8 Contraception

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Naming contraceptives

Table 8.1: Contraceptive names and abbreviations

Abbreviation	Full name	Common name
COC	Combined oral contraceptive pill	Pill
Copper IUD	Copper intrauterine device (eg *TT 380A*, *Multiload 375*)	Coil
Depo	Depot medroxyprogesterone acetate	Depo, needle
ECP	Emergency contraceptive pill	Morning-after pill
ENG	Etonogestrel — type of progestogen	
ENG-implant	Etonogestrel implant (eg *Implanon-NXT*)	Rod, bar, stick
FABM	Fertility awareness based methods	Natural methods, rhythm method
IUD	Intrauterine device	Coil
LARC	Long-acting reversible contraception	
LNG	Levonorgestrel — type of progestogen	
LNG-IUD	Levonorgestrel (hormonal) intrauterine device (eg *Mirena*)	Coil
NE	Norethisterone — type of progestogen	
POP	Progesterone-only pill	Breastfeeding pill, mini pill
UPA	Ulipristal acetate	ECP, morning-after pill

Contraception — general principles

- Women value their fertility
- Modern contraceptives help women prevent, plan and space pregnancies
- Some contraceptives help reduce period pain and bleeding problems
- Modern contraceptives are generally safer than being pregnant
- Clinics and communities should promote effective contraception for all women
  - At routine check ups and consultations
  - Especially if being pregnant is risky for woman
- Women want an **effective** contraceptive that
  - Reliably prevents pregnancy
  - Allows rapid return to fertility when stopped
  - Is easy to use
  - Has few problems (side effects)
- Contraception is reversible. Sterilisation is permanent

Emergency contraceptive pill (ECP)

- Remember to use ECP (*p353*) if woman
  - Had unprotected sex in the last 5 days (120 hours)
  - *AND* has no contraception
  - *OR* her contraception is late or overdue

Always offer ECP straight away, it is very safe.

How effective are contraceptives

Long-acting reversible contraception (LARC) is the most effective.

- Etonogestrel implant (ENG-implant)
- Intrauterine devices
  - Copper IUD
  - Levonorgestrel-releasing IUD (LNG-IUD)
- Depo contraceptive injection (Depo)

Effectiveness of contraceptive types — see Table 8.2

If 100 women use this method for 1 year — % = how many **don't** get pregnant.

- Using ENG-implant, only 1 out of 1000 women become pregnant each year
- Using contraceptive pills, 8 out of 100 women become pregnant each year

Be really safe — 'double-up'

- **Double-up** = contraceptive + condoms
- Using condoms properly can prevent STIs

Table 8.2: Contraceptive effectiveness

% who don't get pregnant	Contraceptive method
99+%	ENG-implant, IUDs (LARC)
94%	Depo (LARC)
92%	Contraceptive pills
82%	Condoms
78%	Withdrawal, 'pulling out'
76%	Fertility awareness-based methods (FABM – eg 'rhythm method')
15%	No contraception

Choosing a contraceptive method

Choosing the best contraceptive method may take time. Explain you may need to ask a lot of questions.

Step 1 — talk about effectiveness

Use Table 8.3: Comparing contraceptives

Step 2 — talk with woman about what method is practical for her

- Has she used contraception before, was the method OK
- LARC (*p343*) are very convenient. Only need to visit clinic
  - Every 3 months (12–14 weeks) for Depo
  - Every 3 years for ENG-implant
  - Every 5 years for LNG-IUD
  - Every 5–10 years for copper IUD
- Would she mind feeling/seeing an implant in her arm
- Could she take a pill reliably, every day

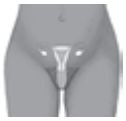
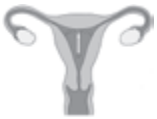
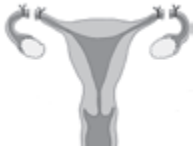
Step 3 — talk with woman about her bleeding patterns

- Many contraceptives change bleeding patterns (see individual methods)
  - So can STIs (eg chlamydia), pregnancy, or abnormal cervix
- At suitable time in your consult, ask about
  - Periods — timing, number days of bleeding
  - Risk of STI — offer STI check – woman (*p238*), young person (*p243*)
  - Recent cervical screening

If abnormal vaginal bleeding —

- **Medical consult** before starting contraception if woman
  - Bleeds straight after sex
  - Bleeds in-between her normal periods
  - Has periods that aren't regular
- See *Abnormal vaginal bleeding in non-pregnant women* (*p301*)

Table 8.3: Comparing contraceptives

Effectiveness	Contraceptive type and features	
99+%	**ENG-implant** (*p343*) (eg *Implanon NXT*) • 99.95%, • Lasts 3 years • Highly reversible 	**LNG-IUD** (*p344*) (eg *Mirena*) • 99.8% • Lasts 5 years • Highly reversible • Reduces bleeding 
	Depo contraceptive injection (*p347*) • 94% • Repeat every 12–14 weeks • Usually stops periods • Average 6 months to restart ovulating 	**Copper IUD** (*p345*) • 99.2% • Lasts 5–10 years • Highly reversible • No hormones • Usual periods 
	Permanent sterilisation (*p358*) • More than 99.8% • Vasectomy (*p359*) • Tubal ligation (*p358*) • Tubal occlusion (*p358*)  	
90%	**COC** (*p349*) • 92% • 1 pill once a day • Regulates periods 	**Vaginal ring** (*p351*) (eg *NuvaRing*) • 92% • Change every 4 weeks • Works the same way and has same issues as COC 
	POP (*p351*) • 92% • Need to use at same time each day (within 3 hours) 	
80%	**Male condom** (*p356*) • 82% • Put on before sex every time • STI protection 	**Female condom** (*p355*) • 79% • Put in before sex every time • STI protection 
	Diaphragm (*p357*) • 88% • Put in before sex, leave in for 6 hours after • Works better in older women • No hormones 	

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Step 4 — exclude pregnancy

- Do urine pregnancy test (*p279*)
- If test negative and unprotected sex in last 5 days (120 hrs) —
  - Offer ECP (*p353*)
  - See Quick Start (*p340*)
- If pregnant — see *Unplanned pregnancy* (*p314*) or *Antenatal care* (*p88*)

Step 5 — check woman's risk

Assessing contraceptive risk is complex. Always get help with working out and talking about risk, if needed.

- Assessment includes
  - Risk of pregnancy occurring with a particular method compared with no contraception at all
  - Risk of pregnancy itself, including woman's physical, emotional health, safety
  - Risk to woman from contraceptive method
- Medical risks from contraception may not be most important issue for woman
- Medical risks from contraception divided into
  - Risk from hormones
    - Absolute (contraindications) (*p339*)
    - High (blood clots) (*p340*)
  - Risks with individual methods

Table 8.4: Best contraception choices for common clinical indications

Condition	Best choices	Comments	Avoid
Psychosocial issues			
Very young — under 14 years	**First choice** ENG-implant (*p343*) **Second choice** Depo (*p347*)	If they have a guardian — contact Office of Public Guardian	COC POP
• Domestic/family violence • Volatile substance use, alcohol misuse • Not a good pill-taker	LARC (*p343*)		COC POP
Depression	ENG-implant (*p343*) IUD (*p344*)	Depo (*p347*) is long lasting and can't be undone if adverse reaction	Depo

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Condition	Best choices	Comments	Avoid
Common medical conditions			
Diabetes	ENG-implant (*p343*) IUD (*p344*)		COC
High BP	ENG-implant (*p343*) IUD (*p344*)		COC
Heart disease (AF, heart attack, stroke)	ENG-implant (*p343*) IUD (*p344*)		COC Depo
Artificial heart valve	ENG-implant (*p343*) IUD (*p344*)		COC
Chronic kidney disease	ENG-implant (*p343*) IUD (*p344*)		COC, if Stage 2 or worse
Postnatal			
• Breastfeeding — child less than 6 weeks	**First choice** LARC (*p343*) **Second choice** POP (*p351*)	Need to take POP at same time every day (within 3 hours)	COC
• Breastfeeding — child 6 weeks or over • Not breastfeeding	LARC (*p343*)	Can start COC at 6 or more weeks postnatal	
Common medicines			
Reduce effectiveness of hormonal contraception			
Enzyme-inducing antiepileptics	IUD (*p344*) Depo (*p347*)		COC POP ENG-implant
Rifampicin	IUD (*p344*) Depo (*p347*)		COC POP ENG-implant
Antiretrovirals		Specialist advice	
Increased blood clot risk			
Anticoagulants	LARC (*p343*)		COC
Note: Common antibiotics, antiparasitics, antifungals don't affect LARC or contraceptive pills.			

Risks with contraception

Hormonal contraception

Absolute risks (contraindications)

- Abnormal vaginal bleeding
- Breast or liver cancer, or had treatment for these in the last 5 years
- Severe liver disease

Women with absolute risks can't use hormonal contraception — need non-hormonal method. **Medical consult**.

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High risk — blood clots

- Blood clots are uncommon, but can cause severe problems
- Oestrogen part of COC increases risk of clots, compared to other methods
- Rural and remote women generally have increased risk factors for clots, and hormonal contraception may add to these. The more risk factors the higher the risk with hormonal contraception
- Women with risk factors for clots still need contraception — **medical consult**

Risk factors for clots

Do not use COC if

- Moderate or high cardiovascular risk (*CARPA STM p230*)
- Previous stroke, heart attack, angina, AF
- Mechanical heart valve
- Anticoagulant use
- Diabetes and any of — poor control (HbA1c more than 84mmol/mol [9.8%]), nerve pain (neuropathy), eye damage, kidney disease
- Chronic kidney disease, Stage 2 or worse
- High BP
- Abnormal blood fats
- Obesity — BMI more than 35
- Localised (focal) migraine with aura
- Smoker over 35 years
- Previous VTE or family history of VTE — first degree relative under 45 years
- Prior thrombogenic mutation (eg Factor V Leiden)
- SLE (antiphospholipid positive)

Risks with individual methods

- LARC (*p343*)
- COC (*p349*)
- ECP (*p353*)
- Barrier contraception (*p355*)
- Permanent sterilisation (*p358*)

Starting contraception

Quick Start — a convenient, safe way

We used to wait until a period before starting contraception (day 1–5) — but some women got pregnant while waiting for their contraception.

- **Quick Start** supports starting a contraceptive method straight away. This means
  - Better chance of woman starting and understanding method
  - Less unplanned pregnancies

- Very early pregnancy can't always be excluded
  - But no known problems for fetus or pregnancy from LARC (*p343*), COC (*p349*), POP (*p351*)
  - **Must** do repeat urine pregnancy test in 4 weeks — **high priority recall**

Quick Start — only 3 steps

Step 1 — exclude pregnancy

- Can be confident of no pregnancy if
  - No sex since last normal period
  - Negative pregnancy test and no unprotected sex in last 3 weeks
  - Day 1–5 of normal period
  - Correct and consistent use of contraception (LARC, Pills, condoms)
  - Less than 21 days after birth of child
  - Less than 5 days after miscarriage or abortion

Urine pregnancy tests — negative urine pregnancy test **only** excludes pregnancy if more than 21 days since last unprotected sex.

Step 2 — start contraceptive method

- If unsure about pregnancy, but want to offer contraception today — explain
  - No known adverse outcomes on fetus or pregnancy from LARC or Pills
  - LARC and Pills take 7 days to work, so no sex or use condoms for first week after starting
  - If first choice method not available on the day — consider other effective contraceptive methods for short-term cover. See Table 8.3
- Always check BP, BMI when starting contraception

Step 3 — follow-up

- **Must** do repeat urine pregnancy test in 4 weeks — **high priority recall**
- If woman pregnant at follow-up —
  - Stop contraception, **medical consult**
  - See *Unplanned pregnancy* (*p314*)
  - Always check BP, BMI

Routine contraception check is simple, be opportunistic.

- Include in STI checks – woman (*p238*) young person (*p243*), cervical screening (*p289*), combined checks for chronic diseases (*CARPA STM p239*), Adult Health Check (*CPM p123*)
  - Always do BP, BMI
  - Re-check contraception risk (*p339*)
    - Is their contraception appropriate, consider LARC
  - Ask about worries, including period problems
  - Check dates of contraceptive — when is it next due

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Stopping contraception

Ask why they stopped or want to stop.

- If woman wants another type of contraception — see Table 8.3
- If woman declining contraception or not using current method properly — tell her that risk of pregnancy is high
  - Fertility returns very quickly when stopping modern contraception, except for Depo
  - Offer pre-pregnancy counselling (*p84*)
    - Advise woman to consider continuing contraception until after pre-pregnancy counselling is complete

Etonogestrel (ENG) implant (eg *Implanon NXT*)

99.95% effective

What — small flexible, plastic rod (40 x 2mm)

Type — hormone. Implant slowly releases ENG (progestogen)

Prescription — must be prescribed by eligible practitioner. Available on PBS

How it works — primarily prevents ovulation

Timing — lasts 3 years. Must be removed/changed before or at 3 years

Fertility return — very quick, within 24 hours of removal

Placement

- Inserted by eligible practitioner — with local anaesthetic in upper, non-dominant arm
- If arm unsuitable — can use upper thigh or lower abdomen
  - **Medical consult**

Quick Start (*p340*) — yes

Who benefits — most women including

- Immediately postnatal or breastfeeding
- Young
- Women with raised cardiovascular risk (*CARPA STM p230*)

Special issues

Bleeding

- Will change period cycle and bleeding
  - Most women have lighter, irregular bleeding
  - 20% have no periods
  - 10% have troublesome spotting or bleeding
- If annoying bleeding for more than 6 weeks — **medical consult**, see *Managing troublesome bleeding on LARC* (*p348*)

Fertility return

- **Always** prepare woman for rapid pregnancy risk after removal

Side effects

- Uncommon — mood change, appetite, acne, headache
- Rare — implant shifts

Young girls

- Good choice for young girls as doesn't affect fertility
- If girl hasn't started her periods — **medical consult** about using

Follow-up

- Set recall for change/removal
- Offer regular Adult Health Check (*CPM p123*), STI check – woman (*p238*), young person (*p243*)

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Do not use ENG-implant if

- Absolute risks (contraindications) (*p339*)
- Using medicines reducing effectiveness (*p335*)

Levonorgestrel intrauterine device (LNG-IUD) (eg *Mirena*)

99.8% effective

What — T-shaped stem, wrapped with small plastic sleeve containing hormone

Type — hormone. Slow-release of LNG (progestogen) into uterus

Prescription — must be prescribed by eligible practitioner. Available on PBS

How it works — variable effects. May prevent ovulation, thicken cervical mucus, thin endometrium, prevent implantation, alter egg and sperm transport

Timing — 5 years contraception, for woman over 45 years lasts to menopause. 7 years bleeding control. **Do not** use LNG-IUD as emergency contraceptive

Fertility return — very quick, within 24 hours of removal

Placement — requires insertion (*p346*) into uterus by eligible practitioner

Quick Start (*p340*) — no

- Must make sure woman is not pregnant. See *Pregnancy testing* (*p279*)
- Schedule for insertion at appropriate time
- Consider other effective contraceptive methods for short-term cover (*p336*)

Who benefits

- Any woman needing effective, long-lasting contraception
- Women with heavy or painful periods
- Women with high cardiovascular risk (*CARPA STM p230*) or other risk factors (*p339*)

Special issues

See *IUD insertion* (*p346*), *IUD removal* (*p347*), *IUD complications* (*p347*).

Bleeding

- Can have frequent bleeding or spotting in first 3 months, then usually (65%) becomes lighter, shorter or absent
- If annoying bleeding for more than 6 weeks — **medical consult**, see *Managing troublesome bleeding on LARC* (*p343*)

Fertility return

- **Always** prepare woman for rapid pregnancy risk after removal

Side effects

- Uncommon — headache, breast tenderness, acne

Follow-up

- Set recall for change/removal
- Offer regular Adult Health Check (*CPM p123*), STI check – woman (*p238*), young person (*p243*)

Do not use LNG-IUD if

- Absolute risks (contraindications) (*p339*)
- Current active uterine or pelvic infection (eg chlamydia, gonorrhoea, PID, septic abortion)
- 48 hours to 4 weeks after birth of baby (postpartum)
- Gestational trophoblastic disease
- Endometrial and ovarian cancer, waiting for treatment
- Severe uterine distortion

Copper intrauterine device (eg *TT 380A*, *Multiload 375*)

99.2% effective

What — small plastic T- or U-shaped stem, wrapped with fine copper wire

Type — non-hormonal

Prescription — must be prescribed by eligible practitioner. Not available on PBS

How it works

- May kill sperm (spermicidal) or reduce sperm's ability to move (motility)
- Affects transport and implantation of egg

Timing

- *Multiload 375* and *TT380A short* effective for 5 years
- *TT 380A standard* effective for 10 years
- Can be used as emergency contraception up to 5 days (120 hours) after unprotected sex
  - 99% effective
  - Insertion as emergency contraception may not be practical

Fertility return — very quick, within 24 hours of removal

Placement — needs insertion (*p346*) into uterus by eligible practitioner

Quick Start (*p340*) — no

- Must ensure not pregnant. See *Pregnancy testing* (*p279*)
- Schedule for insertion at appropriate time
- Consider other effective contraceptive methods (*p336*) for short-term cover

Who benefits — any woman needing effective, long-lasting contraception without hormones. Especially useful if hormone-related risks

Special issues

See *IUD insertion* (*p346*), *IUD removal* (*p347*), *IUD complications* (*p347*).

Bleeding

- Can spot or bleed heavier/longer in first 6 months. Generally settles

Fertility return

- **Always** prepare woman for rapid pregnancy risk after removal

Side effects

- Bleeding changes (*above*), some period cramps

Follow-up

- Set recall for change/removal
- Offer regular Adult Health Check (*CPM p123*), STI check – woman (*p238*), young person (*p243*)

Do not use copper IUD if

- Unexplained abnormal vaginal bleeding
- Current active uterine or pelvic infection (eg chlamydia, gonorrhoea, PID, septic abortion)
- 48 hours to 4 weeks after birth of baby (postpartum)
- Gestational trophoblastic disease
- Endometrial and ovarian cancer, waiting for treatment
- Severe uterine distortion
- Very low platelet levels (severe thrombocytopoenia)
- Allergic to copper

IUD management

IUD insertion

Preparation

- Usually inserted in clinic
- Before insertion
  - STI check – woman (*p238*), young person (*p243*)
    - Presumptive treatment for STI (*p240*) recommended if under 25 years
  - Cervical screening (*p289*) up to date
  - Check that woman is not pregnant. See *Pregnancy testing* (*p279*)
- Make appointment to insert at appropriate time. Consider other effective contraceptive methods for short-term cover (*p336*)

Follow-up

- Inserter usually organises to review 1–6 weeks after insertion
- After this
  - Suggest feeling for threads after each period. If not felt — see *Lost threads* (*p347*)
  - Set recall for change/removal

IUD removal

Removed by eligible practitioner — by gently pulling on IUD threads.

- Minimal discomfort
- Rapid return to fertility

IUD complications

Lost threads

If strings can't be felt/seen —

- When were they last felt/seen
- Exclude pregnancy (*p279*)
- Offer ECP (*p353*), talk with woman about starting extra, reliable contraception
- **Medical consult**, ultrasound

PID or STI

- **Do not** remove device straight away
  - Mild infections responding to treatment in 48–72 hours don't increase risk
  - If severe infection — **medical consult** straight away
- See *PID* (*p260*) or *STI management for women* (*p245*)

Long-acting contraceptive injection (Depo)

(eg *Depo-Provera*, *Depo-Ralovera*)

94% effective

What — deep IM injection

Type — hormone. 150mg long-acting depot medroxyprogesterone acetate (progestogen)

Prescription — must be prescribed by eligible practitioner. Available on PBS

How it works

- Primary effect — prevents ovulation
- Secondary effect — thickens cervical mucus

Timing — injection every 12–14 weeks

Fertility return — slow. Average 6 months, rarely up to 18 months

Placement

- Smaller women — give in buttock
- Larger women — give in deltoid (buttock fat may reduce absorption)
- **Do not** rub injection site

Quick Start (*p340*) — yes

Who benefits

- Women who want long-lasting hormonal contraception without an implant
- Women who want no periods/reduced bleeding
- Women on enzyme-inducing medicines

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Special issues

Bleeding

- 80% women have no periods after second injection
- If irregular or heavy bleeding causes trouble — **medical consult**, see *Managing troublesome bleeding on LARC* (*p348*)

Fertility return

- If pregnancy wanted in next 12–18 months — consider changing method

Side effects

- Can't be reversed once given, but will wear off (after about 3 months)
- Uncommon — headache, mood, bloating, decreased sex drive
- Weight gain
  - 10% increase in body weight in around 20% of users
  - Use with care in obese adolescents
- Bone density
  - Can be reduced, recovers when Depo stopped
  - Use with care if under 18 years or over 45 years

Follow-up

- Talk with woman about next injection date
- Set recall for next injection
- Offer regular Adult Health Check (*CPM p123*), STI check – woman (*p238*), young person (*p243*)

Late/missed Depo injections

- Only late if more than 14 weeks since last injection
- Consider emergency contraception
- See *Starting contraception — Quick Start* (*p340*)

Do not use Depo if

- Absolute risks (contraindications) (*p339*)
- High (relative) risks (*p340*)
- Very low platelet levels (severe thrombocytopoenia)

Managing troublesome bleeding on LARC

- Exclude other causes. See *Abnormal vaginal bleeding in non-pregnant women* (*p301*)
- Reassure woman that it isn't harmful
- Try medicines
  - COC taken continuously or cyclically for 3 months, if no contraindications
  - Mefenamic acid oral 2–3 times (bd–tds) a day for 5 days – adult 500mg, if no contraindications to NSAIDs
  - If bleeding heavy — tranexamic acid oral twice a day (bd) for 5 days – adult 500mg
- If medicines don't work — try a different contraception method

Contraceptive pills

Combined oral contraceptive (COC)

92% effective

What — oral pill with oestrogen and progestogen hormones

Types — several equally effective hormone combinations, different cost and side effects

- Start woman on PBS available version — less than 35microgram oestradiol with LNG or NE (see packet)

How it works — prevents ovulation. Regulates cycle with artificial 'periods'

Prescription — must be prescribed by eligible practitioner. Some on PBS

Timing — 1 pill taken every 24 hours, best taken at same time each day

Fertility return — rapid, within 1 menstrual cycle

Packet

- 28 tablets — LNG/NE has 21 'active' + 7 'sugar/inactive' pills
- Always start with active pill
- Finish 1 pack before starting next
- Some newer types of COC have more active pills (24+) and are more expensive

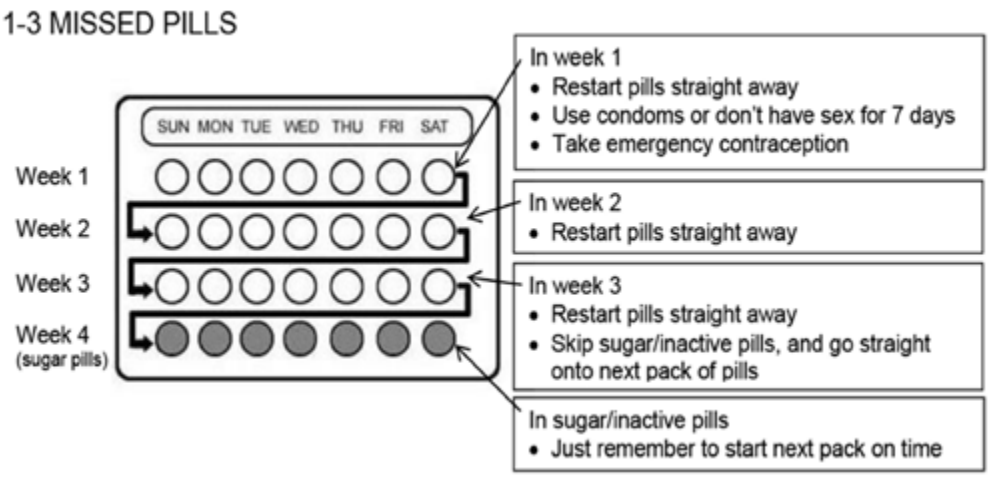
Quick Start (*p340*) — yes

- Take 1 active pill every day for 7 days to give contraception

Missed pill — see F 8.1

Who benefits

- Women who are good pill-takers, want period control or less pain
- Some women find some COCs help improve acne and mood
- Can be used by breastfeeding mothers when child over 6 weeks



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Special issues

Not as effective as LARC (COC 92% – LARC 99+%)

Bleeding

- COC allows women to safely skip periods (by missing 'sugar/inactive' pills)

Diarrhoea/vomiting

- Only important if severe diarrhoea or vomiting less than 2 hours after taking COC
  - Advise no sex or use condoms until 1 active pill taken each day for 7 days in a row, after they are better

Surgery

- Stop COC 4 weeks before elective major surgery
- **Medical consult**

Side effects

- Uncommon — sore breasts, bleeding between periods, mood changes, decreased sex drive, nausea
- Usually settle in 3 months
- Can try different COC — **medical consult**

Caution with clot risk

- COC causes small increase in risk of blood clot. Not usually first choice in populations with multiple clot risks (*p340*)
- **Use LARC where possible**
- **Medical consult** if concerned

Follow-up

- Medical review every year
- Always ask woman using COC about missed pills and bleeding
- Does she know what to do if she misses a pill
- Is this still best method for her
- Offer regular Adult Health Check (*CPM p123*), STI check – woman (*p238*), young person (*p243*)

Do not use COC if

- Absolute risks (contraindications) (*p339*)
- High (relative) risks (*p340*)
- Using medicines reducing effectiveness (*p339*)

Vaginal ring

92% effective. Expensive

What — polyethylene ring with same oestrogen and progestogen hormones as in COC pills (eg *NuvaRing*)

How it works — prevents ovulation

Prescription — must be prescribed by eligible practitioner

Timing — inserted by woman every 3–4 weeks

Who benefits — useful for woman unable to remember to take COC, but wanting relative advantages of method

Special issues

Same issues as COC (*p349*).

Progestogen-only pill (POP)

92% effective

What — oral pill

Type — hormone. 2 types — LNG 30microgram and NE 350microgram

Prescription — must be prescribed by eligible practitioner. Available on PBS

How it works

- Primary effect — thickens cervical mucus preventing sperm penetration
- In 60% of women prevents ovulation, can vary from cycle to cycle

Timing — 1 pill taken at **same time** (within 3 hours) every day

Fertility return — rapid, within 1 menstrual cycle

Packet — 28 tablets, all identical and active, start anywhere

Quick Start (*p340*) — yes

- 1 pill every day for 3 days to give contraception

Missed pill

- If more than 3 hours late — take missed pill straight away, then next pill at correct time
- Advise no sex or use condoms until 1 pill taken each day for 3 days
- Offer ECP (*p353*)

Who benefits

- Women with high cardiovascular risk (*CARPA STM p230*) or over 40 years
- Women who can't tolerate oestrogen in COC
- Breastfeeding mothers

Special issues

- Not as effective as LARC due to strict timing
- Some women not able to manage routine, even though it suits them in theory (eg tired breastfeeding mothers, young women)

Bleeding

- May be predictable or unpredictable

Diarrhoea/vomiting

- Only important in severe diarrhoea or if they vomit less than 2 hours after taking POP
  - Advise no sex or use condoms until 1 pill a day taken for 3 days in a row, after they are better

Side effects

- Uncommon — mood change, bloating, appetite increase

Follow-up

- Medical review every year
- Always ask woman on POP about missed pills and bleeding
  - Does she know what to do if she misses a pill
- Is it still best method for her
- Offer regular Adult Health Check (*CPM p123*), STI check – woman (*p238*), young person (*p243*)

Do not use POP if

- Absolute risks (contraindications) (*p339*)
- Using medicines that reduce effectiveness (*p339*)

Emergency contraceptive pills (ECP)

85% effective — ***Note:*** UPA more effective than LNG, especially days 3–5

What — 2 types of oral pill

Type — hormone

- 30microgram UPA (ulipristal acetate)
- *OR* 1.5mg of LNG (levonorgestrel)

How they work

- Mainly prevent ovulation
- May affect fertilisation, implantation
- Don't affect established pregnancy

Prescription — available over the counter, UPA more expensive than LNG

Timing — use as soon as possible up to 5 days (120 hours) after unprotected sex

Fertility return — quick, next usual ovulation

Packet

- UPA — 1 x 30microgram tablet
- LNG — 1 x 1.5mg tablet or 2 x 0.75mg tablets, depending on manufacturer

Quick Start

- UPA — no. Must wait 5 days before starting hormonal contraceptive
- LNG — yes

Who benefits

- Any woman who has had unprotected sex in the previous 5 days
- Safe to use in women where pregnancy is risky, high cardiovascular risk (*CARPA STM p230*)

Special issues

- Very safe to use
- **Do not** use for long-term contraception
- If ECP tablets not available locally — **medical consult**. There are older regimes using different quantities of related pills
- Always consider STI check – woman (*p238*), young person (*p243*)

Important differences between UPA and LNG

- If vomits after taking ECP— give **antiemetic** (*CARPA STM p105*) and repeat ECP dose
  - UPA — if vomits within 3 hours
  - LNG — if vomits within 2 hours
- Breastfeeding
  - UPA — discard milk for 7 days after taking
  - LNG — OK

- Using enzyme-inducing antiepileptic (*p141*)
  - UPA — **do not** use
  - LNG — give double dose (eg 2 x 1.5mg tablets)
- Severe liver disease or severe asthma treated with glucocorticoids
  - UPA — **do not** use
  - LNG — OK

Side effects

- Uncommon (1%) — headache, nausea, vomiting
- May get altered vaginal bleeding for some days after use

Follow-up

- **Must** do repeat urine pregnancy test in 4 weeks (*p279*) — **high priority recall**
- Ensure ongoing contraception

There are no absolute risks for using ECP.

Always remember the ECP!

Barrier contraception

Condoms

Male condom — **82% effective,** cheap, available over the counter.

Female condom — **79% effective**, more expensive, available over the counter.

What

- Male condom — latex or polyurethane sheath pulled onto erect penis
- Female condom — loose-fitting polyurethane sheath inside vagina or anus

How it works

- Prevents contact between eggs, sperm and some STIs
- Correct use
  - Worn and removed carefully so contents don't spill. See *Male condom demonstration* (*p356*)
  - 'In date' and stored in cool place
  - Disposed of carefully after use, out of reach of children
    - Bury or burn used condom or put in can and flatten
    - Don't flush down the toilet

Timing — Single use only. New one needed each time they have sex

Who benefits — men and women who want

- STI protection
- Cheap, non-hormonal contraception

Promoting condoms

- Important that condoms are easy to get without shame
- Offer condoms, talk about where they can get more
- Talk with ATSIHPs, appropriate local staff and community members about good places to supply condoms — shop, clinic, garage, council, club, toilets

Special issues

- **Type of male condom**
  - Polyurethane
    - Thinner so may transmit body-heat and sensation better
    - Useful if latex allergy
  - Latex
    - Use water-based lubricant. **Do not** use oil-based lubricant
- **Negotiating use** — men and women may feel shame to suggest or use condoms. Women or transgender people may have little power to negotiate. Try to talk about this
- **Condom uncomfortable**
  - Could be too dry — try lubricant
  - Could be latex allergy — try polyurethane condoms
  - Less sensitivity — try polyurethane condoms
  - Check for thrush (candida) (*p254*) or STI (*p238*)

►

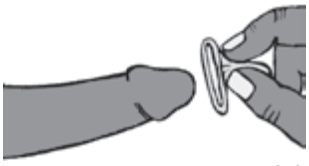
- **Breakage/slippage**
  - Check they know how to use condoms properly. See *Male condom demonstration* (*below*)
  - Check use-by date, packet intact
  - Use lubricant
  - Beware of sharp fingernails/teeth
  - Check size of condom
  - Offer woman ECP (*p353*)
  - Offer both partners STI check – man (*CARPA STM p272*), woman (*p238*), young person (*p243*)

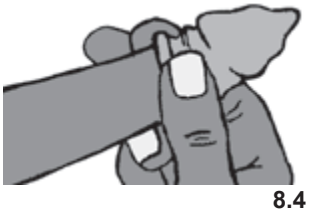
Male condom demonstration

Offer to demonstrate how to use condom

8.2

- Check use-by date — F 8.2. Feel condom packet — should be 'squashy'. Open carefully
- Hold tip of condom, squeeze air from tip — F 8.3
- Roll condom onto erect penis — F 8.4, F 8.5. Show on model of penis
- Use water-based lubricant for anal sex, or if extra lubrication needed for vaginal sex
  - **Do not** use oils or *Vaseline* — weaken rubber


8.3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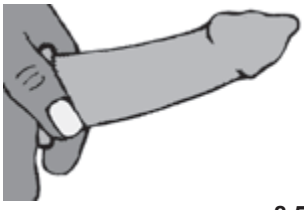
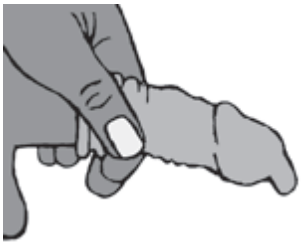

8.5

- After man has ejaculated ('cum', passed sperm) while penis still hard, hold condom on penis, take penis out of vagina or anus slowly
- When penis soft, remove condom — F 8.6
- Tie knot in condom — F 8.7, dispose of carefully
- Wipe excess sperm from penis

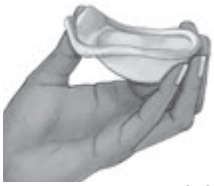

8.6


8.7

Diaphragms

88% effective. Higher failure rates in fertile women
What — dome-shaped silicone cap inserted in vagina. Non-hormonal
How it works — prevents contact between egg and sperm if used correctly
Timing — inserted before intercourse, left in for 6 hours

- Not commonly used by women in remote areas
- If woman would like to try a diaphragm — get help
  - Woman needs informed discussion with knowledgeable practitioner



8.8

Permanent sterilisation

Female sterilisation

99.5% effective

What

- Tubal ligation — cutting or clipping tubes
- Tubal occlusion — blocking tubes with metal spring (eg *Essure*)
  - Not commonly available. **Medical/specialist** consult

How it works — prevents egg reaching uterus/sperm. Periods continue

Timing

- Considered permanent
- Needs effective contraception until done

Operation

- Tubal ligation done by specialist in hospital under general anaesthetic
  - Day surgery — laparoscopy
  - If very overweight — laparotomy, with longer hospital stay
  - During Caesarean section
- Tubal occlusion done by hysteroscopy

Reversal — expensive (thousands of dollars) and may not be successful

Complications of operation — rare. Include anaesthetic risk, bleeding, infection

Preparation — make sure cervical screening (*p289*), STI check (*p238*) up to date

Special issues

- **Talk about**
  - This is permanent — may need several discussions
  - How she might feel later if a child died or she had a new partner
  - Regret is higher in women who
    - Are younger (under 30 years)
    - Have no children
    - Are having an abortion or Caesarean
    - Are having relationship difficulties

Remember: LARC are as effective as female sterilisation, especially ENG-implant (*p343*) and IUD (*p344*), **and** reversible.

Male sterilisation

99.98% effective. Easiest and most effective sterilisation method

What — vasectomy. Cutting, clipping and/or cauterising the sperm tube (vas deferens)

How it works — prevents sperm reaching ejaculate (cum)

Timing

- Considered permanent
- Takes at least 3 months (15 ejaculations) to clear supply of sperm. Effective contraception needed until then

Operation

- Simple, done by doctor/specialist under local anaesthetic
- Complications rare. Include bleeding, infection, swelling

Positives

- Doesn't affect sex drive, erections or cum
- No long-term health issues

Reversal — expensive (thousands of dollars) and may not be successful

Special issues

- **Talk about**
  - This is permanent — may need several discussions
  - How he might feel later if a child died or he had a new partner