CLINICAL PROTOCOL

FAMILY PLANNING

Approved for use by MOH decree No.905 dated 27.12.2006
Ministry of Health of Ukraine

DECREE

27.12.2006 No. 905

On the approval of the clinical protocol on obstetric and gynecological care “Family Planning”

To implement the order of the President of Ukraine dated 06.03.2003 No. 1-1/152 and the directive of the Cabinet of Ministers of Ukraine dated 27.04.2006 No. 244-r “On the approval of the Concept of the State Program ‘Reproductive Health of the Nation, 2006-2015,’” with the aim to unify requirements governing the volume and quality of obstetric and gynecological care,

I decree:

1. Approve the clinical protocol on obstetric and gynecological care “Family Planning” (hereinafter – Clinical Protocol).

2. The Minister of Health of the Autonomous Republic of Crimea; heads of the Dnipropetrovsk, Lviv and Kharkiv Oblast regional main health administrations; head of the Cherkasy Oblast main health and medical catastrophe administration; head of the Vinnysya Oblast health and resort administration; head of the Odesa Oblast health and medical catastrophe administration; heads of the health departments of the regional state administrations; head of the main health and medical care department of the Kyiv city administration; head of the health department of the Sevastopol city administration:

   2.1 Implement the Clinical Protocol into the work of relevant health care facilities under your purview beginning in 2007.

   2.2 Monitor the provision of obstetric and gynecological care in relevant health care facilities under your purview for compliance with the Clinical Protocol.

3. Deputy Minister of Health Y.O. Haydaev is to be responsible for the implementation of this decree.


First Deputy Minister of Health O.M. Orda
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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AP</td>
<td>Antiprogesterone</td>
</tr>
<tr>
<td>BP</td>
<td>Arterial Blood Pressure</td>
</tr>
<tr>
<td>BBT</td>
<td>Basal Body Temperature</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus (HIV)</td>
</tr>
<tr>
<td>VR</td>
<td>Vaginal Ring</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
</tr>
<tr>
<td>IUS</td>
<td>Intrauterine System</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>DMPA</td>
<td>Depot Medroxyprogesterone Acetate</td>
</tr>
<tr>
<td>VSS</td>
<td>Voluntary Surgical Sterilization</td>
</tr>
<tr>
<td>E</td>
<td>Estrogen</td>
</tr>
<tr>
<td>EE</td>
<td>Ethynilestradiol</td>
</tr>
<tr>
<td>w/c</td>
<td>Women’s Consultation</td>
</tr>
<tr>
<td>PID</td>
<td>Pelvic Inflammatory Disease</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Diseases (STD)</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections (STI)</td>
</tr>
<tr>
<td>CIC</td>
<td>Combined Injectable Contraceptives</td>
</tr>
<tr>
<td>COC</td>
<td>Combined Oral Contraceptives</td>
</tr>
<tr>
<td>CP</td>
<td>Contraceptive Patches</td>
</tr>
<tr>
<td>POC</td>
<td>Progestin-Only Contraceptives</td>
</tr>
<tr>
<td>PE</td>
<td>Pulmonary Embolism</td>
</tr>
<tr>
<td>LNG</td>
<td>Levonorgestrel</td>
</tr>
<tr>
<td>LAM</td>
<td>Lactational Amenorrhea Method</td>
</tr>
<tr>
<td>NET-EN</td>
<td>Norethisterone Enantate</td>
</tr>
<tr>
<td>EC</td>
<td>Emergency Contraception</td>
</tr>
<tr>
<td>NSAID</td>
<td>Non-Steroidal Anti-inflammatory Drugs</td>
</tr>
<tr>
<td>OC</td>
<td>Oral Contraceptives</td>
</tr>
<tr>
<td>P</td>
<td>Progestin</td>
</tr>
<tr>
<td>PIC</td>
<td>Progestin-Only Injectable Contraceptives</td>
</tr>
<tr>
<td>NFP</td>
<td>Natural Family Planning</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>POP</td>
<td>Progestin-Only Pills</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>TSS</td>
<td>Toxic Shock Syndrome</td>
</tr>
<tr>
<td>TTC</td>
<td>Transdermal Therapeutic System</td>
</tr>
<tr>
<td>DVT</td>
<td>Deep Venous Thrombosis</td>
</tr>
<tr>
<td>UE</td>
<td>Ultrasound Examination</td>
</tr>
<tr>
<td>CIN</td>
<td>Cervical Intraepithelial Neoplasia</td>
</tr>
<tr>
<td>FPC</td>
<td>Family Planning Center</td>
</tr>
</tbody>
</table>
FAMILY PLANNING

Code ICD-10 - Z 30

Family planning is a service that assists individuals and married couples to achieve certain reproductive goals: avoid unwanted pregnancies; bear children; regulate the intervals between pregnancies; plan for when a baby should be born, taking into account the age of his parents and other factors; and, finally, determine the desired number of children.

Modern approaches to providing information on family planning should include ethical questions for the public on adherence to the requirements of the Declaration on Children’s Rights, which stipulates that a child is entitled to be born under safe conditions.

WHO CLASSIFICATION

Participants of WHO working groups developed a classification system that covers all existing methods of contraception. Methods of contraception are evaluated on a risk-benefit basis (concerning the patient’s health).

The WHO classification system divides all methods of contraception into four categories (classes).

Categories (classes)

1 – A condition for which there is no restriction for the use of the contraceptive method;
2 – A condition where the advantages of using the method generally outweigh the theoretical or proven risks;
3 – A condition where the theoretical or proven risks usually outweigh the advantages of using the method;
4 – A condition which represents an unacceptable health risk if the contraceptive method is used.
### Using the categories in practice

<table>
<thead>
<tr>
<th>Category (class)</th>
<th>With clinical judgement</th>
<th>With limited clinical judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Use method in any circumstances</td>
<td>Yes (Use the method)</td>
</tr>
<tr>
<td>2</td>
<td>Generally use the method</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Use of method not usually recommended unless other more appropriate methods are not available or not acceptable</td>
<td>No (Do not use the method)</td>
</tr>
<tr>
<td>4</td>
<td>Method not to be used</td>
<td></td>
</tr>
</tbody>
</table>

**Explanation:**
- Categories “1” and “4” are self-explanatory.
- Category “2” indicates the method can generally be used, but careful follow-up may be required.
- for Category 3, provision of a method requires careful clinical judgement and access to clinical services. The severity of the condition and the availability, and acceptability of alternative methods should be taken into account. Use of the method is not usually recommended unless other more appropriate methods are not available or acceptable, and the non-use of contraception constitutes a greater risk. Careful follow-up will be required.

Where resources for clinical judgement are limited, a classification of Category 3 indicates that a woman is not medically eligible to use the method.
If the patient is having difficulty choosing between methods of contraception, expert assists her to make an informed choice, providing detailed information on every method and giving advice on a temporary method. Patient is asked to return for a follow-up visit.
SUMMARY TABLE
OF PLANNED EXAMINATIONS CONDUCTED BEFORE THE SELECTION
OF THE METHOD OF CONTRACEPTION

This concerns examinations of individuals in good health that have undergone preventive check-ups over the course of one year.

Gynecological examinations are not mandatory for the recommendation and use of hormonal contraceptives, but are recommended - for preventive aims - not less than once per year. However, medical history should be taken in details.

A preventive examination includes:

– Blood pressure measurement;
– Breast examination;
– Abdominal palpation;
– Gynecological examination;
– Pap test.

The presence of any disease or specific medical condition could necessitate that an additional examination is conducted before prescribing a certain method of contraception.

Class “A” – an examination is recommended in all circumstances for safe and effective use of the contraceptive method.

Class “B” – conducting an examination contributes substantially to safe and effective use of the contraceptive method. However, the expediency of conducting such an examination should align with national standards. The final decision is made on the basis of an assessment of the risk of not performing the necessary examination and not using the necessary contraceptive weighed against the benefits of using the contraceptive.

Class “C” – conducting an examination does not contribute substantially to safe and effective use of the contraceptive method.

The classification explored above was developed with consideration to the correlation between conducting an examination and the guarantee of the safe use of a specific method of contraception. However, the classification does not fully reflect the expediency of examination under other circumstances. For example, some types of examinations that do not play a decisive role in ascertaining the safety and efficacy of a certain method of contraception can offer indispensable assistance in providing preventive services in diagnostics and assessing various pathological conditions.
**Table notes**

* According to “Medical Eligibility Criteria for Contraceptive Use” (3rd edition, 2004), if a woman has a very high individual likelihood of exposure to STIs, she generally should not have an IUD inserted unless other methods are not available or not acceptable. In such cases, an IUD is only recommended for use after these conditions have been treated.

** According to “Medical Eligibility Criteria for Contraceptive Use” (3rd edition, 2004), women at high risk of HIV infection should not use spermicides with nonoxynol-9. Using diaphragms and cervical caps with nonoxynol-9 that provides the contraceptive efficacy are not recommended for women at risk of STIs unless other more appropriate methods are not available or acceptable.

*** It is recommended to measure the blood pressure before using COC, CIC POP, PIC or contraceptive implants. However, women should not be denied use of hormonal methods solely because their blood pressure cannot be measured.

**** Procedures performed using local anesthesia.

---

**Measures to preclude or rule out pregnancy should be taken before using any method of contraception.**

<table>
<thead>
<tr>
<th>Type</th>
<th>COC</th>
<th>CIC</th>
<th>POP</th>
<th>PIC</th>
<th>Implant</th>
<th>IUD</th>
<th>Condoms</th>
<th>Diaphragms, cervical caps</th>
<th>Spermicides</th>
<th>Female sterilization</th>
<th>Vasectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast examination by physician</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>Not conducted</td>
</tr>
<tr>
<td>Pelvic/genital examination</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A</td>
<td>C</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>Not conducted</td>
</tr>
<tr>
<td>Routine laboratory tests</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Hemoglobin test</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>B</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>STI risk assessment: medical history and physical examination</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A*</td>
<td>C*</td>
<td>C**</td>
<td>C**</td>
<td>C**</td>
<td>C</td>
</tr>
<tr>
<td>STI and HIV screening: laboratory tests</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>B*</td>
<td>C*</td>
<td>C**</td>
<td>C**</td>
<td>C**</td>
<td>C</td>
</tr>
<tr>
<td>Blood pressure measurement</td>
<td>***</td>
<td>***</td>
<td>***</td>
<td>***</td>
<td>***</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A</td>
<td>C****</td>
</tr>
</tbody>
</table>
Principles for Selecting a Method of Contraception:

1. Provision of extensive information on methods and means of contraception.
2. Informed desire of the woman/partners to use a method of contraception.
3. Select the method or means of contraception according to the health status of the woman/partners.
4. Select the method or means of contraception according to the age of the woman/partners.
5. Select the method or means of contraception according to the capabilities of the woman/partners.
COMBINED ORAL CONTRACEPTIVES (COCs)

Oral contraceptives are by far the most widespread method of family planning in the world (nearly 100 million women regularly use oral contraceptives). COCs are acknowledged to be a highly effective and safe contraceptives given the absence of contraindications and their proper - in accordance with the instructions - use.

The curative, preventive and cancer risk reduction properties of hormonal contraceptives are highly valued by clinical specialists and patients: reduction of ectopic pregnancies (by 90%), ovarian and endometrial cancer risk reduction (by 50-80%), colorectal cancer (by 40-50 %), and chorionepithelioma (by 100 %), subject to the duration of use, and also decrease in the risk of benign breast diseases (by 40%), and others.

A series of studies has proven the curative and preventive effects of oral contraceptives on endometriosis, uterine fibroids, dysfunctional uterine bleeding and hyperplastic endometrial processes, some forms of amenorrhea, premenstrual syndrome, hypothyroid, rheumatoid arthritis, and osteoporosis. The protective effect of COCs continues for no less than ten years after stopping their use.

Classification

Modern oral contraceptives can be divided into two groups: combined oral contraceptives (COCs) and single-component oral contraceptives (minipills). COCs can be further subdivided into mono-, bi-, and triphasic. At present, no evidence exists that triphasic COCs have any advantages against mono-, or biphasic ones.

TYPES

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Monophasic:</td>
<td>21 active pills contain the same doses of estrogen and progestin (E/P).</td>
</tr>
<tr>
<td>Biphasic:</td>
<td>21 active pills contain 2 different combinations of estrogen and progestin (for example, 10/11).</td>
</tr>
<tr>
<td>Triphasic:</td>
<td>21 active pills contain 3 different combinations of estrogen and progestin (for example, 6/5/10).</td>
</tr>
</tbody>
</table>

There are two types of packaged pills. Some packages contain 28 pills: 21 active hormone pills and 7 placebo pills of a different color. The other sort of packages contains only 21 active hormone pills.

The standard composition of several modern oral contraceptives is provided in details in the table below.
## LIST AND COMPOSITION OF MODERN ORAL CONTRACEPTIVES

### I. Monophasic COC

<table>
<thead>
<tr>
<th>Brand</th>
<th>Quantity</th>
<th>Contents</th>
<th>Composition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercilon</td>
<td>21 pills</td>
<td>0.02 mg 0.15 mg</td>
<td>Ethinyl estradiol desogestrel</td>
</tr>
<tr>
<td>Logest</td>
<td>21 pills</td>
<td>0.02 mg 0.075 mg</td>
<td>Ethinyl estradiol gestodene</td>
</tr>
<tr>
<td>Lindynette-20</td>
<td>21 pills</td>
<td>0.02 mg 0.075 mg</td>
<td>Ethinyl estradiol gestodene</td>
</tr>
<tr>
<td>Yaz 24+4</td>
<td>28 pills</td>
<td>0.02 mg 3 mg</td>
<td>Ethinyl estradiol drospirenone</td>
</tr>
<tr>
<td>Marvelon</td>
<td>21 pills</td>
<td>0.03 mg 0.15 mg</td>
<td>Ethinyl estradiol desogestrel</td>
</tr>
<tr>
<td>Yarina</td>
<td>21 pills</td>
<td>0.03 mg 3 mg</td>
<td>Ethinyl estradiol drospirenone</td>
</tr>
<tr>
<td>Femodene</td>
<td>21 pills</td>
<td>0.03 mg 0.075 mg</td>
<td>Ethinyl estradiol gestodene</td>
</tr>
<tr>
<td>Jeanine</td>
<td>21 pills</td>
<td>0.03 mg 2 mg</td>
<td>Ethinyl estradiol dienogest</td>
</tr>
<tr>
<td>Lindynette-30</td>
<td>21 pills</td>
<td>0.03 mg 0.075 mg</td>
<td>Ethinyl estradiol gestodene</td>
</tr>
<tr>
<td>Novynette</td>
<td>21 pills</td>
<td>0.02 mg 0.15 mg</td>
<td>Ethinyl estradiol desogestrel</td>
</tr>
<tr>
<td>Regulon</td>
<td>21 pills</td>
<td>0.03 mg 0.15 mg</td>
<td>Ethinyl estradiol desogestrel</td>
</tr>
<tr>
<td>Rigevidon</td>
<td>21 pills</td>
<td>0.03 mg 0.15 mg</td>
<td>Ethinyl estradiol levonorgestrel</td>
</tr>
<tr>
<td>Rigevidon 21+7</td>
<td>28 pills</td>
<td>0.03 mg 0.15 mg</td>
<td>Ethinyl estradiol levonorgestrel ferrous fumarate</td>
</tr>
<tr>
<td>Microginon</td>
<td>21 pills</td>
<td>0.03 mg 0.15 mg</td>
<td>Ethinyl estradiol levonorgestrel</td>
</tr>
<tr>
<td>Minisiston</td>
<td>21 pills</td>
<td>0.03 mg 0.125 mg</td>
<td>Ethinyl estradiol levonorgestrel</td>
</tr>
<tr>
<td>Cilest</td>
<td>21 pills</td>
<td>0.035 mg 0.15 mg</td>
<td>Ethinyl estradiol levonorgestrel</td>
</tr>
</tbody>
</table>
**III. Triphasic COC**

<table>
<thead>
<tr>
<th>Product</th>
<th>7 pills</th>
<th>7 pills</th>
<th>7 pills</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tri-Merci</strong></td>
<td>0.035 mg</td>
<td>0.03 mg</td>
<td>0.03 mg</td>
</tr>
<tr>
<td></td>
<td>0.05 mg</td>
<td>0.1 mg</td>
<td>0.15 mg</td>
</tr>
<tr>
<td><strong>Triquilar</strong></td>
<td>0.03 mg</td>
<td>0.04 mg</td>
<td>0.03 mg</td>
</tr>
<tr>
<td></td>
<td>0.05 mg</td>
<td>0.075 mg</td>
<td>0.125 mg</td>
</tr>
<tr>
<td><strong>Tri-Regol</strong></td>
<td>0.03 mg</td>
<td>0.04 mg</td>
<td>0.03 mg</td>
</tr>
<tr>
<td></td>
<td>0.05 mg</td>
<td>0.075 mg</td>
<td>0.125 mg</td>
</tr>
<tr>
<td><strong>Tri-Regol 21+7</strong></td>
<td>0.03 mg</td>
<td>0.04 mg</td>
<td>0.03 mg</td>
</tr>
<tr>
<td></td>
<td>0.05 mg</td>
<td>0.075 mg</td>
<td>0.125 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7 pills</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.03 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.125 mg</td>
</tr>
</tbody>
</table>

**IV. Minipills**

<table>
<thead>
<tr>
<th>Product</th>
<th>28 pills</th>
<th>0.5 mg</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exluton</strong></td>
<td>28 pills</td>
<td>Lynestrenol</td>
</tr>
</tbody>
</table>
**WOMEN ELIGIBLE TO USE COCs:**

- Women of reproductive age;
- Women who have not given birth and those who have;
- Women who need or seek to use a highly effective method of preventing unintended pregnancy;
- Women who are not breastfeeding postpartum;
- Women who have had an abortion;
- Women with anemia;
- Women with dysmenorrhea and chronic pelvic pain;
- Women with an irregular menstrual cycle;
- Women with the history of ectopic pregnancy;
- Women with premenstrual syndrome symptoms;
- Women with hyperandrogenous conditions like acne, seborrhea, or mild hirsutism;
- Women with varicose veins;
- Women suffering from depression;
- Women with thyroid disorders;
- Women with benign breast diseases;
- Women with benign ovarian diseases, endometriosis, or uterine fibroids.

**Pill initiation:** on the first five days of the menstrual cycle; on any day of the menstrual cycle, if one is not pregnant (if one begins to use the contraceptive after the fifth day, specialists recommend using a backup method for seven days).

**Rules for using:** one pill daily – to be taken at the same time. Start on the new package without a break if it contains 28 pills. If the package contains 21 pills, take a seven-day break before using the pills in the new package.

**Managing missed pills:**

<table>
<thead>
<tr>
<th>Missed one active pill</th>
<th>Take the missed pill, and then the next one (at a usual time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missed two or more active pills</td>
<td>Take two pills a day until returning to recommended (in the instruction) schedule – backup method is used for seven days</td>
</tr>
<tr>
<td>Missed placebo pills</td>
<td>Unused pills are discarded and user continue taking pills according to the schedule</td>
</tr>
</tbody>
</table>
WOMEN INELIGIBLE TO USE COCs:

- Pregnant women (known or suspected);
- Women who are breastfeeding;
- Women with unexplained vaginal bleeding (before identifying the cause);
- Women with severe liver diseases or jaundice;
- Women with the history of or current benign or malignant liver tumor;
- Women with the history of or current circulatory disorders, especially related to thrombosis (deep venous thrombosis, pulmonary embolism, ischemic heart disease, stroke etc.);
- Women whose systolic pressure exceeds 160 mm Hg and diastolic pressure is greater than 100 mm Hg;
- Women with blood coagulation disorders or diabetes with complications;
- Women with the history of or current breast cancer or cancer of one of the reproductive system organs;
- Women with migraines and focal neurological symptoms;
- Women who have trouble remembering to take their pills on a daily basis;
- Women with allergy to any COC component;
- Women over age 35 who smoke.

Patients must visit a family planning specialist or women’s consultation if they do not experience a menses-like bleeding:
- While taking the placebo pills (box with 28 pills);
- During a week without pills (box with 21 pills).

## SIDE EFFECTS

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea</td>
<td>Take a pill after dinner or before going to bed</td>
</tr>
<tr>
<td>Diarrhea or vomiting</td>
<td>Use a backup method for seven days</td>
</tr>
<tr>
<td>Spotting or bleeding</td>
<td>See algorithm “Bleeding/spotting during COC use”</td>
</tr>
<tr>
<td>Jaundice</td>
<td>Stop using COCs, see a specialist</td>
</tr>
<tr>
<td>Mastalgia</td>
<td>Stop using COCs if the symptoms persist for more than three months</td>
</tr>
<tr>
<td>Amenorrhea</td>
<td>Do a pregnancy test. If not pregnant, further use of COCs is dependent on woman’s reproductive plans</td>
</tr>
</tbody>
</table>
## CONDITIONS THAT DEMAND SPECIAL CARE

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elevated blood pressure</td>
<td>COC is selected and used only after an extensive evaluation of woman's health status. Women whose blood pressure is less than 160/100 can use COCs.</td>
</tr>
<tr>
<td>Diabetes</td>
<td>COCs can be used in the absence of complications if insulin dosage can be altered.</td>
</tr>
<tr>
<td>Migraines</td>
<td>If the headaches are not accompanied with focal neurological symptoms and independent of hormones, COCs can be used.</td>
</tr>
<tr>
<td>Tobacco smoking</td>
<td>It is recommended (especially for women over age 35) to cease smoking while using COCs.</td>
</tr>
</tbody>
</table>

### Antibacterial drugs and COCs interaction

1. Antibacterial drugs that decrease the concentration of steroids in women using COCs:
   - Rifampicin

2. Antibacterial drugs that do not decrease the concentration of steroids in women using COCs:
   - Ampicillin
   - Doxycycline
   - Flukonazole
   - Metronizadole
   - Miconazole
   - Quinolones
   - Tetracycline

### Anticonvulsants and COCs interaction

1. Anticonvulsants that decrease the concentration of steroids in women using COCs:
   - Barbiturates (including Phenobarbital and Primidone)
   - Carbamazepine and Oxcarbazepine
   - Phelbamate
   - Phenytoin
   - Topiramate
   - Vigabatrin
2. Anticonvulsants that do not decrease the concentration of steroids in women using COCs:
   • Ethosuximide
   • Gabapentin
   • Lamotrigine
   • Levetiracetam
   • Tiagabinet
   • Valproic acid
   • Zonisamide

**Warning Signs for Users of Combined Oral Contraceptives (COC)**

- Chest pain or shortness of breath.
- Severe headache or vision disorders that started or intensified after starting the use of combined oral contraceptives.
- Severe pain in lower limbs.
- Absence of any bleeding or discharges over the course of one week without pills (box with 21 pills) or while using 7 placebo pills (the 28-day package); this may indicate the pregnancy.

*It is essential to visit a physician as soon as possible in case of any of the abovementioned complications.*
ALGORITHM FOR CHOOSING COMBINED ORAL CONTRACEPTIVES (COC)

Patient wants to use COCs

New user

Pregnancy

No

Evaluate health status of patient according to WHO classification categories

Yes

Follow-up at women's consultation depending on reproductive plans

Selected method acceptable

No

Assist to choose alternative method

Yes

Measure blood pressure: 140/90 or higher?

Yes

Counseling on alternative method and referral to internist

No

Regular user

• Check whether COCs are taken correctly
• Review instructions
• Ask about side effects
• Review contraindications
• Provide COCs for 3-12 cycles if possible

Selected method acceptable

No

Counseling on alternative method and referral to internist

Yes

Measure blood pressure: 140/90 or higher?

• Provide method for 3 cycles if possible
• Provide information on:
  – Rules for using COCs;
  – Possible side effects and ways to avoid them;
  – Instructions on troubling symptoms that may arise from COC use.
• Schedule a follow-up visit in three months
• Recommend to visit a physician should problems arise

Follow-up at women's consultation depending on reproductive plans

Evaluate health status of patient according to WHO classification categories
### BLEEDING/SPOTTING DURING COC USE

Spotting and breakthrough bleedings are usually observed in the first three months of COC use.

If COC use began in the last three months, the patient is notified that she may experience breakthrough bleedings, which most often are not harmful for health. If the bleeding continues over a long period of time and becomes a problem for the patient, a specialist will help her to choose a new method of contraception. The table outlines health conditions that may cause bleeding or spotting and recommendations on how to manage them.

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient missed one or more pills or changed the time when she takes her pills</td>
<td>If a woman has missed a pill(s), she is assisted to restore a regular and proper regimen. If this is not possible, she is helped to select a different method of contraception.</td>
</tr>
<tr>
<td>Severe diarrhea or vomiting</td>
<td>If a woman experienced diarrhea or vomiting, she needs to be explained that this might have impact on the efficacy of COCs. Recommended to use a backup method (condom, spermicides, or abstinence) until vomiting/diarrhea ceases and patient takes 7 active pills.</td>
</tr>
</tbody>
</table>
| Takes antibiotics or anticonvulsants | Antibiotics rifampicin and griseofulvin, and also anticonvulsants, with the exception of valproic acid, substantially increase the metabolism of estrogen and progestin in the liver, which reduces their level in the blood causing spotting. Ways of managing the problem:  
- If spotting is not a serious problem, a woman can use a backup method (condom, spermicides) during the short-term treatment by means of these drugs to enhance the contraceptive effect;  
- Switch to DMPA or another effective non-hormonal method;  
- Switch to high-dose COCs, containing 50 mcg of ethynilestradiol or take 1,5 or 2 COC pills containing 30-35 mcg of ethynilestradiol. |
| Gynecological problems ruled out:  
- tumors;  
- pregnancy;  
- abortion;  
- pelvic inflammatory diseases;  
- endometriosis;  
- ectopic pregnancy;  
- cervical pathology | Conduct examination:  
- abdominal palpation;  
- pelvic examination by speculum;  
- bimanual examination;  
- examination by different specialists if necessary;  
- take hemoglobin count |
**Algorithm for Managing Bleeding/Spotting During COC Use**

- If woman is being treated for tuberculosis or epilepsy, she will be recommended to use a backup method of or use a different type or contraceptive until treatment concludes.

- If pills taken improperly, patient is instructed on how to properly take pills.

- If a partial abortion or ectopic pregnancy are suspected, see corresponding protocol.

- Observations:
  - abdominal palpation;
  - pelvic examination by speculum;
  - bimanual examination;
  - ultrasound.

- Pathology identified:
  - Calm down and reassure.
  - Instruct on rules for proper COC use.
  - Suggest keeping a menstrual calendar.
  - Encourage to make follow-up visits.

- When did COC use begin?
  - < 3 months ago
  - > 3 months ago
    - Calm down and reassure.
    - Find out:
      - Regimen of COC use;
      - Whether patient suffers from diarrhea or vomiting;
      - Whether patient took antibiotics or anticonvulsants;
      - See the appropriate table above.

- Observation:
  - Yes
    - Bleeding stopped
    - Calm down and reassure.
    - Recommend to use another reliable method.
    - Prescribe high-dose pills.
    - Recommend marking days when experience bleeding on a calendar.
    - Set a date for a follow-up visit.

- No
  - Follow-up patient taking high-dose pills, consider switching to low-dose COCs
    - Yes
      - Bleeding has been stopped
      - Assist to choose another reliable method of contraception.
      - Treat bleeding.
    - No
      - Bleeding stopped
      - Calm down and reassure.
      - Recommend to use another reliable method.
      - Prescribe high-dose pills.
      - Recommend marking days when experience bleeding on a calendar.
      - Set a date for a follow-up visit.
PROGESTIN-ONLY CONTRACEPTIVES (POCs)

POPs = Progestin-Only Pills  
PICs = Progestin-Only Injectable Contraceptives

PROGESTIN-ONLY PILLS (POPs)

POPs – progestin-only pills contain exclusively gestogen (lynestrenol).

**TYPES**

Package with 0,5 mg lynestrenol.  
28 pills:  
All pills are active (hormonal).

**WOMEN ELIGIBLE TO USE POPs:**

- Women of reproductive age;  
- Women who have not given birth and those who have;  
- Women who want to use an effective method of preventing unintended pregnancy;  
- Breastfeeding mothers who need contraception;  
- Women who are not breastfeeding postpartum;  
- Women who have had an abortion;  
- Women who smoke (any age, any number of cigarettes smoked daily);  
- Women with anemia;  
- Women who don’t want to or cannot use contraceptives with estrogen;  
- Obese women;  
- Women with heart and thyroid disorders;  
- Women with benign breast and ovarian diseases, endometriosis, uterine fibroids.

**Rules for use:** one pill a day, everyday. Women who are not breastfeeding must take their pills everyday at the same time: any delay (even a short delay of several hours) will increase the risk of unwanted pregnancy.

**Missing pills:** if a woman forgets to take one or more pills, she should immediately take a pill and resume her normal schedule for taking pills.

If a woman has recently given birth and her menstrual cycle has yet to be established, and she is three hours late missing a pill (independent of lactation), she must abstain from sexual contact for the next 48 hours or use barrier contraception methods.
<table>
<thead>
<tr>
<th>Indications/Conditions of Use</th>
<th>When to start</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding</td>
<td>Six weeks after giving birth</td>
</tr>
<tr>
<td>Postpartum – woman who is not breastfeeding</td>
<td>At any time, if certain that woman is not pregnant</td>
</tr>
<tr>
<td>After a miscarriage or abortion</td>
<td>Immediately or later, if certain that woman is not pregnant</td>
</tr>
<tr>
<td>After ceasing to use a different method of contraception</td>
<td>Immediately</td>
</tr>
<tr>
<td>Menstrual cycle</td>
<td>On any day of the menstrual cycle, if certain that woman is not pregnant:</td>
</tr>
<tr>
<td></td>
<td>- if the first pill is used on one of the first 5 days of the cycle, additional methods need not to be used;</td>
</tr>
<tr>
<td></td>
<td>- if a woman starts to use pills later, it is necessary, at the very least, to use barrier contraception methods or abstain from sexual contact for the first 48 hours.</td>
</tr>
</tbody>
</table>

**MANAGING COMMON SIDE EFFECTS AND OTHER PROBLEMS**

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amenorrhea (absence of menstrual bleeding)</td>
<td>Pregnancy test. If woman is <strong>not pregnant</strong>, provide counseling on existing problems. In case of a typical uterine pregnancy, a strategy is devised to meet the woman’s reproductive plans. If the woman decides to go through with the pregnancy, she is recommended to stop using pills (a small dose of progestin (LNL) is harmless to fetus). If a specialist suspects <strong>ectopic pregnancy</strong>, the woman is referred for full examination and treatment.</td>
</tr>
<tr>
<td>Spotting</td>
<td>If the use of POPs (no pregnancy) is the cause of spotting and presents no problems for the patient, treatment is not provided. If the patient is still concerned after consultation, she is assisted to choose a different method of contraception.</td>
</tr>
</tbody>
</table>
CONDITIONS THAT DEMAND SPECIAL ATTENTION WHILE USING CONTRACEPTIVES

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>Avoid using POPs unless more appropriate methods are not available or not acceptable.</td>
</tr>
<tr>
<td>Liver diseases</td>
<td>Use is possible after comprehensive examination, and when it is not possible to choose an alternative method of contraception.</td>
</tr>
</tbody>
</table>

**Warning Signs for Users of Progestin-Only Pills (POPs)**

- Delayed menses after several months of regular cycles (can be a sign of pregnancy).
- Severe pain in the lower abdomen (can be a sign of ectopic pregnancy).
- Excessive (twice as long or twice as much in volume as normal) or prolonged (>8 days) menses.
- Migraines (vascular headaches), repeated severe headaches or blurred vision.

*It is essential to visit a physician as soon as possible in case of any of the abovementioned complications.*
**PROGESTIN-ONLY INJECTABLE CONTRACEPTIVES (PICs)**

**TYPES**

Depo-Provera: 150 mg of depot medroxyprogesterone acetate (DMPA), injections **every three months**. An injection can be performed up to 2-4 weeks (28 days) **before** or 2-4 weeks (28 days) **after** the designated date.

Noristerat: 200 mg of norethisterone enanthate (NET-EN), injections **every two months**. Injections can be performed up to 2 weeks (14 days) **before** or 2 weeks (14 days) **after** the designated date.

**WOMEN ELIGIBLE TO USE PICs:**

- Women of reproductive age;
- Women who have not given birth and those who have;
- Women who want to use an effective method of preventing unintended pregnancy;
- Breastfeeding mothers (6 weeks or more after giving birth) who need contraception;
- Women who are not breastfeeding postpartum;
- Women who have had an abortion;
- Women who have their desired number of children, but who are not interested in voluntary sterilization;
- Women with a history of ectopic pregnancy;
- Women who smoke (any age, any number of cigarettes smoked daily);
- Women with blood pressure <160/100, blood coagulation disorders or sickle cell anemia;
- Women with heart and thyroid disorders;
- Women with benign breast and ovarian diseases, endometriosis, or uterine fibroids;
- Women taking anticonvulsants or antituberculosis medications;
- Women who do not want to or are not eligible to use COCs;
- Women who have trouble remembering to take their pills on a daily basis.

**START USING PICs**

- During seven days from the beginning of menses. The use of backup methods of contraception is not necessary.
• On any day of the menstrual cycle, if the patient is certain that she is not pregnant. If the introduction of PICs begins more than seven days after menses have started, it is recommended to abstain from sexual contact or use the backup method for the next seven days.

• After giving birth:
  – After six months, if the woman is using the lactational amenorrhea method (LAM);
  – After six weeks, if she is breastfeeding, but does not use LAM;
  – After three and more weeks, if she is not breastfeeding.

• Post-abortion (immediately or within seven days following the procedure).

• When switching to PICs from other hormonal contraceptives, the first injection can be made without any delay if the woman is not pregnant. It is not necessary to wait for the beginning of the next menstrual cycle.

• If the previous hormonal contraceptive was injected, the introduction of PICs must be conducted on the next scheduled injection date. It is not necessary to use the backup method of contraception.

• If the patient refuses to use non-hormonal methods of contraception (excluding an IUD), the first PIC injection can be performed immediately if the woman is not pregnant.

• If the patient refuses to use an IUD (including the levonorgestrel containing intrauterine system), PICs can be introduced within seven days following the beginning of menses. It is not necessary to use any other backup method of contraception. IUD can be removed during this period of time.

• If PIC use begins at any other time:
  – If the woman had sexual relations during her current menstrual cycle and menses started more than seven days ago, she is advised to remove the IUD during the next menstrual cycle;
  – If the woman had no sexual intercourse during her current menstrual cycle and menses started more than seven days ago, she is advised to abstain from sexual contact during the next seven days or use the backup method of contraception. If an IUD is the backup contraception method, then it should be removed during the next menstrual cycle.

**REPEAT INJECTION OF DMPA**

It is recommended to perform repeat injections of DMPA every three months.

It is recommended to perform repeat injections of NET-EN every two months.

If, for any reason, the patient is unable to adhere to the interval between repeat DMPA and NET-EN injections, it is possible to perform the injection two weeks prior to or two weeks after the scheduled injection date. It is not necessary to use any backup method of contraception.
If the introduction period exceeds two weeks, a repeat injection can be performed if the woman is not pregnant. In this case, the woman is advised to abstain from sexual contact or use backup methods of contraception over the next seven days.

Alternating the use of DMPA and NET-EN is not recommended.

**WOMEN INELIGIBLE TO USE PICs:**

- Pregnant women (known or suspected);
- Women with unexplained vaginal bleeding (before identifying the cause);
- Women who cannot tolerate the changes in their menstrual cycle;
- Women with current or past breast cancer.

**MANAGING COMMON SIDE EFFECTS AND OTHER PROBLEMS**

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amenorrhea</strong> (absence of menstrual bleeding)</td>
<td>Pregnancy test. If she is not pregnant, she will not undergo treatment; rather, she will receive consultation. If normal <em>uterine pregnancy</em> is identified, subsequent action will depend on the reproductive plans of the patient. If the patient chooses to go through with the pregnancy, injections are discontinued (small dose of progestin (LNL) is harmless to fetus). If a specialist suspects <em>ectopic pregnancy</em>, the woman is referred for full examination and treatment.</td>
</tr>
<tr>
<td><strong>Vaginal bleeding/spotting</strong></td>
<td>If the cause is not identified and the woman is not pregnant, she is explained that spotting is not a serious problem and, usually, does not require treatment. In most women the changes in bleeding patterns become regular after 6-12 months. If the patient is not put at ease by consultation, but she wants to continue using PICs, she is recommended two types of treatment (if the use of estrogen is not contraindicated): COC cycle (30-35 mcg EE) or non-steroidal anti-inflammatory drugs (NSAID), excluding aspirin. Menses should begin during the first week after finishing COC use (if the 21-day package was used) or while taking the last seven pills from the 28-day package. If bleeding is heavy, low-dose COCs are prescribed – two pills a day for 3-7 days and then one pill daily for 21 days. The patient is warned that spotting could appear for a week following the discontinuation of COC use.</td>
</tr>
</tbody>
</table>
Patient is explained that weight changes in the range of 1-2 kg are to be expected during the use of PICs. Eating patterns and habits of the woman are examined if her weight change exceeds two kilograms. If the weight changes are still unacceptable for the woman after consultation, injections are discontinued – patient is helped to choose a different method of contraception.

**SPECIAL INSTRUCTIONS**

- Patients with the history of treatment for depression should be carefully followed up during the PIC use.
- Some patients who use DMPA could experience the decrease of glucose tolerance. This should be taken into account while prescribing it for patients with diabetes.
- DMPA use can effect the results of the following laboratory tests:
  - Determining the level of gonadotropins;
  - Determining the level of progesterone, cortisone, and estrogen in the blood plasma;
  - Determining the level of pregnanediol in the urine;
  - Glucose tolerance test.
  DMPA does not affect lactation, as the concentration of the drug in the breast milk is insignificant. DMPA is not known to have a negative effect on child development. Overdose effects have not been documented.

**CONDITIONS THAT DEMAND SPECIAL CARE**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute liver disease (acute viral hepatitis)</td>
<td>Avoid using PICs, with the exception of cases when more appropriate methods are not available or not acceptable.</td>
</tr>
<tr>
<td>Elevated blood pressure (≥ 160/100)</td>
<td>Avoid using PICs, except in cases when more appropriate methods are not available or contraindicated.</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Women with prolonged or progressive diabetes should avoid using PICs, except in cases when more appropriate methods are not available or contraindicated.</td>
</tr>
</tbody>
</table>
Warning Signs for Users of Progestin-Only Injectable Contraceptives (PICs)

- Delayed menses after several months of regular cycles (can be a sign of pregnancy).
- Severe pain in the lower abdomen (can be a sign of ectopic pregnancy).
- Excessive (twice as long or twice as much in volume as normal) or prolonged (>8 days) menses.
- Discharge of puss or bleeding from the injection site.
- Migraines (vascular headaches), repeated severe headaches or blurred vision.

It is essential to visit a physician as soon as possible in case of any of the abovementioned complications.
ALGORITHM FOR MANAGING BLEEDING/SPOTTING DURING DMPA USE

Patient complains on spotting/bleeding during DMPA use. No pelvic inflammatory diseases present.

Examination/Tests:
- blood pressure;
- abdominal palpation;
- pelvic examination by speculum;
- bimanual examination;
- hemoglobin count;
- ultrasound.

Problem identified

If incomplete abortion or ectopic pregnancy suspected, patient is referred to gynecological department.

Problem unidentified

Spotting that lasts < 8 days

Patient counseling

Spotting, excessive bleeding, > 8 days or twice as much as normal menses

Patient satisfied with consultation?

Yes

Follow-up

Problem solved?

Yes

Follow-up continued

No

Bleeding stopped?

Yes

Follow-up patient taking medication

No

Bleeding has not lessened or has intensified

- Prescribe low-dose COCs – 2 pills for 3-7 days, and then 1 pill daily till the 21st day.
- Patient warned that spotting may occur following the discontinuation of COC use during one week.

Bleeding hasn’t stopped:

- Explore the possibility of using another method of contraception;
- Treat bleeding.

Bleeding stopped:

- Return to normal schedule of DMPA use;
- Encourage to make follow-up visits.

Examination/Tests:

- blood pressure;
- abdominal palpation;
- pelvic examination by speculum;
- bimanual examination;
- hemoglobin count;
- ultrasound.

Follow-up continued
CONTRACEPTIVE PATCHES

The patch – transdermal therapeutic system (TTS) – is a hormonal contraceptive intended for systemic use.

TYPES

Evra: 6 mg norelgestromin and 0,6 mg ethynilestradiol; every patch releases 150 mcg norelgestromin and 20 mcg ethynilestradiol over a 24-hour period (both doses approximate the daily rhythm of hormone excretion).

WOMEN ELIGIBLE TO USE TTS:

• Women of reproductive age;
• Women who have not given birth and those who have;
• Women who are not breastfeeding postpartum;
• Women who have had an abortion;
• Women with anemia;
• Women who experience painful menses.

START USING TTS

If a woman didn’t use hormonal contraceptives during her previous menstrual cycle

Use of the hormonal patch can start on the first day of menses. One patch is attached to the skin, where it stays for one week (seven days). The day on which patch is worn for the first time (1st day/initiation day) defines the subsequent changes. The patch is subsequently changed on this day every week (8th and 15th days of the cycle). The patch is removed on the 22nd day of the cycle – the patient does not wear a patch from the 22nd to the 28th day of the cycle. The next day is considered the first day of the new contraceptive cycle.

Patients are advised to attach the patch on the shoulder blade, shoulder, buttocks or lower abdomen. The next patch should always be put on a different part of the body than the previous one.

If a woman decides to start using the patch, but not on the first day of her cycle, it is imperative that she use barrier methods of contraception for the first seven days of the first contraceptive cycle.

If a woman is switching to hormonal patches from COCs

TTS should be attached to the skin on the first day of the menstrual-like reaction which starts upon the discontinuation of the use of combined oral contraceptives. If menstrual-like bleeding does not begin within five days after taking the last contraceptive pill, it is necessary to rule out pregnancy before using patch.
If the use of TTS begins after the first day of menses, the patient must use barrier methods of contraception for seven days. If more than seven days have passed after taking the last contraceptive pill, the patient could begin to ovulate, in this case she should consult with a doctor before start using hormonal patches. Sexual contacts during this extended period when the patient is not using any method of contraception could lead to pregnancy.

**If the woman is switching to the patch from progestin-only contraceptives**

Women can switch to the patch on any day (on the day when her implant was removed or when she was scheduled to have her next injection), but she is advised to use barrier methods of contraception for the first seven days to enhance the contraceptive effect.

**After an abortion or miscarriage**

Women can start using the patch after an abortion or miscarriage before the 20th week of pregnancy. Women do not need to use additional methods of contraception if they begin to use the patch immediately following an abortion or miscarriage. Women should know that they may ovulate during 10 days following an abortion or miscarriage. After an abortion or miscarriage after the 20th week, the patch can be used starting on the 21st day following the abortion or miscarriage or the first day of menses.

**After giving birth**

Women who are not breastfeeding can start using the patch no earlier than 4 weeks since giving birth. Women who begin to use the patch later should use the barrier method of contraception for the first seven days. If women have had sexual contacts, pregnancy should be ruled out before using TTS, or woman should wait till the first menses.

**If the patch completely or partially detached**

If the patch is completely or partially detached, an insufficient amount of its active components reaches the blood stream.

Even if the patch is partially detached:

- For less than 24 hours, should reapply the patch in the same area or replace it with a new patch. It is not necessary to use additional methods of contraception. The next patch should be attached on schedule;

- For more than 24 hours, or the user has no idea when the patch detached, she can become pregnant. Woman starts a new cycle attaching patch, this day is considered to be the first day of the contraceptive cycle. Barrier methods should be used concurrently only during the first seven days of the cycle. She should not attempt to apply a patch that has lost its adhesive properties; it should be replaced with a new patch. She should not use adhesives or wraps to hold the patch in place.
**WHEN THE USER MISSED TO REPLACE THE PATCH (TTS)**

*At the beginning of any contraceptive cycle (first week/first day):*

- Women might not be protected from unintended pregnancy: they should apply the first patch of the new cycle as soon as possible. This day is considered the “first day,” and is used to calculate “replacement days.” Non-hormonal contraceptives should be used concurrently throughout the first seven days.

*In the middle of the cycle (second week/ 8th day or third week/ 15th day):*

- The user should apply a new patch if one to two days (48 hours) have passed since the last replacement day. The next patch should be applied on the regular “replacement day”. If the woman used the patch correctly for seven days preceding first missed replacement day, then there is no need for a backup contraception.
- The user might not be protected from unintended pregnancy if more than two days (48 hours and more) have passed since the patch replacement day. She should stop the current contraceptive cycle and immediately start a new four-week cycle by applying the new patch. This day is considered the “first day,” and is used to calculate “replacement day.” Barrier methods should be used concurrently throughout the first seven days of the new cycle.

*At the end of the cycle (fourth week/ 22nd day):*

- If the patch was not removed at the end of the 4th week (22nd day), it should be removed as soon as possible.
  The next contraception cycle should begin after a seven-day break.

**WOMEN INELIGIBLE TO USE TTS:**

- Women who are overly sensitive to the components of the TTS;
- Women with current and history of venous thrombosis (e.g., deep venous thrombosis, pulmonary embolism), current and history of arterial thrombosis, (e.g., stroke, myocardial infarction, retinal artery thrombosis), or precursors to thrombosis (angina pectoris, transient ischemic attack);
- Women with severe and multiple risk factors for arterial thrombosis:
  - severe arterial hypertension (consistently elevated blood pressure >160/100);
  - diabetes with vascular lesions;
  - inherited dyslipoproteinemia;
  - predisposition to venous or arterial thrombosis, e.g., resistance to activated Protein C, antithrombin III deficit, Protein C deficit, Protein S deficit, hyperhomocysteinemia and antiphospholipid antibodies (antibodies against cardiolipin, lupus anticoagulant).
- Women with migraines with aura;
• Women with confirmed or suspected breast cancer, endometrial cancer, and confirmed or suspected estrogen dependent tumors;
• Women with liver adenoma or liver cancer;
• Women with vaginal bleeding;
• Women who are pregnant, lactating, or those who are not breastfeeding 4 weeks postpartum.

CONDITIONS THAT DEMAND SPECIAL CARE

<table>
<thead>
<tr>
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<th>Recommendations</th>
</tr>
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<tbody>
<tr>
<td>Elevated blood pressure</td>
<td>Women with blood pressure measurements consistently &gt; 160/100 should discontinue using TTS. Resume use when blood pressure returns to normal levels after using hypotensive therapy.</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Closely follow-up the health status of the woman with diabetes, especially during the early stages of hormonal patch use.</td>
</tr>
<tr>
<td>Liver function disorders</td>
<td>Discontinue the use of TTS until the liver function markers return to normal levels.</td>
</tr>
</tbody>
</table>

Warning Signs for Users of Hormonal Patches

• Delayed menses after several months of regular cycles (can be a sign of pregnancy).
• Severe pain in the lower abdomen (can be a sign of ectopic pregnancy).
• Excessive (twice as long or twice as much in volume of blood loss as usual) or prolonged (>8 days) menses.
• Migraines (vascular headaches), repeated severe headaches or blurred vision.

It is essential to visit a physician as soon as possible in case of any of the abovementioned complications.
COMBINED VAGINAL RINGS

Upon placement in the vagina, flexible and elastic rings release ethynilestradiol and etonogestrel from a 54mm ethylene vinyl acetate copolymer ring. The release of hormones from the ring (located in the vagina) is regulated by the user’s body temperature. The hormones make their way through the vagina’s mucous membrane into the bloodstream. Therefore, the systemic impact on the user’s body will be minimal. Combined vaginal rings provide contraceptive effect by suppressing ovulation.

**TYPES**

NuvaRing – 15 mcg ethynilestradiol/120 mcg etonogestrel

**WOMEN ELIGIBLE TO USE VAGINAL RINGS:**

- Women of reproductive age;
- Women who have not given birth and those who have;
- Women who want to use an effective method of preventing unintended pregnancy;
- Women who are not breastfeeding postpartum;
- Women who have had an abortion;
- Women with anemia;
- Women who suffer from severe pain during menses;
- Women with an irregular menstrual cycle;
- Women with the history of ectopic pregnancy;
- Women with varicose veins;
- Women suffering from depression;
- Women with thyroid disorders;
- Women with benign breast diseases;
- Women with benign ovarian diseases, endometriosis, or uterine fibroids.

**START USING COMBINED VAGINAL RINGS:**

- **hormonal contraceptives were not used during the previous cycle**

  Women should insert the ring between the 1st and 5th day of the menstrual cycle, but no later than the 5th day of the cycle, even if menses-like bleeding has yet to cease. It is advised to concurrently use barrier methods during the first seven days of vaginal ring use. It is not necessary to use additional methods of contraception during following cycles.

- **switching from combined oral contraceptives (COCs)**

  Women should insert the ring no later than the seventh day of the pill-free interval.
– switching from contraceptives (pills, implants, or injections) or levonorgestrel-containing intrauterine system

Women can switch to the ring on any day after taking a pill. She can switch to the ring from an implant or levonorgestrel-containing IUS on the day of their removal; from an injectable contraceptive - on the day of the next scheduled injection. In all of the abovementioned cases, women should use backup barrier methods for the first seven days of vaginal ring use.

– after a first-trimester abortion

Women can immediately start using the ring. It is not necessary to use backup methods of contraception.

– after giving birth or a second-trimester abortion

Women can start using the ring four weeks after giving birth (if they are not breastfeeding) or had a second-trimester abortion. If a woman starts using the ring later, she should use barrier methods for the first seven days of use. If a woman has already had unprotected sexual intercourse, pregnancy should be ruled out or should wait till the first menses prior to starting vaginal ring use.

USE

One ring lasts for one whole cycle. The ring stays in the vagina for three weeks, before being removed for a seven-day break. After the seven-day break, a new ring is inserted into the vagina. If the ring is expelled, it should be thoroughly washed with running water and re-inserted into the vagina no later than three hours after its initial removal.

WOMEN INELIGIBLE TO USE COMBINED VAGINAL RINGS:

- Pregnant women (suspected or known);
- Women who are breastfeeding;
- Women with vaginal bleeding (before identifying the cause);
- Women with acute liver diseases (viral hepatitis);
- Women over age 35 who smoke;
- Women with the history of myocardial infarction, stroke and elevated blood pressure (≥ 160/100);
- Women with the history of blood coagulation disorders or diabetes with complications;
- Women with breast cancer;
- Women with migraines and focal neurological symptoms.
Warning Signs for Users of Combined Vaginal Rings

- Delayed menses after several months of regular cycles (can be a sign of pregnancy).
- Severe pain in the lower abdomen (can be a sign of ectopic pregnancy).
- Excessive (twice as long or twice as much in blood loss volume as usual) or prolonged (>8 days) menses.
- Migraines (vascular headaches), repeated severe headaches or blurred vision.

*It is essential to visit a physician as soon as possible in case of any of the abovementioned complications.*
LACTATIONAL AMENORRHEA METHOD

LAM – method of contraception based on breastfeeding. Efficacy of the method is depended on the compliance with criteria for the LAM use. Used as a temporary method of contraception.

LAM is a natural way of protecting against unplanned pregnancy. The method is effective for the first six months following childbirth if the user meets the criteria mentioned below.

Criteria for LAM:
1. Less than six months since childbirth.
2. Lactational amenorrhea.
3. Woman exclusively breastfeeds:
   • Feeds her child on demand:
   • At least six times a day (including nocturnal feeding), and the child receives no other food, except for mother’s milk;
   • Interval between feedings constitutes no more than four hours during the day and six hours during the night;

If a woman is hesitant to rely on LAM only, she should be advised to use other methods of contraception: condoms, spermicides, POP, DMPA, or IUD.

WOMEN ELIGIBLE TO USE LAM:

Women who exclusively breastfeed; women who are less than six months postpartum; women who have not had their menses returned after childbirth.

PATIENT INSTRUCTIONS

How often to feed

Must feed the child on demand from both breasts approximately 6-10 times daily.

At the very least, the child should be fed once a night (the interval between two feedings should not exceed six hours).

Note: providing nutrition to the baby and thus improving his/her health is the main goal of breastfeeding. The child may not demand to be fed 6-10 times a day or may sleep through his or her feeding time. This is a common occurrence; however, it is necessary to warn women that if these things happen, the effectiveness of breastfeeding as a method of contraception is reduced.

Feeding solid food

If the child shows signs of adequate physical growth (including weight gain), and the mother follows a balanced diet and receives sufficient rest in order to
maintain the proper volume of breast milk, then the child will not need other food until he or she reaches six months of age.

As soon as solid food or fluids begin to supplement the mother’s milk, the child will be fed less than 6-10 times a day, and breastfeeding will not be an effective method of preventing unplanned pregnancy.

**Menses**

The return of menses points to a woman’s renewed reproductive capacity – she should immediately start using a different method of contraception.

**WOMEN INELIGIBLE TO USE LAM:**

- Women who have their menses returned;
- Women who do not exclusively breastfeed;
- Women whose children are six months or older.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing regular supplementary feeds (instead of mother’s milk)</td>
<td></td>
</tr>
<tr>
<td>Return of postpartum menses</td>
<td>Assist the patient with choosing a different method of contraception and encourage her to continue breastfeeding.</td>
</tr>
<tr>
<td>Interval between feedings during the day is greater than four hours and at night exceeds six hours</td>
<td></td>
</tr>
<tr>
<td>Child is six months or older</td>
<td></td>
</tr>
</tbody>
</table>
Patient wants to use LAM

Menses returned?

No

Age of the child

Under 6 months

Criteria met

Recommend using LAM as a contraceptive method for up to six months after childbirth

Criteria not met

Advise to use a backup method of contraception and continue breastfeeding

Yes

6 months or older

Assist in choosing an alternative method

Criteria - exclusive breastfeeding:

- Child does not receive other liquid or solid food but receives only mother’s milk on a regular basis;
- No prolonged feeding intervals (day or night).
INTRAUTERINE DEVICES (IUDs)

COPPER-BEARING INTRAUTERINE DEVICES

TYPES OF IUDs:

- Multiload-250 (MLCu-250);
- Multiload-375 (MLCu-375);
- TCu-380A;
- TCu-380Ag;
- TCu-380S;
- TCu-200;
- TCu-200B;
- TCu-200Ag;
- Nova T.

The successful use of an IUD depends on:

- Thorough examination and risk assessment for STIs and HIV;
- Professional insertion of an IUD and adherence to the rules on preventing infections;
- Diligent and attentive counseling of the patient.

IUDs are not recommended for women who haven’t given birth but who plan to do so.

WOMEN ELIGIBLE TO USE IUDs:

- Women of reproductive age who have given birth;
- Women with the history of childbirths;
- Women who want to use a highly effective, long-term method of preventing pregnancy;
- Women who earlier successfully used IUDs;
- Women who are breastfeeding postpartum;
- Women who have had an abortion and have no signs of pelvic inflammatory diseases;
- Women who are at low risk of STIs;
- Women who don’t want to or cannot use hormonal methods of contraception;
- Women who have trouble remembering to take their birth control pills on a daily basis;
- Obese women;
- Women with the history of or current circulatory disorders, especially related to thrombosis (deep venous thrombosis, pulmonary embolism, ischemic heart disease, stroke etc.);
- Women with blood pressure > 160/100;
- Women with migraines;
- Women with malignant and benign breast diseases.

**START USING AN IUD**

**Copper-bearing IUDs**

- If the menstrual cycle is regular, an IUD can be inserted during the first twelve days from the beginning of menses at any time convenient for the patient (not only during menstrual bleeding). It is not necessary to use any backup method of contraception.
- If it is possible to determine that the woman is not pregnant, an IUD can be inserted at any moment of the menstrual cycle. It is not necessary to use any backup method of contraception.
- An IUD can be inserted after childbirth if:
  - less than 48 hours have passed since the childbirth;
  - the woman is more than four weeks postpartum;
- If between 48 hours and four weeks have passed since childbirth, IUD use is not recommended, with the exception of cases when other more appropriate methods of contraception cannot, for one reason or another, be used.
- An IUD can be inserted immediately following an abortion if the patient has not experienced any complications or does not have the history of chronic genital disease.
- If the woman refuses to use any other method of contraception, an IUD can be inserted as soon as it is confirmed that the woman is not pregnant. It is not necessary to wait for the next menstrual cycle.

**PROBLEMS THAT MUST BE RESOLVED BEFORE INSERTING AN IUD:**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia Hb &lt; 90 g/l, hematocrit &lt; 27%</td>
<td>Identify the cause and treat the anemia</td>
</tr>
<tr>
<td>Dysmenorrhea</td>
<td>IUDs (except for a progestin based IUD) should not be the contraceptives of choice</td>
</tr>
<tr>
<td>Valvular heart disease (lung hypertension, history of bacterial endocarditis)</td>
<td>Counseling by the specialist to determine the severeness of the process</td>
</tr>
</tbody>
</table>
Examinations:
- *Abdominal palpation*: symptoms of pain, rule out neoplasms in the abdominal cavity;
- *Pelvic examination by speculum*: status of the cervix, vagina, and nature of discharges;
- *Bimanual examination*: status of the cervix, increased or painful uterus and uterine appendages;
- *Tests*: hemoglobin in blood, hematocrit, vaginal and cervical canal smear for microbiology examination.

**WOMEN INELIGIBLE TO USE IUD:**
- Pregnant women;
- Women who have had a septic abortion;
- Women with postpartum sepsis;
- Women with unexplained vaginal bleeding;
- Women with cervical or endometrial cancer;
- Women with a malignant gestational tumor;
- Women with a pelvic inflammatory diseases at the time of consultation or during the last three months;
- Women who have an STI or had STI in the last three months;
- Women who have anatomical abnormalities of the reproductive organs with distortion of the uterine cavity;
- Women with pelvic tuberculosis;
- Women with uterine fibroids.

**MANAGING COMMON SIDE EFFECTS AND OTHER PROBLEMS**

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amenorrhea</strong> (lack of menstrual bleeding)</td>
<td>Pregnancy test. If she is <strong>not pregnant</strong>, the IUD is not removed. Patient is being counseled. If the patient is <strong>pregnant</strong>, she has her options explained. If her pregnancy is less than 13 weeks and the strings of the IUD are visible, it is recommended to remove the IUD. If the strings of the IUD are not visible and the pregnancy is more than 13 weeks, the IUD will not be removed. If the patient is pregnant and wants to give birth, but do not want to remove the IUD, she is explained that the risk of miscarriage or an infection increases and that she will be under close surveillance.</td>
</tr>
<tr>
<td>Condition</td>
<td>Action/Recommendation</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Contraction-like pain</strong></td>
<td>Rule out pelvic inflammatory diseases (PID) or other causes of pain. Provide medical care. If the IUD is the cause of pain, the patient is prescribed analgesics to reduce discomfort. If the pain is severe, the IUD is removed and the patient will be assisted to choose another method of contraception.</td>
</tr>
<tr>
<td><strong>Irregular or heavy vaginal bleeding</strong></td>
<td>Rule out pelvic inflammatory diseases or ectopic pregnancy. If needed, provide treatment to the patient. If no disease is identified, and the bleeding is prolonged and heavy, counseling and symptomatic treatment are provided. NSAIDs (except for aspirin) are prescribed to reduce the bleeding. Patients can request to remove the IUD. If the IUD was inserted more than three months ago and anemia has been detected (hemoglobin&lt;70 g/l), it is recommended to remove the IUD and the patient is assisted to choose another method of contraception.</td>
</tr>
<tr>
<td><strong>Missing strings</strong></td>
<td>Pregnancy test. Find out whether IUD came out (expulsion) by asking a woman. If the woman is not pregnant and expulsion did not occur, she is advised to use condoms. Examine the cervical canal for the strings. If they are not found in the canal, the woman will be sent to get an ultrasound. If the woman is not pregnant, the IUD came out or could not be found during detailed examination, in the absence of contraindications, either a new IUD is inserted or the patient is assisted to choose another method of contraception. Must keep in mind the possible perforation of the uterine walls by the IUD.</td>
</tr>
<tr>
<td><strong>Vaginal discharges/ suspected PID</strong></td>
<td>Patient tested for STIs. If an infection is suspected or detected, the patient is given antibiotics before the IUD is removed. If the patient has pelvic inflammatory disease, she is treated in accordance with established standards. If the woman wants to continue using the IUD, there is no need to remove it. If the woman refuses to further use the IUD, it is removed after the beginning of the treatment with antibiotics. If the treatment of the pelvic inflammatory disease is unsuccessful, the IUD should be removed and treatment should be continued.</td>
</tr>
</tbody>
</table>
CONDITIONS THAT DEMAND SPECIAL CARE

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe pain during menses</td>
<td>Patient counseled on the possibility of increased menstrual pain and bleeding during IUD use. (As a rule, this is only a problem during the first few cycles of copper-bearing IUD use).</td>
</tr>
<tr>
<td>Valvular heart disease</td>
<td>Prophylactic antibiotics prescribed during the IUD insertion.</td>
</tr>
<tr>
<td>Anemia (hemoglobin &lt;90 g/l)</td>
<td>IUD is chosen only if this is the most appropriate method for the patient and the use of other methods of contraception is not impossible. Anemia treated concurrently; close surveillance of the health status of the patient.</td>
</tr>
</tbody>
</table>

Warning Signs for IUD Users

- Delays in menses with signs of pregnancy (nausea, breast pain and discomfort etc).
- Prolonged or contraction-like pain in the lower abdomen, especially when accompanied by feeling sick, fever (these symptoms may indicate pelvic inflammatory diseases).
- Strings of the IUD missing; or examination of the cervical canal shows the plastic tip of the IUD.
- Risk of contracting an STI – IUDs do not protect against STIs or HIV/AIDS.

It is essential to visit a physician as soon as possible in case of any of the abovementioned complications.
ALGORITHM FOR PRESCRIBING COPPER-BEARING IUDs

Patient wants to use an IUD

Is she pregnant?

No

Evaluate the patient (see WHO classification system table)

No problems

- Referred for IUD insertion.
- Information provided:
  - how to check for strings;
  - side effects;
  - warning signs;
  - return visits.
- Ensure that woman knows about the optimal duration of IUD use.

Yes

Follow-up in women’s consultation according to the reproductive plans

Problems detected

- Counseled on other methods of birth control.

Patients with STIs can start using an IUD in three months after their treatment if there are no relapses and there is no risk of contracting another STI in the future.
LEVONORGESTREL (LNG) INTRAUTERINE SYSTEM (IUS)

**TYPES**

Mirena system is inserted into the uterus by a physician for five years. It releases progestogen (LNG) into the uterine cavity (20 mcg daily).

**WOMEN ELIGIBLE TO USE IUS:**

- Women of reproductive age who have given birth, including women in the late reproductive period;
- Women who have given birth, without distortion of the uterine cavity;
- Women who want to use reliable contraceptives;
- Women who are breastfeeding postpartum;
- Women who have had an abortion (given the absence of inflammatory process or after the recent treatment);
- Women with menorrhagia;
- Women suffering from anemia;
- Women who experience painful menses.

**START USING IUS**

Levonorgestrel IUS

- If a woman's menstrual cycle is regular, the IUS can be inserted at any time during the first seven days following the start of menses (not only during menstrual bleeding). It is not necessary to use any backup method of contraception.
- If it is known that the woman is not pregnant, IUS insertion can be performed at any time during the menstrual cycle. If the IUS is inserted more than seven days after the start of menses, the woman is advised to abstain from sexual contact or use a backup method of contraception for the next seven days.
- It is recommended to insert levonorgestrel IUS after four weeks and more following childbirth.
- Levonorgestrel IUS can be inserted immediately following an abortion in the absence of complications or contraindications.
- Should the patient refuse to use any other method of contraception, an IUS can be immediately inserted (if the woman is not pregnant). There is no need to wait for the next menses:
  - If less than seven days have passed since the beginning of menses, it is not necessary to use a backup method of contraception;
  - If more than seven days have passed since the start of menses, the patient is recommended to abstain from sexual contact or use a backup method of contraception for the next seven days;
– If the previous contraceptive was injected, the insertion of an IUS should take place on the day of the next scheduled injection of the previously used contraceptive. It is not necessary to use a backup method of contraception.

**WOMEN INELIGIBLE TO USE IUS:**

- Pregnant women (suspected or known);
- Women with vaginal bleeding (before identifying the cause);
- Women with current pelvic inflammatory diseases or relapse;
- Women with genital infections;
- Women with septic abortion in the last three months;
- Women with cervicitis;
- Women with cervical dysplasia;
- Women with malignant uterine or cervical tumors;
- Women with active liver disease or liver tumor;
- Women with a distortion of uterine cavity;
- Women with uterine fibroids;
- Women suffering from conditions that are associated with an increased susceptibility to infection;
- Women who are hypersensitive to the components of an IUS.

**MANAGING COMMON SIDE EFFECTS AND OTHER PROBLEMS**

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amenorrhea</td>
<td>The cessation of menses does not imply pregnancy. If a woman is worried by the fact that she does not experience menses for six weeks, she should be tested for pregnancy. If she is not pregnant, she should be calmed and counseled on the mechanism of action of levonorgestrel IUS.</td>
</tr>
<tr>
<td>Changes in the bleeding patterns</td>
<td>Some women may experience additional light intermenstrual bleeding or spotting during the first 3-6 months of IUS use. With time the duration of menstrual bleeding and blood loss will decrease; some women experience the cessation of menses. It is necessary to counsel the patient on the mechanism of action of the IUS.</td>
</tr>
<tr>
<td>Condition</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Heavy vaginal bleeding</td>
<td>Rule out pelvic inflammatory diseases. If needed, provide treatment. If no such disease is detected, and the bleeding is prolonged and heavy, consult the patient and treat the existing symptoms. Prescribe NSAIDs (except for aspirin) to reduce bleeding. Use ultrasound to check on whether the IUS is correctly positioned in the uterine cavity. If the IUS is revealed to be improperly positioned, remove it and insert a new IUS or consult the patient on choosing another method of contraception.</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Some women experience dizziness after beginning to use an IUS. This is a natural reaction to the IUS. It is recommended to rest for a while after the insertion of the system.</td>
</tr>
<tr>
<td>Strings not visible</td>
<td>Pregnancy test. Find out whether IUS came out (expulsion) by asking a patient. If the woman is not pregnant and expulsion did not occur, she is advised to use condoms. Examine the cervical canal for the strings. If they are not found in the canal, the woman will be sent to get an ultrasound. If the woman is not pregnant, the IUS came out or could not be found, in the absence of contraindications, either a new IUS is inserted or the patient is assisted to choose another method of contraception. Must keep in mind the possible perforation of the uterine walls by the IUS.</td>
</tr>
<tr>
<td>Heavy vaginal discharges/ suspected PIDs</td>
<td>Patient tested for STIs. If an infection is suspected or detected, the patient is given antibiotics before the IUS is extracted. If the patient has acute pelvic inflammatory disease, she is treated with antibiotics in accordance with established standards. If the woman wants to continue using the IUS, there is no need to remove it. If the woman refuses to further use the IUS, it is removed after the beginning of the treatment with antibiotics. If pelvic inflammatory disease treatment is unsuccessful, the IUS should be removed and treatment with antibiotics should be continued.</td>
</tr>
<tr>
<td>Contraction-like pain</td>
<td>Rule out pelvic inflammatory diseases or other causes of pain. Provide medical care. If the IUS is the cause of the pain, the patient is prescribed analgesics to reduce discomfort. If the pain is severe, the IUS will be removed and the patient will be assisted to choose another method of contraception</td>
</tr>
</tbody>
</table>
## CONDITIONS THAT DEMAND SPECIAL CARE

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe arterial cardiovascular diseases (stroke, myocardial infarction)</td>
</tr>
<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Migraines</td>
</tr>
<tr>
<td>Acute or recurrent infections</td>
</tr>
<tr>
<td>Confirmed or suspected hormone-dependent neoplasia, including breast cancer</td>
</tr>
<tr>
<td>Significant increase in blood pressure (first time)</td>
</tr>
<tr>
<td>Extremely severe headache (first time)</td>
</tr>
<tr>
<td>Jaundice (first time)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is recommended to remove levonorgestrel IUS.</td>
</tr>
<tr>
<td>It is necessary to monitor the level of glucose in the blood.</td>
</tr>
<tr>
<td>It is recommended to remove levonorgestrel IUS in case of focal migraine with asymmetrical vision disorders or other symptoms of cerebral ischemia that appeared for the first time.</td>
</tr>
<tr>
<td>It is necessary to treat with antibiotics, in case of unsuccessful treatment the IUS should be removed.</td>
</tr>
<tr>
<td>It is recommended to remove levonorgestrel IUS.</td>
</tr>
<tr>
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</tr>
<tr>
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</tr>
</tbody>
</table>
EMERGENCY CONTRACEPTION

Emergency, or emergency postcoital contraception (EC) – refers to the use of different methods of contraception (OC, POP, IUD, and others) soon after unprotected sex to prevent unwanted pregnancy. EC pills are commonly referred to as “morning after pills.”

Emergency contraception is used to prevent unwanted pregnancy after unprotected sex (without a contraceptive) or detection of defective barrier contraceptives (condoms, diaphragms), imperfect use of hormonal contraceptives (missing a pill), cases of rape – especially among teenagers, and in other cases when pregnancy is unwanted or unsafe. The efficacy of the method is relatively high (96%) if no more than 72 hours have passed since the unprotected sexual intercourse.

TYPES OF EMERGENCY CONTRACEPTION:

- Combined estrogen-gestagen OCs;
- Gestagens;
- Intrauterine devices (IUDs);
- Antiprogestins (AP).

INDICATIONS FOR EMERGENCY CONTRACEPTION:

- After unprotected sex (without a contraceptive);
- If barrier contraceptives were defective;
- When the regular intake of hormonal pills is interrupted (missing one or more pills);
- If more than 16 weeks have passed since the last DMPA injection;
- Partners following the natural family planning method failed to abstain and had unplanned sexual intercourse;
- In cases of rape, especially in teenagers.

WOMEN ELIGIBLE TO USE EMERGENCY CONTRACEPTION:

- Patients in need of urgent protection against pregnancy (for example, after unplanned, unprotected sexual intercourse; if the condom was defective; after the case of rape).

PATIENT INSTRUCTIONS

<table>
<thead>
<tr>
<th>COCs:</th>
<th>Take four low-dose COCs (30-35 mcg ethynilestradiol) orally during the first 72 hours after having unprotected sexual intercourse. Take another four pills in 12 hours. A total of eight pills should be taken.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Or</td>
</tr>
</tbody>
</table>
Take two high-dose COCs (50 mcg ethynilestradiol) orally during the first 72 hours after having unprotected sexual intercourse. Take another two pills in 12 hours. A total of four pills should be taken.

**POPs:**
Take one pill of Postinor (750 mcg of levonorgestrel each) orally during 48 hours after having unprotected sexual intercourse. Take another pill in 12 hours. A total of two pills should be taken.

Or

Take two high-dose COCs (50 mcg ethynilestradiol) orally during the first 72 hours after having unprotected sexual intercourse. Take another two pills in 12 hours. A total of four pills should be taken.

**IUD:**
Need to have the IUD inserted within five days after having unprotected sexual intercourse.

**AP:**
Take 600 mg within 72 hours.

**For all methods:**
If menses do not begin during three weeks, the patient should contact a physician in order to be tested for pregnancy.

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**WOMEN INELIGIBLE TO USE EMERGENCY CONTRACEPTION:**
- Women who are identified as pregnant or suspected of being pregnant.

**MANAGING COMMON SIDE EFFECTS AND OTHER PROBLEMS**

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>COCs and POPs: nausea, vomiting</td>
<td>Woman is counseled on possible side effects. If vomiting occurs within two hours following the first or second dose, the patient can take this dose again or insert pills of the same dose in the vagina.</td>
</tr>
<tr>
<td>Bleeding/spotting</td>
<td>Approximately 8% of all women who use COCs as an emergency contraception experience spotting during treatment cycle. Nearly 50% of all women experience the timely start of menses; majority of the rest experience menses earlier than expected.</td>
</tr>
<tr>
<td>IUD: the same ones as during the interval insertion</td>
<td>See the IUD section.</td>
</tr>
</tbody>
</table>
ALGORITHM FOR PRESCRIBING EMERGENCY CONTRACEPTION

Patient needs emergency contraception

Less than 72 hours have passed since the unprotected sexual intercourse

Yes  No

Patient assessment (see WHO category tables)

Yes

• Hormonal emergency contraception provided according to established regimens.
• Inform on potential side effects and how to manage them.
• Instruct on how to act in case of vomiting within two hours after taking the pills.
• Women is recommended to make return visits if menses do not start in three weeks
• IUD (see the IUD section).

No

• Assess the eligibility for IUDs (see the IUD section).
• If the method is acceptable, insert IUD

• Counsel on the methods of contraception and STIs, advise to wait until the end of menses to chose the optimal method of birth control.
• Recommend a return visit if menses do not start in 3 weeks.

If menses do not start during three weeks after taking emergency contraceptives, the woman is tested for pregnancy.

• If an IUD was inserted as an emergency contraceptive, the decision to remove or leave in the device depends on the informed choice of the woman/partners.
• All women who took emergency contraceptive are counseled on the methods of regular contraception.
Use of Contraception Methods after Emergency Contraception:

- Condoms and spermicides can be used immediately after EC;
- COCs – the first pill is taken the day after the completion of EC; barrier methods should be used for the next seven days;
- POPs – taken after menses-like bleeding;
- Women can start using injections and implants within seven days from the beginning of the menstrual cycle. Until then, it is necessary to use condoms;
- Women who chose to use an IUD as a long-term contraceptive can insert the device within five days following unprotected sexual intercourse instead of using other emergency contraceptives.
BARRIER METHODS AND SPERMICIDES

CONDOMS

Male condom – The only method of contraception that offers adequate protection against STIs. Belongs to the barrier methods of contraception. Can be used as a backup method of contraception along with other contraceptives to protect against STIs.

Female condom – A sheath made of transparent polyurethane, which is closed on one end. The open end is a flexible ring of the large diameter that remains outside the vagina. The closed end is a ring of the smaller diameter for easy insertion into the vagina.

Counseling is provided on the rules of using male and female condoms, which are outlined in their instructions.

COUNSELING ALGORITHM

Patient wants to prevent unwanted pregnancy or be protected from STIs

• Rules of use explained:
  – Condom use;
  – Used condom disposal.
• Discuss the possibility of emergency contraception in case of failure during the condom use.
• If possible, condoms are provided.
• Initial counseling on the methods of contraception.

PATIENT INSTRUCTIONS

• Use a condom during every sexual intercourse.
• Use condoms with spermicide for maximum efficacy and protection.
• Condoms are placed on the erect penis prior to its insertion into the vagina (pre-ejaculate contains active spermatozoa).
• If the condom lacks a reservoir, 1-2 cm should be left on the tip for semen.
• After ejaculation, holding the rim of the condom, withdraw the penis from the vagina while it is still erect. This prevents condom slippage and leakage of semen on the woman’s genital organs.
• A condom should only be used once.
• Always keep an adequate supply of condoms. Do not store them in a warm
place – this can damage the condom and lead to leakage during the use.
- Do not use a condom which packaging is damaged. Do not use a condom which looks damaged or brittle.
- Do not use mineral oil, cooking oil, children’s cream or Vaseline as lubricant. This quickly damages the condom. Use saliva or vaginal secretion for lubricant.

**HOW TO USE A CONDOM**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The condom is placed on the erect penis prior to contact with the genital organs of the woman. Pre-ejaculate can contain semen or the STI microorganisms.</td>
</tr>
<tr>
<td>2.</td>
<td>Tear one side of the packaging carefully to avoid damaging the condom inside.</td>
</tr>
<tr>
<td>3.</td>
<td>Air that gets inside of the condom can damage it. Press the nipple-like tip of the condom with the thumb and index finger and place the condom on the erect penis. If the condom lacks a reservoir for semen, leave 1-2 cm on the tip.</td>
</tr>
<tr>
<td>4.</td>
<td>While pressing the nipple-like tip of the condom, use the other hand to carefully unroll the condom down to the base of the penis. Make sure that the condom stays on the penis throughout the duration of the sexual intercourse. If the condom begins to roll up to the top of the penis, push it back down to the base of the penis. If the condom falls off, clean the penis and put on a new condom prior to continuing the sexual intercourse.</td>
</tr>
<tr>
<td>5.</td>
<td>After ejaculation, withdraw the erect penis from the vagina, firmly holding the condom in place. Remove the condom only after fully withdrawing the penis. Avoid the penis coming into the contact with the woman’s body.</td>
</tr>
<tr>
<td>6.</td>
<td>Carefully dispose of the used condom: wrap the condom in tissue and place it in a garbage can (do not flush it down the toilet).</td>
</tr>
</tbody>
</table>
DIAPHRAGMS AND CERVICAL CAPS

Diaphragm and cervical cap belong to the barrier methods of contraception. The use of diaphragms with spermicides significantly increases the efficacy of this method and protection against STIs. Modern diaphragms are made of rubber and latex. Cervical caps are made of latex rubber. They are not widely used in the majority of countries.

**TYPES OF DIAPHRAGMS**

Diaphragms vary in size, which is determined by the diameter of the rim in millimeters. There are four types of diaphragms, which can be differentiated by the construction of the circular rim:

- Flat spring diaphragm;
- Coil spring diaphragm;
- Arcing spring diaphragm;
- Wide-seal rim diaphragm.

**TYPES OF CAPS**

There are three types of caps:

- Deepened hollow cap with a rim (usually, known as cervical cap);
- Bell-shaped cap with an expanded open end;
- Dome-shaped cap — relatively shallow (shape of a wide, flat dome, diaphragm-like).

**WOMEN ELIGIBLE TO USE DIAPHRAGMS AND CERVICAL CAPS:**

- Women who cannot or do not want to use hormonal methods (for instance, women who smoke and are over age 35);
- Women who are forbidden from using or do not want to use IUDs;
- Breastfeeding mothers in need of contraception;
- Women who want protection against STIs whose partners do not want to use condoms;
- Women who need a temporary method of contraception while selecting the long-term method of contraception;
- Women who need a backup method of contraception;
- Women who have infrequent sexual contacts;
- Couples in which partners have more than one sexual partner (at high risk for STI contraction, even if another method of contraception is used).

**RULES FOR USING A DIAPHRAGM:**

- Use during every sexual intercourse.
• Bladder must be emptied before use.
• Check for defects by pulling the rubber, filling the diaphragm with water or examining it in under the light.
• Place a bit of spermicidal cream or gelly into the cap of the diaphragm (to ease the process of insertion place a bit of cream or gelly on the leading end of the diaphragm or the outer edge of the vagina). Press the rim of the diaphragm together and insert it into the vagina.
• The diaphragm stays in place for a minimum of six hours following sexual intercourse, but no longer than 24 hours (Douching is not recommended at any stage. If woman choose to douche, it should be done six hours after sexual intercourse).
• After each use, the diaphragm is washed with water and soap, dried (thoroughly), and placed in its box.

**WOMEN WHO SHOULD NOT USE DIAPHRAGMS OR CERVICAL CAPS:**

• Women whose age, number of childbirths, or health problems make pregnancy extremely dangerous (should assist to choose a highly-effective method of contraception);
• Women with recurrent urinary tract infections;
• Women who experience difficulties in using this method;
• Women who have uterus prolapse (uterus descends into the vagina);
• Women with severe cystocele і rectocele (protrusion of the bladder wall or rectum into the vagina);
• Women with the history of toxic shock syndrome;
• Women with vaginal stenosis (narrowing of the vaginal canal);
• Women with genital abnormalities;
• Women who want to use a highly-effective method of contraception;
• Couples which do not want to follow the instructions for use of the devices during every sexual intercourse.

**MANAGING COMMON SIDE EFFECTS AND OTHER PROBLEMS**

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary tract infections (STIs)</td>
<td>If the patient has frequent inflammatory urinary tract diseases and diaphragms remains her first choice, the bladder is emptied immediately after the sexual intercourse. Vagina is cleaned using disinfectants (no earlier than 6 hours after sexual intercourse). If diaphragms are not the patient’s first choice, another method of contraception is chosen.</td>
</tr>
<tr>
<td>Suspected <strong>allergic reaction</strong> to diaphragm or cervical cap</td>
<td>Although allergic reactions occur rarely, they can cause discomfort and be dangerous for the patient. If an allergy is confirmed, the patient should be assisted to choose another method of contraception.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Suspected <strong>allergic reaction</strong> to spermicides</td>
<td>Pain caused by pressure on the bladder or rectum Evaluate whether the correct size of the diaphragm is being used. If diaphragm is too large, try a smaller diaphragm. Follow-up to prevent this problem from arising again.</td>
</tr>
<tr>
<td><strong>Pain</strong> caused by pressure on the bladder or rectum</td>
<td>Vaginal discharge and unpleasant odor, if the diaphragm is not removed within 24 hours If the patient does not have STIs, she is advised to remove the diaphragm as soon as possible after the sexual intercourse, but no earlier than 6 hours after the most recent sexual intercourse. In case if symptoms recur, consult patient on the rules of hygiene. If the patient has STIs, provide the treatment according to the diagnosis.</td>
</tr>
</tbody>
</table>

**Warning!**

If it is suspected that the patient is suffering from the toxic shock syndrome (TSS), she should be immediately referred to a medical facility.

The risk of TSS is minimal provided that the diaphragm is properly used. The patient should know how to properly use the method and be able to timely identify warning symptoms and signs.
SPERMICIDES

Spermicides are surface-active chemical substances that deactivate spermatozoa in the vagina before they are able to reach the upper reproductive tract. They also protect against STIs to a certain extent.

Benzalkonium chloride has substantial spermicidal and bactericidal effects. Spermicides vary by the type of carrier, and are produced in the form of:

- aerosols (foams);
- paste;
- gel (cream);
- capsules;
- jelly;
- vaginal foaming tablets;
- vaginal foaming suppositories;
- melting suppositories;
- melting film;
- substances used to lubricate condoms;
- sponges.

The main active substance of modern spermicides are: benzalkonium chloride, octoxynol, and menfegol.

Nonoxynol-9 facilitates the spread of STIs through mucous membrane damage and the penetration of microorganisms into the body (not recommended for use by WHO).

Modern spermicides provide from 15 minutes to 1-8 hours of protection (from the beginning of use) depending on their form (tablets, cream, foam etc). For two hours prior to and two hours following the sexual intercourse, it is necessary to abstain from washing with soap (because of the risk of inactivating the active substance).

Creams and jellies can be used alone or with diaphragms and cervical caps. Efficacy increases when they are used together.

Spermicides can be used with condoms, which provides higher contraceptive efficacy and protection against STIs.

CHOICE OPTIONS

- Vaginal foaming tablets, capsules and suppositories are easy to store and transport. However, 15 minutes must pass after their application before the sexual intercourse.
- Melting vaginal suppositories should also be inserted 10-15 minutes prior to sexual intercourse.
- Spermicidal jellies, as a rule, are only used together with a diaphragm.
• Aerosols (foams) are effective immediately following their application. Aerosols are recommended if spermicides are to be the sole method of contraception.

**WOMEN ELIGIBLE TO USE SPERMICIDES:**

• Women who cannot or do not want to use hormonal methods of birth control (women who smoke, over age 35);
• Women who are forbidden to or do not want to use IUDs;
• Breastfeeding women who need contraception;
• Women who want protection against STIs and whose partners refuse to use condoms;
• Women who need a temporary method of contraception while waiting for another method;
• Women who need a backup method of contraception;
• Women who have infrequent sexual contacts;

**PATIENT INSTRUCTIONS:**

• Insert the spermicide before each sexual intercourse.
• After using vaginal tablet, suppository, or film, wait 10-15 minutes. When using aerosols (foams), there is no need to wait.
• It is necessary that the patient follows the instructions of the spermicide’s producer on the proper use and storage. (For instance, to shake the container with aerosol foam prior to squeezing it into a applicator).
• Apply a second dose of spermicide if the sexual intercourse does not begin within 1-2 hours of the first application.
• Apply another dose of spermicide before every following sexual intercourse.
• It is important to insert the spermicide deep into the vagina, so that the cervix is fully blocked off.

**WOMEN INELIGIBLE TO USE SPERMICIDE:**

• Women whose age, number of childbirths, or health problems make pregnancy extremely dangerous;
• Women who experience difficulties in using this method of contraception;
• Women who are allergic to spermicides;
• Women with genital and other abnormalities;
• Women who want to use a highly-effective method of contraception;
• Couples that want to use a method which is not connected with the sexual intercourse.
MANAGING COMMON SIDE EFFECTS AND OTHER PROBLEMS

<table>
<thead>
<tr>
<th>Side Effect/Problem</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal irritation</td>
<td>If the irritation is caused by spermicide, advise the patient to use a spermicide comprised of different chemical substances or assist to choose a different method of birth control.</td>
</tr>
<tr>
<td><strong>Penile irritation</strong> and discomfort</td>
<td></td>
</tr>
<tr>
<td>Worried about a burning sensation in the vagina</td>
<td>Calm down and reassure the patient – explain that this burning is temporary. If the patient is worried, advise to use a spermicide comprised of different chemical substances or assist to choose a different method of birth control.</td>
</tr>
<tr>
<td>Vaginal foaming tablets do not melt</td>
<td>Use a spermicide comprised of different chemical substances or assist to choose a different method of birth control.</td>
</tr>
</tbody>
</table>

COUNSELING ALGORITHM

Patient wants to prevent unwanted pregnancy and lower the risk of STIs

- Explain the rules of spermicide use – their efficacy depends on proper use;
- Method controlled by the woman – only used if necessary;
- Choose the optimal spermicide taking into account that the cream has a substantial moisturizing effect, suppositories – moderate, while vaginal tablets possess no moisturizing properties;
- Tablets, suppositories, and films are applied no later than 10-15 minutes prior to the sexual intercourse;
- Inserted before every sexual intercourse;
- Additional dose of spermicide applied before every new sexual intercourse;
- Explain the potential of spermicide to protect against some STIs;
- Discuss the possibility of emergency contraception;
- If help is needed (advice, change of method) – schedule a follow-up consultation with a patient at a convenient for her time.
TOXIC SHOCK SYNDROME

Toxic shock syndrome is a rare, severe disease characterized by the abrupt and sharp rise in body temperature, vomiting, diarrhea, skin rash, with the rapid fall in blood pressure and shock. It is caused by toxins produced by the bacteria Staphylococcus aureus, and can arise as the result of staphylococcus infection located in any body part.

The majority of cases involving toxic shock occur among menstruating women who use tampons, however, cases of TSS have also been documented among women who used diaphragms and contraceptive sponges.

However, the bacteria's and its toxins mechanism of action is largely unknown. Treatment of the disease with antimicrobials and detoxification therapy entailing the intravenous introduction of certain substances has proven to be extremely effective, if the disease is diagnosed correctly at an early stage.

Such cases are extremely rare, and their causal relationship is not determined. Meanwhile, women who use barrier contraceptive methods are recommended to take certain precautions: do not leave the device in the vagina for longer than 24 hours, and do not use the device during menses. Any woman who notices the symptoms of toxic shock syndrome (fever, rash, muscular pain, vomiting or diarrhea) should immediately go to the nearest medical facility.
NATURAL FAMILY PLANNING (NFP) METHODS  
(Fertility Regulating Methods)

Natural methods can be used if the woman can determine the beginning and end of the fertile period of her menstrual cycle. The fertile period is when the woman can become pregnant.

Natural methods are moderately effective (9-20 pregnancies per 100 women during the first year of use).

NFP Methods

There are several methods of natural family planning. Some of them depend on the use of only one of the fertility indicators. Other methods of natural family planning are based on two or more fertility indicators.

Major characteristics of fertility (cervical mucus, basal body temperature, duration of the cycle etc.) are supplemented with individual signs (breast tenderness, pain in the lower abdomen, menstrual bleeding).

Currently, the following fertility-control methods are used:

- Calendar rhythm method;
- Basal body temperature method;
- Cervical mucus method;
- Symptothermal method.

Calendar rhythm method

The calendar rhythm method of contraception is the oldest form of preventing unwanted pregnancy. Fertile days are counted on a special table – attention is paid to the start of ovulation 14 days before expected menses in the 28-day menstrual cycle. Spermatozoa can survive in a woman's body for up to eight days and the egg after ovulation - 24 hours. The method is rarely used due to its low efficacy.

Basal body temperature method

The method is based on body temperature changes immediately following ovulation. A rise in the basal body temperature indicates that ovulation has begun, but cannot predict when the next ovulation will occur. Basal body temperature drops 12-24 hours before ovulation, after which it increases by 0,2-0,5 C°. Thus, the fertile period starts from the onset of ovulation and ends when the basal body temperature has remained high for three days in a row. The temperature method is reliable for avoiding pregnancy, but forces its users to abstain from sexual activity for quite a long time.

After ovulation concludes, the body temperature remains at a higher level for approximately 14 days before dropping. The first day of menses marks the start of a new cycle. If the basal body temperature remains at a high level for 20 or more days, a woman may notice the first sign of pregnancy.
In order to rule out any inaccuracies and identify even an insignificant rise in temperature, women should use a precise thermometer. Since various factors (illness, stress, sleep disorders etc.) affect basal body temperature, the interpretations of findings should be given thorough attention.

Similar to the calendar rhythm method, this method of contraception is rarely used alone.

**Cervical mucus method** (can only be used if there are no inflammatory diseases of reproductive organs)

Woman determines her fertile phase by observing the secretion of mucus from the vagina. When a woman secretes clear stretchy mucus, she may be fertile. Her “peak day” is the last day when she secretes this type of mucus; it means that ovulation will soon occur or have just occurred. Majority of women have no vaginal secretions during a couple of days, so called “dry days”, which usually follow the cessation of menstrual bleeding. Women should abstain from sexual contact during at least one cycle in order to observe the mucus and determine the method. Women should examine the mucus throughout the day, since it can change. Women should keep a journal or log of their observations, using certain colors and symbols to denote different happenings. Bleeding – red color; dry days – the letter “d”; fertile days – the letter “f”; non-fertile and opaque mucus – the letter “n”.

Women should abstain from sexual contact if they notice mucus or a moist sensation in the vagina. The last day on which the clear stretchy mucus is secreted marks the “peak” of the fertile period; therefore, sexual contact should be avoided for the next three days.

**Symptothermal method**

This method combines the cervical mucus and basal body temperature methods of contraception.

**COUPLES THAT CAN USE NFP:**

*As a method of contraception:*
- Women of reproductive age;
- Women who have or have not given birth;
- Couples whose religious beliefs or philosophies prevent them from using other methods;
- Women who cannot use other methods;
- Couples that can abstain from sex for more than one week of every cycle;
- Couples that are willing to observe, track, and interpret signs related to the fertile phase on a daily basis.

*With the aim to get pregnant:*
- Couples who are planning to get pregnant.
**PATIENT INSTRUCTIONS**

**Calendar rhythm method**
You can determine your fertile period by tracking your menstrual cycles.

*As a method of contraception:*
Determine your fertile period. Track the duration of six menstrual cycles (minimum), during which you will need to abstain from sexual activity or use other methods of contraception. Then calculate your fertile phase using the formula:

- subtract 11 from the number of days in your longest cycle (determining the **last fertile day** of your cycle);
- subtract 18 from the number of days in your shortest cycle (determining the **first fertile day** of your cycle).

**Example:** Longest cycle: 30 days – 11 = 19,
Shortest cycle: 26 days – 18 = 8.

The calculations show that the **fertile period** extends from the 8th through 19th days of the cycle (to prevent pregnancy abstain for 12 days). Abstain from sexual contact on fertile days.

**In order to get pregnant** – Couple engages in sexual activity on the fertile days without using contraception.

**Basal Body Temperature Method**
You can determine your fertile phase by carefully measuring your temperature using a special thermometer that registers even the slightest increase.

Follow the rules of temperature changes:
Take temperature readings at the same time every morning prior to getting out of bed; enter the results into a journal or log.

**WOMEN WHO SHOULD NOT USE NFP:**

- Women whose age, number of childbirths, or health problems make pregnancy extremely dangerous;
- Women who are inexperienced in properly following NFP rules;
- Women whose partners do not want to abstain from sex during certain days of the cycle;
- Women who have personal reasons for not using this method;
- Women with irregular menstrual cycles.
## CONDITIONS THAT DEMAND SPECIAL CARE

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irregular menses</td>
<td>If the calendar rhythm method is being used, counsel the patient and help her to choose an alternative method of contraception.</td>
</tr>
<tr>
<td>Constant vaginal discharges</td>
<td>Explain to the patient that it will be difficult for her to determine her fertile phase using the cervical mucus method. If she wants, assist her in choosing a different method of birth control</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td></td>
</tr>
</tbody>
</table>

## ALGORITHM FOR CHOOSING NATURAL FAMILY PLANNING METHODS

**Patient wants to use NFP method**

- Each method explained:
  - Calendar rhythm,
  - Cervical mucus,
  - Basal body temperature,
  - Symptothermal.
- Patient instructed on how to keep track of her menstrual cycles for six months.
- Consider using withdrawal or abstaining from sexual contact during this time.
- Return visit in six months.

- Fertile days of the menstrual cycle counted according to the selected method.
- Inform on emergency contraception if it is needed (see Emergency Contraception protocol).
- Encourage to make return visits in order to clarify instructions.
POSTPARTUM CONTRACEPTION

A number of accessible and safe family planning methods can be used post-partum. Thus, the main task of physicians of maternity homes, women’s consultations, and family planning clinics and centers is to explain the necessity of family planning in the postpartum period for maintaining the women’s health, extending the period of effective breastfeeding and preventing unwanted pregnancy.

GENERAL FEATURES OF METHODS OF CONTRACEPTION

LACTATIONAL AMENORRHEA METHOD (LAM)
- Highly effective for up to six months if mother exclusively breastfeeds and does not menstruate (amenorrhea).
- Breastfeeding starts immediately after childbirth.
- Substantial benefit for the health of the mother and the baby.
- Gives time to choose and prepare to use another method of contraception.

Remarks:
- Should exclusively breastfeed for maximum efficacy;
- Efficacy of LAM decreases when mother attempts to stop breastfeeding or provide supplementary feeds.

PROGESTIN-ONLY PILLS (POPs)
(implants, Progestin-Only Pills or Progestin-Only Injectable Contraceptives – POPs or PICs)
- Avoid using POPs within 6 weeks following childbirth, except if other methods are not acceptable or not available.
- POP use should be postponed until six months after childbirth if mother is following LAM.
- If mother is not breastfeeding, POPs can be used immediately.
- If mother does not breastfeed and she is more than six weeks after childbirth, or her menses has returned, POP use can be recommended (if the woman is not pregnant).
- Method does not affect the quality or quantity of breast milk and the baby’s health.

Remarks:
- Progestogen can negatively effect normal child growth in the first six weeks following childbirth;
- POP use can cause irregular bleeding in lactating women.
**INTRAUTERINE DEVICES (IUDs)**
- Can be inserted after the placenta is removed or in the postpartum period (within 48 hours after childbirth).
- If the IUD is not inserted after the removal of the placenta or within 48 hours following childbirth, insertion should be postponed for four to six weeks after childbirth.
- If menses has returned while the woman is breastfeeding, the IUD can be inserted on any day of the menstrual cycle (if the patient is not pregnant).
- An IUD does not influence the amount and quality of the mother’s breast milk or the health of the child.
- During IUD insertion, considerably fewer side effects (bleeding, pain) for breastfeeding women are observed.

**Remarks:**
- Important to have experienced staff trained to insert IUD after the removal of the placenta and postpartum;
- Patient should be examined and consulted in the prenatal period with regard to IUD insertion after the removal of the placenta;
- During the interval insertion of an IUD 4-6 weeks after childbirth, a standard insertion is performed (does not require special training).

**VOLUNTARY FEMALE STERILIZATION (VFS)**
- Can be carried out immediately after childbirth (child delivered by c-section) or within 48 hours after childbirth.
- If sterilization is not performed within 48 hours after childbirth, it should be postponed until six weeks have past following childbirth.
- The ideal time to perform VFS is when the mother has fully recovered after childbirth and the child’s health is excellent.
- Method does not affect the quality or quantity of breast milk and the baby’s health.

**Remarks:**
- Postpartum mini-laparotomy should be conducted under local anesthesia (sedation), which lowers the risk for the mother and the chance of prolonged separation of the mother and the baby;
- A vasectomy can be conducted at any time after childbirth. It is not immediately effective. A temporary method of contraception should be used for the first three months after the operation if the couple has sexual activity.

**BARRIER METHODS**
Condoms, diaphragms, and spermicides (foams, suppositories, creams, tablets, and films) can be used at any time after childbirth, as they do not affect the quality or quantity of breast milk and the baby’s health. These methods are convenient as temporary methods of contraception when the use of other method is postponed.
Remarks:
• Barrier methods applied to the cervix (diaphragm with spermicides), should only be used six weeks postpartum.
• The use of spermicides solves the problem of vaginal dryness during sex (common among breastfeeding women).

**COMBINED HORMONAL CONTRACEPTIVES (COCs and CICs)**
• Not recommended for breastfeeding mothers in the first six months after childbirth. COCs or CICs should be used only when the mother begins to stop breastfeeding.
• Breastfeeding mothers should not use unless other options are not acceptable (starting from 6 months).
• COCs and CICs can be used three weeks after childbirth if the mother do not breastfeed.
• The use of COCs and CICs within the first six months following childbirth decreases the quantity of breast milk and can negatively effect a child’s growth (this effect continues to six months).
• COCs and CICs increase the risk of blood clot formation in the first three weeks after childbirth (due to estrogen).

Remarks:
• COCs and CICs are the least acceptable methods for breastfeeding mothers;
• The risk of increased blood clot formation disappears after three weeks following childbirth;
• Women who suffered from gestosis during pregnancy can use COCs and CICs only if they have not suffered complications from the condition and have normal blood pressure before starting the use.

**NATURAL FAMILY PLANNING**
• Not recommended to start using the method before the return of regular menses. Patient can start keeping a journal six weeks after childbirth; however, she should continue to use LAM.
• Method does not affect the quality or quantity of breast milk and the baby’s health.

Remarks:
• Cervical mucus is difficult to “read” before the return of regular menses (ovulation);
• Basal body temperature changes if the mother wakes up at night to breastfeed. Therefore, tracking and studying the rise in basal body temperature in the morning after ovulation may not be entirely reliable.
POST-ABORTION CARE

Complete post-abortion care should include medical and preventive services

The aim of post-abortion care is:

• Providing urgent care in case of an incomplete abortion and life-threatening post-abortion complications;
• Counseling on family planning and providing the selected method of contraception;
• Tying emergency post-abortion care to reproductive health.

Post-abortion counseling on family planning should be a standard aspect of obstetric-gynecological care. Counseling on family planning in an inpatient facility is one of the primary elements of quality post-abortion medical care. Medical specialists should inform women of the quick return to fertility and wide array of safe and effective methods of contraception that can help women avoid another unintended pregnancy.

Moreover, medical specialists who perform abortions can counsel women on methods of contraception, explaining their advantages and proper use. In the early post-abortion period psychologically woman is more inclined to make an informed choice on contraception.

Specialists should use every contact with the patient to provide information on existing family planning methods.

However, some methods may not be used immediately following an abortion. Women should be advised on temporary methods of contraception (condoms, spermicides, injectable or oral hormonal contraceptives).

PROVISION OF EMERGENCY CARE

Emergency care in case of post-abortion complications includes:

• Initial screening (blood pressure, pulse, breathing, temperature, volume of bleeding) to evaluate the patient’s status;
• Explain to the woman her medical condition and plan for treatment;
• Medical evaluation (brief history, limited physical and gynecological examination);
• Stabilization of urgent condition (shock, bleeding, sepsis);
• Immediate referral and transportation of a woman to the competent medical facility if she needs treatment that cannot be provided by the facility in which she is currently receiving care;
• Examination of the uterine cavity - extract any remnants of fetal tissue.

The immediate treatment of post-abortion complications is an important aspect of obstetric care that should be provided in every district hospital.
POST-ABORTION FAMILY PLANNING

Post-abortion family planning should be comprised of the following components, which are typical for quality family planning care services:

- Counseling on the necessity of using contraception with consideration to the reproductive aims of the patient;
- Informing and counseling on all existing methods of contraception – their features, efficacy and side effects;
- Providing a choice (for example, short- and long-term methods, hormonal and non-hormonal);
- Opportunity to refill the supply of the contraceptive;
- Access to follow-up;
- Information on the need to protect against STIs.

The medical specialist should assist the woman to choose the method of contraception most acceptable for her, and also teach her and her partner how to properly (effectively) use this method. The improper use of the selected method of contraception can lead to an unintended pregnancy again. The method of contraception should be selected based on the informed decision made by every woman; discussing this issue should allow the woman to learn about different methods of contraception and express her opinion or doubts.

In the absence of medical contraindications, any method of contraception should be used immediately after the abortion. Although a majority of women do not want to get pregnant after an abortion, some of them have a difficult time deciding on a certain method of contraception. A woman who did not choose a method of contraception immediately following her abortion can be advised to temporarily use condoms and receive counseling (perhaps with her partner) at an outpatient facility at a convenient time once the decision is made.

BEGINNING TO PROVIDE FAMILY PLANNING SERVICES

The provision of family planning services after abortion begins as soon as the woman can adequately comprehend and understand information, since ovulation can occur on the 11th day following an abortion and usually happens before the first menses. All women need post-abortion counseling and should be provided with detailed information that ensures that the patients understand that:

- They can become pregnant again before the start of their next menses;
- Women who do not plan to conceive in the near future or their partners should use another method of contraception that will be effective immediately following the return to sexual activity;
- Safe methods of contraception for the prevention of unintended pregnancy exist – their use can start in the treatment facility where the abortion was performed;
- Where and how they can receive family planning services and methods of
contraception.

Follow-up and counseling on continuing the use of the selected method of contraception is possible in medical facilities. All patients who have selected one of the family planning methods should be provided with the corresponding recommendations on follow-up while using the selected method, and understand that they can always visit a medical specialist should the need arise.

**Abortion in the first trimester.** Recommendations on the use of methods of contraception following the abortion in the first trimester are identical to those given to women who generally use methods of contraception. The involution of the uterus happens quickly, and even barrier methods such as cervical caps or diaphragms can be actively used after an abortion that was performed in the first trimester.

**Abortion in the second trimester.** There is a certain disagreement in opinions with regard to the uterus sizes, which generally return to normal sizes after 4-6 weeks following an abortion. This is an important factor which affects the use of barrier methods, surgical sterilization, and the insertion of an IUD.

**METHODS OF CONTRACEPTION AFTER AN UNCOMPLICATED ABORTION**

The majority of methods can be offered immediately.

- **Oral hormonal contraceptives (combined or progestin-only).** The first COC pill can be taken on the day of the operation; it is immediately effective. Thus, there is no need to use backup methods of contraception.
- **Injectable contraceptives (combined or progestin-only).** The first injection can be performed before discharging the patient from the medical facility after the abortion or within seven days after the abortion.
- **An implant can be inserted within the first week following an abortion and is effective immediately.**
- **A copper-bearing IUD or levonorgestrel IUS can be inserted immediately following an abortion or within seven days following an abortion given the absence of symptoms pointing to an infection.** If the infection is confirmed or suspected, the insertion of an IUD should be postponed until the infection has been fully treated. The patient should be offered a temporary method of contraception. The insertion of an IUD following an abortion is preferable to the interval insertion. It is known that ovulation restores soon after an abortion – one-half of all observed women experienced ovulation within 2-3 weeks following the procedure. Thus, the immediate post-abortion insertion of an IUD provides a reliable protection against unintended pregnancy. Although the risk of the IUD expulsion increases in relation to the gestation term (at the time of the abortion), and can increase in comparison with the interval insertion, providing the immediate and highly-effective method of contraception during one procedure can outweigh mentioned risk factors. Evidence-based medicine findings show that the traditional concerns of
clinical specialists about the high probability of uterine perforation or pelvic inflammatory diseases are not justified.

- The use of barrier methods (condoms and spermicides) should begin during the return to sexual activity.
- Male or female voluntary surgical sterilization has no limitations as a method of contraception. However, it is vital to consider the psychological condition of women who have had an abortion when counseling on this issue – they could make a rash decision that they might regret later.
- It is necessary to wait for the regular menstrual cycle to return before using natural family planning methods.

METHODS OF CONTRACEPTION AFTER A COMPLICATED ABORTION

Infection (confirmed or preliminary diagnosis)
Postpone sterilization or IUD insertion until an infection can be ruled out or the infection is fully treated (no earlier than three months).

- The use of diaphragms or cervical caps should be postponed until an infection can be ruled out or the infection is fully treated

In cases of confirmed or suspected infection, it is necessary to offer the patient to postpone the return to sexual activity until the problem is solved. If this is not possible, the following methods may be suggested: condoms, implants, injectables, or hormonal oral contraceptives.

Trauma (uterine perforation or injury to the cervix or vaginal walls)
Postpone sterilization until the condition is fully treated. If a laparotomy is essential for the treatment of the injury, and there are no additional risks, sterilization can be performed concurrently with the operation.

- Postpone the IUD insertion until uterine perforation or other severe injury is fully treated.

Vaginal and cervical injuries can complicate the use of barrier methods and spermicides. The use of diaphragms or cervical caps should be postponed until the vaginal wall or cervical injury is fully treated. The following methods can be suggested: hormonal oral contraceptives, injectables, implants, or condoms.

Bleeding and Acute Anemia
Family planning services can be provided to a patient after the treatment of bleeding and stabilization of the woman’s health status. If her status is stable but she suffers from acute anemia, she should avoid using contraceptive methods that can lead to the increased blood loss. These methods are copper-bearing IUDs and sterilization. The insertion of implants and injections should be postponed until the normal hemoglobin count is restored. Progestin-only pills should be used with caution. COCs are the most acceptable method of contraception (especially, if the patient has a low hemoglobin count). The use of condoms and levonorgestrel IUS is also possible.
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<thead>
<tr>
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<td>Past ectopic pregnancy</td>
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<td>History of pelvic surgery</td>
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<td>Known thrombogenic mutations</td>
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<td>Superficial venous thrombosis</td>
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<td>Cervical intraepithelial neoplasia (CIN)</td>
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Table 1.

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<th>COC</th>
<th>CIC</th>
<th>P/R</th>
<th>POP</th>
<th>DMPA NET-EN</th>
<th>LNG/ETG implants</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
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</table>

| Age                                             | From menarche to <40 years = 1 ≥40=2 | From menarche to <18 years = 1 18-45 = 1 >45 = 1 | From menarche to <18 years = 2 18-45 = 1 >45 = 2 | From menarche to <18 years = 1 18-45 = 1 >45 = 1 | From menarche to <20 = 2 ≥20 = 1 | From menarche to <20 = 2 ≥20 = 1 |
| Parity                                          | 1   | 1   | 1   | 1   | 1           | 2                | 2      |         |
| a) Nulliparous                                  | 1   | 1   | 1   | 1   | 1           | 2                | 2      |         |
| b) Parous                                       | 1   | 1   | 1   | 1   | 1           | 1                | 1      |         |

| Breastfeeding                                   | 4   | 4   | 4   | 3   | 3           | 3                |         |         |
| a) < 6 weeks after childbirth                   | 3   | 3   | 3   | 1   | 1           | 1                |         |         |
| b) from 6 weeks to 6 months after childbirth    | 2   | 2   | 2   | 1   | 1           | 1                |         |         |
| (primarily breastfeeding)                      |     |     |     |     |             |                  |         |         |
| c) ≥6 months after childbirth                  |     |     |     |     |             |                  |         |         |

| Postpartum (non-breastfeeding women)            | 3   | 3   | 3   | 1   | 1           | 1                |         |         |
| a) < 21 days                                    | 1   | 1   | 1   | 1   | 1           | 1                |         |         |
| b) ≥21 days                                     |     |     |     |     |             |                  |         |         |

| Postpartum (breastfeeding or non-breastfeeding women) | 2   | 2   | 3   | 3   | 1           | 1                | 4       | 4       |
| (including post-caesarean section)              |     |     |     |     |             |                  |         |         |
| a) < 48 hours                                   |     |     |     |     |             |                  |         |         |
| b) ≥48 hours to 4 weeks                         |     |     |     |     |             |                  |         |         |
| c) ≥4 weeks                                     |     |     |     |     |             |                  |         |         |
| d) Puerperal sepsis                             |     |     |     |     |             |                  |         |         |

| Post-abortion                                   | 1   | 1   | 1   | 1   | 1           | 1                | 1       | 1       |
| a) First trimester                              | 1   | 1   | 1   | 1   | 1           | 2                | 2       |         |
| b) Second trimester                             | 1   | 1   | 1   | 1   | 1           | 1                | 4       | 4       |
| c) Immediately post-septic abortion             |     |     |     |     |             |                  |         |         |

| Past ectopic pregnancy                          | 1   | 1   | 1   | 2   | 1           | 1                | 1       | 1       |

| History of pelvic surgery                        | 1   | 1   | 1   | 1   | 1           | 1                | 1       | 1       |
| (including caesarean section)                    |     |     |     |     |             |                  |         |         |
| (see also postpartum section)                    |     |     |     |     |             |                  |         |         |

I=Initiation, C=Continuation
Table 2.

<table>
<thead>
<tr>
<th>Condition</th>
<th>COC</th>
<th>CIC</th>
<th>P/R</th>
<th>POP</th>
<th>DMPA NET-EN</th>
<th>LNG/ETG implants</th>
<th>Cu-IUD</th>
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<tr>
<td><strong>Smoking</strong></td>
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<tr>
<td>a) Age&lt; 35</td>
<td>2</td>
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<tr>
<td>b) Age≥ 35:</td>
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<tr>
<td>(i) &lt;15 cigarettes a day</td>
<td>3</td>
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<tr>
<td>(ii) ≥15 cigarettes a day</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>1</td>
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<td>1</td>
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<tr>
<td><strong>Obesity</strong></td>
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<tr>
<td>Body mass index (BMI) ≥ 30 kg/m²</td>
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<tr>
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<tr>
<td><strong>Cardiovascular Diseases</strong></td>
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<tr>
<td>Multiple risk factors for arterial cardiovascular diseases (older age, smoking, diabetes, and hypertension)</td>
<td>3/4</td>
<td>3/4</td>
<td>3/4</td>
<td>2</td>
<td>3</td>
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<tr>
<td><strong>Hypertension</strong></td>
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</tr>
<tr>
<td>a) History of hypertension where blood pressure cannot be evaluated (including hypertension during pregnancy)</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
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<tr>
<td>b) Adequately controlled hypertension where blood pressure can be evaluated</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
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<tr>
<td>c) Elevated blood pressure (properly measured)</td>
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<tr>
<td>(i) systolic 140-159 or diastolic 90-99</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
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<tr>
<td>(ii) systolic &gt; 160 or diastolic &gt; 100</td>
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<td>d) Vascular disease</td>
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I=Initiation, C=Continuation
Table 3.

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<th>Condition</th>
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<th>CIC</th>
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<th>LNG/ETG implants</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
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<tr>
<td><strong>Deep venous thrombosis (DVT) / Pulmonary embolism (PE)</strong></td>
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<td></td>
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<tr>
<td>a) History of DVT/PE</td>
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<td>c) Family history of DVT/PE (first-degree relatives)</td>
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<td>d) Major Surgery</td>
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<td>(i) With prolonged immobilization</td>
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<td>(ii) Without prolonged immobilization</td>
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<td>e) Minor surgery without immobilization</td>
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<td><strong>Superficial venous thrombosis</strong></td>
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<th>Cu-IUD</th>
<th>LNG-IUD</th>
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<tbody>
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<td><strong>Valvular Heart Disease</strong></td>
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<tr>
<td>a) Uncomplicated</td>
<td>2</td>
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<tr>
<td>b) Complicated (pulmonary hypertension, risk of atrial fibrillation, history of subacute bacterial endocarditis)</td>
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**Neurological Conditions**

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<th>P/R</th>
<th>POP</th>
<th>DMPA NET-EN</th>
<th>LNG/ETG implants</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
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<tbody>
<tr>
<td>a) Non-migrainous (mild or severe)</td>
<td>1</td>
<td>2</td>
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</table>
| b) Migraine (i) Without focal neurological symptoms  
**Age <35** | 3   | 4   | 3   | 4   | 3       | 1                | 2      | 2       |
| **Age ≥35** | 3   | 4   | 3   | 4   | 4       | 1                | 2      | 2       |
| (ii) With focal neurological symptoms (at any age) | 4   | 4   | 4   | 4   | 4       | 2                | 3      | 3       |

**Epilepsy**

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<tr>
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<th>LNG/ETG implants</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
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**Depressive disorders**

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<th>LNG/ETG implants</th>
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**Reproductive Tract Infections and Disorders**

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<th>Vaginal bleeding patterns</th>
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<th>POP</th>
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<th>LNG/ETG implants</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
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</thead>
</table>
| a) Irregular pattern  
without heavy bleeding | 1   | 1   | 1   | 2   | 2           | 2                | 1      | 1       |
| b) Heavy or prolonged bleeding (including regular and irregular patterns) | 1   | 1   | 1   | 2   | 2           | 2                | 2      | 1       |

**Unexplained Vaginal Bleeding**  
(suspicious for serious condition)

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<th>LNG/ETG implants</th>
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<td>Before evaluation</td>
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**Endometriosis**

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<th>LNG/ETG implants</th>
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**Benign ovarian tumors**  
(including cysts)

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**Severe Dysmenorrhea**

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<th>LNG/ETG implants</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
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<td>LNG/ETG implants</td>
<td>Cu-IUD</td>
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<tr>
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<td>b) Benign breast disease</td>
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<tr>
<td>d) Breast cancer</td>
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<td><strong>Ovarian cancer</strong></td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>I</td>
</tr>
<tr>
<td><strong>Uterine fibroids</strong></td>
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<tr>
<td>a) Without distortion of the uterine cavity</td>
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<td>1</td>
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<td>b) With distortion of the uterine cavity</td>
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<td>4</td>
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I=Initiation, C=Continuation
### Table 6.

#### Summary Tables

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<thead>
<tr>
<th>Condition</th>
<th>COC</th>
<th>CIC</th>
<th>P/R</th>
<th>POP</th>
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<th>LNG/ETG implants</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
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<td><strong>Anatomical Abnormalities</strong></td>
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<tr>
<td>a) that distort the uterine cavity</td>
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<td>b) that do not distort the uterine cavity</td>
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<td><strong>Pelvic Inflammatory Diseases (PIDs)</strong></td>
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<tr>
<td>a) Past PID (assuming no current risk factors of STIs)</td>
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<td>b) PID – current</td>
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<td>a) Current purulent cervicitis, chlamydial infection or gonorrhea</td>
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<td>b) Other STIs (excluding HIV and hepatitis)</td>
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<td>c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)</td>
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<td>d) Increased risk of STIs</td>
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<td><strong>HIV/AIDS</strong></td>
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# Table 7. Summary Tables

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I=Initiation, C=Continuation
Table 8.

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<th>Condition</th>
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<th>P/R</th>
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<th>LNG/ ETG implants</th>
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<td><strong>Anemias</strong></td>
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<td>b) Certain anticonvulsants (phenytoin, car-</td>
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<td>bamazepine, barbituates, primidone, topi-</td>
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<td>iramate, oxcarbazepine)</td>
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<td>Antibiotics (excluding rifampicin)</td>
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I=Initiation, C=Continuation
# POSTPARTUM AND POST-ABORTION CONTRACEPTION. CRITERIA FOR USE

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<thead>
<tr>
<th>Method of Contraception</th>
<th>Postpartum Contraception</th>
<th>Post-abortion Contraception</th>
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<tbody>
<tr>
<td></td>
<td>Breastfeeding</td>
<td>No Breastfeeding</td>
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<tr>
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<td>&lt;6 weeks after childbirth</td>
<td>From 6 weeks to 6 months</td>
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<tr>
<td>Combined oral contraceptives (COCs)</td>
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<td>Combined injectable contraceptives, contraceptive patches and rings</td>
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<td>Progestin-only contraceptives</td>
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<tr>
<td>Copper-Bearing IUDs</td>
<td>1. &lt;48 hours after childbirth-2</td>
<td>2. from 48 hours to 4 weeks -3</td>
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<td>Levonorgestrel IUS</td>
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<td>Barrier Methods</td>
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<td>Condoms</td>
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<td>Natural Family Planning Methods</td>
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<td>After return of the menstrual cycle</td>
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<td>Lactational Amenorrhea Method (LAM)</td>
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<td>Voluntary Surgical Sterilization</td>
<td>&lt;7 days or &gt;42 - A from 7 to 42 days - D</td>
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</table>
AUTHORS

Zhylka N.Ya. Director of the Office for Maternal and Child Health of the Department for the Organization and Development of Medical Care for Population, Ministry of Health of Ukraine

Asta-Maria Kenney Director of the “Together for Health” Project

Barylo R.V. Clinical Coordinator of the “Together for Health” Project

Vovk I.B. Head of the Office of Family Planning and Reproductive Development of Children and Teenagers of the PAG Institute of AMS of Ukraine, chief specialist of the Ministry of Health of Ukraine on child and teenage gynecology.

Hryshchenko O.V. Head of the Department of Obstetrics, Gynecology and Perinatology, Kharkiv Medical Academy of Postgraduate Education

Ivasivka Z.M. Deputy Director of the Lviv Oblast Reproductive Health Center

Kaminskyy V.V. Head of the Department of Obstetrics, Gynecology and Reproductology, National Medical Academy of Postgraduate Education, chief specialist of the Ministry of Health of Ukraine on obstetrics and gynecology.

Kashtalyan M.M. Clinical Assistant of the “Together for Health” Project

Kvashenko V.P. Professor of the Department of Obstetrics, Gynecology and Perinatology, Postgraduate Education Faculty, Donetsk State Medical University

Moiseyenko R.O. Director of the Department for the Organization and Development of Medical Care for Population, Ministry of Health of Ukraine

Pyrohova V.I. Head of the Department of Obstetrics, Gynecology and Perinatology, Postgraduate Education Faculty, Lviv National Medical University

Posokhova S.P. Deputy Head Doctor of the Odesa Oblast Clinical Hospital

Say S.Yu. Deputy Director for Polyclinic Work of PAG Institute of AMS of Ukraine

Salo N.Y. Clinical Director of the “Together for Health” Project

Tatarchuk T.F. Deputy Director for Research, Head of the PAG Institute Department of Gynecological Endocrinology of AMS of Ukraine