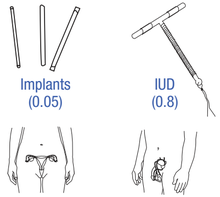
Comparing Effectiveness of Family Planning Methods

More effective
Less than 1 pregnancy per 100 women in 1 year

Less effective
About 30 pregnancies per 100 women in 1 year

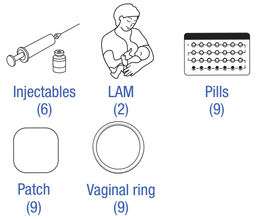
How to make your method more effective



Implants (0.05) | IUD (0.8) | Female sterilization (0.5) | Vasectomy (0.15)

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

Vasectomy: Use another method for first 3 months



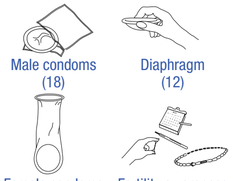
Injectables (6) | LAM (2) | Pills (9) | Patch (9) | Vaginal ring (9)

Injectables: Get repeat injections on time

Lactational amenorrhea method, LAM (for 6 months):
The baby is fully or near fully breastfed

Pills: Take a pill each day

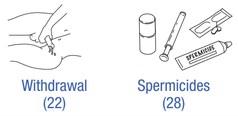
Patch, ring: Keep in place, change on time



Male condoms (18) | Diaphragm (12) | Female condoms (21) | Fertility awareness methods (24)

Condoms, diaphragm: Use correctly every time you have sex

Fertility awareness methods: Abstain from sex or use condoms on fertile days. The Standard Days Method or TwoDay Method can also be used.



Withdrawal (22) | Spermicides (28)

Withdrawal, spermicides: Use correctly every time you have sex

Numbers in parentheses indicate % of women experiencing an unintended pregnancy during the first year of typical use of contraception. Source: Trussell J., 2011

Abbreviations

BMI:	body mass index, calculated weight (kilograms) divided by height (meters squared)
COC:	combined oral contraceptive (pill)
Cu-IUD:	copper-bearing intrauterine device
DMPA (IM):	depot medroxyprogesterone acetate-intramuscular
DMPA (SQ):	depot medroxyprogesterone acetate-subcutaneous
ECP:	emergency contraceptive pill
ETG:	etonogestrel
LNG:	levonorgestrel
MEC:	Medical eligibility criteria for contraceptive use document
NET-EN:	norethisterone enanthate
PEP:	post-exposure prophylaxis
SPR:	Selected practice recommendations for contraceptive use document
STI:	sexually transmitted infection
UPA:	ulipristal acetate (UPA)

CONTRACEPTIVE DELIVERY TOOL FOR HUMANITARIAN SETTINGS

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CONTRACEPTIVE DELIVERY TOOL FOR HUMANITARIAN SETTINGS

About this tool

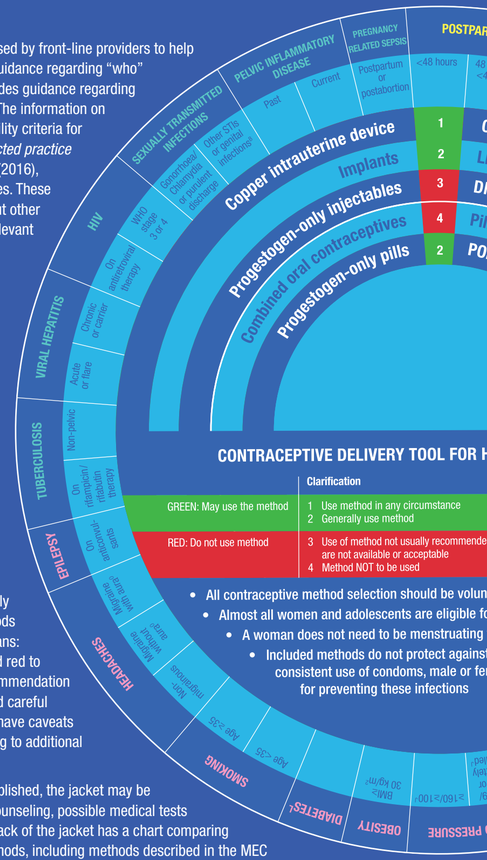
This tool is comprised of a wheel and jacket to be used by front-line providers to help women initiate contraception. The wheel provides guidance regarding "who" can use contraceptive methods and the jacket provides guidance regarding "how" to use these methods safely and effectively. The information on the wheel and jacket is adapted from Medical eligibility criteria for contraceptive use (MEC) 5th edition (2015) and *Selected practice recommendations for contraceptive use:* 3rd edition (2016), respectively, two of WHO's evidence-based guidelines. These documents contain in-depth recommendations about other contraceptive methods, conditions and medically-relevant characteristics that are not included in this tool.

How to use this tool

The wheel matches up the contraceptive methods, shown on the inner disk, with specific medical conditions or characteristics shown around the outer rim. The numbers 1, 2, 3, 4 shown in the viewing slots correspond to recommendations, telling you whether the individual who has this known condition or characteristic is eligible to initiate this contraceptive method. The recommendations are explained on the front of the wheel.

Number 1 means: "Use method in any circumstance", number 2 means: "Generally use method. Benefits outweigh risks". Both 1 and 2 are coloured green to show that the method can be used. Number 3 means: "Use of method not generally recommended unless other more appropriate methods are not available or not acceptable". Number 4 means: "Method not to be used". Both 3 and 4 are coloured red to show that the method should not be used. If a recommendation is 2-3, greater clinical judgement will be needed and careful follow-up may be required. Recommendations that have caveats are annotated with a letter superscript corresponding to additional explanations provided on the back of the wheel.

Once contraceptive method eligibility has been established, the jacket may be reviewed regarding other considerations, such as counseling, possible medical tests required, and timing for initiating the method. The back of the jacket has a chart comparing effectiveness of a broad range of contraceptive methods, including methods described in the MEC document but not on the wheel.



How to be reasonably certain that a woman is not pregnant

NO		YES
☐	1. Do you have monthly menses AND have you abstained from intercourse since your last period?	☐
☐	2. Did your last period start within the last 7 days?	☐
☐	3. Have you been using a modern contraceptive method consistently and correctly?	☐
☐	4. Have you had a baby in the last 4 weeks?	☐
☐	5. Have you had a miscarriage or abortion within the past 7 days?	☐
☐	6. Did you have a baby less than six months ago AND you are fully or nearly fully breastfeeding AND you have had no period since then?	☐

As soon as the woman answers "YES" to any of these questions, you can be reasonably sure she is not pregnant and she is eligible to begin any contraceptive method.

Highly reliable urine or blood pregnancy tests are often extremely useful, if available. Pelvic examination, where feasible, is reliable 8-10 weeks since the first day of the last menstrual period.

In situations in which the healthcare provider is uncertain whether the woman might be pregnant, the benefits of initiating ENG or LNG implant, DMPA or NET-EN injection and COC likely exceed any risk; therefore, starting the method should be considered at any time, with a follow-up pregnancy test in 2-4 weeks. For IUD insertion, in situations in which the healthcare provider is not reasonably certain that the woman is not pregnant, the woman should be provided with another contraceptive method to use until the healthcare provider can be reasonably certain that she is not pregnant.

Management of missed pills

Missed pills	Action	Additional protection	Note
Combined oral contraceptives - COC			
Missed 1 active (hormonal) pill, or starts a pack 1 day late	Take an active (hormonal) pill as soon as possible, then continue taking pills daily, 1 each day	No additional contraceptive protection needed	
Missed 2 active (hormonal) pills in a row, or starts a pack 2 days late	Take 2 hormonal pills together – the missed pill and the dose for the current day	No additional contraceptive protection needed	
Missed 3 or more active (hormonal) pills in a row, or starts a pack 3 or more days late	Take an active (hormonal) pill as soon as possible, then continue taking pills daily, 1 each day	Use condoms or abstain from sex until she has taken active (hormonal) pills for 7 days in a row. If pills missed in the 1st week and unprotected sex takes place, consider use of emergency contraception.	If pills missed in the 3rd week, finish active (hormonal) pills in current pack and start new pack the next day. Do not take the seven inactive pills.
Missed any inactive (nonhormonal) pill	Discard the missed inactive pill. Keep taking the pill once a day. Start new pack as usual		
Progestogen-only pills - POP			
Having menstrual cycles (including those who are breastfeeding) AND missed 1 or more pills by more than 3 hours	Take 1 pill as soon as possible, then continue taking pills daily, 1 each day	Use condoms or abstain from sex for the next 2 days. Consider the use of emergency contraception, if appropriate	In case of the 75µg desogestrel-containing pill, same guidance once pills have been missed for 12 hours
Breastfeeding and amenorrhoeic AND missed 1 or more pills by more than 3 hours	Take 1 pill as soon as possible, then continue taking pills daily, 1 each day	If she is less than 6 months postpartum, no additional contraceptive protection is needed	In case of the 75µg desogestrel-containing pill, same guidance once pills have been missed for 12 hours

Considerations for initiating contraception

If already using contraception and switching to one of these methods below, refer to SPR document to determine if contraceptive protection is needed before new method becomes effective.

	Cu-IUD	LNG/ETG IMPLANTS	DMPA NET-EN	COC	POP
Examinations or tests before initiation	STI risk assessment*; Pelvic/genital examination	Blood pressure screening, if available**	Blood pressure screening, if available**	Blood pressure screening, if available**	Blood pressure screening, if available**
When to start if the provider is reasonably certain that the womanis not pregnant (see previous page for explanation)	Anytime	Anytime	Anytime	Anytime	Anytime
Number of days to use barrier contraception or abstain from sex if initiating method >5 days after menses started	0 days	7 days	7 days	7 days	2 days
When to start after levonorgestrel emergency contraception	Immediately	Immediately	Immediately	Immediately	Immediately
When to start after ulipristal emergency contraception	Immediately	6 days	6 days	6 days	6 days
When to start postpartum (after a vaginal or cesarean birth)	See Wheel	See Wheel	See Wheel	See Wheel	See Wheel
When to start after abortion	Immediately (except if septic abortion)	Immediately	Immediately	Immediately	Immediately
Counsel regarding inconsistent use or dosing errors	Examinations or tests before initiation	Examinations or tests before initiation	If late for re-injection, injection can be given if reasonably certain she is not pregnant, with additional protection for 7 days	Examinations or tests before initiation	Yes, see Management of Missed Pills
Counsel about common changes in menstrual bleeding	Irregular or increased amountor duration of bleeding in first 3-6 months	Irregular or increased amountor duration of bleeding in first year; amenorrhoea	Irregular or increased amountor duration of bleeding in first injectioncycle; amenorrhoea	Irregular bleeding first few months common, then bleeding lighter ormore regular	Irregular bleeding first few months, then regular bleeding or continued irregular bleeding
Delay in return to fertility	No	No	Yes. On average: 10 months after last DMPA injection, 6 months after last NET-EN injection	No	No
Information regarding when the method needs to be removed or next injection due	Yes, depending on device type	Removal at 3 years for Implanon; 4 years for Levoplant; 5 years for Jadelle (4 years if >80 kg)	Next injection: 3 months for DMPA, 2 months for NET-EN. Can be given up to 2 weeks early for both, up to 2 weeks late for NET-EN, 4 weeks late for DMPA	Not applicable	Not applicable
Follow-up after method initiation	1st menses or 3-6 weeks following insertion; when due for removal	When due for removal	When due for next dose	Consider follow-up in 3 months, then annually	Consider follow-up in 3 months

* STI risk assessment may entail medical history and physical examination. Risk of STIs varies by individual behaviour (number of partners, use of condoms) and local STI prevalence. Therefore, while many women at increased risk of STIs can generally have an IUD inserted, some women at increased risk (very high individual likelihood) of STIs should generally not have an IUD inserted until appropriate testing and treatment occur.

** It is desirable to have blood pressure measurements taken before initiation. However, in some settings, blood pressure measurements are unavailable. In many of these settings, pregnancy morbidity and mortality risks are high, and hormonal methods are among the few methods widely available. In such settings, women should not be denied use of hormonal methods simply because their blood pressure cannot be measured.

Considerations for follow-up after contraception initiation

Follow-up visits or contacts should include, at a minimum, counselling to address issues such as side-effects or other problems, correct and consistent use of the method, and protection against STIs. Additional assessment may be appropriate.

Emergency contraception

	Cu-IUD for EC	LNG-ECPs	Combined ECPs	UPA-ECPs
Dose		Single dose 1.50 mg LNG (or two 0.75 mg LNG tablets)	100 µg ethinyl estradiol + 0.5 mg LNG. Repeat 12 hours later	30 mg UPA
Timing / Effectiveness	Up to 120 hours (5 days) after unprotected intercourse	As early as possible, within 120 hours after unprotected intercourse. The longer the delay in taking the ECPs, the lower the effectiveness. Combined ECPs are less effective and have more side-effects than LNG-ECPs and UPA-ECPs		
General eligibility	Same as for general Cu-IUD insertion	All women. Category 2 for history of severe cardiovascular disease, migraine, and severe liver disease		
Post rape	Do not use when high risk of STI	Use and consider adding HIV PEP for women presenting within 72 hours of sexual assault		
Breastfeeding	Continue	Continue	Continue	Express your milk and discard it for 1 week after taking pill

Repeated ECP use is an indication that the woman requires further counselling on other contraceptive options.

Repeated ECP use may be harmful for women with medical conditions or characteristics classified as 2, 3 or 4 for contraceptives containing hormones. An advance supply of ECPs may be given to ensure that she will have them available when needed and can take them as soon as possible after unprotected intercourse.

Intimate partner violence can interfere with a woman's use of family planning

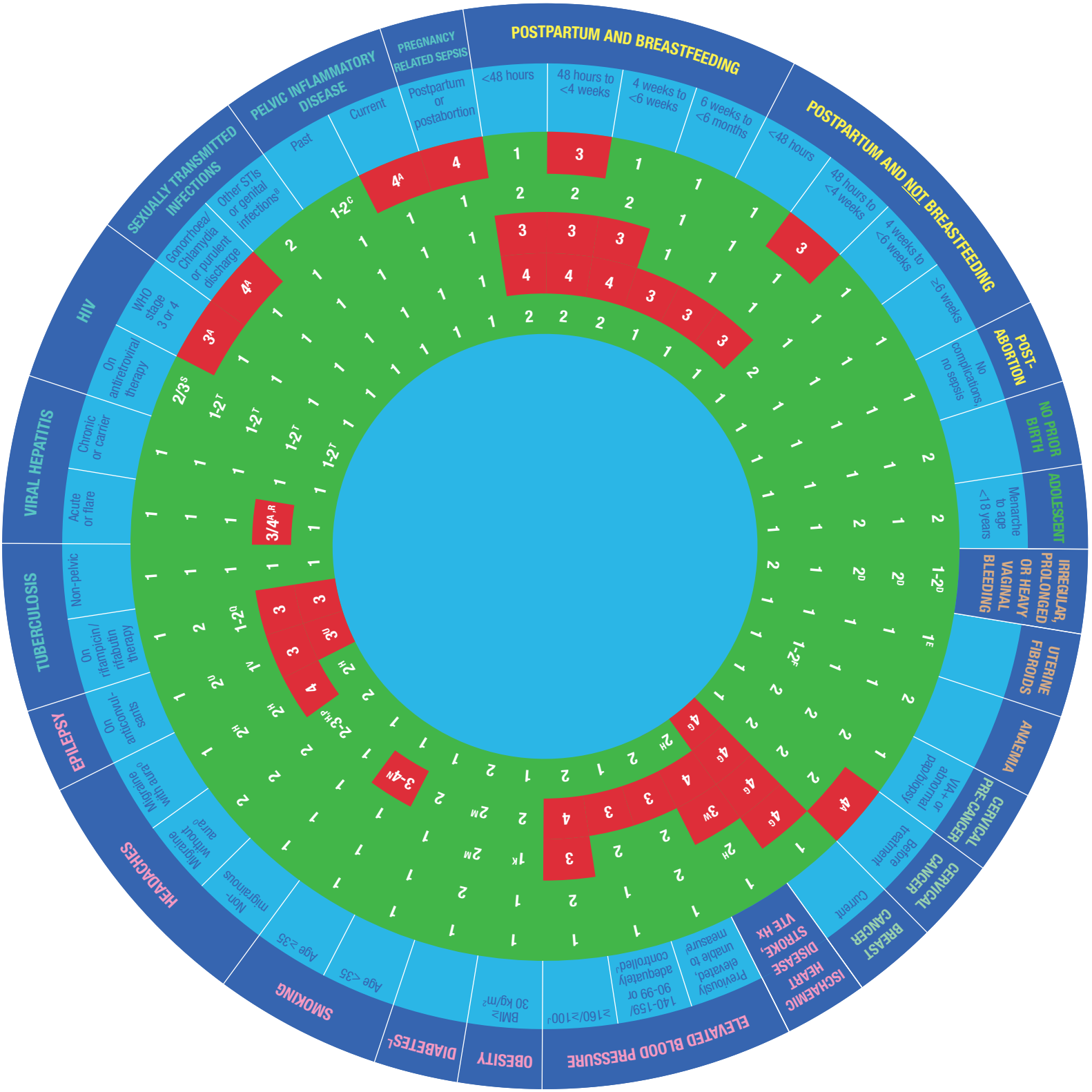
Suspect violence if she has repeated unwanted pregnancies or medical terminations, or difficulties adhering to correct use of contraception, or repeated STIs. In this case, ensuring privacy, ask in a non judgemental way (see reference below on how to ask).

If a client is experiencing violence provide first-line support using **LIVES:**

L isten empathetically and without judgement
I nquire about her needs and concerns and respect her choices
V alidate. Show her that you understand and believe her
E nhance Safety. Identify her risks and help her develop a plan to protect herself/her children.
S upport. Connect her to information, services and social support as needed.

Help her choose a method of contraception that would be harder for her partner to interfere with, e.g. injectables/depo, implants, copper-hormonal IUDs.

For detailed information see : *Family Planning: A global handbook for providers (2018 edition) pp. 360-364.*


POSTPARTUM AND BREASTFEEDING
<48 hours
48 hours to <4 weeks
4 weeks to <6 weeks
6 weeks to <6 months
POSTPARTUM AND NOT BREASTFEEDING
<48 hours
48 hours to <4 weeks
4 weeks to <6 weeks
≥6 weeks
POST-ABORTION
No complications no sepsis
NO PRIOR BIRTH
ADOLESCENT
Menarche to age <18 years
IRREGULAR, PROLONGED OR HEAVY VAGINAL BLEEDING
UTERINE FIBROIDS
ANAEMIA
CERVICAL CANCER PRE-CANCER
VIA+ or abnormal palpdiopsy
CERVICAL CANCER
Before treatment
BREAST CANCER
Current
ISCHAEMIC HEART DISEASE STROKE, VTE HX
ELEVATED BLOOD PRESSURE
Previously elevated, unable to measur
140-159/ 90-99 or adequately controlled
≥160/≥100
OBESITY
BMI≥ 30 kg/m²
DIABETES
SMOKING
Age ≥35
Age <35
HEADACHES
Non-migrainous
Migraine without aura
Migraine with aura
EPILEPSY
On anticonvul-sants
TUBERCULOSIS
On rifampicin/ rifabutin therapy
Non-pelvic
VIRAL HEPATITIS
Acute or flare
Chronic or carrier
HIV
On antiretroviral therapy
WHO stage 3 or 4
SEXUALLY TRANSMITTED INFECTIONS
Other STIs or genital infections
Gonorrhoea/ Chlamydia or purulent discharge
PELVIC INFLAMMATORY DISEASE
Past
Current
PREGNANCY RELATED SEPSIS
Postpartum or postabortion

Women with these additional conditions are eligible for all methods of contraception

Reproductive Conditions: Benign breast disease or undiagnosed mass • Benign ovarian tumours, including cysts • Cervical ectopy (ectropion) • Dysmenorrhoea • Endometriosis • History of gestational diabetes • History of pelvic surgery, including caesarean delivery • Past ectopic pregnancy • Postpartum ≥ 6 months

Medical Conditions: Depression • HIV asymptomatic or mild clinical disease (WHO stage 1 or 2) • High cholesterol • Malaria • Mild cirrhosis • Schistosomiasis (bilharzia) • Superficial venous disorders, including varicose veins • Surgery without prolonged immobilization • Taking antibiotics (excluding rifampicin/rifabutin) • Thyroid disorders • Uncomplicated valvular heart disease

Other: Age ≥40 years • Breast cancer family history • Venous thromboembolism family history • High risk for HIV

Refer to the full MEC document for other conditions that are not listed above or on the front of this tool that may pose risks for women considering female methods of contraception

Explanations

A	If condition develops while using method, can continue using it during treatment
B	For women, genital infections refer to trichomonas vaginalis and bacterial vaginosis. For men, genital infections refer to internal (testes) and external (penis, scrotal skin) infections
C	If had pregnancy after pelvic inflammatory disease, IUD =1, if no pregnancy after, IUD =2
D	If pregnancy or an underlying pathological condition (such as pelvic malignancy) is suspected and has not been evaluated, IUD=4 (if already using IUD, may continue to use); implants and DMPA/NET-EN =3
E	If uterine cavity distorted preventing IUD insertion, IUD =4
F	If sickle cell disease =2
G	If disease in the past and no evidence of disease for 5 years, hormonal method =3
H	If ischemic condition developed while on this method, consider switching to non-hormonal method; for acute VTE=3
I	If history of high blood pressure only during pregnancy and current blood pressure is measured and normal, COC =2 and all other methods =1
J	When blood pressure is measured. Either systolic or diastolic blood pressure may be elevated
K	If age <18 years and obese, DMPA=2
L	Insulin-dependent and non-insulin dependent. If history of diabetes in pregnancy only (gestational diabetes) =1 for all methods
M	If complicated (kidney, eye or nerve disease) or >20 years duration, DMPA/NET-EN =3 and COC =3/4
N	If <15 cigarettes/day, COC =3. If ≥15 cigarettes/day, COC =4
O	Aura refers to reversible, temporary visual or sensory neurological symptoms, (seeing flickering lights, tingling or numbness on one side of the face or one limb)
P	If age <35, COC =2. If age ≥ 35, COC =3
Q	DMPA =1
R	The category recommendation should be assessed according to the severity of the condition
S	If clinically well =2. If not clinically well =3
T	If antiretroviral therapy with EFV, NVP, ATV/r, LPV/r, DRV/r, RTV: Implants, NET-ET, COC, =2; DMPA =1. For all NRTIs, ETR, RPV, RAL each method =1. *See full MEC document for antiretroviral drug abbreviations*
U	exception: lamotrigine=1
V	NET-EN=2
W	For history of VTE, DMPA/NET-EN=2

"Combined" as in combined hormonal contraception, refers to a combination of ethinyl estradiol and a progestogen
BMI: Body mass index; weight (kg) divided by height (m^2)
DMPA (IM, SC): depot medroxyprogesterone acetate
ETG: etonogestrel
MEC: *Medical eligibility criteria for contraceptive use* document
SPR: *Selected practice recommendations for contraceptive use* document
VIA: visual inspection with acetic acid (for cervical cancer screening)
VTE: venous thrombo-embolism
WHO stage 3 or 4: severe or advanced HIV clinical disease

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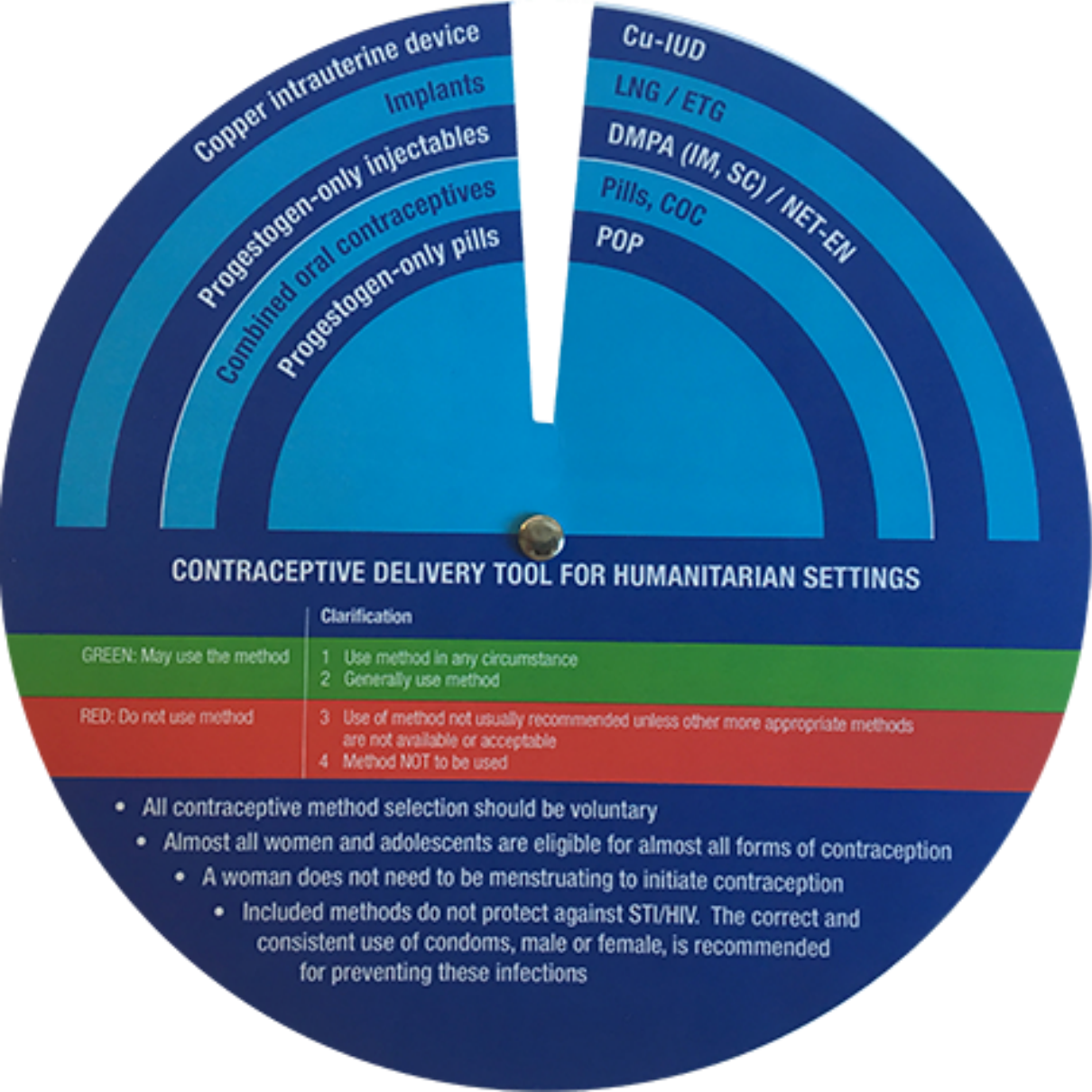

CONTRACEPTIVE DELIVERY TOOL FOR HUMANITARIAN SETTINGS

	Clarification
GREEN: May use the method	1 Use method in any circumstance 2 Generally use method
RED: Do not use method	3 Use of method not usually recommended unless other more appropriate methods are not available or acceptable 4 Method NOT to be used

- All contraceptive method selection should be voluntary
- Almost all women and adolescents are eligible for almost all forms of contraception
- A woman does not need to be menstruating to initiate contraception
- Included methods do not protect against STI/HIV. The correct and consistent use of condoms, male or female, is recommended for preventing these infections