Combined Oral Contraceptives

Key Points for Providers and Clients

- **Take one pill every day.** For greatest effectiveness a woman must take pills daily and start each new pack of pills on time.
- **Take any missed pill as soon as possible.** Missing pills risks pregnancy and may make some side effects worse.
- **Bleeding changes are common but not harmful.** Typically, there is irregular bleeding for the first few months and then lighter and more regular bleeding.
- **Can be given to a woman at any time to start now or later.** If pregnancy cannot be ruled out, a provider can give her pills to take later, when her monthly bleeding begins.

What Are Combined Oral Contraceptives?

- Pills that contain low doses of 2 hormones—a progestin and an estrogen—like the natural hormones progesterone and estrogen in a woman's body.
- Combined oral contraceptives (COCs) are also called "the Pill," low-dose combined pills, OCPs, and OCs.
- Work primarily by preventing the release of eggs from the ovaries (ovulation).

How Effective?

Effectiveness depends on the user: Risk of pregnancy is greatest when a woman starts a new pill pack 3 or more days late, or misses 3 or more pills near the beginning or end of a pill pack.

- As commonly used, about 7 pregnancies per 100 women using COCs over the first year. This means that 93 of every 100 women using COCs will not become pregnant.
- When no pill-taking mistakes are made, less than 1 pregnancy per 100 women using COCs over the first year (3 per 1,000 women).

Return of fertility after COCs are stopped: No delay

Protection against sexually transmitted infections (STIs): None

Side Effects, Health Benefits, and Health Risks

Side Effects (see Managing Any Problems, p. ~~18~~)

Some users report the following:

- Changes in bleeding patterns† including:
  - Lighter bleeding and fewer days of bleeding
  - Irregular bleeding
  - Infrequent bleeding
  - No monthly bleeding
- Headaches
- Dizziness
- Nausea
- Breast tenderness
- Weight change (see Question 6, p. ~~23~~)
- Mood changes
- Acne (can improve or worsen, but usually improves)

~~Bleeding changes are common and may be bothersome. However, they are not harmful. Counseling and support can help women understand this.~~

Other possible physical changes:

- Blood pressure increases a few points (mm Hg). When increase is due to COCs, blood pressure declines quickly after use of COCs stops.

Why Some Women Say They Like Combined Oral Contraceptives

- Are controlled by the woman
- Can be stopped at any time without a provider's help
- Do not interfere with sex
- Are easy to use
- Easy to obtain, for example in drug shops or pharmacies

† *For definitions of bleeding patterns see "vaginal bleeding" page xx.*

Known Health Benefits

Help protect against:

- Risks of pregnancy
- Cancer of the lining of the uterus (endometrial cancer)
- Cancer of the ovary
- Symptomatic pelvic inflammatory disease

May help protect against:

- Ovarian cysts
- Iron-deficiency anemia

Reduce:

- Menstrual cramps
- Menstrual bleeding problems
- Ovulation pain
- Excess hair on face or body
- Symptoms of polycystic ovarian syndrome (irregular bleeding, acne, excess hair on face or body)
- Symptoms of endometriosis (pelvic pain, irregular bleeding)

Known Health Risks

Very rare:

- Blood clot in deep veins of legs or lungs (deep vein thrombosis or pulmonary embolism)

Extremely rare:

- Stroke
- Heart attack

See also Facts About Combined Oral Contraceptives and Cancer, p. 4.

Correcting Misunderstandings (see also Questions and Answers, p. ~~23~~)

Combined oral contraceptives:

- Do not build up hormones in a woman's body. Women do not need a "rest" from taking COCs.
- Must be taken every day, whether or not a woman has sex that day.
- Do not make women infertile after they stop taking COCs.
- Do not cause birth defects or multiple births.
- Do not change women's sexual behavior.
- Do not collect in the stomach. Instead, the pill dissolves each day.
- Do not disrupt an existing pregnancy.

Facts About Combined Oral Contraceptives and Cancer

Overall risk of developing cancer over a lifetime is similar among women who have used COCs and women who have not used COCs. COC users may have small increases in risk of some types of cancer, but they also have long-term reductions in other types of cancer.

Ovarian and endometrial cancer

- Use of COCs helps *protect* users from 2 important kinds of cancer—cancer of the ovaries and cancer of the lining of the uterus (endometrial cancer).
- This protection continues for 15 years or more after stopping use of COCs.

Breast cancer

- Research findings about COCs and breast cancer are difficult to interpret:
  - Studies find that women who used COCs more than 10 years ago face the same risk of breast cancer as similar women who have never used COCs. In contrast, some studies find that current users of COCs and women who have used COCs within the past 10 years are slightly more likely to be diagnosed with breast cancer. On balance, there may be little difference in lifetime risk. It is unclear whether these findings are explained by earlier detection of existing breast cancers among COC users or by a biologic effect of COCs on breast cancer.
  - Previous use of COCs does not increase the risk of breast cancer later in life, when breast cancer is more common.
  - When a current or former COC user is diagnosed with breast cancer, the cancers generally are less advanced than cancers diagnosed in other women.
  - COC use does not increase risk of breast cancer for women whose relatives have had breast cancer.

Cervical cancer

- Cervical cancer is caused by certain types of human papillomavirus (HPV). HPV is a common sexually transmitted infection that usually clears on its own without treatment, but sometimes it persists and sometimes leads to cervical cancer. A vaccine can help to prevent cervical cancer. (See Cervical Cancer, p. 284.) If cervical screening is available, providers can advise all women to be screened every 3 years (or as national guidelines recommend).
- Use of COCs for 5 years or more appears to increase slightly the risk of cervical cancer. After a woman stops using COCs, this risk decreases. By 10 years after stopping COCs, a former COC user has the same risk of cervical cancer as a woman who has never used COCs. The number of cervical cancers associated with COC use is small.

Other cancers

- Use of COCs may decrease the risk of colorectal cancer.
- There is no clear evidence that COC use either decreases or increases the risk of any other type of cancer.

Who Can and Cannot Use Combined Oral Contraceptives

Safe and Suitable for Nearly All Women

Nearly all women can use COCs safely and effectively, including women who:

- Have or have not had children
- Are not married
- Are of any age, including adolescents and women over 40 years old
- After childbirth and during breastfeeding, after a period of time
- Have just had an abortion, miscarriage, or ectopic pregnancy
- Smoke cigarettes—if under 35 years old
- Have anemia now or had in the past
- Have varicose veins
- Are infected with HIV, whether or not on antiretroviral therapy (see Combined Oral Contraceptives for Women With HIV, p. 9)

Avoid Unnecessary Procedures

Women can begin using COCs:

- Without a pelvic examination
- Without any blood tests or other routine laboratory tests
- Without cervical cancer screening
- Without a breast examination
- Without a pregnancy test. A woman can begin using COCs at any time, even when she is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant (see Pregnancy Checklist, p. 372).

Medical Eligibility Criteria for

Combined Oral Contraceptives

Ask the client the questions below about known medical conditions. Examinations and tests are not necessary. If she answers "no" to all of the questions, then she can start COCs if she wants. If she answers "yes" to a question, follow the instructions. In some cases she can still start COCs. These questions also apply for the combined patch (see p. ~~102~~) and the combined vaginal ring (see p. ~~106~~).

1. Are you breastfeeding a baby less than 6 months old?

❑ NO ❑ **YES**

- If fully or nearly fully breastfeeding: Give her COCs and tell her to start taking them 6 months after giving birth or when breast milk is no longer the baby's main food—whichever comes first (see Fully or nearly fully breastfeeding, p. ~~10~~).
- If partially breastfeeding: She can start COCs as soon as 6 weeks after childbirth (see Partially breastfeeding, p. ~~11~~).

2. Have you had a baby in the last 3 weeks and you are not breastfeeding?

❑ NO ❑ **YES** Give her COCs now and tell her to start taking them 3 weeks after childbirth. (If there is an additional risk that she might develop a blood clot in a deep vein (deep vein thrombosis, or VTE), then she should not start COCs at 3 weeks after childbirth, but start at 6 weeks instead. These additional risk factors include previous VTE, thrombophilia, caesarean delivery, blood transfusion at delivery, postpartum hemorrhage, pre-eclampsia, obesity ($\geq$30 kg/m^2), smoking, and being bedridden for a prolonged time.)

3. Do you smoke cigarettes?

❑ NO ❑ **YES** If she is 35 years of age or older and smokes, do not provide COCs. Urge her to stop smoking and help her choose another method but not patch or ring if she smokes fewer than 15 cigarettes a day and also not monthly injectables if more than 15 cigarettes a day.

4. Do you have cirrhosis of the liver, a liver infection, or liver tumor? ~~(Are her eyes or skin unusually yellow? [signs of jaundice])~~ Have you ever had jaundice when using COCs?

❑ NO ❑ **YES** If she reports serious liver disease (such as severe cirrhosis or liver tumor), acute or flare of viral hepatitis, or ever had jaundice while using COCs, do not provide COCs. Help her choose a method without hormones. (She can use monthly injectables if she has had jaundice only with past COC use.)

5. Do you have high blood pressure?

❑ NO ❑ **YES** If you cannot check blood pressure and she reports a history of high blood pressure, or if she is being treated for high blood pressure, do not provide COCs. Refer her for a blood pressure check if possible or help her choose a method without estrogen.

Check blood pressure if possible:

- If her blood pressure is below 140/90 mm Hg, provide COCs. No need to retest before starting COCs.
- ~~If her systolic blood pressure is 140 mm Hg or higher or diastolic blood pressure is 90 or higher, do not provide COCs. Help her choose a method without estrogen, but not progestin-only injectables if systolic blood pressure is 160 or higher or diastolic pressure is 100 or higher.~~
- If blood pressure is 160/100 mm Hg or higher, do not provide COCs. Help her choose a method without estrogen, but not a progestin-only injectable.
- If blood pressure is 140–159/90–99 mm Hg, one measurement is not enough to diagnose high blood pressure. Give her a backup method* to use until she can return for another blood pressure measurement, or help her choose another method.
  - If her next blood pressure measurement is below 140/90 mm Hg, she can start COCs.
  - However, if her next blood pressure measurement is 140/90 mm Hg or higher, do not provide COCs. Help her choose a method without estrogen, but not a progestin-only injectable if systolic blood pressure is 160 or higher or diastolic pressure is 100 or higher.

(Continued on next page)

* *Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.*

Medical Eligibility Criteria for Combined Oral Contraceptives (continued)

6. Have you had diabetes for more than 20 years *or* damage to your arteries, vision, kidneys, or nervous system caused by diabetes?

❑ NO ❑ **YES** Do not provide COCs. Help her choose a method without estrogen but not progestin-only injectables.

7. Do you have gallbladder disease now or take medication for gallbladder disease?

❑ NO ❑ **YES** Do not provide COCs. Help her choose another method but not the combined patch or combined vaginal ring.

8. Have you ever had a stroke, blood clot in your legs or lungs, heart attack, or other serious heart problems?

❑ NO ❑ **YES** If she reports heart attack, heart disease due to blocked or narrowed arteries, or stroke, do not provide COCs. Help her choose a method without estrogen but not progestin-only injectables. If she reports a current blood clot in the deep veins of the legs (not superficial clots) or lungs, help her choose a method without hormones.

9. Do you have or have you ever had breast cancer?

❑ NO ❑ **YES** Do not provide COCs. Help her choose a method without hormones.

10. Do you sometimes see a bright area of lost vision in the eye before a very bad headache (migraine aura)? Do you get throbbing, severe head pain, often on one side of the head, that can last from a few hours to several days and can cause nausea or vomiting (migraine headaches)? Such headaches are often made worse by light, noise, or moving about.

❑ NO ❑ **YES** If she has migraine aura at any age, do not provide COCs. If she has migraine headaches *without* aura *and* is age 35 or older, do not provide COCs. Help these women choose a method without estrogen. If she is under 35 and has migraine headaches without aura, she can use COCs (see Identifying Migraine Headaches and Auras, p. ~~368~~).

(Continued on next page)

11. Are you taking medications for seizures? Are you taking rifampicin or rifabutin for tuberculosis or other illness?

❑ NO ❑ **YES** If she is taking barbiturates, carbamazepine, lamotrigine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, or rifabutin, do not provide COCs. They can make COCs less effective. Help her choose another method but not progestin-only pills, patch, or combined ring. If she is taking lamotrigine, help her choose a method without estrogen.

12. Are you planning major surgery that will keep you from walking for one week or more?

❑ NO ❑ **YES** If so, she can start COCs 2 weeks after she can move about again. Until she can start COCs, she should use a backup method.

13. Do you have several conditions that could increase your chances of heart disease (coronary artery disease) or stroke, such as older age, smoking, high blood pressure, or diabetes?

❑ NO ❑ **YES** Do not provide COCs. Help her choose a method without estrogen but not progestin-only injectables.

Also, women should not use COCs if they report having thrombogenic mutations or lupus with positive (or unknown) antiphospholipid antibodies. For complete classifications, see Medical Eligibility Criteria for Contraceptive Use, p. ~~324~~. Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable, when relevant to the client.

Combined Oral Contraceptives for Women With HIV

- Women can safely use COCs even if they are infected with HIV or are on antiretroviral (ARV) therapy.
- Urge these women to use condoms along with COCs. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs. Condoms also provide extra contraceptive protection for women whose ARV therapy might make COCs less effective (see page xxxx).

Using Clinical Judgment in Special Cases

Usually, a woman with any of the conditions listed below should not use COCs. In special circumstances, however, when other, more appropriate methods are not available or acceptable to her, a qualified provider who can carefully assess a specific woman's condition and situation may decide that she can use COCs. The provider needs to consider the severity of her condition and, for most conditions, whether she will have access to follow-up.

- Not breastfeeding and less than 3 weeks since giving birth, without additional risk that she might develop a blood clot in a deep vein (VTE)
- Not breastfeeding and between 3 and 6 weeks postpartum with additional risk that she might develop VTE
- Primarily breastfeeding between 6 weeks and 6 months since giving birth
- Age 35 or older and smokes fewer than 15 cigarettes a day
- High blood pressure (systolic blood pressure between 140 and 159 mm Hg or diastolic blood pressure between 90 and 99 mm Hg)
- Controlled high blood pressure, where continuing evaluation is possible
- History of high blood pressure, where blood pressure cannot be taken (including pregnancy-related high blood pressure)
- History of jaundice while using COCs in the past
- Gallbladder disease (current or medically treated)
- Age 35 or older and has migraine headaches without aura
- Younger than age 35 and has migraine headaches without aura that have developed or have gotten worse while using COCs
- Had breast cancer more than 5 years ago, and it has not returned
- Diabetes for more than 20 years or damage to arteries, vision, kidneys, or nervous system caused by diabetes
- Multiple risk factors for arterial cardiovascular disease such as older age, smoking, diabetes, and high blood pressure
- Taking barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, or rifabutin. A backup contraceptive method should also be used because these medications reduce the effectiveness of COCs.
- Taking lamotrigine. Combined hormonal methods may make lamotrigine less effective.

Providing Combined Oral Contraceptives

When to Start

IMPORTANT: A woman can start using COCs any time she wants if it is reasonably certain she is not pregnant. To be reasonably certain she is not pregnant, use the Pregnancy Checklist (see p. ~~372~~ 2). Also, a woman can be given COCs at any time and told when to start taking them.

Woman's situation	When to start
Having menstrual cycles or switching from a nonhormonal method	**Any time of the month** • If she is starting within 5 days after the start of her monthly bleeding, no need for a backup method. • If it is more than 5 days after the start of her monthly bleeding, she can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method* for the first 7 days of taking pills. (If you cannot be reasonably certain, give her COCs now and tell her to start taking them during her next monthly bleeding.) • If she is switching from an IUD, she can start COCs immediately (see Copper-Bearing IUD, Switching From an IUD to Another Method, p. ~~148~~ 2).
Switching from a hormonal method	• Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. • If she is switching from injectables, she can begin taking COCs when the repeat injection would have been given. No need for a backup method.
Fully or nearly fully breastfeeding	
Less than 6 months after giving birth	• Give her COCs and tell her to start taking them 6 months after giving birth or when breast milk is no longer the baby's main food—whichever comes first.

* *Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.*

Woman's situation	When to start
Fully or nearly fully breastfeeding (continued)	
More than 6 months after giving birth	• If her monthly bleeding has not returned, she can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills. (If you cannot be reasonably certain, give her COCs now and tell her to start taking them during her next monthly bleeding. Give her a backup method to use until then.) • If her monthly bleeding has returned, she can start COCs as advised for women having menstrual cycles (see previous page).
Partially breastfeeding	
Less than 6 weeks after giving birth	• Give her COCs and tell her to start taking them 6 weeks after giving birth. • Also give her a backup method to use until 6 weeks since giving birth if her monthly bleeding returns before this time.
More than 6 weeks after giving birth	• If her monthly bleeding has not returned, she can start COCs any time it is reasonably certain she is not pregnant.† She will need a backup method for the first 7 days of taking pills. (If you cannot be reasonably certain, give her COCs now and tell her to start taking them during her next monthly bleeding. Give her a backup method* to use until then.) • If her monthly bleeding has returned, she can start COCs as advised for women having menstrual cycles (see previous page).

† *Where a visit 6 weeks after childbirth is routinely recommended and other opportunities to obtain contraception are limited, some providers and programs may give COCs at the 6-week visit, without further evidence that the woman is not pregnant, if her monthly bleeding has not yet returned.*

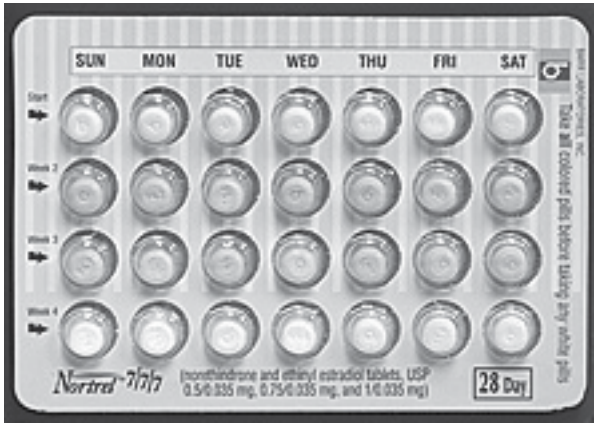
Woman's situation	When to start
Not breastfeeding	
Less than 4 weeks after giving birth	• She can start COCs at any time on days 21–28 after giving birth. Give her pills any time to start during these 7 days. No need for a backup method. (If additional risk for VTE, wait until 6 weeks. See p. 6, Question 2.)
More than 4 weeks after giving birth	• If her monthly bleeding has not returned, she can start COCs any time it is reasonably certain she is not pregnant.† She will need a backup method for the first 7 days of taking pills. (If you cannot be reasonably certain, give her COCs now and tell her to start taking them during her next monthly bleeding. Give her a backup method to use until then.) • If her monthly bleeding has returned, she can start COCs as advised for women having menstrual cycles (see p. ~~10~~ 1).
No monthly bleeding (not related to childbirth or breastfeeding)	• She can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills.
After miscarriage or abortion	• Immediately. If she is starting within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method. • If it is more than 7 days after first- or second-trimester miscarriage or abortion, she can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills. (If you cannot be reasonably certain, give her COCs now and tell her to start taking them during her next monthly bleeding.)

† *Where a visit 6 weeks after childbirth is routinely recommended and other opportunities to obtain contraception are limited, some providers and programs may give COCs at the 6-week visit, without further evidence that the woman is not pregnant, if her monthly bleeding has not yet returned.*

Woman's situation	When to start
After taking emergency contraceptive pills (ECPs)	**After taking progestin-only or combined ECPs:** • She can start or restart COCs immediately after she takes the ECPs. *No need to wait for her next monthly bleeding.* – A continuing user who needed ECPs due to pill-taking errors can continue where she left off with her current pack. • If she does not start immediately, but returns for COCs, she can start at any time if it is reasonably certain she is not pregnant. • All women will need to use a backup method for the first 7 days of taking pills.

After taking ulipristal acetate (UPA) ECPs:

- She can start or restart COCs on the 6th day after taking UPA-ECPs. *No need to wait for her next monthly bleeding.* COCs and UPA ~~may~~ interact, and one or both of them may be less effective when both are present in the body.
- Give her a supply of pills and tell her to start them on the 6th day after taking the UPA-ECPs.
- She will need to use a backup method from the time she takes the UPA-ECPs until she has been taking COCs for 7 days.
- If she does not start on the 6th day but returns later for COCs, she may start at any time if it is reasonably certain she is not pregnant.



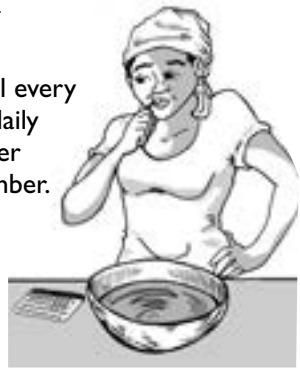
Giving Advice on Side Effects

IMPORTANT: Thorough counseling about bleeding changes and other side effects is an important part of providing the method. Counseling about bleeding changes may be the most important help a woman needs to keep using the method without concern.

Describe the most common side effects	• In the first few months, bleeding at unexpected times (irregular bleeding). Then lighter, shorter, and more regular monthly bleeding. • Headaches, breast tenderness, weight change, and possibly other side effects.
Explain about these side effects	• Side effects are not signs of illness. • Most side effects usually become less or stop within the first few months of using COCs. • Common, but some women do not have them.
Explain what to do in case of side effects	• Keep taking COCs. Skipping pills risks pregnancy and can make some side effects worse. • Take each pill at the same time every day to help reduce irregular bleeding and also help with remembering. • Take pills with food or at bedtime to help avoid nausea. • The client can come back for help if side effects bother her or if she has other concerns.

Explaining How to Use

1. Give pills	• Give up to 1 year's supply (13 packs) depending on the woman's preference and planned use.
2. Explain pill pack	• Show which kind of pack—21 pills or 28 pills. With 28-pill packs, point out that the last 7 pills are a different color and do not contain hormones (some brands may differ). • Show how to take the first pill from the pack and then how to follow the directions or arrows on the pack to take the rest of the pills.
3. Give key instruction	• **Take one pill each day**—until the pack is empty. • Discuss cues for taking a pill every day. Linking pill-taking to a daily activity—such as cleaning her teeth—may help her remember. • Taking pills at the same time each day helps to remember them. It also may help reduce some side effects.
4. Explain starting next pack	• 28-pill packs: When she finishes one pack, she should take the first pill from the next pack on the very next day. • 21-pill packs: After she takes the last pill from one pack, she should wait 7 days—no more—and then take the first pill from the next pack. • It is very important to start the next pack on time. Starting a pack late risks pregnancy.
5. Provide backup method and explain use	• Sometimes she may need to use a backup method, such as when she misses pills. • Backup methods include abstinence, male or female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. Give her condoms, if possible. • If she misses 3 or more hormonal pills, she can consider ECPs.



Supporting the User

Managing Missed Pills

It is easy to forget a pill or to be late in taking it. Adolescents are more likely to forget pills and so may need extra support and guidance.

COC users should know what to do if they forget to take pills. **If a woman misses one or more pills, she should follow the instructions below.** Use the tool on the inside back cover to help explain these instructions to the client.

Making Up Missed Pills With 30–35 µg Estrogen‡

Key message	• **Take a missed hormonal pill as soon as possible.** • Keep taking pills as usual, one each day. (She may take 2 pills at the same time or on the same day.)
Missed 1 or 2 pills? Started new pack 1 or 2 days late?	• Take a hormonal pill as soon as possible. • Little or no risk of pregnancy.
Missed pills 3 or more days in a row in the first or second week? Started new pack 3 or more days late?	• Take a hormonal pill as soon as possible. • Use a backup method for the next 7 days. • Also, if she had sex in the past 5 days, can consider ECPs (see Emergency Contraceptive Pills, p. 47).
Missed 3 or more pills in the third week?	• Take a hormonal pill as soon as possible. • Finish all hormonal pills in the pack. Throw away the 7 nonhormonal pills in a 28-pill pack. • Start a new pack the next day. • Use a backup method for the next 7 days. • Also, if she had sex in the past 5 days, can consider ECPs (see Emergency Contraceptive Pills, p. 47).

‡ *For pills with 20 µg of estrogen or less, women missing one pill should follow the same guidance as for missing one or two 30–35 µg pills. Women missing 2 or more pills should follow the same guidance as for missing 3 or more 30–35 µg pills.*

Missed any non-hormonal pills? (last 7 pills in 28-pill pack)	• Discard the missed nonhormonal pill(s). • Keep taking COCs, one each day. Start the new pack as usual.
Severe vomiting or diarrhea	• If she vomits within 2 hours after taking a pill, she should take another pill from her pack as soon as possible, then keep taking pills as usual. • If she has vomiting or diarrhea for more than 2 days, follow instructions for 3 or more missed pills, above.

How Can a Partner Help?

The client's partner is welcome to participate in counseling and learn about the method and what support he can give to his partner. A male partner can:

- Support a woman's choice of COCs
- Help her to remember to take a pill each day and to start a new pack on time
- Show understanding and support if she has side effects
- Help her to make sure that she has a new pill pack on hand to start on time
- Help to make sure she has ECPs on hand in case she misses pills or starts a new pill pack late
- Use condoms consistently in addition to COCs if he has an STI/HIV or thinks he may be at risk of an STI/HIV

"Come Back Any Time": Reasons to Return

Assure every client that she is welcome to come back any time—for example, if she has problems, questions, or wants another method; she has any major change in health status; or she thinks she might be pregnant. Also if:

- She needs more pills or she wants ECPs because she started a new pack 3 or more days late or missed 3 or more hormonal pills or, if she is using pills with 20 µg of estrogen or less, because she started a new pack 2 or more days late or missed 2 or more hormonal pills.

General health advice: Anyone who suddenly feels that something is seriously wrong with her health should immediately seek medical care from a nurse or doctor. Her contraceptive method is most likely not the cause of the condition, but she should tell the nurse or doctor what method she is using.

Planning the Next Visit

1. Encourage her to come back for more pills before she uses up her supply of pills.
2. An annual visit is recommended.
3. Some women can benefit from contact after 3 months of COC use. This offers an opportunity to answer any questions, help with any problems, and check on correct use.

Helping Continuing Users

1. Ask how the client is doing with the method and whether she is satisfied. Ask if she has any questions or anything to discuss.
2. Ask especially if she is concerned about bleeding changes. Give her any information or help that she needs (see Managing Any Problems, next page).
3. Ask if she often has problems remembering to take a pill every day. If so, discuss ways to remember, making up missed pills, and ECPs, or choosing another method. Adolescents may need extra support.
4. Give her more pill packs—a full year's supply (13 packs), if possible. Plan her next resupply visit before she will need more pills.
5. Every year or so, check blood pressure if possible (see Medical Eligibility Criteria, Question 5, p. 7).
6. Ask a long-term client if she has had any new health problems since her last visit. Address problems as appropriate. For new health problems that may require switching methods, see p. ~~20~~.
7. Ask a long-term client about major life changes that may affect her needs—particularly plans for having children and STI/HIV risk. Follow up as needed.

Managing Any Problems

Problems Reported as Side Effects or Problems With Use

May or may not be due to the method.

- Problems with side effects affect women's satisfaction and use of COCs. They deserve the provider's attention. If the client reports side effects or problems, listen to her concerns, give her advice, and, if appropriate, treat. Make sure she understands the advice and agrees.
- Encourage her to keep taking a pill every day even if she has side effects. Missing pills can risk pregnancy and may make some side effects worse.
- Many side effects will subside after a few months of use. For a woman whose side effects persist, give her a different COC formulation, if available, for at least 3 months.
- Offer to help the client choose another method—now, if she wishes, or if problems cannot be overcome.

Missed pills

- See Managing Missed Pills, p. ~~15~~.

Irregular bleeding (bleeding at unexpected times that bothers the client)

- Reassure her that many women using COCs experience irregular bleeding. It is not harmful and usually becomes less or stops after the first few months of use.
- Other possible causes of irregular bleeding include:
  - Missed pills
  - Taking pills at different times every day
  - Vomiting or diarrhea
  - Taking anticonvulsants, rifampicin, or rifabutin, (see Starting treatment with anticonvulsants ~~or rifampicin~~, p. ~~21~~)
- To reduce irregular bleeding:
  - Urge her to take a pill each day and at the same time each day.
  - Teach her to make up for missed pills properly, including after vomiting or diarrhea (see Managing Missed Pills, p. ~~15~~).
  - For modest short-term relief, she can try 800 mg ibuprofen 3 times daily after meals for 5 days or other nonsteroidal anti-inflammatory drug (NSAID), beginning when irregular bleeding starts. NSAIDs provide some relief of irregular bleeding for implants, progestin-only injectables, and IUDs, and they may also help for COCs.
  - If she has been taking the pills for more than a few months and NSAIDs do not help, give her a different COC formulation, if available. Ask her to try the new pills for at least 3 months.

- If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use (see Unexplained vaginal bleeding, next page).

No monthly bleeding

- Ask if she is having any bleeding at all. (She may have just a small stain on her underclothing and not recognize it as monthly bleeding.) If she is, reassure her.
- Reassure her that some women using COCs stop having monthly bleeding, and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not pregnant or infertile. Blood is not building up inside her. (Some women are happy to be free from monthly bleeding, and for some women this may help prevent anemia.)
- Ask if she has been taking a pill every day. If so, reassure her that she is not likely to be pregnant. She can continue taking her COCs as before.
- Did she skip the 7-day break between packs (21-day packs) or skip the 7 nonhormonal pills (28-day pack)? If so, reassure her that she is not pregnant. She can continue using COCs.
- If she has missed hormonal pills or started a new pack late:
  - She can continue using COCs.
  - Tell a woman who has missed 3 or more pills or started a new pack 3 or more days late to return if she has signs and symptoms of early pregnancy ~~(see p. 371 for common signs and symptoms of pregnancy).~~
  - See p. ~~15~~ for instructions on how to make up for missed pills.

Ordinary headaches (nonmigrainous)

- Try the following (one at a time):
  - Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.
  - Some women get headaches during the hormone-free week (the 7 days a woman does not take hormonal pills). Consider extended use (see Extended and Continuous Use of Combined Oral Contraceptives, p. ~~22~~).
- Any headaches that get worse or occur more often during COC use should be evaluated.

Nausea or dizziness

- For nausea, suggest taking COCs at bedtime or with food.

If symptoms continue:

- Consider locally available remedies.
- Consider extended use if her nausea comes after she starts a new pill pack (see Extended and Continuous Use of Combined Oral Contraceptives, p. ~~22~~).

Breast tenderness

- Recommend that she wear a supportive bra (including during strenuous activity and sleep).
- Try hot or cold compresses.
- Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.
- Consider locally available remedies.

Weight change

- Review diet and counsel as needed.

Mood changes or changes in sex drive

- Some women have changes in mood during the hormone-free week (the 7 days when a woman does not take hormonal pills). Consider extended use (see Extended and Continuous Use of Combined Oral Contraceptives, p. ~~22~~).
- Ask about changes in her life that could affect her mood or sex drive, including changes in her relationship with her partner. Give her support as appropriate.
- Clients who have serious mood changes such as major depression should be referred for care.
- Consider locally available remedies.

Acne

- Acne usually improves with COC use. It may worsen for a few women.
- If she has been taking pills for more than a few months and acne persists, give her a different COC formulation, if available. Ask her to try the new pills for at least 3 months.
- Consider locally available remedies.

New Problems That May Require Switching Methods

May or may not be due to the method.

Unexplained vaginal bleeding (that suggests a medical condition not related to the method) **or heavy or prolonged bleeding**

- Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate.
- She can continue using COCs while her condition is being evaluated.
- If bleeding is caused by sexually transmitted infection or pelvic inflammatory disease, she can continue using COCs during treatment.

Starting treatment with anticonvulsants, rifampicin, or rifabutin

- Barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, and rifabutin may make COCs, patch, and combined vaginal ring less effective. Combined hormonal methods, including combined pills and monthly injectables, may make lamotrigine less effective. If using these medications long-term, she may want a different method, such as a progestin-only injectable, implants, a copper-bearing IUD or LNG-IUD.
- If using these medications short-term, she can use a backup method along with COCs for greater protection from pregnancy.

Migraine headaches (see Identifying Migraine Headaches and Auras, p. ~~368~~)

- Regardless of her age, a woman who develops migraine headaches, with or without aura, or whose migraine headaches become worse while using COCs should stop using COCs.
- Help her choose a method without estrogen.

Circumstances that will keep her from walking for one week or more

- If she is having major surgery, or her leg is in a cast, or for other reasons she will be unable to move about for several weeks, she should:
  - Tell her doctors that she is using COCs.
  - Stop taking COCs and use a backup method during this period.
  - Restart COCs 2 weeks after she can move about again.

Certain serious health conditions (suspected heart or serious liver disease, high blood pressure, blood clots in deep veins of legs or lungs, stroke, breast cancer, damage to arteries, vision, kidneys, or nervous system caused by diabetes, or gallbladder disease). See Signs and Symptoms of Serious Health Conditions, p. 320.

- Tell her to stop taking COCs.
- Give her a backup method to use until the condition is evaluated.
- Refer for diagnosis and care if not already under care.

Suspected pregnancy

- Assess for pregnancy.
- Tell her to stop taking COCs if pregnancy is confirmed.
- There are no known risks to a fetus conceived while a woman is taking COCs (see Question 5, p. ~~23~~).

Extended and Continuous Use of Combined Oral Contraceptives

Some COC users do not follow the usual cycle of 3 weeks taking hormonal pills followed by one week without hormones. Some women take hormonal pills for 12 weeks without a break, followed by one week of nonhormonal pills (or no pills). This is extended use. Other women take hormonal pills without any breaks at all. This is continuous use. Monophasic pills are recommended for such use (see Question 16, p. ~~25~~).

Women easily manage taking COCs in different ways when properly advised how to do so. Many women value controlling when they have monthly bleeding—if any—and tailoring pill use as they wish.

Benefits of Extended and Continuous Use

- Women have vaginal bleeding only 4 times a year or not at all.
- Reduces how often some women suffer headaches, premenstrual syndrome, mood changes, and heavy or painful bleeding during the week without hormonal pills.

Disadvantages of Extended and Continuous Use

- Irregular bleeding may last as long as the first 6 months of use—especially among women who have never before used COCs.
- More supplies needed—15 to 17 packs every year instead of 13.

Extended Use Instructions

- Take 84 hormonal pills in a row, one each day. (These are the hormonal pills in 4 monthly packs.) Users of 28-pill packs do not take the non-hormonal pills.
- After 84 hormonal pills, wait 7 days and start the next pack of pills on the 8th day. (Users of 28-pill packs can take the nonhormonal pills in the 4th pack if they wish and start the hormonal pills the day after the last nonhormonal pill.) Expect some bleeding during this week of not taking the hormonal pills.

Continuous Use Instructions

A woman should take one hormonal pill every day for as long as she wishes to use COCs. If bothersome irregular bleeding occurs, she can stop taking pills for 3 or 4 days and then start taking hormonal pills continuously again.

Questions and Answers About Combined Oral Contraceptives

1. **Should a woman take a "rest" from COCs after taking them for a time?**

   No. There is no evidence that taking a "rest" is helpful. In fact, taking a "rest" from COCs can lead to unintended pregnancy. COCs can safely be used for many years without having to stop taking them periodically.

2. **If a woman has been taking COCs for a long time, will she still be protected from pregnancy after she stops taking COCs?**

   No. A woman is protected only as long as she takes her pills regularly.

3. **How long does it take to become pregnant after stopping COCs?**

   Women who stop using COCs can become pregnant as quickly as women who stop nonhormonal methods. COCs do not delay the return of a woman's fertility after she stops taking them. The bleeding pattern a woman had before she used COCs generally returns after she stops taking them. Some women may have to wait a few months before their usual bleeding pattern returns.

4. **Do COCs cause abortion?**

   No. Research on COCs finds that they do not disrupt an existing pregnancy. They should not be used to try to cause an abortion. They will not do so.

5. **Do COCs cause birth defects? Will the fetus be harmed if a woman accidentally takes COCs while she is pregnant?**

   No. Good evidence shows that COCs will not cause birth defects and will not otherwise harm the fetus if a woman becomes pregnant while taking COCs or accidentally starts to take COCs when she is already pregnant.

6. **Do COCs cause women to gain or lose a lot of weight?**

   No. Most women do not gain or lose weight due to COCs. Weight changes naturally as life circumstances change and as people age. Because these changes in weight are so common, many women think that COCs cause these gains or losses in weight. Studies find, however, that, on average, COCs do not affect weight. A few women experience sudden changes in weight when using COCs. These changes reverse after they stop taking COCs. It is not known why these women respond to COCs in this way.

7. Do COCs change women's mood or sex drive?

Generally, no. Some women using COCs report these complaints. The great majority of COC users do not report any such changes, however, and some report that both mood and sex drive improve. It is difficult to tell whether such changes are due to the COCs or to other reasons. Providers can help a client with these problems (see Mood changes or changes in sex drive, ~~now on p.20~~). There is no evidence that COCs affect women's sexual behavior.

8. What can a provider say to a client asking about COCs and breast cancer?

The provider can point out that both COC users and women who do not use COCs can have breast cancer. In scientific studies breast cancer was slightly more common among women using COCs and those who had used COCs in the past 10 years than among other women. Scientists do not know whether or not COCs actually caused the slight increase in breast cancers. It is possible that the cancers were already there before COC use but were found sooner in COC users (see Facts About Combined Oral Contraceptives and Cancer, p. 4).

9. Can COCs be used as a pregnancy test?

No. A woman may experience some vaginal bleeding (a "withdrawal bleed") as a result of taking several COCs or one full cycle of COCs, but studies suggest that this practice does not accurately identify who is or is not pregnant. Thus, giving a woman COCs to see if she has bleeding later is not recommended as a way to tell if she is pregnant. COCs should not be given to women as a pregnancy test of sorts because they do not produce accurate results.

10. Must a woman have a pelvic examination before she can start COCs or at follow-up visits?

No. A pelvic examination to check for pregnancy is not necessary. Instead, asking the right questions usually can help to make reasonably certain that a woman is not pregnant (see Pregnancy Checklist, p. ~~372~~). No other condition that could be detected by a pelvic examination rules out COC use.

11. Can women with varicose veins use COCs?

Yes. COCs are safe for women with varicose veins. Varicose veins are enlarged blood vessels close to the surface of the skin. They are not dangerous. They are not blood clots, nor are these veins the deep veins in the legs where a blood clot can be dangerous (deep vein thrombosis). A woman who has or has had deep vein thrombosis should not use COCs.

12. Can a woman safely take COCs throughout her life?

Yes. There is no minimum or maximum age for COC use. COCs can be an appropriate method for most women from onset of monthly bleeding (menarche) to menopause (see Women Near Menopause, p. 272).

COCs can be an appropriate method for adolescents. Adolescents may need extra support and encouragement to use COCs consistently and effectively.

13. Can women who smoke use COCs safely?

Women younger than age 35 who smoke can use COCs. Women age 35 and older who smoke should choose a method without estrogen or, if they smoke fewer than 15 cigarettes a day, monthly injectables. Older women who smoke can take the progestin-only pill if they prefer pills. All women who smoke should be urged to stop smoking.

14. What if a client wants to use COCs but it is not reasonably certain that she is not pregnant after using the pregnancy checklist?

If pregnancy tests are not available, a woman can be given COCs to take home with instructions to begin their use within 5 days after the start of her next monthly bleeding. She should use a backup method until then.

15. Can COCs be used as emergency contraceptive pills (ECPs) after unprotected sex?

Yes. As soon as possible, but no more than 5 days after unprotected sex, a woman can take COCs as ECPs (see Emergency Contraceptive Pills, Pill Formulations and Dosing, p. 56). Progestin-only pills, however, are more effective and cause fewer side effects such as nausea and stomach upset.

16. What are the differences among monophasic, biphasic, and triphasic pills?

Monophasic pills provide the same amount of estrogen and progestin in every hormonal pill. Biphasic and triphasic pills change the amount of estrogen and progestin at different points of the pill-taking cycle. For biphasic pills, the first 10 pills have one dosage, and then the next 11 pills have another level of estrogen and progestin. For triphasic pills, the first 7 or so pills have one dosage, the next 7 pills have another dosage, and the last 7 hormonal pills have yet another dosage. All prevent pregnancy in the same way. Differences in side effects, effectiveness, and continuation appear to be slight.

17. Is it important for a woman to take her COCs at the same time each day?

A woman can take her COCs at different times of day, and they will still be effective. However, taking them at the same time each day can be helpful for 2 reasons. Some side effects may be reduced by taking the pill at the same time each day. Also, taking a pill at the same time each day can help women remember to take their pills more consistently. Linking pill taking with a daily activity also helps women remember to take their pills.

18. Should women who choose COCs and certain other hormonal contraceptives be routinely tested for high blood pressure?

It is desirable for all women to have blood pressure measurements taken routinely before starting a hormonal method of contraception. However, in some settings blood pressure measurements are unavailable. In many of these settings, pregnancy-related morbidity and mortality risks are high, and these methods are among the few methods that are widely available. In such settings women should not be denied use of these methods simply because their blood pressure cannot be measured.

Women with high blood pressure or very high blood pressure should not use combined hormonal methods—COCs, monthly injectables, patch, or combined ring. Where blood pressure cannot be measured, women with a history of high blood pressure should not use these methods. Women with very high blood pressure should not use progestin-only injectables. Women can use progestin-only pills (POPs), implants, and LNG-IUDs even if they have high or very high blood pressure readings or a history of high or very high blood pressure.

High blood pressure is defined as systolic pressure 140 mm Hg or higher or diastolic pressure 90 mm Hg or higher. Very high blood pressure is defined as systolic pressure 160 mm Hg or higher or systolic pressure 100 mm Hg or higher.

For more guidance concerning blood pressure, see the Medical Eligibility Criteria checklists in the chapters on COCs (p. 71), monthly injectables, patch, combined ring, and progestin-only injectables.