include other examinations as indicated by the client's history.



Provide a contraceptive method.

- Provide adequate supplies of the method/s and condoms.
- Provide appropriate IEC materials for the client to take away.
- Provide any other medication the client requires.

Make arrangements for the next follow-up visit, as medically indicated.

- All relevant findings should be briefly recorded on the client's card. These may be of particular clinical use when reviewing the client at future clinic visits.

REMEMBER

Quality of care and client satisfaction are important.

After each consultation, clients should:

- feel respected and satisfied they have received the help they came for
- know how to use the method to maximize effectiveness
- understand the potential side effects, be reassured that they are harmless, understand that not all women get side effects, and that they can receive support should side effects result in discomfort or if they feel concerned
- have an understanding of how to prevent HIV and STIs and the importance of dual protection (correct and consistent condom use) as well as other prevention options
- feel reassured that they can return to the health facility for further support
- know when to return for follow-up appointments

5 POSTPARTUM, POST-MISCARRIAGE, AND POST-ABORTION CONTRACEPTION

5.1 Postpartum contraception

Postpartum contraception (PPC) aims to prevent unintended pregnancy and closely spaced pregnancies after childbirth. PPC is often neglected due to misconceptions and lack of training and skills, resulting in missed opportunities for the provision of contraception at a time when women may be highly motivated to start using an effective contraceptive method.

Key points to note regarding postpartum contraception:

- Maternal and neonatal health outcomes improve with spacing between pregnancies. WHO recommends that after a live birth women wait at least 2 years before trying to get pregnant.[6] *Note:* Women who decide to get pregnant after a miscarriage or abortion should wait to have at least one normal menstrual period or longer if there are any conditions (i.e. anaemia) requiring treatment.[16]
- The purpose of comprehensive postpartum contraceptive services is to help women choose a method, to be initiated into the method, and to continue using the method for two years or longer, depending on their reproductive plans.
- Opportunities to provide postpartum contraceptive services include antenatal, delivery, the postpartum period before discharge, the 6-week postnatal visit, as well as well-baby and immunization services.
- As with all contraception provision, postpartum contraception needs to be framed by rights-based, client-centred, quality care. This includes client-based, informed decision-making. Similarly, STI and HIV prevention, condom use, and other prevention options need to form part of postpartum contraception provision.

BOX 3 / THE IMPORTANCE OF POSTPARTUM CONTRACEPTION

POSTPARTUM CONTRACEPTION SAVES LIVES

Worldwide, more than 9 out of 10 women want to avoid pregnancy for two years after having had a baby, but 1 in 7 of them is not using contraception.

PPC can save mothers' lives. Contraception can prevent more than one-third of maternal deaths.

PPC can also save babies' lives. Contraception can prevent 1 in 10 deaths among babies if couples space their pregnancies more than two years apart.

Closely spaced pregnancies within the first-year postpartum increase the risks of preterm birth, low birth weight, and small-for-gestational-age babies.

The risk of child mortality is highest for very short birth-to-pregnancy intervals (i.e. less than 12 months).

The timing of the return of fertility after childbirth is variable and unpredictable. Women can get pregnant before the return of menstruation.

Where possible, the chosen method of contraception should be started before the woman leaves the birthing facility.

- Ovulation and therefore pregnancy can occur before menstruation resumes. Therefore, a woman must not wait until menstruation returns to commence contraception.
- Some couples resume sexual activity 6 weeks after the baby is born.
- Pregnancy can occur by 6 weeks if a woman does not exclusively breastfeed, so it is important to make sure that a method is provided by 4 weeks postpartum.
- Women who breastfeed have amenorrhoea (the absence of menstruation) for varying lengths of time postpartum, depending on their breastfeeding practices. Therefore, it is difficult to predict ovulation and return to fertility for the individual. If a woman is not fully or nearly fully breast-feeding, effective contraception should be commenced by 4 weeks postpartum at the latest.
- For women who are using the LAM as their contraceptive method, it is important to support them to choose and start another method of contraception by or before 6 months postpartum.

5.2 Pregnancy testing and postpartum contraception

If contraception is started:

- Within the first 4 weeks after delivery, there is no need to check for pregnancy.
- After 4 weeks postpartum, particularly if menstrual cycles have returned, then an assessment of the risk of pregnancy should be made.

NOTE: IF PREGNANCY TESTING IS NOT AVAILABLE, THIS SHOULD NOT BE A BARRIER TO STARTING A METHOD.

It is reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following WHO criteria (see Job Aid 3):

- Is within 7 days of the start of normal menstruation
- Has not had sexual intercourse since the start of last normal menstruation
- Is fully or nearly fully breastfeeding, defined as exclusively breastfeeding or the vast majority (at least 85%) of feeds are breastfeeding.
- Is amenorrhoeic, and is no more than 6 months postpartum.

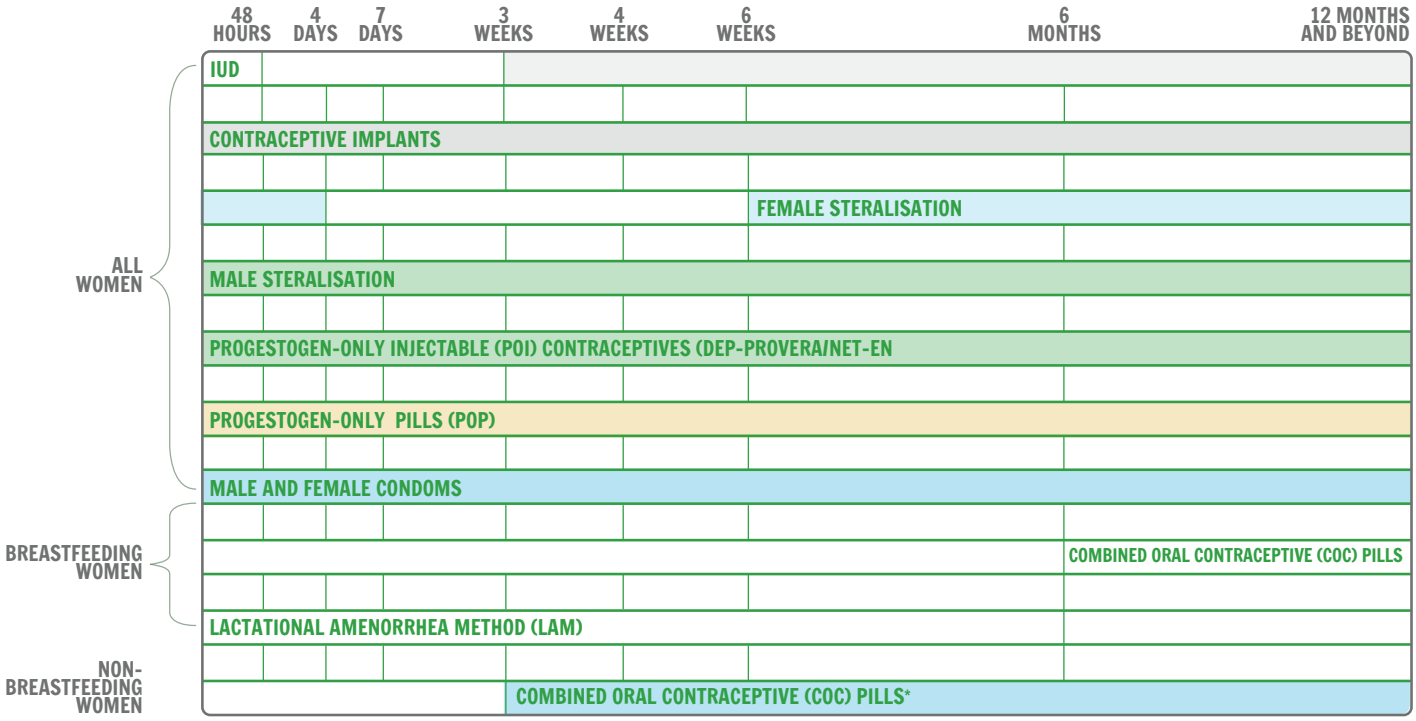
If a woman has had intercourse since the start of her last menstruation, use of emergency contraception should be considered for prevention of unintended pregnancy.

5.3 Postpartum method provision

- There are many myths and misconceptions about which methods of contraception can be provided to women after childbirth. Both healthcare providers and clients need accurate information.
- Counselling (Section 3), method provision (Section 4), informed decision-making (Job Aid 2), and information about contraceptive effectiveness (Job Aid 9) should be combined with medical eligibility and appropriate history taking and screening (Job Aids 4 - 7). Healthcare providers need to be comfortable using the WHO Medical Eligibility Criteria (outlined in Section 1 and Annex 1) to assist women to choose safe and appropriate contraceptives.
- There is evidence that LARCs (subdermal contraceptive implants and IUDs) are much more likely to prevent early unintended pregnancy following childbirth and have superior continuation rates than all other methods.

Timing for postpartum provision is summarised in Figure 4.

Figure 4 / Postpartum contraception options: Timing of method initiation for all women, breastfeeding women, and for non-breastfeeding women (adapted from WHO Programming Strategies for Postpartum Family Planning, 2013)



*Unless there are other risk factors for venous thromboembolism (VTE), in which case only from 6 weeks onward
Adapted from: WHO (2013) Programming Strategies for Postpartum Family Planning

5.4 Summary of method-specific considerations for postpartum contraception

Options for postpartum contraception are summarised in Table 6. For more detail, refer to the respective method-specific guidelines in the **Handbook for Contraceptive Method Provision (2019)**.

NOTE

- **Provide information about emergency contraception** when women may be at risk for unintended pregnancy.
- **For all methods, include counselling** about risk reduction and HIV/STI protection.
- **In the case of unintended pregnancy, counsel** about the risks, rights, and options.

Table 6 / Method specific considerations for postpartum contraception

METHOD	SPECIFIC CONSIDERATIONS FOR POSTPARTUM CONTRACEPTION[‡‡]	TIMING AFTER CHILDBIRTH
CU IUD; LNG-IUS	• Can be inserted after the expulsion of the placenta following vaginal delivery. • It is the most convenient and best practice to insert immediately after the placenta has been delivered. This requires specially trained health care providers. • If this is not possible, it is good practice to insert the IUD before the woman leaves the labour ward. • Can be inserted at the time of caesarean section via the uterine incision once the placenta has been delivered. • While rates of IUD expulsion after postpartum insertion are higher than after interval or later insertion, the benefits of providing highly effective contraception immediately after delivery outweigh this disadvantage. For this reason, it is essential to stress the importance of a 6-week post insertion follow-up visit to ensure that the IUD is well-positioned. • Rates of perforation and infection for postpartum IUD use appear to be similar to, or even lower than, those associated with interval insertion. • Use of a Cu IUD postpartum does not interfere with breastfeeding. • Return of fertility is immediate after an IUD is removed.	**WITHIN 48 HOURS** If not inserted within 48 hours, 4 weeks after the birth (referred to as 'interval insertion') to reduce the risk of uterine perforation.
Implants[§§]	• As implants can be inserted immediately postpartum, it is recommended to have trained staff trained and commodity supply available at the birthing facility. • If inserted before 3-weeks after delivery, there is no need to check for pregnancy. • Postpartum implant use does not interfere with lactation.	**IMMEDIATELY**
Permanent methods: Voluntary female sterilisation (Tubal ligation)	• Can perform within 7 days postpartum or any time after 6 weeks. Between 7 days and 6 weeks there is an increased risk of complications as the uterus has not fully involuted. • If a woman is scheduled for sterilization at a later date, she should be provided with an effective interim method of contraception (e.g. a hormonal method) that will protect her from pregnancy until she undergoes sterilization. • It may be convenient to perform female sterilization at the time of elective caesarean section. *Note:* Refer to the **Handbook for Contraceptive Method Provision (2019)** for further information, particularly relating to sterilisation, rights, and informed decision-making.	**WITHIN 7 DAYS, OTHERWISE ANY TIME AFTER 6 WEEKS**
Permanent methods: Male Sterilisation (Vasectomy)	• A woman whose partner is planning to have a vasectomy should be provided with an effective interim method of contraception (e.g. a hormonal method) that will protect her from pregnancy until the vasectomy has been performed and is deemed to be effective. • If the man has a vasectomy during the first 6 months of his partner's pregnancy, it will be effective by the time she delivers her baby.	**VASECTOMY CAN BE PERFORMED AT ANY TIME, INCLUDING DURING THE ANTENATAL OR POSTPARTUM PERIOD**

[‡‡] Midwives are ideally placed to provide postpartum IUDs. Midwives need to insert 10 PPIUDs under supervision before they can insert independently.
[§§] Midwives are ideally placed to insert subdermal contraceptive implants postpartum. Midwives require three insertions under supervision or until deemed competent.

Table 6 / Method specific considerations for postpartum contraception

Progestogen-only injectable	• Can be started immediately postpartum in both breastfeeding and non-breastfeeding women if no other method is acceptable or available (See Note 1 below). • Postpartum POI contraceptives do not interfere with lactation.	Fully or nearly fully breastfeeding: **6 WEEKS AFTER CHILDBIRTH BUT CAN BE INITIATED IMMEDIATELY. (SEE NOTE 1 BELOW)** Partially breastfeeding or not breastfeeding: **IMMEDIATELY** Earlier use is not recommended unless other more appropriate methods are not available or acceptable.
Lactational amenorrhoea method (LAM)	• Although an effective method of birth spacing when used correctly, LAM is time-limited as it cannot be used after 6 months postpartum and it requires women to be fully or nearly fully breastfeeding. • Women who are breastfeeding their infants can rely on the contraceptive effects of lactation to prevent unintended pregnancy provided that they are: » amenorrhoeic » fully or nearly fully breastfeeding » less than 6 months postpartum	**IMMEDIATELY**
Hormonal contraceptive pills: Progestogen-only (POP, mini pills)	• POPs can be started immediately postpartum. • Postpartum POP use does not interfere with lactation.	**IMMEDIATELY**
Combined oral contraceptive (COC) pills; combined patch; combined vaginal ring	• COCs should not be used by breastfeeding women until the baby is 6 months old because they may interfere with breastfeeding. • Women who are not breastfeeding may start COCs at 3 weeks postpartum unless they have additional risk factors for venous thromboembolism (VTE), in which case they should not start COCs until 6 weeks postpartum. • COCs are usually taken daily for 21 days followed by a 7-day break when withdrawal bleeding (menstruation) occurs.	Fully or nearly fully breastfeeding: 6 months after birth Partially Breastfeeding or not breastfeeding: 21 days after childbirth if not breastfeeding* 6 weeks after childbirth if partially breastfeeding* **Earlier use is not recommended unless other more appropriate methods are not available or acceptable.
Male and female condoms	Can be used during pregnancy and at any time after childbirth Does not interfere with breastfeeding	

Note 1: WHO [MEC 5th edition 2015] considers immediate initiation of injections postpartum MEC 3 due to theoretical concerns about possible risks associated with exposure to the hormone of the neonate under 6 weeks, stating earlier use is not recommended unless other more appropriate methods are not available or acceptable.

WHO also states that in many settings pregnancy-related morbidity and mortality risks are high, and access to services are limited. In such settings, DMPA/NET-EN may be among the few methods available and accessible to breastfeeding women postpartum. Direct evidence demonstrates no harmful effects of PICS on breastfeeding performance and generally demonstrates no harmful effects on infant growth, health, or development.

Despite counselling about the benefits of implants and IUDs, many women in South Africa still prefer to use injections and immediate initiation is most convenient. Therefore, it has been decided to classify immediate postpartum injection use as MEC 2 in these SA National service delivery guidelines, as the benefits of pregnancy prevention outweigh the real or theoretical risks of use of the method.

BOX 4 / A NOTE ON LACTATIONAL AMENORRHOEA METHOD

Lactational amenorrhoea method (LAM)

is not actively promoted in South Africa due to the high prevalence of HIV infection and the local practice of early weaning in many parts of the country, which carries the risk of transmitting the virus from mother to child through breast milk. However, healthcare providers should be well informed about LAM in order to effectively counsel women who wish to use the method.

Women who are known to be HIV-positive should be counselled about all infant feeding options and the risks/benefits involved, so they can make an informed choice. They should be supported in their decision.

Currently, the DOH guidelines recommend exclusive breastfeeding for the first six months.[3]

5.5 Post-abortion and post-miscarriage contraception‡‡‡

Women who have just had an abortion, who have been treated for post-abortion complications, or who have had a miscarriage need access to contraceptive services as soon as is appropriate. Unless there are other underlying problems, return to fertility resumes rapidly and women need to start using a method almost immediately to avoid unintended pregnancies. It is therefore advantageous to integrate contraceptive services as an integral part of post-abortion care.

KEY COUNSELLING POINTS

For post-abortion contraception counselling

- BE NON-JUDGMENTAL AND RESPECTFUL
- CHECK-IN WITH THE CLIENT ABOUT HER FEELINGS AND EXPERIENCE

For post miscarriage counselling

- EXPLORE FEELINGS OF LOSS AND GRIEVING
- PROVIDE SUPPORT

‡‡‡ Adapted from: Family Planning Global Handbook for providers 2018 edition, pages 357-359

Provide information about return to fertility, and the need to use contraception.

within 2 weeks after a first-trimester abortion or miscarriage

within 4 weeks after a second-trimester abortion or miscarriage

Provide information about spacing before next pregnancy after a miscarriage or induced abortion

a minimum interval of at least 6 months before the next pregnancy is recommended to minimise the risk of low birth weight, premature birth, maternal anaemia, and other adverse maternal and perinatal outcomes

Provide relevant information about options to encourage informed decision-making

Note: Methods that women use immediately after giving birth should not pose any specific risks after treatment for abortion complications

- Women should not be pressured or coerced to initiate contraception immediately, but should be encouraged to consider using a backup method when having sex in the meantime
- If a woman decides not to use contraceptives at this time, providers can offer information on available methods and where to obtain them. Offer condoms, oral contraceptives, and emergency contraceptive pills for women to take home and use later.
- To avoid infection, a woman should not have sex until bleeding stops, which usually takes about 5 to 7 days. If being treated for an infection or vaginal or cervical injury, a woman should wait to have sex again until she has fully healed.

Table 7 / Post-abortion and miscarriage – special considerations for contraception

METHOD	RECOMMENDED TIME TO START IN RELATION TO SPECIFIC CONDITIONS/ CIRCUMSTANCES
Combined oral contraceptives Progestogen-only pills, Progestogen-only injectables Monthly injectables Combined patch Implants Male condoms Female condoms	**IMMEDIATELY,** even if the woman has an injury to the genital tract or has a possible or confirmed infection
IUDs Female sterilisation	**CAN BE STARTED ONCE AN INFECTION IS RULED OUT OR RESOLVED** Note: Female sterilisation must be discussed thoroughly, and not while a woman is sedated, under stress, or in pain. Counsel carefully and be sure to mention available reversible methods as sterilisation is permanent.
IUDs Combined vaginal ring Female sterilisation	**CAN BE STARTED ONCE ANY INJURY TO THE GENITAL TRACT HAS HEALED**
IUD	**IUD INSERTION IMMEDIATELY AFTER A SECOND-TRIMESTER ABORTION REQUIRES A SPECIFICALLY TRAINED PROVIDER**
Combined vaginal ring	**CAN BE USED IMMEDIATELY,** even in cases of uncomplicated uterine perforation

6 CLIENTS REQUIRING SPECIAL CONSIDERATION

South Africa has a statutory commitment to ensure that all people have access to health care and SRHR services, as stated in the Constitution of South Africa, the National Health Act, the Batho Pele Principles, and the Patients' Rights Charter.

Key populations who are vulnerable, at risk, or who require more nuanced services to accommodate their needs warrant special considerations in terms of access to contraceptive services. These individuals often face barriers to accessing contraceptive services, which can result in compromised quality of care and method utilisation, unintended and unwanted pregnancies, teenage pregnancies, unhealthy pregnancies (for either mother or baby), and increased vulnerability to STIs and HIV.

Barriers to contraceptive services may arise from ambiguous legislation, discrimination and prejudice, and the attitudes of healthcare providers, resulting in staff being rude, judgemental, and prejudiced, with a disregard for their clients' rights and dignity. These barriers may also arise from assumptions about individuals lifestyle and health needs – all of which impact the quality of care delivered to clients, particularly those from 'key populations'.

BOX 5 / CLARIFICATION OF TERMINOLOGY: VULNERABLE, AT RISK, AND SPECIAL CONSIDERATIONS

In this context the term 'key populations' refers to vulnerable, at risk clients, who may have special needs that require careful consideration when rendering HIV and SRHR services.

- **Vulnerable:** Due to circumstances outside of their control, some people are more vulnerable to situations that can result in unwanted or unplanned pregnancy and/or acquiring HIV. This vulnerability is the result of unequal opportunities, social exclusion, and other social, cultural, political, and economic factors such as status, age, negotiating skills, poor service delivery, level of empowerment, exposure to discrimination, violence, abuse, and exploitation.
- **At risk:** Certain factors, such as lifestyle and sexual behaviour, significantly increase the possibility of a person acquiring or transmitting HIV and/or having an unwanted or unplanned pregnancy. Certain behaviours create, increase, or perpetuate risk. The focus is on behaviour – not on membership in any group – that increases the likelihood of exposure to HIV or unwanted/unplanned pregnancy.
- **Special considerations:** The term 'special considerations' implies that certain groups of clients require a more finely tuned service in order to accommodate specific needs as determined by their physical or mental ability, societal factors, age, sexual orientation, or specific medical condition.

For all these groups, considering special needs is about taking into account the specific needs of the individual, making services accessible, dismantling barriers that would prevent service utilisation, and providing appropriate contraceptive services, including counselling and clinical care.

The section includes:

6.1 Adolescents and contraception

The WHO defines adolescents as young people between the ages of 10-19 years. Adolescents are not a homogeneous group and their SRHR needs vary. When providing contraceptive services to adolescents, there are several factors to take into account in order to effectively meet their needs and ensure services are accessible.

BOX 6 / FACTORS TO TAKE INTO ACCOUNT TO MEET THE NEEDS OF ADOLESCENTS

- ✓ **ADOLESCENT FACTORS** — Age, physical and emotional development, HIV status, culture, life and economic circumstances, levels of risk
- ✓ **HEALTHCARE PROVIDER BARRIERS** — Attitudes/personal prejudice, lack of skills and knowledge as it relates to adolescents, poor communication and counselling skills, lack of rapport with adolescents
- ✓ **HEALTHCARE FACILITY BARRIERS** — Restricted opening times which clash with school, lack of dedicated and private space
- ✓ **LEGAL BARRIERS** — Lack of enabling laws and policies

While designing strategies to dismantle barriers are not within the scope of these guidelines, it is critical to ensure the clinical services are sensitive to the needs of young people (see the National Integrated SRHR Policy for more information) and that barriers to care are dismantled to the extent possible.

ADOLESCENCE AND THE LAW IN SOUTH AFRICA

Key legislation that affects the provision of SRHR and HIV services to young people is outlined below.[17, 18]

Table 8 / Key legislation affecting the provision of SRHR and HIV services to young people in South Africa

SRHR-RELATED ISSUES	AGE CRITERIA	AGE RESTRICTION	SOURCE
Condoms	Age at which a child may be sold or provided with condoms	**12**	Children's Act 38 of 2005. Section 134(1)
Contraception other than condoms	Age at which a child may be provided with contraceptives other than condoms	**12** (with proper clinical screening, advice and management)	Children's Act 38 of 2005. Section 134(2)
HIV counselling and testing	Age at which a child can consent to an HIV test	**12** *Under 12:* If the child is mature enough to understand the benefits, risks and social implications of the test. *For children under 12 who are not mature enough to consent:* Parental or caregiver consent is needed.	Children's Act 38 of 2005. Section 130

Abortion	Age at which a child may choose to terminate her pregnancy	**NO AGE RESTRICTION**	The Choice on Termination of Pregnancy Act 92 of 1996. Sections 1, 5(2) and 5(3). Read with section 129(1) of the Children's Act 38 of 2005
Sterilisation	Age at which a person can consent to be sterilised	**18** A person who is 18 and capable of consenting can be sterilised without the need for parental consent (See the Handbook for Contraceptive Method Provision (2019) for more information on voluntary sterilisation)	The Choice on Termination of Pregnancy Act 92 of 1996. Sections 1, 5(2) and 5(3). Read with section 129(1) of the Children's Act 38 of 2005

Confidentiality: A client who is a minor is entitled to confidentiality. However, this is subject to Section 110(1) of the Children's Act, which obliges health professionals to report cases of physical or sexual abuse, or deliberate neglect of a child to the Department of Social Development, a designated child protection organisation, or the police.

The health professional must always consider the child's best interests before making a decision to breach the minor's confidentiality by reporting the case. This is particularly important in the case of sexually active adolescents who are at risk of becoming pregnant or acquiring an STI or HIV if they cannot access contraception and sexual health services because they fear being reported.[19]

Sexual consent, rape, and sexual abuse: The Sexual Offences and Related Matters Amendment Act (No. 32 of 2007) provides overarching protection for adolescents against rape and sexual abuse.

BOX 7 / SEXUAL CONSENT AND THE LAW FOR MINORS[20]

The age of consent in South Africa for all sexual acts is 16 years, as specified by Sections 15 and 16 of the Criminal Law (Sexual Offences and Related Matters Amendment Act, 2007. Section 15 (statutory rape) prohibits an act of sexual penetration with a child who is 12 years of age or older but under the age of 16 years, while section 16 (statutory sexual assault) prohibits an act of sexual violation with a child who is 12 years of age or older but under the age of 16 years. However sexual acts between two children where both are between 12 and 16, or where one is under 16 and the other is less than two years older, do not constitute a criminal act.

ADOLESCENT AND YOUTH-FRIENDLY SERVICES

The overarching public health imperative to prevent teenage pregnancy, HIV, and STIs need to guide the provision of quality SRHR services for young people. Every effort should be made to provide accessible and acceptable SRHR services that take into account young people's vulnerability and psychosocial needs framed by a rights-based approach. Access, staff attitude, privacy, and services that young people feel positive using are the basis for youth-friendly services.[21]

Contraceptive services are very often the only entry point for a young person into the health care system. It is a useful opportunity to discuss other health issues and concerns and to have a discussion about risk, ensuring young people both understand risks and are empowered to reduce them. Counselling about combination prevention needs to be an integral part of the consultation. Some essential components of youth sensitive services are outlined in Box 8.

BOX 8 / PROVIDING SERVICES SENSITIVE AND RESPONSIVE TO THE NEEDS OF YOUNG PEOPLE – ESSENTIAL COMPONENTS

Establish rapport

- Be warm and welcoming.
- Personalise the consultation, take an interest in their life.
- Show young people that you enjoy working with them.

Show respect for the rights of the young person

- Counsel in private areas where you and the client cannot be seen or overheard. Explain and reassure about confidentiality (with the staff on a need to know basis).
- Check that a young woman's choices are her own and are not pressured by her partner or her family. If a young woman is being pressured to have sex, help her think about what she can say and do to resist and reduce that pressure. Practice the skills to negotiate condom use with her.
- Be aware of young people's norms about gender and gently encourage positive, healthful norms. In particular, you can help young women feel that they have the right and the power to make their own decisions about sex and contraception. You can help young men to understand the consequences of their sexual behaviour for themselves and their partners.
- Discuss their desires to prevent and plan for pregnancy (contraception and healthy conception).

Effective communication

- Listen carefully and ask open-ended questions such as, "How can I help you?" and, "What questions do you have?"
- Use simple language and avoid medical terms.
- Use terms that suit young people. Avoid such terms as "family planning," which may seem irrelevant to those who are not married.
- Be aware of your attitude. Avoid expressing judgment, shock, or criticism (for example, say "you can" rather than "you should").
- Take time to fully address questions, fears, and misinformation about sex, HIV, STIs, different forms of prevention, and contraceptives.
- Many young people want reassurance that the changes in their bodies and their feelings are normal. Be prepared to answer common questions about puberty, monthly bleeding, masturbation, night-time ejaculation, and genital hygiene.

Contraceptive counselling

- Encourage informed decision-making.
- Offer a range of contraceptive methods, starting with the most effective methods, including long-acting reversible methods. Discuss benefits and possible side effects and drawbacks of each method in the context of the young person's life and needs.

Clinical management

- Discuss other health issues and concerns.
- Discuss their behavioural risks and empower them to reduce these risks.
- Screen for other conditions, such as STIs.
- Perform a clinical risk assessment on all clients to ensure the chosen method is safe for them.
- Follow up with patients as needed
- Provide written information especially about side effects, informative websites, and any social media platforms available.

CONTRACEPTION PROVISION FOR YOUNG PEOPLE

Young people can safely use any contraceptive method. The following must be taken into consideration:

- Age alone is not a reason for denying any method to adolescents (see WHO MEC for medical eligibility and any exclusions).
- Non-medical factors need to be considered and addressed through counselling and the process of informed decision-making.
- Medical factors need to be addressed through thorough risk assessment and physical examination, if appropriate, aligning with the WHO MEC.
- Young clients are prone to erratic or inconsistent use – this must be addressed.
- Young women are often less tolerant of side effects than older women. With counselling, however, they will know what to expect: the fact that symptoms improve with time, and this may result in them being less likely to stop using their methods.
- Reassure the adolescent client that they can return at any time should they have a problem and they can switch to another method should they not tolerate a specific method.
- Do not make assumptions about sexuality, sexual identity, or sexual preferences and practices. Discuss risks relating to vaginal, anal, and oral sex.

IMPORTANT: Adolescent girls and young women are particularly vulnerable to HIV and STIs and so counselling for all methods needs to focus on prevention options, such as condoms (male and female) and PrEP, where available (see Boxes 8 and 9).

An overview of some key counselling points and any key issues to be taken into account for adolescents specifically are summarised in Table 11. This needs to be used as per the WHO MEC. Refer to the **Handbook for Contraceptive Method Provision (2019)** for method-specific details.

Table 9 / Key counselling points and issues relevant to adolescents and young women

MODERN METHODS OF CONTRACEPTION	KEY COUNSELLING POINT RELEVANT TO ADOLESCENTS AND YOUNG WOMEN	KEY ISSUES TO TAKE INTO CONSIDERATION FOR ADOLESCENTS AND YOUNG WOMEN
Intrauterine contraception e.g. Cu IUD, hormonal IUSs	• Safe, highly effective, non-hormonal method. • Counsel on side effects. • Provide ongoing support and management of side effects. • Clients should be counselled that there is a small possibility of device expulsion and be encouraged to return for a follow-up visit 3–6 weeks after insertion to check that the device is in position and that there is no sign of infection. • Encourage and promote dual protection and other methods of prevention where appropriate and available. • Self-examinations are not essential unless the client is comfortable with this. • IUDs do not increase the risk of infection, PID, ectopic pregnancy, or infertility – but high-risk sexual behaviour does.	• Nothing to remember, private, and requires no visits to the clinic for 5 or 10 years (depending on the type) after an initial check at 3-6 weeks after insertion. No supplies need to be kept at home. • Pelvic examination and method of insertion require sensitivity and reassurance, which is potentially embarrassing and uncomfortable for young people. • Health providers are often reluctant to provide Cu IUDs in adolescents. Insertion requires confidence and technical competence, particularly for nulliparous adolescents on the part of the health providers (see the **Handbook for Contraceptive Method Provision (2019)**). • Reassure that side effects are transient and not harmful, particularly changes in bleeding patterns, and encourage the client to return if experiencing challenges. • Young, nulliparous women may use Cu IUDs (WHO MEC Category 2 for <20 years). • Smaller LNG-IUS may be particularly appropriate as it is smaller and is designed for the nulliparous uterus, it also tends to reduce menstrual bleeding. • Immediate return to fertility.

Subdermal contraceptive implants	• Safe, highly effective, and long-acting method. • Counsel on side effects, changes in bleeding patterns. • Provide ongoing support and management of side effects. • Encourage and promote dual protection and other methods of prevention where appropriate and available.	• Nothing to remember, private, and requires no visits to the clinic for 3 or 5 years (depending on the type). No supplies need to be kept at home. • Reassure that side effects are not harmful, particularly changes in bleeding patterns, and encourage the client to return if experiencing challenges. • Increased bleeding and spotting may be of concern in terms of sanitary pads – some facilities supply these; or counsel on cheaper options where available. • Does not affect bone density. • Immediate return to fertility.
Condoms (male and female)	Counselling young people on condom use needs to focus on the following: • Correct use. Technical usage (how and when to put it on and take it off), overcoming fears and anxieties (men, about losing their erection with male condoms, young women, about feeling uncomfortable inserting the female condom), use of lubrication, and developing confidence. • Communicating with a partner about condom use (including barriers, fears, and how to overcome these). • Consistent use – only effective if used every time. • Storage, expiration date, and disposal. • The risk of pregnancy needs to be explained and the client should also be counselled on other less client-dependent and more effective methods of contraception and the benefits of dual method use.	• Available without a prescription, immediately effective, user-controlled, and only need to be used when required. • Emergency contraception should be promoted and provided for backup in the event of incorrect/failed condom use.
Progestogen-only injectables	• Injectables often result in irregular bleeding, spotting, or amenorrhoea, which may worry some clients. • Delay in return to fertility (6-9 months) – may be an issue if planning for pregnancy. • Counselling about side effects. • Encourage and promote dual protection and other methods of prevention where appropriate and available.	• Only requires periodic visits to the clinic. • The link between DMPA and decrease in bone mineral density is of concern as this may affect young women achieving peak bone mass. Evidence suggests that losses in bone mineral density (BMD) appear to be reversible.22 WHO considers injection use by adolescents to be generally safe. • Allows confidentiality – no supplies need to be kept at home.
Oral contraceptive pills	• Adherence may be a challenge for young women, particularly POPs, therefore need to focus on careful guidance. • Adherence counselling includes linking pill-taking to everyday activity (e.g. teeth brushing, cell phone reminders). • Provide clear guidance on what to do if pills are missed.	• COCs often results in menses that are lighter, regular, and less painful which may benefit young women who experience menstrual irregularities and menstrual cramps. • COCs often reduce acne. • The individualisation of contraception choice for adolescent requires that non-contraceptive benefits of oral contraceptives are considered. If a client has acne, currently

Oral contraceptive pills *(continued)*	• Stopping and starting pill-taking results in suboptimal contraceptive cover and an increase in side effects. Adolescents should be advised to use them without interruptions even if they go through phases when they are not sexually active. • Encourage and promote dual protection and other methods of prevention where appropriate and available.	available triphasic pills (e.g. Triphasil or Trigestrel) are preferable to the monophasic COC (e.g. Nordette/Oralcon) as these are more estrogenic. If pills containing desogestrel, gestodene or drospirenone are available, they are particularly skin-friendly having an antiandrogenic effect. If a client complains of premenstrual syndrome, bloating or water retention, a monophasic pill is preferable. If available, a pill containing drospirenone which has an anti-mineralocorticoid effect, is best. • POPs are less effective than COCs in non-breastfeeding women, require more rigid compliance, and are more likely to cause irregular bleeding-therefore should only be considered when oestrogen is contraindicated. • Weight gain is not a side effect of either COCs or POPs. • There are many different pills on the market, young women should be encouraged to switch to a different pill if she experiences side effects on one. • Can use to postpone menses.
Emergency contraception (EC)	• An important method in terms of prevention of unintended pregnancy for adolescents. • Must be taken as prescribed. • It is safe but not recommended to use ECPs multiple times between monthly bleedings. However, the client should be counselled that using a regular more reliable method is more effective. Counsel about contraceptive options. • Encourage and promote dual protection and other methods of prevention where appropriate and available.	• Relatively effective if used within 120 hours (5 days) after unprotected sex, but the sooner the more effective. • For many young people, sexual activity can be sporadic, unplanned, and possibly non-consensual. It is important for young people to know about, and have easy access to, emergency contraception. • Useful after contraceptive accidents, such as condom breakage or missed pills. • Emergency contraception is not recommended as a regular contraceptive method and does not protect against the transmission of STIs and HIV. • Condom use should be actively promoted.
Voluntary sterilisation	• Requires careful and sensitive counselling. Explore the client's rights with regards to informed decision-making and ensure that there is an understanding that it is permanent and irreversible. • Counsel on alternative methods of contraception (including LARCs).	• Seldom an appropriate method for adolescents or young adults because it is permanent and irreversible.

BOX 9 / SUMMARY OF RECOMMENDED CONTRACEPTIVE METHODS FOR YOUNG PEOPLE

ABSTINENCE	OR	CONDOMS ONLY	OR	MODERN CONTRACEPTION	AND REMEMBER... EMERGENCY CONTRACEPTION
(including secondary abstinence) **DELAY OF SEXUAL DEBUT**		(male or female) with emergency contraception		with condoms (male or female): Progestogen-only implant Cu-IUD LNG-IUS Progestogen-only injection Combined hormonal contraception	to be actively promoted and accessible in the event of unprotected sex, method misuse or failure

6.2 Women approaching menopause[§§§]

As women mature their menstrual patterns change and become unpredictable. Many women think they have reached menopause and do not use contraception because they assume they are no longer fertile. This is assumption, which often isn't true, makes this a vulnerable age for unintended pregnancies.

Perimenopause describes the transitional phase about three to five years before menopause. The main changes during this phase are variations in the menstrual cycle – decreased or increased bleeding and menstrual irregularities. Due to intermittent ovulation and anovulation, sexually active women are at risk of getting pregnant until menopause has been reached.

Menopause usually occurs between the ages of 45 and 55. About half of women reach menopause by age 50. By age 55 some 96% of women have reached menopause. It is diagnosed after 12 consecutive months without any menstrual bleeding, while not on any hormonal therapy (including hormonal contraception), or if her follicle-stimulating hormone (FSH) level is at the menopausal level specified by the laboratory.

MANAGEMENT OF PERIMENOPAUSAL WOMEN

- ***Provide reassurance***
  - Many women feel that the menopause is the end of their womanhood, so reassure and explain that it is only the end of her ability to bear children. It is the beginning of a new era without periods, without period cramps, and without the fear of getting pregnant! She can still be sexually active and enjoy sexual activity without the need for contraception.
- ***Healthy lifestyle***
  - Encourage a healthy lifestyle to prevent medical conditions that she is at risk of at this age, i.e. heart disease, stroke, osteoporosis, and diabetes. This includes watching her weight, regular exercise, eating a balanced diet, and regular health checks.
- ***Health checks and screening***
  - Encourage annual health checks where a woman has her blood pressure, weight, heart, cholesterol, and sugar levels checked.
  - Screening for breast and cervical cancer remains important.
- ***Management of menopausal symptoms***
  - Encourage natural ways to overcome menopausal symptoms like wearing cool clothing, fans, and avoiding caffeine and smoking.
  - If a woman is severely debilitated, counsel about the availability of hormonal replacement therapy (HRT) and refer where possible. HRT has both benefits and disadvantages.
- ***STI and HIV prevention:***
  - It is often assumed that older women are less at risk of STIs and HIV. However,

[§§§] Adapted from Global Handbook 2017 and KwaZulu-Natal Department of Health. Contraception and Fertility Planning Counselling Tool for healthcare providers, KZN DOH/UNFPA/WRHI Nov 2016

perimenopausal and postmenopausal women may be at the same risk of STIs and HIV as women of any age and need to use condoms to prevent HIV and STIs (See Job Aid 7) unless they are in a mutually monogamous relationship with an HIV-negative partner.

- *Planning for a healthy pregnancy:*
  - Emphasise to women over 35 years old that pregnancy may have more complications and risks and will need to be monitored by a healthcare provider.
  - Fertility declines and it is often more difficult to conceive over 35 years of age. So if planning further pregnancies do not leave it too late.

PROVIDING CONTRACEPTION TO PREMENOPAUSAL WOMEN

- A woman approaching menopause can use any method to prevent pregnancy, providing she has no medical condition that limits its use. Age alone does not restrict a woman from using any contraceptive method.
- Seek opportunities to discuss this when women come in for other services, such as for health problems, chronic conditions, and bringing children to the clinic.
- Providers should be aware that certain medical conditions that may make some methods unsuitable are more common in this age group, such as hypertension and other cardiovascular risk factors.
- Combined hormonal contraception has non-contraceptive benefits that are worth considering.

Table 10 / Contraception options for women approaching menopause

Combined hormonal methods (COCs, monthly injectables, combined patch, combined vaginal ring)	• Women age 35 and older who smoke, regardless of how much, should not use COCs, the patch, or the combined vaginal ring. • Women age 35 and older who smoke 15 or more cigarettes a day should not use monthly injectables. • Women age 35 or older should not use COCs, monthly injectables, the patch, or the combined vaginal ring if they have migraine headaches (whether with migraine aura or not).
Progestogen-only methods (POPs, progestogen-only injectables, implants)	• This is a good choice for women who cannot use methods with oestrogen. • During use, DMPA decreases bone mineral density slightly. This may increase the risk of developing osteoporosis and possibly having bone fractures after menopause. WHO has concluded that this decrease in bone mineral density does not place age or time limits on the use of DMPA. • Little evidence available but NET-EN is possibly less likely to affect bone mineral density.
Emergency contraceptive pills	• Can be used by women of any age, including those who cannot use hormonal methods continuingly.
Female sterilization and vasectomy	• Might be a good choice for older women and their partners who know they will not want more children. • Older women are more likely to have conditions that require a delay, referral, or caution for female sterilization.
Male and female condoms	• Protection for HIV and STIs. • Affordable and convenient for women who may not have sex often.
Intrauterine device (Cu IUDs, LNG-IUSs)	• Expulsion rates fall as women grow older and are lowest in women over 40 years of age. • Insertion may be more difficult due to the tightening of the cervical canal.

NON-CONTRACEPTIVE BENEFITS OF HORMONAL CONTRACEPTION

There are certain benefits for women with the conditions listed below.

- Vasomotor symptoms (hot flashes). Combined hormonal contraception may reduce symptoms.
- Osteoporosis. Combined hormonal contraception may increase bone mineral density; while progestogen-only injectables can reduce bone mineral density.
- Menstrual pain, bleeding, and irregularity. Combined hormonal contraception may reduce symptoms.
- Menstrual pain. Progestogen-only methods may reduce symptoms.
- Heavy menstrual bleeding. The LNG-IUS reduces menstrual bleeding and can cause amenorrhoea; COCs, injectables, and POPs may also reduce bleeding if there are no other contraindications for use of these methods.

WHEN SHOULD CONTRACEPTION BE STOPPED AT MENOPAUSE?

The Cu IUD and the LNG-IUS can be retained longer during the perimenopause. In addition:

- Women who have any Cu IUD inserted at or after the age of 40 may retain the device until they no longer require contraception.
- Women who have an intrauterine system inserted at or after the age of 45 may retain the device until they no longer require contraception.

Table 11 / Advice for women on stopping hormonal contraception[23]

CONTRACEPTIVE METHOD	ADVICE ON STOPPING CONTRACEPTION	
	AGE <50 YEARS	AGE ≥50 YEARS
Non-hormonal	Stop contraception after 2 years of amenorrhoea	**STOP CONTRACEPTION** after 1 year of amenorrhoea
CHC	Can be continued to age 50 years*	**STOP CHC** at age 50 years and switch to a non-hormonal method or progestogen-only pill, then follow appropriate advice
DMPA	Can be continued to age 50 years*	**STOP DMPA** at age 50 years and choose from options below: • Switch to a non-hormonal method and stop after 2 years of amenorrhoea **OR** • Switch to the POP, implant, or LNG-IUS and follow the advice below
Implant **POP** **LNG-IUS**	Can be continued to age 50 years or longer*	**CONTINUE METHOD** If amenorrhoeic either: • Check FSH levels and stop method after 1 year if serum FSH is ≥30 IU/L on two occasions 6 weeks apart OR • Stop at age 55 years when the natural loss of fertility can be assumed for most women If not amenorrhoeic, consider investigating any abnormal bleeding or changes in bleeding pattern, and continue contraception beyond age 55 years until amenorrhoeic for 1 year

* If a woman wishes to stop hormonal contraception before age 50 years she should be advised to switch to a non-hormonal method and to stop once she has been amenorrhoeic for 2 years (or 3 years if switched from DMPA due to the potential delay in the return of ovulation).

CHC= combined hormonal contraception; DMPA= depot medroxyprogesterone acetate; FSH= follicle stimulating hormone; IU= international unit; LNG-IUS= levonorgestrel releasing intrauterine system; POP= progestogen-only pill

RELIEVING SYMPTOMS OF MENOPAUSE

Women may experience physical effects before, during, and after menopause, including hot flushes, excess sweating, difficulty holding urine, vaginal dryness that can make sex painful, and difficulty sleeping.

Providers can suggest practical ways to reduce some of these symptoms:

- Deep breathing from the diaphragm may make a hot flash go away faster.
- Eating foods containing soy or taking 800 international units per day of vitamin E.
- Eating foods rich in calcium (such as dairy products, beans, fish).
- Exercising and engaging in physical activity to help slow the loss of bone density that comes with menopause.
- Using vaginal lubricants or moisturizers for vaginal dryness and irritation. During sex, use a commercially available vaginal lubricant, water, or saliva if vaginal dryness is a problem.
- Finding ways to deal with difficulty in holding in urine:
    - urinate more frequently
    - practising pelvic floor (Kegel) exercises to prevent difficulty in holding in urine

KEGEL EXERCISES

When urinating, stop mid-stream, then release. Focus on the muscles being used.

These are the muscles to strengthen by drawing them in several times a day – pull in and contract the pelvic floor muscles for a few seconds then relax, then repeat.

Do this a few times a day to strengthen your pelvic floor muscles.

6.3 Clients with physical and intellectual disabilities

People with physical or intellectual disabilities face many barriers to accessing SRHR services, particularly contraception and fertility planning. Healthcare providers, caretakers, and family members often make assumptions about the SRHR needs of the disabled in terms of, for example, their desires to become pregnant and have children, their ability to care for children, their sexual needs, their need for intimate partners, and their ability to make informed decisions.

Physical and intellectual disabilities vary enormously, and so every client must be treated as an individual with respect for their dignity and rights. Their needs, capabilities, and aspirations should be assessed, together with the client, as far as is feasible. Where possible and appropriate, family or caretaker involvement may be helpful; however, the client's rights must be respected, consent must always be sought from the client, and the client's privacy and confidentiality upheld at all times.

In order to do this effectively, one of the first principles is making services accessible. This includes transport to health services, physical access for people with disabilities, plus assistance with communication (for example, sign language or other translation) plus an enabling, supportive attitude from all staff rendering the service.

Health care providers need to take into account the following factors when considering the contraceptive options for disabled clients:

- immobility and possible increased risk of blood clotting, degree of lack of physical sensation, and limitation of manual dexterity
- whether the condition is stable, and any possible drug interactions with current medication
- the mental health of the person (such as signs of depression)
- problems the client has handling menstruation and menstrual hygiene
- for the intellectually disabled, factors such as psychiatric condition, and the ability to use a method correctly is important
- vulnerability to sexual abuse and exploitation

- respect for the rights of the client, and where necessary, supported decision-making (as described in Box 10 and 11)
- adolescents with disabilities may be at higher risk of sexual abuse or exploitation
- adolescents with disabilities require the same information as to their able-bodied counterparts; this includes information on sexuality, rights, prevention, and other SRHR services.

BOX 10 / WHAT IS SUPPORTED DECISION-MAKING?

In ***supported decision making***, supporters, advocates, or others help people with disabilities to make their own decisions, free of conflict of interest, or undue influence, and without giving decision-making power to someone else. This process may include documenting informed consent.

BOX 11 / KEY ISSUES TO BE AWARE OF WHEN WORKING WITH DISABLED CONTRACEPTIVE CLIENTS

A RIGHTS-BASED APPROACH NEEDS TO FRAME SERVICES FOR DISABLED CLIENTS.

This includes avoiding the following:

- the use of menstrual suppressant drugs as a form of forced contraception
- this should only be used where it is medically indicated and where counselling and informed choice is not feasible with the client
- performing abortions or sterilisations without informed consent, unless it is medically indicated and where counselling and informed choice is not feasible
- the denial of sexual education and information, especially to women with learning disabilities
- the infantilising and patronising of women with disabilities (talking down to a disabled client like a child)
- the assumption that women with disabilities are asexual without the same needs, aspirations, and desires as able-bodied women

SPECIAL CONSIDERATIONS: PHYSICAL DISABILITIES

Special considerations to guide contraceptive provision for the physically disabled are summarised in Table 12. Please refer to the Handbook for Contraceptive Method Provision (2019) together with the WHO MEC.

Table 12 / Contraception options for clients with physical disabilities

Hormonal contraception	• Women with certain physical disabilities may find it difficult to use COCs correctly and consistently or return to the clinic on time for progestogen-only injectables. • The increased risk of venous thromboembolism, associated with impaired circulation and/or immobility, is a consideration for women with some physical disabilities who wish to use COCs. Risk of venous thrombosis is not increased by progestogen-only methods (oral, injectables, implants or LNG-IUS). • Progestogen-induced amenorrhoea may be an extra benefit for those clients who have difficulty in coping with menstrual hygiene.

Intrauterine contraception	• Cu IUDs are appropriate unless clients have difficulty in coping with menstrual hygiene. • Women who have severe anaemia may benefit from a method that reduces menstrual blood loss. • Women with lower-body sensory loss are at risk of being unaware of signs of Cu IUD-related complications (for example symptoms of infection or expulsion) and so routine follow-up at 4–6 weeks is important. • For some clients, the LNG-IUS is a highly appropriate contraceptive option, particularly because of the reduced bleeding over time.
Condoms	• Condoms should be encouraged for all clients at risk of exposure to STI and HIV. • Correct condom use, however, may be difficult for people with poor coordination and/or lack of manual dexterity. • Where appropriate and possible, able-bodied partners should be encouraged to assist.
Voluntary surgical contraception	• Male or female sterilisation may be appropriate if an individual with a physical disability personally requests it. However, as with any client requesting sterilisation, careful counselling should be provided to ensure a thorough understanding of the procedure, especially its permanence and irreversibility, as well as of the equally effective long-acting reversible methods of contraception. • It is important to ensure that the client's rights are respected and that the client with a disability is not coerced into sterilisation. ***Note:*** Health care providers should be aware of the necessary legal process that must be followed if the parents, guardian, or curator request/s sterilisation for a client who is not considered competent to consent to surgery. The legal requirements are set out in the Sterilisation Act (No. 44 of 1998) and the Sterilisation Amendment Act (No. 3 of 2005). A team of professionals need to consider each case individually.

SPECIAL CONSIDERATIONS: INTELLECTUAL DISABILITIES

People with intellectual disabilities, including psychiatric disturbances, require careful consideration regarding their contraceptive and fertility planning needs. The nature of their disability, level of function, ability to understand the consequences of sexual intercourse and make reproductive choices, as well as their long-term prognosis, must be taken into consideration. Key considerations are provided in Table 13.

Table 13 / Contraception options for clients with intellectual disabilities

Hormonal contraception	Hormonal methods are highly effective, but for a mentally disabled client the following need to be considered: • the client's ability to comply with regular pill-taking or ability to return for re-injection on time • the client's ability to cope with the irregular bleeding often caused by progestogen-only methods, particularly injectable contraceptives • benefits of progestogen-induced amenorrhoea for women unable to cope with menstrual hygiene (although it is important to remember that becoming amenorrhoeic may take time and clients should be able to cope with the irregular bleeding that frequently precedes amenorrhoea)

Intrauterine contraception	• Cu IUDs provide very effective contraception without the need for client compliance • LNG-IUS may be a better option as it will also reduce menstrual bleeding
Condoms	• condoms should be promoted and made available whenever possible to protect against STIs and HIV • compliance may present a major problem and clients, where pregnancy is undesirable, should be encouraged to use more effective, client-independent contraceptive methods in addition to condoms to ensure dual protection
Voluntary surgical contraception	• informed consent should be obtained if the client is capable of understanding the nature of the sterilisation procedure, and it is certain that they will not wish to conceive in the future ***Note:*** Health care providers should be aware of the necessary legal process that must be followed if the parents, guardian, or curator request/s sterilisation for a client who is not considered competent to consent to surgery. The legal requirements are set out in the Sterilisation Act (No. 44 of 1998) and the Sterilisation Amendment Act (No. 3 of 2005). A team of professionals need to consider each case individually.

6.4 LGBTQI+

Although there are many differences between these groups, and further variation within the subgroups, lesbian, gay, bisexual, transgender, intersex, and queer/questioning persons (LGBTQI+) persons share common challenges. Their sexual orientation, gender identity, and gender expressions fall outside of the heteronormative culture in which service provision is offered. As such, these groups are often marginalised and despite being protected by the Constitution of South Africa, continue to face prejudice, discrimination, and stigma, especially in the area of SRHR.

In terms of health care, there are several barriers that limit access to services. Barriers include staff attitudes, together with stereotypical assumptions about the needs of LGBTQI+ persons. These prevent an honest, open exchange about clients' sexual orientation, gender identity, and the needs related to these. Even well-intentioned health care providers seldom have the required knowledge and skills to provide quality SRH care appropriate to the needs of all respective groups.

While it is not within the scope of this policy to provide expanded guidelines on health care for LGBTQI+ clients, the following provides some basic considerations related to contraceptive and fertility counselling within an SRH and rights-based framework.

ISSUES TO CONSIDER WHEN WORKING WITH LGBTQI+

- Many LGBTQI+ clients will not feel comfortable disclosing their sexual orientation or gender identity for fear of judgement and prejudice. Health care providers need to be sensitive to this and ask questions in a way that does not automatically assume that every client is heterosexual. For example, by asking, 'What form of contraception does your partner use?' (rather than using the terms wife/girlfriend or husband/boyfriend). In this way, questions can be asked in a gender-neutral manner and openings can be created to indicate that people can have sexual partners of either sex. Furthermore, asking which pronoun a person prefers (he or she or gender-neutral replacement) can create an environment that is affirming to different gender identities and expressions.

- If a client discloses their sexual orientation or gender identity, then health care providers need to have a non-judgmental and accepting attitude. It is important to discuss issues relating to lifestyle, sexual health, risk, safe sex, HIV testing, fertility planning and, where appropriate, the need for contraception.
- A starting point is to ensure that all clients, including LGBTQI+ clients, have access to services that foster informed decision-making and encourage healthy relationships based on shared responsibility and mutual respect, without sexual or physical abuse and violence.
- LGBTQI+ persons are at equal risk of acquiring or transmitting HIV as their heterosexual and cisgender[****] counterparts. Discussion about risk and risk reduction, HIV prevention, and HIV testing needs to be part of every consultation. There are certain practices, such as anal sex, which increases the risk of HIV transmission, but these safer sex messages apply as much to LGBTQI+ persons as they do to heterosexual persons. Furthermore, no assumptions should be made as to the sexual practices a person engages in or the type of body a person has (as this may be different from how they present themselves in terms of their gender identity).
- The rights of LGBTQI+ persons need to be safeguarded and promoted. This includes protection from violence and rape, including, notably, the worrying trend of rape perpetrated because of a person's sexual orientation and/or gender identity. Health care providers can assist in reducing stigma and work together with the communities, law enforcement, and human rights organisations to ensure that the rights of LGBTQI+ persons are upheld.

KEY CONSIDERATIONS FOR CONTRACEPTION FOR LGBTQI+ PERSONS

Some factors to consider when providing contraceptive and fertility planning services for LGBTQI+ persons are given below.

- Throughout the public health system, there needs to be a commitment to understanding the needs of transgender persons and developing strategies to meet those needs. Transgender men may still have to access services such as pap smears for example.
- Oral contraceptives should not be used by transgender women and health providers should discourage this practice.
- Lesbian and gender non-conforming persons may need contraception hormonal treatment to address conditions such polycystic ovary syndrome (PCOS), menstrual regulation, or endometrioses and may not want to use the language of family planning and this should be avoided. Some transgender men use DMPA to stop menstruation.
- The use of any hormonal therapy should be done under medical supervision.[24, 25]
- Where possible, transgender women and men should be referred to specialised transgender clinics, for assessment and hormonal therapy as indicated. The existing clinics (e.g. Steve Biko and Groote Schuur Hospitals) need to be replicated elsewhere.
- Training of health care personnel should include sensitisation to the challenges and health needs of LGBTQI+ persons, including the fact that they have similar desires to heterosexual couples, and may have similar aspirations in terms of having a family.
- Lesbians and gender non-conforming persons may need contraception hormonal treatment to address health issues, other than pregnancy prevention (i.e. PCOS, menstrual regulation or endometriosis).
- Post-abortion contraception counselling with lesbian and gender non-conforming persons needs to be addressed with care, asking the client if and what services they may need as opposed to imposing contraception as an assumed option.

For further information, see FSRH CEU Statement: Contraceptive Choices and Sexual Health for Transgender and Non-binary People, 16th October 2017

[****] Cisgender (also known as gender normative) refers to a person whose gender identity is aligned with the gender assigned at birth, i.e. a person who is not transgender.

6.5 Men

Contraception is traditionally seen as a woman's responsibility, and women predominantly use contraceptive services. However, male involvement is important for several reasons: a man has a vested interest and partnership in a woman's decision to prevent or plan pregnancies, male partners play a vital role in STI and HIV prevention with regards to risk reduction, HIV testing, and condom use, and there are methods of contraception specifically for men, namely, condoms and vasectomy. ***It is also important for couples to know their partners' HIV status in terms of planning for pregnancy and risk reduction.***

The following are ideas for how men can be encouraged to share responsibility and participate as partners in SRHR more broadly and in contraceptive services more specifically.

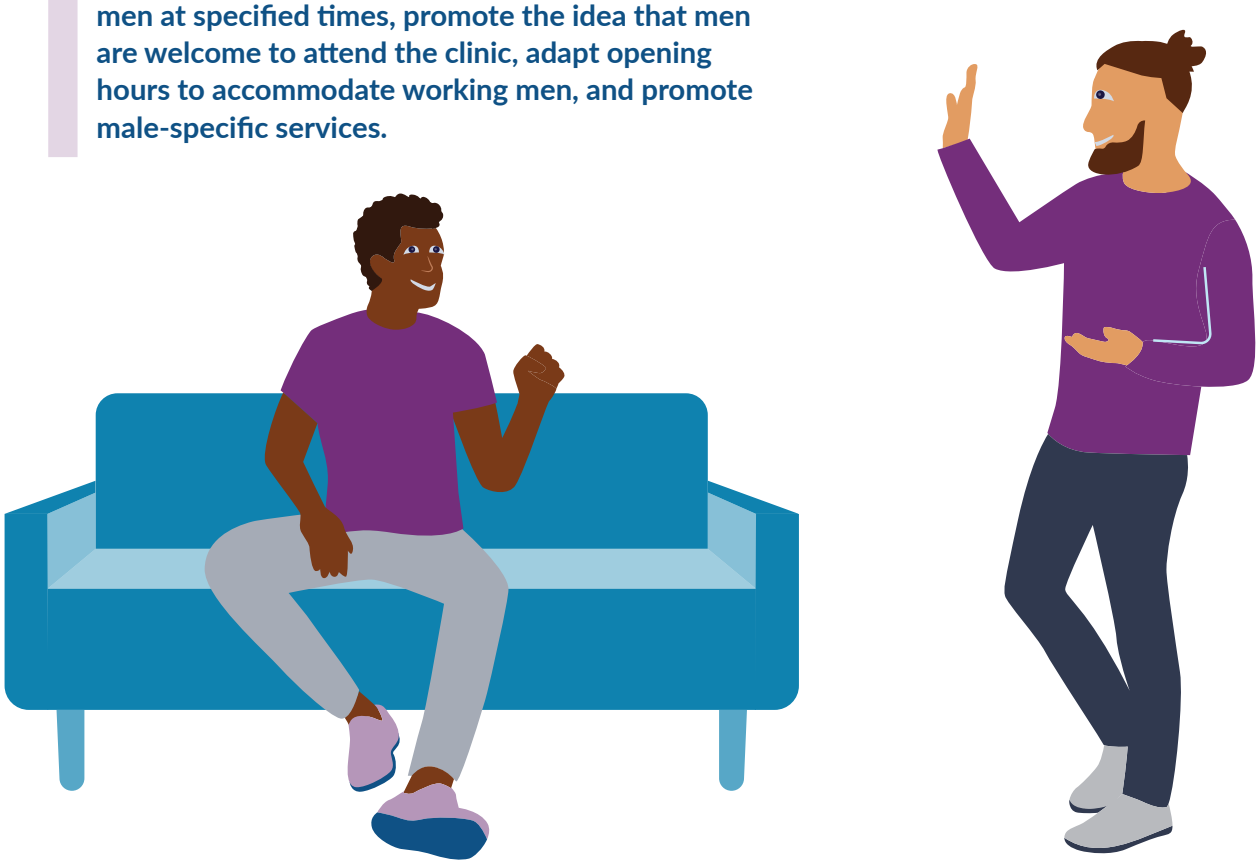
> ***Encourage women to bring their male partners with them to the clinic and conduct a joint consultation*** **that solicits a mutual commitment to both HIV and pregnancy planning or prevention.**

> ***Provide women with the confidence and skills*** **to discuss with their partner's fertility planning, sex, HIV and STI prevention.**

> ***Encourage both partners to be tested*** **and offer couples counselling and testing, where appropriate.**

> **Encourage HIV-positive,** ***seroconcordant and serodiscordant couples to attend sessions for joint counselling, sessions related to pregnancy prevention and/or planning, PMTCT and HIV prevention,*** **according to their needs.**

> **Explore options for** ***making women-dominated clinics more men friendly,*** **for example, hold sessions for men at specified times, promote the idea that men are welcome to attend the clinic, adapt opening hours to accommodate working men, and promote male-specific services.**



Actively promote health services for men,
which can include provision or referral of the following:

CONDOMS, VASECTOMY AND COUNSELLING ABOUT OTHER CONTRACEPTIVE METHODS

COUNSELLING AND HELP FOR SEXUAL PROBLEMS

INFERTILITY COUNSELLING

TB PREVENTION AND TREATMENT

STI/HIV COUNSELLING, TESTING AND TREATMENT

VOLUNTARY MEDICAL MALE CIRCUMCISION

SCREENING FOR PENILE, TESTICULAR, AND PROSTATE CANCER

Develop outreach strategies and promote men's SRHR, which includes issues such as mutual respect; shared responsibility; contraception; STI prevention, treatment, and partner notification; HIV prevention, HIV testing, ART; discussion of gender issues that fuel violence against women, rape; the importance of reducing sexual partners; pregnancy prevention, pregnancy planning, pregnancy spacing, pregnancy care, and safe delivery; and infertility.

In order to encourage men to utilise contraceptive and fertility-planning services, it is useful to integrate them with other aspects of male SRHR and other health issues. For example, HIV testing, medical male circumcision, TB, STIs, sexual health, prostate health, blood pressure, and diabetes screening.

CONTRACEPTIVES SPECIFICALLY FOR MEN

Two contraceptives designed specifically for men are outlined below. Men can be encouraged to use these methods by integrating them with other services.

CONDOMS

- Condoms provide protection against HIV, STIs, and pregnancy if used correctly and consistently with all sexual partners during each and every event of sexual intercourse. Therefore, men need to know, in detail, how to use condoms correctly and consistently for each sexual act. Men who use condoms need to understand the importance of emergency contraception in the case of breakage, slippage, or incorrect use of the condom. They will also need to have an HIV test, and post-exposure prophylaxis may be necessary if either partner is HIV-positive.

VASECTOMY

- Vasectomy is a permanent choice of contraception and, as such, requires serious consideration. It has fewer side effects and complications than most contraceptive choices for women. It is, therefore, suitable for men who definitely do not want to have any more (biological) children. (See the Handbook for Contraceptive Method Provision (2019).

7 CHRONIC MEDICAL DISORDERS

For many women with serious chronic medical disorders, the prevention of unwanted pregnancy is very important, because pregnancy may pose a major health risk to the mother and/or the foetus. The pregnancy itself may cause deterioration in the medical condition, and/or the necessary drug treatment for the condition may be harmful to the foetus.

Counselling clients with medical conditions about their fertility and contraceptive options should include a careful weighing of the benefits, risks, safety, acceptability, and effectiveness of each method against the pregnancy-related risks for the client. For example, methods that have no or few side effects (such as barrier methods) but are less effective in typical use than other methods (such as voluntary sterilisation, COCs, Cu IUD, LNG-IUS, implants, and injectables) can expose the client to an unintended high-risk pregnancy.

The use of certain contraceptives that may exacerbate the medical disorder or cause additional risk of complications must also be avoided. In addition, when selecting a suitable method careful consideration must be given to potential drug interactions.

Some of the more common medical disorders that require special attention in terms of contraceptive method provision are discussed below. For more detailed information on a broader range of conditions, refer to the WHO MEC.

The following conditions are discussed in this section:

CARDIOVASCULAR DISEASE

DIABETES MELLITUS

VENOUS THROMBOEMBOLISM

EPILEPSY

ARTERIAL DISEASE

TUBERCULOSIS

VALVULAR HEART DISEASE – UNCOMPLICATED CASES

WOMEN WITH MALIGNANT DISEASE

breast cancer, cervical and other genital-tract cancers

HIV

CARDIOVASCULAR DISEASE

Cardiovascular disease includes a wide range of conditions with various implications for contraception, as discussed below.

- If hypertension develops during COC use, the method should be discontinued and an alternative contraceptive method chosen. For women with blood pressure over 140/90 and those on antihypertensive treatment:
  - Methods containing oestrogen (combined pills, patches, vaginal rings, and injectables) are not recommended because they increase the risk of serious complications, such as heart attacks and strokes.
  - POPs, injectables, implants, Cu IUD, and LNG-IUS are safe alternative choices. However, injectables should not be initiated (or should be discontinued) in women with very high blood pressure levels (systolic ≥160 and/or diastolic ≥100).
- Vasectomy is the preferred method of sterilisation if the couple is sure that they do not wish to have any more children. Tubal ligation under local anaesthesia can be considered if the service is available.

VENOUS THROMBOEMBOLISM

Venous thromboembolism includes deep vein thrombosis and pulmonary embolism (DVT/PE) with various implications for contraception, as discussed below.

- Current or a past history of venous thromboembolism is an absolute contraindication to the use of estrogen-containing contraceptives (combined oral, patch, vaginal ring, or combined injectables).
- POPs, injectables, implants, and LNG-IUS are suitable choices for women with a history of DV/PE but should not be initiated or used by women with acute DVT/PE until she is well established on anticoagulant therapy.
- The Cu IUD may be used but concurrent use of anticoagulants may give rise to excessive bleeding. LNG-IUS may be more appropriate in these circumstances.
- Female sterilisation should be delayed until the condition has been stabilised on anticoagulant therapy (and preferably after treatment has been discontinued).

ARTERIAL DISEASE

The arterial disease includes acute myocardial infarction, angina, cerebral haemorrhage or thrombosis, and transient ischaemic attacks with various implications for contraception, as discussed below.

- Arterial disease or high-risk factors, including heavy smoking in women over 35 years of age, contraindicate the use of all oestrogen-containing methods (for example combined hormonal contraceptives, namely COCs, patches, vaginal rings, or combined injectables).
- Progestogen-only injectables should not be used by women with these conditions. All other progestogen-only methods, including LNG-IUS, subdermal implants, and POPs, can be initiated or continued, but careful follow-up is required and the method should be discontinued if the condition worsens.
- The Cu IUD is safe and highly effective.
- There are associated anaesthetic risks with female sterilisation. Vasectomy should be the sterilisation procedure of choice for couples who are sure that they do not wish to have any children in the future.

NOTE

Smoking increases the risk of cardiovascular disease for all ages and should be discouraged.

- the use of CHCs is not recommended in smokers of 35 years or older
- heavy smoking (more than 15 cigarettes per day) in women of 35 years or older is an absolute contraindication to oestrogen-containing contraceptives
- smokers can safely use progestogen-only methods, Cu IUDs, and sterilisation

VALVULAR HEART DISEASE – UNCOMPLICATED CASES

There are no absolute contraindications to the use of any contraceptive method, although combined hormonal contraceptives (WHO MEC category 2) would require careful follow-up.

- Combined hormonal contraceptives are absolutely contraindicated (WHO MEC category 4) in the presence of complications, such as pulmonary hypertension, risk of fibrillation, or history of subacute bacterial endocarditis.
- Progestogen-only methods can be used safely.
- In the presence of complicated valvular heart disease, Cu IUD or LNG-IUS can be inserted (WHO MEC category 2), and prophylactic antibiotics to prevent bacterial endocarditis are advised.

DIABETES MELLITUS

- Women with diabetes (both non-insulin and insulin-dependent) who do not have vascular complications can use any contraceptive method safely.
- Women with long-standing disease (more than 20 years) or those with vascular complications (neuropathy, nephropathy, or retinopathy) should not use combined hormonal methods (COCs, patches, etc.) or progestogen-only injectables as they are in WHO MEC Category 4. They can safely use Cu IUDs, LNG-IUS, or other progestogen-only methods, such as POPs and implants.
- Female sterilisation has associated anaesthetic and surgical risks. Therefore, vasectomy is the sterilisation procedure of choice for couples who are sure that they do not wish to have any children in the future. When alternative, highly effective long-acting reversible methods are unacceptable, female sterilisation can generally be performed in women with complicated diabetes if specialised settings if a trained surgical team and adequate support equipment are available (WHO MEC Category S[††††]).

EPILEPSY

Epilepsy itself does not preclude the use of any contraceptive method. But some of the commonly used anticonvulsant drugs (namely phenytoin, carbamazepine, ethosuximide, phenobarbitone, and primidone) may reduce the efficacy of hormonal contraceptives and thus increase the risk of pregnancy.

- Progestogen-only injectables are effective, injection intervals do not need to be shortened.
- Cu IUDs, LNG-IUS or sterilisation may be a good choice for clients with epilepsy, if no

[††††] WHO S = procedure should be undertaken with experienced surgeon and staff

specific contraindications to these methods are identified during appropriate screening.

- POPs should not be used.
- CHCs generally should not be used by women taking anticonvulsants long term (WHO MEC category 3). For women taking anticonvulsants that are EIDs short term, higher dose preparations containing 50 µg oestradiol (to a maximum 70 µg, this may require taking two pills each day) may be considered to counteract the potentially reduced effectiveness of COCs. Extended dosing regimens of monophasic pills, i.e. three or four packs of active pills (9–12 weeks) followed by a hormone-free interval of only four days are recommended.
- Lamotrigine has no effect on contraceptive efficacy, but the use of COCs are not recommended with this anticonvulsant in monotherapy as oestrogen reduces seizure control. If the drug dose is increased to improve therapeutic effects, patients may then suffer lamotrigine toxicity during the placebo/hormone-free week. However, when lamotrigine is used in combination with sodium valproate, COCs do not seem to have any negative effects and can be used. Progestogen-only methods are safe and effective as are IUD/IUS.
- Women who are on anticonvulsants, or who took anticonvulsants that are enzyme-inducing drugs within 28 days of the act of unprotected sex, should be offered an intrauterine device for emergency and on-going contraception if ECP is used the dose should be increased by 50%.

TUBERCULOSIS

TB does not contraindicate the use of any method, except intrauterine devices in the presence of pelvic TB.

- If the potent enzyme-inducing drugs rifampicin or rifabutin are used in treatment, hormone levels can drop by >40%, reducing the efficacy of POPs and CHCs (even high dose) significantly, therefore their use is not advised.
- Progestogen-only injectables are suitable and injection intervals do not need to be shortened.
- The Cu IUD, LNG-IUS, or sterilisation can be used safely in women with the non-pelvic form of TB.
- Female sterilisation in women with pelvic TB can be considered, but only in specialised settings with a trained surgical team and adequate support equipment, as per WHO MEC Category S‡‡‡‡.

WOMEN WITH MALIGNANT DISEASE

Breast cancer:

- Pregnancy must be avoided for at least 5 years following diagnosis of breast cancer, as it may exacerbate the disease, therefore highly effective contraception is essential.
- Hormonal methods are contraindicated for women with current breast cancer (WHO MEC Category 4 for all hormonal contraceptives). For women with a history of breast cancer (no evidence of current disease for at least five years), hormonal methods are not generally recommended, although if nothing else is available or acceptable, progestogen-only methods may be allowed with approval from the attending oncologist and under careful medical supervision (WHO MEC Category 3 for all hormonal contraceptives).

‡‡‡‡ WHO S = procedure should be undertaken with experienced surgeon and staff

- The Cu IUD is a safe choice as it is highly effective and has no hormonal effects.
- Voluntary sterilisation is appropriate for women who are certain that they do not want to have children in the future.
- Other methods require careful counselling as they generally carry a greater risk of contraceptive failure.
  Note: Benign breast disease, undiagnosed breast lumps, and a family history of breast cancer do not contraindicate the use of any specific method.

Cervical and other genital-tract cancers

HPV infection is the main cause of cervical cancer. The onset of sexual activity at a young age and multiple sexual partners increase the risk of exposure to HPV and thus are associated with a higher risk of cervical cancer. Therefore, delay of sexual debut and safer sexual practices should be encouraged to reduce HPV infection. Introduction of HPV vaccines for adolescents should be considered as a strategy to reduce cancer of the cervix in South Africa.

- *Cervical intraepithelial neoplasia*
  - If cervical intraepithelial neoplasia is diagnosed on the cervical (pap) smear, it must be managed appropriately. The condition does not preclude any form of contraception, including hormonal methods and intrauterine devices. Sterilisation would be suitable for women or couples who do not wish to have children in the future.

- *Invasive cervical and other genital tract cancers, for example, ovarian and endometrial cancers.*
  - These cancers require treatment that generally results in sterility. Any contraceptive method can be initiated if needed while the woman awaits treatment. The only exception is the insertion of Cu IUD or LNG-IUS in the presence of cervical and endometrial cancer (WHO MEC category 4), or ovarian cancer (WHO MEC category 3). If a Cu IUD or LNG-IUS user is diagnosed with cervical cancer, the device can be kept in place while she awaits treatment (WHO MEC category 2).
  - Hormonal contraceptives provide protection from genital tract cancers. The use of hormonal contraceptives, both oral and injectables (and theoretically other hormone delivery systems, for example, LNG-IUS, implants, patches, and vaginal rings) have been shown to significantly reduce the risk of developing endometrial and ovarian cancer by as much as 50%. This protective effect increases with duration of use and extends up to 15 years after discontinuing the method.

HIV

Contraception and HIV progression

There is no evidence suggesting that any method contributes to HIV disease progression.

Drug interaction: There are certain enzyme-inducing TB and antiretroviral drugs which contribute to reduced efficacy of certain contraceptive methods (refer to Section 2.12 and 2.13 for the drug to drug interactions). Job Aid 11 provides a one-page summary of HIV, ART, and contraception.

Contraception for HIV-positive women: HIV-positive women can use most methods as guided by the WHO MEC and outlined in figure 5 below.

HIV acquisition: See Section 2.11 where this is discussed in more detail.

NOTE

South Africa has a high incidence of HIV, and as such, women of reproductive age are at particularly high risk of acquiring HIV, irrespective of their contraceptive method. Interventions which reduce this risk include condom use (male and female), pre-exposure prophylaxis, post exposure prophylaxis, and an HIV-positive partner being fully adherent and with an undetectable viral load.

Figure 5 / WHO MEC 2015: HIV and method-specific guidance

= Use the method
= Do not use the method
I = Initiation of the method
C = Continuation of the method
– = Continuation not listed; does not affect eligibility for method
NA = Not applicable

Condition	Combined oral contraceptives	Monthly injectables	Combined patch and Combined vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills	Copper-bearing intrauterine device		Levonorgestrel intrauterine device		Female sterilization
								I	C	I	C	
High risk of HIV	I	I	I	I	I	I	–	I	I	I	I	A
Asymptomatic or mild HIV clinical disease (WHO stage 1 and 2)	I	I	I	I	I	I	–	2	2	2	2	A
Severe or advanced HIV clinical disease (WHO stage 3 and 4)	I	I	I	I	I	I	–	3	2	3	2	S[A]
ANTIRETROVIRAL THERAPY												
Treated with nucleoside reverse transcriptase inhibitors (NRTIs)[B]	I	I	I	I	I	I	–	2/3[P]	2	2/3[P]	2	–
TREATED WITH NON-NUCLEOSIDE REVERSE TRANSCRIPTAT INHIBITORS (NNRTIS)												
Efavirenz (EFV) or nevirapine (NVP)	2	2	2	2	DMPA I / NET-EN 2	2	–	2/3[D]	2	2/3[D]	2	–
Etravirine (ETR) or rilpivirine (RPV)	I	I	I	I	I	I	–	2/3[D]	2	2/3[D]	2	–
Treated with protease inhibitors (PIs)[C]	2	2	2	2	DMPA I / NET-EN 2	2	–	2/3[D]	2	2/3[D]	2	–

I = INITIATION C = CONTINUATION

[A] Presences of an AIDS-related illness may require a delay in the procedure
[B] NRTIs include: abacavir (ABC), tenofovir (TDF), zidovudine (AZT), lamivudine (3TC), didansine (DDI), emtricitabine (FTC), stavudine (D4T).
c PIs include: ritonavir-boosted atazanavir (ATV/r), ritonavir-boosted lopinavir (LPV/r), ritonavir-boosted darunavir (DRV/r), ritonavir (RTV).
[D] Condition is category 2 for IUD insertion for asymptomatic or mild HIV clinical disease (WHO stage 1 or 2), category 3 for severe or advanced HIV clinical disease (WHO stage 3 or 4).

8 SERVICE DELIVERY GUIDELINES: KEY COMPONENTS

In this section, the following three components of service delivery are outlined:

1. **Opportunities for integrating contraceptive services with other health services**
2. **Levels of service delivery within the tiers of primary health care delivery in South Africa**
3. **Method provision as appropriate for the respective cadre of staff in South Africa**

8.1 Integration

The framework for integration is provided by the National Integrated Sexual and Reproductive Health and Rights (SRHR) Policy.[1]

Contraceptive services need to be integrated into other health services, as appropriate. Linkages and integration need to be bilateral. Health care providers should seek opportunities to offer contraception and discuss fertility planning at other SRH and health consultations. The contraception consultation needs to be used to promote relevant aspects of SRH, HIV, and general health.

- Seek opportunities to provide contraceptive services (information, motivation, method provision, or referral) at the following, as appropriate:
  - planning for pregnancy (fertility planning and safer conception)
  - SRH services (including STI, breast and cervical screening, termination of pregnancy services, rape and sexual assault, and PEP and PrEP provision)
  - HIV care pathway (including HIV counselling and testing, PMTCT, HIV management, ART services)
  - maternal health services, including:
    - » antenatal, postnatal, postpartum (for example, breastfeeding advisory sessions, well-baby clinics, increased access to postpartum voluntary sterilisation)
    - » increased access to postpartum voluntary sterilisation
  - integrated management of childhood illnesses and expanded programme on immunisation
  - other chronic services, such as diabetic and hypertension services for women in the fertile age group
  - Centralised Chronic Medicines Dispensing and Distribution (CCMDD)
    - » seek opportunities for the inclusion of contraceptive methods such as oral contraceptive pills
  - medical male circumcision
    - » provides an opportunity to engage men in terms of shared responsibility, and to provide information about dual protection (contraception and condom use) and male sterilisation
- Form and strengthen partnerships with other government sectors, the private sector, development partners, and non-governmental organizations to increase access to contraceptive services for all those of reproductive age.

  These may include:
  - non-clinic-based delivery systems, such as social marketing and community-based programmes
  - community health workers
  - school-based clinics
  - workplace-based clinics

- public-private partnerships
    - » this should include, for example, a review of the enhanced role general practitioners and retail pharmacists could play in terms of contraception provision, especially within the context of National Health Insurance
- Provide contraceptive services at different levels of care in accordance with the service delivery guidelines and scopes of practice.
- Provide contraceptive services within a framework of quality health care and supportive health systems, with attention paid to effective and responsive referral systems between all levels of care.

NOTE

SRH and HIV services are intimately linked. **Sexually transmitted infections can increase the risk of HIV acquisition and transmission. HIV is primarily sexually transmitted but is also associated with pregnancy, childbirth, and breastfeeding. Sexual and reproductive ill-health and HIV share root causes, including poverty, gender inequality, and social marginalisation of the most vulnerable populations.**

Therefore, improving the integration of SRH and HIV programmes can better meet the complex and diverse SRH and HIV needs of women.

8.2 Service delivery guidelines for different levels of health care provision

Tables 14-19 describe contraceptive and fertility-planning services for the following levels of provision:

- community, schools, workplaces, and retail (community) pharmacies
- primary health care (PHC)
    - PHC clinics and mobile units
- secondary health care
- district hospitals
- referral tertiary hospitals, academic and quaternary centres

For guidelines for levels of health care providers and method-specific service provision, see the following Tables.

NOTE

Whatever the level of care, it is assumed that staff should:

- **have appropriate training**
- **meet regulatory requirements**
- **have regular supervision**
- **The levels of care are framed by the package of SRH service delivery described in the National Integrated Sexual and Reproductive Health and Rights (SRHR) Policy.[1]**
- **the full package of screening is described in Job Aids 3-7**
- **condoms include both male and female condoms**

Table 14 / Service delivery guidelines

COMMUNITY, SCHOOLS, WORKPLACES, RETAIL (COMMUNITY) PHARMACIES, AND PRIVATE PRACTICE

COMMUNITY

CONTRACEPTIVE METHOD	SERVICE	POINT OF SERVICE DELIVERY	SERVICE DELIVERY PERSONNEL
Male condoms	• package of IEC and BCC initiatives • and provision of condoms	• community-based outlets (e.g. non-governmental organisations, community-based organisations, faith-based organisations) • specifically targeted outlets (e.g. workplace, public toilets, shebeens, brothels, truck stops, sports stadiums) • specifically targeted groups (e.g. sex workers, youth) • retail outlets (e.g. garages, pharmacies)	• all: no special qualification required (e.g. community health workers, health promoters, peer educators, outreach workers) • ward-based PHC teams, community health workers
Female condoms	• package of IEC and BCC initiatives, provision of female condom with appropriate training	• community-based outlets	• trained personnel: community health workers, health promoters, peer educators, outreach workers • ward-based PHC teams: community health workers
Natural family planning	• information, teaching and support to people using this method	• selected community-based health organisations, faith-based organisations, outreach programmes	• personnel trained in natural family planning
The three methods above, plus CHCs and Injections SC and emergency contraceptive pills	• package of IEC/BCC, provision of condoms, oral contraceptives, patches, vaginal rings, and SC Injections • (repeats – initiation by the nurse at PHC facility) • provision of emergency contraception and counselling/referral	• health organisations/NGOs providing community- based sexual and reproductive health outreach services	• ward-based PHC teams: community health workers • legislative and scope of practice changes needed for trained CHW and enrolled nurses to give DMPA-SC

Table 14 / Service delivery guidelines (continued)

COMMUNITY, SCHOOLS, WORKPLACES, RETAIL (COMMUNITY) PHARMACIES, AND PRIVATE PRACTICE

SCHOOLS

CONTRACEPTIVE METHOD	SERVICE	POINT OF SERVICE DELIVERY	SERVICE DELIVERY PERSONNEL
Condoms and emergency contraception **Hormonal contraceptives** (pills, patches, vaginal rings) and injectables IM and SC (if qualified school nurse in attendance)	• IEC/BCC • method provision or referral	• school or referral to PHC facility	• school health nurses for all methods listed under 'contraceptive method' • peer educators (condom only)

COMMENTS:

- Because of the prevalence of teenage pregnancy, every effort needs to be placed on the prevention of pregnancy and keeping school-age girls in education.
- The interventions need to be aligned to relevant policies of the Department of Basic Education, Department of Health, local education authority, and School Governing Boards (e.g. Revised Policy Guidelines for Adolescent and Youth Health; National School Health Policy and Implementation Guidelines; Department of Basic Education: Integrated Strategy on HIV and AIDS, 2011–2015 Full Report).
- Education on condoms and contraceptives need to be closely linked with life skills/sexuality education interventions.
- Legislative and scope of practice changes needed for trained CHW and auxiliary nurses to give DMPA-SC.

FURTHER EDUCATION / TERTIARY EDUCATION INSTITUTIONS

CONTRACEPTIVE METHOD	SERVICE	POINT OF SERVICE DELIVERY	SERVICE DELIVERY PERSONNEL
Condoms and emergency contraception **Hormonal contraceptives** (pills, patches, vaginal rings), injectables IM and SC, Cu IUD/LNG-IUS, and implants (if qualified school nurse in attendance and suitable facilities available)	• IEC/BCC • method provision or referral	• institution-based student health clinics	• qualified nurses and doctors • peer educators (condom only)

COMMENTS:

- Legislative and scope of practice changes needed for trained CHW and auxiliary nurses to give DMPA-SC.

Table 14 / Service delivery guidelines (continued)

COMMUNITY, SCHOOLS, WORKPLACES, RETAIL (COMMUNITY) PHARMACIES, AND PRIVATE PRACTICE

WORKPLACE

CONTRACEPTIVE METHOD	SERVICE	POINT OF SERVICE DELIVERY	SERVICE DELIVERY PERSONNEL
Condoms and emergency contraception **Hormonal contraceptives** (pills, patches, vaginal rings), injectables IM and SC, Cu IUD/LNG-IUS, and implants (if the qualified nurse is in attendance and suitable facilities available)	• IEC/BCC • method provision or referral	• workplace-based occupational health services	• occupational health nurses, doctors • peer educators (condom only)

COMMENTS:

- Many working women have difficulty in accessing contraceptive services, workplaces should be encouraged to provide such services.
- Legislative and scope of practice changes needed for trained CHW and auxiliary nurses to give DMPA-SC.
- Where referrals are necessary, provision should be made for time off.

RETAIL (COMMUNITY) PHARMACIES

CONTRACEPTIVE METHOD	SERVICE	POINT OF SERVICE DELIVERY	SERVICE DELIVERY PERSONNEL
Condoms and emergency contraception **Hormonal contraceptives** (pills, patches, vaginal rings), injectables IM and SC, implants if suitably trained pharmacist or qualified nurse in attendance)	• IEC/BCC • method provision and repeats	• pharmacies	• pharmacists, pharmacist's assistants (post-basic), pharmacy technicians (new cadre introduced in 2013), nurses based at pharmacy-based clinics

COMMENTS:

- **Recommended regulatory change:** down-scheduling of contraceptives to enable pharmacists to initiate hormonal contraception and amendment of legislation to enable pharmacist's assistants (post-basic) and pharmacy technicians to provide repeats.

Table 14 / Service delivery guidelines (continued)

COMMUNITY, SCHOOLS, WORKPLACES, RETAIL (COMMUNITY) PHARMACIES, AND PRIVATE PRACTICE

PRIVATE PRACTICE

CONTRACEPTIVE METHOD	SERVICE	POINT OF SERVICE DELIVERY	SERVICE DELIVERY PERSONNEL
Condoms and emergency contraception **Hormonal contraceptives** (pills, patches, vaginal rings) and injectables IM and SC (if qualified school nurse in attendance)		• private practice; not for profit organisations	• doctors or nurses in private practice and/or on behalf of the Department of Health

COMMENTS:

- Legislative changes needed for nurses (CNPs, midwives, professional nurses) in private practice.

Table 15 / Service delivery guidelines: Primary level of care

PHC CLINICS

CONTRACEPTIVE METHOD	SERVICE	POINT OF SERVICE DELIVERY	SERVICE DELIVERY PERSONNEL
PHC CLINICS			
Male condoms	• method provision and information on correct and consistent use	• accessible points within the facility and promoted at all services, including HIV, TB, STIs, contraception, and antenatal services	• all health care providers, community health workers, peer educators, HCT counsellors, ART adherence counsellors, community health workers, ward-based outreach teams
Female condoms	• method provision and information on correct and consistent use	• all services, including HIV, TB, STI, contraception, and antenatal services	• all health care providers trained in female condom insertion and use
Male and female condoms **Combined hormonal contraceptives: oral and injectables** **Cu IUD** **Emergency contraception (pills and Cu IUD)** **Intrauterine system / implants**	• IEC/BCC • screening as appropriate • contraceptive and fertility-planning counselling and information • infertility counselling and referral • method provision or referral • medical abortion under 12 weeks • TOP counselling and referral • HIV/PMTCT/NIMART • combination prevention including PrEP where available) • SRH services (cervical and breast cancer screening, rape/ sexual assault, STI management) • other services as per PHC package for South Africa	• integration with other services, including SRH, HCT, ART, TB, STI, maternal and child health (PMTCT, postnatal, antenatal, and EPI)	• refer to Table 18 for levels of health care providers and method service provision

Table 16 / Service delivery guidelines: Primary level of care

MOBILE SERVICES

NOTE: Mobile units provide PHC services to under-served and/or remote rural areas. They differ from district to district and vary according to space, staff levels and the range of services provided. In this table, mobile services have been categorised as (a) limited and (b) expanded. Limited mobile services provide minimal, basic services. Expanded mobile services provide more services and have more resources, including space, equipment and staff levels.

LIMTED MOBILE SERVICES

CONTRACEPTIVE METHOD	SERVICE	POINT OF SERVICE DELIVERY	SERVICE DELIVERY PERSONNEL
Condoms (male and female) **Hormonal contraceptives** (pills, patches, vaginal rings), and injectables IM and SC emergency contraceptive pills	• IEC/BCC • screening (as appropriate) • contraceptive and fertility-planning counselling and information • method provision • other services as per DOH service delivery guidelines	• mobile units	• refer to Table 18 for levels of health care providers and method service provision

EXPANDED MOBILE SERVICES

CONTRACEPTIVE METHOD	SERVICE	POINT OF SERVICE DELIVERY	SERVICE DELIVERY PERSONNEL
As above, plus **Cu IUD/LNG IUS**	As above, plus: • medical abortion under 12 weeks • other services as per DOH service delivery guidelines	• mobile units	• refer to Table 18 for levels of health care providers and method service provision

Table 17 / Service delivery guidelines: Secondary level of care

THE SECONDARY LEVEL OF CARE (INCLUDING CHCs)

CONTRACEPTIVE METHOD	SERVICE	POINT OF SERVICE DELIVERY	SERVICE DELIVERY PERSONNEL
As per PHC (Table 15), plus: **Subdermal implants and LNG-IUS** **Low-risk tubal ligation and vasectomy** **Where not available, referral to district hospitals/tertiary level for intrauterine system/implants**	As per PHC, plus: • maternal health (antenatal, maternity and post-natal) • TOP and medical abortion at designated sites, or referral • limited infertility investigation and referral	• more specialised contraception services • maternity (PMTCT, antenatal and postnatal services) • HIV/ART service points • TOP services	• refer to Table 18 for levels of health care providers and method service provision

Table 18 / Service delivery guidelines

DISTRICT HOSPITALS

DISTRICT HOSPITALS

CONTRACEPTIVE METHOD	SERVICE	POINT OF SERVICE DELIVERY	SERVICE DELIVERY PERSONNEL
As per CHC (Table 16), plus: **Tubal ligation and vasectomy** **Infertility management**	• specialist service for complications, referrals and problems beyond the capacity of PHC and CHC • provision of contraceptives to any patient attending the institution • provision of a method – initiative and/or appropriate down referral to PHC facility • medical abortion and surgical abortion • management of infertility, endocrine-related problems	**Inpatients and outpatients:** More specialised contraceptive services, referral methods, especially: • maternity (PMTCT, antenatal and postnatal services) • HIV/ART service points • obstetric and gynaecological outpatient services	• refer to Table 18 for levels of health care providers and method service provision • as per department and area of specialisation

COMMENTS:

- initiation of a method, appropriate down referral and, where indicated, on-going care at the district level
- medical officers, obstetric and gynaecological specialist doctors (e.g. HIV Clinicians)
- *This level should play a key role in terms of support, training, and continuing professional development. It should also provide support for CHC and PHC services.*

Table 19 / Service delivery guidelines

TERTIARY LEVEL OF CARE, INCLUDING REFERRAL TERTIARY HOSPITALS, ACADEMIC AND QUATERNARY CENTRES

TERTIARY LEVEL OF CARE (INCLUDING REFERRAL TERTIARY HOSPITALS, ACADEMIC AND QUATERNARY CENTRES)

CONTRACEPTIVE METHOD	SERVICE	POINT OF SERVICE DELIVERY	SERVICE DELIVERY PERSONNEL
As for district hospitals (Table 20)	• specialist service, referrals, and problems beyond the capacity of PHC/CHC/district hospital	• as for district hospitals (Table 17)	• as for district hospitals (Table 17)

COMMENTS:

- ***Recommendation:*** Academic teaching centres of excellence should be developed, focussing on contraception and fertility planning, and for referral of difficult cases.

8.3 Categories of staff and provision of contraception

Table 20 / Categories of staff and provision of contraception

KEY

Y = Yes, this category of personnel is required
N = No, this category of personnel is NOT required
Tr: Requires additional clinical training
Rec: Recommended but needs legislative change

health care provider
LAY COMMUNITY OUTEACH / PEER EDUCATOR / VOLUNTEER

IEC/BCC*	Y	Cu IUD	N
Counselling	Y	LNG-IUS	N
Oral contraceptive pills prescription and initiation	N	Hormonal contraceptive pills, patches, and vaginal rings	N
Subdermal implant	N	Voluntary sterilisation	N
Progestogen-only injectables	N	HCT	N

health care provider
HCT COUNSELLOR

IEC/BCC*	Y	Cu IUD	N
Counselling	Y	LNG-IUS	N
Oral contraceptive pills prescription and initiation	N	Hormonal contraceptive pills, patches, and vaginal rings	Y Tr Rec
Subdermal implant	N	Voluntary sterilisation	N
Progestogen-only injectables	N	HCT	N

* IEC/BCC integrated package, including contraceptive choice/rights/HIV/STI/TB

health care provider
COMMUNITY HEALTH WORKER

IEC/BCC*	Y	Cu IUD	N
Counselling	Y	LNG-IUS	N
Oral contraceptive pills prescription and initiation	N	Hormonal contraceptive pills, patches, and vaginal rings	Y Tr Rec
Subdermal implant	N	Voluntary sterilisation	N
Progestogen-only injectables	Y†	HCT	Y Tr

health care provider
ENROLLED NURSING ASSISTANT

IEC/BCC*	Y	Cu IUD	N
Counselling	Y	LNG-IUS	N
Oral contraceptive pills prescription and initiation	N	Hormonal contraceptive pills, patches, and vaginal rings	Y
Subdermal implant	N	Voluntary sterilisation	N
Progestogen-only injectables	Y†	HCT	Y

* IEC/BCC integrated package, including contraceptive choice/rights/HIV/STI/TB
† Legislative changes needed for nurses (CNPs, midwives, prof nurses) in private practice (Section 56(6) of the Nursing Act)
Legislative and scope of practice changes needed for trained CHWs, enrolled nurses and enrolled assistant nurses to give DMPA-SC

health care provider
ENROLLED NURSE

IEC/BCC*	Y	Cu IUD	N
Counselling	Y	LNG-IUS	N
Oral contraceptive pills prescription and initiation	N	Hormonal contraceptive pills, patches, and vaginal rings	Y
Subdermal implant	N	Voluntary sterilisation	N
Progestogen-only injectables	Y†	HCT	Y

health care provider
CLINICAL ASSOCIATE

IEC/BCC*	Y	Cu IUD	Y Tr
Counselling	Y	LNG-IUS	Y Tr
Oral contraceptive pills prescription and initiation	Y	Hormonal contraceptive pills, patches, and vaginal rings	Y
Subdermal implant	Y Tr	Voluntary sterilisation	Y Tr
Progestogen-only injectables	Y	HCT	Y

* IEC/BCC integrated package, including contraceptive choice/rights/HIV/STI/TB
† Legislative changes needed for nurses (CNPs, midwives, prof nurses) in private practice (Section 56(6) of the Nursing Act)
Legislative and scope of practice changes needed for trained CHWs, enrolled nurses and enrolled assistant nurses to give DMPA-SC

health care provider

PROFESSIONAL NURSE / REGISTERED NURSE / ENROLLED MIDWIFE / ADVANCED MIDWIFE†

IEC/BCC*	Y	Cu IUD	Y Tr
Counselling	Y	LNG-IUS	Y Tr
Oral contraceptive pills prescription and initiation	N	Hormonal contraceptive pills, patches, and vaginal rings	Y
Subdermal implant	Y Tr	Voluntary sterilisation	N
Progestogen-only injectables	Y	HCT	Y

health care provider

CLINICAL NURSE PRACTITIONER / ADVANCED MIDWIFE

IEC/BCC*	Y	Cu IUD	Y Tr
Counselling	Y	LNG-IUS	Y Tr
Oral contraceptive pills prescription and initiation	Y	Hormonal contraceptive pills, patches, and vaginal rings	Y
Subdermal implant	Y Tr	Voluntary sterilisation	N
Progestogen-only injectables	Y	HCT	Y

health care provider

MEDICAL OFFICER

IEC/BCC*	Y	Cu IUD	Y Tr
Counselling	Y	LNG-IUS	Y Tr
Oral contraceptive pills prescription and initiation	Y	Hormonal contraceptive pills, patches, and vaginal rings	Y
Subdermal implant	Y Tr	Voluntary sterilisation	Y Tr
Progestogen-only injectables	Y	HCT	Y

health care provider

FAMILY PHYSICIAN / DOCTOR

IEC/BCC*	Y	Cu IUD	Y
Counselling	Y	LNG-IUS	Y
Oral contraceptive pills prescription and initiation	Y	Hormonal contraceptive pills, patches, and vaginal rings	Y
Subdermal implant	Y	Voluntary sterilisation	Y
Progestogen-only injectables		HCT	Y

health care provider

MEDICAL SPECIALIST OBSTETRICIAN GYNAECOLOGIST

IEC/BCC*	Y	Cu IUD	Y
Counselling	Y	LNG-IUS	Y
Oral contraceptive pills prescription and initiation	Y	Hormonal contraceptive pills, patches, and vaginal rings	Y
Subdermal implant	Y	Voluntary sterilisation	Y
Progestogen-only injectables	Y	HCT	Y

health care provider

PHARMACIST

IEC/BCC*	Y	Cu IUD	N
Counselling	Y Tr	LNG-IUS	N
Oral contraceptive pills prescription and initiation	Y Rec	Hormonal contraceptive pills, patches, and vaginal rings	Y Rec
Subdermal implant	N	Voluntary sterilisation	N
Progestogen-only injectables	N	HCT	Y Tr

health care provider

AUTHORISED PHARMACIST PRESCRIBER (NEW CADRE)

IEC/BCC*		Cu IUD	N
Counselling		LNG-IUS	N
Oral contraceptive pills prescription and initiation	Y Rec	Hormonal contraceptive pills, patches, and vaginal rings	Y Rec
Subdermal implant	N	Voluntary sterilisation	N
Progestogen-only injectables	Y Rec	HCT	Y Tr

health care provider

PHARMACIST'S ASSISTANT (POST-BASIC)

IEC/BCC*	Y	Cu IUD	N
Counselling	Y	LNG-IUS	N
Oral contraceptive pills prescription and initiation	N	Hormonal contraceptive pills, patches, and vaginal rings	Y Rec
Subdermal implant	N	Voluntary sterilisation	N
Progestogen-only injectables	N	HCT	Y Tr

* IEC/BCC integrated package, including contraceptive choice/rights/HIV/STI/TB
† Legislative changes needed for nurses (CNPs, midwives, prof nurses) in private practice (Section 56(6) of the Nursing Act)
Legislative and scope of practice changes needed for trained CHWs, enrolled nurses and enrolled assistant nurses to give DMPA-SC

health care provider

PHARMACIST WITH FAMILY PLANNING PERMIT (SECT 22A(15) OF MEDICINES ACT)

IEC/BCC*	Y	Cu IUD	N
Counselling	Y Tr	LNG-IUS	N
Oral contraceptive pills prescription and initiation	Y Rec	Hormonal contraceptive pills, patches, and vaginal rings	Y
Subdermal implant	N	Voluntary sterilisation	N
Progestogen-only injectables	N	HCT	Y Tr

health care provider

PHARMACIST WITH PRIMARY CARE DRUG THERAPY PERMIT (SECT 22A(15) OF MEDICINES ACT)

IEC/BCC*	Y	Cu IUD	N
Counselling	Y	LNG-IUS	N
Oral contraceptive pills prescription and initiation	Y Rec	Hormonal contraceptive pills, patches, and vaginal rings	Y
Subdermal implant	N	Voluntary sterilisation	N
Progestogen-only injectables	N	HCT	Y Tr

health care provider

PHARMACY TECHNICIAN (NEW CADRE)

IEC/BCC*	Y	Cu IUD	N
Counselling	Y	LNG-IUS	N
Oral contraceptive pills prescription and initiation	N	Hormonal contraceptive pills, patches, and vaginal rings	Y Rec
Subdermal implant	N	Voluntary sterilisation	N
Progestogen-only injectables	N	HCT	Y Tr

* IEC/BCC integrated package, including contraceptive choice/rights/HIV/STI/TB

JOB AIDS

Job Aid 1 / BASIC COUNSELLING SKILLS

A positive relationship with health care providers encourages the client to utilise and trust the health service and to discuss issues more openly, ask questions, adhere to the advice, and return for follow-up visits when required. A positive health encounter includes the following elements:

ESTABLISH RAPPORT WITH YOUR CLIENT

Be welcoming, greet the client politely and respectfully

Give your full attention to the client

Give positive feedback in terms of the client coming to the health service to seek a method

AWARENESS OF ONE'S OWN ATTITUDE

Be aware of how your own personal views influence your interaction with the client

BE EMPATHETIC, RESPECTFUL, AND NON-JUDGEMENTAL TOWARDS ALL CLIENTS

Regardless of their age, sex, race, religion, culture, disability, social status, sexual orientation, sexual preferences, and the number of sexual partners.

EFFECTIVE COMMUNICATION

Communicate in a manner that encourages trust and openness, and fosters education and understanding. This includes:

- Being aware of body language: focusing on the client, maintaining eye contact
- Listening to the client and providing opportunities throughout the consultation for the client to ask questions, raise issues, and voice concerns without embarrassment or fear of ridicule
- Using simple, non-technical language

PERSONALIZE THE CONSULTATION AND DEVELOP EMPATHY WITH THE CLIENT

Take an interest in the client as an individual and seek to understand their needs, concerns, and barriers by stepping into their shoes.

RESPECT THE RIGHTS OF THE CLIENT

Accept the client's right to make their own informed choice of contraceptive method. Clients should be given adequate information and counselling, without the influence of health-care provider biases, in order to assist them to make an informed and voluntary decision about contraception and method to use.

Discuss confidentiality and the people who may be told about the consultation on a 'need to know' basis. This is especially important for adolescents who are often concerned that information will be disclosed to their parents or guardians.

Counselling should be provided in a private and comfortable environment.

Job Aid 2 / COUNSELLING ABOUT INFORMED DECISION-MAKING AND CHOICE

The purpose of **INFORMED DECISION-MAKING** is to:

- Assist clients to explore and consider their own needs, including their fertility intentions, health, and life circumstances.
- Provide information about options for clients to explore available methods in relation to their needs.
- Ensure that the client has a sense of ownership and agency concerning her selection of a method.

INFORMED DECISION-MAKING / KEY POINTS

WHAT ARE THE OPTIONS?

To make an informed choice, one needs to know what the possibilities are.

✓ **DISCUSS AVAILABLE METHODS AND THEIR ADVANTAGES AND DISADVANTAGES**

✓ **ENCOURAGE QUESTIONS**

EFFECTIVENESS

The relative effectiveness of respective methods may be of primary concern to clients, especially if getting pregnant is of major concern. This needs to be explained to clients in a way that is understandable. See Job Aid 8, which shows that long acting reversible provider dependent methods are more reliable than shorter acting, client-dependent methods.

RETURN TO FERTILITY

This may be a factor to take into account, so it is important for clients to understand how long after they stop using the method, fertility (the ability to get pregnant) returns.

PERMANENT OR REVERSIBLE

This involves a discussion and careful counselling concerning their future desire to get pregnant.

SIDE EFFECTS

Side effects are tolerated by women differently, and contraceptive users need to weigh this up for themselves. Some women are happy to put up with side effects as the benefits outweigh the disadvantages.

METHOD SPECIFIC FACTORS

Indications, advantages/non-contraceptive benefits, the way the method is administered and removed (injection, insertion in the arm, vaginal insertion into the uterus, etc.) may influence a client's decision.

CLIENT OR PROVIDER DEPENDENT

Some clients prefer to have control over their methods to start and stop, other prefer the fact that they do not have to remember to do anything for the method to be effective (e.g. LARCs).

Job Aid 3 / RULING OUT PREGNANCY: PREGNANCY CHECKLIST AND PREGNANCY TESTS

Ruling out pregnancy is recommended before starting a hormonal contraceptive and before IUD insertion. There are three useful tools available for this routine task:

- ✓ MEDICAL HISTORY (OFTEN COLLECTED USING THE PREGNANCY CHECKLIST)
- ✓ PREGNANCY TESTS
- ✓ DELAYING THE START OF THE METHOD UNTIL THE CLIENT'S NEXT MONTHLY BLEEDING

HOW AND WHEN TO USE THE PREGNANCY CHECKLIST AND PREGNANCY TESTS

CLIENT WITH AMENORRHOEA (postpartum or other type)

Implants, pills, ring, injectables, or patch

USE PREGNANCY CHECKLIST[1]

Pregnancy ruled out: PROVIDE METHOD

Pregnancy NOT ruled out: USE PREGNANCY TEST

- Pregnancy test is negative (or test is not immediately available): Provie the method now.[2] Schedule a follow-up pregancy test in 3-4 weeks.
- Pregancy test is negative (or test is not immediately available): Advise woman to use COCs, DMPA, or condoms or abstain for 3-4 weeks, then repeat pregnancy test. Second pregnancy test is negative: Provide the IUD.

IUDs Copper or LNG

USE PREGNANCY CHECKLIST[1]

Pregnancy ruled out: PROVIDE METHOD

Pregnancy NOT ruled out: PROVIDE THE METHOD NOW.[2] Return for a pregnancy test if next menses are delayed.

CLIENT BETWEEN TWO REGULAR MENSES (monthly bleeding)

Implants, pills, ring, injectables, or patch

USE PREGNANCY CHECKLIST[1]

Pregnancy ruled out: PROVIDE METHOD

Do not use a pregnancy test (in most cases it is too earlt for the test to be effective)

Pregnancy not ruled out: DO NOT PROVIDE METHOD. Advise woman to return for LNG-IUD insertion within 7 days of onset of her next menses, or within 12 days for a copper IUD; but in the meantime, use COCs, DMPA, or condoms or abstain. Return for a pregnancy test if next menses are delayed.

IUDs Copper or LNG

[1] Pregnancy Checklist on following page

[2] For implants, counsel about the need to remove the implant if pregnancy is confirmed and the woman wishes to continue the pregnancy

[*] If the client presents with a late/missed menses, use a pregnancy test to rule out pregnancy. If using a highly sensitive pregnancy test (for example, 25 mIU/ml) and it is negative, provide her desired method. If using a test with lower sensitivity (for example, 50 mIU/ml) and it is negative during the time of her missed period, wait until at least 10 days after expected date of menses and repeat the test. Advise the woman to use condoms or abstain in the meantime. If the test is still negative, provide desired method. If test sensitivity is not specified, assume lower sensitivity.

In cases where pregnancy cannot be ruled out, offer emergency contraception if the woman had unprotected sex within the last 5 days.
Counsel all women to come back any time they have a reason to suspect pregnancy (for example, if a woman misses a period).

PREGNANCY CHECKLIST

NO	Ask the client questions 1–6. As soon as the client answes "yes" to ANY question, stop and follow the instructions below.	YES
	1 Did your last monthly bleeding start within the past 7 days?*	
	2 Have you abstained from sexual intercourse since your last monthly bleeding, delivery, abortion, or miscarriage?	
	3 Have you been using a reliable contraceptive method consistently and correctly since your last monthly bleeding, delivery, abortion, or miscarriage?	
	4 Have you had a baby in the last 4 weeks?	
	5 Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no monthly bleeding since then?	
	6 Have you had a miscarriage or abortion in the last 7 days?*	

* If the client is planning to use a copper-bearing IUD, the 7-day window is expanded to 12 days

If the client answered NO to all of the questions, pregnancy cannot be ruled out using the checklist. Rule out pregnancy by other means.

If the client answered YES to at least one of the questions, you can be reasonably sure she is not pregnant.

NOTE ON

Job Aid 3 / RULING OUT PREGNANCY: PREGNANCY CHECKLIST AND PREGNANCY TESTS

- ✓ Unless the client has missed her monthly bleeding, ruling out pregnancy starts with the Pregnancy Checklist. This checklist can provide reasonable certainty that a woman is not pregnant.
- ✓ Pregnancy tests are not likely to work before the first day of missed monthly bleeding. Using a test earlier is pointless and wasteful.
- ✓ The only contraceptive method known to pose a health risk if started during pregnancy is the IUD (either copper or hormonal). If the Pregnancy Checklist cannot rule out pregnancy, a provider should use another tool to rule out pregnancy before inserting an IUD.
- ✓ All hormonal methods, except the LNG-IUD, can be provided without delay even when uncertainty about pregnancy exists.
- ✓ Follow-up is required in some cases (see How and when to use the pregnancy checklist and pregnancy tests box above).
- ✓ Delaying the start of the method is the worst choice among the 3 tools for assessing pregnancy. She may become pregnant before her next monthly bleeding. The other tools should be used first whenever possible.
- ✓ Both the Pregnancy Checklist and a pregnancy test are highly accurate for ruling out pregnancy when used appropriately. When the checklist can be used, there is no reason to prefer a test.

Job Aid 4 / COMPREHENSIVE HISTORY-TAKING CHECKLIST FOR CONTRACEPTIVE SERVICES

Adapt the questions in this checklist appropriately for male and female clients and according to each client's needs.

PERSONAL DETAILS

- ☐ How old are you?
- ☐ Do you have children?

REPRODUCTIVE GOALS

- ☐ Are you planning to get pregnant?
  - ☐ **IF YES:** When?
  - ☐ **IF NO:** Are you using a contraceptive method?

CONTRACEPTIVE HISTORY

- ☐ Have you used contraception before?
  - ☐ **IF YES:** Which method(s) have you used?
    Did you have any side effects?
    How long did you use it/them for?
    Why did you stop using it/them?

HIV

- ☐ Have you been tested for HIV?
  - ☐ **IF YES, AND HIV-NEGATIVE:**
    When were you last tested? Would you consider re-testing?
  - ☐ **IF YES, AND HIV-POSITIVE:**
    Ask ART-related questions as per national HIV management guidelines
- ☐ Do you know your partner's HIV status?
- ☐ HIV prevention? Condom use? PrEP?

OBSTETIC HISTORY

- ☐ How many pregnancies have you had? How many births have you had?
- ☐ When was your last pregnancy? Are you currently breastfeeding?
- ☐ How many living children do you have?
- ☐ Did you have any health problems during pregnancy, labour or after childbirth?
- ☐ Have you had any miscarriages?
  - ☐ **IF YES:** How many?
    At what stage of pregnancy did you miscarry?
    Were there known causes?
- ☐ Have you had a termination of pregnancy?
  - ☐ **IF YES:** Why? At what stage of pregnancy?

MENSTRUAL HISTORY

- [ ] Are your periods regular?
- [ ] On average, how many days are there between the first day of one period and the first day of the next one?
- [ ] Are your periods heavy? Are your periods painful?
- [ ] How many days of bleeding do you have?
- [ ] When was your last period?

GYNAECOLOGICAL HISTORY

- [ ] Have you experienced any abnormal vaginal bleeding (i.e. bleeding between periods and/or after sexual intercourse)?
- [ ] Have you had/do you have an abnormal vaginal discharge/pelvic infection?
- [ ] Have you ever had a pregnancy outside of the womb (ectopic pregnancy)?
- [ ] Have you had/do you have pain during sexual intercourse (i.e. dyspareunia)?
- [ ] Have you had a pap smear? When?
    - [ ] **IF YES:** What was the result?

BASIC MEDICAL HISTORY

- [ ] Have you ever had any serious illnesses or operations?
- [ ] Do you suffer from any diseases (such as diabetes, heart disease, serious liver disease, cancer, blood clots in your legs, anaemia, hypertension, tuberculosis, or epilepsy)?
- [ ] Are you taking any medicines at the moment?
    - [ ] **IF YES:** Which ones?
- [ ] Are you allergic to any medicines or anything else that you know of?
    - [ ] **IF YES:** Which ones?
- [ ] Do any close members of the family suffer from any serious illnesses?
  Ask specifically about early heart attack, stroke, hypertension, diabetes, and breast cancer.

Job Aid 5/ ROUTINE SCREENING

What examinations or tests should be done routinely before providing contraception?

While various types of examination, tests, and screening procedures may be desirable for optimal SRHR care, time and resources do not always allow for them.

Various examination and screening procedures for different contraceptive methods are shown in the table below, classified according to three criteria.

CLASS A	Essential and mandatory in all circumstances for safe and effective use of the contraceptive method.
CLASS B	Contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context. The risk of not performing an examination or test should be balanced against the benefits of making the contraceptive method available.
CLASS C	Does not contribute substantially to the safe and effective use of the contraceptive method.

This classification system applies only to the safe initiation of a contraceptive method. It is not meant to address the appropriateness of these examinations or tests in other circumstances, such as in the provision of preventive health care services or integrated SRHR services, or for diagnosing and assessing suspected medical conditions.

A classification system for examinations and screening procedures to assist in decision-making

	COMBINED ORAL CONTRACEPTIVE	COMBINED INJECTABLE CONTRACEPTIVE	PROGESTOGEN-ONLY INJECTABLES	IMPLANTS	Cu IUDs AND LNG-IUD	CONDOMS	FEMALE STERILISATION	VASECTOMY
BREAST EXAM	C	C	C	C	C	C	C	N/A
PELVIC OR GENITAL EXAM	C	C	C	C	A	C	A	A
CERVICAL CANCER SCREENING	C	C	C	C	C	C	C	N/A
ROUTINE LAB TEST	C	C	C	C	C	C	C	C
HAEMOGLOBIN TEST	C	C	C	C	B	C	B	B
STI RISK ASSESSMENT	C	C	C	C	A*	C	C	C
STI AND HIV LABORATORY TESTS	C	C	C	C	B*	C	C	C
BLOOD PRESSURE SCREENING	‡	‡	‡	‡	C	C	A	C§

* If a woman has a very high individual likelihood of exposure to STIs, she should generally not have a Cu IUD inserted unless other methods are not available or not acceptable. If she has current purulent cervicitis, gonorrhoea, or chlamydial infection, then she should not have a Cu IUD inserted until these conditions are resolved and she is otherwise medically eligible. Women who request IUD insertion and are at risk of exposure to STI/HIV infection should be counselled about the need for additional correct and consistent use of condoms. These guidelines also recommend the use of prophylactic antibiotics to cover women who may already have asymptomatic infections.

‡ It is desirable to have blood pressure measurements taken before initiation of combined oral contraceptive pills, combined injectable contraceptives, progestogen-only pills, progestogen-only injectables, and implants. However, in some settings, blood pressure measurements are unavailable. In many of these settings, pregnancy morbidity and mortality risks are high, and hormonal methods are among the few methods widely available. In such settings, women should not be denied the use of hormonal methods simply because their blood pressure cannot be measured.

§ For procedures performed using local anaesthesia.

Job Aid 6/ INTEGRATED ROUTINE SCREENING

For many women, contraceptive services are the entry point to other aspects of health care. Contraceptive services provide an opportunity for HIV, STI, TB, and gender-based violence screening.

A comprehensive screening package should include the following (as appropriate for the level of care and the qualifications of the health care provider, and according to the guidelines recommended by their respective policies, pregnancy test or pregnancy screening (see Job Aid 3)).

☐ MEASUREMENT OF BLOOD PRESSURE AND WEIGHT

☐ HIV TEST

All clients requesting contraceptive services should be encouraged to be tested for HIV or re-tested depending on the likelihood of exposure after the last test and initiated onto ART as per national HIV guidelines. Where possible this should be integrated into the package of care.

☐ TB TEST

TB screening should be done according to national guidelines and managed or referred, according to levels of care and provincial/local protocols.

☐ URINE, BLOOD, STI TESTS

Specific tests, such as urine, blood, and STI screening tests, should be done as indicated (for example if diabetes mellitus, anaemia, and/or genital infection is suspected).

☐ CERVICAL SMEAR TESTS

Cervical smear tests should be conducted to detect pre-malignant lesions and early cancer of the cervix should be performed in line with national guidelines and local protocols for screening, or if specifically indicated. For example, if the client has post-coital bleeding, genital warts, previous atypia, and/or a suspicious lesion is seen on the cervix. Current guidelines make provision for the following:

- Cervical cancer screening for all HIV-negative, asymptomatic women over the age of 30 at 10-year intervals (until age 50, three screenings, one every 10 years)
- All HIV-positive women screened for cervical cancer at diagnosis and subsequently every three years if the screening test is negative, and at annual intervals if the screening test is positive for the disease.

☐ BREAST EXAMINATION

A breast examination should be conducted to detect breast masses should be done, combined with the illustration and encouragement of breast self-examination.

Job Aid 7 / RISK ASSESSMENT, COMBINATION PREVENTION, AND SRHR/HIV INTEGRATION

A risk assessment is a focused discussion with clients concerning aspects of their lives that may make them more vulnerable and susceptible to unwanted pregnancy, HIV, STI, sexual and/or physical violence, abuse, exploitation, and other medical or psychosocial problems. The questions below provide a loose framework for the kind of issues to explore. The questions are given in no particular order and might be asked whenever the opportunity arises during the consultation. The aim is to discuss and explore the issues, rather than follow a formal questionnaire.

- Explain why you would like to discuss some personal issues and ask permission to do so.
- Ensure that you use sexual terms that the client understands. Get to know the terms that are used by clients in your area.
- Ask questions relevant to the person's health requirements and circumstances.
- Be non-judgmental and empathetic – this is pivotal to a successful discussion.
- Do not make assumptions:
    - clients may have more than one sexual partner
    - clients may identify as male, female, X (non-binary), or transgender
    - clients may have vaginal or anal sex

Risk discussion: Issues to explore

HIV

- ☐ Are you worried about HIV?
- ☐ Do you know your HIV status?
- ☐ If HIV-positive: Are you on ART?
- ☐ If HIV-negative: When were you last tested? Any possible exposure since your last HIV test? Would you consider a re-test?
- ☐ Do you know the HIV status of your sexual partner?

STIs

- ☐ Have you or your partner had an STI in the past six months?
- ☐ Were you tested?
- ☐ Was your partner treated?

Lifestyle factors that may influence health/increase risk

- ☐ Ask client about drug and alcohol use in the past year, including use of recreational drugs or use of prescription medication for nonmedical reasons?
- ☐ Explore drug and alcohol use of both client and partner, in applicable

Emotional Health

- ☐ How is your relationship with your sexual partner/s?
- ☐ Ask the client if they are comfortable with questions on Gender-based and intimate partner violence. If yes, ask the client if they've experienced sexual or physical violence inside/outside their home.

Other HIV prevention options - information, provision and adherence, as appropriate

- [ ] PEP?
- [ ] PrEP?
- [ ] Condom use - male or female? Consistent and correct use? Regularly? Occassionally?

Cervical and Breast cancer screening

- [ ] Assess the client for risk of cervical and breast cancer by asking:
  - [ ] Do you perform a self-breast exam regularly?
  - [ ] Have you noticed any changes in your breasts?
  - [ ] Have you experienced any abnormal vaginal bleeding?
  - [ ] Have you ever had a PAP smear?
  - [ ] Do you have a family history of cancer?

TB

- [ ] Assess client for the following symptoms:
  - [ ] Cough of 2 weeks or more, which is not improving on treatment
  - [ ] Persistent fever of more than two weeks
  - [ ] Unexplained weight loss >1.5kg in a month
  - [ ] Drenching night sweats

Job Aid 8/ COMPARING CONTRACEPTIVE EFFECTIVENESS

Contraceptive effectiveness is an important aspect that influences choice. Method selection needs to incorporate effectiveness combined with medical eligibility and the client's preferences, including, for example, side effects, mode of delivery (how it is used, inserted, or provided), whether it is provider or client dependent, and return to fertility.

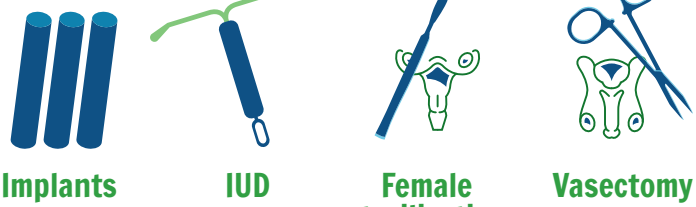
The following table shows contraceptive effectiveness in terms of the percentage of women who experience an unintended pregnancy during the first year of typical use and perfect use. This table is useful for healthcare provider training and information.

The following figure is a simplified chart which can be useful for clients to see the relative effectiveness of methods. It categorises methods according to their effectiveness as commonly used, and how the user can maximise on effectiveness through correct use.

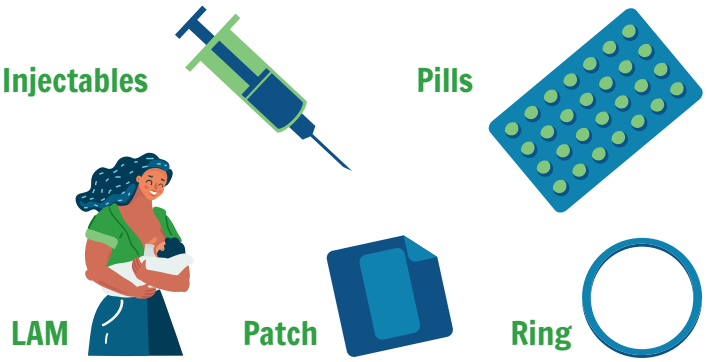
COMPARING EFFECTIVENESS OF FAMILY PLANNING METHODS

MORE EFFECTIVE

Less than 1 pregnancy per 100 women in one year



Implants | IUD | Female sterilization | Vasectomy



Injectables | Pills | LAM | Patch | Ring

Male condoms | Diaphragm | Fertility awareness methods

Female condoms | Withdrawal | Spermicides

LESS EFFECTIVE

About 20 pregnancies per 100 women in one year

HOW TO MAKE YOUR METHOD MORE EFFECTIVE

Implants, IUD, female sterilization
After procedure, little or nothing to do or remember

Vasectomy
Use another methods for first 3 months

Injectables
Get repeat injections on time

Lactational Amenorrhea Method (for 6 months)
Breastfeed often, day and night

Pills
Take a pill each day

Patch, ring
Keep in place, change on time

Male condoms, diaphragm
Use correctly every time you have sex

Fertility awareness methods
Abstain or use condoms on fertile days. Newer methods (Standard Days Methods and Two Day Method) may be easier to use

Female condoms, withdrawal, spermicides
Use correctly every time you have sex

Some points to note when explaining effectiveness using the job aid above[6]:

- In general, methods that require little or no action by clients are the most effective. The four most effective methods – implants, IUDs, female sterilization, and vasectomy —are shown in the top row of the chart. All four methods need a health care provider's help to get started, but then they need little or no action by the user. These methods are very effective for everyone who uses them — less than one pregnancy in 100 women in 1 year of use. Moreover, implants and IUDs are highly effective for three to five years or more, and female sterilization and vasectomy are permanent.

- Methods in the second row can be highly effective when used correctly and consistently. They require some repeated action by the user. Some are seldom, such as getting four injections a year, and some are more often, such as taking a pill every day, 365 days a year. As a result, they are less effective, on average, than methods in the top row, but still effective. Pregnancy rates for these methods range from two to seven pregnancies in 100 women in a year.

- The methods in the lower rows of the chart usually have much higher pregnancy rates — as high as 20 or more pregnancies in 100 women in 1 year of use for the least effective methods. The effectiveness of these methods depends greatly on the user taking correct action repeatedly, such as using a condom with every act of sexual intercourse. Particularly for these methods, some highly motivated couples are much more successful than average. Others make more mistakes and are more likely than average to get pregnant.

- Women tend to underestimate the effectiveness of the methods on the upper rows of the chart and overestimate the effectiveness of the methods on the lower rows. This may lead them to make misinformed decisions and to choose a contraceptive method that does not meet their needs.

Percentage of women experiencing an unintended pregnancy during the first year of typical use and the first year of perfect use of contraception, and the percentage continuing use at the end of the first year, United States.[7]

Method (1)	Typical use[a] (2)	Perfect use[b] (3)	% of women continuing use at one year[c] (4)
Male sterilization	0.15	0.10	100
Female sterilization	0.5	0.5	100
Implanon©	0.05	0.05	84
Intrauterine contraceptives			
Mirena©	0.2	0.2	80
ParaGard (copper T) ©	0.8	0.6	78
Depo-Provera	6	0.2	56
NuvaRing©	9	0.3	67
Evra patch	9	0.3	67
Combined pill and progestin-only pill	9	0.3	67
Diaphragm[d]	12	6	57
Condom[e]			
Male	18	2	43
Female	21	5	41

MOST EFFECTIVE
HIGHEST CONTINUATION

Sponge			36
Nulliparous women	12	9	
Parous women	24	20	
Withdrawal	22	4	46
Fertility awareness-based methods	24		47
Sympto-thermal method	-	0.4	-
Ovulation Method[f]		3	
TwoDay Method©[f]		4	
Standard Days Method©[f]		5	
Spermicides[g]	28	18	42
No method[h]	85	85	

Emergency contraceptives: Emergency contraceptive pills or insertion of a copper intrauterine contraceptive after unprotected intercourse substantially reduces the risk of pregnancy.

Lactational amenorrhoea method: LAM is a highly effective, temporary method of contraception.[i]

[a] Among typical couples who initiate use of a method (not necessarily for the first time), the percentage who experience an accidental pregnancy during the first year if they do not stop use for any other reason. Estimates of the probability of pregnancy during the first year of typical use for spermicides and the diaphragm are taken from the 1995 National Survey of Family Growth corrected for underreporting of abortion; estimates for fertility awareness-based methods, withdrawal, the male condom, the pill, and Depo-Provera are taken from the 1995 and 2002 National Survey of Family Growth corrected for underreporting abortion.

[b] Among couples who initiate use of a method (not necessarily for the first time) and who use it perfectly (both consistently and correctly), the percentage who experience an accidental pregnancy during the first year if they do not stop use for any other reason.

[c] Among couples attempting to avoid pregnancy, the percentage who continue to use a method for one year.

[d] With spermicidal cream or jelly.

[e] Without spermicides.

[f] The Ovulation Method and Two Day Method© are based on evaluation of cervical mucus. The Standard Days Method© avoids intercourse on cycle days 8-19. The symptom-thermal method is a double-check method based on the evaluation of cervical mucus to determine the first fertile day and evaluation of cervical mucus and temperature to determine the last fertile day.

[g] Foams, creams, gels, vaginal suppositories, and vaginal film.

[h] The percentages becoming pregnant in columns 2 and 3 are based on data from populations where contraception is not used and from women who cease using contraception to become pregnant. Among such populations, about 89% become pregnant within one year. This estimate was lowered slightly (to 85%) to represent the percentage who would become pregnant within one year among women now relying on reversible methods of contraception if they abandoned contraception altogether.

[i] However, to maintain effective protection against pregnancy, another method of contraception must be used as soon as menstruation resumes, the frequency or duration of breastfeeds is reduced, bottle feeds are introduced, or the baby reaches six months of age.

Adapted from Trussell, 2011.

Job Aid 9 / DRUG-DRUG INTERACTIONS

	COC/P/ CVR	CIC	POP	DMPA/ NET-EN	LNG/ETG/ IMPLANTS	CU IUD		LNG-IUD	
						I	C	I	C
ANTIRETROVIRAL THERAPY (ART)									
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)									
Abacavir (ABC)	1	1	1	1	1	2/3[a]	2[a]	2/3[a]	2[a]
Tenofovir (TDF)	1	1	1	1	1	2/3[a]	2[a]	2/3[a]	2[a]
Zidovudine (AZT)	1	1	1	1	1	2/3[a]	2[a]	2/3[a]	2[a]
Lamivudine (3TC)	1	1	1	1	1	2/3[a]	2[a]	2/3[a]	2[a]
Didanosine (DDI)	1	1	1	1	1	2/3[a]	2[a]	2/3[a]	2[a]
Emtricitabine (FTC)	1	1	1	1	1	2/3[a]	2[a]	2/3[a]	2[a]
Stavudine (D4T)	1	1	1	1	1	2/3[a]	2[a]	2/3[a]	2[a]
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIs)									
Efavirenz (EFV)	2[b]	2[b]	2[b]	DMPA=1, NET-EN=2[b]	2[b]	2/3[a]	2[a]	2/3[a]	2[a]
Etravirine (ETR)	1	1	1	1	1	2/3[a]	2[a]	2/3[a]	2[a]
Nevirapine (NVP)	2[b]	2[b]	2[b]	DMPA=1, NET-EN=2[b]	2[b]	2/3[a]	2[a]	2/3[a]	2[a]
Rilpirivine (RPV)	1	1	1	1	1	2/3[a]	2[a]	2/3[a]	2[a]
PROTEASE INHIBITORS (PIs)									
Ritonavir-boosted atazanavir (ATV/r)	2[b]	2[b]	2[b]	DMPA=1, NET-EN=2[b]	2[b]	2/3[a]	2[a]	2/3[a]	2[a]
Ritonavir-boosted lopinavir (LPV/r)	2[b]	2[b]	2[b]	DMPA=1, NET-EN=2[b]	2[b]	2/3[a]	2[a]	2/3[a]	2[a]
Ritonavir-boosted darunavir (DRV/r)	2[b]	2[b]	2[b]	DMPA=1, NET-EN=2[b]	2[b]	2/3[a]	2[a]	2/3[a]	2[a]
Ritonavir (RTV)	2[b]	2[b]	2[b]	DMPA=1, NET-EN=2[b]	2[b]	2/3[a]	2[a]	2/3[a]	2[a]
INTEGRASE INHIBITORS									
Raltegravir (RAL)	1	1	1	1	1	2/3[a]	2[a]	2/3[a]	2[a]

	COC/P/ CVR	CIC	POP	DMPA/ NET-EN	LNG/ ETG/ IM-PLANTS	CU IUD	LNG-IUD
ANTICONVULSANT THERAPY							
Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	3[b]	2	3[b]	DMPA=1, NET-EN=2[b]	2[b]	1	1
Lamotrigine	3[b]	3	1	1	1	1	1
ANTIMICROBIAL THERAPY							
Broad-spectrum antibiotics	1	1	1	1	1	1	1
Antifungals	1	1	1	1	1	1	1
Antiparasitics	1	1	1	1	1	1	1
Rifampicin or rifabutin therapy	3[b]	2[b]	3[b]	DMPA=1, NET-EN=2[b]	2[b]	1	1

Footnote (a)
There is no known interaction between ART and IUD use. However, severe or advanced HIV clinical disease (WHO stage 3 or 4) as a condition is classified as MEC Category 3 for initiation and Category 2 for continuation.
Asymptomatic or mild HIV clinical disease (WHO stage 1 or 2) is classified as Category 2 for both initiation and continuation.

Footnote (b)
The interaction of enzyme-inducing drugs (EIDs) and strong enzyme-inducing drugs (SEIDs) with some ARVs (particularly NNRTIs and ritonavir-boosted PIs) as well as certain anticonvulsants and TB therapy (rifampicin or rifabutin) with CHCs, POPs, NET-EN and LNG/ETG implants, is likely to variably reduce the blood levels of steroid. Whilst this is not harmful to women, these interactions may reduce the effectiveness of the hormonal contraceptive.

Use of other contraceptives, not affected by DDIs should be encouraged for women who are long-term users of any of these drugs.
Use of DMPA is Category 1 because its effectiveness is not decreased by the use of EIDs or SEIDs

A woman should not be denied use of the contraceptive method of her choice (i.e., particularly implants) if after thorough counselling about drug interactions and the possibility of reduced effectiveness she chooses. Counselling should include information about more effective contraceptive options (i.e. Cu or LNG-IUD, DMPA or sterilisation) and the benefits of additional correct and consistent condom use to minimize unintended pregnancy.

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ADVERSE DRUG REACTION (ADR)/ PRODUCT QUALITY PROBLEM REPORT FORM (PUBLIC AND PRIVATE SECTOR)

(Including Herbal Products)

mcc MEDICINES CONTROL COUNCIL

Reports will be shared with the Pharmacovigilance Centre for Public Health Programmes (PCPHP) - 0123959506

Reporting Health Care Facility/Practice					
Tel: 012 395 8197 (MCC) 021 447 1618 (NADEMC) **Fax:** 086 620 7253 **E-mail:** adr@health.gov.za	Facility/Practice				
	District		Tel		
	Province		Fax		

Patient Details									
Patient Initials		File/Reference Number				Date of Birth/Age			
Sex	☐ M ☐ F ☐ Unk	Race		Weight (kg)		Height (cm)		Pregnant?	☐ N ☐ Y
Allergies				Estimated Gestational Age at time of reaction					

Suspect Medicine(s) [Medicines suspected to have caused the ADR]

Trade Name [Generic Name if Trade Name is unknown]	Route	Dose (mg) and Interval	Date Started/Given	Date Stopped	Reason for use	Batch Number	Expiry Date

All other Medicines Patient was taking at time of reaction [Including over-the-counter and herbal products]

Trade Name [Generic Name if Trade Name is unknown]	Route	Dose (mg) and Interval	Date Started/Given	Date Stopped	Reason for use	Batch Number	Expiry Date

Adverse Drug Reaction/Product Quality Problem			
Date and time of onset of reaction		Date reaction resolved/duration	

Please describe Adverse Reaction/Product Quality Problem: (kindly add as much clinical information as possible)

Intervention(tick all that apply)	**Patient Outcomes (tick all that apply)**
☐ No intervention	☐ ADR recovered/resolved ☐ recovering/resolving
☐ Intervention unknown	☐ not recovered/not resolved
☐ Patient Counselled/non-medical treatment	☐ Patient Died: Date of death:_____
☐ Discontinued Suspect Drug; **Replaced with:**_____	☐ Impairment/Disability ☐ Congenital Anomaly
☐ Decreased Suspect Drug Dosage; **New Dose:**_____	☐ Patient Hospitalised or Hospitalisation prolonged
☐ Treated ADR - with:_____	☐ Life Threatening ☐ Other:_____
☐ Referred to Hospital: **Hospital Name**_____	☐ ADR reappeared after restarting suspect drug/similar drug (rechallenge)?: ☐ N ☐ Y ☐ Not done ☐ Unknown
☐ Other Intervention (e.g. dialysis): _____	

Laboratory Results			**Additional Laboratory Results**		
Lab Test	**Test Result**	**Test Date**	**Lab Test**	**Test Result**	**Test Date**

Co-morbidities/Other Medical Condition(s)

Reported by			
Name		E-mail	
Designation	☐ Nurse ☐ Pharmacist ☐ Doctor ☐ Other:	Telephone	
Date reported:		Signature	

THIS ADR REPORT IS NOT A CONFIRMATION THAT THE REPORTER OR THE SUSPECT MEDICINE(S) CAUSED THE ADR **v4.0 07/16**

Job Aid 11 / CONTRACEPTIVE METHOD CONSIDERATIONS FOR CLIENTS WITH HIV INCLUDING THOSE ON ART: A PROVIDER REFERENCE TOOL

Contraceptive Method Considerations for Clients with HIV Including Those on ART: Provider Reference Tool

HIV-related* Treatments or Conditions →	Antiretroviral Therapy (ART)					Rifampicin or rifabutin	HIV Disease Stage I or II	HIV Disease Stage III or IV		Increased Risk of STIs		Current purulent cervicitis (women only), gonorrhea or chlamydia infection	
	NRTIs	NNRTIs		Ritonavir or Ritonavir-boosted PIs	Integrase Inhibitors								
Contraceptive Methods* ↓	ABC, TDF, AZT, 3TC, DDI, FTC, D4T	ETR, RPV	EFV, NVP	RTV, ATV/r, LPV/r, DRV/r	RAL, DTG		asymptomatic or mild clinical disease	severe or advanced clinical disease		excluding HIV infection			
DMPA (3-month injectable)													
Implants													
NET-EN (2-month injectable)													
Progestin-only oral contraceptives													
Combined oral contraceptives													
Combined injectables (1 month)													
Combined patch or ring													
Copper IUD [a,b]								I	C	I	C	I	C
Hormonal IUD (LNG IUD or LNG-IUS) [a,b]								I	C	I	C	I	C
Tubal ligation [b]							A	S		A		D	
Vasectomy [b]							A	S				D†	
Emergency contraceptive pills (ECPs) [c]													

* For other eligibility conditions and contraceptive methods see: *Medical Eligibility Criteria (MEC) for Contraceptive Use, 5th edition.* Geneva: World Health Organization, 2015. Available: http://www.who.int/reproductivehealth/publications/family_planning/en/index.html

- Category 1 — No restrictions for use.
- Category 2 — Generally use; some follow-up may be needed.
- Category 3 — Usually not recommended unless other more appropriate methods are not available or acceptable.
- Category 4 — The method should not be used.
- No restrictions (although not formally classified by WHO).

a If a woman is not clinically well on ART, an IUD should not be inserted until health improves (Category 3).

b See the MEC for additional clarification.

c Strong liver enzyme inducers (rifampicin, efavirenz) may reduce the effectiveness of ECPs.

I or C Initiation or Continuation: Eligibility category may vary depending on whether a woman is initiating or continuing to use a method. Where I or C is not marked, the category is the same for initiation and continuation.

Category 3 if risky behaviors are present; otherwise, Category 2 (STI prevalence or young age alone are not reasons to deny an IUD).

A Accept: no medical reason to deny the sterilization procedure.

S Special: the procedure should be undertaken in a setting with an experienced surgeon and staff and other medical support.

D Delay: the procedure is delayed until the condition is evaluated and/or corrected.

† Men seeking a vasectomy should also delay if they have other active STIs, a scrotal skin infection, balanaitis, epididymitis, or orchitis.

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Information for Providers on HC/ARV Interaction[1]

Concurrent use of hormonal contraceptives (HCs) and antiretroviral drugs (ARVs) can lead to interactions that affect how the liver metabolizes the drugs. This, in turn, can lead to reduced effectiveness of some hormonal methods. Drugs used for treatment of tuberculosis (TB) interact with HCs in a similar way, reducing effectiveness of some HCs (see chart). When TB and ARV drugs are taken together, it is possible that HC effectiveness will be reduced even more than by ARV or TB treatment alone. ARV effectiveness or toxicity seems unaffected by concurrent use of HC.

How do ARVs affect COC effectiveness?

- Commonly used non-nucleoside reverse transcriptase inhibitors (NNRTIs), particularly efavirenz, may reduce the contraceptive effectiveness of combined oral contraceptives (COCs). In studies, pregnancy rates were somewhat higher among COC users taking an efavirenz-containing ARV regimen (11–15%), compared with COC users on a nevirapine-containing ARV regimen (6–11%). This constitutes a slight increase when compared to a typical COC pregnancy rate of 7–8%.
- Protease inhibitors (PIs) and nucleoside reverse transcriptase inhibitors (NRTIs) do not reduce COC effectiveness. Studies show that ovulation remains consistently suppressed in COC users who take PIs, NRTIs, or integrase inhibitors.

How do ARVs affect contraceptive implant effectiveness?

- Concurrent use of contraceptive implants and NNRTIs may reduce implant effectiveness. In studies, pregnancy rates among implant users who take NNRTIs ranged from 5.5 to 15% and were higher among levonorgestrel implant users (two-rod implants) who take efavirenz (7.1–15%) compared to etonogestrel implant users (one-rod implants) on efavirenz (0–5.5%).
- Pregnancy rates are not affected in implant users on either NRTIs or PIs. There is no evidence that contraceptive effectiveness of implants is affected by integrase inhibitors.

How do ARVs affect DMPA effectiveness?

- Effectiveness of the injectable depot medroxyprogesterone acetate (DMPA) is not reduced by ARVs.
- Studies of DMPA users who take NNRTIs found that pregnancy rates were comparable or even lower than pregnancy rates in DMPA users who are not on ARV therapy. This was true for users of both efavirenz and nevirapine.
- While there are no data for injectable norethisterone enanthate (NET-EN), it is possible that its effectiveness could be affected by ARVs, so some caution is warranted.
- No ovulations or pregnancies were reported in DMPA users taking PIs or NRTIs; no evidence that contraceptive effectiveness of DMPA is affected by integrase inhibitors.

While the evidence is limited, it is unlikely that the effectiveness of the hormonal intrauterine device (LNG IUD) is reduced by drug interaction with ARVs.

How does HC/ARV interaction affect contraceptive use and counseling?

Available evidence does not support limiting access to any hormonal contraceptive method for women on antiretroviral therapy (ART). Efficacy is only one of many factors that a woman may consider when choosing a contraceptive method. Client-centered counseling, that addresses the specific health and social needs of clients living with HIV, is essential to helping women on ART make an informed decision about a contraceptive method and then use it effectively. When counseling women on ART about contraception, providers should:

- Ensure that every woman has the opportunity to make voluntary, informed decisions about whether and when she becomes pregnant or whether to use contraception and which method to use. Do not restrict the use of any contraceptive method, unless medically contraindicated by the WHO *Medical Eligibility Criteria*.
- Emphasize the importance of using condoms in addition to a hormonal method (dual method use). This maximizes prevention of pregnancy and STIs/HIV. When used consistently and correctly, condoms offer protection from pregnancy if a primary contraceptive method (e.g., implants, COCs) fails.
- Promote informed choice by ensuring that family planning counseling for clients with HIV includes discussion of how the effectiveness of hormonal contraceptives may be affected by ARVs and then support a woman's decision.
  - Explain that COCs and contraceptive implants may be less effective in women who use certain ARVs, particularly efavirenz. This is also true for other, less commonly used contraceptives, such as the patch, vaginal ring, combined injectables, progestin-only pills, and NET-EN.
  - Counsel contraceptive pill users about the importance of taking their pill on time. Missing contraceptive pills while on ART may further reduce contraceptive effectiveness.[2]
  - Counsel clients about effective contraceptive methods that do not interact with ARVs, such as DMPA or IUDs (copper or hormonal). For clients who have all of the children they desire, a permanent method, such as female or male sterilization, may be another good option.
  - Discuss the client's ARV regimen. Counsel on dual method use and consider the possibility of switching to another ARV regimen if there is potential for interaction with the desired contraceptive method.
- Discuss the risk of unintended pregnancy. Encourage women to come back without delay if they experience early signs/symptoms of pregnancy, such as breast tenderness, nausea, late menstrual period, weight change, moodiness, or being tired all the time. Most of these signs/symptoms may also be side effects of hormonal contraception so a pregnancy test will be needed to rule out pregnancy.
- Educate about emergency contraceptive pills (ECPs) to be used if unprotected sex occurred in the last 5 days. Give ECPs to have on hand to use in an emergency. Explain that they should be taken within 120 hours after unprotected sex, the sooner the better, and the ECP dose is the same regardless of the ARV regimen.

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[1] For more details on drug interactions: Kavita Nanda, et al., Drug interactions between hormonal contraceptives and antiretrovirals. *AIDS.* 2017; 31: 917–952.

[2] For more information on how to take oral contraceptives: *Selected practice recommendations for contraceptive use, 3rd edition.* Geneva: World Health Organization, 2016.

ANNEXES

Annexe 1 WHO MEC CRITERIA SUMMARY

Extract from: WHO RHR and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), Knowledge for Health Project. Family Planning: A Global Handbook for Providers (2018 update). Baltimore and Geneva: CCP and WHO, 2018.

MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE

The table on the following pages summarizes the World Health Organization Medical Eligibility Criteria for Contraceptive Use. These criteria are the basis for the Medical Eligibility Criteria checklists in most chapters of this handbook on family planning methods. These checklists are based on the 2-level system for providers with limited clinical judgment (see table below). The checklist questions address conditions in MEC categories 3 or 4 that the woman knows of. The boxes "Using Clinical Judgment in Special Cases" list conditions that are in MEC category 3: The method can be provided if other, more appropriate methods are not available or acceptable to the client, and a qualified provider can carefully assess the specific woman's condition and situation.

CATEGORIES FOR TEMPORARY METHODS

Category	With Clinical Judgment	With Limited Clinical Judgment
1	Use method in any circumstances	Yes (Use the method)
2	Generally use method	
3	Use of method not usually recommended unless other more appropriate methods are not available or not acceptable	No (Do not use the method)
4	Method not to be used	

Note: In the table beginning on the next page, category 3 and 4 conditions are shaded to indicate that the method should not be provided where clinical judgment is limited. Categories that are new or changed since the 2011 edition of this handbook are shown in dark type.

CATEGORIES FOR FEMALE STERILIZATION AND VASECTOMY

Accept (A)	There is no medical reason to deny the method to a person with this condition or in this circumstance.
Caution (C)	The method is normally provided in a routine setting, but with extra preparation and precautions.
Delay (D)	Use of the method should be delayed until the condition is evaluated and/or corrected. Alternative, temporary methods of contraception should be provided.
Special (S)	The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anesthesia, and other backup medical support. The capacity to decide on the most appropriate procedure and anesthesia support also is needed. Alternative, temporary methods of contraception should be provided if referral is required or there is otherwise any delay.

= Use the method
= Do not use the method
I = Initiation of the method
C = Continuation of the method
— = Condition not listed; does not affect eligibility for method
NA = Not applicable

Condition	Combined oral contraceptives	Monthly injectables	Combined patch and combined vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device	Levonorgestrel intrauterine device	Female sterilization*
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY										
Pregnant	NA	NA	NA	NA	NA	NA	NA	4	4	D
Age	Menarche to < 40 years			Menarche to < 18 years				Menarche to < 20 years		Young age
	1	1	1	1	2	1	—	2	2	C
	≥ 40 years			18 to 45 years				≥ 20 years		
	2	2	2	1	1	1	—	1	1	
				> 45						
				1	2	1	—			
Parity										
Nulliparous (has not given birth)	1	1	1	1	1	1	—	2	2	A
Parous (has given birth)	1	1	1	1	1	1	—	1	1	A
Breastfeeding										
< 6 weeks postpartum	4	4	4	**2**	3[a]	**2**	1 **UPA=2**	b	**b**	*
≥ 6 weeks to < 6 months postpartum (primarily breastfeeding)	3	3	3	1	1	1	1 **UPA=2**	b	b	A
≥ 6 months postpartum	2	2	2	1	1	1	1 **UPA=2**	b	b	A
Postpartum (not breastfeeding)										
< 21 days	3	3	3	1	1	1	—	b	b	*
With other added VTE risk factors	**4**	**4**	**4**							
21–42 days	2	2	2	1	1	1	—	b	b	
With other added VTE risk factors	**3**	**3**	**3**							
> 42 days	1	1	1	1	1	1	—	1	1	A
Postabortion										
First trimester	1	1	1	1	1	1	—	1	1	*
Second trimester	1	1	1	1	1	1	—	2	2	
Immediate post-septic abortion	1	1	1	1	1	1	—	4	4	

* For additional conditions relating to emergency contraceptive pills and female sterilization, see p. 397. (Continued)

[a] In settings where pregnancy morbidity and mortality risks are high and this method is one of few widely available contraceptives, it may be made accessible to breastfeeding women immediately postpartum.

[b] Postpartum IUD use: For the copper-bearing IUD, insertion at <48 hours is category 1. For the LNG-IUD, insertion at <48 hours is category 2 for breastfeeding women and category 1 for women not breastfeeding. For all women and both IUD types, insertion from 48 hours to < 4 weeks is category 3; ≥ 4 weeks, category 1; and puerperal sepsis, category 4.

= Use the method = Do not use the method I = Initiation of the method C = Continuation of the method — = Condition not listed; does not affect eligibility for method NA = Not applicable **Condition**	Combined oral contraceptives	Monthly injectables	Combined patch and combined vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device	Levonorgestrel intrauterine device	Female sterilization*
Past ectopic pregnancy	I	I	I	2	I	I	I	I	I	A
History of pelvic surgery	I	I	I	I	I	I	—	I	I	C*
Smoking										
Age < 35 years	2	2	2	I	I	I	—	I	I	A
Age ≥ 35 years										
<15 cigarettes/day	3	2	3	I	I	I	—	I	I	A
≥15 cigarettes/day	4	3	4	I	I	I	—	I	I	A
Obesity										
≥ 30 kg/m² body mass index	2	2	2	I	I†	I	I	I	I	C
Blood pressure measurement unavailable	NA[c]	NA[c]	NA[c]	NA[c]	NA[c]	NA[c]	—	NA	NA	NA
CARDIOVASCULAR DISEASE										
Multiple risk factors for arterial cardiovascular disease (older age, smoking, diabetes, and hypertension)	3/4[d]	3/4[d]	3/4[d]	2	3	2	—	I	2	S
Hypertension[e]										
History of hypertension, where blood pressure CANNOT be evaluated (including hypertension in pregnancy)	3	3	3	2[c]	2[c]	2[c]	—	I	2	NA
Adequately controlled hypertension, where blood pressure CAN be evaluated	3	3	3	I	2	I	—	I	I	C
Elevated blood pressure (properly measured)										
Systolic 140–159 or diastolic 90–99	3	3	3	I	2	I	—	I	I	C[f]
Systolic ≥ 160 or diastolic ≥ 100[g]	4	4	4	2	3	2	—	I	2	S[f]

† From menarche to age <18 years, ≥30 kg/m² body mass index is category 2 for DMPA, category 1 for NET-EN.

[c] In settings where pregnancy morbidity and mortality risks are high and this method is one of few widely available contraceptives, women should not be denied access simply because their blood pressure cannot be measured.

[d] When multiple major risk factors exist, any of which alone would substantially increase the risk of cardiovascular disease, use of the method may increase her risk to an unacceptable level. However, a simple addition of categories for multiple risk factors is not intended. For example, a combination of factors assigned a category 2 may not necessarily warrant a higher category.

[e] Assuming no other risk factors for cardiovascular disease exist. A single reading of blood pressure is not sufficient to classify a woman as hypertensive.

[f] Elevated blood pressure should be controlled before the procedure and monitored during the procedure.

= Use the method = Do not use the method I = Initiation of the method C = Continuation of the method — = Condition not listed; does not affect eligibility for method NA = Not applicable **Condition**	Combined oral contraceptives	Monthly injectables	Combined patch and combined vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device	Levonorgestrel intrauterine device	Female sterilization*
Vascular disease	4	4	4	2	3	2	—	1	2	S
History of high blood pressure during pregnancy (where current blood pressure is measurable and normal)	2	2	2	1	1	1	—	1	1	A
Deep venous thrombosis (DVT)/**Pulmonary embolism** (PE)										
History of DVT/PE	4	4	4	2	2	2	*	1	2	A
Acute DVT/PE	4	4	4	3	3	3	*	1	3	D
DVT/PE and on anticoagulant therapy	4	4	4	2	2	2	*	1	2	S
Family history of DVT/PE (first-degree relatives)	2	2	2	1	1	1	*	1	1	A
Major surgery										
With prolonged immobilization	4	4	4	2	2	2	—	1	2	D
Without prolonged immobilization	2	2	2	1	1	1	—	1	1	A
Minor surgery without prolonged immobilization	1	1	1	1	1	1	—	1	1	A
Known thrombogenic mutations (e.g., factor V Leiden, prothrombin mutation; protein S, protein C, and antithrombin deficiencies)[g]	4	4	4	2	2	2	*	1	2	A
Superficial venous disorders										
Varicose veins	1	1	1	1	1	1	—	1	1	A
Superficial venous thrombosis	2	2	2	1	1	1	—	1	1	A
Ischemic heart disease[g]				I C		I C			I C	
Current	4	4	4	2 3	3	2 3	*	1	2 3	D
History of										C
Stroke (history of cerebrovascular accident)[g]	4	4	4	2 3	3	2 3	*	1	2	C
Known dyslipidemias without other known cardiovascular risk factors[h]	2	2	2	2	2	2	—	1	2	A

[g] This condition may make pregnancy an unacceptable health risk. Women should be advised that because of relatively higher pregnancy rates, as commonly used, spermicides, withdrawal, fertility awareness methods, cervical caps, diaphragms, or female or male condoms may not be the most appropriate choice.

[h] Routine screening is not appropriate because of the rarity of the condition and the high cost of screening.

(Continued)

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Condition	Combined oral contraceptives		Monthly injectables		Combined patch and combined vaginal ring		Progestin-only pills		Progestin-only injectables		Implants		Emergency contraceptive pills*	Copper-bearing intrauterine device		Levonorgestrel intrauterine device		Female sterilization*
Valvular heart disease																		
Uncomplicated	2		2		2		1		1		1		—	1		1		C[i]
Complicated [‡,g]	4		4		4		1		1		1		—	2[i]		2[i]		S*
Systemic lupus erythematosus									I	C				I	C			
Positive (or unknown) antiphospholipid antibodies	4		4		4		3		3	3	3		—	1	1	3		S
Severe thrombocytopenia	2		2		2		2		3	2	2		—	3	2	2		S
Immunosuppresive treatment	2		2		2		2		2	2	2		—	2	1	2		S
None of the above	2		2		2		2		2	2	2		—	1	1	2		C
NEUROLOGICAL CONDITIONS																		
Headaches[j]	I	C	I	C	I	C	I	C	I	C	I	C				I	C	
Nonmigrainous (mild or severe)	1	2	1	2	1	2	1	1	1	1	1	1	—	1		1	1	A
Migraine													2					
Without aura	I	C	I	C	I	C	I	C	I	C	I	C				I	C	
Age < 35	2	3	2	3	2	3	1	2	2	2	2	2	—	1		2	2	A
Age ≥ 35	3	4	3	4	3	4	1	2	2	2	2	2	—	1		2	2	A
With aura, at any age	4	4	4	4	4	4	2	3	2	3	2	3	—	1		2	3	A
Epilepsy	I[k]		I[k]		I[k]		I[k]		I[k]		I[k]		—	1				C
DEPRESSIVE DISORDERS																		
Depressive disorders	I[l]		I[l]		I[l]		I[l]		I[l]		I[l]		—	1		I[l]		C
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS																		
Vaginal bleeding patterns																I	C	
Irregular pattern without heavy bleeding	1		1		1		2		2		2		—	1		1	1	A
Heavy or prolonged bleeding (including regular and irregular patterns)	1		1		1		2		2		2		—	2		1	2	A
Unexplained vaginal bleeding (suspicious for serious condition), before evaluation	2		2		2		2		3		3		—	I 4	C 2	I 4	C 2	D
Endometriosis	1		1		1		1		1		1		—	2		1		S
Benign ovarian tumors (including cysts)	1		1		1		1		1		1		—	1		1		A
Severe dysmenorrhea	1		1		1		1		1		1		—	2		1		A

‡ Pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis.
[i] Prophylactic antibiotics are advised before providing the method.
[j] Category is for women without any other risk factors for stroke.
[k] If taking anticonvulsants, refer to section on drug interactions, p. 396.
[l] Certain medications may interact with the method, making it less effective.

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Condition	Combined oral contraceptives	Monthly injectables	Combined patch and combined vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device		Levonorgestrel intrauterine device		Female sterilization*
								I	C	I	C	
Gestational trophoblastic disease												
Decreasing or undetectable ß-hCG levels	1	1	1	1	1	1	—	3		3		A
Persistently elevated ß-hCG levels or malignant disease[g]	1	1	1	1	1	1	—	4		4		D
Cervical ectropion	1	1	1	1	1	1	—	1		1		A
Cervical intraepithelial neoplasia (CIN)	2	2	2	1	2	2	—	1		2		A
Cervical cancer (awaiting treatment)	2	2	2	1	2	2	—	4	2	4	2	D
Breast disease												
Undiagnosed mass	2	2	2	2	2	2	—	1		2		A
Benign breast disease	1	1	1	1	1	1	—	1		1		A
Family history of cancer	1	1	1	1	1	1	—	1		1		A
Breast cancer												
Current[g]	4	4	4	4	4	4	—	1		4		C
Past, no evidence of disease for at least 5 years	3	3	3	3	3	3	—	1		3		A
Endometrial cancer[g]	1	1	1	1	1	1	—	4	2	4	2	D
Ovarian cancer[g]	1	1	1	1	1	1	—	3	2	3	2	D
Uterine fibroids												
Without distortion of the uterine cavity	1	1	1	1	1	1	—	1		1		C
With distortion of the uterine cavity	1	1	1	1	1	1	—	4		4		C
Anatomical abnormalities												
Distorted uterine cavity	—	—	—	—	—	—	—	4		4		—
Other abnormalities not distorting the uterine cavity or interfering with IUD insertion (including cervical stenosis or lacerations)	—	—	—	—	—	—	—	2		2		—
Pelvic inflammatory disease (PID)												
Past PID (assuming no current risk factors for STIs)								I	C	I	C	
With subsequent pregnancy	1	1	1	1	1	1	—	1	1	1	1	A
Without subsequent pregnancy	1	1	1	1	1	1	—	2	2	2	2	C

(Continued)

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Condition	Combined oral contraceptives	Monthly injectables	Combined patch and combined vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device		Levonorgestrel intrauterine device		Female sterilization*
Current PID	I	I	I	I	I	I	—	4	2[m]	4	2[m]	D
Sexually transmitted infections (STIs)[g]								I	C	I	C	
Current purulent cervicitis, chlamydia, or gonorrhea	I	I	I	I	I	I	—	4	2	4	2	D
Other STIs (excluding HIV and hepatitis)	I	I	I	I	I	I	—	2	2	2	2	A
Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	I	I	I	I	I	I	—	2	2	2	2	A
Increased risk of STIs	I	I	I	I	I	I	—	2/3[n]	2	2/3[n]	2	A
HIV/AIDS[g]												
								I	C	I	C	
High risk of HIV	I	I	I	I	**2**	I	—	2	2	2	2	A
Asymptomatic or mild HIV clinical disease (WHO stage 1 or 2)	I	I	I	I	I	I	—	2	2	2	2	A
Severe or advanced HIV clinical disease (WHO stage 3 or 4)	I	I	I	I	I	I	—	3	2	3	2	S[o]
Antiretroviral therapy												
Treated with nucleoside reverse transcriptase inhibitors (NRTIs)**	**I**	**I**	**I**	**I**	**I**	**I**	—	2/3[p]	**2**	2/3[p]	**2**	—
Treated with non-nucleoside reverse transcriptase inhibitors (NNRTIs)												
Efavirenz (EFV) or nevirapine (NVP)	**2**	**2**	**2**	**2**	DMPA **I** NET-EN **2**	**2**	—	2/3[p]	**2**	2/3[p]	**2**	—
Etravirine (ETR) or rilpivirine (RPV)	**I**	**I**	**I**	**I**	**I**	**I**	—	2/3[p]	**2**	2/3[p]	**2**	—
Treated with protease inhibitors (PIs)[††]	**2**	**2**	**2**	**2**	DMPA **I** NET-EN **2**	**2**	—	2/3[p]	**2**	2/3[p]	**2**	—

[††]PIs include: ritonavir-boosted atazanavir (ATV/r), ritonavir-boosted lopinavir (LPV/r), ritonavir-boosted darunavir (DRV/r), ritonavir (RTV).

**NRTIs include: abacavir (ABC), tenofovir (TDF), zidovudine (AZT), lamivudine (3TC), didanosine (DDI), emtricitabine (FTC), stavudine (D4T).

[m] Treat PID using appropriate antibiotics. There is usually no need to remove the IUD if the client wishes to continue use.

[n] The condition is category 3 if a woman has a very high individual likelihood of STIs.

[o] Presence of an AIDS-related illness may require a delay in the procedure.

[p] Condition is category 2 for IUD insertion for asymptomatic or mild HIV clinical disease (WHO stage 1 or 2), category 3 for severe or advanced HIV clinical disease (WHO stage 3 or 4).

Condition	Combined oral contraceptives	Monthly injectables	Combined patch and combined vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device		Levonorgestrel intrauterine device		Female sterilization*
								I	C	I	C	
Treated with integrase inhibitors (raltegravir [RAL])	1	1	1	1	1	1	—	2/3[p]	2	2/3[p]	2	—
OTHER INFECTIONS												
Schistosomiasis												
Uncomplicated	1	1	1	1	1	1	—	1		1		A
Fibrosis of liver (if severe, see cirrhosis, next page)[g]	1	1	1	1	1	1	—	1		1		C
Tuberculosis[g]								1	C	1	C	
Non-pelvic	1	1	1	1	1	1	—	1	1	1	1	A
Known pelvic	1	1	1	1	1	1	—	4	3	4	3	S
Malaria	1	1	1	1	1	1	—	1		1		A
ENDOCRINE CONDITIONS												
Diabetes												
History of gestational diabetes	1	1	1	1	1	1	—	1		1		A[q]
Non-vascular diabetes												
Non-insulin dependent	2	2	2	2	2	2	—	1		2		C[i,q]
Insulin dependent[g]	2	2	2	2	2	2	—	1		2		C[i,q]
With kidney, eye, or nerve damage[g]	3/4[r]	3/4[r]	3/4[r]	2	3	2	—	1		2		S
Other vascular disease or diabetes of > 20 years' duration[g]	3/4[r]	3/4[r]	3/4[r]	2	3	2	—	1		2		S
Thyroid disorders												
Simple goiter	1	1	1	1	1	1	—	1		1		A
Hyperthyroid	1	1	1	1	1	1	—	1		1		S
Hypothyroid	1	1	1	1	1	1	—	1		1		C
GASTROINTESTINAL CONDITIONS												
Gallbladder disease												
Symptomatic												
Treated by cholecystectomy	2	2	2	2	2	2	—	1		2		A
Medically treated	3	2	3	2	2	2	—	1		2		A
Current	3	2	3	2	2	2	—	1		2		D

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(Continued)

[q] If blood glucose is not well controlled, referral to a higher-level facility is recommended.
[r] Assess according to severity of condition.

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Condition	Combined oral contraceptives		Monthly injectables		Combined patch and combined vaginal ring		Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device	Levonorgestrel intrauterine device	Female sterilization*
	I	C	I	C	I	C							
Asymptomatic	2		2		2		2	2	2	—	I	2	A
History of cholestasis													
Pregnancy-related	2		2		2		I	I	I	—	I	I	A
Past combined oral contraceptives-related	3		2		3		2	2	2	—	I	2	A
Viral hepatitis													
Acute or flare	3 / 4[r]	2	3	2	3 / 4[r,s]	2	I	I	I	2	I	I	D
Carrier	I		I		I		I	I	I	—	I	I	A
Chronic	I		I		I		I	I	I	—	I	I	A
Cirrhosis													
Mild (compensated)	I		I		I		I	I	I	—	I	I	A
Severe (decompensated)[g]	4		3		4		3	3	3	—	I	3	S[t]
Liver tumors													
Focal nodular hyperplasia	2		2		2		2	2	2	—	I	2	A
Hepatocellular adenoma	4		3		4		3	3	3	—	I	3	C[t]
Malignant (hepatoma)[g]	4		3/4		4		3	3	3	—	I	3	C[t]
ANEMIAS													
Thalassemia	I		I		I		I	I	I	—	2	I	C
Sickle cell disease[g]	2		2		2		I	I	I	—	2	I	C
Iron-deficiency anemia	I		I		I		I	I	I	—	2	I	D/C[u]
DRUG INTERACTIONS (for antiretroviral drugs, see HIV/AIDS)													
Anticonvulsant therapy													
Certain anticonvulsants (barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate)	3[l]		2		3[l]		3[l]	DMPA I NET-EN 2	2[l]	—	I	I	—
Lamotrigine	3[§]		3[§]		3[§]		I	I	I	—	I	I	—
Antimicrobial therapy													
Broad-spectrum antibiotics	I		I		I		I	I	I	—	I	I	—

[s] In women with symptomatic viral hepatitis, withhold these methods until liver function returns to normal or 3 months after she becomes asymptomatic, whichever is earlier.

[t] Liver function should be evaluated.

[u] For hemoglobin < 7 g/dl, delay. For hemoglobin ≥ 7 to < 10 g/dl, caution.

[§] Combined hormonal contraceptives may reduce the effectiveness of lamotrigine.

= Use the method = Do not use the method I = Initiation of the method C = Continuation of the method — = Condition not listed; does not affect eligibility for method NA = Not applicable **Condition**	Combined oral contraceptives	Monthly injectables	Combined patch and combined vaginal ring	Progestin-only pills	Progestin-only injectables	Implants	Emergency contraceptive pills*	Copper-bearing intrauterine device	Levonorgestrel intrauterine device	Female sterilization*
Antifungals and antiparasitics	I	I	I	I	I	I	—	I	I	—
Rifampicin or rifabutin therapy	3[I]	2	3[I]	3[I]	DMPA I NET-EN 2	2	—	I	I	—

*Additional conditions relating to emergency contraceptive pills:

Category 1: Repeated use; rape; **CYP3A4 inducers** (e.g., rifampicin, phenytoin, phenobarbital, carbamazepine, efavirenz, fosphenytoin, nevirapine, oxcarbazepine, primidone, rifabutin, St. John's wort/Hypericum perforatum).

Category 2: History of severe cardiovascular complications (ischemic heart disease, cerebrovascular attack, or other thromboembolic conditions, and angina pectoralis).

*Additional conditions relating to female sterilization:

Caution: Diaphragmatic hernia; kidney disease; severe nutritional deficiencies; previous abdominal or pelvic surgery; concurrent with elective surgery.

Delay: Abdominal skin infection; acute respiratory disease (bronchitis, pneumonia); systemic infection or gastroenteritis; emergency surgery (without previous counseling); surgery for an infectious condition; certain postpartum conditions (7 to 41 days after childbirth); severe pre-eclampsia/eclampsia; prolonged rupture of membranes (24 hours or more); fever during or immediately after delivery; sepsis after delivery; severe hemorrhage; severe trauma to the genital tract; cervical or vaginal tear at time of delivery); certain postabortion conditions (sepsis, fever, or severe hemorrhage; severe trauma to the genital tract; cervical or vaginal tear at time of abortion; acute hematometra); subacute bacterial endocarditis; unmanaged atrial fibrillation.

Special arrangements: Coagulation disorders; chronic asthma, bronchitis, emphysema, or lung infection; fixed uterus due to previous surgery or infection; abdominal wall or umbilical hernia; postpartum uterine rupture or perforation; postabortion uterine perforation.

Conditions relating to vasectomy:

No special considerations: High risk of HIV, asymptomatic or mild HIV clinical disease, sickle cell disease.

Caution: Young age; depressive disorders; diabetes; previous scrotal injury; large varicocele or hydrocele; cryptorchidism (may require referral); lupus with positive (or unknown) antiphospholipid antibodies; lupus and on immunosuppressive treatment.

Delay: Active STIs (excluding HIV and hepatitis); scrotal skin infection; balanitis; epididymitis or orchitis; systemic infection or gastroenteritis; filariasis; elephantiasis; intrascrotal mass.

Special arrangements: Severe or advanced HIV clinical disease may require delay; coagulation disorders; inguinal hernia; lupus with severe thrombocytopenia.

Conditions relating to male and female condoms, spermicides, diaphragms, cervical caps, and the lactational amenorrhea method:

All other conditions listed on the previous pages that do not appear here are a category 1 or NA for male and female condoms, spermicides, diaphragms, and cervical caps, and not listed in the Medical Eligibility Criteria for the lactational amenorrhea method.

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Condition	Male and female condoms	Spermicides	Diaphragms	Cervical caps	Lactational amenorrhea method[‡‡]
REPRODUCTIVE HISTORY					
Parity					
Nulliparous (has not given birth)	1	1	1	1	—
Parous (has given birth)	1	1	2	2	—
< 6 weeks postpartum	1	1	NA[v]	NA[v]	—
CARDIOVASCULAR DISEASE					
Complicated valvular heart disease (pulmonary hypertension, risk of atrial fibrillation, history of subacute bacterial endocarditis)[g]	1	1	2	2	—
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS					
Cervical intraepithelial neoplasia	1	1	1	4	—
Cervical cancer	1	2	1	4	—
Anatomical abnormalities	1	1	NA[w]	NA[x]	—
HIV/AIDS[g]					
High risk of HIV	1	4	4	4	—
Asymptomatic or mild HIV clinical disease (WHO stage 1 or 2)	1	3	3	3	C[y]
Severe or advanced HIV clinical disease (WHO stage 3 or 4)	1	3	3	3	C[y]
OTHERS					
History of toxic shock syndrome	1	1	3	3	—
Urinary tract infection	1	1	2	2	—
Allergy to latex[z]	3	1	3	3	—

[v] Wait to fit/use until uterine involution is complete.

[w] Diaphragm cannot be used in certain cases of uterine prolapse.

[x] Cap use is not appropriate for a client with severely distorted cervical anatomy.

[y] Caution: Women living with HIV should receive appropriate ARV therapy and exclusively breastfeed for the first 6 months of a baby's life, introduce appropriate complementary foods at 6 months, and continue breastfeeding through 12 months. (See Maternal and Newborn Health, Preventing Mother-to-Child Transmission of HIV, p. 352.)

[z] Does not apply to plastic condoms, diaphragms, and cervical caps.

[‡‡] For additional conditions relating to the lactational amenorrhea method, see next page.

⌗Additional conditions relating to the lactational amenorrhea method:

Conditions affecting the newborn that may make breastfeeding difficult: Congenital deformities of the mouth, jaw, or palate; newborns who are small-for-date or premature and needing intensive neonatal care; and certain metabolic disorders.

Medication used during breastfeeding: To protect infant health, breastfeeding is not recommended for women using such drugs as anti-metabolites, bromocriptine, certain anticoagulants, corticosteroids (high doses), cyclosporine, ergotamine, lithium, mood-altering drugs, radioactive drugs, and reserpine.

Conditions relating to fertility awareness methods:

A = Accept C = Caution D = Delay **Condition**	Symptoms-based methods	Calendar-based methods
Age: post menarche or perimenopause	C	C
Breastfeeding < 6 weeks postpartum	D	D[aa]
Breastfeeding ≥ 6 weeks postpartum	C[bb]	D[bb]
Postpartum, not breastfeeding	D[cc]	D[aa]
Postabortion	C	D[dd]
Irregular vaginal bleeding	D	D
Vaginal discharge	D	A
Taking drugs that affect cycle regularity, hormones, and/or fertility signs	D/C[ee]	D/C[ee]
Diseases that elevate body temperature		
Acute	D	A
Chronic	C	A

[aa] Delay until she has had 3 regular menstrual cycles.
[bb] Use caution after monthly bleeding or normal secretions return (usually at least 6 weeks after childbirth).
[cc] Delay until monthly bleeding or normal secretions return (usually < 4 weeks postpartum).
[dd] Delay until she has had one regular menstrual cycle.
[ee] Delay until the drug's effect has been determined, then use caution.

Conditions relating to the progesterone-releasing vaginal ring:

Pregnancy	**N/A**
Breastfeeding ≥ 4 weeks postpartum	**I**

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Page #s	*Topics*
	CHAPTER 1. COMBINED ORAL CONTRACEPTIVES
17-18	Management of Missed COCs
24	Extended and Continuous use of COCs
	CHAPTER 4. PROGESTIN ONLY INJECTABLES
68-70	DMPA for Subcutaneous Injection Delivering Injectables in the community
81-89	DMPA-SC Sayana press
	CHAPTER 5. COMBINED MONTHLY INJECTABLES
97-118	Extracted Essential information about Combined Monthly Injections
	CHAPTER 6. COMBINED PATCH
119-124	Essentials about Patch explaining how to use and management of dosing errors Combined Vaginal Ring
125-129	Essentials about Combined patch explaining how to use and management of dosing errors
	CHAPTER 9. SUB DERMAL IMPLANTS
131-151	Edited and adapted content of the entire chapter
	CHAPTER 10. COPPER BEARING IUDS
157	Correcting Misunderstandings about Cu IUDs and LNG IUS
166	Preventing Infection at IUD Insertion
167-169	Inserting the IUD
170	"Come Back Any Time" Reasons to return
171	Removing the Cu IUD
176-177	Suspected Perforation, IUD Partially Expelled or IUD Complete Expulsion
178	Does the IUD Cause Pelvic Inflammatory Disease
	CHAPTER 11. LEVONORGESTREL INTRAUTERINE DEVICE
182	Side Effects Health Benefits and Risks
183	Correcting Misunderstandings LNG-IUS
184	Screening for Medical Eligibility
192-194	Timing of Insertion LNG IUS
195-197	Preventing Infection during Insertion and Inserting the LNG IUS
199	"Come back anytime" Reasons to return
200	Removing LNG IUS
202-209	Management of Problems with LNG IUS

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