PHC Chapter 7: Family planning

Introduction to contraception

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The guidance contained in this chapter is currently limited to contraception and does not cover all aspects of family planning such as pre-conception care. Refer to the National guidelines for safe conception and infertility for further guidance.

INTRODUCTION TO CONTRACEPTION

For comprehensive guidance, consult the most recent National Contraception Clinical Guidelines (especially for women with medical conditions), the National Clinical Guidelines for Safe Conception and Infertility, as well as the WHO Medical eligibility criteria for contraceptive use and the WHO family planning handbook for providers.

LoE:IVb[1]

Women should decide their own family planning method in consultation with their healthcare professional, taking into account the individual considerations of safety, efficacy, acceptability, and access. Always obtain a complete medical and sexual history and perform an appropriate physical examination to ensure that there are no contra-indications to using a particular method. Provide counselling and always exclude pregnancy before commencing contraception.

Contraceptive methods

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

Contraceptive method	Advantages include:	Disadvantages include:
Copper IUCD (see Section 7.1)	» Suitable for most women, including nulliparous women. » Provides long-term protection, i.e. 5 years. » Convenient, does not require frequent follow up. » Works immediately upon insertion. » Non-hormonal, therefore no interaction with other medication and no hormonal side effects. » Fertility returns immediately upon removal of IUCD in women of child-bearing age. » Can be used for emergency contraception (see Section 7.4). » Safe to use during breastfeeding.	» Some discomfort or cramping during, and following insertion. » IUCD must be inserted or removed by a trained healthcare professional. » Should not be used in women with menorrhagia, high risk of STIs, active STIs and active pelvic inflammatory disease (PID), purulent cervicitis, unexplained uterine bleeding, cervical and endometrial cancers or other uterine abnormalities.
Levonorgestrel Intrauterine device (LNG-IUD) (see Section 7.2.2)	» Suitable for most women, including nulliparous women. » Provides long-term protection (up to 5 years). » Convenient, does not require frequent follow-up. » Works immediately upon insertion. » Immediate return to fertility upon removal.	» Bleeding changes are common but not harmful. Typically, lighter and fewer days of bleeding, or infrequent or irregular bleeding. » LNG-IUD must be inserted or removed by a trained healthcare professional.

	» Reduces menstrual cramps, heavy menstrual bleeding, and symptoms of endometriosis. » Similar to the Copper IUCD, can be inserted at the time of a caesarean section and postpartum (within 48 hours after delivery). *LoE:IIb*[2]	» Should not be used in women with active PID. *LoE:IIIb*[3]
Hormonal subdermal: progestin-only implant (see Section 7.2.1)	» Provides long-term protection, i.e. 3 years (etonogestrel) or 5 years (levonorgestrel). » Convenient, does not require frequent follow up. » Can also be used in women >35 years who are obese, who smoke, or who have diabetes, hypertension, or a history of venous thromboembolism. » Fertility returns upon removal of the implant in women of child-bearing age.	» Frequent bleeding irregularities. » Implant must be inserted or removed by a trained health care professional under aseptic conditions to prevent infection. » Incorrect insertion and removal techniques may result in complications.
Hormonal injectable: progestin-only (see Section 7.2.3)	» Daily adherence is not required. » Long-acting, i.e. given every 8 or 12 weeks. » Interactions with other medicines do not lower the contraceptive effect. » Can be used postpartum. » Can also be used in women >35 years who are obese, who smoke, or who have diabetes, hypertension, or a history of venous thromboembolism.	» Delayed return to fertility of up to 9 months after the last injection. » Frequent bleeding irregularities (irregular, prolonged and/or heavy bleeding, or amenorrhoea). » Associated with a possible weight gain *LoE:IIIb*[4]
Hormonal oral: progestin-only (see Section 7.2.4)	» Fertility returns within 3 months of discontinuing the pill. » Can be used postpartum. » Can also be used in women >35 years who are obese, who smoke, or who have diabetes, hypertension, or a history of venous thromboembolism.	» Daily adherence is required. » Interactions with other medicines can lower contraceptive effect. » Lower efficacy compared with COC. » Frequent bleeding irregularities.
Hormonal oral: combined oral contraceptive (COC) (see Section 7.2.4)	» Non-contraceptive benefits, e.g.: alleviation of dysmenorrhoea, premenstrual syndrome, and menorrhagia. » Fertility returns after discontinuation of COC but can take upto 3 months.	» Daily adherence is required. » Interactions with other medicines can lower contraceptive effect. » Cannot be used in women with venous thrombo-embolic disease. » Cannot be used immediately postpartum.

Barrier: male and female condoms (see Section 7.3)	» Protects against STIs, including HIV.	» Possibility of breakage or slipping off. » Possible allergic reaction to latex. » Lower efficacy than other contraceptive methods therefore advised as dual contraception. » Consistent and correct use is required to prevent pregnancy

Refer to the most recent SAHPRA registered professional information for detailed information.

Effectiveness of family planning methods

Rates of unintended pregnancies per 100 women:

Contraceptive method	Failure rate in 1st year (%)	
	Consistent and correct use	Typical use
Sterilisation: male – vasectomy	0.1	0.15
Sterilisation: female - tubal ligation	0.5	0.5
Progestin-only subdermal implant	0.1	0.1
LNG-IUD	0.5	0.7
Copper IUCD	0.6	0.8
Progestin-only injectable	0.2	4
Progestin-only oral pill (during breastfeeding)	0.3	7
Combined oral contraceptive (COC) pill	0.3	7
Progestin-only oral pill (not breastfeeding)	0.3	8
Barrier: male condoms	2	13
Barrier: female condoms	5	21
No method	85	85

Key:

0-0.9: very effective	1-9: effective	
10-19: moderately effective	20+: less effective	*LoE:IVb*[5]

7.1 INTRAUTERINE CONTRACEPTIVE COPPER DEVICE (IUCD)

Z30.0/Z30.1/Z30.5

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

The copper IUCD (also known as the Copper T) is a long-term contraceptive method that is effective, safe and reversible. It has no hormonal effects or drug interactions. It does not require daily adherence or frequent follow up.

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

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

- Copper IUCD, e.g:
- Cu T380A, 380mm² copper device.
  - Devices with lower copper surface area are not recommended.

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

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

Alternatively, an IUCD may be inserted at least 4 weeks postpartum. *LoE:IIb*[6]

Advise women to check the strings of the IUCD monthly to ensure that the device is still in place.

Advise women when to return:

» Expulsion of IUCD or if strings of the IUCD become visible.
» Complications (excessive bleeding, excessive pain, fever, or foul-smelling discharge). *LoE:IVb*[7]
» Routine follow-up 4–12 weeks after insertion.
» If the strings of the IUCD cannot be felt.

Copper IUCD is not recommended for women with menorrhagia, active STI, active pelvic inflammatory disease (PID), purulent cervicitis, unexplained uterine bleeding, cervical and endometrial cancers or other uterine abnormalities. If a woman has a very high individual likelihood of exposure to STIs, she should generally not have a Copper IUCD inserted unless other methods are not available or not acceptable.

For mild pain and discomfort after insertion:

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

REFERRAL

» Excessive pain or bleeding after insertion.
» Signs of infection within 7 days of insertion (e.g. fever, abdominal pain and/or foul-smelling discharge).

» Abnormal or heavy menstrual bleeding for > 3 months.

7.2 CONTRACEPTION, HORMONAL

CAUTION

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

7.2.1 SUBDERMAL IMPLANT

Z30.0/Z30.4/Z30.8

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

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

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

The progestin-only subdermal implant can be inserted at any time during the menstrual cycle, once pregnancy has been excluded. If the implant is inserted within day 1 to day 5 of the onset of the menstrual cycle, the contraceptive effect is achieved within 24 hours of placement.

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

The progestin-only subdermal implant is contraindicated in certain conditions, e.g. unexplained vaginal bleeding, active liver disease. Consult the package insert in this regard.

CAUTION

Medicines that induce the metabolism of progestins could reduce contraceptive efficacy. These medicines include efavirenz, rifampicin, phenytoin, carbamazepine, and phenobarbital.

Women receiving any of the above listed hepatic enzyme-inducing medicines should be advised that the efficacy of the subdermal implant may be reduced. If it is decided to continue using the subdermal implant, women should be advised to also use a non-hormonal contraceptive method during the time of concomitant use (the subdermal implant is not contra-indicated when using the above medicines). Dolutegravir, however, can be effectively used in combination with subdermal implants. *LoE:IIIb*[8]

Insertion and removal procedures

» Training on the techniques for insertion and removal of the sub-dermal implant is strongly recommended.
» Only health care professionals familiar with these procedures should insert and remove subdermal implants, under aseptic conditions.
» Insert the implant **subdermally just under the skin of the upper non-dominant arm.**
» **Important: Refer to the specific professional information for detailed guidance on the product available on the National contract**.

Insertion of etonogestrel 68 mg implant:

» Insertion should only be performed with the preloaded applicator.
» Ask the woman to lie on her back on the examination table with her non-dominant arm flexed at the elbow and externally rotated, so that her hand is underneath her head (or as close as possible).
» Identify the insertion site, which is on the inner side of the non-dominant upper arm. The insertion site overlies the triceps muscles about 8 to 10 cm from the medial epicondyle of the humerus and 3 to 5 cm posterior to the sulcus (groove between the biceps and triceps muscles). This location is intended to avoid large blood vessels and nerves lying within and surrounding the sulcus. If it is not possible to insert the implant in this location (e.g. in women with thin arms), it should be inserted as far posterior from the sulcus as possible.
» Make two marks with a surgical marker: First, mark the spot where the implant will be inserted, and second, mark a spot at 5 cm proximal (toward the shoulder) to the first mark. This second mark (guiding mark) will later serve as a direction guide during insertion.
» Clean the insertion site with an antiseptic solution.
» Anaesthetise the insertion area. *LoE:IVb*[9]
» Insert the implant subdermally:
  - Hold the applicator just above the needle at the textured surface area. Remove the transparent protection cap by sliding it horizontally in the direction of the arrow away from the needle.
  - Puncture the skin with the tip of the needle slightly angled less than 30° relative to the skin surface. If you insert the needle past the bevel, withdraw it until only the bevel is beneath the skin.
  - Lower the applicator to a horizontal position. To facilitate subdermal placement, lift the skin with the needle, while sliding the needle to its full length. You should be able to see the applicator just below the skin. In a seated position, look at the applicator from the side and NOT from above to clearly see the insertion and positioning of the needle just under the skin.
  - While keeping the applicator in the same position and the needle inserted to its full length, the purple slider should be unlocked by pushing it slightly down. The slider should be moved fully back until it stops.
  - The implant is now in its final subdermal position. Remove the applicator.

» Always verify the presence of the implant in the woman's arm immediately after insertion by palpation, and allow her to feel the implant as well.
» Apply sterile gauze with a pressure bandage to minimise bruising. The woman may remove the pressure bandage in 24 hours, and the small bandage over the insertion site after 3–5 days.

Insertion of levonorgestrel 2 x 75 mg implants:

» Clean the woman's upper arm with an antiseptic solution.
» The optimal insertion area is on the medial aspect of the upper arm about 6-8 cm above the fold of the elbow.
» The implants will be inserted subdermally, in the shape of a narrow V, opening towards the armpit.
» Anesthetise two areas about 4.5 cm long, to mimic the V shape of the implantation site.
» Mark the insertion site with a marker.
» Use the scalpel to make a small incision (about 2 mm) just through the dermis of the skin. Alternatively, the trocar may be inserted directly through the skin without making an incision.
» Open the implant pouch by pulling apart the film of the pouch and let the two implants drop on a sterile cloth. Note: Always use sterile gloves or forceps when handling the implants. If an implant is contaminated (e.g. falls on the floor), leave it for later disposal, open a new package, and continue with the procedure.
» The implant is provided with a disposable trocar that is sharp enough to penetrate the skin directly. Thus, the disposable trocar can be used to puncture the skin and insert the rods, without the need for an incision.
» The trocar has two marks. One mark is close to the handle and one close to the tip. When inserting the implants, the mark closest to the handle indicates how far the trocar should be introduced under the skin before loading each implant. The mark closest to the tip indicates how much of the trocar should be left under the skin after the insertion of the first implant. When inserting the trocar, avoid touching the part of the trocar that will go under the skin.
» Once the tip of the trocar is beneath the skin it should be directed along the subdermal plane horizontally by pointing it slightly upwards and raising the skin (tenting). Failure to keep the trocar in the subdermal plane may result in deep placement of the implants, causing a more difficult removal. The trocar should be oriented with the bevel up throughout the insertion procedure.
» Advance the trocar beneath the skin, about 5.5 cm from the incision to the mark closest to the handle of the trocar. Do not force the trocar; if you feel any resistance, try another direction.
» Remove the plunger when the trocar is advanced to the correct mark.
» Load the first implant into the trocar with either tweezers or fingers.
» Push the implant gently with the plunger to the tip of the trocar until you feel resistance. Never force the plunger.
» Hold the plunger steady and pull the trocar back along it until it touches the handle of the plunger. It is important to keep the plunger steady and not to push the implant into the tissue.

» Do not completely remove the trocar until both implants have been placed. The trocar is withdrawn only to the mark closest to its tip.
» When you can see the mark near the tip of the trocar in the incision, the implant has been released and will remain in place beneath the skin. You can check this by palpation.
» Insert the second implant next to the first one, to form a V shape. Fix the position of the first implant with the left fore-finger and advance the trocar along the side of the finger. This will ensure a suitable distance between implants. To prevent expulsions, leave a distance of about 5 mm between the incision and the ends of the implants. You can check their correct position by cautious palpation of the insertion area.
» After inserting the second implant, press the edges of the incision together, close with a skin closure and dress the wound.
» Advise the woman to keep the insertion area dry for 3 days.
» The gauze and the bandage may be removed as soon as the incision has healed, usually after 3 to 5 days.

For pain after insertion:
- Ibuprofen, oral, 400 mg 8 hourly with or after a meal as needed for up to 5 days.

Removal of progestin-only subdermal implants:
Remove etonogestrel implants at the end of 3 years and levonorgestrel implants at the end of 5 years.
» Locate the implant/s by palpation. If impalpable, refer for ultrasound-guided removal.
» Mark the distal end (end closest to the elbow) with a surgical marker.
» Clean the removal site with an antiseptic solution.
» Anaesthetise the removal area. Inject the local anaesthetic under the implant to keep the implant close to the skin surface.
» Push down the proximal end of the implant. A bulge may appear to indicate the distal end of the implant.
» Make a longitudinal (parallel to the implant) incision of approximately 2 mm towards the elbow.
» Very gently remove the implant, using a small forceps (preferably curved mosquito forceps). Where an implant is encapsulated, dissect the tissue sheath to remove the implant with the forceps.
» Confirm that the complete implant has been removed by measuring the length (etonogestrel rod: 40 mm; levonorgestrel rods: 43 mm). Close the incision with a steristrip or plaster and dress.
» Advise the woman to keep the arm dry for a few days.

REFERRAL

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

7.2.2 LEVONORGESTREL INTRA-UTERINE DEVICE (LNG-IUD)

Z30.0/Z30.5/Z30.8

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

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

- Progestin-only intrauterine device, e.g.:
- Levonorgestrel, intrauterine device, 52 mg. *LoE:IIb*[10]

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

LoE:IIIb[11]

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

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

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

Advise women when to return:

» Expulsion of LNG-IUD or if strings of the LNG-IUD protrude.
» Complications (excessive bleeding, excessive pain, fever or foul smelling discharge). *LoE:IIIb*[12]
» Routine follow-up 3 to 6 weeks after insertion.
» First time migraine or severe headaches during use.

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

<u>For mild pain and discomfort after insertion:</u>

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

REFERRAL

» Excessive pain or bleeding after insertion.
» Signs of infection within 7 days of insertion (e.g. fever, abdominal pain and/or foul-smelling discharge).

» Abnormal or heavy menstrual bleeding for > 3 months.
» First time migraine or severe headaches.

LoE:IVb[13]

7.2.3 INJECTABLE

Z30.0/Z30.4

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

- Progestin-only injectable contraceptive, e.g.:
- Medroxyprogesterone (long-acting), IM, 150 mg, 12 weekly. *LoE:IIIb*[14]

OR

- Medroxyprogesterone (long-acting), SC, 104 mg, 12 weekly.

LoE:IVb[15]

Progestin-only hormonal contraceptives are contraindicated in certain conditions, e.g. unexplained vaginal bleeding. Cons

ult the individual professional information in this regard.

Using the Progestin-only IM Injection

When to start the injection

» The injection can be started anytime within the menstrual cycle, provided pregnancy has been excluded. If the first injection is given within 7 days of the onset of the menstrual cycle, the contraceptive effect is achieved on the day of the first injection.
» If started after day 7, advise the woman to abstain from intercourse or use condoms for the next 7 days.
» Can be started immediately postpartum in both breastfeeding and non-breastfeeding women if no other method is acceptable or available. *LoE:IVb*[16]

Late injection

» The next injection can be as much as 4 weeks late if using the medroxyprogesterone acetate DMPA (long-acting), or 2 weeks late if using norethisterone enanthate (NET-EN).
  Injectable contraceptive may be administered later than recommended (>4 weeks late for DMPA or >2 weeks late for NET-EN) if:
  - She has not had sexual intercourse since 2 weeks after the scheduled date of her injection, or
  - She has used a backup method or has taken emergency contraceptive pills after any unprotected sexual intercourse since 2 weeks after the scheduled date of her injection, or
  - She is fully or nearly fully breastfeeding and she gave birth less than 6 months ago.

However, in all three cases she will need a backup method for the first 7 days after the injection. *LoE:IVb*[17]

Assess the need for emergency contraception in the event of a late injection (See Section 7.4: Contraception, Emergency).

Using the Progestin-only SC Injection
May be administered by a healthcare professional (HCP) or with adequate training when considered appropriate by the HCP, self-injected by the patient, with medical follow up as necessary.

When to start the injection
» The first injection of 104 mg SC should be given during the first 5 days of a normal menstrual cycle to ensure the client is not pregnant.
» The second and subsequent injections should be given at a 3 month interval (12 -14 weeks).
» Can be started immediately postpartum in both breastfeeding and non-breastfeeding women if no other method is acceptable or available.

CAUTION

» Alternative contraceptive options should be considered if the continued use of medroxyprogesterone acetate (IM or SC) is extended beyond 2 years. All effective contraceptive options should be considered, taking into account client preferences and circumstances.
» A small increased risk of meningiomas (rare, and mostly benign tumours) have been reported following long-term administration of medroxyprogesterone acetate (long-acting).
» Medroxyprogesterone (long-acting) should be discontinued if a meningioma is diagnosed.
» Caution is advised when recommending medroxyprogesterone (long-acting) to patients with a history of meningioma.

LoE:IVb[18]

REFERRAL
Heavy or prolonged bleeding, despite adequate treatment with combined oral contraceptives (see Section 7.6: Breakthrough bleeding with contraceptive use).

7.2.4 ORAL
Z30.0/Z30.4

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

Monophasic preparations:
- Progestin only pills, e.g.:
- Levonorgestrel, oral, 30 mcg daily. *LoE:IIIa*[19]
- Progestins and estrogen, fixed combinations, e.g.:

- Ethinylestradiol/levonorgestrel, oral, 30 mcg/150 mcg:
  - 21 tablets ethinylestradiol/levonorgestrel, 30 mcg/150 mcg; and
  - 7 tablets placebo.

LoE:IIIa[20]

Triphasic preparations:

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

LoE:IIIa[21]

Counselling:

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

Contraindications and guidance to starting the hormonal oral pill

	Progestin only	**Combined estrogen/progestin**
Contra-indications	Progestin only preparations are contraindicated in certain conditions (consult the package insert in this regard). Contraindications include: » Abnormal uterine bleeding of unknown cause. » Myocardial infarction/stroke. » Liver disease. » Cancer of the breast/ genital tract. » Known or suspected pregnancy. *LoE:IVb*[22]	Combination preparations contraindicated in certain conditions (consult the package insert in this regard). Contraindications include: » Women >35 years of age who smoke ≥15 cigarettes a day or have risk factors for cardiovascular disease: – heart disease – liver disease – thromboembolism – certain cancers
When to start the pill	» Exclude pregnancy. » May be started anytime within the menstrual cycle, but it is advisable to start during menses. » If the first pill is given between days 1 and 5 of the menstrual cycle, the contraceptive effect is achieved immediately. » If the pill is started at any other time, it needs to be taken for at least 7 days before contraceptive efficacy is established. The use of condoms is recommended during these 7 days.	

Medicine interactions

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

Lamotrigine:
» Lowering of contraceptive effect not expected.
» Oral contraceptives may reduce lamotrigine concentration, increasing the risk of seizures. Change to IUCD or progesterone only methods (i.e levonorgestrel implant, etonogestrel implant, or LNG-IUD), if lamotrigine is going to be used long term.

LoE:IVb[23]

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

REFERRAL
Abnormal vaginal bleeding for >3 months.

7.2.5 MISSED PILLS

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

LoE:IVb[24]

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

Combination of progestin and estrogen in each pill
Missing active pills and extending hormone free interval leads to decreased contraceptive efficacy. Recommend dual contraception for all scenarios for at least 7 days.

LoE:IVb[25]

LoE:IVb[26]

Scenario	Action
One active pill forgotten.	Take pill as soon as remembered and take next one at usual time.

Two or more pills forgotten during the first 7 active pills of the pack and unprotected sexual intercourse has occurred in the past 5 days.	Give emergency contraception (see Section 7.4). Restart active pills 12 hours later.
Two or more pills forgotten during the middle 7 active pills of the pack.	Take the most recent missed pill immediately (discard the other missed pills). Continue taking remaining pills as usual. No emergency contraception required.
Two or more pills forgotten in the last 7 active pills of the pack and unprotected sexual intercourse has occurred in past 5 days.	Continue active pills of current pack. Omit the inactive pills and immediately start the active pills of the next pack.

7.3 CONTRACEPTION, BARRIER METHODS

Z30.0

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

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

7.4 CONTRACEPTION, EMERGENCY

Z30.0/Z30.4

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

» Forgotten tablets (see Section 7.2.5: Missed pills).
» Slipped or broken condom.
» Injectable contraception given late (>2 weeks for NET-EN, >4 weeks for DMPA).
» Sexual assault.

A woman who needs emergency contraception often should be counselled to consider a longer-acting and more effective family planning method.

Emergency contraception after pregnancy is excluded

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

- Copper IUCD inserted as soon as possible after unprotected intercourse and no later than 5 days.

LoE:IIIb[27]

OR

- Levonorgestrel, 1.5 mg, oral, as a single dose as soon as possible after unprotected intercourse, and not later than 5 days.
  - If the client vomits within 2 hours, repeat the dose.

LoE:Ia[28]

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

If using enzyme inducing drugs or woman weighs > 80 kg / BMI ≥ 30:

» It is recommended to have a copper IUCD inserted.

» If this is not possible, double the dose of levonorgestrel administered:

- Levonorgestrel, 1.5 mg, oral, 2 tablets taken as a single dose.

» If the dedicated product is not available, use COCs containing 30 µg ethinylestradiol + 150 µg levonorgestrel (e.g. Nordette®/Oralcon®):

- Ethinylestradiol/levonorgestrel, oral, 30 mcg/150 mcg, 6 tablets taken as a single dose, followed by 6 tablets 12 hours later.

CAUTION

» Emergency contraceptive tablets must be taken as soon as possible, preferably within 72 hours of unprotected intercourse, and not later than 5 days.

» Enzyme inhibitors (ketoconazole, fluconazole) significantly increase the bioavailability of levonorgestrel and may increase nausea and vomiting. Women taking these medicines should preferably have copper IUCD inserted.

LoE:IIIb[29]

REFERRAL

Women in need of emergency contraception must be referred for HIV counselling and testing and PEP (see Section 21.3.6.2: Post exposure prophylaxis, rape and sexual assault).

7.5 VOLUNTARY STERILISATION, MALE AND FEMALE

Z30.2

Female sterilisation

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

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

Male sterilisation

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

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

CAUTION

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

LoE:IIIb[30]

7.6 BREAKTHROUGH BLEEDING WITH CONTRACEPTIVE USE

N92.0/N92.1/N92.4

DESCRIPTION

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

GENERAL MEASURES

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

Clinical assessment:

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

Hormonal contraceptives causing breakthrough bleeding	Treatment
Progestin-only injectables	• COC containing 30 mcg ethinylestradiol, oral, for 14 days. *LoE:IIIb*[31]
Progestin subdermal implants	Progestins and estrogen, fixed combinations, e.g.: • Ethinylestradiol/levonorgestrel, oral, 30 mcg/150 mcg for daily for 20 days.
Progestin intrauterine devices	Refer – see Section 7.2.2: Levonorgestrel intra-uterine device (LNG-IUD)
Combined oral contraceptive pill » Unscheduled bleeding with COC usually settles with time. » Changing to another COC in the first 3 months is not recommended.	• Change COC to another COC containing the lowest dose of ethinylestradiol, oral, daily. <u>If bleeding persists:</u> • Change COC to a COC containing at least 30mcg ethinylestradiol, oral, daily.

		LoE:IVb

REFERRAL

» Pelvic pain.
» Pelvic mass.
» Heavy bleeding.
» Abnormal cervix on speculum examination (e.g. polyps).
» Bleeding not controlled by the treatment above.

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SOUTH AFRICAN NATIONAL DEPARTMENT OF HEALTH
NEMLC SUMMARY REPORT ON UPDATES MADE TO THE
THE STANDARD TREATMENT GUIDELINES AND ESSENTIAL MEDICINE LIST GUIDANCE PRODUCTS

PHC Chp 7 Family Planning

Document Version Control

Report Version	Date	Detail
V1.0	*30/07/2025*	**7.2 .1 Subdermal implant** - Referral Criteria not amended **7.2.3 Injectable** – *Retention of DMPA-SC (update of review recommendation and rationale of review)*

Summary Tables

Medicine Amendments

Medicine amendment recommendations, with supporting evidence and rationale are listed below. If appropriate can include non-medicine amendments if appropriate (for example if item has a large impact on how medicine is accessed). Kindly review the medicine amendments in the context of the respective standard treatment guideline (STG). Include updates post initial publication first or mark/highlight appropriately.

STG/SECTION	GUIDANCE PRODUCTS (Tick relevant)				MEDICINE / MANAGEMENT	ADDED / DELETED / AMENDED	TI* CONSIDERATIONS (if applicable)
	PHC STGs & EML	AH STG & EML	PaedH STG & EML	TQ EML			
Report v1.0: *Relative contraindication – Implanon*							
7.2 .1 Subdermal implant	√				Referral criteria not amended	Retained	n/a
7.2.3 Injectable	√				Medroxyprogesterone (long-acting), SC, 104 mg, 12 weekly	Retained	Medroxyprogesterone (long-acting), IM, 150 mg, 12 weekly

*Therapeutic Interchange

Report V1.0

PHC Family Planning Chapter 7

Section 7.2.1 Subdermal implant

An external commentator indicated that the standard treatment guideline (STG) implies that Implanon can be used safely in women with previous venous thromboembolism, however the professional information leaflet[1] states

[1] South African Health Products Regulatory Authority. Professional information (PI) leaflet. Implanon NXT® 68 mg Implant. Organon South Africa (Pty) Ltd. Text last revised 27 August 2019.

that "venous or arterial thromboembolic disorders or history thereof" is a contraindication. It was suggested by the external commentator that woman with a previous stroke requesting a subdermal implant to first be discussed, as differentiating between haemorrhagic vs thrombembolic stroke is not always possible at primary health care level.

The query relates to Venous Thrombo-Embolism (VTE) and progesterone-only contraceptives (POC). POCs are regarded as safe to use in women with a previous history of VTE; it is estrogen that increases the risk. But the suggested change speaks about women with a previous stroke; which is a slightly different topic than VTE (strokes can be multifactorial, but usually arterial thrombi; relate to cardiac conditions, and other arterial causes).

The National Contraceptive Guidelines[2] aligns with the STG indicating the following:

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).
- Progestogen only pills (POPs), injectables, implants, and Levonorgestrel releasing intrauterine system (LNG-IUS) are suitable choices for women with a history of DVT/PE but should not be initiated or used by women with acute DVT/PE until she is well established on anticoagulant therapy.

ARTERIAL DISEASE

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.

This is supported by the WHO Medical Eligibility Criteria (MEC[3]) i.e. the STG, National Contraceptive Guideline, and International Evidence (WHO) all agree.

[2] National Department of Health. National Contraception in Clinical Guidelines. December 2012. Available at: https://www.gov.za/sites/default/files/gcis_document/201409/contraceptionclinicalguidelines28jan2013-2.pdf.
[3] Medical eligibility criteria for contraceptive use, sixth edition. Geneva: World Health Organization; 2025. Licence: CC BY-NC-SA 3.0 IGO.

The challenge is therefore the professional information leaflet (PIL)[4], which does qualify their 'contra-indication' by saying (under "Warnings") that Women with a history of thromboembolic disorders should be made aware of the possibility of a recurrence, which agrees with a MEC 2[3].

The committee retained the STG, with no change, as this is a relative contraindication, and the guidance currently provided in the STGs is in line with local and international recommendations.

Section 7.2.3 Injectable

Medroxyprogesterone (long-acting), SC, 104 mg, 12 weekly: Retained

During the 2020 – 2024 review cycle, NEMLC had recommended the use of DMPA-SC with a proposed maximum price of R29.63 incl. VAT. The review was updated in June 2026. No reference price was provided in the review; only the principles of pricing included.

The recommendation and review indicator wording in the review was updated as follows:

From:

NEMLC Recommendation: NEMLC suggests that either low dose DMPA-SC or intramuscular progestogen injectables may be used by women for preventing pregnancy. (Conditional recommendation, moderate certainty evidence).

Remarks:
This marks a change of DMPA-SC from a therapeutic interchange option to an EML item and is based on available evidence of efficacy and safety, the change in access given the updated approval of DMPA-SC by the South African Health Products Authority (SAHPRA) for self-administration, along with updated evidence of feasibility, acceptability and affordability.

Rationale: The current review found that there is evidence that DMPA-SC is acceptable to stakeholders, feasible to implement and access, and cost-effective. This is in addition to the previously appraised evidence of safety and efficacy which has not changed since first reviewed in 2020. NEMLC noted that the option for self-administration and expansion of contraceptive options may have important equity implications and public health benefit for women in the South African setting. This recommendation is conditional on the product being available at the indicative price provided herein (R29.63 incl VAT) or less.
Level of Evidence: Review indicator: *Increase in product price*

To:

NEMLC Recommendation: NEMLC suggests that either low dose DMPA-SC or intramuscular progestogen injectables may be used by women for preventing pregnancy. (Conditional recommendation, moderate certainty evidence).
Remarks:
This marks a change of DMPA-SC from a therapeutic interchange option to an EML item and is based on available evidence of efficacy and safety, the change in access given the updated approval of DMPA-SC by the South African Health Products Authority (SAHPRA) for self-administration, along with updated evidence of feasibility, acceptability and affordability.
Rationale: This recommendation is conditional on the product being available at a comparable price to that accepted in 2024, after consideration of inflation. The decision should also be aligned with the national policy in this regard (National Contraception Clinical Guidelines and the National Integrated Sexual and Reproductive Health and Rights Policy, updated in 2021). South African policy has embraced a rights-based approach to sexual and reproductive health (SRH), defined as "Affirming choice, confidentiality, and individual agency in a non-discriminatory manner while seeking, accessing, and receiving all SRH related services at community levels and health facilities."
Level of Evidence: Review indicator: *Increase in product price, considering inflation*

[4] South African Health Products Regulatory Authority. Professional information (PI) leaflet. Implanon NXT® 68 mg Implant. Organon South Africa (Pty) Ltd. Text last revised 27 August 2019.